



Community-Based Health Planning and Services (CHPS) National Implementation Guidelines



This guide is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Program and do not necessarily reflect the views of USAID or the United States Government.

Additional technical support provided by Japan International Cooperation Agency JICA and Financial Support from the World Bank and Korea International Cooperation Agency KOICA

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Abbreviations

ANC	Antenatal Care
ARI	Acute Respiratory Infection
BF	Breastfeeding
BP	Blood Pressure
CBSV	Community-Based Surveillance Volunteer
CDS	Community Decision System
CETS	Community Emergency Transport System
CHAP	Community Health Action Plan
CHMC	Community Health Management Committee
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community-Based Health Planning and Services
CHV	Community Health Volunteer
CMAM	Community Management of Acute Malnutrition
CWC	Child Welfare Clinic
DA	District Assembly
DCE	District Chief Executive
DDHS	District Director of Health Services
DHD	District Health Directorate
DHIMS2	District Health Information Management System
DHMT	District Health Management Team
DHSP	District Health Service Profile
EMD	Estate Management Department
EN	Enrolled Nurse
EPI	Expanded Programme on Immunization
FHD	Family Health Division
FP	Family Planning
FSV	Facilitative Supervision
GHC	Ghana Cedi
GHS	Ghana Health Service
HASS	Health Administration and Support Services
HC	Health Centre
IEC	Information, Education, and Communication
ICD	Institutional Care Division
IGF	Internally Generated Funds

IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Neonatal and Childhood Illness
IPO	Immediate Postpartum Observation
ITN	Insecticide-Treated Net
IYCF	Infant and Young Child Feeding
JICA	Japan International Cooperation Agency
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MMDA	Metropolitan, Municipal, and District Assembly
MNDA	Maternal and Neonatal Death Audit
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MP	Member of Parliament
N/A	Not Applicable
NGO	Non-Governmental Organisation
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NTD	Neglected Tropical Diseases
OPD	Outpatient Department
OPV	Oral Polio Vaccine
PFM	Public Financial Management
PHC	Primary Health Care
PLA	Participatory Learning Approach
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
PPMED	Policy, Planning, Monitoring and Evaluation Division
PR	Performance Review
PS	Performance Standard
RDHS	Regional Director of Health Services
RHD	Regional Health Directorate
RHMT	Regional Health Management Team
SDHT	Sub-District Health Team
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant

Foreword

The Community-Based Health Planning and Services (CHPS) initiative as a strategy to deliver primary health care services at the community level is a key health system reform for the Ghana Health Service (GHS). The levels of health care provision have been clearly defined and articulated in the GHS and Teaching Hospitals ACT, 1996 (ACT 525).

Over the years, the predominant notion of health service delivery has largely been facility-

based. As such, GHS have concentrated on improving both volume and quality of service delivery at the Hospitals and Health Centres. We have invested in constructing health facilities since independence, hoping that the presence of these facilities will make the population healthier. However, Ghana's outpatient department (OPD) attendance has plateaued and maternal mortality and child mortality and morbidity remain high. For a very long time, there has been little or no community participation in health decision-making.

If the health sector is to achieve the health-related Sustainable Development Goals in Ghana, then there is the need to accelerate the paradigm shift in health service provision with the CHPS strategy. The CHPS strategy, if implemented faithfully according to this National CHPS Implementation Guidelines of the Ministry of Health/Ghana Health Service, provides us with a vehicle to deliver primary health care services at the community level by engaging the community members themselves in taking decisions concerning their own health. The primary producers of health are the individuals within households - especially mothers.

The goal and vision of the Ghana Health Service is that every member of the household remains healthy with unlimited access to primary health care services for all ages everywhere and at all times. An enabling environment to provide referral services and backstopping will facilitate the delivery of continuum of care.

I am confident that in harmonizing and standardizing the collective efforts of all stakeholders in scaling up CHPS implementation in this country, we will be steadily cruising towards providing all people living in Ghana with universal access to quality primary health care services by 2030.



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September 2016

Acknowledgments

The National CHPS Implementation Guidelines was developed as a result of the collaboration between Ministry of Health, Ghana Health Service, JICA, USAID, Maternal and Child Survival Project–USAID, and System for Health Ghana-USAID and ably led by Dr. Koku Awoonor-Williams, Director Policy Planning, Monitoring, and Evaluation Ghana Health Service (GHS). Through this collaboration, resource persons in various fields relevant to the development of the guidelines worked as Technical Working Group to develop this National CHPS Implementation Guidelines. In no special order these Technical Working Group members are:

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The writing team would also like to acknowledge the support and rich contribution of Dr. Ebenezer Appiah-Denkyira, Director General of Ghana Health Services, Dr Erasmus Agongo, former Director PPMED/GHS, Tomoya Yoshida, then Policy Advisor PPMED/GHS/JICA, and Dr. Koshie Nazzar, then Consultant, PPMED/GHS/JICA in facilitating the development of this document.

Chapter One: Introduction

The Ghana Health Service (GHS), as mandated by Act 525 of 1996, is to provide and prudently manage comprehensive and accessible quality health services with emphasis on Primary Health Care in accordance with approved National Policies. In pursuit of this mandate, the GHS has over the years implemented a number of initiatives including CHPS to significantly reduce health inequalities and to promote equity of access to health by removing geographic barriers at the community level.

The CHPS strategy involves mobilisation of community leadership, decision-making systems, and resources in a defined catchment area, the placement of reoriented frontline health staff known as Community Health Officers (CHOs) with logistics support, and community volunteer systems to provide services according to the principles of primary health care (PHC).

CHPS as a strategy must be used as a unified platform to deliver all health services at the community level and must be based on the Health Family Concept.

Background

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 (TBAs). This preceded the Alma Ata Declaration in 1978 of “Health for All by year 2000” that focused on PHC.

CHPS began as a community health and family planning project based on lessons learnt from Bangladesh (Phillips, 1988) and was piloted in Navrongo as operations research in 1994. CHPS became a breakthrough in enhancing community involvement and ownership of PHC interventions towards achieving Universal Health Coverage. In 1999, consensus was reached to adopt and scale up the CHPS initiative as a national strategy to improve access, efficiency, and quality of health care (Ghana Health Service, 2003).

Fifteen steps were developed to guide the implementation process. Community health nurses (CHNs) were provided further training and were designated CHOs as resident health care providers in geographical coverage areas known as CHPS zones. The CHOs:

- Provided reproductive, maternal, and child health services;
- Managed diarrhoea;
- Treated malaria, acute respiratory infections (ARIs), and childhood illness; and
- Provided comprehensive family planning (FP) and childhood immunisation outreach.

The CHOs were supported by volunteers whose roles involved educating the community on basic health issues and serving mainly as agents of referral services and community social mobilisation, generally delivering these services through home visits. Treatment was provided for those who visited the CHOs at their residence compound. The CHPS model relied on communities and other stakeholders to provide financial or in-kind resources for construction and provide oversight for service delivery and welfare of the CHOs.

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 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 barriers of access to care. The National Health Insurance Scheme (NHIS) was seen as the social intervention to address the financial barrier and CHPS was to address the geographical barrier by making basic services available “close to client”.

Ghana has been implementing the CHPS programme at national scale for the past 10 years. Implementation of CHPS is fraught with several policy and systems-level challenges. Different reviews point to a lack of clear policy direction, unclear definitions, and an unending conceptual debate. There are also issues in relation to effective leadership and technical direction. Planning and budgeting for CHPS at the national, regional, district, and community levels has been inadequate. The CHPS Policy was therefore revised and launched in March 2016 to address the implementation challenges.

This CHPS National Implementation Guidelines has been developed to translate the policy into guidelines to serve as a vehicle to deliver PHC services at the community level based on known evidence and proven strategies. It outlines the community-level systems and the enabling environment needed to provide referral services and backstopping that will facilitate the delivery of care along the continuum from household to CHPS compound.

CHPS Policy Directives

The CHPS policy directives cover five areas as follows:

- **Duty of care and minimum package:** defines the core package of services to be provided within the CHPS zone by the CHO and Community Health Volunteer (CHV). The package focuses predominantly on maternal and child health (MCH) and nutrition services. Coordination and linkages with private health facilities in the CHPS zone is emphasised.
- **Human resources for CHPS:** clarifies who a CHO is and determines the CHO-to-population ratio. It directs that a system for career progression be developed and incentive schemes instituted. It also identifies the essential role of the CHVs.
- **Infrastructure and equipment for CHPS:** defines standards for a CHPS compound and the accompanying list of equipment and furnishings, and directs that all CHPS compound construction shall comply with MOH standard design. Guidance for completing ongoing projects is provided. Establishment of CHPS zones and location of CHPS compounds shall be determined by District Assembly (DA) and all land for construction shall be documented and sealed at the Land Title Registry. Rural and underserved areas shall be prioritised for CHPS construction and guidance is provided for urban CHPS.
- **Financing:** Directs that all services delivered in a CHPS compound shall be free and assigns government the primary responsibility for financing.

- **Supervision, monitoring, and evaluation:** The main policy provides for the hierarchy of supervision, monitoring, and evaluation. It indicates that the Officer in charge of the sub-district shall supervise the work of the CHO, with technical support from the District Health Management Team (DHMT).

General Principles for CHPS Implementation

The general principles guiding the development and implementation of CHPS are:

- Community participation, empowerment, ownership, gender considerations, and volunteerism
- Focus on community health needs to determine the package of CHPS services
- Task shifting to achieve universal access
- Communities as social and human capital for health system development and delivery
- Health services delivered using a system approach
- CHO as a leader and community mobiliser

Purpose of the CHPS National Implementation Guidelines

This Implementation Guidelines seeks to provide direction on the implementation of the essential elements of CHPS to ultimately:

- Improve equity in access to basic health services,
- Improve efficiency and responsiveness to community health needs,
- Strengthen inter-sectoral collaboration and community engagement systems, and
- Empower households to support PHC.

Chapter Two: CHPS Implementation

Introduction

Implementation of the CHPS strategy contributes towards health sector efforts to achieve Universal Health Coverage by establishing a District Health System comprising three service delivery levels - community (CHPS zone) level, sub-district (health centre) level, and district (hospital) level - with strong referral components between levels. Universal Health Coverage can be achieved through careful planning based on adequate knowledge of the disease patterns and services within the sub-district. Implementation is focused on providing access to, and promoting utilisation of, PHC while actively engaging the community to participate.

This chapter describes a detailed approach to CHPS implementation by defining key terms, specifying roles and responsibilities of CHOs and Volunteers, articulating the 15 steps of CHPS implementation, and describing the basic package of services to be provided.

Definition of Key Terms

CHPS

The National CHPS Policy (March 2016) defines CHPS as “a national strategy to deliver essential community- based health services involving planning and service delivery with the communities”. Its primary focus is communities in deprived sub-districts and in general bringing health services close to the community. The policy determined that the following constitute the components for CHPS implementation:

- **CHPS Zone:** A demarcated geographical area of up to 5,000 persons or 750 households in densely populated areas and may be conterminous with electoral areas where feasible.
- **Functional CHPS Zones:** A *functional* CHPS *zone* can be either *completed* or *uncompleted*. The functionality of a CHPS zone does not necessarily depend on the presence of a compound, though a CHPS Compound is *highly* desirable in a zone where there is no health centre or hospital, particularly in an underserved or “oversea area”.
- **Completed Functional CHPS Zone:** A completed functional CHPS zone is one in which all the milestones have been completed and the CHO actually resides in the community (in a CHPS compound) and provides a basic package of services to the catchment population.
- **Uncompleted Functional CHPS Zone:** An uncompleted functional CHPS zone is a CHPS zone where:
 - The community entry process is completed and community members are sensitised and are fully engaged;
 - The CHMC has been formed and introduced to the community through a durbar (formal community gathering) and is actively involved in health planning and service delivery design;
 - A CHO has been deployed to the defined zone after being introduced to the community through durbar or meeting with key stakeholders;
 - Volunteers have been selected from the community, introduced to the community through durbar, and trained for service delivery;
 - A community profile (see Appendix A) is in place;

- Health service delivery is targeted at households and families, particularly through home visits;
 - The CHPS zone is in the District Health Information Management System (DHIMS2) database as an organisational unit and data on activities are entered monthly*;
 - The Community Health Compound (newly constructed, rented, hired, or refurbished) and some of the needed equipment are not yet ready.
- Where a functional CHPS zone does not have a CHPS compound, the CHPS zone shall have at least an operating point of reference such as office working space.
 - **CHPS Compound:** An approved structure consisting of a service delivery point and CHO residential accommodation complex, both of which must be present.
 - **Community Health Officer (CHO):** A trained and oriented (in CHPS) Health Staff working in a CHPS zone. The CHO may be assigned to live in a community within the zone.
 - **Community Health Volunteers (CHVs):** Non-salaried community members identified and trained to support CHOs in a community within the CHPS zone.
 - **Community Health Management Committee (CHMC):** A group of community leaders with different competencies and responsibilities drawn from the communities within the CHPS zone. CHMC members volunteer to provide community-level guidance and mobilisation for the planning and delivery of health activities and to see to the welfare of CHOs in their communities.

Roles and Responsibilities

This section outlines the roles and responsibilities of the CHOs, CHMC, and CHVs in a CHPS zone.

CHO

The CHO is a trained health worker oriented in CHPS and placed in a CHPS zone to work with communities to achieve the objectives of providing basic PHC. Their roles are summarised in Box 1. CHO, like District Director of Health Services (DDHS) or Sub-District Head, is a position requiring a worker with technical skills as well as community mobilisation skills but *not* a professional grade. The CHO in a CHPS zone is a member of the SDHT responsible for carrying out basic health services. The CHO in the community shall perform three main tasks:

* In the event that a facility such as a health centre or a district hospital falls within a CHPS zone and has a CHO assigned, data generated by the CHO working from that facility as operating point of reference shall be separately reported in the DHIMS2 database.

1. As a health service provider (see more details in Appendix B and Table 2)
 - Sexual and reproductive health: FP, antenatal care (ANC), PMTCT/early infant diagnosis, skilled delivery, postnatal care, adolescent sexual and reproductive health
 - Child health: expanded programme on immunization (EPI), community integrated management of neonatal and childhood illnesses
 - Growth monitoring programme
 - Disease surveillance and control
 - Treatment of minor ailments
 - Health education and counselling for healthy lifestyles and good nutrition
 - Household visits (house-to-house and home visits)
 - Understanding community needs and communicating these needs to the sub-district to enable the DHMT to plan a more effective and relevant service delivery intervention
 - Community Mental health
 - Care of the aged
2. As a leader
 - Establish and sustain good interpersonal relationships
 - Work with community leaders and CHMC members
 - Participate and lead national health activities in the communities
 - Conduct meetings with key social groups
 - Participate in CHMC meetings, health durbars, and special health education sessions
3. As a manager
 - Managing resources (logistics, money, equipment)
 - Supervising CHVs and TBAs
 - Participating in sub-district/district activities
 - Record-keeping and reporting

Box 1: Roles of the CHO

- Engage the CHMC to manage community health service;
- Initiate process for and develop community profile in collaboration with CHMC and CHVs;
- Act as change agent for community health-seeking behaviour;
- Engage community stakeholders for dialogue on CHPS;
- Carry out community advocacy and diplomacy for CHPS;
- Deliver home-specific and home-relevant health services (prevention, promotion, and minor ailment treatment);
- Treat minor ailments at the CHPS compound and refer more severe cases to higher care level;
- Supervise supportive cadres and volunteers in technical community health service delivery;
- Deliver school health services (prevention, promotion, and minor ailment treatment) with the support of the sub-district;
- Manage and account for resources (financial and logistical) at the CHPS compound;
- Work closely with and report to the Sub-District Health Team.

CHMC and CHVs

For successful CHPS implementation, selection, approval and training of CHMCs and CHVs are key. In selecting the CHMCs and CHVs, both sexes shall be well represented.

CHMC

The CHMCs are volunteers, made up of dedicated, respected, and willing leaders (both men and women), who supervise the health system at the community level and also administratively supervise the CHVs. These are opinion leaders from the various development bodies in the constituent communities that come together to form the CHPS zone. They report directly to the chief and are accountable to the community members. Their roles are explained in Box 2.

CHVs

The CHO shall be assisted by the CHVs. The volunteers are publicly identified, vetted, and approved for community service through a community durbar. The selected volunteers are then trained by the DHMT/SDHT/CHO and presented publicly at another durbar where the tasks the CHVs may and may not carry out are explained to all community members. Volunteers are then commissioned for community work to assist the CHO. They are administratively supervised by the CHMC while the CHO supervises their technical performance. Their roles are explained in Box 3.

15 CHPS Implementation Steps

The implementation of the CHPS strategy demands systematic and joint planning and execution by the DHMT, the SDHT, and the community leadership as well as the citizenry at large. Table 1 outlines the step-by-step activity sequence and the milestone that each series of steps will achieve. In practice, GHS shall carry out steps as needed, and not necessarily in order, to improve the implementation process. Below are further details on each step.

Box 2: Roles of the CHMC

- Liaise between traditional leaders and health authorities;
- Carry out community advocacy and diplomacy for CHPS;
- Develop Community Health Action Plans (CHAPs);
- Mobilize and sensitize the community for health action;
- Collaborate with the CHO and support the CHPS service delivery;
- Engage and administratively supervise the CHV to support CHPS service delivery;
- Mobilize resources for CHPS service delivery;
- Organize community health meetings (durbars) and provide feedback to communities on health issues with the support of the CHO;
- Settle disputes between CHOs, CHVs, and the community;
- Assist in the maintenance of the CHPS compound.
- Establish Community Emergency Transport System (CETS)

Box 3: Roles of the CHV

- Mobilize and sensitize the community to take action to manage health in the community;
- Collaborate with the CHO and support CHPS service delivery;
- Visit, assess, and advise on environmental factors in the home that can affect health;
- Assist the CHO in home visits, outreach services, and work at the CHPS compound;
- Conduct home visits for health education and follow-up of defaulters;
- Carry out disease surveillance and report on disease and health events;
- Liaise between CHO and community members on health status of community;
- Support in the organization of community durbars and disseminate health information;
- Provide first aid and treatment of minor ailments in hard-to-reach areas (which shall be context specific), and refer cases to the CHO;
- Assist in compiling and updating a community register and profile;
- Refer serious cases to the CHO or notify the CHO and refer to a higher level.

Table 1: Summary of 15 steps and milestones for CHPS implementation

Step	Key Task	Activities	Responsible	Output	Milestone Achieved
One	Plan	<ul style="list-style-type: none"> Situation analysis and problem identification at the DHMT level Consultation with District Assembly (DA): the District Chief Executive (DCE) and the Social Services Sub-Committee Zoning of communities in the district District CHPS Scale-up Plan 	The DHMT (DDHS and public health nurses/ midwives)	<ul style="list-style-type: none"> Compiled situation analysis of available resources and programme requirements Detailed report showing the list of demarcated CHPS zones prioritised by year of implementation 	Detailed plan created
Two	Consult and raise awareness of CHPS	<ul style="list-style-type: none"> Consultation and sensitisation of health workers 	DHMT	<ul style="list-style-type: none"> Health workers accept CHPS strategy 	
Three	Dialogue with community leadership	<ul style="list-style-type: none"> Identify contact persons e.g. assembly member Meet with the community's leadership Sensitise the chief and his elders highlighting key support areas from the chief and community (e.g. community durbar, workspace, land) 	The DHMT (DDHS and public health nurses/midwives)	<ul style="list-style-type: none"> Chief and elders of the communities making up the zone sensitised 	Community entry conducted
Four	Organise community information durbar	<ul style="list-style-type: none"> Community information durbars Participation by all communities making up the zone Address questions and concerns of community members Site selection and approval Roles and responsibilities of stakeholders including community members 	Community leaders/DHMT	<ul style="list-style-type: none"> Informed community created 	
Five	Select and train staff as CHOs	<ul style="list-style-type: none"> Assess, counsel, and select staff who are interested in community work Train/orient selected staff as CHOs Discuss with each CHO the zone where she/he shall be assigned 	DHMT/SDHT	<ul style="list-style-type: none"> Certification of CHOs 	
Six	Select, approve, and orient CHMC	<ul style="list-style-type: none"> Selection of CHMC members based on the criteria outlined in the section "Step 6: Select, Approve, and Orient CHMC" in this guideline Durbar for approval of CHMC Orientation of CHMC 	Community leadership, SDHT, DHMT	<ul style="list-style-type: none"> CHMC members confirmed, and have signed a social commitment contract during the durbar 	
Seven	Compile community profile	<ul style="list-style-type: none"> Compilation of community profile: information on geographic and demographic characteristics, 	DHMT; SDHT; CHMC members;	<ul style="list-style-type: none"> Community profile brief and register established 	

Step	Key Task	Activities	Responsible	Output	Milestone Achieved
		settlement patterns, existing human habitation, and health features and facilities <ul style="list-style-type: none"> • Read any available literature about the communities making the zone especially where the compound shall be sited • Ask individuals in the community about the history, norms, taboos, sacred places, occupations, etc. • Conduct a transect walk to identify important landmarks including schools, churches, mosque, chief palace, market, etc. • Inform the opinion leaders on the necessity and time needed to register community members • Register community members by community and by household • Summarise the results to obtain population by community, number of households by community, etc. 	DA; community leadership		
Eight	Construct/ operationalise compound	<ul style="list-style-type: none"> • Procurement (construction, renovation, hiring, renting, or rehabilitation) of Community Health Compound for CHO residence • Refer to the boxes 26, 27 and 28 in the “Community Participation in the Planning . . .” section of this guideline for further details 	CHMC	<ul style="list-style-type: none"> • Community Health Compound constructed 	Community Health Compound operationalised
Nine	Provide CHPS logistics	<ul style="list-style-type: none"> • Provide sufficient supplies, medicines, equipment, furniture, and transport to CHPS zone for service provision 	DHMT	<ul style="list-style-type: none"> • Logistics stocking and Management System Established 	Essential equipment supplied
Ten	Organise durbar to launch activities of the CHPS zone	<ul style="list-style-type: none"> • Organise community information durbar to formally launch CHPS in the community • Formal introduction of CHOs to the community at the durbar 	Community leaders supported by DHMT/DA	<ul style="list-style-type: none"> • Community awareness, understanding and support for CHPS and the CHOs 	CHO posted
Eleven	Select CHVs	<ul style="list-style-type: none"> • Selection of CHVs (refer to “Step 11: Select CHVs” section of these guidelines for selection criteria) 	CHMC, SDHT	<ul style="list-style-type: none"> • CHVs’ acceptance of status 	CHVs deployed
Twelve	Approve CHV selection	<ul style="list-style-type: none"> • Host durbar to finalise the selection and gain approval of CHVs from community and community leadership 	CHMC, SDHT	<ul style="list-style-type: none"> • Community approval obtained 	
Thirteen	Train CHVs	<ul style="list-style-type: none"> • Training of CHVs based on the training content spelt out in section “Step 13: Train CHVs” 	DHMT, SDHT	<ul style="list-style-type: none"> • Certification of CHVs 	

Step	Key Task	Activities	Responsible	Output	Milestone Achieved
Fourteen	Procure logistics, equipment, and volunteer supplies	<ul style="list-style-type: none"> Mobilisation of logistics and equipping the volunteers 	DHMT, SDHT	<ul style="list-style-type: none"> Logistics management system established 	
Fifteen	Launch the CHPS zone	<ul style="list-style-type: none"> Launch the CHPS zone Introduce CHMC, CHVs, and CHO during the durbar Introduce security guard for the compound, etc. 	Chiefs, CHMC, and SDHT	<ul style="list-style-type: none"> CHPS zone launched and services provided 	

Practical Implementation of the 15 Steps

This section outlines the key steps that are useful in developing a micro plan to create a CHPS zone from the list of demarcated CHPS zones. A partnership micro plan developed in collaboration with the DDHS and DCE and captured in the District Medium-Term Plan has proved to be most successful (Awoonor, 2015).

Step 1: Planning and Demarcating a CHPS Zone

Conducting Situational Analysis

The essential or key step in implementing CHPS for all districts is conducting a *situational analysis* of service delivery and coverage as well as an appraisal of the status of CHPS implementation in the sub-district (See Appendix C for further details). This is the stage where health managers reflect on the performance of the health sector, use the information to design the CHPS programme, select demarcated electoral areas for priority intervention with CHPS, consult and sensitise health workers, and dialogue with community leaders and the DA for their inputs into the design (For a brief description, see Box 4).

CHPS zones shall be aligned to the electoral areas. The number of CHOs and CHPS zones in an electoral area shall be calculated based on the recommended CHO-to-Population ratio of 1:1,440. The calculation is based on the assumption that a CHO uses 50% of days in the week for home visits to households and the average size of a household is six people (See more detail in Box 5). If the electoral area has more people than one CHPS zone can serve, the electoral area can be demarcated into multiple CHPS zones. However, based on the local context and available resources, this CHO-to-Population ratio could vary upon consultation with DDHS and RDHS.

Within existing resource constraints, the focus in establishing CHPS shall be prioritised for the most underserved communities in both rural and urban areas in districts before the eventual roll-out to cover 100% of the population of sub-district/municipal/metropolitan areas.

Planning to Create a CHPS Zone

Once the list of demarcated CHPS zones in the district is agreed on by all stakeholders including health team, DA, chiefs, etc., it then becomes a working document for the District Director of Health Services to use for lobbying and advocating for resources to increase geographical access. Agreed demarcated CHPS zones, like sub-districts, shall not be changed

Box 4: What is a situation analysis?

This is the process by which the DHMT carries out a critical examination of its operations in the delivery of primary health care services to the people of the district with the view of:

- Assessing the DHMT's capabilities,
- Identifying the challenges, and
- Developing a new and more relevant program of action.

By this process, the DHMT constitutes itself into a special review team made up of the DDHS, the medical superintendent in charge of the district hospital, the public health nurse, the disease control officer, the medical assistant, and the sub-district heads.

Box 5: CHO-to-Population calculations and assumptions

Home visits = 8 homes a day

Working 5 days a week, but performing home visits at 50% of working time \approx 3 days a week

4 weeks a month ($8 \times 3 \times 4 = 96$ homes)

10 months a year = 960 homes

To be able to make four visits to each home in a year = $960 / 4 = 240$ homes per CHO

Average # of people per home = $6 \times 240 = 1,440$ persons per CHO

arbitrarily without any compelling reasons for change. Where a demarcated zone is perceived to be big by population size or surface area, it will be better to assign more CHOs to the zone than to re-demarcate the zone. The list of agreed demarcated CHPS zones for a district shall therefore remain constant and shall be prioritised by zone and year for implementation. The plan for making these demarcated CHPS zones functional over a period of years shall be developed by the DDHS and shared with the DCE and other stakeholders.

While there are several other successful approaches to planning to create a CHPS zone, one approach that has worked well is the DDHS-DCE partnership approach. The DDHS, DCE, and other development partners shall consider a number of these zones in the medium-term development plans and budget for these zones appropriately. This shall be an annual affair, especially in the most underserved districts in the country. Intermittent political interference must be considered and tolerated at this stage. A detailed implementation plan shall be developed specifically for the zone. This plan shall include community entry and sensitisation durbars; siting or workspace selection; assigning a CHO; provision of essential medical equipment, logistics, and other working materials; compound construction depending on the situation; etc.

Step 2: Consult and Raise Awareness of CHPS

Once the preparatory work is concluded between the DHMT and DA or any other development partner, the SDHT is briefed on the level of preparation for that particular zone. The awareness creation meeting shall highlight staffing of the zone, community entry and registration, logistics support, and the roles and responsibilities of SDHT, DHMT, DA, community and other stakeholders.

Step 3: Dialogue with Community Leadership in the Zone

The dialogue meeting between the DHMT/SDHT and the chiefs shall discuss the following:

- The distribution of health facilities and health workers in the district
- The weaknesses in the health delivery system and the problems of access
- The role of chiefs, elders, and key stakeholders and their people in improving access to health delivery
- The community health programme/CHPS concept
- Other areas include:
 - Formation of CHMCs as an advisory body
 - Operation of CHV system—selection of volunteers and their supervision
 - Construction of CHPS compounds
 - Safety and security of the CHPS compound and health workers
 - Identifying and using other community structures—opinion leaders, youth groups, etc.—to facilitate CHPS programme activities

Refer to Chapter Four for how to organise a community durbar.

Step 4: Organise a Community Information Durbar with Communities in the CHPS Zone

The community information durbar is a durbar organised for all the participating communities and their members. The following are highlighted during the durbar:

- The roles of chiefs, elders, and key stakeholders and their people in improving access to health delivery
- The community health programme/CHPS concept

Other areas include:

- Formation of CHMCs
- Operation of CHV system—selection of volunteers and their supervision
- Construction of CHPS compounds
- Safety and security of the CHPS compound and health workers
- Identifying and using other community structures—opinion leaders, youth groups, etc.—to facilitate CHPS programme activities

Step 5: Select and Train Staff as CHOs

Health staff such as CHNs, midwives, and enrolled nurses (ENs) are selected from all the districts in the region based on the need of each district and the availability of resources for the training. The training consists of 6 days of theory on the Volumes 1, 2, & 3 of the CHO Training Manual (including “must-do” modules) and other special lectures plus 4 days of field work. The field work covers the following:

Box 6: Must-do Modules in CHO Training Manual Volume 1

- Current Health Status and CHPS Concept
- Managing CHO activities
- Home Visiting for Health Activities
- Supporting Community Health Volunteers
- Behaviour Change Communication
- Working with Communities (including use of PLA tools and CHAP)
- Resource Management

Day 1

- Interaction with CHO and volunteers
- Transect walk to identify key landmarks in the community, e.g., market, church/mosque, chief palace, water source, schools

Day 2

- Home visits

Day 3

- School health

Day 4

- Organise a community durbar and give feedback

A preparatory meeting is organised prior to the main training to:

- Review modules, case studies, pre- and post-test, and programme
- Share roles and responsibilities
- Organise learning aids and other materials
- Discuss field work arrangements

The modules, training duration, and field work shall be revised after CHPS training is implemented as part of CHN education curricula nationwide.

Step 6: Select, Approve, and Orient CHMC

The CHMC, made up of dedicated, respected, and willing leaders (both men and women), shall supervise the health system at the community level and also administratively supervise the CHVs. These are opinion leaders from the various development bodies in the communities that constitute the CHPS zone. CHMC members report directly to the chief and are accountable to the community members. After the identification and selection of the CHMC members by the community members with the facilitation of the community leadership (chiefs, queen mothers, elders, assembly members, opinion leaders, etc.), the CHMC members undergo orientation by the DHMT/SDHT. This prepares them to play lead roles in effectively mobilising the communities for participation in CHPS implementation.

CHMC Composition

CHMCs shall be gender balanced and include the following:

- A representative from each village within the zone
- A generally recognised and respected women's leader
- A generally recognised and respected male personality/opinion leader in the community
- A representative of the Unit Committee/Area Council
- The assembly member of the area
- A representative of the Paramount Chief
- Any other personality the community deems necessary

Step 7: Compile Community Profile and Delineate CHO Work

The SDHT and the staff assigned to the zone shall develop a community profile and define the initial scope of work of the CHO and share this with the District Health Administration. The scope of work and available resources shall include whether the assigned staff will be resident or not, work 5 days or less in the zone, and the type of logistics required. The profile (Appendix A) includes, but is not limited to, the following:

- Names of communities making up the zone and the proposed name of the CHPS zone
- Map of the zone showing important landmarks in the zone
- Major economic activities of the zone
- Social services and amenities in the zone
- Estimated population by gender, service target groups, etc.

Step 8: Construct/Operationalise Compound

When planning for the construction of a new CHPS compound, the DHMT shall plan an initial meeting with all the community leaders residing in the CHPS zone. This is often done during the dialogue meeting with the chief and elders and, subsequently, during the community sensitisation durbar.

Ensure that the site selected is in the proper area for the intended use:

- The site shall be checked for possible constraints to its use: size, topography, drainage, soil conditions, natural features and limitations, catchment area to be served, social acceptability, convenience to the community and the CHOs, etc.
- The site shall be free from dangers of flooding and pollution of any kind, including air, noise, water, and land pollution. Refer to the “Infrastructure Management” section of this guideline on how to properly acquire land titles.

Step 9: Provide CHPS Logistics

Some equipment and supplies are needed to ensure productivity. For example:

- Motorbikes for CHOs and bicycles for volunteers
- Relevant registers and reporting formats
- Medical and non-medical consumables
- Home visiting bags with contents
- Medical equipment and other comfort items
- CHPS compound (Service delivery area and residential accommodation for CHO)

Step 10: Launch the CHPS Programme at Durbar

This durbar is used to sensitise the community members of the key activities that shall be carried out in preparation for the actual launching or commissioning of the CHPS compound. Some of these activities include:

- Introduction of the CHO to the communities as the provider of PHC
- Community registration and developing a community profile
- Volunteer selection and orientation

Step 11: Select CHVs

The selection criteria for a CHV shall include community trust, volunteer spirit, dedication, honesty, and willingness to stay permanently or long term within the community. The CHV shall also be able to relate to people in the community to make the CHV's work easier. A CHV is a person who can be trusted to maintain confidentiality when this is needed to support health services delivery activities in that community. Both men and women shall be chosen for this important role, and there shall be a CHV representative from each community within the zone. In practice, however, existing volunteers or a mixture of new and old volunteers are normally considered.

Factors to Consider in the Selection of CHVs

The CHV must be:

- Literate (ability to read and write)
- Committed to work
- Available on a regular basis to help the CHO in the organisation of health activities in his or her catchment community
- A person with no recent history of long-term or seasonal migration from the village
- Active and energetic
- Resident in the community
- Experienced with prior volunteer work
- A credible role model, with a reputation as being selfless
- Trustworthy and well-received within the community
- Supportive of reproductive rights, FP, and open discussion
- Effective social mobiliser
- Able to communicate effectively
- Ready to work under supervision of community leaders and health staff
- Community development oriented

Step 12: Approve CHV Selection

CHVs shall be selected and approved by the community during a community durbar. The durbar is organised by the District Assembly and the communities forming the CHPS zone with the facilitation of the District Health Management Team (DHMT) and the respective Sub-District Health Teams (SDHTs). Prior to the training of the CHVs, a durbar is held to seek the communities' approval for the selected CHV members.

Step 13: Train CHVs

The selected CHVs shall be trained by the DHMT/SDHT and the CHO and commissioned to work directly with the CHO. CHVs are provided with a minimum of 3 days' training in community health mobilisation, health promotion, basic records keeping, logistics management, and reporting.

Step 14: Procure Logistics, Equipment, and Volunteers' Supplies

The following logistics shall be provided as a minimum to all CHPS zones to make them fully functional:

Service Delivery Logistics

- Cold chain equipment
- Service delivery consumables
- Working gear
- Communication equipment—two-way radio or mobile phones etc.
- Personal digital assistants for data collection

Mobility Logistics

- Motorcycle for the CHO
- Bicycles for the CHVs in each community within the zone

Where necessary, the following:

- Tricycles
- Tiller Ambulance
- Tractor Ambulance
- Motorboat

Comfort Logistics

- Accommodation: It can be new, or rented and renovated
- Consumer durables: Bed, Furniture, TV, Radio Set, Kitchen ware, etc.

For a detailed list of equipment and logistics see Appendix F

Step 15: Launch the CHPS Zone

Organise a grand durbar of chiefs, opinion leaders, community members, health workers, DA, and other decentralised departments to launch the zone. The durbar shall highlight the following:

- Community participation and ownership
- Scope of services
- Introduction of staff, volunteers, etc.

Basic Package of Services

CHPS provides a platform for provision of integrated primary health care to communities. The provision of these services is carried out jointly by the CHO and CHV and supported by the CHMC. The package includes community linkage and outreach services; basic clinical services; and management of activities, logistics, and services. Table 2 outlines the various components of the CHPS basic package of services. Refer to Appendix D for the detailed compendium of performance standards (PSs) for Sub-district and CHPS zone levels [For PSs for region to district and district to sub-district refer to the Performance Standard Manual]. This section covers the basic package of services that are rendered in a CHPS zone. The

service package shall be implemented based on the staff mix, availability of equipment, and service delivery space and shall be developed by each zone to reflect the health needs of the community.

Table 2: CHPS basic package of services

1. Provided by CHO		
1.1	Community linkage and outreach services	Key tasks
1	Health promotion and education	Organise health education and promotion through durbars and home visits; conduct community walkabout, record and report.
2	Disease surveillance	Identify diseases requiring prompt reporting, investigate outbreaks, do surveillance, report according to protocol.
3	Home visits	i. Routine House to house visit: Day to day service delivery visits to households and individuals in their homes. ii. Special/Targeted: Designate special clients; prepare and conduct home visits. Trace defaulters, follow up patients referred by hospital after discharge, and advise and support clients with non-communicable diseases like diabetes and hypertension. Document and report on these activities.
4	School health	Prepare activities, conduct health education and physical examinations, inspect environment, brief school authorities on findings, and write report.
5	Outreach activities	Prepare and conduct outreach activities; document and report.
6	Managing CHVs	Organise meetings, revise CHAPs, and submit reports.
7	Working with the CHMC	Conduct meetings, write community profiles, draw map of community, and give technical assistance.
1.2	Basic clinical services	Key tasks
A1. Child health		
8	Immunisation	Education, administration and management of vaccines, recording and reporting.
9	Breastfeeding (BF), growth monitoring, and nutrition	Education, BF support, weighing babies and children, recording, identifying malnourished children, education on prevention of malnutrition.
10	Acute care of infants and children (Integrated Management of Neonatal and Childhood Illness [IMNCI])	History taking; initial assessment; physical examination; identification, classification, and management (jaundice, diarrhoea, ARI, fever, measles, ear infection); recording; referral if needed.
A2. Reproductive health		
11	Family planning	Counselling on all methods, education on preferred method, administration of method (i.e. condoms, combined oral contraceptive, injectable, implants), and referral for other or permanent methods.
12	HIV/AIDS and sexually transmitted infections (STIs)	Education, condom use, physical examination, preparing client and using rapid diagnostic test, giving feedback, appropriate management, and referring where necessary.
13	ANC	History taking, identification and management of anaemia, malaria in pregnancy, syphilis in pregnancy, implementation of PMTCT activities, counselling pregnant women based on findings, and teaching danger signs in pregnancy.

14	Safe emergency delivery and newborn resuscitation	Immediately assess mother, prepare for delivery, monitor labour, deliver baby, resuscitate if baby is not breathing well, and conduct active management of the third stage of labour.
15	Postnatal care (PNC) and essential newborn care	Conduct immediate PNC to mother and baby, educate family on PNC, assess baby and mother at 6 weeks.
A3. Other clinical services		
16	Infection prevention	Manage supplies; decontaminate, clean, sterilise, and store instruments appropriately. Dispose of waste properly.
17	Communicable diseases (HIV, malaria, TB)	Recognise signs and symptoms, refer, follow up, conduct home visits for TB. Perform HIV rapid test. Perform malaria rapid test and treat.
18	Non-communicable and chronic diseases (hypertension, diabetes)	Recognise signs and symptoms, refer, follow up, conduct home visits.
19	Neglected tropical diseases (NTDs)	Recognise signs and symptoms, refer, follow up, conduct home visits.
20	Adolescent health	Adolescent-friendly health services, counselling (e.g. FP, STIs and HIVs, nutrition), provision of services, referral as needed, follow-up and home visits.
21	Mental health	Assess and diagnose clients, give appropriate care, and treat if possible.
22	Minor ailments	Assess, diagnose, give appropriate treatment.
23	First aid and home emergencies	Identify signs and symptoms; diagnose and manage shock, snake bite, poisoning, convulsion and seizures, burns, sprains and strains, fractures and dislocations, and epistaxis; and wound dressing.
24	Caring for the Aged	Home visit to the aged to provide education on care and nutrition.
1.3	Resource management	Key tasks
25	Planning	Plan activities monthly and implement them.
26	Logistics management	Request supplies, manage them, manage vaccines well, and keep CHPS compound clean.
27	Financial management	Keep value books, receive completed books, procure utilised books, and receive cash revenues and bank them daily. Collect cheques and bank them; manage petty cash.
28	National Health Insurance Agency (NHIA)	Record and submit NHIS claims.
29	Data collection, reporting, analysis, and use	Collect and record all data; analyse, interpret, and use for decision-making. Ensure that data is entered separately into the DHIMS2 for that particular CHPS zone.
2. Provided by CHVs		
30	Disease prevention and environmental sanitation	Report any suspected epidemic-prone disease immediately to the CHO; educate community members on proper environmental sanitation practices in their communities.
31	Home visiting	Prepare, conduct, and end visits appropriately.
32	Home management of minor ailments (integrated community case management)	Identify and manage fevers, diarrhoea at home.
33	Community outreach	Participate, give health education, promote BF, family planning, and wearing and removal of condoms. Equip oneself with home visiting bag.

3. Provided by CHMC		
35	Governance, membership, and operation	Ensure community recognises CHPS and community members know their responsibilities, write down minutes during meetings, support health education activities, and resolve conflicts.
36	Selection and supervision of CHVs	Supervise CHVs and provide motivation for CHVs.
37	Welfare of CHO (include Security)	Care for CHOs and ensure security for CHOs.
38	Facility maintenance	Manage waste well and create community ambulance system.
39	Resource mobilisation and management	Keeps CHPS compound clean; records contributions made by others and all financial transactions.

Continuous Delivery of Services

Over the past decade, the CHPS strategy aimed at improving geographical access to health services has gained both national and international attention. The resources made available in the expansion and establishment of health training institutions, construction of CHPS compounds by DA and other partners, provision of medical equipment, and capacity building of frontline service providers requires that quality essential basic health services are delivered to all beneficiary communities at all times. Once the 15 steps have been implemented, the emphasis is on continuous delivery of services as outlined in the basic package to maximise the huge investment from government and development partners.

A well-functioning CHPS zone that stands the test of time shall have the following characteristics;

- A well –functioning supervision system
- A well-organised team of health workforce (CHO and Volunteers)
- Continuous quality health services
- A good health financing system
- Good leadership and governance
- Team approach to service delivery

1. A Well-Functioning Supervision System

One of the biggest challenges in scaling up of CHPS implementation is supervision. These guidelines have a chapter on supervision, however, the following key components must be addressed:

- Standardisation of methods and procedures
- Standardisation of tools and formats
- Effective feedback and utilisation of supervision results
- Conduct of supervision in a facilitative manner that addresses system weaknesses

A CHPS Roll-Out Assessment Tool is provided in Appendices E and K as a guide for use by health teams to monitor and supervise CHPS implementation at all levels.

The team shall also be empowered to use data for decision-making, e.g. improving first trimester registration if that is found to be low.

2. A Well-Organised Team of Health Workforce (CHO and Volunteers)

CHOs and volunteers shall be well trained and provided with the requisite materials and logistics to work. CHOs shall be responsive, fair, and efficient to achieve the best health outcomes possible, given available resources and circumstances:

- Well trained using the standard materials
- Provided with the needed resources to conduct all home visits and outreaches
- Encouraged to design health solutions that meet the needs of the communities they serve

It is imperative to assess the skills of CHOs from time to time to give them refresher training on the job or as in-service. Such trainings shall be well planned and executed. Onsite coaching and mentoring sessions shall also be organised for CHOs using available technologies. A well-organised team shall also facilitate learning and in turn provide a practicum site for other trainees.

3. Continuous Quality Health Services

CHPS zones are required to provide 24-hour service throughout the week. The services they deliver shall be effective, safe, quality personal and community health interventions to meet client needs at the right time and in the right place, with minimum waste of resources. A well-functioning health system ensures equitable access to *essential medical products, vaccines, and technologies* of assured quality, safety, efficacy and cost-effectiveness, as well as their scientifically sound and cost-effective use.

4. A Good Health Financing System

Financing CHPS shall come from different sources such as Government of Ghana, Community members, Donor Agencies, District Assemblies, Internal Generated Fund, Community-based Organizations and Civil Society Organizations. Where services are provided and qualified for NHIA reimbursement, the cost is claimed through the health centres drawing from the accounts of the CHPS zone. Under capitation, individuals shall tend to select health centres and hospitals as their preferred primary provider. The SDHT and DHMT shall ensure that all services delivered in CHPS compounds are delivered free of charge at the point of use. All CHPS services on the NHIS benefit package shall be reimbursed. CHOs and CHVs shall facilitate the registration of their populations onto the NHIS. All functional CHPS zones with compounds shall be assisted by the District Health Directorate (DHD) to get NHIS accreditation to improve access to affordable basic health services.

5. Leadership and Governance

The CHO is a service provider, a manager, and a leader. The CHO technical skills training and other refresher trainings enhance the service provision skills of the CHOs. Good leadership and governance requires that the CHO:

- Identifies with the people, live with the people, and work with the people
- Lobbies and advocates for the establishment of community structures such as CHAPs, Community Emergency Transport System (CETS), etc.
- Organises durbars and promotes community participation at all times
- Organises and chairs meetings with volunteers and other groups

- Gives feedback to community members

6. Team Approach to Service Delivery

The new CHPS policy outlines that CHPS zones shall be staffed with up to three CHOs. In reality, these three staff members are usually a mix of ENs, CHNs, and midwives. In this multi-disciplinary team, it is important that an in-charge of the CHPS team is specified by the DHMT/SDHT. There shall be both flexibility and teamwork while rendering daily services and the responsibilities must be clearly outlined and delegated (see Table 3).

Table 3: Basic package of services and responsible persons

Basic Package of Services	CHN	Enrolled Nurse	Midwife
Community Linkage and Outreach Services	<ul style="list-style-type: none"> Health promotion/education Disease Surveillance Home Visits School health Outreach Activities Managing CHVs Working with the CHMC 	<i>Support CHN when necessary:</i> <ul style="list-style-type: none"> Outreach Activities Home visits Management of minor ailments 	<ul style="list-style-type: none"> Maternal Health care, promotion/education
Basic Clinical Services			
<i>Child Health</i>	<ul style="list-style-type: none"> Immunisation BF, Growth Monitoring, and Nutrition 	<ul style="list-style-type: none"> Acute care on Infant and Children (IMNCI) 	<ul style="list-style-type: none"> BF, Growth Monitoring, and Nutrition Acute care on Infant and Children (IMNCI)
<i>Reproductive Health</i>	<ul style="list-style-type: none"> FP HIV/AIDS and STIs <i>If there is no midwife:</i> <ul style="list-style-type: none"> ANC Safe Emergency Delivery and Newborn Resuscitation PNC and Essential Newborn Care 	<ul style="list-style-type: none"> STI management 	<ul style="list-style-type: none"> FP HIV/AIDS ANC Delivery and Newborn resuscitation PNC and essential newborn care
<i>Other Clinical Services</i>	<ul style="list-style-type: none"> Infection Prevention Communicable Diseases (HIV, Malaria, TB, Cholera) NTDs Adolescent Health Mental Health Care for the aged 	<ul style="list-style-type: none"> Infection Prevention Non-communicable and Chronic Diseases (Hypertension, Diabetes) Minor Ailments First Aid and Home Emergencies 	<ul style="list-style-type: none"> Infection Prevention Adolescent Health

Basic Package of Services	CHN	Enrolled Nurse	Midwife
Management of Activities, Services, and Logistics	<ul style="list-style-type: none"> • Planning • Logistics Management • Financial Management • HR management • NHIA • Data collection, reporting, analysis, and use 	<ul style="list-style-type: none"> • Planning • Logistics Management • Financial Management • NHIA • Data collection, reporting, analysis, and use 	<ul style="list-style-type: none"> • Planning • Logistics Management • Financial Management • HR management • NHIA • Data collection, reporting, analysis, and use

Implementing CHPS in Urban Settings

It is a common claim that residents of urban areas have greater access to health facilities and better health outcomes than rural counterparts. In Ghana, however, such assumptions fail to consider the rapidly growing proportion of urban populations residing in rapidly growing slums and shantytowns in informal settlements. Such areas have poorer socioeconomic conditions than many of the most underprivileged rural areas. Moreover, it has become difficult for urban health systems to accommodate these rapidly growing populations. For this reason, unlike the rural population, where CHPS coverage is expanding, vast areas of Ghana's urban population live in neighbourhoods that have no access to basic PHC facilities. Geographic proximity is deceptive. Because public transportation is expensive, deficient, or lacking altogether, the urban poor are often isolated from health care of any kind.

Urban Features that Affect Urban CHPS Implementation

- Informal settlements are rapidly expanding, and oftentimes have poor sanitation, poor ventilation, and over-crowding.
- Access to urban health facilities is often lacking; urban transport is expensive.
- Unhealthy urban lifestyle choices including consuming junk food and the lack of exercise.
- Dual burden of disease challenge and sustained risk of rural disease burden among children of the very poor: the urban poor experience diseases that affect rural people as well as those that affect urban people.
- High prevalence of non-communicable diseases such as hypertension, diabetes, and cancer.
- High prevalence of HIV and STIs.
- High rates of unmet need for FP.
- Families direct all their time to economic survival, hence volunteerism is very weak.
- Populations are mobile, hence tracking people in need of health care is difficult.
- Housing is very expensive, hence getting a community-donated Community Health Compound for the CHPS is difficult.

In view of the uniqueness of the urban settlement, CHPS implementation milestones could be modified to suit the urban context.

Community-Based Planning

Situation analysis is important for clarifying “zones” in terms of block and neighbourhood identification, and the CHO residence and service location shall be well clarified. Rural

patterns of doorstep rounds of outreach do not work because few urban residents remain home during regular work hours. Clarification of geographic responsibility of CHO and identification of opinion leaders and political networks can be challenging in the urban setting.

Community Entry

Focus on identifying social networks (corresponding to ethnicity of settlers). Focus on outreach to formal authorities and politicians. Traditional leaders may exist but have limited authority, therefore, identification of trade and market networks is essential. The CHO needs to do detailed community assessment of the availability of the community members. A detailed assessment will inform the CHO's ability to draw an activity plan that will be suitable to meet the needs of the various target groups within the catchment.

Essential Equipment

Due to the urban terrain, motorbikes are inappropriate: Low-cost 3- or 4-wheel vehicles are more appropriate. Augment clinical equipment for Integrated Management of Childhood Illness (IMCI), EPI, and (FP)/RH with equipment for monitoring chronic diseases (particularly diabetes and high blood pressure [BP]). GHS and municipal authorities shall facilitate the acquisition of essential equipment. Refer to Appendix F for a detailed list of equipment.

Facility Development

Arrangements shall be made for donation of secure living space or renovation of donated space. (It is difficult to build CHPS compounds in urban areas due to the high cost of land and the absence of donation mechanisms.) Dealing with space challenges requires coordination with urban government, churches, or non-governmental organisations (NGOs). The CHO might not reside in the community in a compound, but may reside in his or her own rented apartment and commute to the community every day.

Nurse Recruitment, Training, and Service Provision

Urban nurses shall focus on adolescent and adult health needs in addition to chronic disease and sanitation. Midwifery is less important for the urban nurse, since there are a lot of health facilities offering the same services. IMCI and FP training shall be augmented with training for preventing and treating prevalent non-communicable diseases and chronic illness. The doorstep model which is central to rural CHPS implementation is inappropriate for urban CHPS. Home visits during the week-days and during the daytime might also not be fruitful, hence weekend and evening visits could be better. FP services shall focus on the long term rather than the short term.

Volunteer Identification, Training, and Development

Service-focused volunteers with no provision of curative services (more limited role) take the place of CHVs in urban CHPS implementation. Link volunteerism to urban institutions that engage in activities that are compatible with adding health components: Private pharmacies, faith-based organisations, political organisations, trade associations, etc. Urban volunteers shall be given some stipend since there is greater opportunity cost for their involvement.

CHO Work Itinerary

Itinerary for CHOs shall include the following:

1. Modes of Delivery
 1. House to house and Home visits
 2. Home visits for follow up clients /patients
 3. Health durbars
 4. Social Groups' meetings/ health education
 5. Outreach service delivery
 6. Static service delivery
2. Attending activities at sub-district & District
3. Other travels
4. Annual Leave

Home visits can be routine house to house or targeted/special activities for CHOs. All staff shall undertake home visits to realize the aim of CHPS in bringing health care close to individuals and households in their homes. The Table 4 is a checklist for home visits for CHOs to help him/her provide a life course approach of service delivery at the CHPS zones.

Table 4 Checklist for Home Visits by CHO

Cohort	Type of intervention	Done		Remarks
		Yes	No	
Neonate/ Infant	Newborn/Infant care -Essential newborn care/Cord care/ Early initiation of breastfeeding			
	Exclusive BF up to 6 months			
	Kangaroo mother care (KMC)			
	Nutrition – IYCF/GMP/CMAM			
Neonate/ Infant	C-IMNCI & referral of serious cases			
	Disease surveillance & control - malaria prevention, including sleeping under ITNs/ Paediatric diagnosis and ART/Education on prevention			
Pregnant women	Focus Ante Natal Care(FANC)-Pregnancy monitoring/Education on nutrition/Micronutrients (iron, folate)/Birth preparation/IPT/HCT/Maternal ART			
	Skilled attendance at delivery			
	EmONC			
	PNC			
Children under – five years	Vaccination			
	Nutrition- GMP/ vit A supplementation/CMAM			
	Disease Control - Deworming 2yrs - 5yrs/Education on prevention & treatment of fevers, diarrhea & ARI/Malaria/			

Cohort	Type of intervention	Done		Remarks
		Yes	No	
Adolescents	ASRH including Family planning/Education against teenage/early pregnancy			
	Education on preventable diseases (HIV/STIs, malaria,) & NCDs (obesity, drug abuse,)			
School children	School health activities (based existing guidelines)			
WIFA	FP (short term methods (pill, male & female condoms, injectables, etc) and implant insertion & removal			
	Household nutrition /iodated salt consumption			
General Population				
Discharged Patients	Follow up of discharged patients & DOTS (e.g children, TB, leprosy, hypertension, epilepsy, diabetes, malnourished children etc, Regenerative health & nutrition/Household iodated salt consumption			
General Population	Mass Drug Administration (yaws, filariasis, schistosomiasis, intestinal worms)			
	Disease surveillance & control - Investigation & reporting on rumours/unusual events/ (malaria, HIV/STIs, TB, NTDs, diseases for eradication/elimination & NCDs (hypertension, diabetes, SCD, asthma,))			
The Aged	Home visits to the Aged to provide education on care & nutrition			

The Health Family Forum/Meeting

The District, Sub-district or CHPS zone Health Family Forum is a meeting of all key stakeholders to discuss public health and clinical care issues of common interest to facilitate the delivery of health service seamlessly. The objectives are:

- To improve linkage between clinical care and public health
- To improve the referral system
- To strengthen the sub-district system
- To strengthen the CHPS strategy
- To transfer knowledge and experience between centre and periphery of the district health system
- To decrease preventable deaths in the district
- To decrease delays in health delivery in the district
- To improve teamwork and perception of teamwork by subordinates

Strategies:

- Meeting shall be organised as follows at various levels of the district health system
 - At the District level- by the hospital Medical Superintendent quarterly in consultation with the District Director of Health Services (DDHS). Key participants include Heads/Unit heads of public and private health facilities including CHPS zones and CHAG, District Coordinating Officer, District Planning Officer, CSOs including NGOs, Prominent traditional leaders,
 - At the Sub-district level-by Sub-district Head monthly in consultation with the DDHS and SDHT. Participants include Heads / Unit heads of public and private health facilities including CHPS zones and CHAG, Prominent Traditional Leaders, Assemblymen and women, CBS, CSOs, NGOs
 - At the CHPS zone level- by the CHO in charge of CHPS zone monthly in consultation with the Sub-district Head. Participants include, Traditional/Opinion Leaders, Assemblyman and woman, CBS, CSOs, NGOs, leaders of social groups

There shall be exchange of telephone numbers of key participants of these meetings to facilitate referrals from one level to the other in the district health system.

- Minutes of meetings shall be documented
- Reports of meetings shall be submitted by Medical Superintendents to the Regional Health Directorates; by the Sub-district Heads to District Health Directorates; and by CHOs to Sub-District Heads respectively.
- The DHMT and the Hospital Management Team at the District level, Sub-District Head and SDHT at the sub-district level and CHO in charge at the CHPS zone level respectively shall provide leadership for the overall success of the various level meetings. The DDHS shall provide oversight responsibility for the success of the Health Family forums in the District.

Implementation steps include:

1. Letters for meeting shall be sent at least a week prior to the meeting.
2. Dates of meetings shall be synchronised with district/sub-district/CHPS zone calendar of activities.
3. *The sitting arrangement is circular to create an atmosphere of friendship and family.*
4. Meetings shall be held in the District Hospital, Health Centre and CHPS compounds/delivery points
5. Discussions shall include, but are not limited to, the following:
 - Referrals among health facilities
 - Surveillance in the district
 - Clarifications of diagnoses, case definitions, and treatment modalities
 - Sub-district/CHPS zones feedback of clients' experience in the health facilities and CHPS zones
 - Improvement of pre-referral preparation of clients before clients leave the sub-district facilities and CHPS zones

6. Refreshments shall be provided by hospital and health centres and travel and transportation funded by the sub-district facilities.

The following conditions are required for the successful implementation of Health Family Forums:

- Willingness of leadership of various levels of the District Health System to work together and to lead.
- Availability of problem-solving skills in the team.
- Availability of moderation skills at the meeting to keep the blame game to a minimum.
- Clinical visits to the sub-district by the Medical Superintendent and the Medical Superintendent's team improve the quality of the meeting.
- Regional Director of Health Services (RDHS) and other Heads of the District Health System demand for reports formalises the procedure and imposes responsibility for success.
- DDHS/SDH willingness to coordinate the linkage during the interval between meetings is critical to success.
- Management of teamwork between the district hospital and DHD, the SDH and DDHS, and between CHO in-charge and SDH is important for the sustainability of the meetings.
- Needs assessment shall be done in critical areas like leadership, team building, etc.

Chapter Three: Establishing and Managing a Referral System

Introduction

Effective referral requires proper judgement guided by checklists, protocols, and guidelines; skilled personnel; clear communication; and timely transport to ensure that a patient receives optimal care at each level of the health system according to the patient's need, vulnerability, and disease severity. The roles of referring and receiving facilities as spelt out in Box 7.

General Principles for Referrals

CHPS is a crucial gate-keeper system within the referral system when the CHO in every community is the preferred PHC provider. Other levels of health care delivery above the CHPS zones are health centres, polyclinics, and district, municipal, regional, tertiary, and specialised hospitals.

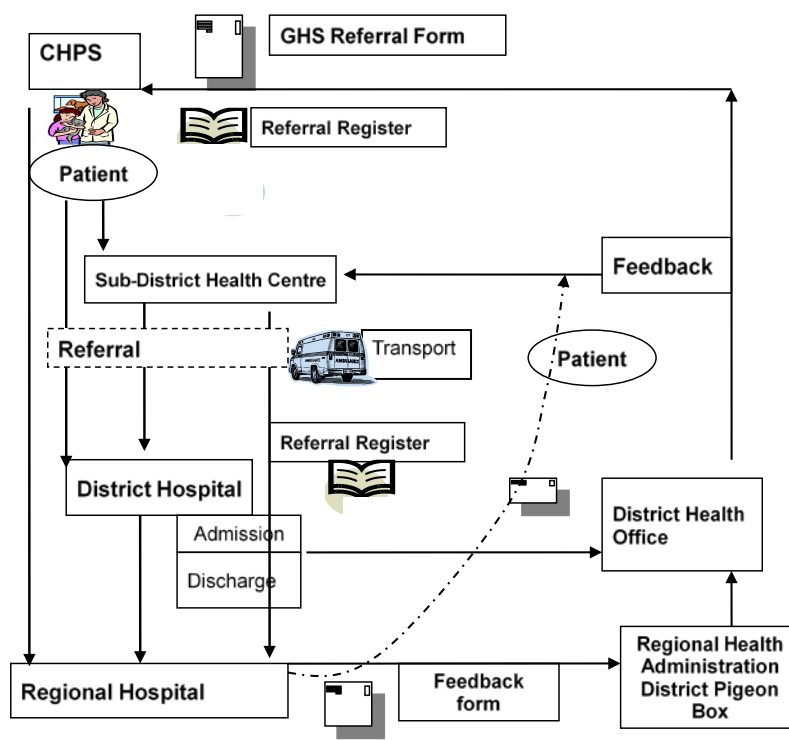
The referral system in the CHPS zones shall be in line with the MOH referral policy and guidelines.

- The National Referral Policy and Guidelines shall be available in all the CHPS zones.
- Two-way referral system shall be implemented in all facilities. In this regard, referrals can be from CHPS to a health centre—or in special cases to a higher or specialist facility—and vice versa.

Box 7: Role of Facilities

- Referring facility Shall:
 - Have clear judgement on health status of patient
 - Complete referral form
 - Document the reason for the referral in a register
 - Advise patient to go to receiving facility
 - Activate emergency transport arrangements for the patient if so required
 - Inform receiving facility ahead of arrival of patient
- Receiving facility Shall:
 - Prioritize referred patient
 - Retain referral form
 - Register referred patient
 - Have clear judgement on health status of patient
 - Provide feedback on referred case to referring facility

Figure 1. Referral pathway and procedure within the region



- The DDHS shall prepare and make available in all CHPS zones in the district, a directory of facilities and services provided. This shall be annually updated.
- Registers shall be maintained for monitoring and evaluation of internal and external referrals in all health facilities.

Establishing a Referral System

In each CHPS zone, an appropriate referral system shall be established by the District Assembly and the community, with initiation through health education and technical input from GHS, for clients needing a higher level of care (see Table 5). The referral system is meant to ensure that there is a continuum of care from household level to CHPS compound, from CHPS compound to health centre, and from health centre to district hospital. The referral process at the referring facility shall follow the GHS referral procedure (see Figure 1). Logistics needed for a good referral system include referral forms, a referral register, and a referral feedback file.

Table 5: Interventions for developing a well-functioning emergency referral system

Requirements for an Emergency Referral System	Potential Activities this Could Involve	Level of the Health System
Referral strategy informed by the assessment of population needs and health systems capabilities	1.1: Conduct a situational analysis of your district. This can include gathering information on other referral schemes that may exist in the district.	District, Sub-district, CHPS zone
Adequately resourced referral centre	2.1: Utilise data collected during district-led routine monitoring of community- and sub-district-level facilities to resolve any deficiencies identified (relevant to referral) and ensure the facilities' basic readiness for emergency management.	Sub-district, CHPS zone
Active collaboration between referral levels and across sectors	3.1: Hold a meeting with regional, district, and sub-district stakeholders to review implementation strategy and reach consensus on an implementation plan. 3.2: Conduct qualitative appraisal to assess community stakeholder reactions to the emergency referral system.	Region, District, Sub-district, CHPS zone
Formalised communication and transport arrangements	4.1: Develop and test an emergency communication system to facilitate effective referral and transportation services. 4.2: Strategically deploy and test vehicles for emergency transportation services at the community and sub-district levels.	District, Sub-district, CHPS zone
Setting-specific protocols for referrer and receiver	5.1: Develop a protocol (or refine an existing one) as needed for the referral programme. Create a database for routine data entry and analysis. 5.2: Conduct trainings for referral personnel on equipment and protocols. 5.3: Develop the capacity of community members to recognise signs of an emergency and the importance of seeking care.	District, Sub-district, CHPS zone
Supervision and accountability	6.1: Train district and sub-district supervisors to oversee referral programme activities in their localities and provide routine monitoring and supervision to intervention sites. 6.2: Hold quarterly review meetings with regional-, district-, and sub-district-level supervisory staff to review preliminary results and discuss any challenges that may arise. 6.3: Seek feedback from users of the emergency referral service at the community level.	Region, District, Sub-district, CHPS zone
Affordable service costs	7.1: Hold meetings with local DA members, elders, and other community leaders to discuss localised solutions to addressing the costs for transportation.	District, Sub-district, CHPS zone
Capacity to monitor effectiveness	8.1: Refine existing data collection tools and develop new instruments as needed to collect data for monitoring the referral scheme. 8.2: Conduct routine monitoring and evaluation of referral programme.	District, Sub-district, CHPS zone
Policy support	9.1: Orient policy makers and district leaders to emergency referral strategies. 9.2: Communicate lessons learnt to wider community.	Region, District, Sub-district, CHPS zone

General Medical Conditions Requiring Referral

- Bleeding that will not stop
- Breathing problems (difficulty breathing, shortness of breath, not breathing)
- Choking
- Convulsions or seizures
- Coughing up or vomiting blood
- Severe diarrhoea and/or vomiting with dehydration
- Fainting or loss of consciousness
- Change in mental status (such as unusual behaviour, confusion, difficulty in arousing suicidal feelings)
- Severe anaemia
- Severe hypertension
- Severe, sudden abdominal pain
- Severe, sudden dizziness, blurred vision, severe headache
- Snake bite or bee sting with a reaction
- Poisoning
- Head or spine injury
- Accidents such as road traffic accident with serious injury, extensive burns or smoke inhalation, near drowning, or deep cuts
- Others (Any other condition not manageable at CHPS level)

Maternal Health–Related Conditions Requiring Referral

Pregnant Women

1. Bleeding during pregnancy
2. Severe sudden dizziness, blurred vision
3. Severe headache
4. Convulsions/fits
5. Swelling over body, hands, and face
6. Absence of foetal movements
7. High fever during pregnancy or after delivery
8. Trauma during pregnancy
9. All medical conditions in pregnancy such as:
 - High BP in pregnancy
 - Diabetes mellitus
 - Urinary tract infection
 - Offensive vaginal discharge

10. Persistent vomiting
11. Preterm labour
12. Abnormal presentations (breech, arm, cord prolapse, cord around neck, etc.)
13. Prolonged labour
14. Excessive bleeding during delivery or after delivery
15. Retained placenta
16. Bursting of water bag without labour pains

Newly Born Baby

1. Breathing problems/difficulty
2. Skin infection
3. Cord infection
4. Lethargy
5. Jaundice
6. High/low temperature

Communication during Patient Care and Transportation

Where possible, referrals must have prior communication (telephone, radiophone, email, fax, etc.) to the receiving facility, providing patient details as stated in the national referral policy. The CHO should write down and display telephone directories of all the receiving facilities near communications equipment for easy communication during emergencies.

Medico-Legal Issues

- All requests for medico-legal examinations (e.g., rape, assault) must be accompanied by an official request from the police and other relevant authorities.
- Medico-legal requests not within the capability of the CHO shall immediately be referred to the appropriate level.

Circumstances under which CHOs may refer a Client to a Higher Level

To ensure an effective gate-keeping system, CHOs shall refer cases that are beyond their ability to manage to the health centre for further management after having completed a referral form (Appendix J). After the cases are managed, the health centre shall inform the CHO about the type of care given to the client; this will inform the type of follow-up care given when the client is treated and discharged to the community. Therefore, as part of the referral process, there shall be regular communication between the referral facility and the receiving facility.

The client could be referred straight to the district hospital, polyclinic, or regional hospital under the following circumstances:

- When the distance from the CHPS zone to the other, higher-level service delivery point is shorter than to the health centre
- When the road network to the other, higher-level service delivery facilities is better than that to the health centre

- When the condition, to the discretion of the CHO, is beyond the management of the health centre, e.g. a child who is very anaemic and would need blood transfusion, which might not be available at the health centre level

Community-Managed Referral System

A community-managed referral system is a community-led and community-managed mechanism for referral and transportation of clients seeking care. This mechanism is usually linked to formal health services such as CHPS or health centres or hospitals and focuses on providing transportation in cases of emergency referral. In these guidelines, the Community Emergency Transport System (CETS) will be described, although there are other examples of community-managed referral systems in Ghana.

CETS

CETS is the pre-arrangement and payment by community members for transport services to a health facility for emergency cases and urgent referrals. CETS is set up by community members with leadership from the CHMC and technical guidance from the CHO as part of their CHAP implementation strategy (see Box 8). It has a constitution that specifies its membership, executives and their roles and term of office, fixed-amount contributions/mode of funding and other income-generating activities, bank accounts, the CETS's management, etc. Community members are encouraged to contribute money or find any appropriate means of raising funds into a common fund. Vehicles and drivers are identified in the community to be used as community ambulances. Fixed rates are agreed with transport owners as reimbursement for the use of vehicles and emergency phone numbers of the drivers are distributed among the community members and the CHOs. Drivers are responsible for taking referrals and transporting clients with emergency needs to the nearest point of referral.

Implementation Process

Box 8: Establishing CETS

- CHO shall brief community leaders, CHMC members, CHVs, and other opinion leaders on the importance of CETS.
- The concept shall be shared with the whole community during a community durbar on CHAPs.
- An action plan shall be drafted explaining how to implement CETS if it is accepted by the CHMC and CHO.
- A simple constitution, which is a requirement for opening bank accounts, shall be developed by the CHMC and CHO with support from the Sub-District Head.
- An executive body shall be selected to manage CETS implementation (chairperson, secretary, treasurer, organizer, and a trustee).
- Agree on source of funding or fixed-amount contributions by all members.
- Open bank accounts with the chairperson and treasurer as signatories.
- Identify transport and negotiate with private owners including National Ambulance Service.
- Clarify communication channels in case of emergency, including telephone directory with assigned person who can be contacted.
- Announcement of the CETS service to the community members.
- Report on CETS as part of CHAPs.
- CETS funds are treated as loans to beneficiary members.
- Manage/sustain CETS through regular contributions, repayment of loans, and income-generating activity like annual farming by members where the farm proceeds are used to supplement their contributions. Transparency and good remarks from beneficiaries are also helpful in sustaining the system.

Roles/Responsibilities of the CETS Drivers

Prior to the notification of an emergency, there are several crucial responsibilities for the volunteer driver, including:

- The drivers shall maintain roadworthiness of vehicles and carry out regular maintenance. Keep the vehicle adequately fuelled (it should never go below half a tank).
- Maintain the external appearance of the vehicle (ensure it is clean and not damaged).
- Maintain cleanliness of the vehicle.
- Be familiar with road networks, shortcuts, and the layout of communities.
- Stay informed of changes in road conditions and areas inaccessible; proactively come up with potential solutions for inaccessible areas.
- Become familiar with the various communities being served.

Upon notification of emergency, it is expected that the driver shall:

- Follow communications protocols.
- Provide estimated time to reach the CHPS zones (via phone).
- Get to the site immediately.

Upon arrival at site of emergency, it is expected that the driver shall:

- Assist in transporting patient into ambulance/car.
- If required, support accompanying health worker in emergency management.

While in transit, it is expected that the driver shall:

- Follow road safety and traffic rules.
- Remain calm and alert. Listen for any instructions from accompanying health worker.
- Be able to quickly change routes if there is a change in receiving facility.
- Troubleshoot for any unanticipated inaccessible roads.

Upon arrival at receiving facility, it is expected that the driver shall:

- Assist receiving worker with lifting/moving patient out of vehicle (if needed).
- Stand by until accompanying health worker has completed his/her onsite responsibilities if possible.
- Send, or if applicable transport, accompanying health worker back to referring facility.

Chapter Four: Community Engagement

Introduction

Community engagement in CHPS is the process by which health workers engage community leadership and individuals to build ongoing, permanent relationships for the purpose of applying a collective vision in the implementation of CHPS for the benefit of the community. Sustaining CHPS operations continuously over time requires continuous community engagement, dialogue, and diplomacy to be pursued by DHMT, SDHT, District Assembly, stakeholders, and other partners. This chapter is intended to guide health workers to harness community resources for CHPS implementation.

Community Entry

Community entry is the process of combining principles and techniques to mobilise communities and get them to participate in and take ownership of health care delivery activities. It is the first step in community engagement, and involves recognising the community leaders, structure, people and applying appropriate strategies in interacting with them. The first contact programme staff have with the community usually leaves an impression that influences subsequent interactions. The community entry process is outlined in Box 9.

Box 9: Community Entry Process

- Form a community entry team
- Learn about the community
- Identify contact persons
- Meet with the community's leadership
 - Let community leaders and people know you and your mission in the community
 - Seek approval and support for CHPS's activities and become conversant with the customs and traditions of the people
- Conduct meetings with the community
- Conduct community needs assessment

Community Consultation

Community consultation with community leadership and people engenders ownership and sustains community health care in CHPS. Consultation and consensus-building with traditional leadership shall be organised along the levels of hierarchy with respect to the traditional authority system in the area (see Box 10).

Box 10: Community Consultation Process

- Identify the leadership and recognize their positions and roles
- Meet them upfront to let them understand your message, purpose, mission, and vision
- Organize several meetings to convey message
- Work with them to organize community durbars to present your message to the wider community
- Follow the community protocols

Meetings between the DHMT/SDHT and the chiefs shall focus discussions on the following:

- The patterns of health care delivery in the district/sub-district. (The District Health Service Profile, which describes the nature of the district – major economic activities, disease burden, availability of health facilities, etc. – and the 5-year health development plan, is presented.)
- The weaknesses in the health delivery system and the problems of access.
- The roles of chiefs, elders, and key stakeholders and their people in improving access to health delivery.

- The CHPS process.
- Consensus-building on the roles of the chiefs and their people. (Key areas specified in Box 11.)

Community Needs Assessment

Community needs assessment is a process of finding out and prioritising the local problems of a community, identifying the environmental and socio-cultural factors influencing such problems, and discovering resources available in the community to solve the problems. It establishes the essential foundation for vital planning, and identifies the strengths and resources available in the community to meet the needs of children, youth, and families.

Box 12 outlines the community needs assessment process.

Box 11: Key areas for consensus-building in CHPS

- Formation of CHMCs
- Operation of CHV system—selection of volunteers and their supervision
- Construction/Maintenance of CHPS compounds
- Safety and security of the CHPS compound and health workers
- Organization of communal labour
- Fund raising to support CHPS activities
- Identifying and using other community structures—opinion leaders, youth groups, etc.—to facilitate CHPS programme activities

Box 12: Community Needs Assessment Process

- Collect information and organize discussion on health needs with community members
- Discuss and analyse community health issues with community members, SDHT, and other health workers
- Hold meetings with chiefs, leaders, and social groups, e.g. Mothers club
- Use information to develop CHAPs with community members
- Implement CHAPs and evaluate

Community Mobilisation

Community mobilisation is a process by which communities are motivated to bring together human, material, or financial resources to take action to improve their state of development and well-being.

It involves activities that are planned, carried out, evaluated by community members or with the support of others in a participatory manner, and sustained to achieve the community's developmental goals. The steps in community mobilisation are detailed in Box 13.

Community Decision System (CDS) in CHPS

The CDS is a community-based health information system that is designed to offer specific information about an individual community's health status to its members at a gathering or durbar. In CDS, community members gather and use information about their health problems to facilitate decision-making, planning interventions, acting together, and monitoring to improve their own health situations. Details of the process of community decision-making are outlined in Box 14.

Box 13: Steps in Community Mobilization

- Identify stakeholders
- Meet with stakeholders to discuss health issues
- Identify resource strength of each stakeholder
- Share roles and responsibilities for all stakeholders
- Develop a community mobilization plan which includes agreed-upon contributions from stakeholders with timelines
- Follow up on the pledged resources from stakeholders
- Mobilize all resources

Key Players in CDS

- All members of the community
- CHMC
- Other community health providers *e.g. herbalists, TBAs, chemists, Wanzams (circumcisers)*
- An Okyeame/Linguist or MC
- CHVs
- CHOs

The findings from the CDS, when completed at a durbar, give rise to the drawing of a CHAP.

Box 14: CDS Process

- Design community bulletin board/screen/wall (see Figure 1)
- Design pictorial indicator cards (cards on health issues)
- Formation of Community Health Team
- Data collection by the Community Health Team
- Organize community durbar to return information to the community
- Present the information in a clearly understandable form (*numbers, percentages, etc., using the cards*)
- Facilitate discussions and analysis of information
- Use the information to make decisions and take action
- Prepare CHAPs
- Implement planned activities
- Monitor, supervise and evaluate the action plan

CHAP

A CHAP (See Appendix G) is a community roadmap summarised in a format that indicates what community members want to achieve within a specified period with a view to improving their health conditions.

CHAP is developed by community members with GHS staff such as CHO, SDHT, and DHMT providing the necessary support. The CHAP is implemented by community members. It is reviewed and updated on a regular basis by community members and the CHO to make room for new activities after the achievement of current targets on the plan.

Name of Community: TAMPANA LA Total Population: 1588
 Children under 5: 187 Boys: 99 Girls: 88
 People over age 15: _____ women: _____ men: _____

Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
10	19	12	10	8	7
10	8	10	9	6	8
4	3	5	4	8	5
1	2	3	2	2	3

The rationale for CHAP is to promote community involvement, develop ownership, and help set a vision for the CHPS zone. It serves as a monitoring and evaluation tool for the CHPS implementation and can attract donors and philanthropists to the community.

In CHPS implementation, CHAP highlights the “*P*” component of CHPS which is “*Planning*”. Generally, CHAP can be used to establish a common fund for health issues, e.g. CETS, or increase/improve low-performing areas, e.g. to increase ANC registrants or supervised delivery. Also, CHAP can be applied to CHPS-related issues such as construction of extra space for CHPS (emergency delivery room), gardening, water fetching, and security guard.

Box 15: CHAP Implementation Action Plan

- Assess needs of community using PLA tools
- Hold meetings to sensitize communities on CHAP
- Hold a series of durbars involving all the community members
- When communities embrace the CDS ideas and findings, enumerate challenging issues and prioritize them for CHAP
- Community draws CHAP facilitated by health worker/CHO and an active community member
- Display CHAP on local wall for reference by all members involved in its implementation
- Health worker/CHO/CHMC/CHVs to follow up with persons responsible for activities specified

See CHAP implementation process in Box 15.

Stakeholders’ Responsibilities in CHAP

District Level

The DHMT shall provide guidance and supportive supervision to the sub-district and CHPS zone to facilitate the CHAP process.

Sub-District Level

The SDHT;

- Meet the CHO, review and discuss:
 - CHPS data
 - Service delivery (e.g. most common illnesses)
 - Common issues (e.g. late first ANC visit)
- Identify issues to discuss with the community (e.g. emergency transportation)
- Support the CHO to prepare a presentation to the community
- The sub-district shall support facilitation of this meeting

CHPS Zone Level

The CHOs;

- Organise the durbar—set date and time with CHMC
- Invite District Assembly
- Work with CHMC to notify the Chiefs, opinion leaders, etc., of the date and time
- Inform the community what is needed (e.g. venue, beat the gong-gong, chairs)

At the Meeting

The CHOs;

- Make a presentation on key issues, data findings/challenges
- Facilitate the action planning process with the community
- Note the actions, persons responsible, and deadlines for each action in a CHAP
- Document the CHAP

Community Level

The CHMC;

- Supports the hosting of the meeting
- Ensures full participation especially opinion leaders and key influential persons (*e.g. teachers, pastors, herbalists, chemists, Imam, women's groups, youth groups, welfare groups, Unit Committee Representative, assembly members*)
- Identifies an *Okyeame/Linguist* to facilitate the meeting
- Participates fully in the meeting
- Responsible to implement tasks assigned (*e.g., tasks could be assigned to Unit Committee*)
- Supports CHAP implementation

Organising Community Durbars

Durbars are formal community gatherings for discussing issues concerning the community to give information and build consensus on issues of importance to the community. The steps in organising durbars are listed below:

Planning the durbar:

1. Determine the topic and set objectives
2. Conduct community entry
3. Contact community leaders
4. Brief leaders on the objectives of the durbar
5. Draw programme and assign responsibilities with community leaders
6. Arrange venue, date, and time in consultation with community leaders, taking into consideration convenient time for participants
7. Discuss with community leaders how durbar Shall be announced, e.g. by gong-gong beating
8. Ensure that announcement of the durbar is carried out in good time
9. If there is cancellation of the durbar, ensure that is announced in good time

At the Durbar

1. The health team shall be punctual to the durbar
2. Ensure that community leaders are present
3. Ensure participation of men, women, and marginalised groups
4. Inform and educate community members on the objectives of the durbar
5. Allow everybody to participate in the discussions
6. Ensure that one person talks at a time
7. Give a summary of the issues discussed and the decisions taken

Post-durbar activities:

1. Discuss outcome with community leaders
2. Write report
3. Conduct any follow-up activities

Organising Community Meetings

Steps in Organising a Meeting

1. Establish rapport
2. Outline your mission to community members
3. Ask community members for their support
4. Ensure the message is clear and devoid of unnecessary jargon
5. Encourage questions
6. Encourage effective dialogue through the use of two-way communication skills
7. Create an enabling environment for effective interpersonal relationships

Meeting Process

- Introduce self, greet in a relaxed atmosphere
- Build rapport
- Encourage and direct discussion and involve minorities
- Write minutes
- Ensure action areas are clear to all
- Agree on follow-up issues
- Summarise and evaluate the session to see if objectives have been met

Chapter Five: Management Responsibilities

Introduction

The organisational layout of the health sector in Ghana is a five-tier service delivery system from the national level to the community level forming the frontline. Management arrangements at the various levels are as described below.

National Level

The Ministry of Health (MOH) shall provide policy direction clarifying the CHPS concept, mobilise resources, and build partnerships and inter-sectoral collaboration for the implementation of CHPS across the country. It shall also coordinate monitoring and evaluation.

GHS Headquarters, shall mobilise resources and provide implementation guidelines, technical guidance, coordination, support, supervision, monitoring and evaluation, and oversight function for CHPS implementation. The Director General is accountable for overall success of CHPS implementation. The Divisional Directors and Programme Managers are responsible for mainstreaming their programme areas into the CHPS implementation framework.

The roles and responsibilities to promote and implement the CHPS policy and strategy by each division of GHS at the national level are in Appendix H. Each division shall report progress of CHPS in respect of the division's mandate at Senior Managers and Performance Review Meetings.

Regional Level

The RDHS shall advocate for CHPS to create a better understanding and buy-in of the concept by the Regional Coordinating Council, local and foreign NGOs, and corporate bodies. She or he shall also mobilise external resources to assist communities willing to implement CHPS (see Box 16).

Box 16: Roles of Regional Health Management Team (RHMT)

RHMT Members shall:

1. Plan and coordinate CHPS implementation in the region
2. Carry out advocacy for CHPS
3. Mobilise resources for CHPS implementation
4. Provide training and technical support to Districts
5. Monitor, supervise and evaluate the implementation of CHPS in the region

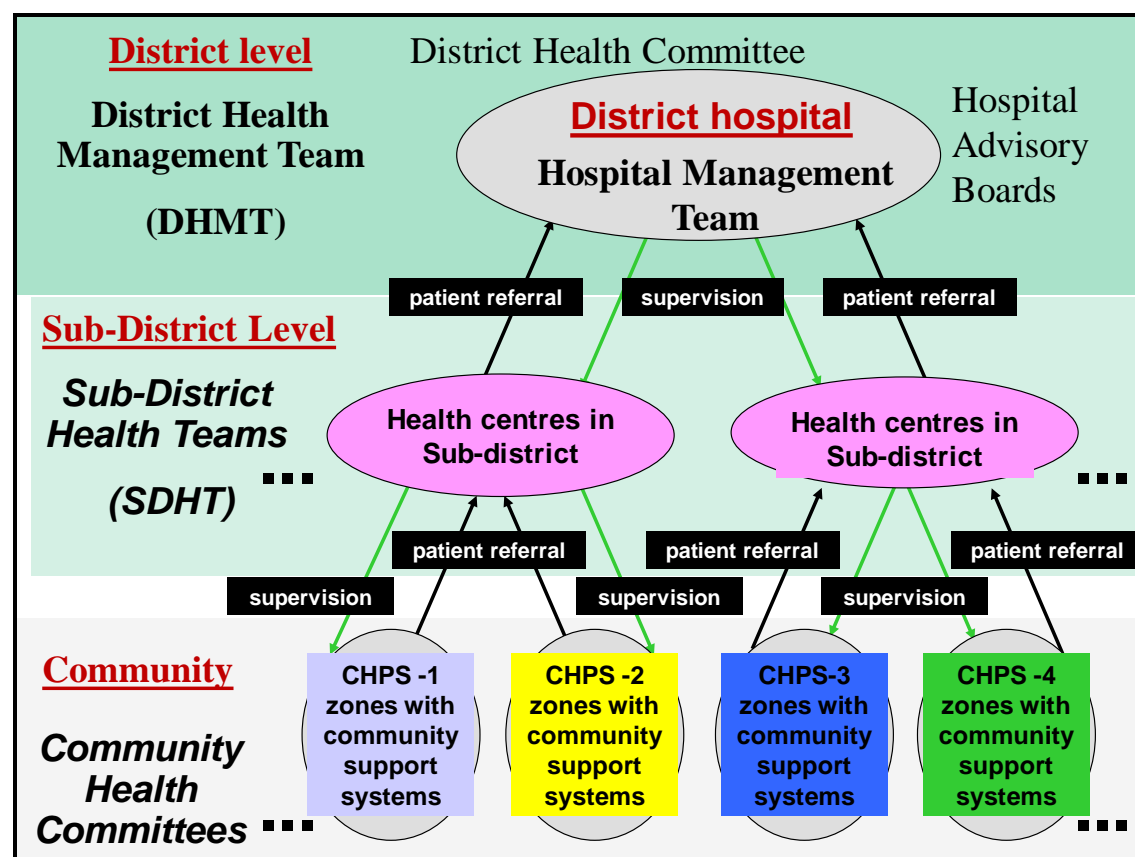
The RDHS is accountable for CHPS implementation in the region and may delegate coordination of CHPS to an appropriate RHMT member, who shall coordinate, support, supervise, monitor, and report on CHPS implementation in the districts on behalf of the RDHS. The designated RHMT member shall also provide technical support to the districts for effective implementation. She or he shall be oriented to perform the duties delegated.

District Level

The district is the apex service delivery point of PHC organisation and management in Ghana. The district hospital provides support to the sub-district in various activities such as referrals, emergencies, and trainings. Within the district, health services are organised in a

three-tiered hierarchy with the district level (level C) at the top, the sub-district level (level B) in the middle, and the community level (level A) at the bottom (see Figure 2).

Figure 2: District health system



Source: Community-Based Health Planning and Services (CHPS). The Operational Policy GHS Policy Document No. 20, pg. 18. 2005.

The District Health Management Team (DHMT)

The DHMT serves as the decision-making, programme development, and coordinating body for health services within the district. The DHMT supports the SDHTs for CHPS implementation and scale-up within the district. The DDHS directs the CHPS implementation process. The DDHS does this with the support of the DHMT (Roles of DHMT -see Box 17).

The DDHS is accountable for implementation of CHPS in the district and may delegate coordination of CHPS to an appropriate member of the DHMT, who shall coordinate, support, supervise, monitor, and report on CHPS implementation in the sub-districts on behalf of the DDHS. The designated DHMT member shall also provide technical support

Box 17: Roles of District Health Management Team (DHMT)

DHMT Members shall:

- Engage the community for dialogue on CHPS with advocacy and diplomacy;
- Support overall CHPS programme implementation in the district;
- Provide guidance and technical assistance to SDHTs;
- Plan and budget for CHPS programme activities;
- Serve as liaison and organize meetings between DHMT and SDHT;
- Provide essential medical supplies to SDHT;
- Provide supportive supervision for SDHT CHPS implementation activities;
- Train the SDHT and CHOs in CHPS implementation activities; and
- Manage data generated by CHOs and CHVs and provide feedback to SDHT.

to the sub-districts for effective CHPS implementation across the district. He or she shall be oriented to perform the duties delegated.

The DDHS is responsible for overall management of the CHPS strategy, providing guidance, assistance, planning and budgeting for district health service delivery activities. However, the Sub-District Head has the delegated responsibility to implement CHPS services in the CHPS zones in his/her particular sub-district.

The Sub-District Level

The SDHT supervises CHOs and links them to district-level officers. The SDHT plans and budgets programme activities in its CHPS zones. It manages the flow of essential medicines and FP supplies between the DHMT and CHO/CHMCs. The CHMC then distributes needed resources to the CHVs to complete actual delivery.

(Refer to Box 18 for the roles of SDHTs).

Box 18: Roles of SDHTs

SDHT members shall:

- Engage community for dialogue on CHPS with advocacy and diplomacy
- Consult communities to set up new CHPS zones
- Explain the CHPS concept to stakeholders
- Sensitize and mobilize the community for CHPS
- Supervise all CHPS zones within the sub-district catchment area
- Organize monthly zonal meetings for CHOs and other stakeholders to share best practices and experiences and learn from each other
- Manage logistics for service delivery
- Budget for CHO service delivery as well as general activities within the individual CHPS zones
- Collate and analyse service delivery data from all CHOs, CHVs, and CHMCs
- Write reports to DHMT and provide feedback to CHPS zones

Community Level

CHPS service delivery targets individuals, families, and groups within the community for primary healthcare services. The community has a critical role in ensuring that the CHPS zone operates effectively and efficiently.

(Refer to Box 19 for the roles of the community leadership).

Box 19: Roles of the Community Leadership

- The community leadership shall be responsible for the welfare of the CHOs and assist in the selection of the CHMC and CHVs.
- They shall assist in the organization of community health durbars and CHMC meetings.
- They shall assist the CHOs, CHVs, and CHMC in the preparation of the CHAP.

Roles of Metropolitan, Municipal, District Assemblies (MMDA) and Community

MMDAs

The MMDAs have key roles to play in the implementation of CHPS (Box 20) and their level of participation would depend on how effectively the DDHS can engage with them. Through this engagement, CHPS implementation roll-out can be accelerated in the district. To facilitate the active involvement of the local government and simplify the engagement process, CHPS zones have been redefined to be coterminous with the electoral areas whenever possible. In this way, the assembly members can lobby the

Box 20: Roles of the MMDA

- Assist communities that cannot provide CHPS compounds to construct and maintain CHPS compounds
- Provide utility services such as safe water and electricity to the compound
- Assist in providing security to the CHPS compound and the CHO
- Support to maintain the volunteer system
- Mobilize other resources to support CHPS activities
- Monitor the CHPS implementation in the district
- Sponsor staff for training

District Assemblies on behalf of their communities to place health on their development agenda.

Members of Parliament (MPs)

MPs represent constituencies within the districts and are the links between the national parliament and the DA. They advocate for the needs of the electorates in parliament. MPs' common fund for health is used to undertake activities in the area of health.

(Refer to Box 21 for roles of MPs)

Box 21: Roles of Members of Parliament

- Construction and renting of CHPS compounds
- Equipping CHPS compounds
- Funds for training
- Provision of sanitation facilities for community members
- Provision of incentives for CHOs and CHVs
- Any other health needs of the CHPS zone

Traditional Authority

Traditional authorities have the power and authority based on customs and traditions to make legitimate decisions in their traditional area of jurisdiction.

(Refer to Box 22 for roles of Traditional Authority).

Box 22: Roles of the Traditional Authority

- Mobilize community members for the formation of the CHMC;
- Manage and resolve conflict within the community;
- Sit on various committees as advisors;
- Release land for development and resolve land disputes;
- Serve as knowledgeable people for consultation on affairs concerning the community.

Unit Committees

Each electoral area has one Unit Committee with five members, all elected. A unit is normally a settlement or a group of settlements with a population of between 500 and 1,000 in the rural areas, and a higher population (1,500) for the urban areas. Unit Committees, being in close touch with the people, play the important roles of education, organisation of communal labour, revenue-raising for and ensuring environmental cleanliness, registration of births and deaths, and implementation and monitoring of self-help projects, among others. They work in close collaboration with the assembly members. Given their official role within the local government structure, they can form the nucleus of the CHMC for the CHPS zone.

Other District Development Partners

Development organisations have become essential partners in local level development. They marshal support for social and health development projects. They provide support for CHPS Community Health Compound construction and implementation activities.

Identifying the development partners, NGOs, CBOs, etc in the district and CHPS zones and effectively collaborating with them can enhance CHPS implementation and scale up in the district.

Chapter Six: Resource Management

Introduction

Different resources are required at different stages for the effective and efficient implementation of CHPS. CHPS implementation requires human, financial, and logistical resources. A combination of these resources is necessary for effective functioning of CHPS. This chapter therefore provides in-depth understanding of how these resources can be managed for the successful implementation of CHPS across the country.

Human Resource Management

This section covers the establishment of a CHN grading system, CHO staff requirements in a CHPS zone, preparation for deployment of CHOs, internship for CHOs, and the duration of stay of CHOs in a CHPS zone as well as their incentive package. CHVs' requirements, their training, and incentive package in a CHPS zone are also covered.

Establishment of CHN Grading System

The Human Resource Directorate (HRD) of the GHS shall take immediate steps to establish a CHN grading system within the GHS for the purpose of providing career progression towards a certificate, diploma, or any higher class of the CHN cadre. Any CHN acquiring a professional nursing grade or a degree-level qualification shall migrate onto the new promotional grade categories. The HRD shall also develop schemes and conditions of service that shall make the CHN category attractive.

CHO Requirement

A CHPS zone of population up to 5,000 or 750 households shall have up to three CHOs of appropriate staff mix based on types of services needed and staff availability. Where population density is high, as in urban or peri-urban areas, and the geographical area is small, additional CHOs may be added to a CHPS zone without necessarily establishing additional zones. A higher level of training shall not preclude the person from becoming a CHO.

Preparation for Deployment of CHOs

There are currently enough CHNs and other health workers trained within the GHS for CHPS implementation. However, the majority are not deployed into the CHPS zones.

The challenge now is how to deploy these human resources into the communities to provide PHC using the CHPS strategy. To meet this challenge, GHS shall do the following:

- Re-orient all staff at management levels (national to sub-district) to the vital role of the CHPS strategy in the delivery of PHC services in Ghana through a series of workshops and study tours of exemplary good and promising CHPS zones
- Create awareness and understanding of the CHPS concept and how to implement and sustain the dialogue on CHPS among the current pool of DDHSs, decision makers, and all health workers
- Mobilise and engage District Assemblies of the Local Government, Chiefs, and Elders to appreciate the concept and the benefits of the CHPS service delivery strategy
- Re-orient trained CHOs on community service delivery
- Systematically deploy CHOs into mobilised and sensitised communities to implement service delivery with the CHPS strategy
- Monitor and evaluate CHPS roll-out strategy

Internship of Trainees of Health Training Institutions

- The Heads of Training Institutions whose training of graduants does not include the CHO Training Curriculum shall in collaboration with RDHS ensure that their trainees before graduation undergo a 2-week refresher course on the contents of *The CHO Training Manual Volumes 1, 2 & 3*. Thereafter, they shall undergo a mandatory 3-month structured attachment to a completed CHPS zone of reputed good practice[†] to understudy a senior CHO before they complete their programmes. The newly recruited CHOs shall be oriented for 5 days by RHMT/DHMT before they are posted to work in CHPS zones. The orientation shall be based on the must-do-modules in CHO Training Manual Volume 1 with emphasis on field practice both in the CHPS compound for clinical experience and in outreach and home visits for public health experience in the CHPS zone.
- In the event that CHO Training Curriculum is fully mainstreamed in the school curricula of CHN and other Health Worker Training Schools i.e. the CHO Training Manual Volumes 1, 2, & 3 as part of the training and mandatory 3-month structured internship completed, the newly recruited CHOs shall be oriented for 5 days by RHMT/DHMT before they are posted to work in CHPS zones. The orientation shall be based on the must-do-modules in CHO Training Manual Volume 1 with emphasis on field practice both in the CHPS compound for clinical experience and in outreach and home visits for public health experience in the CHPS zone.

Duration of CHO Stay in a Community

The CHO shall remain and work in a community for not less than 3 years after which he/she shall be eligible for transfer. The CHO in his/her last year shall impart his/her experience and skills in the field by coaching and mentoring newly recruited CHNs/CHOs and trainees.

Team Approach to Service Delivery and Headship of CHPS Zones

The new CHPS policy outlines that CHPS zones shall be staffed with up to 3 CHOs. In reality, these three staff members are usually a mix of ENs, CHNs, and midwives. In this multi-disciplinary team, it is important that one person be selected by the DHMT/SDHT as the leader of the CHPS team, who must be well oriented in CHPS. There should be both flexibility and teamwork while rendering daily services and the responsibilities must be clearly outlined and delegated.

Incentives for CHOs

The Human Resource Directorate of GHS, in collaboration with key stakeholders, shall develop and institute an appropriate incentive scheme to reward CHOs depending on performance, duration of stay, and category of deprivation of the CHPS zone. The incentive scheme shall recognise staff opting to serve in deprived areas.

Volunteers for CHPS Zone

Volunteers shall continue to be an integral part of each CHPS zone's service delivery. There are two types of volunteers for CHPS. They are CHVs and members of the CHMC.

[†] Where a CHO has had a minimum of 3 years' working experience in the community and has a well-rehearsed and satisfactory set of service delivery routines in the CHPS zone.

Volunteer Requirement

Each CHPS zone shall have at least two CHVs selected by the community. CHVs shall be provided with a one (1) week orientation in community health mobilisation, with particular emphasis on FP, RH, diagnose & management of minor ailments. The initial training shall be done using a manual for training CHPS zone CHVs. However the Youth Employment Agency (YEA) Community Health Worker (CHW) program aimed at supporting CHPS implementation shall undergo 6 weeks training to work under the supervision of the CHO in the CHPS zone.

In-service or refresher training is very important to keep the CHVs abreast with their responsibilities. These training sessions shall be organised by the DHDs in collaboration with the various sub-districts and regional teams. The CHMCs shall also be trained by DHDs in collaboration with the various sub-districts using the manual for Training Community Health Management Committee to enable the CHMC to facilitate the work of the CHO. This will enable CHMC members to understand the concept of CHPS and the roles they are expected to play in its implementation.

Maintaining Volunteer Engagement and Motivation

Sustaining volunteerism in health service delivery requires efforts from all health stakeholders—including the volunteers themselves and community members—and collaboration between the health directorates at all levels, the District Assembly, and community leadership. Another way to sustain volunteerism is to ensure community ownership from the beginning and for DHMTs/SDHTs to be at the centre of interactions to enhance loyalty by volunteers and community members.

CHVs' incentives shall reflect the context: workload, opportunity costs, and the environment in which they work. Consistent incentives, whether for salary, allowances, or per diem payments, can help encourage accountability, commitment, motivation, and in many cases, can facilitate an uninterrupted provision of health services.

Non-financial incentives shall be included as essential components of any community health programme, including paid and volunteer programmes. Such incentives, including regular training, supervision, public recognition, and opportunities for advancement and professional development, improve the capacity of CHVs and ensure high-quality service provision. SDHTs shall make budgetary allocations for provision of appropriate logistics, including raincoats, wellington boots, torch light, ID cards, and certificates for CHVs. ID cards and certificates are important because they differentiate CHVs from their community peers, indicating that the CHVs hold a special role in their communities and shall be acknowledged for their hard work. The community, together with the DHMT, shall put together a package/token as a way of motivating the volunteers. Another important motivation for volunteers are frequent visits by DHMT members or Regional Health staff to supervise their work and help resolve their challenges. Awards can also be given to reward deserving volunteers and to encourage other volunteers to continue their hard work.

The Policy, Planning, Monitoring and Evaluation Division (PPME) of GHS shall harmonise incentives, trainings, reporting, and supervision among national programmes and donors supporting CHV programmes to reduce duplicative costs, improve capacity and use of services, and limit frustration related to inconsistent incentives.

Financial Management

Resources in the form of money, salaries, infrastructure, equipment, and medical supplies are required for service delivery and other operations such as home visits, treatment of minor ailments, outreaches, CHMC meetings, community health durbars, and maintenance of buildings, equipment, and motorbikes. The CHO in charge of the CHPS zone shall manage funds sent to the zone and report appropriately to the Sub-District Head.

Sources of Funds

Sources of funds for PHC at the CHPS zone shall come from:

- Government of Ghana
- Community members
- Donor agencies
- Community-based organisations
- District Assemblies
- Civil society organisations
- Internally generated funds

MOH and the GHS shall lead the advocacy for mobilising resources for infrastructure, major equipment, and funds for preventive health care for the effective implementation of CHPS. GHS shall work closely with stakeholders to coordinate, leverage, and make efficient use of available pools of resources for CHPS implementation.

Financial management at the community level by the CHO shall be in line with standard public financial management (PFM) procedures adopted by the Government of Ghana. PFM covers the following areas: planning and budgeting, budget execution, accounting, reporting, procurement and supplies management, and auditing (internal and external audit). The volume of activities under these areas varies with the value and scale of operations. As such, this guideline covers relevant aspects of the PFM process which are in tune with the scale of operations at the CHPS level.

Work Plans and Budgets

CHPS zones shall prepare annual work plans and budgets for the ensuing year and submit to the sub-district to be ultimately included in the consolidated sub-district budget. The work plans and budgets must be prepared in line with budgeting guidelines communicated to the sub-district. The work plans and budgets shall cover the following activities: management of minor ailments, quarterly review meetings, supervision of volunteers, community durbars, maintenance (building, equipment, and motorbikes), outreaches/growth promotion, home visits, and school health and community mobilisation. The work plans and budgets take into consideration potential local resources from the DA, clients, community members, and other stakeholders. The capacity of CHOs must be developed to promote the production of sound and attainable plans and budgets. These budgets shall form part of the sub-district annual approved budget.

Budget Execution

The budget shall be executed in line with the quarterly action plans submitted. Such action plans must conform to the approved work plans and budgets.

The CHO in-charge of the CHPS zone shall make monthly requests for funds to the Sub-District Head to execute the action plans. Timelines for submitting returns to retire previous imprest releases shall be strictly followed.

Bank Accounts

Bank accounts shall be opened by the District/Sub-District in the name of the CHPS zone. Such accounts shall be used to manage the funds of the CHPS zones by way of receipts and disbursements or releases to the zones for their operational activities. Two bank accounts—an internally generated funds (IGF) services account and an IGF medicines account—shall be opened for each CHPS zone.

Where the sub-district is endowed with a good complement of staff including an Accountant, the signatories to the CHPS accounts shall be the Sub-District Head, the CHO, and the Sub-District Accountant. However, where there is no Accountant at the sub-district, then the DDHS, the District Accountant, and the CHO shall be signatories to the accounts. The District/Sub-District Accountant shall keep custody of the value books pertaining to the account, including cheque books, and shall conduct all bank transactions pertaining to the account on behalf of the CHPS zone.

Financial Transactions

Funds released from the district/sub-district to the CHPS zones for operations shall be treated as imprest to the CHPS zone. These operations include management of minor ailments, quarterly review meetings, supervision of volunteers, community durbars, outreaches/growth promotion, home visits, school health and community mobilisation. Imprest shall be retired within set timelines where such timelines exist for specific activities. Generally, these timelines shall not exceed one month. IGF received for service at the CHPS zone shall be lodged into the relevant CHPS account for utilisation by the CHPS zone. IGF shall be used to replenish medicines, non-medical consumables, and other operations for service delivery. The capacity of the CHOs shall be built to enhance their compliance with and understanding of basic accounting and the maintenance of basic account records.

To execute a transaction (either imprest recoupment or other transactions), the following basic procedure shall be followed:

- Request from the CHO through the Sub-District Head to the District Director of Health Services or request from the CHO to the Sub-District Head for approval where the sub-district has an Accountant
- Approval by the District Director or the Sub-District Head, as the case may be
- Accountant prepares voucher with relevant documentation
- Voucher is approved by the District Director of Health Services/Sub-District Head, as the case may be
- Cheque is written by the Accountant

Cheque is signed by:

- The District Director of Health Services and Accountant and the CHO or
- The Sub-District Head and Accountant and the CHO where the sub-district has an Accountant
- Payment is then effected by the Accountant either to a supplier or to the recipient
- CHO shall manage the imprest as explained above

Recording and Accounting

The CHPS zones shall keep basic books of account for imprest received from the sub-district. This shall include a petty cash book or an analysis cash book to track the imprest. The CHPS zone shall also keep proper records and custody of relevant supporting documents on transactions to facilitate the retirements. Supporting documents may include honour certificates (where appropriate) and relevant receipts. Accounts officers at the sub-district shall support the CHPS zone to ensure the latter adheres to these guidelines.

Basic records on revenue from service shall also be kept to track and account for revenues and expenditures of the CHPS zones. Such records shall include basic expenditure and revenue ledgers to capture cash as well as deferred payment revenues (national health insurance). In instances where cash is received for services, such amounts shall be paid in gross into the relevant bank account or sent to the sub-district/district, as the case may be, on a weekly basis at most. Expenditures shall not be made out of cash receipts. Accounts officers at the sub-district shall support the CHPS zones to ensure the latter adheres to these guidelines.

Financial Reporting

On a monthly basis, the CHPS zones shall summarise the transactions for the month and submit to the sub-district for compilation to the district. Accounts officers at the sub-district shall support the CHPS zones to ensure the latter adheres to these guidelines. Details of the procedures covering these guidelines can be obtained from the Accounting Treasury and Financial Rules and Instructions.

Logistics Management

“Logistics”, as used in this document, refers to the basic tools required for effective operations at the CHPS zones. Such tools shall usually include vaccines, vaccine carriers, commodities, registers, fuel, and many other apparatuses required for effective service delivery at the CHPS zones.

Logistic Requirements

The annual CHPS work plans and budgets shall capture the needed logistics for the management of minor ailments, quarterly review meetings, supervision of volunteers, community durbars, outreaches/growth promotion, home visits, and school health and community mobilisation. Adequate supply of logistics shall be provided to enable the CHPS zone to execute their quarterly action plans. Such action plans must conform to the approved work plans.

The CHO in charge of the CHPS zone shall make requests for logistics to the Sub-District Head to facilitate service delivery as and when necessary. Logistics shall be properly received into store, properly stored under good and secure conditions, and issued appropriately for utilisation on service operations. Equipment and motor bikes shall be regularly maintained and stored according to standard guidelines for the maintenance and storage of same.

Recording of Logistics

The CHPS zones shall keep basic records to take account of all logistics. Such records shall enable the tracking of the logistics from requisition through receipt to utilisation or disposal. For assets, an assets register shall be kept to capture and track all assets in the CHPS zone.

Reporting on Logistics

On an annual basis, the CHPS zones shall prepare a report on logistics and assets and submit to the sub-district. Details of the procedures covering these guidelines can be obtained from the Accounting Treasury and Financial Rules and Instructions and other relevant policy documents.

Logistics Audit

Audit operations shall be carried out periodically in line with audit guidelines of both the Internal Audit Division of the GHS or the Ghana Audit Service to provide assurance to relevant stakeholders and higher-level managers of the effective use of resources at CHPS zones.

Infrastructure Management

Infrastructure as used in this guideline refers to the CHPS compound. CHPS compounds play a critical role in CHPS implementation by serving as a residence for the CHOs and also as a service delivery point from which CHOs reach out to the community and from which community members can also obtain early diagnosis and treatment of common ailments and timely referral of serious cases. Each level of GHS has a role to play in the planning, design, construction, and management of CHPS compounds.

National Level

Design and Construction of CHPS Compounds

A national standard design for CHPS compounds has been approved by MOH. The aim of the standard design is to establish standards and specifications for CHPS compounds. It is also to provide the basis for determining not only the cost of constructing CHPS compounds, but the quality of construction as well.

- The approved standard design for a CHPS compound is provided in Appendix I.
- The MOH shall, in collaboration with GHS, revise the design from time to time to reflect the changing needs of service delivery.
- All new construction of CHPS compounds shall be done in accordance with the approved standard designs of MOH and requirements of the Estate Management Department (EMD) of GHS (refer to Box 23 for the roles of EMD).
- The construction shall also be in accordance with the relevant national and local government laws.
- In the case of ongoing construction of CHPS compounds, they shall be completed with their planned design or modified to the new design, except that the cost due to the modifications shall not be more than 15% of the suggested cost of construction of the new prototype.
- Where a community has provided a temporary structure to serve as the CHPS compound, this shall be replaced in due course with the standard approved design.
- Where maternity services have been approved for a particular CHPS compound, a separate maternity facility co-located within the CHPS compound shall be constructed based on the approved standard design.

Box 23: The Estate Management Department (EMD) of GHS shall:

- Promote the use of the approved standard design and monitor and ensure that all new construction of CHPS compounds across the country conforms to the requirements of the approved prototype
- Monitor and ensure accessibility compliance for persons with disabilities
- Develop cost regimes for the approved CHPS compound design options.
- Lay out design for CHPS compounds with cost estimates.
- Provide technical support and advice to GHS and other institutions for construction of CHPS compounds and procurement procedures that are consistent with National Procurement Law.
- Facilitate the development of annual budget and capital plans for CHPS infrastructure.
- Build and update a comprehensive facility database on CHPS compounds as part of the national facility health inventory.
- Build and update a comprehensive database on all civil work on CHPS compounds in the regions.
- Monitor and provide updates on progress and status of all GHS civil work/contracts on CHPS compounds as well as CHPS compounds being constructed for GHS by other organisations.
- Create and update case files with site plans, land title documents, building permits, and building designs for each CHPS compound across the country. This shall help create a land inventory database for CHPS compounds and also help identify the status of the ownership of the land as well as the size of the land on which each CHPS compound is built.
- Ensure the standard design for CHPS compound meets the specific needs of both sexes

Regional Level

The RHDs shall monitor and ensure that the construction of new CHPS compounds in their regions conform to the requirements of the approved standard design. The roles of the Estate Unit of RHD are as shown in Box 24.

District and Sub-District Levels

Planning for Construction of New CHPS Compound

The DHMT shall:

- In collaboration with the District Assembly, develop a master physical development plan and a prioritised list for CHPS compounds as part of the District Health Strategic Development Plan. The plan and list shall be based on needs assessment, engagement with community leaders, and broad consensus-building with all stakeholders including the MP.
- Plan an initial meeting to discuss construction of a new CHPS compound with all the community leaders residing in the CHPS zone. This is done during the dialogue meeting with the chief and elders and, subsequently, during the community sensitisation durbar.
- Ensure that land for the construction of the CHPS compound is properly acquired and the site selected is in the proper area for the intended use. The location of the CHPS compound shall be such that it should be readily accessible to the community.
- Obtain the approved standard designs from the RHD or EMD (GHS Headquarters) and monitor and ensure that the construction of CHPS compounds conforms to the requirements of the approved standard designs.
- Obtain relevant building permits and approval from the appropriate departments in the assemblies, as required.

Box 24: The Estate Unit of RHD shall:

- Provide technical support and advice in the construction of CHPS compounds in the region
- Build and update a comprehensive database on existing CHPS compounds and all civil work on CHPS infrastructure in the region
- Collect and update geographical coordinates for mapping purposes
- Monitor and provide updates on progress and status of all GHS civil works/contracts on CHPS compounds as well as CHPS compounds being constructed for GHS by other organisations in the region
- Create and update land case files with site plans, land title documents, building permits, and building designs for each CHPS compound in the region

Box 25

- As a condition for the construction of the CHPS compound, the DHMT in collaboration with the District Assembly shall ensure that all issues with acquisition of the land for the compound are resolved before actual construction work begins.
- The land shall have proper ownership title and shall be litigation free. (Unsolved problems of ownership can constrain full utilization of the site and therefore sites with ownership problems shall not be used.)
- The DHMT shall actively collaborate with the District Assembly to facilitate the smooth acquisition of the land including processing and obtaining legal title (site plan, land title documents, and building permits).
- The land documents shall include site plans, land title documents, designs, and building permits.
- The site shall be checked for possible constraints to its use: *size, topography, drainage, soil conditions, natural features and limitations, catchment area to be served, social acceptability, convenience to the community and the CHOs, etc.*
- The site shall be free from dangers of flooding as well as pollution of any kind,
- Including air, noise, water, and land pollution.

Land Acquisition for Construction of CHPS Compounds

- Acquiring land for construction of the CHPS compound and protecting land boundaries from future encroachment shall be taken more seriously by all stakeholders.
- The land for the construction of CHPS compounds shall be provided by the host community as a freehold with appropriate documentation sealed at the land title registry.
- The government, on receipt of the land, shall have a right to vest in a third party for the sole purpose of achieving the objective of establishing a CHPS compound.

(Refer to Box 25 for the roles of the DHMT on CHPS compound construction).

Transfer of Ownership of CHPS Compounds

Where a CHPS compound is constructed by a private individual or organisation as their contribution to the health of the community, the ownership of the structure shall be transferred with proper documentation to the GHS. The Regional or District Estate Unit and representatives from the RHD, DHMT, SDHT, District Assembly, and the community shall be actively involved in the transfer of the ownership of the structure.

CHPS Facility Database at the District

The DHMT shall build and update comprehensive health facility data on existing CHPS compounds as well as all ongoing civil work on CHPS compounds in the district.

Community Participation in the Planning and Construction of CHPS Compounds

The DHMT and SDHT shall collaborate and dialogue actively with the community on the planning and construction of the CHPS compound. This will help to get the broader community fully involved in the construction of the CHPS compound

(Refer to Boxes 26, 27 and 28 on the DHMT roles in involving the communities in planning and construction of CHPS compounds).

Box 26

The DHMT and SDHT shall:

- Hold a durbar with the community to inform them of the work that is going to happen and allow them to discuss and express their concerns.
- Present the design and cost of the construction and its appropriateness to the community members during the durbar.
- Harness the potential of the communities to support the construction of the CHPS compound. The community can directly support the construction of the CHPS compound in several ways, including the following:
 - Provision of land
 - Provision of materials
 - Human resources (communal labour, contractor, labourers to the contractor, etc.)
 - Funding (payment of cash for land, labour, materials, etc.)
 - Voices for political advocacy

Box 27

To also maintain the trust and relationship with the community, the DHMT/SDHT shall:

- Involve the community leaders in the site meetings. Hold periodic meetings (durbars) with the broader community members to present progress on the work and allow the committee members to discuss any problem areas.
- Organise periodic site visits for the community members to show them the rationale behind doing a piece of work a certain way, or discuss ways in which the infrastructure can be altered to suit technical and user criteria.

The use of local people either as labourers, supervisors, technicians, or monitors can cut project cost as well as present an excellent opportunity to allow the local communities to physically participate in the construction of the CHPS compound. The local people may not have high levels of technical knowledge, but they have knowledge of the local area and the problems they face.

Box 28

To increase community responsibility and participation, the DHMT/SDHT shall:

- Make use of local contractors (petty contractors) in the construction of the CHPS compounds.
- Where local people do not have the requisite skills, they can be employed as unskilled labour to support contractors from outside the community.

Maintenance of CHPS Compounds

“Maintenance” here refers to work undertaken in order to restore premises, buildings, facilities, and their contents to a good state of repair and efficient working order and to an agreed acceptable standard. The presence and strong role of the DA, NGOs, churches, traditional leaders, and community-based organisations at the community level offer immense opportunities which the DHMT/SDHT and the staff of CHPS compounds can exploit to facilitate the maintenance activities at the CHPS compound (see Box 29).

Box 29

The DHMT/SDHT shall:

- Put in place an effective maintenance programme to prevent untimely breakdown of buildings and equipment. The CHPS compound building and equipment shall be kept in a state of good repair.
- Monitor and ensure proper cleaning and upkeep of the CHPS compounds. This shall focus on maintaining a healthy and aesthetic environment for the personnel, clients, and the community.
- Put in place security measures to ensure adequate physical security and safeguarding of assets, including protection of patients and staff from assault or loss of property.
- Forge active collaborative links with other relevant stakeholders such as the Department of Environmental Health, Department of Community Development, the Community and Water Sanitation, and MP to facilitate the implementation of maintenance activities at the CHPS compound.
- Set imprest specifically for the preventive maintenance and also show commitment by releasing all approved funds for preventive maintenance at the CHPS compound.
- Ensure the District Estate Officer/Manager periodically visits the CHPS compounds to undertake monitoring and facilitative supervision of preventive maintenance activities at the facilities.
- Make use of local artisans (masons, carpenters, painters, plumbers, etc.) in carrying out maintenance activities at the CHPS compound.

Maintenance and repairs of CHPS facilities shall be taken into account in the construction of CHPS compounds. Technology shall be chosen taking into account local capacities for

maintenance and repair. Maintenance and repairs of CHPS facilities including equipment, water supplies, and health-care-waste facilities shall be planned and adequately budgeted for. The role of CHOs working with the CHMC is as shown in Box 30.

Box 30

The staff of the CHPS compounds, through the CHMC, shall:

- Collaborate and dialogue actively with the communities on the maintenance and development at the CHPS compound.
- Establish good relationships and have regular interaction with the community leaders, churches, and other organizations as a means of whipping up their interest in supporting maintenance activities at the CHPS compound and providing equipment and other logistics to support service delivery. Support can be in the form of periodic communal labour for maintenance of the grounds, donation of cleaning materials, painting of the building, clean-up exercises, etc.

Documentation on Planned Preventive Maintenance (PPM) Activities

CHPS compounds shall have records on the maintenance work performed, date, materials used, names of artisans who carried out the maintenance, and reasons the maintenance or repairs were done. This helps in decisions as to whether to continue to repair or replace the items with new ones as well as whether to continue to buy the same materials for the repairs.

Asset Register

Assets include such items as medical equipment, office equipment, maintenance equipment, telecommunications equipment, kitchenware, furniture and fittings, and residential items. The responsibility of the District Estate Officer/Manager is stated in Box 31.

Box 31

The District Estate Officer/Manager shall provide technical support to the CHOs to maintain an updated asset register for all assets of the CHPS compound.

Comfort Logistics

The DHMT shall ensure that accommodation (new, rented, or renovated) and consumer durables such as beds, furniture, TV, radio, and kitchenware are provided as comfort logistics at the CHPS compounds.

In urban areas where CHPS activities may be provided from an existing facility, such as a health centre or hospital, accommodation may be provided to the CHOs if no accommodation already exists for the CHOs.

Utilities

The DHMT shall ensure that electricity, water, and a communication system are available at the CHPS compounds. If the facility is not connected to the national grid, generators or solar panels shall be provided to provide power. Radio communication lines shall be established where there is no communication system.

Water, Sanitation, and Hygiene

Water, sanitation, and hygiene are critical in the provision of basic healthcare at the CHPS compounds. The lack of these basic services has the potential to cause infections and diseases in clients, staff, and the community as a whole. Adequate water, sanitation, and hygiene services shall therefore be provided at the CHPS compound to prevent or minimise the risk of infections and water-borne diseases in staff, clients, and the community. The compounds shall have indoor plumbing for water supply, with sinks and taps at all workstations and flush toilets available to staff and patients. The facilities are expected to be well maintained and clean at all times to ensure healthcare-transmitted infections are totally controlled or contained. See Boxes 32–35.

Box 32: Water

- The CHPS compound shall use the approved public water supply system whenever available. If not, boreholes with water pumps shall be provided and the water must be potable and adequate in amount.
- The water must meet the water quality standards for Ghana as described in the Ghana Standards Authority (GSA) Water Quality Standards.
- Water must be available within treatment rooms and at workstations.
- Delivery rooms must be supplied with water.
- Rain harvesting systems shall be incorporated in the roofing of the CHPS compound.

Box 33: Sanitation

- Toilet must be on-site
- Separate toilets shall be provided for staff and patients
- Toilets must be accessible to all categories of users including males, females, children, and people living with disabilities
- The toilet area shall provide privacy during use, especially for women
- Toilets shall be regularly maintained and clean to ensure there is a hygienic environment in and around the toilet at all times
- The management of excreta and disposal of sludge/wastewater shall be done in a manner prescribed by the relevant local authority and/or shall not pollute the environment

Box 34: Hygiene

- Hygiene promotion shall be carried out by DHMT and SDHT at all times for the staff at the CHPS compounds, with a focus on infection control, hand washing, and correct use of toilet facilities
- Water points with soap or alcohol-based hand rub shall be provided in all treatment areas, waiting rooms, and near toilets for clients and staff
- Where water storage is provided, the containers shall be kept clean and hygienic at all times
- Provision shall be made for proper and hygienic disposal of different categories of waste

Box 35: Waste Disposal

- Liquid, solid, and other waste (infectious and hazardous wastes including sharps) shall be disposed of in accordance with GHS Guidelines on Health Waste Management and Infection Prevention and Control (IPC)
- Staff at the CHPS Compounds shall be encouraged to practice source separation of wastes
- Special containers shall be provided for sharps
- Where incinerators are provided, operations shall be carried out in accordance with the design and operational specifications
- All efforts shall be made to avoid the release of pollutants from incinerators into the atmosphere as these can create health complications when inhaled

Fire Safety

In line with fire safety regulations, the DHMT shall ensure that:

- Fire extinguishers are installed and are easily visible and accessible in strategic areas of the CHPS compounds in the district
- Fire risk assessment is periodically carried out in the CHPS compounds in the district and actions taken to implement recommendation of the assessment
- The CHOs are periodically trained in fire safety procedures

Signage

- There shall be adequate directional signs to CHPS compounds
- The signs and labels shall be visible, clear, and appropriately sited

Equipment Management

The availability of the requisite equipment in its required numbers and working condition plays an important role in CHPS implementation. Such equipment may include, but is not limited to, delivery sets, BP apparatus, thermometers, weighing scales, and vacuum extractors.

Equipment List for CHPS

The list of necessary equipment required for service delivery by the CHO and CHV is in Appendix F.

Equipment Inventory

- Equipment inventory shall be maintained by CHOs for all equipment in their care at the CHPS compounds.
- All relevant information about the equipment must be entered, including date of receipt, name of equipment, manufacturer, serial number, its location, and records of repair and maintenance.
- The DHD shall, as part of their monitoring to the CHPS compound, check to ensure that equipment inventories are maintained by the CHOs.

Planned Preventive Maintenance of Equipment

Planned preventive maintenance is regular, repetitive work done to keep equipment in good working order and to optimise its efficiency and accuracy. This activity involves regular, routine cleaning, lubricating, testing, calibrating, and adjusting; checking for wear and tear; and eventually replacing components to avoid breakdown. Roles of various stakeholders are stated in Box 36.

Box 36

- The CHOs shall undertake routine planned preventive maintenance of equipment in their care.
- Technical repairs, which are the responsibility of the equipment technicians, shall be scheduled on a periodic basis.
- The SDHT shall liaise with DHD to ensure that the equipment technicians visit the CHPS compounds to undertake technical repairs of equipment.

Equipment User Training

It is important that the users (CHOs) are trained on the safe and proper use and maintenance of equipment given to them. The sub-district shall therefore liaise with DHD to organise periodic user training of equipment to CHOs at the CHPS zones.

Transport Management

An effective and reliable means of transport is very critical for the work of the CHO and therefore very important in CHPS implementation.

Type of Transport

The means of transport outlined in Box 37 shall be provided as a minimum requirement to all CHPS zones to make them mobile and fully operational.

The acquisition, use, maintenance, and repairs of motorbikes and other transport for CHPS activities shall be done in accordance with GHS Transport Policy and Operational Guidelines.

The specification for procurement of motorbikes shall take into account the varying needs of the riders, particularly with regard to gender considerations.

Box 37

- Motorbikes for the CHOs
- Bicycles for the CHVs in each community within the zone
- Where necessary, tricycles, tiller ambulances, motorboats, and tractor ambulances shall be provided

Operating Motorbikes

- The DHD shall ensure motorbike riders at the CHPS zones have the knowledge, skills, and training necessary to operate a motorbike safely, or are closely supervised until they are assessed as competent.
- The DHD shall liaise with RHD to provide riders with the training and supervision they need to operate the bikes safely.
- The DHD shall provide safety information relevant to motorbike use to GHS staff before allowing them to operate GHS motorbikes.
- The Sub-District shall ensure fuel is provided at all times to facilitate movement of CHOs to the communities for outreach services.
- Responsibilities of the motorbike riders are in Box 38.

Box 38

Motorbike riders shall:

- Conduct a pre-operation check before riding
- Wear a helmet at all times the bike is being ridden
- Ensure the bike is in reliable working condition by undertaking routine cleaning and lubricating, conducting regular maintenance checks, and taking remedial action where shortcomings are found
- Put security measures in place to control access to the bike and keys when the motorbike is not in use

Records on Transport

- All relevant information about the motorbikes including date of receipt, registration number, make, manufacture date, and records of repair and maintenance must be maintained by CHOs.

Use of Personal Motorbikes for Official Duties

- CHOs may use their personal motorbikes to undertake CHPS activities including outreach services.
- CHOs who use their motorbikes for official work shall be reimbursed for fuel and maintenance. However, this must be authorised by the Sub-District Head or Designated Officer.
- The fuel use shall be refunded according to the prevailing government rate or the rate established by GHS.

Chapter Seven: Supervision

Introduction

Supervision is a mainstreamed integral component of program management. This chapter describes the concept of facilitative supervision (FSV); structure to be put in place to support FSV; areas, performance standard, and tools for FSV; and steps in conducting FSV.

Concept of Facilitative Supervision

Facilitative supervision (FSV) is a system of management whereby supervisors at all levels in an institution focus on the needs of the staff they oversee. This approach emphasises monitoring, joint problem-solving, and two-way communication to strengthen the learning process between the supervisor and those being supervised.

The overall objective of FSV is improvement of DHMT performance. The specific objectives are to:

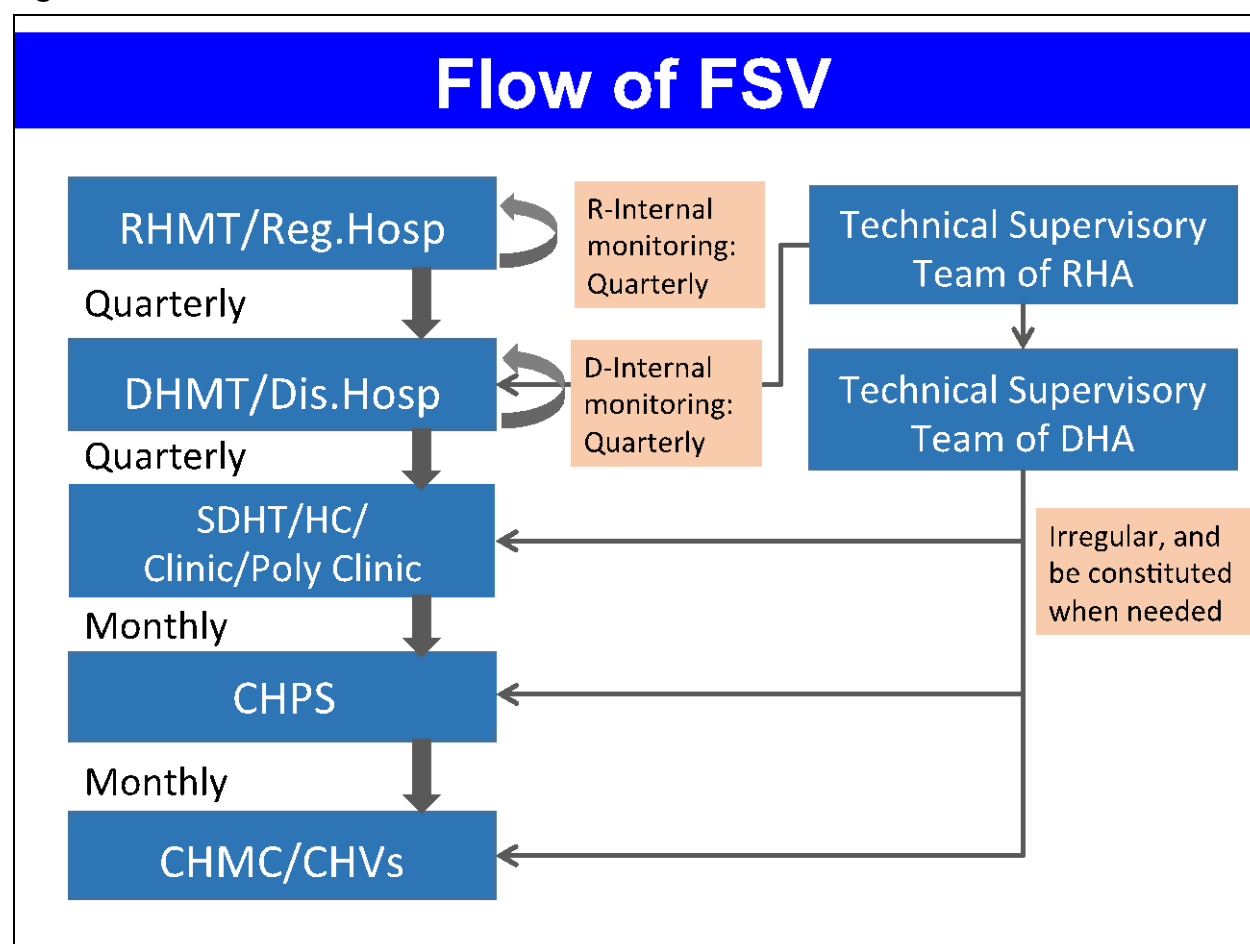
- Find out challenges of DHMT performance.
- Strengthen problem-solving capacity at all levels.
- Assess training needs to improve service delivery through coaching on the job.
- Document issues to be reflected on in the next planning phase.
- Discuss policy directives on new ways of doing things.
- Supply logistics where applicable.

Structure

Flow

FSV shall be established at all levels of service delivery (RHMT, DHMT, SDHT, CHPS) in each region as a routine process of managing health service delivery. The flow of FSV is shown in Figure 3.

Figure 3: Flow of FSV



Abbreviations: D-Internal, district-level internal; RHA, Regional Health Administration; R-Internal, regional-level internal.

Frequency

FSV shall be conducted at appropriate times as described in Figure 3.

- Monthly: CHO to CHMC members/CHVs, sub-district to CHPS zone
- Quarterly: District to sub-district, region to district, internal FSV at district with technical supervisory team, and internal FSV at region
- When needed: Technical FSV from district and region

Team Composition

FSV team shall be formed at each level by the Head (Sub-District Head, DDHS, RDHS) comprising an appropriate mix of staff.

- At RHD level, each FSV team shall be led by Deputy Directors (public health/reproductive and child health, clinical care, and support services).
- At DHD level, an FSV team shall consist of at least three officers from public health, clinical care, and support services.
- At CHPS level, at least one person (Midwife or Physician Assistant) shall conduct FSV.
- A technical supervisory team shall be constituted as necessary for each level.

Areas, Performance Standards (PSs), and Tools

Areas

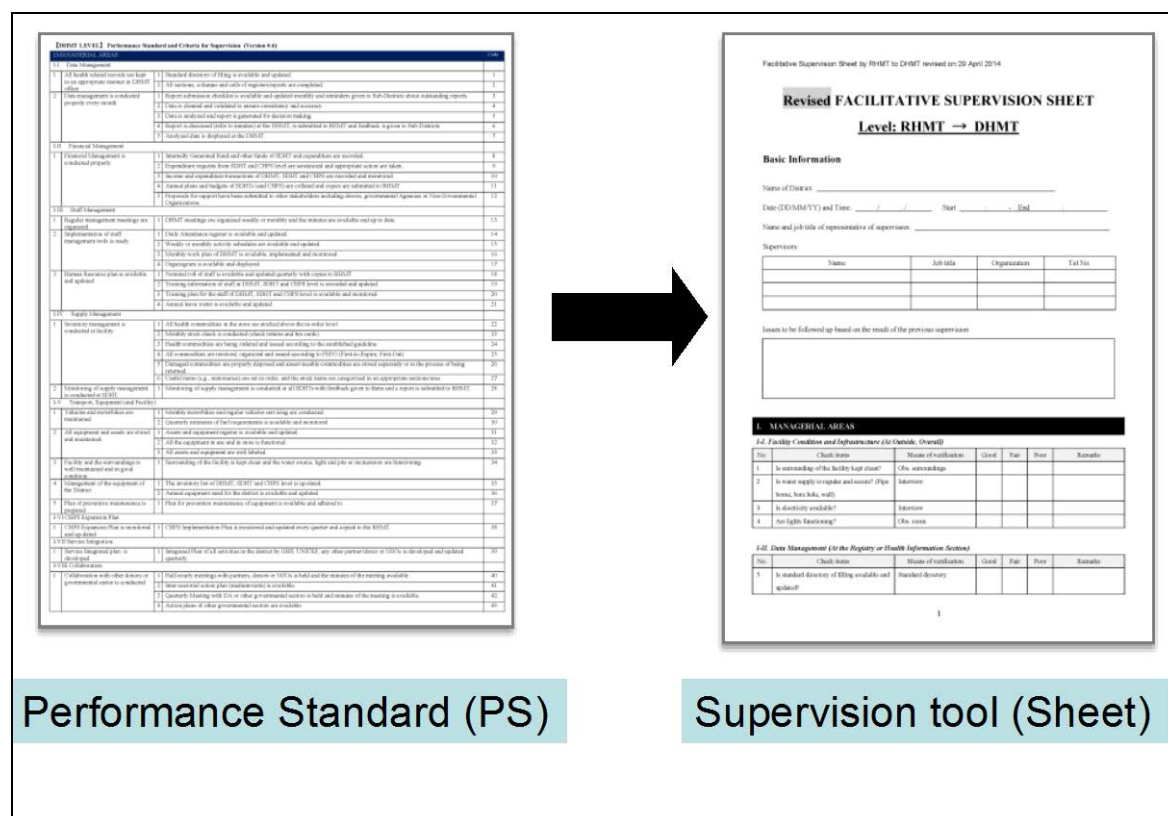
FSV shall cover performance of various service-management areas:

- Managerial areas (facility condition and infrastructure, data management, staff management, equipment and assets management, financial management, supply management)
- Quality improvement of workplace
- Service Delivery (infection prevention and control; maternal, neonatal, and child health; disease control/surveillance; health promotion)
- Referral and feedback
- Monitoring and supervision systems

PSs

FSV shall be conducted based on the performance standards on all the areas mentioned above. PSs shall be developed at each of the levels to reflect key services to be provided to each level. Models of PSs at sub-district and CHPS zone levels are presented in Appendix D. [Refer to PS booklet for PSs for other higher levels] PS is used as a basis for developing the FSV tools, as shown in Figure 4.

Figure 4: Performance standard and tools sheet



Tools

FSV shall be conducted by using standardised tools (sheets) and the guidelines on scoring. The tools (sheets) are structured in three parts, as shown in Table 5.

Table 5: Structure of FSV tools (sheets)

Part 1: Basic information	<ul style="list-style-type: none"> • Location • Date • Duration • Name of supervisee • Supervisors • Issues to be followed up based on the result of the previous supervision
Part 2: Main tool	<ul style="list-style-type: none"> • Managerial areas • Quality improvement of workplace • Service delivery • Referral and feedback • Monitoring and FSV
Part 3: Summary	<ul style="list-style-type: none"> • Challenges found • Follow-up issues (actions to be taken) • Timeframe • Name and signature of supervisor and supervisee

Implementation Steps

In conducting FSV, the following four steps shall be implemented.

1. Planning

- Collect and analyse information (e.g. number of SDHTs/CHPS zones responsible, travel times, convenient day in a month, seasonal factors at site, availability of transport and fuel).
- Include supervisory plan in annual/monthly calendar.
- Share the plan with to supervisee to prepare for the visit and to give necessary support.

2. Preparation

- Prepare logistics (supplies, transport, etc.)
- Confirm the appointment.
- Review documents.
- Organise preparatory meeting for team members.
- Review the previous FSV report.
- Examine the problems and actions to be taken in the previous FSV.
- Check the status of programme implementation.
- Check supplies to be delivered and identify priority areas.
- Follow up the problems identified in the previous FSV.
- Identify performance that was not satisfactory in the previous FSV.

3. Implementation

- Greet and explain the purpose of visit.
- Monitor DHMT/SDHT performance/CHPS implementation by using FSV tool.
- Check if the problems found during the previous visit were solved.
- Assess performance of various service-management areas.
- Conduct on-the-job training.
- Observe if DHMT/SDHT/CHO staff applies correct technique in his/her work.
- Train and update DHMT/SDHT/CHO staff's skills through practice if necessary.
- Provide feedback.
- Discuss with DHMT/SDHT/CHO staff. (Give constructive and objective feedback. Summarise and emphasise important points. Give enough time to DHMT/SDHT/CHO staff to respond.)
- Summarise the findings in summary sheet. (Findings shall be short and clear. Prioritise findings. Use information to identify problems. Discuss and take decisions together.)
- Give verbal feedback if it is urgent and the case needs quick support. Give feedback in written form that can be kept as a record and shared with others.

FSV conducted by Supervision Team shall to be:

- **Balanced:** give and take, mutual questioning, sharing of ideas and information, not one-sided.
- **Concrete:** focus on objective aspects of performance.
- **Respectful:** use behaviours that convey that the other person is a valued and fully accepted counterpart.

Feedback given from supervision team must be:

- Immediate and direct
- Appropriate to the situation and in the right cultural context
- Politely given
- Constructive and non-judgmental

4. Follow-Up

- Organise and interpret data.
- Include follow-up activities in the action plan (e.g., technical visits to DHMT/SDHT/CHO staff, frequent communication with DHMT/SDHT/CHO staff, support to resolve conflicts between DHMT and SDHT/CHO staff or community). Communicate with higher levels for support if necessary.
- Take actions based on the plan.

Chapter Eight: Performance

Introduction

This chapter looks at the monitoring and evaluation (M&E) of CHPS implementation within the larger context of the M&E that guides the implementation of GHS programme of work. The M&E for CHPS implementation focuses on the progress and effectiveness of the implementation.

M&E of CHPS Implementation

M&E forms an integral component of programme management. They help to ensure that programmes are implemented as planned and allow assessment of achievement of the results desired.

Monitoring is the day-to-day follow-up of activities to measure progress and ensure that activities are occurring according to plan and are on schedule. M&E shall occur at all levels (and at multiple stages of a programme).

The goals of monitoring are to:

1. Track and provide feedback on the progress of activities
2. Identify challenges and problems with implementation
3. Take corrective action and make modifications as and when necessary

Monitoring of CHPS implementation involves using various approaches to monitor how districts have implemented CHPS using the resources available to them.

Evaluation deals with strategic issues such as project effectiveness, efficiency, and relevance in the light of specified objectives, as well as project impact and sustainability. It is designed specifically to attribute changes to an intervention, although total attribution is extremely difficult to achieve. Importantly, it also aims at systematic learning from experience and the usage of learnt lessons to improve current activities and promote better planning for future activities. Evaluation of CHPS implementation shall be done periodically as part of the overall evaluation of health sector medium-term development plans. Evaluation of CHPS implementation can also be done as part of national review of CHPS implementation.

The CHPS *Implementation Guidelines* spells out 15 steps and six milestones that guide the establishment of CHPS. Compliance with these guidelines shall be monitored and documented to indicate progress and status of the implementation of these steps and milestones. M&E of the progress and status of CHPS implementation shall take place at all levels as mentioned, namely: community, sub-district, district, regional, and national. The tool for conducting the M&E is shown in Appendix K and supplemented by Appendix E.

PSs from sub – districts to CHPS zone levels and assessment tools are shown in Appendix D and actions that can be borne by the MMDAs to facilitate implementation are shown in Appendix L.

Key Roles and Responsibilities

Regions

All regions are expected to provide quarterly updates on their CHPS implementation through the DHIMS2. All regions are to ensure that all districts in their region have completed the quarterly CHPS reporting form in the DHIMS2. Regions shall conduct CHPS verification twice each year to authenticate the data on CHPS that districts have reported in the DHIMS2.

All regions shall produce half-year and annual health service performance reports; these reports shall include sections on CHPS implementation. The region shall, in this section of the reports, provide details of the extent to which the 15 CHPS implementation steps have been completed for each CHPS zone (this can be an appendix to the reports). The reports shall also include the performance of the districts against the targets for CHPS roll-out and CHPS's contribution to service delivery.

Districts

All districts are required to report quarterly on the status of CHPS implementation in their districts using the DHIMS2. Districts are to ensure that the CHPS quarterly reports in DHIMS2 are completed before the 15th of the month after the quarter closes (e.g. the First Quarter report shall be entered into DHIMS2 before 15 April).

The district shall analyse and interpret CHPS data in the DHIMS2 and the progress reports from the sub-districts. These shall form the basis for all planning, monitoring, and decision-making processes to guide CHPS implementation.

Districts shall provide the regions with quarterly reports on the processes and status of completion of the 15 steps for each CHPS zone in their district. To be able to submit this report, all districts shall keep a database of all CHPS zones in both manual and electronic formats, showing the level of completion of the 15 implementation steps for each of the CHPS zones (See Appendix E). This shall be updated quarterly by the district.

All districts shall produce half-year and annual health service performance reports, each including a section on CHPS implementation. The district shall in this section of the half-year and annual reports provide details of the extent to which the 15 CHPS implementation steps have been completed for each CHPS zone (Appendix E). They shall also show the performance of the districts against the targets for CHPS roll-out.

Sub-Districts

Sub-districts shall provide monthly reports on CHPS implementation in their sub-districts to the district. This report shall include progress made in coverage, the extent of completion of the 15 implementation steps for each CHPS zone, and the work performance of each CHO working in the sub-district. The sub-district shall keep a database, either manual or electronic, showing the progress of each zone in each of the 15 implementing steps. Service performance from each functional CHPS zone shall be reported to the sub-district or entered directly into the DHIMS2 after verification, if the CHO has access to the internet and has been trained on the DHIMS2.

The sub-district shall organise monthly data validation meetings of all CHOs working in the sub-district to validate the summary forms. At these meetings, the CHOs shall bring their service registers along for sample verification to be conducted to ensure that the data

recorded on the summary forms are the same as those in the registers. These meetings shall also provide an avenue for capacity building in data management for the CHOs. Officers from the district level can be occasionally invited to join these meetings. Reports on these data validation meetings shall be submitted to the district.

The sub-district shall analyse the service data and use it to monitor the performance of the sub-district. Standardised tools shall be used by the sub-districts to assess the performance of each CHO in their sub-district (see Appendix D). The sub-district shall use feedback, peer review, and other mechanisms to improve overall CHO performance.

CHPS

All functional CHPS zones shall keep standard registers for all the services that they are offering. These registers shall include the consulting room register, the maternal health register, the child health register, the FP register, the school health register, and the home visit register. At the end of every month, CHOs shall prepare monthly summary reports on service performance using the appropriate monthly summary reporting forms and send these reports to the sub-district or enter the data directly in the DHIMS2 if they have access to the internet. Data from CHPS shall not be added to that of the health centre in the sub-district and reported under the health centre. CHPS data shall be reported on their own.

A newly posted CHO shall be trained on the standard operating procedures for health information management. She or he shall be provided with all the necessary registers and summary forms after the training. *Once this is done, the CHO shall report on services delivered in his/her zone and this information shall be entered directly into the DHIMS2 by the sub-district or by the district in the name of the CHPS zone.*

CHVs

The CHVs shall report on their activities monthly to the CHO using the standard Community Volunteers reporting form. All suspected epidemic-prone disease shall be reported immediately to the CHO.

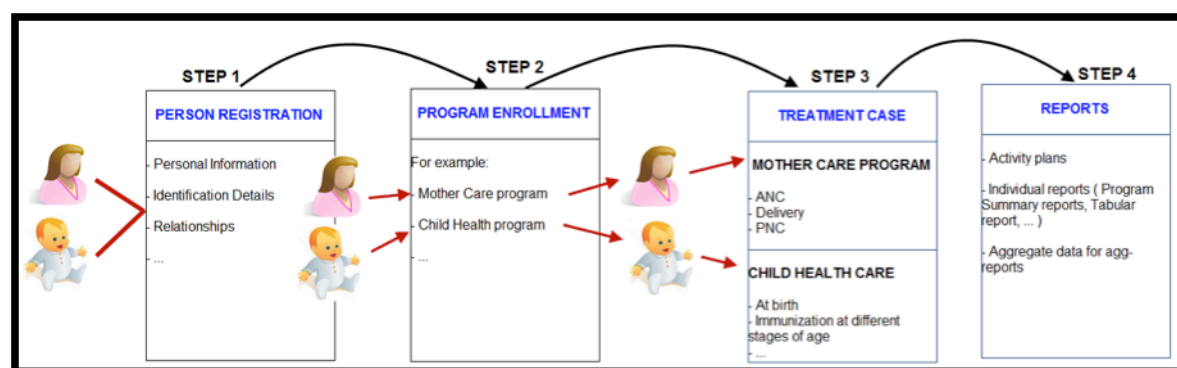
E-Tracker: Freeing Up More Time for the CHO to Offer Service

The Ghana Essential Health Interventions Programme conducted a study of CHOs' use of work time. The study found that CHOs spend many hours each month on collating data from the various service registers for reporting. To effectively address this issue and provide more time for the CHO to offer direct service, as well as to improve the quality of health service data, the e-tracker was developed.

The DHIMS2 e-tracker enables the facilities at the CHPS level to collect, manage, and analyse transactional, case-based data records on a web-based system using tablets, phones, or laptops. The e-tracker allows the CHO to store information about individuals and track these persons over time using a flexible set of identifiers (see Figure 5). The tracker allows the CHO to configure SMS reminders, track missed appointments, and generate visit schedules. The CHO can create monthly service reports as well as dynamic reports based on cases and generate on-the-fly statistical reports.

It is envisaged that all CHOs will be using the e-tracker to collect and manage patient data for both service delivery and reporting. The e-tracker shall facilitate the follow-up of defaulters. Analysis of each client's status in the continuum of care shall be facilitated by the e-tracker.

Figure 5: Name-based information-tracking process



Indicators for Monitoring CHPS Performance and Their Source

The data on establishing the CHPS zone and scaling up CHPS implementation shall be captured at district level on the “District CHPS Quarterly Monitoring Form” in DHIMS2. From this quarterly report, FSV visit reports, and CHPS verification visit reports, the status of the roll-out of CHPS in the district, as well as the implementation of the 15 steps in each CHPS zone, can be monitored. Service performance of the CHPS zone can be monitored through the various service-reporting forms in the DHIMS2.

The quarterly CHPS report shall be completed in the DHIMS2 by all districts (see Table 6). It provides a summary of the status of the processes of setting up CHPS in the districts.

Table 6. Quarterly CHPS report in DHIMS2

No.	Data Element	Definition
1	Number of Electoral Areas	Number of electoral areas in the district.
2	Total Number of Communities in District	Total number of communities in district.
3	Number of Communities Served by GHS	Number of communities served by GHS facilities and outreaches in the district.
4	Number of Communities Served by Other Partners	Number of communities whose health needs are served by other partners.
6	Number of Outreach Sites	Number of outreach sites in the district.
7	Number of Demarcated CHPS Zones	Number of demarcated CHPS zones in the district.
8	Number of Completed CHPS Zones	Number of completed CHPS zones in the district (a completed CHPS zone is defined as one in which “all the milestones have been completed and the CHO actually resides in the community (in a CHPS compound) and provides a basic package of services to the catchment population”).
9	Number of CHPS Compounds	Number of CHPS compounds (each of which consists of a residence for CHOs and clinic in any form) at the end of the quarter, including compounds newly constructed during the quarter.
10	Number of Functional CHPS Zones with Equipment	Number of functional CHPS zones which have basic equipment necessary for CHOs to provide basic service. Equipment includes: <ul style="list-style-type: none"> • Cold chain equipment • Service delivery equipment and consumables • Working gear (wellington boots, raincoat, torch light, etc.) • Communication equipment (two-way radio or mobile phones, etc.) • Personal Digital Assistants (PDAs) for data collection

No.	Data Element	Definition
		<ul style="list-style-type: none"> Motorcycle for the CHO Bicycles for the CHVs in each community within the zone
11	Population Covered by CHPS	Population covered by completed and functional CHPS zones (Total population of communities within the completed and functional CHPS zones).
12	Number of Functional CHPS Zones	<p>Number of functional CHPS zones (not counting completed CHPS zones) in the district. A functional CHPS zone shall be commissioned when:</p> <ol style="list-style-type: none"> 1. The community entry process is completed and community members are fully engaged; 2. The CHMCs are formed and actively involved in health planning and service delivery design; 3. A CHO is deployed to the defined zone; 4. CHVs are selected from the community and trained for service delivery; 5. A community profile (see Appendix A) is in place; 6. Health service delivery is targeted at households and families; 7. The CHO has developed a schedule of home visits that covers all homes in the catchment area and is implementing regular home visits on schedule; 8. Identifiable service delivery data from the CHPS zone as an organizational unit are reported and are available in the health information management system; and 9. The Community Health Compound (newly constructed, rented, hired, or refurbished) and the needed equipment are not yet ready.
13	Number of Trained CHOs	Number of trained CHOs who are assigned to CHPS zones in the district.
14	Number of Active CHMCs with Meeting Held At Least Once in the Last 6 Months	Number of active CHMCs which held their last meeting within the last 6 months.
15	Number of Active CHVs	Number of active CHVs in the district.
16	Number of Functional CHPS Zones with CHAP	Number of functional CHPS zones which have a CHAP.
17	Number of Zones planned to Be Made Functional for the Year	Number of CHPS zones which are planned to be functional in the year.
18	Number of Zones Planned to Be Made Functional for the Quarter	Number of CHPS zones which are planned to be functional in the quarter.
19	Number of CHPS Compounds Planned to Be Constructed in the Quarter	Number of CHPS compounds which are planned to be constructed in the quarter.
20	New Functional CHPS Zones during the Quarter	Number of CHPS zones which became functional in the quarter.
21	Number of CHPS Compounds Constructed in the Quarter	Number of CHPS compounds newly constructed during the quarter.
22	Number of Home Visits Done in the Quarter	Total number of home visits done by all CHOs during the quarter.
23	Number of Durbars in the Quarter	Number of durbars related to CHPS activities held in the quarter.
24	Number of Meetings with Social Groups in the Quarter	Number of meetings with social groups such as women's group or youth group in the quarter.
25	Number of Volunteers Trained in Surveillance	Number of CHVs trained in surveillance (Community-Based Surveillance Volunteers or CBSVs) in the district.
26	Number of Volunteers Trained in Malaria	Number of CHVs trained in malaria control activities.
27	Number of Volunteers Trained in Child Health	Number of CHVs trained in child health activities (IMNCI).
28	Number of Volunteers Trained in FP Distribution	Number of CHVs trained in FP commodity distribution.

No.	Data Element	Definition
29	Number of Trained TBAs	Number of trained TBAs.
30	TBA Deliveries	Number of deliveries conducted by TBAs.
31	TBA Postnatal	Number of postnatal clients seen by TBAs.
32	TBA Antenatal	Number of antenatal clients seen by TBAs.

To monitor the inputs, processes, outputs, outcomes, and impacts of CHPS implementation, the minimum set of indicators outlined in Table 7 shall be monitored at the levels indicated.

Table 7: Minimum set of indicators

Indicator	Metrics	Data source	Level
Input			
Percentage of districts with -CHPS roll-out plan	Total number of districts with -CHPS roll-out plan / Total number of districts in the region	Regional Annual and Half-year reports	Regional National
Percentage of functional zones with compounds	Number of functional zones with officially constructed compounds / Total number of functional CHPS zones	DHIMS2—CHPS quarterly reporting form	Sub-district District Region National
Percentage of functional CHPS zones with temporary compounds	Number of functional zones with temporary or rented compounds / Total number of functional CHPS zones	District Annual Reports	Sub-district District Region National
Percentage of functional zones with basic CHPS equipment	Number of functional zones with basic CHPS equipment / Total number of functional CHPS zones	DHIMS2 CHPS quarterly report	Sub-district District Region National
CHO per population ratio (equity index)	Equity index = CHO per population ratio of the worst sub-district / CHO per population ratio of the best district	DHIMS2 Human resource quarterly form	District Region
Proportion of CHNs trained on CHPS module	Number of CHNs trained on CHPS / Total number of CHNs in the district	DHIMS2—CHPS Quarterly Report	Sub-district District Region National
Proportion of trained community volunteers	Number of volunteers trained on CHPS / Total number of volunteers	DHIMS2—CHPS Quarterly Report	Sub-district District Region National
Process			
Proportion of scheduled community durbars organised	Number of durbars held for the period / Total number of scheduled community durbars for the period	DHIMS2 Sub-district CHPS narrative reports	CHPS zone Sub-district District
Proportion of scheduled home visits held	Number of home visits held for the period / Total number of scheduled visits for the period	DHIMS2 Sub-district CHPS narrative reports	CHPS zone Sub-district District
Proportion of scheduled district health family meetings held	Number of district health family meetings held / Total number of scheduled district family meetings	District Quarterly Health service performance report	District Region National
Proportion of scheduled social group meetings held	Number of meetings held with identified social groups / Total number of scheduled social group meetings	Monthly CHPS reports Monthly sub-district reports Quarterly district reports	CHPS zone Sub-district District
Output			

Indicator	Metrics	Data source	Level
Proportion of pregnant women reached on home visits	Number of pregnant women reached per expected pregnancies	Sub-district CHPS narrative reports E-tracker	CHPS zone Sub-district District
Proportion of neonates reached on home visits	Number of neonates visited per expected live births	Sub-district CHPS narrative reports E-tracker	CHPS zone Sub-district District
Proportion of children under 5 years old reached on home visits	Number of children under 5 years visited per total number of children under 5	Sub-district CHPS narrative reports E-tracker	CHPS zone Sub-district District
Outcome			
Proportion of functional CHPS zones	Total number of functional CHPS zones / Total number of demarcated zones	DHIMS2—CHPS Quarterly Report	Sub-district District Region National
Proportion of zones with CHAP	Total number of functional zones with CHAP / Total number of functional zones	DHIMS2—CHPS Quarterly Report	Sub-district District Region National
Proportion of trained CHMC	Total number of CHMCs trained / Total number of CHMCs	District Quarterly CHPS report	Sub-district District Region National
Proportion of active CHMC for the period	Total number of CHMCs which held meetings with minutes in the last 6 months / Total number of CHMCs	DHIMS2—CHPS Quarterly Report	Sub-district District Region National
Percentage of population covered by functional CHPS zones	Total population covered by CHPS / Total population at level of monitoring	DHIMS2—CHPS Quarterly Report	Sub-district District Region National
Percentage of CHPS contribution to ANC	Total ANC clients seen by CHPS / Total ANC clients seen for the level	DHIMS2—Form A (Midwifery form) disaggregated by type of facility	Sub-district District Region National
Percentage CHPS contribution to early PNC (within 48 hours)	Total number of early PNC clients seen by CHPS / Total PNC clients for the level	DHIMS2—Form A (Midwifery form) disaggregated by type of facility	Sub-district District Region National
Percentage contribution of CHPS to Penta 3 immunisation	Total number of children under 1 year receiving Penta 3 through CHPS / Total number of Penta 3 immunisations administered	DHIMS2—EPI disaggregated by type of facility	Sub-district District Region National
Percentage contribution of CHPS to FP acceptors	Total number of FP acceptors seen at CHPS level / Total number of FP acceptors	DHIMS2—Form B disaggregated by type of facility	Sub-district District Region National
Percentage contribution of CHPS to skilled delivery	Total number of deliveries conducted at CHPS level / Total number of deliveries	DHIMS2—Form A (Midwifery form) disaggregated by type of facility	Sub-district District Region National

Reviews and Awards (DA, Peer Reviews, Regional, National)

The M&E framework of the Health Sector Medium-Term Development Plan 2014–2017 has CHPS implementation as one of the important indicators. The number of functional CHPS zones is one of the indicators used to monitor the strategy of strengthening the district and sub-district health systems as the bedrock of the national PHC strategy.

Reporting on progress of CHPS implementation shall therefore be one of the critical components of all annual and half-year reviews of service performance held at the district, region, and national levels.

The national level, as part of its monitoring reporting responsibilities, is supposed to report to the MOH on the number of functional CHPS zones in the reporting year.

The DDHS, being the technical lead in the district and reporting to the District Chief Executive and the DA, shall have overall responsibility for guiding service delivery in the CHPS zones in the district. The District Director shall, in the review of the district's service performance, include the extent to which the district's CHPS roll-out plan has been executed.

The District Chief Executive shall, in collaboration with the DDHS, commission annual reviews of progress in CHPS implementation in the district and make the report available to be discussed by the DA. The report and recommendations of the DA shall be made available to the RDHS of the region, the Director General of the GHS, and the Minister of Health by June of the reviewing year.

Improving CHOs' performance over time is very important. Feedback on performance, peer reviews, and performance-based rewards can be used to facilitate this improvement. Rewards, like being allowed study leave out of turn, shall be used by districts to facilitate improved performance of CHOs. Each district and region, working with its stakeholders, shall look at innovative and sustainable ways of motivating and rewarding CHOs working in the CHPS zones.

Communities and District Assemblies offering support for CHPS implementation can be publicly recognised, including with citations from the DHDs and RHD at Annual Review meetings.

Appendices

Appendix A: Community Profile

A typical community profile shall present the following:

- Name of sub-district
- Names of zones
- Name of the community
- Names of villages making up the community - cluster
- Physical characteristics - topography and vegetation
- Population of each village - male/female/adults/children (a community register shall be compiled)
- Main customs and beliefs of the people
- Predominant religious groups and organisations
- Economic activities - sources of income
- Economic facilities - markets etc.
- Communication - road networks, transportation etc.
- Water facilities
- Sanitation facilities
- Housing - nature of houses and pattern of housing
- Educational facilities - schools etc.
- Health facilities - hospitals, clinics, chemist shops etc. and
- Disease pattern:
 - Most common causes of ill health,
 - Most frequently diagnosed diseases, and
 - Special and unusual health problems.
- Sickness and health behaviour:
 - Who do people see for health when sick?
 - What do people do to prevent illness and stay healthy?
 - What role do traditional healers and TBAs play in health services delivery?

Appendix B: Service Interventions for CHOs

Target	Service interventions
Neonate/infant	<ul style="list-style-type: none"> • Newborn/Infant care—Essential newborn care/Cord care/Early initiation of BF • Exclusive BF up to 6 months • Kangaroo mother care • Nutrition—infant and young child feeding (IYCF)/growth monitoring and promotion (GMP)/Community Management of Acute Malnutrition (CMAM) • Community Integrated Management of Newborn and Childhood Illness (C-IMNCI) and referral of serious cases • Disease surveillance and control—malaria prevention, including sleeping under insecticide-treated nets (ITNs)/Paediatric diagnosis and antiretroviral therapy/Education on prevention
Pregnant women	<ul style="list-style-type: none"> • Focused antenatal care (FANC)—Pregnancy monitoring/Education on nutrition/Micronutrients (iron, folate)/Birth preparation/intermittent preventive treatment (IPT)/HIV counselling and testing/Maternal antiretroviral therapy • Skilled attendance at delivery • Emergency Obstetric and Neonatal Care (EmONC) • PNC
Children under 5 years old	<ul style="list-style-type: none"> • Vaccination • Nutrition—GMP/vitamin A supplementation/CMAM • Disease Control—Deworming 2yrs–5yrs/Education on prevention and treatment of fevers, diarrhoea and ARI/Malaria
Adolescents	<ul style="list-style-type: none"> • adolescent sexual and reproductive health including FP/Education against teenage/early pregnancy • Education on preventable diseases (HIV/STIs, malaria) and non-communicable diseases (obesity, drug abuse)
School children/women of fertile age	<ul style="list-style-type: none"> • School health activities (based existing guidelines) FP (short term methods (pill, male and female condoms, injectables, etc.) and Jadelle insertion and removal • Household nutrition/iodated salt consumption
Discharged patients	<ul style="list-style-type: none"> • Follow-up of discharged patients and directly observed therapy short course (e.g. children, TB, leprosy, hypertension, epilepsy, diabetes, malnourished children)
General population	<ul style="list-style-type: none"> • Regenerative health and nutrition/Household iodate salt consumption • Mass Drug Administration (yaws, filariasis, schistosomiasis, intestinal worms) • Disease surveillance and control - Investigation and reporting on rumours/unusual events/malaria, HIV/STIs, TB, NTDs, diseases for eradication/elimination and non-communicable diseases (hypertension, diabetes, sickle cell disease, asthma)
The aged	<ul style="list-style-type: none"> • Home visits to the aged to provide education on care and nutrition

Appendix C: Conducting a Situation Analysis

This is the process by which the DHMT carries out a critical examination of its operations in the delivery of PHC services to the people of the district with the view of:

- Assessing its capabilities
- Identifying the challenges, and
- Developing a new and more relevant program of action.

By this process the DHMT constitutes itself into a special review team made up of the DDHS, the medical superintendent in charge of the district hospital, the public health nurse, the disease control officer, the nutrition officer, the medical assistant and the sub-district heads. The following areas are assessed in conducting the situational analysis:

Service Coverage

Objectives

- Identification of areas of low coverage of services
- Identification of areas of low patronage of services

In assessing service coverage the DHMT examines the existing service map of the district or creates one where it is not available. This map shall indicate

- The sub-districts and the main communities
- The existing service delivery points, and
- The types of services offered.

The district health service map shall therefore reveal the pattern of service coverage in the district and provide response to the following *key questions*:

- Which areas of the district are receiving better coverage of services?
- Why?
- In which areas of the district are services being poorly patronised?
- Why?
- Which services are receiving better patronage?
- Why?
- Which services are being poorly patronised?
- Why?
- How can service coverage and service quality be improved with the existing resources and plan for more resources later?

Resource Status

Objectives

- Identify the existing service delivery structures
- Identify the sources of funding for implementing CHPS

An examination of the available resources for service delivery is necessary. In this exercise the DHMT takes account of the existing service delivery structures in the district. These shall include the number of hospitals, clinics, health centres and outreach points etc., their capacity and state of functionality. The resource survey shall provide answers to the following *key questions*:

- To what extent are the existing service structures being used to maximise service delivery to community members?
- What can we do to improve upon the level of functionality of these structures?

Table C1 may be adopted:

Table C1: Status of facilities

Sub-district	Type of Facility	Number	State of Functionality			
			0–25%	26–50%	51–75%	76–100%

Sources and levels of funding and equipment for various services and structures shall also be identified. The identification of the sources of funding shall provide answers to the following *key questions*:

- How much money would be available to support CHPS from the various funding organisations?
- Which particular components of the CHPS implementation programme are the various organisations interested in?

Table C2 would be useful:

Table C2: Sources of funding

Organisation	Estimated Amount of Money	Type of Equipment	Targeted Component of CHPS
Govt. of Ghana funds/financial encumbrances			
Internally generated funds (IGF)			
Donor funds			
DA			
Communities NGOs			

Others			
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CHNs and Level of Work

Objectives

- Identify the pattern of distribution of CHNs in the district
- Identify the level of performance of CHNs – whether underutilised or not

The DHMT shall conduct a work analysis of the performance of the CHNs in particular to identify the following:

- Number of public health nurses in the district;
- Number of CHNs in the district;
- Number of CHNs in the sub-district;
- Number of patients seen by the CHNs at each of the identified service points in a month;
- Nurse-patient ratio i.e. average number of patients seen by each CHN in a week, a month etc.

Tables C3 and C4 will be used to facilitate the CHN Work Analysis:

Table C3: Availability of health worker

Category Of Staff	Number In District	Total Number Required
Public Health Nurse		
CHN		
Medical Assistant		
Health Assistant (Clinical)		
Others		

Table C4: CHN-to-patient ratio

Category of Service Point	Expected Number of Patients to Be Seen by CHN	Number of Patients Seen by A CHN per Month

This work analysis will provide answers to the following *key questions*:

- Are the CHNs performing to their fullest capacity?
- If not, why?
- Are the community members making full use of the available facilities?
- If not, why?
- Could the available staff of health workers provide PHC services using the CHPS strategy?

Output of the Situation Analysis

Two outputs will result from carrying out the situation analysis of the district health service system:

Draft District Health Service Profile

The first is the District Health Service Profile (DHSP), which shall reveal the merits and inadequacies in PHC delivery in the district as well as the sub-districts. The DHSP will indicate the following:

- The most patronised services according to sub-districts;
- The most patronised service points according to sub-districts, indicating communities in which they are located;
- The less patronised services in each sub-district;
- The less patronised service points in each sub-district indicating communities in which they are located;
- Communities with little or no access to services;
- Distribution of service providers according to sub-districts;
- Distribution of services;
- Distribution of service facilities;
- Existing sources of funding and their assessment;
- Other possible sources of funding; etc.

Draft Health Action Plan

The DHSP shall guide the DHMT to start developing the District Health Service Action Plan for implementing CHPS. This initial plan will reveal:

- Pattern of redistribution of service providers, particularly CHNs and their supervisors, to meet the requirements for CHPS;
- Pattern of reorganisation of services to meet the requirements of CHPS; and
- Timelines on CHPS implementation activities in the district.

Appendix D: PSs from Sub-district to CHPS zone Levels and Assessment Tools (Refer to PS booklet for PSs for other higher levels)

Performance Standard and Criteria for Supervision

(Revised in May 2016)

I. Managerial Areas				Code
I-I Data management				
1	All health related records (ANC Register, Birth and Emergency plan, Maternal Health Record, Postnatal Register, Child Health Records, Referral Records, Midwives Returns, Home Visit Book, Child Welfare Clinic [CWC] Book, Health Promotion Activity Report, etc.) are kept according to standard.	1	Standard directory of filling is available and updated.	1
		2	All sections, columns and cells of registers/reports are completed and up to date.	2
		3	Community registers are updated monthly and community profile updated annually.	3
I-II Financial management				
1	Financial Management is conducted according to standard operations guidelines.	1	Internally Generated Fund is recorded according to standard operations guidelines and cash is banked or sent to the SDHT (daily, weekly, monthly).	4
I-III Activities schedule and meetings				
1	Regular meetings are organised.	1	Meetings are organised monthly with CHVs and the Minutes are available and current.	5
		2	Quarterly CHMC meetings are organised and minutes are available.	6
2	Action plans and information sharing with SDHT and CHVs	1	Daily Attendance register is available and current	7
		2	Monthly work plan of CHPS zone is available, implemented and monitored	8
I-IV Supply management				
1	Standard Inventory management is conducted at facility.	1	All health commodities as specified in the guideline are stocked above the re-order level.	9
		2	Monthly stock check is conducted.	10
		3	All commodities are kept in good condition, organised and issued according to “first-to-expire, first-out”.	11
		4	All unserviceable commodities are stored separately or excess stock is in process of being returned.	12
		5	Health commodities are ordered and issued according to the established guideline.	13
I-V Transport, equipment, estates and facility				
1	Motorbikes are maintained.	1	Monthly motorbikes servicing is conducted.	14
2	All equipment and assets are stored and maintained according	1	Assets register is available and updated. (Equipment part of assets)	15

I. Managerial Areas				Code
	to standard	2	All the equipment in use and in store is functional.	16
		3	All items (e.g., stationeries) are set in order, and the stock items are categorised in appropriate sections/areas.	17
		4	All assets and equipment are embossed according to standard or guideline.	18
		5	Cold chain equipment, fridge is monitored with a thermometer and the temperature recorded on the daily monitoring sheet	19
3	Facility and its surroundings are well maintained and in good condition.	1	The rooms are well organised for the purpose. Cleanliness and privacy are maintained.	20
		2	Surrounding of the facility is kept clean, well lit, water source and disposal pit are functioning.	21
		3	Mobile network is available.	97

II. Quality Improvement of Workplace				
II-I Preventive maintenance				
1	All equipment and assets are stored and maintained according to guidelines.	1	Non-functioning equipment are separated and stored in designated place for disposal or repair.	22
		2	Necessary manuals and instructions accompanied with equipment are filed or displayed near equipment for easy access and reference.	23
		3	Regular maintenance of equipment is conducted.	24
II-II Infection prevention and control				
1	Universal standard precautions are followed in the facility.	1	Implementation of routine cleaning of the facility is conducted according to schedule.	29
		2	Soap, alcohol rub and water are readily available at each procedure room.	25
		3	Hand-washing is done before and after every procedure according to protocol.	26
		4	Personal Protective Materials are readily available for use (such as "disposable Glove").	27
		5	Re-Usable Personal Protective Materials (e.g., utility gloves, plastic apron, wellington boots, and mackintosh) are maintained, cleaned and stored according to protocol	28
2	Medical equipment is disinfected and readily available for use.	1	Relevant disinfectants (Chlorine/Chlorhexidine solution) are available and properly labelled.	30
		2	Medical instruments/equipment are processed and maintained for safe use according to guideline(decontamination and cleaning)	31
		3	Medical equipment are stored according to guideline to avoid possible contamination.	32
3	Waste from facility is managed according to standard precaution guidelines.	1	Labelled waste containers for different type of waste are available at where the services are provided.	33

II. Quality Improvement of Workplace					
		2	All medical waste is disposed according to the set guideline or procedure.		34
		3	No hazardous items are exposed in the facility.		35
II-III Emergency preparedness					
1	The facility is prepared for receiving delivery and emergency cases.	1	Minimum set of equipment are available and ready for emergency (including at least two sterile delivery kits.)		36
		2	Essential emergency procedures/protocols are displayed for easy access and reference.		37

III. Service Delivery				
III-I MNH and child health				
1	Guideline and Protocol are available at the service delivery point and accessible to all staff.	1	Guideline and protocol/charts are placed on the wall at the appropriate places for reference in performing procedures.	38
2	FP is provided according to policy guidelines.	1	FP commodities are available and above re-order level.	39
		2	FP is given as specified in the guideline.	40
3	Adolescent health services are provided.	1	Adolescent health corner is available and records of services provided.	90
4	Focused ANC is provided according to policy guidelines.	1	Commodities for focused ANC are available. (Iron/folate tablets, TT vaccine, SP package).	41
		2	ANC is given as specified in the guideline.	42
		3	PMTCT services are provided according to policy guidelines.	43
5	Delivery and emergency services are provided according to policy guidelines.	1	Minimum quantity of emergency drugs and supplies are available in the facility, ready for use (oxytocin, antibiotics).	44
		2	Intrapartum, postpartum and newborn care is given as specified in the protocol.	98
6	Postnatal care is provided according to policy guidelines.	1	Commodities for postnatal care are available (Iron/folate tablets, vaccines, Vitamin A etc.).	45
		2	Postnatal care is given as specified in the guideline.	46
7	Quality is maintained in the report on RCH services (FP, ANC, Delivery and PNC)	1	Reporting of FP, ANC, Delivery and Postnatal is done at specified interval correctly.	47
		2	Used registers/reports are kept at a section in the stores.	48
8	EPI is conducted according to policy guidelines.	1	EPI is conducted and recorded.	99
		2	There is an updated graph showing coverage of various antigens (Bacillus Calmette–Guérin, Oral Polio Vaccine [OPV1-3], Penta 1-3, Pneumococcal conjugate vaccine [PCV1-3], Rotavirus [Rota 1-2], measles [MLS 1-2], yellow fever, Tetanus Toxoid, etc.) clearly displayed.	49

III. Service Delivery				
		3	Dropout rate is calculated correctly and updated chart displayed.	50
		4	There is a chart showing wastage of various antigens.	51
9	School health services are conducted according to guidelines.	1	School health services are conducted according to schedule.	52
10	CWC (growth monitoring) is conducted properly	1	CWC (growth monitoring and promotion) is conducted monthly and entries done correctly.	53
11	List of the structured training experience of each staff on MNH is recorded and updated.	1	List of the structured training experience of each staff on MNH is recorded and updated.	54
12	Nutrition activities are conducted recorded	1	Nutrition activities are correctly reported.	94
		2	Nutrition registers including CMAM and IYCF are available and updated.	95
		3	Support visits on nutrition activities including growth monitoring are conducted.	96
		4	There updated graphs/charts showing nutrition status of children.	55
III-II Disease control/surveillance				
1	Surveillance is conducted according to guidelines and reports submitted timely	1	There is updated graph showing cases/vital events and diseases under surveillance.	100
		2	All CBSVs are supervised monthly and reports submitted	56
		3	There are spot maps showing areas in the CHPS zones where diseases of public health importance occur.	57
III-III Health promotion				
1	Reproductive health promotion is conducted.	1	FP promotion is carried out.	58
		2	Promotion of early ANC, skilled delivery and PNC is carried out.	59
		3	The number of population reached with health promotion is recorded by sex and age group.	60
2	Information, education, and communication (IEC) materials are available and in use.	1	IEC materials are available in the facility (such as ANC, skilled delivery, PNC etc. flip charts etc.)	61
		2	IEC materials are used to carry out health promotion activities.	62
3	Health promotion is conducted.	1	Health promotion sessions are conducted during the last month.	63
III-IV Community participation				
1	Regular home visits are carried out.	1	Regular home visits for ANC, PNC are carried out by the CHOs, or CHV.	64
		2	Defaulter tracing is conducted (evidence of defaulter tracing)	65
2	Community's health activities are implemented with support of CHOs.	1	Community members with the support of the CHO develop CHAPs and it is regularly monitored, reviewed and updated.	66
		2	CHO support communities to implement CETS and ensure its monitoring and operation.	67

III. Service Delivery				
3	Communities are sensitised.	1	Durbars and meetings are organised quarterly	68
		2	Meetings with community-based volunteers (Community-Based Agent, CBSVs, TBA, etc.) are conducted monthly (quarterly).	69
		3	Visit to other health partners (the traditional healers, chemical sellers or private midwives) are conducted monthly.	70
4	Community supports maintenance of CHPS compound	1	Community support CHO/CHN in water fetching, cleaning, security and other activities.	85

IV. Referral and Feedback				
1	Availability of standard referral tools and treatment guidelines.	1	At least 10 sets of GHS referral forms are available.	71
		2	Entries in the referral register are completed including feedback received.	72
		3	Current National Treatment Guideline is available and accessible at the area where consultation is done.	73
2	Referral system is functioning.	1	No. of referral cases sent in last 3 months is recorded.	78
		2	No. of feedbacks received in last 3 months is recorded.	79
3	Records are kept properly.	1	Documented evidence of referral sent (pink form) remain in the GHS referral booklet.	74
		2	Received feedback forms are kept in each patient folder or a feedback file.	75
4	Support system for referral is established.	1	Transport is available (National Ambulance, CETS or other available means of transport mode).	76
		2	Telephone directory is accessible to all staff, displayed and regularly updated.	77

V. Monitoring and Supervision System (FSV)				
1	FSV from CHO to CHV is conducted.	1	Monthly CHVs-supervision is conducted.	80
2	All the monitoring sheets are submitted to SDHT.	1	Copies of supervisory reports are submitted to SDHT.	81
		2	Findings of supervision is implemented from SDHT to CHO and from CHO to CHV that the CHO is responsible.	82
3	The report and documents of CHMC and CHV level are submitted to CHO on time.	1	Monitoring reports of CHVs by CHO are submitted timely.	83
4	CHO participates in CHPS Review Meeting.	1	CHOs participate in the quarterly CHPS Review Meeting (conducted by DHMT).	84

Facilitative Supervision Checklist

Level: Sub-District → CHPS Zone

Basic Information (Interview with CHO)

District: Sub-district:

Name of CHPS Zone:

Date (DD/MM/YY) and Time: / / Start: End:

No. of communities (catchment areas): No. of CHMC members:

No. of active/registered CHVs:___/___

Status of CHO/CHN/others

CHO/ CHN/ others	Name	Tel. no.	Email	Supervisee (tick)

Supervisors

Name	Job title	Organisation	Tel no.

Issues to be followed up based on the result of the previous supervision

I. Managerial areas

I-I. Facility condition and infrastructure

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
1	Are the rooms well organised and cleaned?	Observation at room				
2	Is surrounding of the facility kept clean?	Observe surroundings				
3	Is water supply regular and secure? (Pipe borne, bore hole and well)	Interview				
4	Is electricity available?	Interview/Observation				
5	Are lights functioning?	Observation at room/Interview				
6	Is mobile network available?	Interview				

I-II. Data management

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
7	Is current standard directory of filing updated?	Standard directory				
8	Is community register updated monthly?	Community registers				
9	Is community profile updated and current?	Community profile				
Check the availability and completeness of the reports on the list below						
No.	Reports/Records		Good	Fair	Poor	Remarks
10	Monthly Midwife Returns					
11	Monthly Family Planning Returns					
12	Monthly Child Health Returns					
13	Monthly CBSV reports					
14	Monthly Revenue Returns					
15	Monthly Drug Returns					
16	EPI Record					
17	Monthly Nutrition Returns					

I-III. Financial management

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
18	Is internally generated fund recorded appropriately?	Revenue collection book, Notional Revenue Budget Ledger (NHI), summary cash book				

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
19	Is General Counterfoil Receipt (GCR) Book available and used?	GCR/Controller and Accountant General Department (CAGD), Approved receipt book of MOH, value book stock register				
20	Are claims of NHIS compiled daily?	Daily claims forms, Notional Revenue Budget Ledger (NHIS), revenue returns				
21	Is revenue sent to the SDHT?	Duplicate Pay-in-Slip, passbook, Notional Revenue Budget Ledger (NHIS), cash analysis book, revenue returns (software), GCR				

I-IV. Activities schedule, meetings, and training

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
22	Is Daily Attendance register available and current?	Daily Attendance Register				
23	Is monthly work plan of CHPS zone available and current?	Monthly work plan				
24	Are meetings organised monthly with CHVs and meeting minutes available and current?	Interview, Minutes with CHV				
25	Does CHO have a logbook and in use?	Training logbook, interview				

Tick the training experienced on each staff below.

CHO/ CHN	Name	Fresher CHO	Refresher (1) ^a	Refresher (2) ^b	Refresher (3) ^c	Life Saving Skills
^a Refresher (1) = CHO Refresher Training (1) ANC/Delivery/PNC ^b Refresher (2) = CHO Refresher Training (2) Community-Based MNH ^c Refresher (3)= CHO Refresher Training (3) Community Mobilisation/FSV						

I-V. Equipment and assets management

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
26	Is Assets register available and updated?	Assets register/Store ledger book				
27	Are assets labelled?	Check labels				
28	Are all equipment in use functional?	Assets register/Store ledger book/Obsv. Eqpts				
29	Are non-functioning equipment separated for sending to repair?	Observation at storeroom, Unserviceable store ledger				
30	Are manuals and instruction filed or displayed in designated area?	Place of keeping user's manuals and instructions				
31	Is regular maintenance of equipment (e.g. Refrigerator, Solar system) conducted?	Maintenance schedule, Interview with CHO				
32	Is monthly motorbikes servicing conducted?	Interview, maintenance schedule and register				

I-VI. Supply management

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
33	Are health commodities requested and issued by standard forms?	Requisition, Issue and Receipt Voucher, Requisition form book				
34	Does each drug have a bin card?	Bin cards				
35	Are all health commodities stocked above the re-order level?	Bin cards, Drug returns				
36	Are commodities kept in good condition (No sunlight, heat, moisture, dust, insect or animal)?	Storage condition at dispensary/store				
37	Are commodities aligned on shelves by labels indicating where the drug belongs?	Cross-check between labels on the shelves and drugs				
38	Are commodities organised according to first-to-expire, first-out?	Check 2-3 drugs aligned				
39	Are unserviceable stock stored separately to be returned?	Observation at storeroom, unserviceable store register				
40	Are office supplies (stationery) set in order by category?	Observation at storeroom				
41	Are copies of Maternal Health Records Booklet stocked?	Stock of the booklet at store/service point				
42	Are copies of Child Health Records Booklet (CWC Book) stocked?	Stock of the booklet at store/service point				
43	Are used Registers/reports kept in the stores?	Storeroom				

II. Quality improvement of workplace

II-I. Infection prevention and control

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
44	Is routine cleaning of the facility conducted?	Interview with staff, Schedule of cleaning				
45	Are soap, alcohol rub and water or Veronica buckets available for hand-washing at service points?	Observation at service points				
46	Are Personal Protective Equipment available with appropriate stock (Disposable glove, Mask)?	Observation at OPD and store room				
47	Are Re-Usable Personal Protective Materials (e.g., utility gloves, plastic apron and mackintosh) maintained cleanly?	Observation at room				
48	Are relevant disinfectants (Chlorine/Chlorhexidine) available and labelled?	Expiry dates, strengths on labels				
49	Is medical equipment processed and maintained for safe use (Sterilisation)?	Interview with CHO				
50	Are medical equipment stored appropriately to avoid contamination?	Observe equipment storage				
51	Are labelled waste containers for different type of waste available?	Observe waste containers (Label, Place), Safety box				
52	Are no hazardous items (sharps, contaminated materials, flammables, harmful chemicals) exposed in the facility?	Observe Facility				
53	Are disposal pits for general medical wastes available?	Observe disposal pit				
54	Is placenta disposal pit available and in use?	Observe placenta disposal pit				
55	Are medical wastes disposed appropriately (incinerator, waste disposal pit, or landfill)?	Interview with staff/Observe				

III. Service delivery

III-I. MNH and child health

A. FP

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
56	Is Family Planning Guideline/Protocol available?	FP Guidelines/Protocol				Not updated
57	Are FP commodities (Condoms, Pills, Injection, Implant, and IUD) available in stock?	Check all FP commodities				
58	Is Family Planning register available and correctly completed?	Family Planning register				
59	Is the record of FP service correctly completed on the FP Client Card?	Check 1-2 FP Client Card				
60	Is Family Planning flipchart used for counselling?	Observe if clients are available. GHS Family Planning flipcharts on the desk				

B. Adolescent health

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
61	Is adolescent health corner available?	Observe the corner				
62	Is there an adolescent health profile for the sub-district?	Sub-district profile				
63	Is adolescent health service record updated?	Adolescent health service record				
64	Is there an adolescent health action plan for the sub-district?	Action plan				

C. ANC and PMTCT

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
65	Are Guides for Maternal and Newborn Care Part 1 and Part 2 available?	Observation at maternity service point				
66	Is National Safe Motherhood Service Protocol available?	Observation at maternity service point				N/A
67	Is the record of ANC services correctly completed on the ANC register?	ANC register				
68	Is the birth preparedness plan completed on the Maternal Health Record Booklet?	Maternal Health Record Booklet (If pregnant women available)				N/A

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
69	Is the record of ANC service correctly completed on the Maternal Health Record Booklet?	Maternal Health Record Booklet (If pregnant women available)				N/A
70	Are commodities for focused ANC available?	Check Iron/folate, Multivitamin, TD, SP				
71	Are PMTCT commodities available (HIV test, Syphilis test)?	PMTCT commodities				
72	Is the record of PMTCT services correctly completed on the register?	PMTCT register				
73	Is client's privacy ensured (Screen, Door closed or Partition) in the room?	Observation at room				

E. Emergency delivery

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
77	Are minimum quantity of emergency drugs and supplies available in the facility?	Check Oxytocin, IV fluid, Antibiotics				
78	Are minimum set of equipment available and ready for use?	See condition of two sterilised delivery kits				
79	Is partograph used to monitor women in labour? <i>Fill in the number of cases monitored with partograph at "Remarks"</i>	Used partographs of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases monitored using partograph among recent 10 cases: (___/ 10)
80	Is partograph used correctly?	Used partographs of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases using partograph correctly among recent 10 cases: (___/ 10)
81	Is Immediate Postpartum Observation (IPO) sheet used to monitor mother and baby after delivery for 10 times in 6 hours? (quarterly for 1 hour, half hourly for 1 hour and hourly for 4 hours) <i>Fill in the number of cases monitored with partograph at "Remarks"</i>	Used IPO sheet of recent 10 cases of sample 10 cases on Delivery Register of the last quarter				Fill in the number of labour cases monitored using IPO sheet among recent 10 cases: (___/ 10)

F. Child health (CWC, EPI)

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
82	Are the CWC services correctly recorded on the CWC Registers?	CWC Register (Check two different age group registers)				
83	Are the CWC services recorded on the Child Health Record Booklet?	If children available, see the booklet (CWC booklet)				
84	Is the refrigerator monitored and temperature recorded on the daily monitoring sheet?	Temperature monitoring sheet				
85	Is EPI protocol displayed?	Observe Service corner				
86	Are there updated graphs showing coverage of various antigens (BCG, OPV, Penta, PCV, Rota, MLS, YF, TD) displayed?	Charts of coverage of eight antigens				
87	Are dropout rates (OPV, Penta, PCV, Rota, MLS) calculated correctly and updated chart displayed?	Dropout rate chart (normally same charts the above)				
88	Are No. of vaccinations and No. of opened vials reported monthly?	EPI returns				
89	Is there a chart showing wastage of various antigens?	Vaccine wastage chart				
90	Are school health services conducted according to the schedule?	Child health returns				

G. Nutrition

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
91	Are nutrition registers including CMAM and IYCF available and updated?	CMAM and IYCF registers				
92	Are support visits to volunteers on nutrition activities conducted?	Monitoring reports				
93	Are there updated graphs/charts showing: <ul style="list-style-type: none"> Prevalence of underweight among children 0 to 59 Vitamin A coverage Low birth weight prevalence CMAM discharge rates (cure, defaulter, died) CMAM treatment coverage Pregnant/lactating mothers (children 0–23 months) 	Graphs/charts of listed indicators				

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
	counselled <ul style="list-style-type: none"> • IYCF support groups formed • IYCF support groups facilitated 					

III-II. Disease control/surveillance

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
94	Are there updated graphs showing cases/vital events and diseases under surveillance?	Graph of surveillance				
95	Are all CBSVs supervised monthly?	CBSV Supervisory report				
96	Are CBSV reports submitted on time by CHO to SDHT?	CBSV report				
97	Are there spot maps showing areas in the CHPS zones where diseases occur?	Spot map				

III-III. Health promotion

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
98	Is family planning health promotion carried out?	FP returns, Health promotion activity report				
99	Is promotion of early ANC, skilled delivery and PNC carried out?	Health promotion activity report				
100	Is the number of population reached from health promotion recorded by sex?	Health promotion activity report				
101	Are IEC materials for reproductive and child health available such as flip charts, leaflets?	Observation in the facility				
102	What do you use during health promotion activities?	Interview				
103	Were health promotion sessions conducted during the last month?	Reports of home visits, school health education and promotion, Health promotion activity report				

III-IV. Community participation

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
104	Are regular home visits for	Home Visit Book				

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
	ANC, PNC carried out by the CHO/CHV?					
105	Is defaulter tracing conducted?	Defaulters record				
106	Have community members developed CHAP with the support of the CHO?	CHAP				
107	Is CHAP regularly monitored, reviewed and updated?	CHAP monitoring report				
108	Are CETS established in the CHPS zone?	Interview/Report/Telephone directory				
109	Does CHO support and monitor communities to implement CETS?	CETS meeting minutes (Check CHO's name)				
110	Are Durbars organised quarterly?	Meeting reports				
111	Are quarterly CHMC meetings organised and minutes available?	CHMC meeting minutes				
112	Are visits to other health partners (e.g. traditional healers) conducted regularly?	Visit record/Home visit book				
113	Is security man for CHPS compound provided and supported by communities?	Interview with CHO				
114	Do communities support in water fetching for CHO/CHN?	Interview with CHO				
115	Do communities support in cleaning/weeding at CHPS compound?	Interview with CHO/Observe				
116	Do communities support CHPS for other activities (e.g. health campaign)?	Interview with CHO				

IV. Referral and feedback

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
117	Are at least 10 sets of GHS referral forms available?	Referral booklet				
118	Are entries in the referral register completed including feedback received?	Referral register				
119	Is current National Treatment Guideline available at the consultation area?	National treatment guideline				
120	No. of referral cases sent in last 3 months	Referral register				No.
121	No. of feedbacks received in last 3 months	Referral register				No.
122	Are Essential Emergency procedures/protocols	Essential Emergency				

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
	displayed for easy access and reference?	procedures/protocols at service points				
123	Does documented evidence of referral sent (pink form) remain in the GHS referral booklet?	Referral booklet				
124	Are received feedback forms kept in each patient folder or a feedback file?	Patient folders/feedback file				
125	Is transport available (National Ambulance, CETS or other mode)?	Interview				
126	Is telephone directory accessible to all staff, displayed and updated?	Telephone directory				

V. Monitoring and supervision system (FSV)

No.	Check Items	Means of Verification	Good	Fair	Poor	Remarks
127	Is monthly CHVs-supervision conducted?	Monthly CHV-supervision report				
128	Are copies of supervision reports submitted to SDHT?	Copies of submitted reports at SDHT				
129	Are findings of supervision implemented from CHO to CHV?	Interview with CHO/CHV				
130	Do CHOs participate in the quarterly FSV Review Meeting conducted by DHMT?	Interview with CHO				

Summary Sheet of FSV by SDHT to CHPS

Name of CHPS:

Date:

Q#	Issues identified	Action	Implementation Level (CHPS/SDHT)	Name of Person Responsible	Timeframe	Remarks

Name(s) and signature(s) of supervisor(s):

Name(s) and signature(s) of supervisee(s):

Appendix E: CHPS Roll-Out Assessment Tool

Step	Milestone	Detailed Tasks	Responsible Institution/Official	Done		Comment
				Yes	No	
One	Detailed plan created	Situation analysis and problem identification at the level of the DHMT Consultation with DA—the DCE and the Social Services Sub-Committee Selection of communities	The DHMT (DDHS and public health nurses/midwives)			
Two		Consultation and sensitisation of health workers	DHMT			
Three	Community entry conducted	Dialogue with community leadership: DA, area council, Unit Committee members, social groups responsible for the communities, chiefs, leaders, women's groups, etc.	The DHMT (DDHS and public health nurses/midwives)			
Four		Community information durbars	Community leaders/DHMT			
Five		Selection and training/orientation of CHOs	DHMT/SDHT			
Six		Selection and orientation of CHMC members	Community leadership, SDHT, DHMT			
Seven		Compilation of community profile: information on geographic and demographic characteristics, settlement patterns, existing human habitation, and health features and facilities	DHMT; SDHT; CHMC members, DA; community leadership			
Eight	Community Health Compound operationalised	Procurement (construction, renovation, hiring, renting, or rehabilitation) of Community Health Compound for CHO residence	CHMC			
Nine	Essential equipment supplied	Mobilisation of logistics	DHMT			
Ten	CHO posted	Launching of CHO programme—community information durbar	Community leaders supported by DHMT/DA			
Eleven	CHVs deployed	Selection of CHVs	CHMC, SDHT			
Twelve		Approval of CHVs at a durbar	CHMC, SDHT			
Thirteen		Training of CHVs	DHMT, SDHT			
Fourteen		Mobilisation of logistics and equipping the CHVs	DHMT, SDHT			
Fifteen		Durbar to launch CHPS programme	Chiefs, CHMC, SDHT			

Appendix F: Equipment, Tools, Supplies, Drugs for CHPS Zones

	Category	Description	Quantity Needed
1	General	Sphygmomanometer	2
2	General	Stethoscope	2
3	General	Weighing Scale (adult)	2
4	General	Height Scale (adult)	2
5	General	Weighing Scale (baby, flat type)	2
6	General	Height Scale (baby)	2
7	General	Measuring tape	2
8	General	Thermometer digital	2
9	General	Wall Clock	2
10	General	Examination couch	1
11	General	Snellen's chart	1
12	General	Nurse scissors (5 1/2")	1
13	General	Apron, vinyl	1
14	General	Kidney dish (L, M, S)	1
15	General	Gallipot (L, M, S)	1
16	General	Instrument tray with cover (M, S)	1
17	General	Sterilizing drum (Medium)	2
18	General	Boiling Sterilizing case with lid	1
19	Outreach	Pedal waste bin	3
20	Outreach	Home visiting bag	1
21	Outreach	Weighing scale (hanging type for baby)	1
22	Dressing	Dressing instrument set	1
23	ANC	Foetal stethoscope	1
24	ANC	Vaginal speculum cusco (medium)	1
25	ANC	Examination bed for obstetrics	1
26	Delivery	Delivery instrument set	1
27	Delivery	Ambubag (for adult & infant)	1
28	Medical furniture	Consultation desk & chair	1
29	Medical furniture	Chair for patient	1
30	Medical furniture	Medical cupboard	1
31	Medical furniture	Veronika bucket (small)	1
32	Medical furniture	Veronika bucket (large)	1
33	EPI	Refrigerator for vaccine	1
34	Transport	Motorbike	1

For Home Visit for CHO and CHV

(1) For CHO

NO.	ITEM	Quantity
1	Back pack	1
2	Dressings (Bandage, Gauze swabs, Cotton Wool swabs, Plaster 1" & 2", Crip bandage, Vaseline Gauze etc.)	5
3	Raincoat	1
4	Cup & Spoon	2
5	Soap dish & Soap	1
6	Hand towels	6
7	Notebook	2
8	Pen & Pencil	2
9	Torch Light and batteries	1
10	Wellington Boots	1
11	Family Planning methods	Samples & For sale
12	Oral Rehydration salts (ORS)	Samples & For sale
13	Insecticide Treated Nets (ITNs)	1
14	Methylated Spirit/Glycerin (Alcohol Rub)	1
15	Penis Model	1
16	Health education -Maternal Health Record Book -Breastfeeding Care -Complementary Feeding -Malaria Prevention etc.	1 each
17	Brochures (Assorted)	1 each
18	Community Register	1
19	Volunteer T-shirt (Lacoste)	2
20	Plastic sheet 2 yards	1
21	First Aid items (Parafin, Mecurochrome, Activated charcoal,) *	1
22	Tape measure	1
23	Drugs – Anti-malarials	
24	Artesunate Amodiaquine (various age groups)*	5 each
25	Artemeter Lumifantrine (lonart, coaterm)*	2
26	Sulphadoxine Pyremethame (SP)*	10
27	Paracetamol	2 sachet
28	Disposable gloves	2 pairs or more
29	Methylated spirit	1
30	Data Management tools	Various in Plastic wallet
31	Blood Pressure kit (digital)	1
	Midwifery Kit	
32	Plastic sheets	1 (2 Yards)
33	Disposable gloves	2 pairs
34	Cord Ligatures (twine)	2 pairs
35	New Blade	2
36	Methylated spirit	1 100ml.
37	Oxytocin	4
38	Soap (wrapped in Polybag)	1
39	Gauze Swabs	5 packs
40	Cotton wool swabs	5 packs
41	Polythene bag for waste	2 (1 for placenta)
42	ORS	1

(2) For CHV

NO.	ITEM	Quantity
1	Knapsack	1
2	Plastic file	2
3	Community book	1
4	Data tools	4
5	Stationery	1
6	Plaster	1
7	Bandage	1
8	Ekrobewu	1
9	Cotton Wool swabs	5
10	Guaze swabs	5
11	Small notebook	1
12	Contraceptive methods	3
13	Anti malarials (Green leaf)	2
14	Plastic sheet	1
15	ORS	5
16	Scissors	1
17	Health education material	4
18	Gloves	1
19	Torch with Batteries	1
20	Wellington books	1
21	Plastic bowl (as galipot)	2
22	Rain Coat	1

Kit		Quantity
	Domiciliary midwifery kit: plastic sheet, plastic apron, blade, cord ligatures, tablet of Misoprostol, cotton wool/gauze swabs, gloves, soap	2 kits/sets
	Sterile delivery set: sterile gauze/cotton wool, artery forceps, disposable gloves, umbilical clamp/sterile string, scissors, sponge holding forceps (2)	Kits/sets
Medications		To be determined by CHO
	Albendazole	
	Amoxicillin	
	Artemether + lumefantrine	
	Artesunate + amodiaquine	
	Chloramphenicol eye ointment	
	Condoms	
	Cotrimoxazole	
	Depo-Provera (DMPA):	
	Distilled water	
	Ferrous folate	
	Gentian violet, 5%	
	Mebendazole tablet	
	Metronidazole	
	Misoprostol tablet	

	Multivitamin	
	Noristerat, Norigest (NET-EN)	
	Norygnon:	
	Oral Rehydration Solution and Zinc tablet	
	Oxytocin, 10 units	
	Paracetamol	
	Sulfadoxine + Pyrimethamine	
	Tetanus Toxoid	
	Vitamin A	

Appendix G: CHAP

What Are CHAPs?

CHAPs stands for community health action plans. They are community road maps summarised in a certain format, and indicate what community members want to achieve within a specified period with a view to improving their health conditions. CHAPs are developed by community members with GHS staff members such as CHO, SDHT and DHMT, providing the necessary backstopping. The CHAPs are implemented by community members. They are reviewed and updated on a regular basis by community members and the CHO to make room for new activities after the achievement of current targets on the plan.

Functions of CHAPs

- CHAPs stimulate community interest and sustain enthusiasm in health promotion through the people's participation in designing activities, and monitoring progress against set targets.
- CHAPs bring about full community involvement through its participatory development process. As a result, it promotes community ownership in community health activities.
- CHAPs serve as M&E tools for the community members as well as the stakeholders outside the communities.
- CHAPs attract donors and philanthropists who are interested in supporting similar initiatives when they are publicly displayed.

Preparation and Support

Engagement of the community takes commitment, preparation and support from all levels starting from DHMT and including SDHT and CHPS Zone. Responsibilities include the following:

District Level:

- Articulate a commitment to community engagement and participation in health
- Meet with SDHT to map electoral areas
- Zone district into sub-districts
- Sub-district further demarcated into CHPS zones (aligning with electoral areas)
- Ensure all communities covered by CHPS zones
- Clearly describe population dynamics (e.g. total population, children under 5 years, children under 1 year, expected pregnancies, and women of fertile age) in district, sub-district, CHPS zones and communities (e.g., number of households)

Sub-District Level:

- Meet the CHO
- Review and discuss CHPS data
- Service delivery (e.g., most common illnesses)
- Common issues (e.g. late first ANC visit)
- Identify issues to discuss with the community (e.g. emergency transportation)
- Support the CHO to prepare a presentation to the community
- In future the sub-district could support the CHO financially to facilitate this meeting

CHPS Zone and CHO:

- Call a durbar—set date and time with CHMC
- Invite District Assembly
- CHMC notifies the Chiefs and opinion leaders of the date and time
- Inform the community what is needed (e.g. venue, beat the gong-gong, chairs)
- At the meeting:
 - Makes a presentation to the community meeting on key issues, data challenges
 - Leads the action planning process with the community
 - Notes the actions, persons responsible and deadlines for each action in a CHAP
 - CHAP is documented

Community Level:

- Supports the hosting of the meeting
- Ensures full participation especially opinion leaders and key influential participants (e.g. teachers, pastors, herbalists, chemist, imam, women's groups, youth groups, welfare groups, Unit Committee Representative, assembly member)
- 'Okyeame' is identified to facilitate the meeting
- Participates fully in the meeting
- Responsible to implement tasks assigned (e.g., tasks could be assigned to Unit Committee)
- Support action plan implementation

Description of the Components of the CHAP Format

The following headings constitute the components of the CHAP format.

- **CHPS zone:** This refers to the CHPS zone, which implement targets in the CHAP.
- **Implementing CHPS community:** The community or communities within the zone responsible for carrying out the planned activities.

- **Facilitator:** The person who guides the CHAP's development process; in other words, the person who leads the community members in the drawing-up of the CHAP e.g. civil society organization (NGO) or Ms Gloria (CHO).
- **Date:** This is the date on which the action plan was developed.
- **Target:** This originates from the issues/problems prioritised by all groups/communities. You can convert/rephrase the original issues/problems into what refers to the results earmarked to be accomplished within a specified period e.g., "Poor access road to CHPS compound (issues/problems)". This is converted/reworded into "Access road to CHPS compound is improved (Target)".
- **Overall timeframe:** The total amount of time needed to accomplish the targeted activities.
- **Main activities:** They originate from the actions prioritised by all groups/communities. These are the key tasks to carry out in order to achieve the target. For one target, you should set several activities which are rephrased/re-developed based on the original actions.
- **Schedule:** This indicates when each activity is carried out for the target. In CHPS implementation, CHAPs are expected to be updated every three months. Therefore, the schedule for activities in the next three month is described.
- **Resources required:** These are the logistics/materials needed to carry out the activities. Items will be described as clearly as possible. For example, "GHC (Ghanaian cedi) 150.00" will be mentioned instead of a less-precise description such as "money". For example, 15 note pads, 10 buckets of stone, GHC 5.00 for transportation fee.
- **Persons in Charge:** They are the community members selected to lead the whole community in working to achieve a particular target. Writing the names of community members against a task, makes him/her feel recognised and motivated to work hard.
- **Indicators:** They are the milestones or sign post that tell community members whether or not they are on track and progressing towards achieving their planned activities. Ideally, evidence as a means of verifying shall also be described, e.g., number of participants (minutes of meeting).
- **Remarks:** They are statements about the status of planned activities. That is whether the activity is accomplished, ongoing, or stopped. It shall also have reasons assigned for such actions if possible.

Example of CHAPs

CHPS ZONE: Dabo

CHPS Community: All Communities

Date: 18th August 2008

Facilitators: CHC/CHVs/CHO/NSD Team

Target/Implementing Community/Overall Time Frame	Main Activities	Schedule			Resources Required	Persons in Charge	Indicator	Remarks
		1 st Month (Sept., 08)	2 nd Month (Oct., 08)	3 rd Month (Nov., 08)				
Target: 1 Advocate for the construction of a culvert between the road and the CHPS compound. <u>Implementing Community</u> All CHPS Communities <u>Overall Time Frame</u> Sept. 08 to Nov. 08	1. Organise a community wide meeting to discuss the issue.	Initial meeting			Daworo Time Minutes Book	Chief Assemblyman CHC Chairman	1. Meeting attendance 2. Minutes of Meetings	
	2. Make a follow up to DA on the application sent earlier for support.	Organise a meeting to discuss the issue.	Possible follow-up visits Organise a meeting to brief the community on the follow up.		Paper Pens Envelops T & T (GHc20.00)	Sambonaa Dongyiel Sambonaa Dongyiel Kpiiba Kwaku	1. Copy of application letter	
	3. Fetch sand, stones, and water to support construction of culvert.		Communal labour to fetch sand, stones and water.		Pick-axes Pans Shovels Time		1. No. of trips of stones and sand fetched 2. No. of days of communal labour	
Target: 2 Harvest the CHO's crops.	1. Organise a meeting to set the days for Harvesting.	Meeting to set the day.			Daworo Time Minutes Book	Kwasi Sutah CHC Chairman	1. No. of meetings organised 2. Minutes of	

Appendix H: Roles and Responsibilities of the GHS Headquarters Divisions

Division	Roles and Responsibilities	Activities
Office of the Director General (ODG)	<ul style="list-style-type: none"> Ensuring that the CHPS zones contribute significantly to reducing morbidity and mortality 	<ul style="list-style-type: none"> Provide direction and oversee the implementation of the CHPS strategy Advocate for inter-sectoral collaboration and support for the CHPS implementation Mobilise resources to support the CHPS implementation Develop and disseminate indicators for assessing CHPS level performance in respect of the Divisions mandate Institute an award system for good performance
PPME	<ul style="list-style-type: none"> Policy development and review CHPS strategic and operational planning CHPS implementation monitoring 	<ul style="list-style-type: none"> Review and disseminate CHPS policy Develop and disseminate CHPS implementation guidelines Prioritise CHPS in planning guidelines Develop and disseminate indicators for assessing CHPS level performance in respect of the Division's mandate Monitor CHPS implementation and information system and report on CHPS contribution to attainment of GHS objectives
Public Health Division (PH)	<ul style="list-style-type: none"> Mainstreaming community-level public health activities into CHPS 	<ul style="list-style-type: none"> Mainstream public health programmes planning and implementation into CHPS Develop appropriate guidelines and build CHPS zones capacity in public health service delivery (equipment, guidelines, training, etc.) Develop and disseminate indicators for assessing CHPS level performance in respect of the Divisions mandate Monitor community-level public health activities and report on CHPS contribution to attainment of public health targets and objectives
Intitutional Care Division (ICD)	<ul style="list-style-type: none"> Mainstreaming Community-level clinical services into CHPS 	<ul style="list-style-type: none"> Mainstream development of planning of management of emergencies and minor ailments/injuries, quality assurance and referral system (training, equipment, etc.) into CHPS Develop appropriate material and build capacity of CHPS zones in management of minor ailments and referrals (equipment, training, guidelines etc.) Develop and disseminate indicators for assessing CHPS level performance in respect of the Divisions mandate Monitor CHPS implementation of clinical services and contribute to institutional care objectives and targets

Division	Roles and Responsibilities	Activities
Family Health Division (FHD)	<ul style="list-style-type: none"> Mainstreaming community-level MCH activities into CHPS 	<ul style="list-style-type: none"> Mainstream MCH programmes planning and implementation into CHPS Develop appropriate guidelines and build CHPS zones capacity in MCH service delivery (equipment, guidelines, training, etc.) Develop and disseminate indicators for assessing CHPS level performance in respect of the Divisions mandate Monitor community-level MCH activities and report on CHPS contribution to attainment of MCH targets and objectives
Human Resources Development Division (HRDD)	<ul style="list-style-type: none"> Human resource planning for CHPS zones Management of CHOs Coordination of In-service training of CHOs, CHMCs and CHVs. 	<ul style="list-style-type: none"> Liaise with Health Training Institutions in the training of CHNs, midwives for deployment as CHOs Plan and coordinate the equitable deployment of CHOs and CHNs, midwives to CHPS zones Liaise with other institutions that train other health professionals to factor in their training the principles and strategy of CHPS Work with other divisions to develop structured in-service training programme for CHOs, CHMCs, and CHVs Develop and disseminate indicators for assessing CHPS level performance in respect of the Divisions mandate Monitor staff deployment and management in CHPS zones and report on staff performance
Health Administration Support Service (HASS)	<ul style="list-style-type: none"> Provision and coordination of infrastructure, transport and equipment support systems for CHPS 	<ul style="list-style-type: none"> Plan for infrastructural, transport and equipment needs for CHPS zones Develop appropriate guidelines and build CHPS zones capacity in maintenance of estate, transport and equipment (equipment, guidelines, training, etc.) Develop and disseminate indicators for assessing CHPS level performance in respect of the Divisions mandate Coordinate the management and monitor the infrastructural development, transport and equipment provision in CHPS zones
Supplies, Stores and Drug Management (SSDM)	<ul style="list-style-type: none"> Ensuring availability of the requisite medicines and medical commodities without stock-outs in CHPS zones 	<ul style="list-style-type: none"> Plan for CHPS level capacity and commodities needs Develop and disseminate indicators for assessing CHPS level performance in respect of the Divisions mandate Coordinate, monitor and report on logistics management in CHPS zones
Finance Division (FD)	<ul style="list-style-type: none"> Ensuring sound financial management in CHPS zones 	<ul style="list-style-type: none"> Factor in CHPS in the Division's planning Develop and disseminate financial management guidelines for CHPS zones Develop and disseminate indicators for assessing CHPS level performance in respect of the Divisions mandate Monitor and report on financial management in CHPS zones

Division	Roles and Responsibilities	Activities
Internal Audit Division (IAD)	<ul style="list-style-type: none"> • Ensure accountability for resources provided to CHPS zones 	<ul style="list-style-type: none"> • Factor in CHPS in the Division's planning • Develop and disseminate simple accountability guidelines for CHPS zones • Develop and disseminate indicators for assessing CHPS level performance in respect of accountability for resources • Monitor and report on accountability for resources in CHPS zones
Research and Development Division	<ul style="list-style-type: none"> • Ensuring that strategies adopted at CHPS zones are evidence based 	<ul style="list-style-type: none"> • Investigate the effectiveness and efficiency of the strategies employed in CHPS zones • Periodically conduct or support the conduct of impact evaluation of the CHPS strategy • Develop and disseminate indicators for assessing CHPS level performance in respect of the Divisions mandate • Explore for new innovations for improving the effectiveness and efficiency of community-level health programmes

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Appendix I: Standard Design for CHPS Compound

CHPD Compound (Apartment 2)

PROJECT: CHPS COMPOUND

CLIENT: MINISTRY OF HEALTH



OUTLINE:

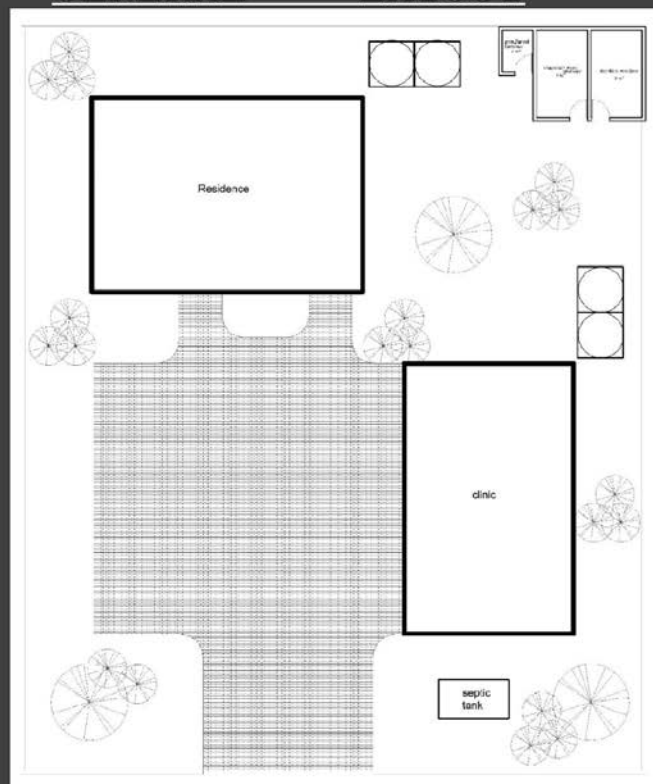
ARCHITECTURE

Clinic (area=115 sq.m)

Residence (area=83 sq.m)

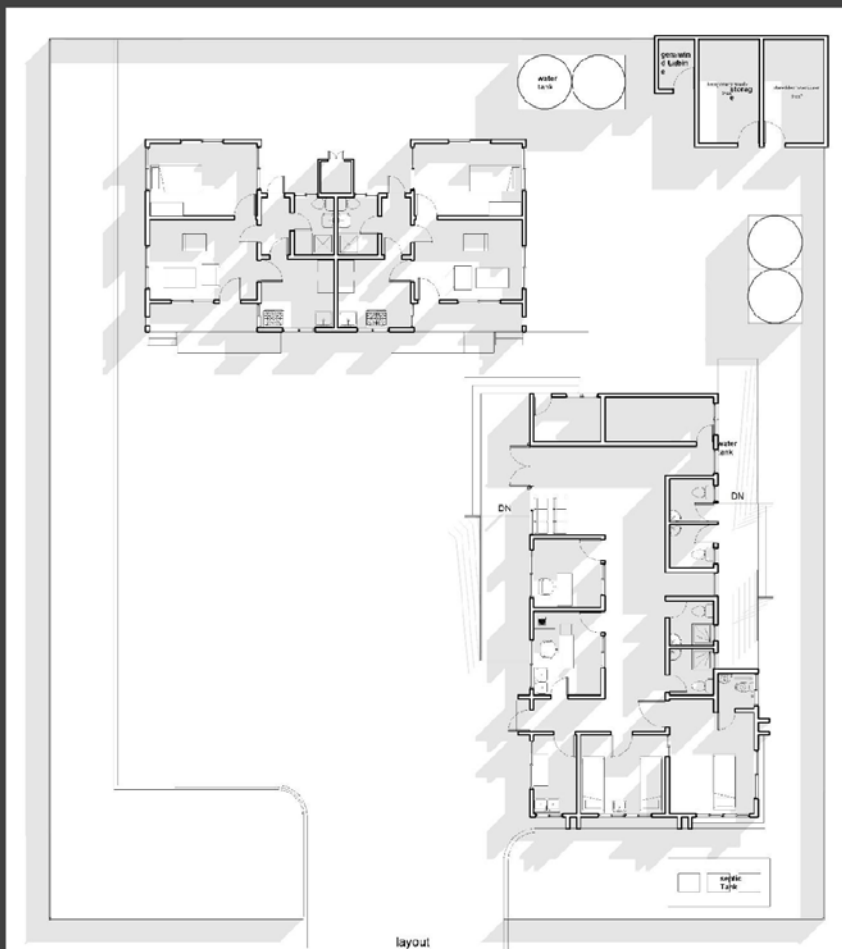
ARCHITECTURE:

GENERAL LAYOUT



ARCHITECTURE:

Layout



ARCHITECTURE: 3Ds



CLINIC

Floor Plan with legend



Area=115 sq.m

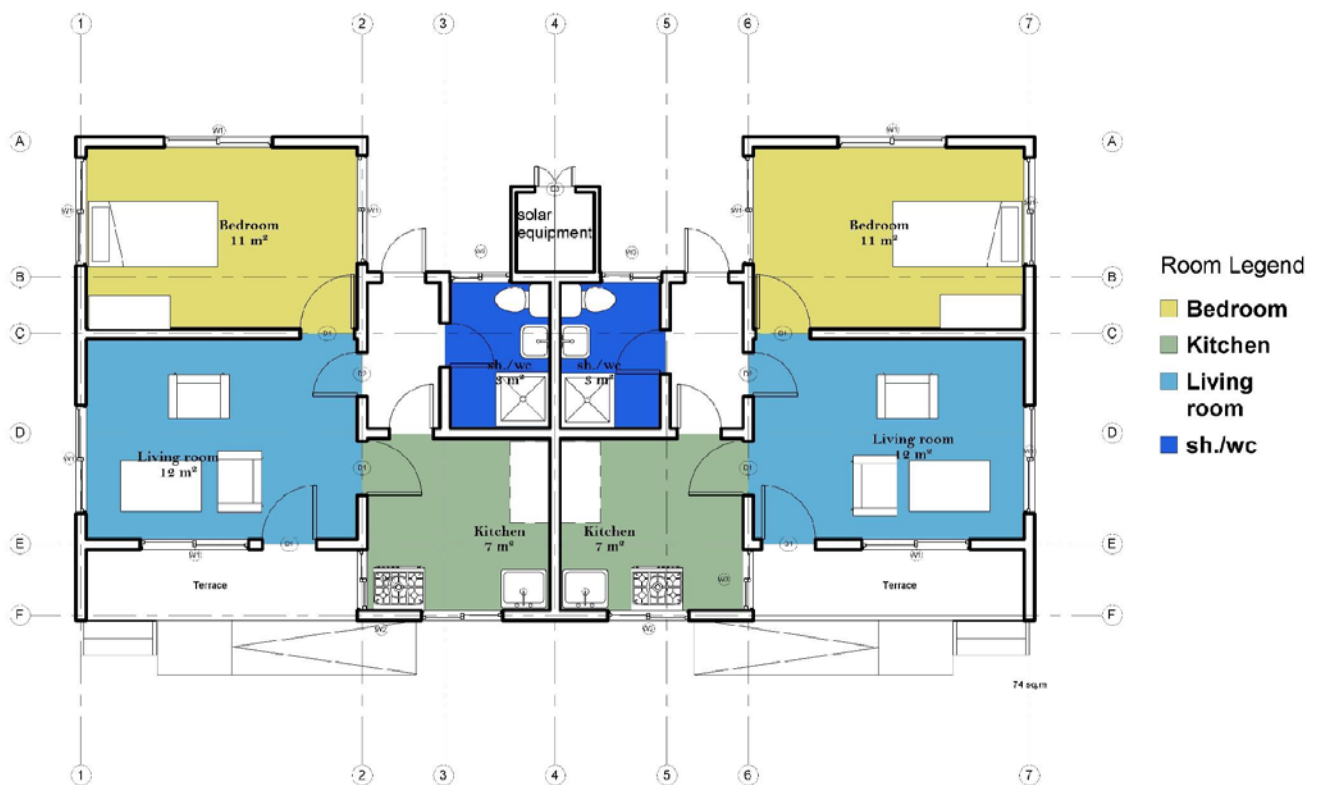
3D view



RESIDENTIAL

Floor Plan with legend

Area=83 sq.m



3D Floor Plan



CHPD Compound (Apartment 3)

3D View



Appendix J: Referral Forms



GHS Health Facility Referral Form (updated and reprinted in 2013)

Instructions for Use

1. The referral form can be used for clinical or diagnostic services referrals.
2. The instructions below are to assist in completing the form and referring clients appropriately.
3. The form comes in three-fold (original, duplicate and triplicate), with each sheet in different colour.
 - Each set of three sheets has one unique serial number. When the client is referred, the triplicate is to be retained in the referring facility and the client takes the duplicate and original to the referred facility (i.e. the facility to which the client is referred).
 - The duplicate is kept by the referred facility.
 - The original is clipped to the client NHIS bill as evidence that the client was referred.
 - Where the client's condition requires feedback, a separate feedback form must be filled and returned to the referring facility.
 - Please complete form legibly.
 - Where necessary, staple extra plain sheet to referral form to provide additional information.

Form developed by the Institutional Care Division

GHS Health Facility Referral Form

Patient reg. no. _____

Serial no. (Pre-printed)

Day	Month	Year
-----	-------	------

Health Facility Information

Name and address of referring health facility:	
Name and address of health facility referred to:	
Time referred:	Time of departure (if emergency):

Patient/Client Information

Surname:		Other name(s):		
Sex	Date of birth	Age	Insurance status Uninsured <input type="checkbox"/> Insured <input type="checkbox"/> ID no. _____	
Male <input type="checkbox"/> Female <input type="checkbox"/>	<table border="1"><tr><td>Day</td><td>Month</td><td>Year</td></tr></table>			Day
Day	Month	Year		
Name and address of contact person/relative:				
Telephone no. of contact person:				

Patient/Client Clinical Details

Presenting complaint(s)				
Examination findings				
Temperature:	Pulse:	Respiratory rate:	BP:	Weight:
Results of investigations carried out				

Diagnosis/es	
Medical management/treatment given	
Reason for referral and comment for next level	
Name of officer referring:	
Position:	
Signature:	Date:
Contact(s) of officer referring:	



GHS Health Facility Referral Feedback Form

Instructions for Use

1. The referral feedback form can be used for providing feedback on patients whose conditions and clinical management require sharing between the facilities concerned for continuity and improving quality of care.
2. The instructions below are to assist in completing the form:
 - The form comes in two-fold (original and duplicate) with each sheet in different colour.
 - Each set of two sheets has one unique serial number. The duplicate is to be retained in the facility and the original copy submitted to the health facility which referred the client (i.e. the facility where the client came from).
 - Please complete form legibly.
 - Where necessary, staple extra plain sheet to feedback form to provide additional information.

Form developed by the Institutional Care Division

GHS Health Facility Referral Feedback Form

Patient reg. no. _____

Serial no. (Pre-printed)

Day	Month	Year
-----	-------	------

Kindly fill this form in duplicate and return a copy to the facility which referred this client.

Health Facility Information

Name and address of health facility providing feedback:
Name and address of health facility to which feedback is being sent:
Name and position of clinician who received client:

Patient/Client Information

Surname:		Other name(s):							
Sex	Date of birth	Age	Insurance status						
Male <input type="checkbox"/>	<table border="1"><tr><td>Day</td><td>Month</td><td>Year</td></tr></table>	Day	Month	Year		Uninsured <input type="checkbox"/>			
Day	Month	Year							
Female <input type="checkbox"/>			Insured <input type="checkbox"/>						
Name and address of contact person/relative:									
Telephone no. of contact person:									
Date of referral	Date of arrival at referred facility	<u>Diagnosis on referral</u>							
<table border="1"><tr><td>Day</td><td>Month</td><td>Year</td></tr></table>	Day	Month	Year	<table border="1"><tr><td>Day</td><td>Month</td><td>Year</td></tr></table>	Day	Month	Year	<hr/> <hr/>	
Day	Month	Year							
Day	Month	Year							
Final diagnosis									
Medical management/treatment given (please write how patient was managed)									
Outcome (please tick)	Discharged <input type="checkbox"/>	<table border="1"><tr><td>Day</td><td>Month</td><td>Year</td></tr></table>		Day	Month	Year			
Day	Month	Year							
	Died <input type="checkbox"/>	<table border="1"><tr><td>Day</td><td>Month</td><td>Year</td></tr></table>		Day	Month	Year			
Day	Month	Year							
If client is being referred back to another facility on discharge, please provide advice for further management and any other recommendations. Use extra sheet if need be.									

Next review date (where applicable):			
Name of officer providing feedback:			
Position:			
Signature:		Date:	
Contact(s) of officer providing feedback:			

Appendix K: M&E of CHPS Implementation for the Districts

Form 1—Community

	Name given to the CHPS zone	List all communities under the zone	0: Directly served by SDHT 1: Served by CHPS zone	Number of active CHMC (Active CHMC = attended meeting at least once in the last 6 months)	Number of Active CHV (Active CHV = reports to CHO monthly)	0: No CETS has started 1: CETS is not functioning in the last quarter 2: CETS is functioning in the last quarter	No of population
Bamahu	Bamahu	Dagaabayiri	1	6	1	1	618
Bamahu	Bamahu	Kongpaala	1	4	1	1	404
Bamahu	Bamahu	Yarihiyiri	1	4	1	1	676
Bamahu	Boli	Boli	1	12	3	1	2,583
Bamahu	Piisi	Piisi	1	8	4	0	1,983

Form 2—CHPS Resources

No.	Mother SDHT	Electoral Area	CHPS ^c	Coverage ^d	No. of CHOs	No. of CHNs	No. of ENs	No. of Midwives	Total No. of Staff	Compound ^e	Sponsor of Construction ^f	Equipment ^g	Service Delivery ^h	CHAPI ⁱ	CHMCs ^j	CHVs ^k	CHPS with health staff and service	Functional CHPS zones	Population Covered by CHPS with health staff	Population covered by functional CHPS	Remarks
Criteria					Refer to staff list and count the number.														Same as coverage		
12	Bamahu	Bamahu	Boli	2356	1	1	1	1	4	1	DA	1	2	1	0	8	1	1	2356	2356	Newly Added

^c If demarcated CHPS zones are added, add another row at the end of the group of the same mother SDHT. Mention in the remarks in the last column "newly added".

^d Currently population of the

^e Please enter the following numbers: 0 = no compound, 1 = compound constructed, 2 = under construction.

^f Please enter the following: DA = District Assembly; JICA = grants or donor name; or other name as applicable.

^g Refer to the list of essential equipment: 0 = no equipment; 1 = partially equipped; and 2 = fully equipped.

^h Please enter the following: 0 = No service delivery; 1 = partial (CHO based SDHT); 2 = fully (CHO works in compound)

ⁱ Please enter the following: 0 = No CHAP started; 1 = CHAP is not updated in the last quarter; 2 = CHAP is updated in the last quarter

^j The CHMC has conducted a meeting in the last six months. Please enter the following: 0 = no; 1 = yes.

^k No. of CHVs who reports to the CHO monthly.

Form 3—Technical Staff Available

Mother Sub-District	CHPS	Name of Health Workers	Title (CHO, CHN, EN, Midwife)	Background of CHO	Mobile No.	Email Address
Bamahu	Bamahu					
		Yaa	CHO	CHN		
Bamahu	Boli	Mensah	CHO	EN		
		Anne	CHN	CHN		
		Mary	Midwife	CHN		

Appendix L: List of Feasible Actions Taken by MMDAs

1. Community Level

No.	Category	No.	Sub-category	Indicators	Source of information
1-1	Support CHAP implementation	1-1-1.	Provide required technical skills to implement CHAP activities that are construction-related in CHPS zones such as drawing plans, appropriate locations and supervision of construction work	# of CHPS zones receiving technical skills from MMDAs to implement CHAP	MMDAs Annual Accounts MMDAs Activity Report
		1-1-2.	Bear the cost of relevant materials to implement CHAP activities that relate to construction and maintenance e.g. zinc and wood for roofing, etc.	# of CHPS zones which received materials from MMDAs to implement CHAP	MMDAs Annual Accounts
		1-1-3.	Organise community durbar on health issues	# of community durbar organised by MMDAs	MMDAs Activity report
		1-1-4.	Advocate involvement of community members in implementing CHAP activities	# of advocacy sessions by MMDAs that target community members to involve them in CHAP activities	MMDAs Activity report
		1-1-5.	Provide the cost and material for durbar and/or meeting to develop CHAP such as stationary, snack, etc.	# of CHPS zones which received material from MMDAs to develop CHAP	MMDAs Stores Receipt Voucher/Facility Assets Register
1-2	Support CETS creation	1-2-1.	Give initial money to create CETS	# of CHPS zones receiving money from MMDAs to start CETS	MMDAs Stores Receipt Voucher/Assets Register
		1-2-2.	Support communities to procure tricycles	# of CHPS zones getting tricycles by MMDAs support	MMDAs Annual Accounts
		1-2-3.	MMDAs to set aside one vehicle as emergency transport for CETS to communities that cannot get and make funds available to fuel such emergency transport	# of communities that have used MMDAs emergency vehicle for CETS purposes and # of cases supported by MMDA on fuel cost	CETS Records at the CHPS zones
1-3	Motivate CHVs/CHMCs	1-3-1.	Pay registration fees to CHVs/CHMCs to enrol into NHIS	# of CHVs/CHMCs enrolled into NHIS with fees from MMDAs	MMDAs Annual Accounts
		1-3-2.	Provide funds for CHMC training	# of CHMC sponsored for CHMC training by MMDAs	MMDAs Annual Accounts
		1-3-3.	Provide funds and support for CBSVs	# of volunteers sponsored for training by MMDAs	MMDAs Annual Accounts
		1-3-4.	Pay fees to renew membership status of CHV/CHMC in NHIS	# of CHVs/CHMCs NHIS renewed by MMDAs	MMDAs Annual Accounts
		1-3-5.	Provide funds as allowance for CHVs	# of CHVs receiving allowance from MMDAs	MMDAs Annual Accounts

No.	Category	No.	Sub-category	Indicators	Source of information
		1-3-6.	Purchase bicycles for CHVs	# of CHVs who receive bicycles purchased by MMDAs	MMDAs Stores Receipt Voucher
		1-3-7.	Provide funds to purchase Identification cards for CHVs/CHMCs	# of CHVs/CHMCs who receive identification card	MMDAs Annual Accounts
1-4	Support community health activity	1-4-1.	Organise food demonstration to raise awareness on appropriate complementary feeding practices	# of community supported for garbage collection by MMDAs	MMDAs Activity Report
		1-4-2.	Carry out community-based surveillance activities	# of community-based surveillance supported by MMDAs	MMDAs Activity Report
		1-4-3.	Carry out maternal auditing and mortality durbars	# of maternal auditing and mortality durbars supported by MMDAs	MMDAs Activity Report
		1-4-4.	Procure ITNs to reduce malaria	# of ITNs procured by MMDAs	MMDAs Activity Report

2. CHPS Level

No.	Category	No.	Sub-category	Indicators	Source of information
2-1	Support capacity building of CHOs	2-1-1.	Provide fund for CHO fresher training	# of CHN sponsored for fresher training by MMDAs	MMDAs Annual Accounts
		2-1-2.	Provide funds for CHO refresher training	# of CHO sponsored for refresher trainings by MMDAs	MMDAs Annual Accounts
		2-1-3.	Sponsor eligible local indigenes into CHN training school	# of students sponsored for CHN training school by MMDAs	MMDAs Stores Receipt Voucher/ Assets Register
2-2	Support compound construction	2-2-1.	Construct new CHPS Compounds	# of new compounds constructed by MMDAs	MMDAs Contracts Register
		2-2-2.	Furnishing of new compounds	# of new compounds furnished By MMDAs	MMDAs Stores Receipt Voucher/ Facility Assets Register
2-3	Support with logistics to CHPS zones	2-3-1.	Purchase cold chain equipment for CHPS zones	# of CHPS zones supplied with cold chains purchased by MMDAs	MMDAs Stores Receipt Voucher/ Assets Register
		2-3-2.	Procure motorbike for CHPS zones	# of CHPS zones with motorbikes provided by MMDAs	MMDAs Stores Receipt Voucher/ Facility Assets Register
		2-3-3.	Purchase communication equipment - two-way radio or mobile Phone for CHPS zones	# of CHPS zones with communication equipment provided by MMDAs	MMDAs Stores Receipt Voucher/ Facility Assets Register
		2-3-4.	Construct toilet facilities for CHOs and visitors	# of toilets constructed by MMDAs	MMDAs Contracts Register
		2-3-5.	Support comfort logistics for CHO and CHN	# of CHPS zones with the items provided	MMDAs Stores Receipt Voucher/

No.	Category	No.	Sub-category	Indicators	Source of information
			(bed, furniture, kitchen ware, TV, radio, etc.)	by MMDAs	Facility Assets Register
		2-3-6.	Construct outreach activity points in communities far from CHPS compounds	# of new outreach activity points constructed by MMDAs	MMDAs Contracts Register
2-4	Support with utilities at the CHPS compound	2-4-1.	Provide electricity at CHPS compounds	# of compounds with electricity provided by MMDAs	MMDAs utilities extension records
		2-4-2.	Provide water (borehole)	# of compounds with boreholes provided by MMDAs	MMDAs Contracts Register
2-5	Security for the compound	2-5-1.	Pay allowance to the security at the CHPS compound	# of CHPS zones with security paid for by MMDAs	MMDAs Annual Accounts
		2-5-2.	Build security fence around CHPS compounds	# of CHPS compounds with fence built by MMDAs	MMDAs Contracts Register
2-6	Maintenance of existing compounds	2-6-1.	Organise food demonstration to raise awareness on appropriate complementary feeding practices	# of advocacy sessions organised by MMDAs to involve community members in maintenance	MMDAs Activity report
		2-6-2.	Purchase materials and pay labour cost for maintenance of CHPS compounds	# of compounds maintained using materials purchased and labour cost paid by MMDAs	MMDAs Stores Receipt Voucher

3. SDHT Level

No.	Category	No.	Sub-category	Indicators	Source of information
3-1	Support build the capacity of staff of the facility	3-1-1.	Sponsor candidates for CHN/ENs/midwives for training	# of CHNs/ENs/midwives sponsored by MMDAs	MMDAs Annual Accounts
		3-1-2.	Support midwives/CHN with transportation and accommodation cost for attending training sessions	# of midwives/CHNs supported with transport cost to attend training sessions	MMDAs Annual Accounts
		3-1-3.	Sponsor eligible local indigenes into midwifery training school	# of students sponsored for Midwifery training school by MMDAs	MMDAs Stores Receipt Voucher/Assets Register
		3-1-4.	Provide motivational package to midwives	# of midwives receiving motivation package from MMDAs	MMDAs Annual Accounts
3-2	Strengthen maternal and neonatal death audit (MNDA)	3-2-1.	Attend MNDA reviews sessions	# of MNDA reviews attended by MMDAs	MMDAs Stores Receipt Voucher/Facility Assets Register
		3-2-2.	Sponsor MNDA review sessions	# of MNDA reviews sponsored by MMDAs	MMDAs Stores Receipt Voucher/Assets Register

No.	Category	No.	Sub-category	Indicators	Source of information
		3-2-3.	Provide venue for MNDA reviews	# of times venue has been provided for MNDA reviews	MNDA review report
3-3	Support facility improvement	3-3-1.	Construct a new health centre	# of H/Cs constructed by MMDAs	MMDAs Contracts Register
		3-3-2.	Construct health centres' (HCs') facilities (e.g. resting place for newly delivered mothers and children, children's ward, theatre block, medical laboratory, male/female wards, maternity block)	# of facilities constructed by MMDAs	MMDAs Contracts Register
		3-3-3.	Construct and furnish staff accommodation at the HCs	# of Apartments for staff at HC constructed and furnished by MMDAs	MMDAs Contracts Register
		3-3-4.	Provide generator for HCs, fuel and maintenance	# of HCs using generator provided by MMDAs	MMDAs Stores Receipt Voucher/Facility Assets Register
		3-3-5.	Provide telephone line and pay for the monthly fees or give some monthly credits for telephone call	# of HCs with telephone line or given credits for phone by MMDAs	MMDAs Stores Receipt Voucher/Facility Assets Register/actual telephone line
		3-3-6.	Construct placenta pit and safe disposal (covered/fenced) for medical/common wastes	# of HCs with placenta pits and safe (covered or fenced) waste disposal by MMDAs	Actual pits/waste disposal pit
		3-3-7.	Maintain water supply (borehole, tap water etc.)	# of HCs with water supply maintained by MMDAs	MMDAs Annual Accounts
		3-3-8.	Help HCs to create woman and baby friendly delivery room and ANC/PNC rooms (to keep privacy such as curtain, screen)	# of HCs helped by MMDAs to provide means to protect privacy for women	MMDAs Contracts Register
		3-3-9.	Organise food demonstration to raise awareness on appropriate complementary feeding practices	# of HCs receiving maintenance and renovation sponsored by MMDAs	MMDAs Annual Accounts
3-4	Support running of the HC	3-4-1.	Provide a person for cleaning the HC and pay the remuneration for such a person, if none	# of HCs using cleaners hired and their remunerations paid by MMDAs	MMDAs Annual Accounts
3-5	Transport for SDHT	3-5-1.	Provide motorcycles, helmets and maintain them	# of HCs provided with motorcycles, helmets and maintained by MMDAs	MMDAs Annual Accounts
		3-5-2.	Provide fuel for motorcycles for official trips	# of HCs provided with fuel for official trips	MMDAs Annual Accounts
		3-5-3.	Pay allowance for midwives in the district as motivation	# of midwives in the receiving motivation allowance by MMDA	MMDAs Annual Accounts

4. Hospital Level

No.	Category	No.	Sub-category	Indicators	Source of information
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No.	Category	No.	Sub-category	Indicators	Source of information
4-1	Support effective operation of ambulance	4-1-1.	Bear the cost fuelling the ambulance	Amount of funds provided MMDAs to fuel ambulance	MMDAs Annual Accounts
		4-1-2.	Maintain ambulance	# of times ambulance has been maintained by MMDAs	MMDAs Annual Accounts
4-2	Strengthen MCH classes	4-2-1.	Procure IEC materials for MCH classes	# of hospitals with IEC materials for MCH classes provided by MMDAs	MMDAs Annual Accounts
		4-2-2.	Advocacy for increased participation in MCH classes	# of advocacy sessions conducted by MMDAs	MMDAs activity Report
4-3	Support capacity building of staff	4-3-1.	Sponsor the training of nurses/midwives working at the hospital	# of nurses sponsored by MMDAs	MMDAs Stores Receipt Voucher/Facility Assets Register
		4-3-2.	Pay for refresher training for nurses/midwives to update them with current skills	# of nurses sponsored for refresher trainings	MMDAs Stores Receipt Voucher/Assets Register
		4-3-3.	Pay transport for the staff going for the training	# of hospital staff supported for the transport in order to attend training by MMDAs	MMDAs Annual Accounts
		4-3-4.	Pay motivation allowance to doctors	# of doctors receiving motivation allowance from MMDAs	MMDAs Annual Accounts
4-4	Support the running of the facility	4-4-1.	Maintain water supply system	# of hospitals whose water supply are maintained by MMDAs	MMDAs Annual Accounts
		4-4-2.	Maintain power supply or give a generator, if necessary (give fuel and maintenance if to provide a generator)	# of hospitals supported by MMDAs for the power supply	MMDAs Annual Accounts
		4-4-3.	Help general repair/maintenance of facility	List of work supported by MMDAs per hospital	MMDAs Annual Accounts
		4-4-4.	Construct waiting homes for pregnant women and families	# of constructed waiting homes at hospital	MMDAs Contracts Register
		4-4-5.	Help to create woman and baby friendly delivery room and ANC/PNC rooms (to keep privacy such as curtain, screen)	# of HCs helped by MMDAs to provide means to protect privacy for women	MMDAs Contracts Register
		4-4-6.	Construct operating theatre at the district hospital	# of operating theatres constructed at the district hospital by MMDA	MMDAs Contracts Register
		4-4-7.	Construct casualty ward at the district hospital	# of casualty ward constructed at the district hospital by MMDA	MMDAs Contracts Register
		4-4-8.	Organise food demonstration to raise awareness on appropriate complementary feeding practices	# of nutrition block constructed and a rehabilitated centre worked on by MMDA	MMDAs Contracts Register

No.	Category	No.	Sub-category	Indicators	Source of information
		4-4-9.	Construct bungalow for a doctor in the district	# of Doctor bungalow constructed by MMDA	MMDAs Contracts Register
		4-4-10.	Construct fence wall for district hospital	# of A fence wall constructed around the district hospital MMDA	MMDAs Contracts Register

5. Referral

No.	Category	No.	Sub-category	Indicators	Source of information
5-1	Strengthen national ambulance operations	5-1-1.	Provide accommodation for ambulance staff	# of apartments for staff provided by MMDAs	Physical inspection of accommodation
		5-1-2.	Furnish the accommodation of ambulance staff	# of apartments for ambulance staff furnished by MMDAs	MMDAs Stores Receipt Voucher/Assets Register
		5-1-3.	Provide office space for ambulance services	Office space available for ambulance services	Direct inspection of office space
		5-1-4.	Bear the cost of maintenance of the office space	# of times office space is maintained using MMDAs funds	MMDAs Stores Receipt Voucher/Facility Assets Register
		5-1-5.	Provide furniture for office space	Available office furniture provided by MMDAs	MMDAs Stores Receipt Voucher/Assets Register
		5-1-6.	Bear the cost of maintaining ambulance	Cost of ambulance maintenance paid for by MMDAs	MMDAs Annual Accounts
5-2	Alternative emergency transport to back ambulance service	5-2-1.	Make agreement with private car owners	# of private car owners with agreement to provide emergency transport services	Signed agreement
		5-2-2.	Set maximum fares for emergency transport services	Availability of maximum rates to operate emergency transport	Statement of maximum rate of emergency transport
5-3	Strengthen referral reviews	5-3-1.	Attend referral reviews sessions	# of referral review sessions attended by MMDAs	Referral Review Report
		5-3-2.	Pay for the cost referral review sessions	# of referral review sessions sponsored by MMDAs	MMDAs Financial Report
		5-3-3.	Provide venue for referral review session	# of referral review sessions held with venue provided by MMDAs	Referral Review Report
5-4	Improvement of access between	5-4-1.	Construct new road/bridge around health facilities where there are none	# health facilities with new roads/bridges constructed to facilitate referral	MMDAs Annual Accounts
		5-4-2.	Repair the damaged road/bridges around health facilities	# of Health facilities with repair of	MMDAs Annual Accounts

No.	Category	No.	Sub-category	Indicators	Source of information
	community and hospitals/SDHTs for referral			roads/bridges damaged	
		5-4-3.	Arrange hospital ambulances (Vehicle, Regular maintenance cost, Fuel)	# of times the hospital ambulance is maintained or fuelled	MMDAs Annual Accounts
		5-4-4.	Organise food demonstration to raise awareness on appropriate complementary feeding practices	# and location of mast built to enhance effective communication	Document with telephone companies

6. Other

No.	Category	No.	Sub-category	Indicators	Source of information
6-1	DHMT	6-1-1.	Renovate and refurbish DHMT office	# of DHMT office rehabilitated by MMDA	MMDAs Contracts Register
		6-1-2.	Renovate and refurbish DHMT staff accommodation	# of DHMT officer's accommodation rehabilitated by MMDA	MMDAs Contracts Register
		6-1-3.	Award for hard working and retired staffs	# of DHMT officer awarded by MMDA	MMDAs Activity Report
6-2	Training school (schools for CHN, midwifery, or medical assistant)	6-2-1.	Drill and mechanise a borehole at training school	# of borehole drilled and mechanised at training school by MMDA	MMDAs Stores Receipt Voucher/Facility Assets Register
		6-2-2.	Furnish training school	# of school furnished by MMDA	MMDAs Stores Receipt Voucher/Assets Register
		6-2-3.	Construct students' hostel	# of Student hostel constructed by MMDA	MMDAs Contracts Register
		6-2-4.	Provision of teaching/learning materials and equipment	Amount of funds provided MMDAs to purchase materials	MMDAs Annual Accounts
6-3	Junior staff	6-3-1.	Rehabilitate semidetached quarters for junior staff	# of semidetached quarters rehabilitated by MMDA	MMDAs Contracts Register
		6-3-2.	Construct junior staff quarters	# of junior staff quarters constructed by MMDA	MMDAs Contracts Register
6-4	Campaign support	6-4-1.	Support district response initiative on malaria prevention	Amount of funds provided MMDA	MMDAs Annual Accounts
		6-4-2.	Support district response initiative on HIV/AIDS	Amount of funds provided MMDA	MMDAs Annual Accounts
		6-4-3.	Support kangaroo mother care programme	Amount of funds provided MMDA	MMDAs Annual Accounts
		6-4-4.	Support blood donation campaign	Amount of funds provided MMDA	MMDAs Annual Accounts
		6-4-5.	Support exclusive BF campaign	Amount of funds provided MMDA	MMDAs Annual Accounts
		6-4-6.	Support food demonstration to raise awareness on appropriate complementary feeding practices	Amount of funds provided MMDA	MMDAs Annual Accounts
		6-4-7.	Support National Immunisation Day programmes	# of National Immunisation Day	MMDAs Activity Report

No.	Category	No.	Sub-category	Indicators	Source of information
				programmes organised by MMDA	
		6-4-8.	Support cerebrospinal meningitis programmes	# of cerebrospinal meningitis programmes organised by MMDA	MMDAs Activity Report
6-5	Food support	6-5-1	Provide food supplementation	# of malnourish people provided with food supplementation	MMDAs Activity Report
		6-5-2	Construct supplementary feeding centres	# of centres constructed by MMDA for feeding	MMDAs Activity Report

Resources

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3. Awoonor-Shalliams John Koku et al Making the System Work. 2015.
4. Awoonor-Shalliams, John Koku, Ellie S. Feinglass, Rachel Tobey, Maya N. Vaughan-Smith, Frank K. Nyonator, Tanya C. Jones. “Bridging the gap between evidence-based innovation and national health-sector reform in Ghana”. *Studies in Family Planning* 35(3): 161–177. 2004.
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