COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)

THE OPERATIONAL POLICY

Ghana Health Service
Policy Document No. 20
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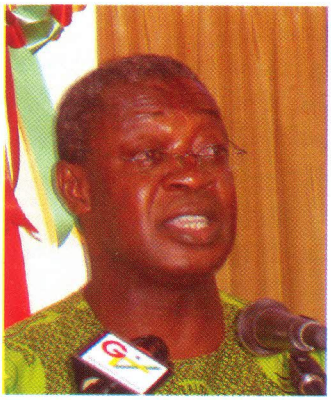
Foreword



Community-based Health Planning and Services (CHPS) initiative as a strategy to deliver community level service is a key health system reform for the Health Sector in general and the Ghana Health Service in particular. The levels of health care provision have been clearly defined and articulated in the GHS and Teaching Hospitals ACT, 1996 (ACT 525). We have, over the years since independence, concentrated on improving service delivery at the Hospital and Health Centres by investing in the construction of health facilities, hoping that the presence of these facilities will lead to an increase in uptake of health services.

However, our OPD attendance is stagnating, maternal mortality, child mortality and morbidity remain high. There is little or no community participation in health decision making. If the health sector is to achieve the Health Millennium Development Goals' in Ghana, then there is the need for a drastic shift in the paradigm of service provision. CHPS provides us with a vehicle for making this paradigm shift so as to deliver community level service by engaging communities in taking decisions concerning their own health and recognizing that the primary producers of health are the individuals within households especially mothers. It is the goal and vision of the Ghana Health Service to see that all households have access to community-based service delivery by 2015. Health Centres and Hospitals will then provide referral services and backstopping for this level of service delivery.

Two documents "CHPS Operational Policy" and "CHPS National Strategic Plan" have been produced to provide policy direction as well as strategic guidance for rolling out CHPS, especially for Sub-district Health Teams, District Health Management Teams, Regional Health Management Teams, Divisions and our Development Partners.

It is my hope that these documents will guide the Ghana Health Service and other service providers in implementing CHPS.

Implementing the Community level service delivery is not merely an option; it is the key to attaining universal coverage and as such must be operationalised.

Professor Agyeman Badu Akosa
Director General
Ghana Health Service
January, 2005

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Abbreviations

BCC	Behaviour Change Communication
CDMR	Case Detection, Mobilization and Referrals
CHC	Community Health Compound
CHPS	Community-based Health Planning and Services
CHN	Community Health Nurse
CHO	Community Health Officer
CHV	Community Health Volunteer
DHA	District Health Administration
DHMT	District Health Management Teams
FP	Family Planning
GHS	Ghana Health Service
GoG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
HQ	Headquarters
IE&C	Information Education and Communication
ITN	Insecticide Treated Nets
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHRC	Navrongo Health Research Centre
NTBA	National Traditional Birth Attendant Secretariat
OPD	Out-patient department
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
RHA	Regional Health Administration
SDHT	Sub-district Health Team
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID	United States Agency for International Development
USD	United States Dollar
UTI	Urinary Tract Infection
VHV	Village Health Volunteer
VHW	Village Health Worker

Background

The Health Status of Ghanaians has been improving since independence, however, the rate of change has been slowing and current health service indicators are still far from desirable. Maternal Mortality Rates, Child mortality and morbidity rates remains high; Malaria and other communicable diseases including HIV/AIDS are persistent. Between 1957 and 1988 the Ghanaian Child and Infant Mortality Rates had declined from 154 to 110 and 133 to 57 per 1000 live births, respectively. These declines however have stopped or been reversed in the past few years. In 2003, Child Mortality rates were 111 per 1000 live births, approximately the same as in 1988; while Infant Mortality increased to 64 over the same time period. So, despite substantial investments in expanding and upgrading the network of government health facilities, evidence for increased uptake of health services is mixed.

Extending the coverage of basic and primary health care services to all Ghanaians has been the major objective of the Ministry of Health since the Alma Ata conference on "Health for All" in 1977. A major policy statement of the Ministry of Health in 1977 stated that "most disease problems that cause the high rates of illness and deaths among Ghanaians are preventable or curable if diagnosed promptly by simple basic and primary health care procedures. The major objectives (of the ministry) are to extend coverage of basic and primary health services to the most people possible during the next ten years. In order to provide this extent of coverage it will be necessary to engage the co-operation and authorization of the people themselves at the community level. It will involve virtual curtailment of the sophisticated hospital construction and renovation and will require a re-orientation and re-deployment of at least some of the health personnel from hospital-based activities to community-oriented activities." *(Health Policies for Ghana. NHPU, 1977)*

The strategic policy direction of the Ghana Health Service is to have a three tier level of service provision within a district the District (Hospital) Level, the Sub-District (Health Centre) Level and Community-based. As captured in the Medium Term Health Strategy, geographical access is a major barrier to health care and as such, the first and second five-year programs of works had set out to improve geographic access to services by building new facilities to expand the government owned and staffed facility network. In line with this health service delivery strategy, the number of facilities doubled over the first and second five-year programs of work at the Sub-district and District Levels, but exacerbated by the 'brain drain', the investment in 'sub-district structures' did not remove the barriers to health care. From independence to the early

80's there was a rapid expansion of government-owned and staffed facilities with the assumption that these will benefit the poor by increasing geographic access to relatively low priced services. Overall, the general consensus is that it is now important to develop the community-based level to focus on the client and community orientation of the services and to tailor services to individual and community needs and wishes the 'close-to-client' service delivery system.

Rationale and Evidence

The primary producers of health are the individual households with mothers often taking the first key decision to seek health care for her sick child. This decision to seek health care, and which health care is sought, depends on information available to the household. Communities provide the social cohesion in which families function. And to increase the uptake of health services by households, it is necessary to provide health information and education to the households in a way that is acceptable and convenient for them.

In attempting to address the fundamental challenges in both access and quality of care and household/community or demand side participation in service provision, Health System Policy Reform in Ghana focused on the mobilization of health care resources and the traditional society to achieve the end points of increased health status, decreased mortality and fertility. This is to be done in the context of the Strategic Pillars of Health Sector Reform - Improving Access & Gender Equity, Enhancing Quality, Developing Efficiency, Fostering Partnership and Sustaining financing of service delivery.

In an effort to provide the Community based level, or 'close-to-client' doorstep health delivery with household and community involvement, the Ministry of Health through the Ghana Health Service pioneered the implementation of a national programme to replicate the results of Navrongo Community Health and Family Planning Project (CHFP) known as the Community-based Health Planning and Services (CHPS) initiative in key pilot districts of Nkwanta, Birim North and Asebu-Abura-Kwamankese. The Community-Based Health Planning and Services (CHPS) Initiative is therefore the national strategy for implementing community based service delivery by reorienting and relocating primary health care from sub-district health centres to convenient community locations. The CHPS organizational change process relies upon community resources for construction labour, service delivery, and programme oversight.

As such, it is a national mobilization of grass-roots action and leadership in health service delivery. The community-based level service provision will enable the Ghana Health Service (GHS) to reduce health inequalities and promote equity of health outcomes by removing geographic barriers to health care. CHPS is a component of other government policy agendas, such as the Ghana Poverty Reduction Strategy (GPRS) which identifies CHPS as a key element in pro-poor health services, as well as the ruling Party's Manifesto which identifies CHPS as a priority health activity. In addition, various health sector performance reviews since 2002 commended CHPS as an appropriate way to deliver health care to communities in undeveloped and deprived areas distant from health facilities.

The specific elements of the CHPS service delivery model are based on Navrongo research results demonstrating that *placing a nurse in the community substantially reduces childhood mortality, and combining nurse outreach with traditional leader and volunteer involvement builds male participation in family planning and improves health service system accountability.* Recent results, based on rigorous experimental research, demonstrate that the Navrongo experiment reduced total fertility by one birth and childhood mortality by 38 percent in the first three years of project operation.

The advantage of intersectoral action as a tool for placing the nation's health within the wider national developmental context is key to the effective delivery of poverty-focused health interventions. A reasonable amount of collaboration is on-going at different levels of service provision but the level of progress is limited. However, present arrangements for joint working are either weak or ineffective both at the national and local levels. There are no guidelines, policies and effective mechanisms in place for the health sector to work with other government departments and agencies. Some work has been done in this direction, which needs to be improved and guided. For the purpose of CHPS, civil society and community-based organizations have an essential role to play in improving health. Thus, it is imperative that the health sector provides policy direction for this.

The CHPS Policy

The strategic policy of the Ghana Health Service is to have a three tier level of service provision within a district the District (Hospital) Level, the Sub-District (Health Centre) Level and Community-based level. All Sub-districts are to be divided into zones with a catchment population of 3000 to 4500 where primary health care services will be provided to the population by a resident Community Health Officer assisted by the Community structures and volunteer systems. The deployment of all elements necessary for the CHO to provide house-to house service shall make that zone a fully functional CHPS zone within the sub-district

Definition of CHPS

'CHPS is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination - It focuses on the health by the people by placing people's health in people's hands'

The Community-based Health Planning and Services is defined as 'the mobilization of community leadership, decision making systems and resources in a defined catchment area (zone), the placement of reoriented frontline health staff [known as Community Health Officers (CHO)], with logistics support and community volunteer systems to provide services according to the principles of primary health care (PHC-Plus).' It is a "close-to-client" service delivery system.

Key Elements of CHPS

The key component of CHPS is a community-based service delivery point that focuses on improved partnership with households, community leaders and social groups addressing the demand side of service provision and recognising the fact that households are the primary producers of health. A community health officer (CHO) engages each Community within the zone (catchment area) in micro planning of health activities sometimes termed "community decision making systems."

Key elements of CHPS

- Community (as social capital)
- Households and individuals (as target)
- Planning with the community (community participation)
- Service delivery with the community (client focused)

A 'zone' usually comprises a delineated health service delivery catchment area of up to three (3) Unit Committees (population 3000-4500) within a subdistrict.
Frontline health cadres include Community Health Nurses/Nurses, Field Technicians.

The Strategic Goal

The overall strategic goal of CHPS is to improve the health status of people living in Ghana by facilitating actions and empowerment at household and community levels.

The Vision

The Vision of the Ghana Health Service is to have core services defined within the CHPS Initiative be available and accessible to all Ghanaians who need it by 2015.

By implementing CHPS, the health sector thus fulfils its health systems reform process of establishing a whole "District Health System" comprised of three service delivery levels community level, sub-district (health centre) level and district (hospital) level with strong referral components between levels.

Objectives

Within the context of the Ghana Poverty Reduction Strategy (GPRS) community-based health service delivery using the CHPS approach provides a unique opportunity for achieving the critical intermediate performance measures of the health sector programme areas of work. The focus of the CHPS approach is to achieve three important objectives:

1. Improve equity in access to basic health services.
2. Improve efficiency and responsiveness to client needs.
3. Develop effective intersectoral collaboration.

Improve Access and Equity to Basic Health Services

The mal-distribution and problems associated with geographical and financial access coupled with staff attrition of highly qualified staff mean that new ways of working are required to deal with the basic ailments that plague the poor.
The CHPS strategic response takes into considerations that working with households and communities to ensure the availability of appropriate community-based services, and addressing all barriers to access at the local level are some of the most important areas that require new and innovative approaches. If this can be achieved, key barriers are removed.

Improve Efficiency and Responsiveness to Client Needs

Community-based service provision can only be effective if services are efficiently delivered and are responsive to client needs. This translates into a requirement for health worker performance to be dealt with through the introduction of critical tactical measures such as:

- Improving basic in-service training, supervision and performance management at the district and sub-district levels;
- Improving remuneration and the incentives to work in deprived areas;
- Improving supply of essential drugs and diagnostics;
- Improving logistics and infrastructure and disseminating clinical audits regularly; and
- Developing a new sub-district team with a focus on communities and households.

The content of service provision is a package of interventions that responds to the needs of communities, is delivered with a human face and provided in a dignified and culturally sensitive manner. Working through an effective combination of facility and community- based service providers can achieve this and ensure that the people are able to access services and health information as and when they need them. It also requires ensuring increasing accountability and performance of health providers on quality, responsiveness and efficiency through enabling community organization to exercise some levels of accountability of providers.

Improve Inter-Sectoral Collaboration and Partnerships in Service Delivery

This will require strengthening the role of the community, civil society and community based organizations to support strategy implementation, client access to services and protect and promote client rights to quality health services with the following elements.

- Build effective partnership with district assemblies in establishing health services in the sub-districts in pursuit of reduced health inequities and better health for all, e.g. improving water availability, sanitation and environmental health.
- Strengthen the capacity of the sub-district level of the health sector to plan and manage intersectoral programmes in support of community services and actions.
- Reorganize the sector's resource flows to support the goal of working in partnership with communities, households and district assemblies.

Policy Implementation

Creating the CHPS Zone

The regional and district levels hold the key to achieving the target of providing access to CHPS services for all households. The first essential and key step in implementing CHPS is for all districts to conduct a *situation analysis* of their service delivery and coverage. This analysis should define minimum indicators to warrant start-up in CHPS for a district, including physical distances, coverage for basic services and existing disease patterns. In line with this policy direction, the community level (Level A) of the District Health System should be implemented such that all people living in Ghana are covered by its services by the year 2015. To accomplish this, all sub-districts within every district should be demarcated into service delivery "zones" following the guidelines provided in the National Implementation Plan.

CHPS zones should be created in synchrony with existing local government structures utilizing the District Assemblies and Unit Committees (population of 1500). The recommended population of a CHPS zone is 3000 to 4500 people i.e. covering two to three Unit Committees of the District Assembly.

Once the decision is taken by the DHMTs and the communities, the transformation of community health systems from clinic-focused care to community-based care zones then involves the achievement of "milestones" that are documented in a monitoring system. The following largely sequential "milestones" are essential to the establishment of a fully functional CHPS zone within a sub-district (Appendix 3).

1) *Preliminary planning* involves grouping communities into service zones, specifying where each nurse is assigned to provide care, identifying community leaders and planning optimal location of the facilities to be used as service points for community-based health care (health compounds);

2) *Community entry* includes conducting meetings and diplomacy with village leaders, convening public gatherings known as durbars for communicating plans and activities to communities, and constituting health liaison committees for providing daily support to the programme;

3) *Health compound construction* utilizes volunteer labour and community resources to develop the dwellings where nurses live and work;

4) *Procurement of essential equipment* such as motorbikes, bicycles, and clinical equipment;

5) *Posting nurses* and providing them with technical refresher training and orientation to communities where they are assigned; and

6) *Volunteer recruitment* involves engaging health committees in designating health volunteers to assist with community activities in child health, family planning and other reproductive health services.

At least 20 specific component activities have been identified (Appendix 3), although their sequence of implementation differs from locality to locality.

Community Health Officers

Technical health service provision will be undertaken by trained health providers (i.e. the frontline health service providers who should be able to deliver a defined package of health services). These health personnel could be either from the public or private segments of the health sector. These health personnel are typically the community health nurses (CHN), community health nurse midwives (CHNM), midwives, enrolled nurses, field technicians, etc. As the number of trained staff improves, other skilled staff can be reoriented to provide services at the community level. This frontline staffs are given standard conversion courses with additional midwifery skills (if they do not have them already) before being redeployed into the community as community health officers.

The technical service provision will be supported by others within the community, especially the following:

- Community-based volunteers
- Community members, community health committees, mothers and children,
- Community/traditional health delivery personnel (native doctors, TBAs, herbalists, etc.)

The CHO are expected to deliver a package of essential primary health care and promotion services at the community level. They are expected to pursue a work routine that revolves around home visiting, and has its base in outreach by the health provider, rather than a static service base for the client to attend. The idea is to take services to the clients rather than follow the traditional method of expecting the client to seek out the health care provider.

Community Health Volunteers

CHO will be assisted by community health volunteers who are supervised by a community health committee. Whether community health volunteers will be used in a given district or not will depend on the local circumstances and decision-making. Where they are to be used, guidance on the details of their functioning, issues related to selection and supervision, and issues related to the community health committee can be found in the *Community Based Health Planning and Services Manual.*

The Basic Package of Interventions

The Basic Package of interventions to be delivered by the CHO is in line with the concept of Primary Health Care **"essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford".** And that this should include **at least** the following elements: health education related to prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; provision of an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization programmes against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common ailments and injuries; and provision of essential drugs. The basic service package to be delivered in the communities would be as a result of teamwork and not only by the CHO.

Therefore the recommended Basic Package of Services by the team at the Community level will in these broad areas:

- Promotion and prevention
- Management of minor/common ailments and their referrals; and
- Case detection, mobilization and referral

The specific duties and responsibilities include:

- Community and compound level education on primary health care;
- Immunizing and providing pre and post natal care delivery;
- Supervising and monitoring sanitation efforts;
- Provision of nutrition education and care;
- Primary care for simple cases of diarrhoea, malaria, acute respiratory diseases, wounds and skin diseases;
- Providing referrals for more serious afflictions;
- Provision of education on prevention and management of STDs and HIV/AIDS;

- Provision of family planning services and referrals;
- Supervision and monitoring of community volunteers' and TBAs;
- Conducting disease surveillance; and
- Submission of written reports to the SDHT.

Services shall be provided in accordance with the existing regulation of the Ghana Health Service.

The basic package of services provided by the CHO is outlined in **appendix 1**. The development of the human and institutional capacities within the CHPS zones for the different providers is as essential as any emphasis placed on a single one of them. The emphasis placed on the CHOs in CHPS policy documents does not single them out as having more priority than the others. The emphasis however draws attention to the absence of attention to their critical role in primary health care in the past and the need for a conscious development process as part of the comprehensive improvement of the sub-district health service system.

Training & Preparation for Volunteers/Assistants

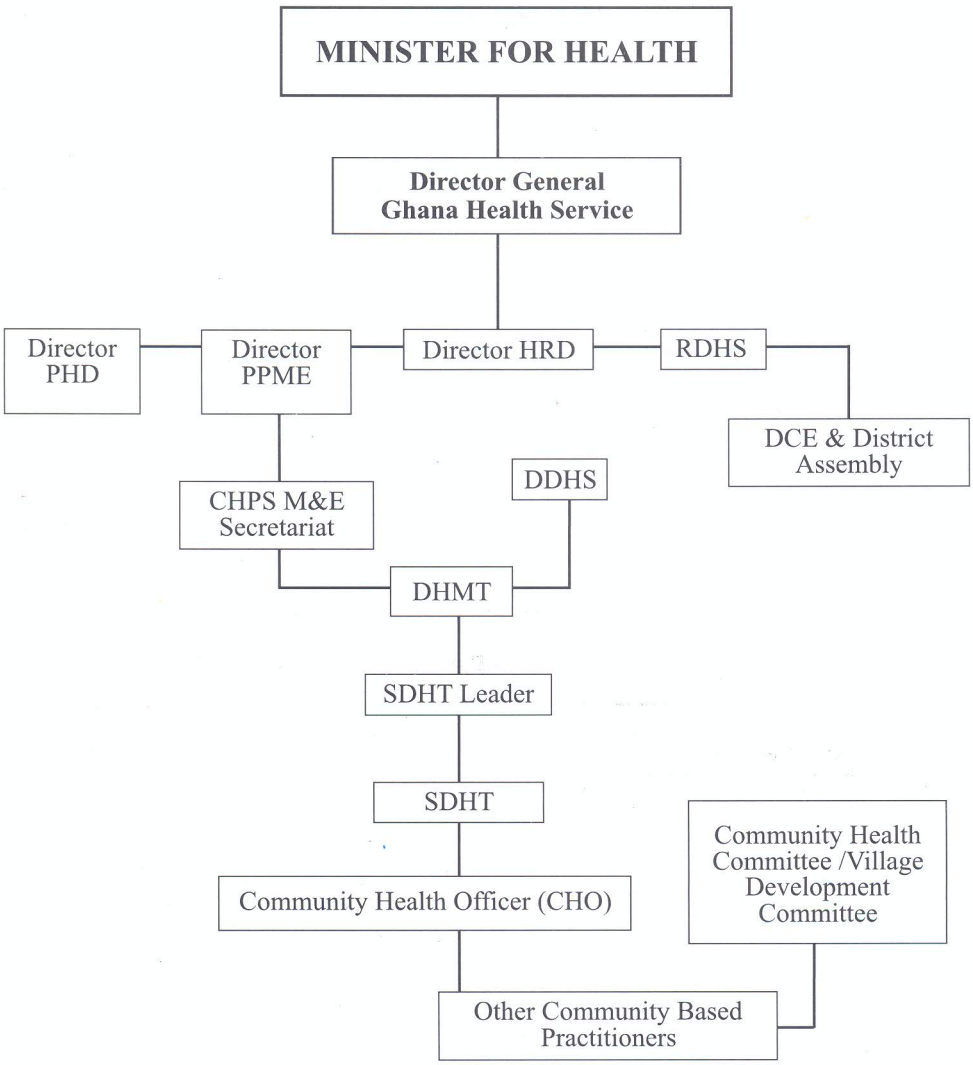
The Community/Village Health Volunteers are the core support persons to the CHOs and will receive basic training in the Promotion, Prevention and Case Detection Mobilization and Referral areas. They will also be provided with basic first aid skills in home accidents. All other activities can only be undertaken under the direct supervision of the CHO.

Beneficiaries (targets)

As stated earlier the Vision of the Ghana Health Service is to have all Ghanaians covered by Community based service delivery using CHPS Initiative by 2015. The beneficiaries or targets of this service delivery are all Households and Communities.

However, within existing financial constraints, it is strongly recommended that the process of establishing CHPS should prioritized so as to serve the most deprived communities in both rural and urban areas in districts before the eventual roll out to cover 100% population of sub-districts and districts.

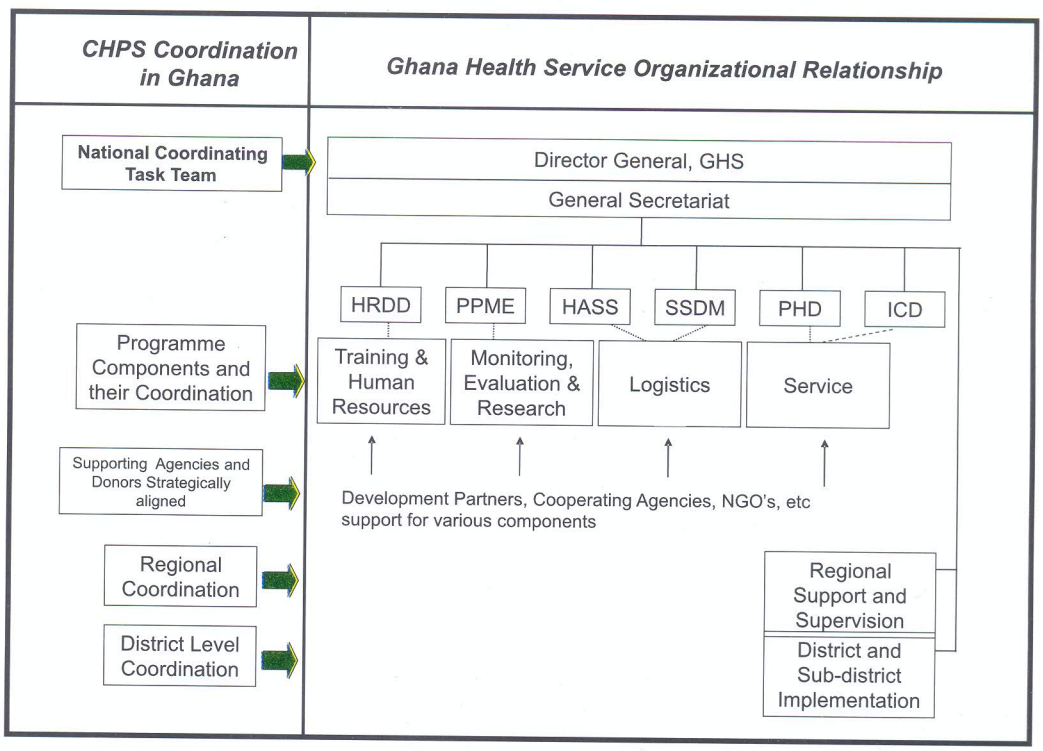
Organizational Context for CHPS



In implementing the CHPS process reorienting and restructuring the health delivery system of the MoH is crucial. This requires clear definition and acceptance of the roles and responsibilities of the District Health Management Team (DHMT), the Sub District Health Team (SDHT) and other service providers. The organizational layout of Health Sector service provision is a five-tier service delivery system with the community-based level forming the frontline or the level 'A'.

The National Level

In the MOH and at the national level of the Ghana Health Service (GHS), the main functions needed to facilitate the implementation of the Community Health Services strategy are those of defining policy direction, facilitating policy implementation and ensuring that the appropriate resources are channeled to support policy implementation. The national level also needs to play a role in the coordination of monitoring and evaluation as well as some direct monitoring and evaluation functions to provide input for refining policy direction. A National Coordination Task Team constituting the Divisional Directors, Representative Regional and District Directors as well as the key Development partners has been established under the office of the Director General of the Ghana Health Service. The National Coordination Task Team meets on regular basis to take stock of the overall country implementation of CHPS

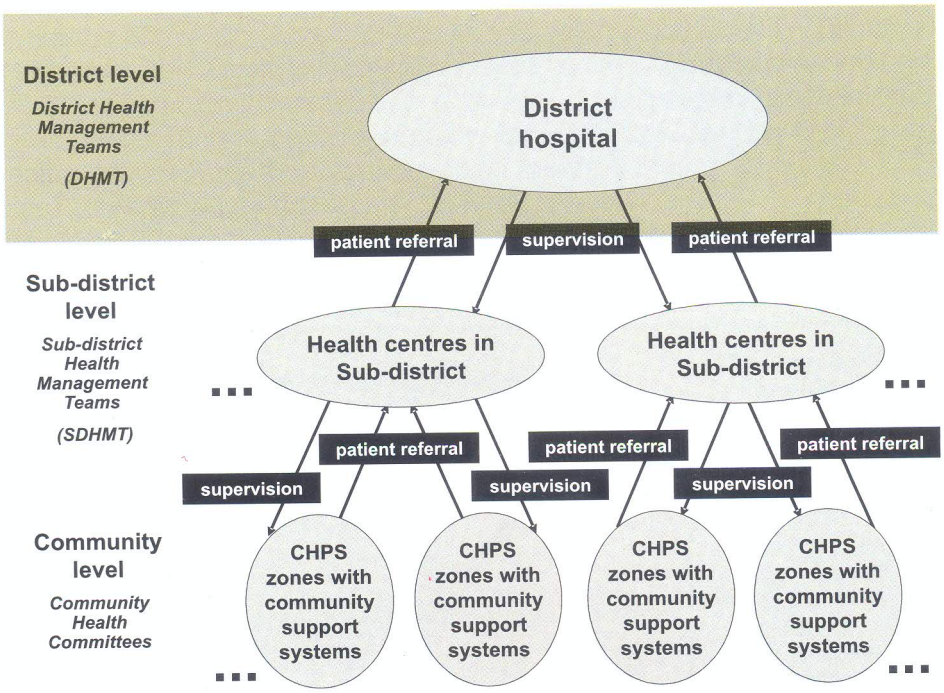


The Regional Level

The Regional Level provides a coordination, support and supervision oversight for Districts, Sub-districts and CHPS zones. It also provides specialist referral services to these levels.

The District Level

The District is the major unit of primary health care organization and management for service delivery in Ghana. Within the district, health services are organized in a three tiered hierarchy with the District level (level C) at the top, the Sub-district level (level B) next and the Community level (level A) at the bottom.



The District Health Management Team serves as the decision making, programme development and co-ordination for CHPS. The District Director of Health Services (DDHS) who is a member and head of the DHMT functions as the Director of the CHPS process. One experienced and capable member of the DHMT, the Disease Control Officer, the Public Health Nurse or the Nutrition Officer is selected to assist the Director.

The DHMT as the central point for health management in the district processes decisions and programmes from the Regional Health Management Team and issues directives for community level health care provision through the Sub-District Health

Team (SDHT). Specifically, the DHMT develops, organises and implements the community level health care programme. It collates all field reports form supervisors, CHOs and Community Health Committees for realistic and community relevant decisions and effective action. The DHMT oversees the identification, orientation, training and posting of the CHOs to the Sub-District locations in the communities with the assistance of the District Public Health Nurse.

While the District Director of Health Services (DDHS) is responsible for overall programme management, providing guidance and technical assistance, planning and budgeting DHMT members:

- Assist in overall programme management;
- Provide guidance and technical assistance to Sub District Health Teams;
- Plan and budget programme activities;
- Serve as liaison and organise meetings between DHMT and SDHT;
- Supply essential medical supplies to SDHT;
- Supervise SDHT activities;
- Coordinate programme activities of DHMT members and services delivery units;
- Train CHOs; and
- Manage data generated by CHOs and Community Health Volunteers and provide feedback to SDHT.

The Sub-district Level

Each District is zoned into four or more Sub-districts depending on its size. A sub-district has a population of about 20,000 30,000. Sub-districts in the health sector administrative classification generally correspond to **area councils** in the local government classification; the difference being that sometimes the health sector may put two or three area councils together as one Sub-district.

The Sub District Health Team supervises CHOs and Community Health Volunteers and provides a liaison to District level offices. SDHT leaders plan and budget programme activities in their zones. The SDHTs manage the flow of essential medicines and family planning supplies between the DHMT and the Community Health Committees who distribute them to the volunteers to complete actual delivery.

Specific responsibilities of the Sub District Health Team include:

- Holding management meetings with Community Health Committees and CHOs;
- Collecting data on CHO and Volunteer programmes for the DHMT;
- Managing supplies and monitoring usage of drugs and family planning materials by CHOs and Volunteers; and

- Writing progress reports to the DHMT.
- Strengthening of the role of the Sub-District as an operational support unit with direct responsibility for implementing village level health care is key to the implementation of CHPS.

The Community Level

There are numerous communities within a sub-district. In rural areas, a community usually corresponds to a village or cluster of hamlets but it is not always easy to concisely define a community in terms of population alone. The definition of a community for purposes of service delivery has to take into account geographic location as well as population. Some rural communities may have as few as 100 or less people, but are so far from everybody else it is difficult to group them with another community. On the other hand, a large town with a several thousand or more population may not be easy to classify or deliver service to as a single community even though the people are fairly closely clustered in the same geographic location.

It is recommended that CHPS zones should be created in synchrony with existing local government structures. The District Assemblies and **Unit Committees** use population of 1500. The recommended Population of a CHPS Zones is 3000 to 4500 people i.e. covering two to three Unit Committees of the District Assembly. The CHPS zone should have a maximum of TWO trained CHO's placed within them to provide services to households within the Communities. These services should focus more on Outreach and House to House services, establishing Community Decision Making Systems and using community register to trace defaulters and people with special conditions like pregnant women and children at risk.

The CHO in a CHPS zone is the staff of the Sub-District Health Staff responsible for advocating for and promoting health in the assigned communities

Volunteer Systems are to be set up in a way that the Community Health Committees are in direct control of the volunteers. Their selection and incentive systems should be under the direct control of the Community Health Committee. The District Health Administration can also provide additional incentives, like Bicycles, through the Sub-District Health Team.

Within a CHPS zone, the CHO is expected, for the purposes of comprehensive health services delivery and promotive activities, develop close links with the

- Chiefs
- Volunteers
- Assemblyman
- Traditional Birth Attendants

- Private Midwives
- Traditional healers
- Private Institutions/ Church Hospitals Association of Ghana (CHAG)
- Religious groups
- District Health Management Teams (DHMT) and District Assemblies

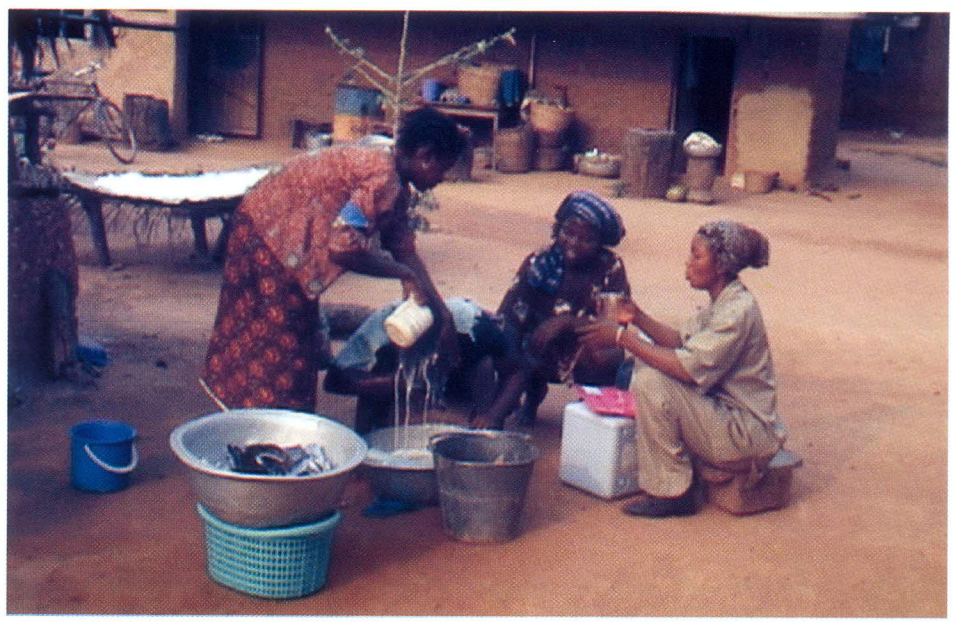
Support and Supervision Systems

The Sub-District Health Team is the direct supervisor of all CHPS zones within the Sub-district catchment area. The SDHT are responsible for budgeting for CHO service delivery as well as general activities within the individual CHPS zones. All visitors to the CHPS zones should at least inform each Sub-district Health Team. There should be facilitative supervision and support from District to the CHO's and CHPS Zones through the Sub-district team.

It is recommended that Focal persons should be placed at the Regional and District Levels to ensure coordination and uniformity in the CHPS Systems set-up.

Health Service Data Returns and Reporting Systems shall follow existing health Information Systems within the Ghana Health Service. Aggregation of health data from CHPS zones shall be done at the Sub-district level. However, new forms are to be developed for

- Community Level CHO activities; and
- Volunteers systems reporting through the CHO's to the Sub-districts.



Resources to Implement CHPS

Financial

Financing CHPS is expected to be an integral part of the Health Sector financing and must be sustained. Funds to develop the CHPS activities will come from the current sources of fund as well as those to be generated from health system activities such as internally generated funds and local based Health Insurance Schemes or Mutual Health Organizations.

Current sources of funds:

- Government resources
- Community
- Non Governmental Organizations
- Donor Agencies
- Community Based Organizations
- District Assemblies
- Civil Society Organizations
- HIPC funds

System Funds expected

- Health Insurance or Mutual Health Organization
- Internally generated

(Need to look separately at Capital/Development funding and then recurrent/operational funding resources (e.g. Mutuals). It should be clear that RHAs and DHAs should set aside budgets for scaling up and supporting CHPS).

Human Resources

Success of CHPS depends on the availability of human resources to be deployed in communities as Community Health Officers.

As stated in this policy, technical health service provision will be undertaken by trained health providers (i.e. the frontline health service providers who should be able to deliver defined package of health services). These health personnel could either come from public or private segments of the health sector). Implementing a country-wide communitybased services, whether urban or rural, using the present cadre of Community Health Nurses, will require about ten times the present number CHNs in the employment of the Ghana Health Service. To address this situation, the following strategies will be adopted:

- Pre-Service schools will expand numbers through doubling intake, and new

schools will be established in each of the ten regions to complement the existing ones at Winneba, Oda, Tamale and Ho
- Existing cadres to be retrained with standard package to become CHOs
- Quality of Care will be strengthened through regular in service training for CHOs and strong supervision from strengthen SDHTs.
- Incentives systems will be developed to retain CHOs for at least 3-4 years in a zone

Logistics

The goal of the CHPS logistics effort is to make every CHPS zone efficiently run through the procurement of service delivery, transport, communication and personal comfort logistics for the Community Health Officer(s) stationed in the zone. The following logistics shall be provided as a minimum to all CHPS zones to make them fully operational

Service Delivery Logistics
- Cold Chain equipment
- Service delivery consumables
- Working gear
- Communication equipment two way radio or mobile phones etc.
- Personal Digital Assistants (PDA's) for data collection

Mobility Logistics
- Motorcycle for the CHO
- Bicycles for the Volunteers in each Community within the zone
- And where necessary the following:
  Tricycles, Tiller Ambulance, Tractor Ambulance, Motorboat

Comfort Logistics
- Accommodation; new, rented, renovated
- Consumer durables; Bed, Furniture, TV, Radio Set, Kitchen ware, etc

Detailed logistics needs will be determined and revised from time to time by GHS Logistics committee and may vary according to location, and other factors such as water, electricity availability.

Monitoring, Evaluation and Feedback Systems

The appropriate type of monitoring and evaluation for this program is a formative evaluation of the relevance, progress and effectiveness of implementation of the different components of the program, with the results being fed back into a redesign of the program. Monitoring and evaluation will occur at all levels namely:

- Community
- Sub-district
- District
- National

To lend coherence to the scaling up process of CHPS Implementation, a Monitoring and Evaluation component has been developed to assess achievements, report progress to all key actors in the health sector and take stock of problems that may arise. The Monitoring and Evaluation component of CHPS administration lies within the PPME Division of the Ghana Health Service. This is in line with the overall organizational layout of CHPS Coordination within the Ghana Health Service.

The monitoring and evaluation unit has the following tasks:

- Organize and ascertain the development of the national plan of action fore the implementation of the CHPS program. This involves the development of annual operational plans and targets for all districts and regions in CHPS implementation
- Develop and maintain support systems for DHMT and RHMT in sourcing for resources including funds for district and community level operations
- Seek and co-ordinate technical assistance for capacity building in terms of training for all levels of staff and development of appropriate community level IEC materials for professional and non professional health providers engaged

in community based health care delivery

- Provide/organize advocacy for the CHPS program activities among policy makers, donor agencies and high level professionals and authorities
- Document and organize the dissemination of experiences in the implementation of the CHPS program among all districts and regions
- Organize and supervise technical assistance in the monitoring and impact evaluation of the nation wide implementation of CHPS
- Operate as the central co-ordination unit for the expanded nation wide implementation of the CHPS process

Rolling Out CHPS Zones as Learning Organizations.

The Ghana Health Service is determined to create cohesive structures at the zonal level with shared visions of improving the health of each house hold

References:

1. Awoonor-Williams, John Koku, Ellie S. Feinglass, Rachel Tobey, Maya N. Vaughan-Smith, Frank K. Nyonator, Tanya C. Jones. 2004. "Bridging the gap between evidence-based innovation and national health-sector reform in Ghana." Studies in Family Planning 35(3): 161177.

2. Debpuur, Cornelius, James F. Phillips, Elizabeth F. Jackson, Alex Nazzar, Pierre Ngom, and Fred N. Binka. 2002. "The impact of the Navrongo Community Health and Family Planning Project on reproductive preferences, knowledge, and use of modern contraceptives." *Studies in Family Planning* 33(2): 141-164.

3. Ministry of Health 1977; National Health Policy Unit: *Health Policies for Ghana.*

4. Ghana Health Service, January 2005; The National Strategic Plan for CHPS

5. Nyonator, Frank K, J Koku Awoonor-Williams, James F. Phillips, Tanya C. Jones, Robert A. Miller. 2005. "The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation. Health Policy and Planning 20 (1): 25-34.

6. Nyonator Frank K., J. Koku Awoonor-Williams, James F. Phillips, Tanya C. Jones, and Robert A. Miller. 2003. "The Ghana Community-based Health Planning and Services (CHPS) Initiative for Scaling up Innovation in a Resource-constrained Setting." Paper presented at the Bellagio Meeting on Scaling-Up 'From pilot projects to policies and programs' March 31 April 5, 2003

APPENDIXES

Recommended boundaries of Basic Package of Services to be provided by CHOs

Promotion and Prevention:

- Advocacy on community sanitation
- Community directed treatments
- Distribution of insecticide treated nets (ITNs)
- Distribution of condoms and non-injectable FP devices
- Counseling on STIs/Family Planning services, counseling and advice
- Counseling on ante-natal and post-natal care
- House to house visits coverage
- Provision of Expanded Programme in Immunization (EPI) services
- Provide and support community based DOTS

Curative and rehabilitative - Management of minor ailments and Referrals

- Treatment of uncomplicated malaria and fevers
- Treatment of simple cough and URTIs
- Treatment of simple diarrhea
- First Aid for burns, cuts, toxic inhalations and consumptions (Home Accidents)
- Blood pressure monitoring
- First Aid for spontaneous delivery

Case Detection, Mobilization and Referrals (CDMR)

- Reporting of unusual conditions
- Referral of all conditions beyond the scope of authority
- Mobilization of communities for health talks creating community awareness
- Mobilization of communities for outreach services
- Providing support for Community Decision Making Systems
- Availability and completeness of community register

DETAILED JOB DESCRIPTION FOR COMMUNITY HEALTH OFFICERS IN CHPS

Job Title: Community Health Officer (CHO).
Job Purpose: The CHO serves as a front line health worker based in the community. He/She collaborates with community members, other service providers and partners in the planning, management, implementation and promotion of quality health services.

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

Department: Sub-District Health Team.
Responsible to: Sub-District Health Team Leader
District Director of Health Services

Duties and Responsibilities:

1. Prepare and implement action plans on community health programs and activities in collaboration with community members and other partners.
2. Carry out regular home visits.
3. Provide Ante Natal service both in the homes and communities
4. Monitor growth and development of children in the communities.
5. Provide immunization to children, pregnant women and other individuals in the homes and communities.
6. Create awareness, motivate individuals and couples to consider family planning, help them make appropriate methods.
7. Provide appropriate Family Planning services to individuals and couples both in homes and communities.
8. Carry out surveillance on health events in the community and report promptly.
9. Conduct emergency deliveries in the home and community.
10. Provide postnatal care in homes and community.
11. Recognize complications in pregnancy, delivery and post delivery and make prompt referrals
12. Manage commonly occurring conditions in the community, using standard treatment guidelines and protocols.
13. Provide health promotion and health education services on specific health issues in the home and community.
14. Facilitate compilation of community registers.
15. Keep and update community health register and submit report promptly.
16. Supervise, monitor and support TBAs, and other community health volunteers
17. Collaborate with Traditional Healers and other service providers chemical sellers, private midwives
18. Assist in mobilizing community resources for health programmers.
19. Perform and other duties assigned to him/her by the immediate supervisor
20. Perform periodic self-appraisals
21. Prepare and submit report on community health activities regularly

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

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

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

Job Specification
Essential: CHN certificate, Field Technician certificate, or Midwifery certificate.
Desirable: In-service Training on components of CHO functions
Orientation of CHPS program (including management and advocacy)

- In-service training in Reproductive Health programs
- In-service training in management of commonly occurring conditions
- In-service training in health promotion strategies and disease prevention.

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

Skills required
- Communication and interpersonal relations
- Decision making and problem solving skills
- Planning and organization
- Recording and reporting
- Communicating in the local dialect

- Participatory Rapid Appraisals
- Technical skills (in reproductive, health family planning, treating minor ailments, immunization, health promotion)
- Monitoring skills
- Supervisory skills
- Motor bike and bicycle riding

Personal qualities/attributes:

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

Minimum Reward and incentive package

- Opportunity for reposting after satisfactory two-years service
- Opportunities for further training and upgrading
- Sub District allocation of FEs should be sent to support activities in CHPS

Functional components of CHOs in CHPS

- Home visits
- Health Promotion, Disease Prevention and Basic Surveillance activities
- Immunizations
- Family Planning Activities
- Antenatal care
- Basic Health Services
- Post-natal Care Activities
- Managing Commonly occurring illnesses including Home Accidents
- Delivery Responsibility
- IE&C Services
- Compilation of Community and Health Registers
- Supporting and monitoring TBAs and volunteers
- Collaboration with community agencies

Appendix 2: CHO Activities by Level and their indicators

Activities by level		Indicators
1) Direct activities of the CHO		**…to be reported by the CHO**
Preventive - Promotion	House to house visits, FP, Immunization status, Health Education, Referrals, special cases picked up – e.g. HIV, Community sensitization on specific health issues; Community mobilization, mop up immunization activities	Number of Households visited, Number of F/P acceptors, Fully immunized kids, rare special) cases picked up, Number of cases community has been sensitized on (e.g. insecticide treated nets); Number of community durbars attended, Number of mop up activities organized and carried out.
Curative	Management of minor ailments e.g. First Aid, Malaria, Diarrhea, referrals, Follow-up of cases	Number of uncomplicated malaria/fever cases treated/referred, number of diarrhea cases treated/referred. Number of cases given First Aide and referred, Number of cases given follow-up.
Reporting	Reporting to sub-district, supervision of volunteers, Financial administration (accountability)	Number reports written and submitted completely and timely; Number of volunteers/TBAs supervised; State of accountability with sub-district
Other	Special case reports as determined by the sub-district e.g. guinea worm, Emergency delivery	Number of special cases picked up and reported on, Number of emergency deliveries carried out.
2) In-direct contributions to corporate activities		**…to be obtained from the sub-district records**
Preventive – Promotion	Routine immunization, ANC, PNC, CWC Durbars, School Health, Compilation of community register,	Fully immunized (or # of defaulters) from examination of Road to Health cards on home visits; ANC attendance; PNC attendance; results of school health screening; availability, completeness and use of community register.
Curative	OPD cases treated at outreach by health centre team,	# and type of cases seen and treated
Reporting	Use of HMIS	Evidence based decision making.

Other	Rare and targeted disease conditions	Rare and targeted disease conditions picked up at outreach, e.g. tuberculosis, yaws, polio, Oncho, elephantiasis.
3) In-direct activities impacting output from the sub-district		**…to be obtained from the sub-district records**
Preventive – Promotion	Immunization (e.g. TT of pregnant women), clinical and surgical methods of FP (minilap sterilization, vasectomy, IUCD, Norplant implant, etc,	TT injections given at outreach OPD; # of clinical and surgical contraceptive devices supplied as a result of referrals from CHO;
Curative	OPD attendance, referred cases	OPD attendance; # of referred cases from CHO;
Reporting	Reports received from CHPS zones	Timeliness and completeness of reports from CHO
Other	Rare or targeted cases unearthed from home visits	# of rare cases or targeted cases identified by CHO

Appendix 3: The CHPS Activity Sequence

The operationalization of the Community-based Health Planning and Services process demands systematic planning and execution of the DHMT, the SDHT and the Community leadership as well as the citizenry at large. A step-by-step activity sequence is provided as a guideline for implementation based on the NHRC experience. As with any guideline, these steps can be modified to suit the specific needs in a given district.

ACTIVITY ONE: PROGRAM PLANNING –

- Situation analysis and problem identification at the level of the DHMT
- Consultation with District Assembly – the Chief Executive and the Social Services Sub Committee
- Selection of Communities.

Responsible Institution/Official:

- The DHMT (DDHS & PHOs)

Milestone/Indicator:

- Compiled Situational Analysis of Available Resources and Program Requirements.

ACTIVITY TWO: CONSULTATION AND SENSITIZATION OF HEALTH WORKERS.

Responsible Institution/Official:

- DHMT

Milestone/Indicator:

- Health Workers Acceptance of CHO Concept

ACTIVITY THREE: DIALOGUE WITH COMMUNITY LEADERSHIP

District Assembly, Area Council and Unit
Committee Members responsible for
Communities, Chiefs, Elders, Women Leaders etc.

Responsible Institution/Official:

- DHMT (DDHS/PHOs)

Milestone/ Indicator:

- Community Leaders Acceptance Recorded

ACTIVITY FOUR: COMMUNITY INFORMATION DURBAR –

Responsible Institution/Official:
Community Leaders supported by the DHHMT
Milestone/Indicator:

- Informed Community Created

ACTIVITY FIVE: SELECTION AND TRAINING OF CHOS.
Responsible Institution/Official:
DHMT/SDHT
Milestone/Indicator Certification of CHOs

ACTIVITY SIX: SELECTION AND ORIENTATION OF COMMUNITY HEALTH COMMITTEE MEMBERS; AND DURBAR FOR APPROVAL OF COMMUNITY HEALTH COMMITTEE

Responsible Institution/Official:

- Community Leadership and SDHT/DHMT

Milestone/Indicator

- Community Health Committee Members Confirmed
- Community Health Committee members Sign
- Commitment Contract

ACTIVITY SEVEN: COMPILATION OF COMMUNITY PROFILE –
Information on Geographic and
Demographic Characteristic, Existing
Health Features and Facilities.
Responsible Institution/Official:

- DHMT,SDHT, and Community Health Committee and Leadership

Milestone/Indicator:

- Community Profile Brief and Register Established

ACTIVITY: EIGHT: CONSTRUCTION OF COMMUNITY HEALTH COMPOUND
Responsible Institution/Official:

- Community Health Committee and Community Leadership

Milestone/Indicator

Community Health Compound constructed

ACTIVITY NINE: MOBILISATION OF LOGISTICS
Responsible Institution/Official:

- DHMT

Milestone/Indicator

- Logistics Stocking and Management System Established

ACTIVITY FOUR: COMMUNITY INFORMATION DURBAR –

Responsible Institution/Official:

- Community Leaders supported by the DHHMT

Milestone/Indicator:

- Informed Community Created

ACTIVITY FIVE: SELECTION AND TRAINING OF CHOS.

Responsible Institution/Official:

DHMT/SDHT

Milestone/Indicator Certification of CHOs

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Milestone/Indicator

- Community Health Committee Members Confirmed
- Community Health Committee members Sign
- Commitment Contract

ACTIVITY SEVEN: COMPILATION OF COMMUNITY PROFILE –

Information on Geographic and
Demographic Characteristic, Existing
Health Features and Facilities.

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- DHMT,SDHT, and Community Health Committee and Leadership

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- Community Profile Brief and Register Established

ACTIVITY: EIGHT: CONSTRUCTION OF COMMUNITY HEALTH COMPOUND

Responsible Institution/Official:

- Community Health Committee and Community Leadership

Milestone/Indicator

Community Health Compound constructed

ACTIVITY NINE: MOBILISATION OF LOGISTICS

Responsible Institution/Official:

- DHMT

Milestone/Indicator

- Logistics Stocking and Management System Established

Appendix 4: Milestones in establishing community-based services by type of operational change required in the scaling-up process

Milestone	*Type of operation in the ....*		
	...existing clinic-based system	*... community- based services*	*Implementation tasks*
Planning	District Health Management Team; office-based planning	Defined community service areas, termed "zones;" traditional leaders; community nurses	Community mapping and enumeration; outreach to traditional leaders
Community Entry	None	Community leadership support for health services; Community health committees for governing operations	Community awareness building, Liaison with leaders; Community Health Committee Selection; training of community nurse for community entry; community leadership training
Community Health Compound	None (sub-district health centre and hospital services)	Community constructed or refurbished nurse service and dwelling units; community ownership of primary service point	Community mobilization for facility development; community support for maintenance
Essential Equipment	Four-wheel vehicle for bi-weekly outreach clinics (rarely available); sub-district and district hospital equipment	Bicycles or motorbikes for continuous outreach by nurse; basic clinical equipment for community health compounds	Procurement of bicycles, motorbikes, and basic community clinical equipment
Nurse Posting	Nurses resident at the sub-district or district level; sub-district health centre based services; passive (facility-focused); bi-weekly/monthly outreach clinics at fixed locations	Community resident nurses providing static services based in community health compound augmented by active (client-seeking) outreach to families in their homes	Supervisory provision of fuel for household visitation activities and supplies for clinical work; supervisory community backstopping of nursing operations; community support for operations; in-service training for nurses; motorbike rider training and maintenance capacity building
Volunteer Deployment	None	Selection by traditional leaders and Community Health Committees, supervision by Community Health Committees; training by District Health Management Team	Train community leaders in volunteer recruitment and management; train Community Health Committees to select and supervise volunteers; train volunteers

Appendix 5: CHPS Logistics Requirements and Funding Source

CHPS LOGISTICS REQUIREMENT			
NO.	**LOGISTICS**	**DETAILS**	**Possible FUNDING SOURCE**
1	ACCOMMODATION	Home: two bedrooms,	DA
		kitchen, toilet, bath,	COMMUNITIES
		store, hall	
		Community Health Compound	DA, COMMUNITIES
2	FURNITURE	Living Room set	DHA
		Dining Hall Set	DHA
3	TV	Black and white	DHA
4	RADIO		DHA
5	KITCHEN WARE	set of plates & cups	DHA
		set of cooking ware	DHA
		set of cutlery	DHA
6	REFRIDGERATOR	Gas and Elect.	DHA, RHA
7	DRUGS	Basic Drugs	DHA
8	WORKING GEAR	Boot	RHA, DHA
		Rain Coat	RHA, DHA
		Heavy Duty Gloves	RHA, DHA
9	REPACKAGE DELKIT		RHA, DHA
10	STETHOSOSCOPE		DHA
11	CONSUMABLES	Basic Consumables	RHA, DHA
12	THERMOMETRES		DHA
13	ANGIOPOID LAMPS		DHA
14	WEIGHING SCALE	Bathroom Scale	DHA
		Salter Hanging	DHA
15	TRAINING MANUALS & DISSEMINATION		HQ, RHA
16	IE & C MATERIALS		HQ,RHA
17	COLD BOXES		HQ
18	TRANSPORT	Motorcycle	HQ
19		Bicycle	HQ, RHA
		Boat	HQ
20	BOAT LOGISTICS	Flash Light	HQ
		Camp Bed	
		Student Mattress	
		Life Jacket	
		Kerosene Stove	
		Megaphone	
		Wellington boot	
21	DELIVERY KIT		DHA

		Megaphone	
		Wellington boot	
21	DELIVERY KIT		DHA
22	SOLAR ELECTRIFICATION		DHA
23	THERMOMETER		DHA
22	STERILISER (SIMPLE)		DHA
23	VACCINE CARRIERS		DHA
24	COMMUNICATION		DHA
25	TORCH LIGHT		DHA
26	POTABLE WATER		DA, DHA

DRAFT PLANS FOR ROLLING OUT CHPS

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

NATIONAL REGIONAL SUMMARY

	Region	No of District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
					2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	Central	13	61	182	19	28	24	21	13	12	7	6	5	2	2
2	Western	13	70	168	13	34	27	21	19	15	12	11	6	4	4
3	Volta	15	70	160	32	25	27	16	12	17	9	9	8	5	1
4	Brong Ahafo	19	98	349	24	59	53	53	39	32	19	18	15	10	27
5	Ashanti	21	111	315	34	71	45	33	15	24	2	3			
6	Eastern	17	92	417	91	64	53	51	40	26	15	13	10	10	5
7	Upper East	8	51	181	28	17	17	15	15	12	12	9	8	5	2
8	Upper West	8	59	170	26	23	21	19	18	15	13	12	9	9	9
9	Greater Accra	6	31	90	3	15	11	12	8	9	9	9	8	7	6
10	Northern	18	86	284	21	28	28	27	27	22	30	22	24	27	28
11															
25	TOTAL	**138**	**729**	**2316**	**291**	**364**	**306**	**268**	**206**	**184**	**128**	**112**	**93**	**79**	**84**

**1: Each subdistrict is to be demarcated into zones comprising up to 3 or 4 Unit Committees (Population up to 5000) A zone could include a health centre or a hospital.*

**2: Priority for operationalisation will depend on availability of exsisting facilities. Areas without facility to be a priority*

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: UPPER WEST

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	JIRAPA/LAMBRUSI	13	30	5	3	3	4	3	3	2	3	2	2	3
2	LAWRA	10	22	2	2	2	2	2	2	2	2	2	2	2
3	WA MUNICIPAL	3	12	2	2									
4	WA EAST	6	21	3	3	6	5	4						
5	WA WEST	4	19	4	3	2	2	3	2	3	2	3	3	3
6	SISSALA EAST	6	18	2	2	2	2	2	3	2	2			
7	SISSALA WEST	4	14	1	3	3	2	2	2	1				
8	NADWLI	13	34	7	5	3	2	2	3	3	3	2	2	1
9														
	TOTAL	**59**	**170**	**26**	**23**	**21**	**19**	**18**	**15**	**13**	**12**	**9**	**9**	**9**

**1: Each subdistrict is to be demarcated into zones comprising up to 3 or 4 Unit Committees (Population up to 5000) A zone could include a health centre or a hospital.*

**2: Priority for operationalisation will depend on availability of exsisting facilities. Areas without facility to be a priority*

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: UPPER EAST

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	KASSENA NANKANA	5	37	4	3	2	2	2	2	2	2	2	2	
2	BOLGATANGA	9	16	1	2	2	2	2	2	2	1	1		
3	BAWKU EAST	9	24	5	1	2	1	2	2	2	1	1	1	1
4	BAWKU WEST	6	15	5	2	2	2	1						
5	BONG	6	36	4	4	4	4	3	3	2	2	1	1	1
6	BUILSA	5	17	4	1	1	1	1	1	1	1	1	1	
7	TANLENSI-NABDAM	6	17	2	2	2	1	1	1	1	1	1		
8	GARU-TEMPANE	5	19	3	2	2	2	3	1	2	1	1		
9														
12	**TOTAL**	**51**	**181**	**28**	**17**	**17**	**15**	**15**	**12**	**12**	**9**	**8**	**5**	**2**

**1: Each subdistrict is to be demarcated into zones comprising up to 3 or 4 Unit Committees (Population up to 5000) A zone could include a health centre or a hospital.*

**2: Priority for operationalisation will depend on availability of exsisting facilities. Areas without facility to be a priority*

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: BRONG AHAFO

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	KINTAPO NORTH	7	21	2	2	2	3	2	2	2	2	1	2	1
2	KINTAPO SOUTH	6	26	3	6	7	4	3	2	1				
3	DORMAA	8	42	1	3	6	6	6	3	4	4	2	1	6
4	BEREKUM	3	17		3	5	4	3	2					
5	TANO NORTH	5	18		5	3	5	4	1					
6	TAIN	5	18	3	3	2	3	2	3	1	1			
7	JAMAN SOUTH	5	16		2	2	2	2	2	2	1	1	1	1
8	ASUNAFO SOUTH	2	9	1	2	1	1	1	1	1	1			
9	NKORANZA	8	7	1	2	1	1	1				1		
10	SENE	5	17	4	4	5	3	1						
11	TANO SOUTH	3	11		3	1	2	1	1			2		1
12	ASUTIFI	6	17	1	2	1	1	2	2	1	2	1	2	2
13	ASUNAFO NORTH	3	11	2	3	2	1	1	1	1				
14	SUNYANI MUNICIPAL	7	23	3	4	7	4	2	2	1				
15	TECHIMAN MUNICIPAL	8	22	3	3	2	3	3		1	1	4	1	1
16	JAMAN NORTH	3	9		3	1	2	1	2					
17	ATEBUBU	5	28		3	3	3	2	3	2	2	1	1	8
18	PRU	6	25		2	2	2	2	2	2	2	2	2	7
19	WENCHI	3	12		4		3		3		2			
	TOTAL	**98**	**349**	**24**	**59**	**53**	**53**	**39**	**32**	**19**	**18**	**15**	**10**	**27**

*1: *Each subdistrict is to be demarcated into zones comprising up to 3 or 4 Unit Committees (Population up to 5000) A zone could include a health centre or a hospital.*

*2: *Priority for operationalisation will depend on availability of exsisting facilities. Areas without facility to be a priority*

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: ASHANTI

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	ADANSI NORTH	5	15		4	2	1	1	1					
2	ADANSI SOUTH	5	15	4	5	1	4	1						
3	AFGYA SEKYERE	6	18			1	2							
4	AHAFO ANO NORTH	5	11		3	3	5							
5	AHAFO ANO SOUTH	6	22	3	4	3	3	2	2	2	1			
6	AMANSIE CENTRAL	5	12		7	5								
7	AMANSIE EAST	5	14		1		1		1		1			
8	AMANSIE WEST	7	8	3	3		2							
9	ASANTE AKIM NORTH	5	17		2	2	2	2	2					
10	ASANTE AKIM SOUTH	6	15	1	1	1	1	1	10					
11	ATWIMA MPONUA	6	17	6	5	1	1	2	2					
12	ATWIMA NWABIAGYA	5	12		1	1	1	1	1					
13	BOSNTWE-ATWIMA-KWAWOMA	5	21		4	7	1		1					
14	EJISU-JUABEN	5	18	8	2	2	2	1	2		1			
15	EJURA-SEKYEDUMASE	7	18	3	8	5	1							
16	KUMASI	5	32	4	13	7	2	1						
17	KWABRE	2	2		2									
18	OBUASI MUNICIPAL	5	6		2	2	1	1						
19	OFFINSO	5	16	1	1		1	1						
20	SEKYERE EAST	5	19		3	1	2	1	1					
21	SEKYERE WEST	6	13	1	2	3	1	1	1					
25	**TOTAL**	**111**	**321**	**34**	**73**	**47**	**34**	**16**	**24**	2	3			

**1: Each subdistrict is to be demarcated into zones comprising up to 3 or 4 Unit Committees (Population up to 5000) A zone could include a health centre or a hospital.*

**2: Priority for operationalisation will depend on availability of exsisting facilities. Areas without facility to be a priority*

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: EASTERN

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	EAST AKIM	6	17	4	3	2	3	2	2	1				
2	ATIWA	5	24		3	2	2	2	3	2	3		4	1
3	KWAEBIBIREM	6	22	5	5	2	5	4	1					
4	FANTEAKWA	6	20	4	8	5	3							
5	BIRIM NORTH	6	30	20	3	1	1	2	2					
6	KWAHU WEST	4	20		2	2	2	2	2	2	2	2	2	2
7	KWAHU SOUTH	6	25	4	3	3	3	3	2	1	3	2	1	
8	MANYA - KROBO	6	32	3	3	3	3	2	3	2	2	2	2	2
9	YILO - KROBO	5	17	4	2	5	3	2	1					
10	ASUOGYAMAN	4	14	3	2	3	2	2	2					
11	AFRAM PLAINS	4	36	9	5	5	4	6	3	2				
12	NEW - JUABEN	4	24	4	8	6	5	1						
13	AKWAPIM NORTH	5	30	3	4	4	4	4	3	3	3	2		
14	AKWAPIM SOUTH	6	24	2	4	3	1	5	1	3	1	3		
15	WEST AKIM	6	22	7	4	1	5	5	2					
16	BIRIM SOUTH	7	28	11	5	6	6							
17	SUHUM - K - COALTAR	6	32	11	4	4	3	2	2	2	2	1	1	
18														
	TOTAL	**92**	**417**	**94**	**68**	**57**	**55**	**44**	**29**	**18**	**16**	**12**	**10**	**5**

**1: Each subdistrict is to be demarcated into zones comprising up to 3 or 4 Unit Committees (Population up to 5000) A zone could include a health centre or a hospital.*

**2: Priority for operationalisation will depend on availability of exsisting facilities. Areas without facility to be a priority*

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: VOLTA

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	KRACHI WEST	3	6	1	2	2	1							
2	KRACHI EAST	2	5			2	1	1	1					
3	NKWANTA	5	12	12										
4	KADJEBI	4	4	1	1	1	1							
5	JASIKAN	6	5	1	3	4								
6	HOHOE	3	5	2	1	2								
7	KPANDO	6	25	1	2	3	3	3	3	3	3	3	1	
8	SOUTH DAYI	4	3	1	1	1								
9	HO MUNICIPAL	4	4	1	1	1	1							
10	ADAKLU ANYIGBE	3	3	1	1	1								
11	AKATSI	5	15	2	4	1	2	1	5					
12	KETU	9	2		1	1								
13	SOUTH TONGU	6	17	3	2	2	1	1	2	1	1	1	1	
14	NORTH TONGU	6	23	4	4	4	4	2	2	1	1	1		
15	KETA	4	31	2	2	2	2	4	4	4	4	3	3	1
16														
	TOTAL	**70**	**160**	**32**	**25**	**27**	**16**	**12**	**17**	**9**	**9**	**8**	**5**	**1**

**1: Each subdistrict is to be demarcated into zones comprising up to 3 or 4 Unit Committees (Population up to 5000) A zone could include a health centre or a hospital.*

**2: Priority for operationalisation will depend on availability of exsisting facilities. Areas without facility to be a priority*

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: GREATER ACCRA

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	Accra Metro	13	3	1	1	1								
2	Dangme East	4	27		2	3	3	2	3	2	3	2	3	3
3	Dangme West	4	32	2	4	2	3	3	4	4	3	4	2	1
4	Ga West	3	29		5	3	4	3	2	3	3	2	2	2
5	Ga East	4	3		1	1	1							
6	Team Municipality	3	4		2	1	1							
7														
8														
		31	98	3	15	11	12	8	9	9	9	8	7	6

*1: Each subdistrict is to be demarcated into zones comprising up to 3 or 4 Unit Committees (Population up to 5000) A zone could include a health centre or a hospital

*2: Priority for operationalisation will depend on availability of exsisting facilities. Areas without facility to be a priority

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: WESTERN

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	MPOHOR WASSA EAST	5	20	2	1	2	1	2	2	2	2	2	2	2
2	SEFWI WIAWSO	6	26	2	4	4	3	3	3	3	2	1		
3	SHAMA AHANTA EAST	5	17		2	2	2	3	2	2	3			
4	WASSA WEST	7	7		2	2	2	1						
5	BIBIANI ANHWIASO BEKWAI	5	10		1	1	2	1	2	1	1	1		
6	NZEMA EAST	6	12		2	1	1	2	1	1	1	1	1	1
7	JOMORO	4	5	1	2	2								
8	WASSA AMENFI EAST	4	13	3	7	3								
9	JUABESO	7	12		3	2	2	2	2	1				
10	BIA	7	12		2	1	1	2	1	1	1	1	1	1
11	WASSA AMENFI WEST	5	11	3	1	1	2	1	1	1	1			
12	AOWIN SUAMAN	5	19	2	5	4	5	2	1					
13	AHANTA WEST	4	4		2	2								
14														
	TOTAL	**70**	**168**	**13**	**34**	**27**	**21**	**19**	**15**	**12**	**11**	**6**	**4**	**4**

**1: Each subdistrict is to be demarcated into zones comprising up to 3 or 4 Unit Committees (Population up to 5000) A zone could include a health centre or a hospital.*

**2: Priority for operationalisation will depend on availability of exsisting facilities. Areas without facility to be a priority*

DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: CENTRAL

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	KOMENDA EDNA EGAUFO ABREM	5	24	2	2	2	2	2	2	1	1	1	1	1
2	AGONA	8	11	1	2	1	1	1	1	1	1	1		
3	TWIFO HEMANG LOWER DENKYIRA	4	16	2	3	2	2	1	1	1	1	1		
4	ASSIN SOUTH	4	10	2	3	2	3							
5	ASSIN NORTH	4	9		3	4	3							
6	ASIKUMA ODOBEN BRAKWA	4	5		1	1	1	1	1					
7	AJUMAKO ENYAN ESSIEN	4	20	2	1	2	2							
8	ABURA ASEBU KWAMANKESE	4	19	2	2	2	1	1	1	1				
9	CAPE COAST MUNICIPAL	4	3	1	1	1								
10	AWUTU EFUTU SENYA	5	18	4	2	2	2	2	1	2	2	1		
11	MFANTSIMAN	5	13	2	2	2	2	2	2					
12	UPPER DENKYIRA	5	16	1	3	1	1	1	1	1	1	1	1	1
13	GOMOA	5	18		3	2	1	2	2					
14														
15														
25	**TOTAL**	**61**	**182**	**19**	**28**	**24**	**21**	**13**	**12**	**7**	**6**	**5**	**2**	**2**

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DRAFT REGIONAL PLANS FOR ROLLING OUT CHPS

Name of Region: NORTHERN

	District	No. of Subdistrict	No of Zones Demarcated following Guideline *1	No of Zones Prioriterized for operationalise each year *2										
				2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1	Bole	6	20	1	2	2	2	2	2	2	2	1	2	2
2	Sawla/Kalba	6	13	2	1	1	2	2		1	1	1	1	1
3	East Gonja	6	27	1	2	2	3	2	3	3	2	2	4	3
4	Yunyuo/Bungrugu	3	6		1		1	1		0	1	1	1	
5	East Mamprusi	5	21	1	2	2	2	2	2	2	2	2	2	2
6	Gushegu	3	18	2	1	2	2	1	1	2	2	1	2	2
7	Karaga	3	7	1	1	1	1			1	1		1	
8	Nanumba North	4	15	1	1	2	1	2	1	3		2	1	1
9	Nanumba South	3	10	1	1	1		1	1	1	1	1	1	1
10	Saboba/Chereponi	5	22	4	2	2	2	2	2	1	1	2	2	2
11	Savelugu/Nanton	6	20	1	2	2	2	2	2	2	1	2	2	2
12	Tamale	6	8	2	1	1		1		1	1	0		1
13	Tolon/Kumbungu	5	22	2	2	2	2	2	2	2	2	2	2	2
14	West Gonja	6	14	1	2	1	1	2	1	1	1	1	1	2
15	Central Gonja	5	15		2	1	2	1	1	3	1	1	1	2
16	West Mamprusi	5	8		1	1	1		1	1	1		1	1
17	Yendi	5	22		2	3	2	2	2	2	2	3	2	2
18	Zabzugu/Tatale	4	16	1	2	2	1	2	1	2		2	1	2
	TOTAL	**86**	**284**	**21**	**28**	**28**	**27**	**27**	**22**	**30**	**22**	**24**	**27**	**28**

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ANTE NATAL CARE REGISTER

Year: ----------

Facility / Zone: ..... **Sub-district:** ..... **District:** .....

DATE	NHIS Reg. No.	Serial No.	Mother's Reg. No.	Address (Location/ Community, Hse No.)	Mother's Name	Parity	AGE	HT (m)	GEST	EDD	HB at Reg.	HB at 36	Blood Group (ABO)	VDRL	Pre Test Counselling for VCT (HIV/AIDS)	BP	TRIMESTER			Protein in Urine	Subsequent Visits										TT			IPT			ITN (Y/N)	Remarks
																	1	2	3		2	3	4	5	6	7	8	9	10	11	12	1	2	Booster	1	2	3		

IMMUNIZATION REGISTER

Year: .....

Facility / Zone: ..... Sub-district: ..... District: .....

													POLIO				PENTA								
DATE	NHIS Reg. No.	Child's Reg. No.	Child's Name	Mother's Name	Parity	Address (Location/ Community / Hse. No.)	Date of 1st Reg.	DOB	SEX (M/F)	Weigh t (Kg)	Vit A	BCG	Po	P1	P2	P3	1	2	3	Measle s	YF	CSM	ITN	Remarks

OPD/CONSULTING ROOM (CHC)/HOME VISITS REGISTER Year:----------

Facility / Zone: ..... Sub-district: ..... District: .....

DATE	NHIS Reg. No.	Out Patient No.	Name	Address (Location /Community/Hse No.)	Age	Sex (M/F)	New Case (Tick)	Old Case (Tick)	Principal Diaganosis	Additional Diagonosis	Treatment given	Referred (Y/N)	Receipt No.	Remarks

FAMILY PLANNING CLIENT REGISTER Year: ----------

Facility / Zone: ..... Sub-district: ..... District: .....

DATE	NHIS Reg. No.	Serial No.	Client's Card No.	Name	Address (Location / Community / Hse No.)	Method of Choice	1st ever use (Y/N)	Age (circle if < 20 or > 35 yrs)	Parity (circle if >4)	MONTHS												Remarks
										Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	
										Mark under each month the commodity and the number of units issued. E.g. Lo-fem 3. Write "Referred" if the Client was conselled and referred for method. Put a circle if the client is supposed to return. This will help find defaulters.												

COMMUNITY HEALTH PROMOTION REGISTER Year: ----------

Facility/Zone: ..... **Sub-district:** ..... **District:** .....

DATE	Name of Community / Locality/School	Target / Audience	Health Talk / Meeting							School Health Services Provided (If any)	Supervision (indicate No.)		Remarks
			Topic	Purpose	Location (Tick)						Volunteers	TBAs	
					Durbar	CHC	Home Visit	School	Church				

DISEASE SURVEILLANCE REGISTER

Year: ----------

Facility/Zone: ..... Sub-district: ..... District: .....

DATE	Disease / Condition	No. of cases (Estatimate)	Informant (Who first reported disease)	Where was disease first identified? Address (Location / Community, eg. CHC)	Date subdistrict / district was notified	Date suspected outbreak was investigated by the district.	Outcome of District's investigation (Confirmed, Ruled Out, or Unknown)	No. of cases actually identified	Date Outbreak Begun (Date onset index case/date crossed threshold or first cluster)		Date case was first seen at a health facility	Date Appropriate intervention began	Type of Appropriate Intervention that was began	Date CHO/ subdistrict received District's response	Remarks
									Index Cases	Threshold					

MATERNITY / PNC REGISTER Year: ----------

Facility / Zone: ..... Sub-district: ..... District: .....

DATE	NHIS Reg. No.	Serial No.	Name	Address (Location / Community / Hse No.)	Age	Parity	Duration of pregnancy	Date Seen	Date		Outcome of delivery (Tick)		Type of Birth (Tick)		Delivered by who?	Post Natal Family Planning		VIt. A (Y/N)	ITN (Y/N)	Remarks
									Discharged	Referred	Single	Multiple	Live	Still		Accepter (Y/N)	Method (If Y)			

This report was made possible through an award of the Population Council that is supported by the Office of Population, Bureau of Global Programs, Field Support & Research, U. S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010

“ CHPS is essential health care based on practical,
scientifically sound and socially
acceptable methods and technology made universally accessible to
individuals and families in the community through their full participation and
at a cost that the community and the country can afford to maintain at
every stage of their development in the spirit of self-determination -
It focuses on the health by the people by placing
people's health in people's hands”