Community Mobilization and Home Visits: Key Pillars of the Community-Based Health Planning and Services (CHPS) Program in Ghana

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Introduction

Community-Based Health Planning and Services (CHPS) is a national health program that delivers community-based primary health care services in Ghana. Its main goal is to bring essential services closer to the community and deprived subdistricts. The ultimate aim of CHPS is to achieve universal health care coverage and bridge the equity gap in access to health care by 2030. Community ownership and community participation are key elements in successful CHPS implementation. The on-the-ground CHPS implementer is the community health officer (CHO), who is a trained and oriented community health nurse, midwife, or enrolled nurse. The CHO is placed at a CHPS compound, which serves both as accommodations for the CHO and as the service delivery point for the immediate community. The CHO's main services are home visits, preventive care, health education and promotion, and referral. CHPS provides basic maternal and child health care services and minor curative services.

> "[C]ommunity members are the producers of health, so the traditional approach where we give health services to them is not sustainable, and they don't get involved; that's why we have to live and plan with them, and deliver comprehensive services in a more holistic manner. That is the fundamental principle of the CHPS concept….so that they are no longer passive participants or recipients, but active producers of health."
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> —Regional Health Director, Ashanti Region

CHPS is valued as Ghana's main platform for bringing primary health care services to the entire population. The program caters to rural populations and communities in isolated areas. It is important to the Ghanaian government to continue to ensure quality of care and improvement of service provision within the CHPS program. Toward this end, the Maternal Child Survival Program (MCSP), the United States Agency for International Development's (USAID's) global maternal and child health program, worked with the Ghana Health Service to develop a set of case studies highlighting best practices in CHPS program implementation. The case studies are intended to complement the new national implementation guidelines for the CHPS strategy by highlighting real-life examples of and strategies used in best practice implementation.

Research Methodology

Topic selection: Potential case study topics were developed from best practices identified during the first annual CHPS seminar in 2015. In addition, a review of the literature on community-based primary health care program best practices and the CHPS program was conducted, and CHPS technical experts were consulted to determine key questions and themes that should be emphasized in each case study. The following definition of "best practice" was used: "Processes, tools, principles, or implementation practices that have shown evidence of effectiveness in improving population health when implemented in a specific real-life setting and are likely to be replicable in other settings. Additionally, the practice must meet specific criteria in the areas of relevancy, effectiveness, efficiency, replicability, sustainability, ethical soundness, key stakeholder

participation, and community engagement."[1] Community mobilization and home visits were selected as topics for the case studies.

Community selection: The MCSP team contacted the regional health directors and CHPS coordinators in all five MCSP regions via email and phone to explain the case studies and their objectives. Regional health teams were familiarized with the best practice criteria, and were informed of the goals for each potential case study topic. Regional CHPS coordinators then gave guidance on identifying particular CHPS zones and districts that were known to be implementing best practices in CHPS. (A CHPS zone is "a demarcated geographical area of up to 5,000 persons or 750 households in densely populated areas and may be conterminous with electoral areas where feasible."2) Based on logistical considerations, the Ashanti region was selected for the case studies. The MCSP team actively collaborated with the Ashanti regional CHPS coordinator to identify the two CHPS zones (Abotanso and Nsuaem) that would serve as the settings for the case studies.

Interview procedure: An MCSP team of CHPS technical experts created interview guides based on an interview guide tool developed by the Center for Clinical Management Research (http://www.cfirguide.org/index.html). A different interview guide was designed for each case study and for each type of participant. Questions were designed to ascertain whether the CHPS zone met predetermined best practice criteria and outcomes, as well as to learn details of the best practice and related contextual factors.

All CHPS staff present at each CHPS compound were interviewed. For the home visits case study, five CHPS staff—two CHOs, one midwife, and two nurses—were interviewed. In addition, two district CHPS coordinators and the regional CHPS coordinator were interviewed with the CHPS staff in a focus group format.

The regional health director was interviewed about his views on CHPS at the regional level.

Consent procedure for interviews: In advance of the interviews, the Ashanti regional CHPS coordinator contacted the local CHPS zone staff to notify them of the case studies and obtain verbal consent for the CHPS zone staffs' participation in the interviews. Immediately before the interviews, the MCSP team conducting the interviews again explained the purpose and details of the case studies. A photo consent form was used to obtain consent from CHPS staff, patients, and community members who might appear in photos used in the case studies.

Case study structure: The case studies each focus on an area of "best practice" in CHPS—one on home visits and one on community mobilization. They present the context for and process of implementation, challenges, and what makes the practice a best practice. Finally, the future of CHPS at the community and regional level, including initiatives to improve CHPS, is described.

[1] Ng E, de Colombani P. Framework for selecting best practices in public health: a systematic literature review. *Journal of Public Health Research* 4(3): 2015.
[2] CHPS National Implementation Guidelines.

Case Study 1: Community Mobilization

Abotanso CHPS zone, Sekyere Kumawu district

The CHO hard at work in the CHPS compound in the Abotanso CHPS zone.

This case study addresses community mobilization, one of the fundamental components of CHPS implementation. It shows how community mobilization can be done well and describes the best practices that are currently being implemented in the Ashanti region of Ghana. Community mobilization is needed to encourage a community's ownership and initiative to implement CHPS. This case study was developed in an attempt to answer the following research questions:

1. How can the program effectively enter the community and how can the CHO be integrated into the community?
2. What are the major platforms for mobilization?
3. Who are the key stakeholders involved in this process (i.e., community health committee, village leaders, volunteers, district health management team, etc.)?

Context

The Abotanso CHPS zone serves four communities with a total population of 3,025. The CHPS compound is a temporary building rented with the support of the community. A midwife, a community health officer (CHO), and an enrolled nurse operate out of the CHPS compound. They work as a team to provide health care services to the community.

Implementing Community Mobilization

The CHPS staff who were interviewed described the process of community mobilization, noting that one of the first steps in successful community mobilization—entering the community—occurs when a CHPS zone is started. To establish a CHPS zone, the district health management team (DHMT) must achieve six milestones and complete 15 implementation steps. The six milestones are: planning, community entry, procuring essential equipment, operationalizing the physical CHPS compound, placing the CHO and support staff at the zone, and deploying community volunteers. The implementation steps culminate in the launch of the CHPS zone. All of the steps and milestones are included in the new implementation guidelines for the CHPS strategy.

Potential communities for CHPS zones are selected by the DHMT and the subdistrict health team based on need and other considerations. When entering a community, the district CHPS coordinator and the subdistrict heads visit the community and inform the chief of the purpose of CHPS, why it is important, and the services that CHPS could provide to the community. This sensitizes the community to the CHPS concept. Although the DHMT selects the communities to enter, it is up to the community to make the decision and ask the district to start a CHPS zone to serve their area. Because community members themselves decide to start the CHPS zone, they take ownership of it.

> "You actually cannot succeed in CHPS rollout without community mobilization. Because the basis is the community, and you are planning with community . . . [y]ou are bringing them together in terms of their ideas, as to what is the service gap they want to address, where are the resources to address the gaps identified, who will be responsible for what. With that idea, you need to use community mobilization."
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> —District Health Director

In the Abotanso CHPS zone, a community health management committee (CHMC) consisting of 11 members was established. The members included the assemblyman for the electoral area of the four communities in the zone, representatives of the four communities' independent chiefs, teachers, and church leaders. Members of this committee are most often nominated by the community chiefs and approved by the communities. They are considered to be influential and respected members of the communities, such as leaders of women's groups and other social groups. The CHMC members help ensure that the views and needs of the communities are always prioritized and made known to the CHO. The CHO asks CHMC for resources for organizing events such as durbars.

After community sensitization, a durbar is held to formally introduce CHPS and the CHO and other health workers to the community. A durbar is a traditional event or ceremony that is used in the CHPS context to gather everyone in the community to share news, communicate with community members, and collect input.

Durbars are held every three months in Abotanso CHPS zone, and they serve as the main platform for mobilizing the communities. Minutes are taken during the durbars to keep a record of what is discussed. The CHO updates community members on the state of health within the zone and also gives health talks on issues that are prevalent in the communities. For example, because malaria is common in Abotanso CHPS zone, the CHO often gives talks on malaria prevention. The durbars offer a chance for members of the communities to provide feedback and ask questions about CHPS services.

In addition to durbars, the local CHPS team uses home visits, the community information center, and child welfare clinics for community mobilization efforts. Many communities have a small information center (in this particular community, it is a local radio station) where members of the community can find news posts that give the time and location of durbars and other information about CHPS. The Abotanso zone also has three active volunteers who help disseminate information to the communities. The volunteers also bring information from the communities back to the CHO.

The CHPS team takes advantage of events and gatherings that the communities have organized, using them as opportunities to give health talks or provide services. For example, the CHO and her team visit churches to give family planning talks to men and women. They also visit schools to give talks on family planning to adolescents. This saves time and resources because the CHO does not have to rent a venue and gather people in order to communicate with them. The CHPS staff also take advantage of "taboo days," on which, for

religious reasons, families do not work on their farms. These are good days to conduct mobilization and other CHPS activities because families are likely to be at home.

In order to earn the trust of the community, it is important for the local CHPS team to work with the traditional birth attendant (TBA), who was in the community for a long time before the CHPS zone was started. The CHPS midwife communicates with the TBA, and the TBA notifies the midwife when she learns that a woman is pregnant. Stillbirths and deaths due to birth complications were common in the area before CHPS began. However, the midwife stated in the interview that, since the TBA and midwife have been working together, rates of neonatal mortality in the community have decreased significantly.

> "Home delivery used to be very high; now we work with the TBA, and there is none, they do the deliveries here (at the compound). There is a strong TBA here who conducted the deliveries; the TBA is very influential."
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> —CHPS Midwife

> "Another strength [of CHPS] is giving the patient privacy, and how we relate to the patient. They prefer coming to us than going to other facilities."
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> —CHO

What makes this community mobilization effort a best practice?

- Rapport and trust have been established between the community and the CHPS health workers, with the help of the CHMC.
- There are platforms for feedback and communication between the CHO and the community.
- The CHPS team works with the local TBA.
- The communities are notified of durbars in advance.

Challenges

A major challenge in this zone was the dispute between the chiefs of the CHPS zone's four communities. Each chief wanted the CHPS compound to be located on his land. The dispute was resolved when the district CHPS team and CHO spoke to the chiefs and clarified that the CHPS compound would serve all four communities equally, regardless of where the physical compound was located.

> "Communities have their own ways of life, especially where you do not have one chief for a community (i.e., one compound serves four zones, where each zone has a different chief). You have to engage all the chiefs that are there. Where there are chieftaincy disputes, you have to engage the assemblyman and opinion leaders. Sometimes it takes time and you have to do consultations."
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> —District CHPS Coordinator

Another challenge mentioned by the CHPS staff was getting community members to participate in durbars. To address this issue, the CHPS staff started making an extra effort during home visits to explain the importance and value of community members' contributions to and feedback on CHPS functioning.

The durbars are challenging to organize because they require a lot of resources, but the CHO feels that they are the most effective way to communicate with the community and give health talks. CHPS staff must find chairs for the durbars and make arrangements to gather in a space within the community. Community members attending the durbars sometimes expect to be offered refreshments at the durbars, but the CHPS staff do not always have funds to provide them. In the interview, the CHO reported that she feels comfortable asking the community and the CHMC for things she might need for the durbar, such as extra chairs.

Looking Ahead

The CHPS staff commented on their hopes for CHPS in their community and future goals:

- Specialists and other CHPS experts to come to future durbars as guest speakers
- Continuing to save on costs of community mobilization efforts by using community events and gatherings to conduct CHPS activities

In the Abotanso zone, community mobilization has been and continues to be a major factor in making CHPS successful across the communities it serves. With successful community mobilization, the communities feel ownership of CHPS and have taken the initiative to continue to support it, and this makes CHPS an integral and sustainable part of the communities it serves.

Case Study 2: Home Visits

Nsuaem CHPS zone, Bosome Freho district

The Abotansu CHPS team—community health officers (CHOs), midwife, nurses, district CHPS coordinators, and regional CHPS coordinator—in front of their CHPS compound.

This case study addresses home visits, one of the fundamental components of CHPS implementation. It shows how home visits can be done well and describes the best practices that are currently being implemented in the Ashanti region of Ghana. In a home visit, health promotion, education, referral, follow-up, and community mobilization are the primary activities. This case study was developed in an attempt to answer the following research questions:

1. How can home visits be used as an effective community health tool in CHPS?
2. How can CHOs prioritize activities efficiently with respect to both routine and special home visits?
3. What is the role of volunteers in supporting and conducting home visits?

Context

The Nsuaem CHPS zone is located in the Bosome Freho district in Ashanti. The zone serves a population of 3,531 in two communities. The CHPS zone has five staff members: two CHOs, one midwife, and two nurses.

Implementing Home Visits

Two CHPS staff conduct home visits every day in the Nsuaem CHPS zone communities. The CHPS compound has one motorbike that the staff use to travel to households. The first thing the local CHPS staff team does each day is plan their itinerary. They determine the geographic area and specific households they would like to visit and then plan the logistics accordingly. They document their visits in daily and weekly calendars.

Each household in the communities receives a routine visit at least once every three months, and because home visits are conducted every day, some households are visited more often than once every three months. The Nsuaem CHPS has two CHOs, so one CHO and the nurse or midwife can conduct home visits while the other CHO stays at the compound to provide services. Staff make special household visits whenever there is a need. Special clients are identified during routine visits in the community; they include but are not limited to TB clients, diabetics, pregnant women, children under age 5, and malnourished and anemic children. For example, TB clients are visited every day to ensure that they adhere to their daily medication regimen. The staff also regularly contact the families of special clients to give them reminders about the client's medication. When special clients are identified, they are entered into a special register, which the CHPS staff use to document information about the clients and to monitor their status. Child welfare clinics are held in the community to help identify children who are malnourished.

> "There is a saying that 'prevention is better than cure.' If we don't go to the community to detect what is actually wrong with the community members, they will be falling sick very often. If you are to practice CHPS as a CHO, you have to stay with the community and live with the community members. It's not staying at the clinic and rendering services… As part of CHPS implementation, we have to let the home visits be more on our schedules, so we can render services to the community."
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> —CHO, Nsuaem CHPS zone

Clients are referred to higher levels, such as health facilities or hospitals, when the care they need is beyond what the CHO can provide at the CHPS level. The CHOs and nurses at Nsuaem follow up with referred clients after they are discharged. They find out what happened at the referral facility visit and ensure that the client follows any treatment regimen they were given. Occasionally the CHO or nurse will accompany a client to the referral facility.

The CHPS staff contact households in the community in advance of home visits to ensure that the family is at home. If they are not home, the schedule is adjusted. During the home visits, the CHPS staff establish rapport with the family and inform the household of the purpose of the visit. They observe the environment and assess the client's well-being. It is important that they learn the household's health behaviors and practices, speak to the family about their good practices they are doing, and educate them about good practices that they might not be doing. Information about the home visits, including the type of visit, the date, patient information, and what occurred during the visit, is documented in a home visit book. The book includes space for feedback from the patient.

WhatsApp is the communication tool used to communicate across all CHPS levels. There is a WhatsApp group that all health workers across the district and region can use to ask questions and share ideas and events from their own zones. In the Nsuaem zone, for example, the CHO used the WhatsApp group to contact a nutritional specialist for advice on caring for a malnourished 12-year-old boy. The CHO took a photo of the child and posted it on the group site to show the nutritionist what the case looked like. The nutritionist responded right away, and the CHO was able to share the advice he received with his staff. He then gave the child the needed care and advised the family on what to feed the child, based on what he learned from the nutritionist. Because this communication occurred on the WhatsApp group site, other CHOs and health staff from other zones in the district could read and learn from the case, and can apply this knowledge in the future if a similar case occurs in their zones.

A sense of team spirit and passion was evident in this zone. One of the CHOs had recently attended a refresher training where they learned how to improve practices for home visits. The training helped the CHPS staff understand that home visits should be made a priority in their activities. It was also clear that there is good communication between the CHPS staff at the community level and those at the district and regional level. Good communication contributes to better morale among the CHPS staff, making them more comfortable and confident in asking for assistance and doing their work.

What makes home visits a good practice?

- Home visits are conducted daily; households are notified in advance of a home visit.
- All special clients are identified and monitored.
- Registers are used to document home visits, and they include space for feedback from the client.
- WhatsApp is used as a communication and education tool for CHPS staff across all levels, allowing easy access to specialist advice.
- A sense of team spirit and passion pervades the CHPS staff.

Challenges

One of the challenges that CHPS staff have encountered when educating others about family planning practices is that men in the community do not always accept family planning methods. The CHPS staff must take time and be persistent in communicating about family planning, explaining that the advantages outweigh the disadvantages, and trying to clear up misconceptions.

Another challenge is that sometimes a woman's family or husband does not allow her to access family planning methods. In these situations, the CHPS staff try to keep the woman's visits (whether at the compound or at home) secret. They do this by leaving the woman's family planning card at the compound when conducting a visit at the woman's home. The woman's household is only told of the date of the woman's visits; the services that are given during the visits remain confidential.

Thus, good communication and taking the time to understand the client's concerns are important ways to effectively address a client's needs.

Looking Ahead

The CHPS staff are currently in the process of setting up a community emergency transport system, which will include a fund for disadvantaged families in the community who cannot afford to pay for transportation. A letter has been written to the local municipal party member to ask for additional funding to set up the emergency transport system. In addition, advocacy efforts are under way to encourage the CHMC to procure another motorbike for making home visits as well as standard medical bags for the staff and other needed materials.

The Future of CHPS in Ashanti Region

Beyond the best practices described in these case studies, the Ashanti region is also expecting to implement new initiatives in the near future that will improve CHPS effectiveness across the entire region.

The Nsuaem CHPS zone is part of the pilot districts in Ashanti region that are expected to implement telemedicine within the next year to further improve CHPS effectiveness. Qualified and trained nurses and specialists will operate a "Tele Consultation Center" 24 hours a day. If a CHO is conducting a home visit and encounters a case in which they need more information or need to refer a client, they can call the center for an expert consultation. This will enable the CHO to address the case right away, without referral. If the client needs additional care, an ambulance will be called immediately.

The Ashanti region is also training volunteers to become community health workers (CHWs). CHWs receive an additional orientation and are paid a salary. The CHW cadre will bolster the workforce in CHPS zones. They will be integrated into the CHPS system and will be responsible for conducting their own home visits. If CHOs or CHPS staff are not able to visit a household every three months, a CHW will visit the household and report back to the CHO. This will ensure that every household in the community is visited at least the requisite number of times per year.

Finally, in an effort to further strengthen and prioritize CHPS, Ashanti will hold a regional CHPS forum for the first time this year to share and showcase good practices and ideas across all districts.