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PROGRESS OF COMMUNITY-BASED HEALTH PLANNING AND SERVICES IN GHANA

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Key Words: Community Health, CHPS zone, Functional CHPS, Service Delivery, Community Mobilization

ABSTRACT

Background: *Community-based Health Planning and Services (CHPS) is a national Strategy to deliver essential community-based health services involving planning and service delivery within the communities in Ghana. Ghana has an organized official policy and guidelines in implementing contextualized and country-specific primary health care at the lower level. Health managers have traditionally been unaware of programme financial needs, funding sources, funding gaps, and the resources needed to sustain programme trajectory. This lack of economic and financial data has thwarted resource mobilization efforts and contributed to inefficient spending and unsustainable programme financing. To sustain the improvement in health service delivery under the Community Health Planning & Services system, the Government of Ghana (GoG) has prioritized development of a business plan that enables a clear roadmap for the mobilization, allocation, and management of financial resources. The objectives of this article however, is to discuss the overview of CHPS and how it has influenced health outcomes in rural Ghana. The article also brings out some best practices documented over a decade scale up of CHPS implementation and the business case developed for future investment in CHPS.* ***Methods:*** *Secondary data was used. Programmatic and cost data originated from CHPS zones, donors, and private sector partners that was used by Douche and Delloite to estimate the investment case for CHPS. Regular regional, district, sub-districts and CHPS zones monitoring reports were also accessed and analysed.* ***Results:*** *Analysis reveals that CHPS services are underfunded, jeopardizing progress made to date and unlikely sustainability. Secured funding for CHPS services varies greatly across regions analyzed. Underfunding of CHPS services results in financial instability and significant programme vulnerabilities, and even the most securely-funded programme is not fiscally independent. Similarly, the findings show that, the value of CHPS is enormous with positive health outcomes.* ***Recommendations:*** *The business plan should be considered as a necessary framework for short-medium- and long-term planning, augmenting capacity development in strategic social partnership and advocacy. Widespread analysis and use can increase domestic resources and opportunities for benchmarking, reduce donor dependence, and contribute to attaining Universal Health Coverage (UHC) and bridging the access inequity gap by 2030.*

INTRODUCTION

Ghana's health system has over the years been premised on the basic healthcare model with a network of health posts and dispensaries at the lowest level, linked to health centers, polyclinics and hospitals. In 1977 Ghana adopted a strategy of service delivery at the community level using Community Health Workers called Community Clinic Attendants and Traditional Birth Attendants. This preceded the Alma Ata Declaration in 1978 of 'Health for All by year 2000' that focused on Primary Health care (PHC). Primary Health Care in Ghana was designed at the district level as a 3 tiered system: Levels A, B and C. These three levels were designed to work seamlessly to provide the appropriate quality primary health care services supported by a system of referrals to the appropriate levels of care when needed.

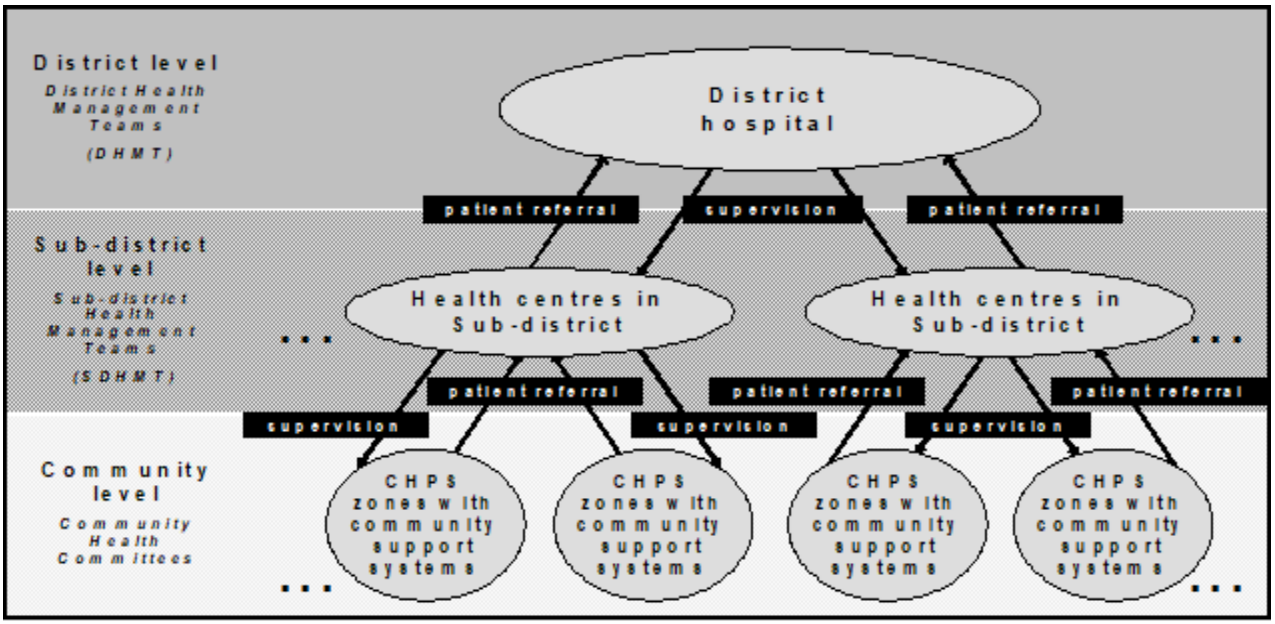
The Apex (Level C) is at the District Hospital and the District Health Administration. Management at this level works with the local government and the decentralized agencies and they are responsible for planning, supervision, monitoring and coordination of health service delivery in the district. The District Hospital provides the first level of comprehensive health care managed by all categories of health workforce.

The Sub-district (Level B) plans, monitors and supervises the implementation of community based service delivery within the sub-district. This level is also responsible for providing direct supportive supervision to the Community Health Officer (CHO) who is also a trained Community Health Nurse(CHN).

The Community level (Level A) is organized to bring services close to the community members. At the community level the CHO works alongside communities to achieve basic primary health care objectives. Together they are responsible for close-to-client health service delivery that includes clinical care for minor ailments, as well as preventive and promotive service, delivered through house to house visits and emergency service delivery at CHO residence

Interactions among the various levels ensure a seamless and effective functioning of the Primary Health Care structure and system through a well thought and designed referral system despite current challenges. Each level, with the appropriate resources available to it, will manage the health conditions presented to it and refer to the higher level if the condition is beyond their mandate.

Figure 1 District Health System in Ghana (Primary Level)



Source: Ghana Health Service, 2016

PHC was the bedrock of the first Medium Term Health Strategy and the Sector-wide Approach leading to over 40% of the discretionary sector budget consistently being allocated to the district and sub-district levels. Since then the Ghana health sector has continuously worked on strategies for delivering care direct to communities. Over time Community-based Health Planning and Services (CHPS) has emerged as the main strategy providing close-to-client health care delivery to the rural poor who form 70% of our population.

National efforts to address geographic and financial barriers to accessing quality health care over the years are beginning to yield results.

a. There has been significant reduction in child (under-5) mortality (111 per 1,000 live births in 2003 to 82 per 1,000 live births in 2011) and maternal mortality (740 per 100,000 live births in 1990 to 350 per 100,000 live births in 2010) and most recently in from 2007-2017 310/100,000 LBs. The major driver for high under-five mortality is stagnation in the reduction of neonatal mortality (32 per 1000 live births) and this is responsible for 40 percent of under-five deaths.

b. The proportion of OPD attendance by insured clients increased from 55.81% in 2010 to 82.11% in 20.11, OPD per capita increased from 0.98 in 2010 to 1.07 in 2011, with CHPS contributing approximately 5% to the total OPD attendance countrywide. There has been a corresponding progressive and significant increase in IGF from increasing attendance of insured clients at GHS facilities. During 2011, attendance of insured clients at GHS facilities contributed to more than 80% of their total IGF after suffering a dip in 2010 (72%) in comparison to 77.9% in 2009.
c. The safe motherhood indicators show fairly sustained ANC coverage over the three - year period being reviewed that is, 92.1% (2009); 93.3% (2010) and 94.4% (2011). This has been in spite of the proportion of clients achieving the 4+ visits, which has continued to decline from 88% (2009); 82.4%(2010) and 74.9% (2011). The national rate of skilled delivery has continued to improve from 45.6% (2009), 49.5% (2010) to 52.2% (2011).
d. With the national target at 90%, national performance in immunization, as measured by Penta-3 coverage, continued its decline for a second year running, dropped from 89.3%(2009) and 87.1% (2010) to 85.8% (2011).

It estimated that up to 80% of illnesses could be prevented by the combination of improved nutrition, adequate clean water supplies, education on personal hygiene, family planning, vaccination services, treatment of common ailments and injuries. These are the main activities of the Primary Health Care (PHC) System. However, there exists significant inequity in access to health services between the rural and urban population. To bridge the inequity access gap, CHPS was introduced and up to date it has remained relevant in Ghana's quest to live no one behind in the SDGs era.

Objectives

The objectives of this article include:

1. Discuss the overview of CHPS implementation
2. Discuss some documented best practices and value of CHPS
3. Post CHPS verification and implications for policy
4. Provide details of financial estimates needed by government to implement CHPS and discuss issues of sustainability

MATERIALS AND METHODS

Secondary data and desk review of published paper, articles were used. Programmatic and cost data originated from CHPS zones, donors, and private sector partners that was used by Douche and Deloite to estimate the investment case for CHPS. The author also used his experience in the field trough periodic regional, district, sub-districts and CHPS zones monitoring reports to inform the discussions.

Overview of CHPS Implementation

Ghana's CHPS program can be likened to that of Tunia where the 'Citizens' Jury' is part of a new Social Dialogue Programme supported by the WHO through the Universal Health Coverage Partnership. This Programme builds on evidence-based research, coupled with workshops, focus groups, and town hall meetings. As quoted by Dr Marie-Paule Kieny, Assistant Director-General at WHO, where he explained that: "Involving the community is part of a people-centred approach to health systems that aims to motivate individuals to make decisions about their own health – making health systems more efficient and effective." (WHO,2014)

Ghana has been implementing the Community-based Health Planning and Services (CHPS) program for over 15 years. In 2008 a new terminology "functional" was defined and added to the demarcation of CHPS zones. It was then generally accepted that it is not mandatory to have a purpose-built CHPS compound in implementing CHPS
(GHS, 2013). The geographical demarcation for a CHPS zone was changed in 2010 from Size of Population or Unit Committees to be conterminous with electoral areas. This new definition gave way for CHPS zones to be demarked in line with electoral areas. This has ensured that service delivery at the periphery increased and made available and accessible to the people.

In 2000, work began on scaling up the CHPS strategy, but was initially limited by resource constraints. The Ghana Macroeconomics and Health Initiative (GMHI, 2005) and the opportunities presented by funding made available from the debt relief under the World Bank Highly Indebted Poor Countries (HIPC) initiative provided impetus for scaling up. The backdrop to this was worsening health status indicators, increasing cost of care and limited access to any kind of health services. A twin track strategy was envisaged which was to remove both the financial and geographical barrier of access to care. The National Health Insurance Scheme (NHIS) was seen as the social intervention to address the financial challenge and CHPS was to address the geographical barrier by making basic services available "close to client".

Regional distribution of CHPS Surveyed

Region	Number surveyed	Percent
Ashanti	1097	18.5
Brong Ahafo	742	12.5
Central	352	5.9
Eastern	786	13.3
Greater Accra	572	9.7
Northern	493	8.3
Upper East	337	5.7
Upper West	297	5.0
Western	600	10.1
Volta	642	10.8
All Regions	**5918**	**100**

Regional Distribution of CHPS

The recent CHPS Verification survey conducted by the GHS revealed that we have a total of 5,198 CHPS zones across the country. Similarly, the results revealed various status of infrastructure and equipment availability across the regions.

Source: GHS CHPS Verification Survey (2018)

Table 4.1: CHPS Infrastructure Availability in Ghana by Region

Indicator	Ashanti	Brong Ahafo	Central	Eastern	Greater Accra	Northern	Upper East	Upper West	Western	Volta	All Regions
CHPS with an operating site	52.4	72.9	90.3	76.6	51.7	81.7	**91.7**	85.9	85.7	73.7	72.4
CHPS with purposefully built compounds	13.2	27.7	59.1	36.1	7.9	55	64.4	**74.7**	34	36	34.3
CHPS built by Government	15.2	16	14.4	12	11.1	14	12	4.5	8.8	**20.3**	12.9
CHPS built by District Assembly	44.8	46.6	53.4	35.2	35.6	60.5	**70.5**	54.1	30.4	36.8	47.8
CHPS built by NGOs	20.7	13.6	20.7	**31.3**	17.8	12.5	8.8	36.9	21.1	25.1	21.3
CHPS built by philanthropists	6.2	2.9	4.8	3.2	0	2.6	1.4	0.5	**6.4**	6.1	3.5
CHPS built by community	42.1	22.3	26.9	**48.9**	15.6	7	19.4	7.7	46.6	36.8	27.9
CHPS built by Other agencies	7.6	2.4	4.8	7.7	**22.2**	8.5	3.2	2.3	15.2	5.2	6.7
Avg. # of staff accommodated at CHPS	2.1	1.9	2.2	2.1	2.2	2.2	**2.3**	2	2.1	2	2.1

Source: GHS CHPS Verification Survey (2018)

Value of CHPS

Political: provide a link between politicians and the people, encourages the response the people's will and needs and the implementation of the "national health agenda" within a national development policy. Promotes political will and cooperation between government agencies, traditional authorities and private sector.

Economical: engenders the need for Financial Authorities / Private Sectors/ People to cooperate by focusing on strengthening prevention and health promotion and operation at community-level. Create healthier workers, increases opportunities of gaining productivity of society by investing in prevention and health promotion which is beneficial to the private sector and the people. Prevent Future burden (promote healthy life and health life expectancy, cost effective in preventing future medical expense).

Social: promotes People-centred health services, and is close to where people live people. CHPS Creates opportunities for empowerment and ownership and managing health by people (e.g. CHMC). • Facilitate developing a resilient health system in the community • Engender community participation in health, one of the pillars of primary health care. • CHPS

promote shared responsibility and ownership of community members in their own health. • Change community people's life style.

Technical: Address inequity in health systems, improves access to health services, and develop resilient community-based health service by responding to new health challenges based on a life-course approach. • Promote care for the aged • Collect health care data (collect community's information on health issues, strengthen health research capability in Ghana).

National Security: contributes to health security. Community health is the bedrock of responding to the epidemic / disaster reporting from the community and the lowest level health facilities i.e. CHPS Detect major challenges at the early stage and plan ahead of time. Contribute significantly to national health preventive and promotive efforts in the communities where people live.

Global: Potential to make Ghana a leader in Africa as a showcase to address Post MDG as well as SDG which other African counties have not experienced.

Progress in CHPS implementation

The main activities of CHPS implementation were centred on Service Delivery, Supply of equipment, Health Financing, Construction of CHPS compounds and Human Resource for Health Development as per the strategies outlined. Based on the strategies mentioned above there was a national consensus to have a standardized design of the CHPS compound which was approved in 2016. The compound consists of a one-bedroom semi-detached apartment for staff and a clinical area for service delivery. The first prototype was built in Korlenu CHPS in the Afadjato district of the Volta region. After the construction, the feedback from users indicated that the sizes of the rooms were too small. Similarly, based on the CHPS policy at least three staff should be posted to a CHPS zone which therefore requires additional room. Following this feedback, the Ministry of Health has reviewed the design and now have two-bedroom for the senior staff and one-bderoom semi-detached for the two-junior staff.

On service delivery, all functional CHPS zones have been reactivated to provide the minimum service package as contained in the revised policy document with funding from a World Bank loan and Trust Fund. This has led to increase of the functional zones from 2,948 in 2014 to 4007 in 2016 an increase of 1059.(GHS, 2016)

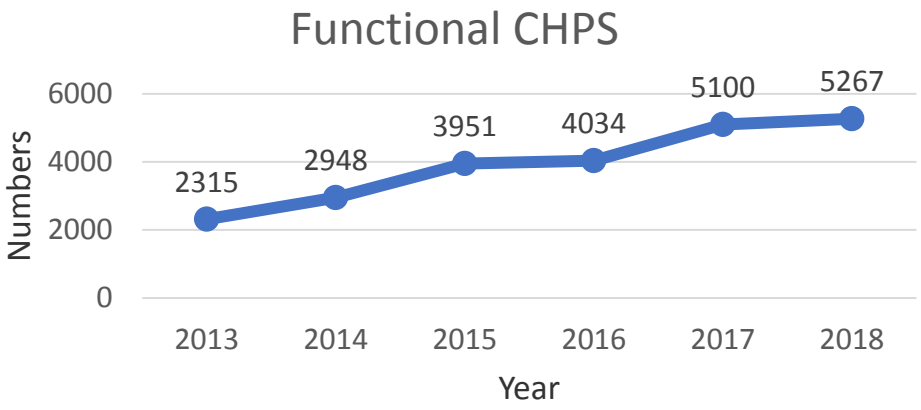
Through the Maternal, Child health and nutrition improvement project(MCHNP) still under the World Bank loan, funds have been provided for all the functional zones in order to carry out their routine activities. Equipment and logistics supply have been provided to some districts while procurement of medical equipment and vehicles are ongoing.

Over the last decade, the Government through a deliberate policy increased pre-service training and development of Community Health Nurses and Midwives to manage the CHPS zones. In-service training has also been a major activity to orient all health care cadres about the CHPS concept. Over 2000 staff have benefited from this training across the country. Again, the Ministry through the collaboration with the Nursing and Midwifery Council have introduced CHPS into the training curriculum for the training of nurses and midwives which has been made examinable. A CHPS training manual and workbooks have been developed for all aspects of tailored training for staff

Advocating and Refocusing for CHPS implementation: The Ministry of health and the implementing agencies continue to have also placed more value and emphasis on the CHPS concept thereby receiving local and international buy-in by key strategic partners and stakeholders. A nationwide dissemination of the revised policy is also on-going.

Developing community level actions for effective CHPS implementation: Community sensitizations exercises have been done ensuring that all communities participate in the development of Community Health Action Plans

(CHAP) through Community Health Committee and community durbars. This has led to some individuals in the community to donate their homes for service delivery while some constructed new buildings for CHPS.



Source: MoH, 2019

The figure above shows how we have come with making all the demarcated CHPS zones functional across the country. The graph shows a constant increase in functional zones which depicts a very positive indication of bridging the access gap in terms of service delivery to the population.

Regional Distribution of CHPS

The recent CHPS Verification survey conducted by the GHS revealed that we have a total of 5,198 CHPS zones

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across the country. Similarly, the results revealed various status of infrastructure across the regions.

Source: GHS CHPS Verification Survey (2018)

DISCUSSIONS

Leadership and Governance

There is a leadership and governance framework with a national steering committee on CHPS and Technical Working Group in place. These two national groups have oversight responsibilities with specific terms of references to ensure CHPS is effectively implemented. There is a National CHPS coordinator at the Ministry and a coordinator at the Ghana Health Service Headquarters (main implementing agency) with Regional, Districts, Sub-district CHPS coordinators. The community members are not left out. We have Community Health Volunteers who support the community health officer. We also have Community Health Management Teams in place. Roles of key stakeholders have been outlined in the implementation guidelines. Different resources are required at different stages for the effective and efficient implementation of CHPS. A combination of these resources is necessary for effective functioning of CHPS. CHPS implementation essentially is dependent on effective leadership and governance from the national to the community level coupled with provision of basic medical equipment, reliable means of transportation for outreach services and incentive for staff.

REGISTRATION, LICENSING AND CREDENTIALING OF CHPS

Evidence available from MoH monitoring to the regions emerged that a lot of the CHPS zones and compounds have not been credentialed by the NHIA and accredited by the Health Facility Regulatory Agency(HeFRA). This situation affects access to healthcare at the CHPS zones. One of the concerns raised is inability of the CHPS zones to pay for the cost of credentialing because; CHPS zones do not make any profits since their activities are more of health promotion and prevention.

One of the recommendations that have come up is whether or not we could waive the process of credentialing at the CHPS level so that once the Regional Director has approved for a zone to be functional with all the necessary steps fulfilled, a letter through the Director-General to the NHIA should be adequate enough to get approval from NHIA. Otherwise, our inability as a sector to ensure this issue is resolved; will provide the fertile ground for staff at CHPS zones to continue to charge the vulnerable group for accessing services at CHPS zones thereby defeating the very purpose of providing free services to our people at CHPS zones. The CHPS report revealed that about 60% of CHPS zones do not generate revenue internally. The question is, how do the zones raise funds for credentialing and registration? This question is still lingering with no concrete answer or solution from the decision and policy makers. Can we look at a more flexible system of getting the registration and accreditation of the CHPS zones which also is a requirement for NHIA credentialing? These two key statutory requirements have financial implications on CHPS zones.

Service Delivery at CHPS level

CHPS is close-to-client intervention aimed at bridging the inequity access gap and attaining Universal Health Coverage. Since the implementation of CHPS in 2000 a lot of progress has been made. CHPS contribution to service delivery in the country is very significant. Currently we have over 6445 demarcated CHPS zones of which 5,987 have been made functional through the deployment of Community Health Officers, supply of basic equipment and provision of means of transport. The implementation of CHPS has produced some positive results as the proportion of their contribution to service delivery increased (GHS Annual Report, 2016). In 2015, CHPS contributed 8.1% to total OPD attendance with the highest coming from the three northern regions. CHPS also contributed over 36% to immunization using penta 3 as proxy indicator. CHPS contribution to family planning was also over 25% coverage rate (GHS, 2015).

The CHPS verification survey done in 2018 also revealed that, based on the minimum package of service,

- CHPS is providing 52.5% of all Ante Natal Care(ANC) services
- Contributes 54.7% of Post Natal Care(PNC) services
- More than half of CHPS zones lacked official registers
- Contributes 33% of Family Planning services
- Constitutes 51% of Expanded Programme in Immunization(EPIs)
- Catchment population for most CHPS zones are not in line with the CHPS policy
- The dynamics of CHPS coverage in urban communities is still not clear

Implications

PNC and ANC coverage is critical in reducing maternal and child mortalities. The percentage coverage as stated above means that, a good number of pregnant women are not having access to maternal and child health services at the CHPS level. This has serious implications on deprived and hard to reach communities in the country. There is the need to increase ANC and PNC coverage in areas with low percentages.

Proportional Contribution of CHPS to health sector

	Service Category	2017 %	2018 %
Curative	OPD Attendance	9.24	9.48
	Skilled Delivery	5.92	7.08
Preventive	FP Acceptors	31.24	32.62
	Immunization Coverage (Penta 3)	48.84	50.84
	ANC Registrants	15.17	15.80
	ANC Visits	11.28	11.97
Promotive	Community Durbars		1567(95%)

As parts of efforts to improve referral systems and emergency response from the primary care level, innovative interventions dubbed "Community Emergency Transport Systems (CETS)' have been explored in some parts of the country with support from development partners. This led to the introduction of Tricycles as ambulance vehicles that transport emergency cases from CHPS zones to the Health Centre level and up to the District Hospital. These interventions have improved referral systems and reduced the second delay of causing mortalities in vulnerable communities.

Human Resource

Over a decade now, Ghana has made great strides to improve on her workforce

- CHPS with trained CHOs was 41% as national average
- Average number of trained CHOs as 0.7% national average
- CHPS Staff Trained as CHOs as 26.6% national average
- CHPS with Midwives (14.8% national)

The results have the following implications:

1. Has implication on competency and skills levels of CHOs at CHPS and their ability to implement the policy directives and fundamental principles of CHPS, most especially engaging and working with the community.
2. We need to speed-up the training of the remaining Community Health Nurses(CHNs) who have not been trained under the MCNHP training plan by Ghana Health Service
3. It also means that we have to deepen the collaboration between Service Agencies and Pre-Service Health Training Institutions.
4. Deliberate efforts need to be made to increase the numbers of midwives at CHPS zones based on specific contexts.

Infrastructure and Equipment

Following the revised CHPS policy in 2016, over 1000 CHPS compounds have been constructed with one prototype of the approved standardized CHPS compound constructed at Korlenu in the Afadjato District of the Volta Region.

3D Impression of the CHPS Compound

First Korlenu CHPS at construction stage in the Volta Region of Ghana.

Source: MoH CHPS Monitoring Report (2017)

Medical Equipment, Motorbikes, bicycles and Vehicles have been procured and supplied to a number of Districts and CHPS zones across the country. For instance, in 2018, JICA through its sector budget support to Ghana procured the following to augment CHPS implementation in the current Five Northern Regions:

Description of Items	**Quantity**
4x4 Double Cabin Pick-Ups	26
Station Wagon	4
Heavy Duty Bicycle	1000
Motor Cycle	300

The cost of these items amounts to Five Million, Seven Hundred and Fifty-Two Thousand, Seven Hundred and Seventy Ghana Cedis (GHS5,752,770.00).

Again through the World Bank Maternal Health, Child Health and Nutrition Improvement Project, 50 pick-ups vehicles, 6 Station Wagons, 300 motorbikes and 1000 bicycles are being procured for distribution in all the sixteen regions of the country. A number of CHPS compounds have also been built by the USAID, JICA and more refreshingly our respective District Assemblies in all the regions.

The table below gives a snapshot of CHPS compounds availability in all the regions

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CHPS built by District Assembly	44.8	46.6	53.4	35.2	35.6	60.5	**70.5**	54.1	30.4	36.8	47.8
CHPS built by NGOs	20.7	13.6	20.7	**31.3**	17.8	12.5	8.8	36.9	21.1	25.1	21.3
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CHPS built by Other agencies	7.6	2.4	4.8	7.7	**22.2**	8.5	3.2	2.3	15.2	5.2	6.7
Avg. # of staff accommodated at CHPS	2.1	1.9	2.2	2.1	2.2	2.2	**2.3**	2	2.1	2	2.1

Source: Ghana Health Service, 2018

The CHPS verification however revealed that

- Numbers of CHPS with compounds – 2,030 (34.3%) out of which 47.8% were built by District Assemblies
- Number of CHPS without compounds stood at 3,888
- CHPS built by Central Government **constitutes 12.9%**
- CHPS built by District Assembly constitutes 47.8%
- Purposefully built CHPS compound comes to 34.3%
- The rest of the CHPS were built by NGOS and our development partners
- And about 30% of CHPS zones had no specific operating site
- Tablet for Data Collection (3.8% national average)-Upper-West and Western regions have nothing
- Motorbikes for CHOs constitute 23.4% as national Average
- Cold Box availability is 28.8% national Average
- Vaccine fridges availability was 21.7% national average
- Home Visits Bags availability constitutes 46.9% on national average

Implication: The CHPS policy directs that the central government shall be the major financier of CHPS implementation. As a result, it was agreed that at least, annually 250-300 CHPS compounds should be constructed in deprived areas. As per the above data, majority of the CHPS compound were built by the District Assemblies. In most instances, they only construct the structures without equipment.

This phenomenon has left a number of such CHPS compound lying idle. The situation has effects on output and outcome indicators for access to healthcare services in the country which also affects staff morale in the execution of their duties. The MoH monitoring visits to some regions also revealed that in places where motorbikes were absent, staff use their personal funds to board taxies to provide services at outreach points. In most instances, those points are abandoned for a period. This year 2019, the MoH is constructing about 40 CHPS compounds across the country.

The CHPS policy had prescribed the type of equipment needed in CHPS compounds for effective service delivery. Unfortunately, more than half of the zones don't have all the required equipment. CHPS contributes about 51% of EPI services yet the logistics such as cold box and vaccine fridges availability is less than half in the CHPS zones. These situations only jeopardize the effective and efficacious delivery of immunization services. The implications are that service delivery and coverage in these zones will decline. There is the need to secure and supply equipment to zones in deprived communities.

Financing

As part of sustainability of the CHPS concept, the ministry through the support of JICA has engaged a consultant to develop a CHPS business plan aimed at attracting investors.

A CHPS business plan has been developed for financial sustainability. The purpose of the business plan is to attract strategic investors to invest in CHPS scale up through the construction of CHPS compounds, supply of basic equipment, capacity building for staff and provision of transport.

Community participation and ownership is key to primary healthcare. Some communities become very interested and take responsibilities for their own health. Issues of healthcare quality and accountability at the community level help to improve health systems. Community mobilization of resources and leveraging the utilization of social capital of individuals, families and organizations is very fantastic. We have documented instances where some individuals have constructed and donated completed structures and supply of equipment due to CHPS activities.

An analysis of cost for running CHPS was done as a guide for planning and providing the appropriate annual budget for the sustainable implementation of CHPS. The cost for a nationwide implementation of CHPS considering the optimal package of services, human resources, infrastructure and equipment including maintenance, financing and supervision, monitoring and evaluation is estimated at GHS 247,236 of Operating and GHS 530,020 of investment costs per zone.

The Unit costs build-up (as shown below) can be used by MOH and its agencies to develop a costed plan for national CHPS scale-up, which can be used to advocate for financing from the private sector, GoG and Development Partners (DPs). The costed plan could present estimates for different CHPS implementation realities.

CHPS Compound Running Cost	**Expenditure/month**
Security services	3,600
Stationary / Office consumables (A4 sheets, pens, pencils etc…)	960
Repairs and maintenance of general equipment	7,200
Postage and delivery	960
Communication	2,480
Internet	1,200
Electricity	5,746
Water	1,584
Rent (office space + accommodation for CHOs)	3,000
Photocopy	600
Allowance for the CHV (GHS350 *2 CHV)	7,200
Miscellanous	2,400
Total	36,930

Source: MoH, 2017

Capacity Building

Monitoring and Evaluation

CHPS is Effective because it ensures judicious and direct use of resources at the lower levels with the community playing a major role in the management of health. It also ensures leadership and accountability. CHPS implementation is efficient through Regular facilitative supervision from the regional to district to sub-districts and the CHPS level ensuring that standards, policy directives and guidelines are adhered to. CHPS Relevance cannot be underestimated since it remains the key strategy of Ghana in attaining Universal Health Coverage including financial risk protection, quality of care, supply of essential and safe quality medicines for the poor and vulnerable, and bridging the inequity access gap.(WHO, 2013).

There are still some limitations regarding the scale up of the CHPS program which include inadequate basic medical equipment supply, training gap for CHOs and inadequate transport systems.

The results as presented have implications on the degree of attaining the Sustainable Development Goal 3 for Ghana and the need to redouble ourselves as a country to overcome factors militating against Universal Health Coverage.

Challenges

- Prioritization and funding of high-level activities over providing the basics that is needed for service delivery by CHPS
- Inadequate equipment and logistic to make more CHPS zones functional
- Inadequate funds for service delivery- fuel for outreach, maintenance of motorbike, compounds etc.

- International potentially distractive programmes with potential of diverting funds from CHPS implementation. Ethiopia model, Community Management of Childhood Illnesses, 1 million CHW Project etc

Conclusions

The Achievement of the Community-Based Health Planning Services (CHPS) policy is a key policy priority in the Health Sector of the Ghana. The Agenda for transformation and Ghana beyond aid should identify equity gaps in health care delivery to ensure prioritisation and adequate allocation of resources for preventive and promotive health which are equitable, accessible, quality and affordable for all people resident in Ghana.

Recommendations

Moving forward, all relevant and key stakeholders most especially the community in the planning, execution and evaluation of CHPS activities. There is the need to consider Financial Sustainability strategies in ensuring a smooth implementation of CHSP across the country living no one behind. Community Health Officers must be trained and given capacity in community resource mobilisation. Special Incentives for Health Workers working in the communities should be reintroduced to secure quality health care delivery at the lower level. It is recommended that Ghana will progress in an integrated approach by harmonizing all interventions aimed at achieving Universal Health Coverage particularly using an effective health technology to manage data.

1. The MoH should consider undertaking an assessment of all constructed CHPS compounds without equipment in the regions requiring quick intervention. The findings should assist the MoH to supply specific equipment to such compounds.
2. The MoH should advocate for more CHPS compounds to be constructed by government since the model being used makes provision for accommodation to at least 2 staff. The incorporation of decent accommodation encourages staff to accept postings to such zones.
3. There is need to orient and train tutors at all community health training schools, incorporate the CHPS curriculum into pre-service as well as train preceptors for all training sites.
4. MoH shall initiate discussions between NMC, GHS and HTI to address the gaps between Pre-service training and Post-Training(practice)
5. Diversify the sources of funding for CHPS and encourage active participation and support from the private sector and development partners in funding CHPS
6. Apply national standard and structured motivation package for CHVs. In addition adopt non-monetary incentives to motivate and enhance the work output of CHOs

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