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BRINGING HEALTH CARE TO THE DOORSTEP OF THE RURAL FOLK IN GHANA: ASSESSING THE POTENTIALS AND CHALLENGES OF CHIPS

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ABSTRACT

The Community Based Health Planning and Services (CHPS) was introduced in Ghana's health system in the year 2000. This was aimed at addressing the fundamental bottlenecks regarding access to quality health care services in the hinterland. The Ghana health service adopted CHPS concept as a national strategy for promoting quality, accessibility and equitable heath care to all citizens in rural Ghana. The concept is therefore a national policy for implementing community based service delivery by orientating primary healthcare from the sub district centres to convenient communities. This paper aimed at assessing the potentials and challenges of the CHPS in addressing the health needs of the rural dwellers. In conducting this survey, mixed sampling methodology was adopted. The three regions in the northern Ghana were selected for the study because they are noted to be the poorest in Ghana. Also these regions are noted for high incidence of infant and maternal mortality. The Greater Accra region was also selected for the study because on the basis of a growing urban poverty in the region. The study revealed that the establishment of the CHPS strategy has actually reduced mortality rate in rural communities in the country. It further revealed that modern health care is now closer to the rural folk and therefore help in addressing the health needs of the rural people. The study also revealed that some of the CHIP are white elephants since there are no health professionals to man some of them in some of the deprived areas.

Keywords: CHPS, Healthcare, Rural Communities, Health systems, Challenges and Potentials.

INTRODUCTION

The failure of vertical health approach in the early 1970's brought to the fore the need for a comprehensive health strategy that provided not only health services but also addressed the underlying social, economic and political causes of health issues. The concept of Primary Health Care (PHC) was first defined in the Declaration of Alma-Ata at the International Conference in 1978. The declaration states that health is a human right and attaining it should be the primary goal of every government. Since then various countries have adopted various strategies to achieve the objectives of PHC.

In Ghana, the government's key policy objective on PHC is to provide accessible, equitable, quality and efficient primary healthcare and family planning services to all Ghanaians, irrespective of where they are located. To achieve this objective, three main strategies were adopted by the GHS. These include: decentralization of authority for primary healthcare to the district level; strengthening of the role of the sub-district as an "operational support units" with direct responsibility for implementing village level healthcare planning and services. However, the operationalization of these strategies to achieve the policy goals has proven to be a major challenge for the Ministry of Health [1]. In an effort to address the underlying challenges, the community - based Health Planning and Services (CHPS) strategy was introduced into the health system in 2000.

The Community-based Health Planning and Services (CHPS) was introduced into Ghana's health system in the year 2000 to address fundamental challenges regarding access to quality healthcare services. The Ghana

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Health Services (GHS) adopted CHPS concept as a national strategy for promoting accessible, quality and equitable healthcare service to all Ghanaians, particularly those in the rural areas to eliminate disparities in access to basic medical and health services. The CHPS programme is, therefore, the national strategy for implementing community based service delivery by reorienting and relocating primary healthcare from sub-district health centres to convenient community locations. The CHPS has been recognized by policy makers, development partners and public health providers as a pro-poor health service delivery strategy. This report assesses the effectiveness of the CHPS strategy in meeting the health needs of rural dwellers.

Historical Perspective of the Community-based Health Planning Service (CHPS) in Ghana

The Community-based Health Planning and Services was adopted by the Ghana Health Services a national strategy for promoting accessible, quality and equitable services to all Ghanaians- particularly those in rural areas to eliminate disparities in access to basic medical and health services. The strategy was introduced to provide community-based health delivery services with household and community involvement. Defined as 'close-to-community. The CHPS mobilizes community leadership, decision making systems and resources in defined catchment area (zone) and the placement of reoriented frontline health staff (known as CHOs) with logistics support and community volunteer systems to provide services in accordance with principles of primary healthcare.

Prior to the introduction of CHPS, various strategies were adopted in the past to achieve the objectives of Primary Health Care after the Alma health conference. However, none had been integrated into more general policies of reform, and the provision of sustainable community health services has not progressed in Ghana. The Ministry of Health using evidence emerging from Danfra Comprehensive Rural Health and Planning project adopted the Village Health Workers (VHWs0 as part of the PHC strategy in the 1980s. this strategy however, could not stand the test of time when the programme was scale up as it suffered from serious organisational, resource, training, monitoring and supervision challenges, and had to be abandoned [2].

As a way of addressing the challenges confronting the VHWs and CHNs strategy was introduced as a way of providing more professional, and potentially more acceptable and effective services to the communities. In pursuance of this objective, over 2000 community health nurses were trained and deployed to assist in healthcare delivery at the sub district level. However, the main challenge that accompanied this initiative was the irregular and static manner with which the outreach clinics operated. Also, all the community nurses were operating from the sub district levels with or no participation by household members as key producers of healthcare services.

The CHPs strategy attempts to deal with fundamental challenges of the CHNs strategy by focusing more on household /community (demand-side) participation in service provision. By working with households and communities to ensure the accessibility of right community –based services and focusing on all barriers to access to the community level, new and ground-breaking approaches are applied to the challenges of healthcare provision. It also places much emphasis on improving; basic in-service training, supervision and performance management; remuneration and the incentives; supply of essential drugs and dignonistics; logistics and infrastructure; disseminating clinical audits; and developing a new sub-district team with the focus on communities and households. The CHPS provides a vehicle for making a paradigm shift approach adopted to deliver community level services by engaging communities in making decisions concerning their own health.

The introduction of the CHPS strategy in Ghana Health Services programme has seen improvement of healthcare delivery at the community level and has received support from most stakeholders such as the District Assemblies, the International Community and beneficiaries. The number of functional CHPS has increased from 868 in 2009 to 1675 in 2011 and total population covered by CHPS moved from 16.4% in 2009 to 21.8% of Ghanaians in 2011. In addition, a number of CHOs have received training in the management of CHPS centres. The table below shows progress of implementation of CHPS by regions from 2009 to 2011.

The CHPS programme, since its inception, has helped in reducing infant and maternal mortality in Ghana. In the Upper East region, where the programme was first introduced, most health indicators have improved significantly. For instance, the contribution of the programme to OPD cases increased from 5% in 2009 to 13% in 2011, while supervised deliveries increased from 52.6% in 2009 to 67.5% in 2011 thus aiding GHS to reduce health inequalities and promoting inequalities and promoting equity in health outcomes by removing geographical barriers to healthcare. Notwithstanding these achievements, most CHPS compounds lack the CHOs Toolkit containing basic clinical tools such BP apparatus, weighing scales and thermometer.

Furthermore some compounds do not have solar fridges, television and basic furniture to create a congenial atmosphere in rural areas that would motivate health professionals to accept postings, as well as motivate them to stay in such deprived communities.

MATERIAL AND METHODS

Two main sources of data were employed for this study. These were primary and secondary. Mixed sampling method was also employed in this study. In all 30 districts

and sub-districts were selected randomly from four regions in Ghana. These were the Northern region (12), Upper East (6), Upper West (6) and the Greater Accra region (6). The northern region was given the highest number of communities because is the largest in ghana in terms of land mass. Ten household were randomly selected from each district for interview and two sub District Health Management Teams (SDHMTs) from each district.

FINDINGS AND DISCUSSING

Availability and effectiveness of Community Health Volunteers

The CHPS operational policy document recognizes the importance of Community Health Volunteers (CHVCs) in the implementation of the CHPS programme. They serve as the link between the community and the healthcare system and work alongside the CHOs. CHVs are men and women recruited on the basis of their commitment to work, by the chiefs and elders of the communities with technical support from Sub-district Health Management Teams and the CHOs. They are members of the community who can be trusted with confidential information.

The CHVs work in partnership with Health committees to establish community health governance structures to support the CHOs; and mobilize community and traditional health delivery personnel including native doctors, Traditional Birth Attendants and Herbalist. They provide supportive services to the CHOs and also undertake basic first aid management in case of home accidents. Volunteers services are focused on mobilizing labour and men for clinic construction and participation in family planning promotion respectively. Per the CHPS operational policy, CHVs are required to receive basic training on health promotion and prevention, case detection, mobilization and referrals.

The study assessed the availability of these volunteer and their level of training. The results showed that 83.3% of the CHPS compounds have volunteers as indicated in figure 1. Lack of interest and commitment of community members have been cited as the main reasons why some CHPS compounds do not have volunteers, as in the case of 16.7% without volunteers.

Positively, 93% of volunteers have received training on the following; primary healthcare, the CHPS concept and volunteerism, community mobilization, basic equipment and the role of CHVs. The 7% who have not received any training are volunteers recently recruited. The training was provided at the inception of CHPS in the various communities. Although the training manual of CHVs stipulates two refresher trainings per year CHPS zone, 71% of the volunteers admitted that two no refresher courses or trainings have been organized to upgrade their skills and knowledge after the initial training. The effect is that, although most CHPS compounds have volunteers, majority of the CHVs lack the required skills and knowledge to work efficiently and effectively. This has a lot of implications on the quality of services provided by these CHVs in their operational areas. Yet the CHVs are very important for health delivery at the community level, especially, where the CHPS compound is serving cluster of communities as in the case of Tampala in the Jirapa District of the Upper West Region which covers seven scattered communities.

Volunteer Motivation

Motivation is essential for securing CHVs dedication, interest and ownership. When a certain level of time, intensity and skills are needed, some sort of regular compensation or there extrinsic motivation is usually required. Although they experience personal satisfaction when they make a difference in somebody's life, there is the need for some level of compensation, not necessarily financial reward but logistics and other working tools to help the volunteers to work effectively. Per the policy document, CHVs are required to be provided with means of transportation since most of their work involved home visits or public education.

The study noted motivation for CHVs within communities. For instance, 64.4% of CHVs do not have bicycles. This makes their work more difficult especially where the communities are scattered as in the cases of Garinkuku in the Northern region, which is made up of 26 communities; and Tamapala in the Upper West Region serving 7 communities.

CHPS Compounds with Community Health Committees (CHCs*)*

The lines of responsibility and authority for the management of the CHPS programme remain with the community (GHS, 1999). The Community Health Committees is composed of representatives from various groups of people from the community leadership. They are to settle disputes that emanates from the work of CHVs; organizing communal activities in support of the programme; advocating community health and family planning services; financial management of accounts; managing CHVs, stock of drugs, family planning materials and supervising bicycle maintenance for the CHVs. They are expected to hold regular meetings to discuss issues affecting the implementation of community health plans. The availability and the effectiveness of the committees in the performance of their duties are thus critical for the smooth running of CHPS compounds.

Using regularity of meetings and collaboration of with CHOs as a measurement of effectiveness, 83.3% do not meet regularly (on monthly basis) to discuss issues affecting the implementation of their work plans. In Nasia in West Mamprusi and Garinkuka in the Chereponi Districts, although the community members confirmed the formation of the CHCs, the CHOs are yet to meet members of the committees. In New Ningo in the Greater Accra

Region, the Assembly Member of the area was not aware of the existence of the committee. (*His attention was however drawn to the fact that, he selected a woman to lead the committee members to the chief for introduction*)

On collaboration between CHOs and communities, results from the study show high level of collaboration. Out of 15 communities where focused group discussions were held, 11 communities confirmed the existence of cordial relationship between them and the CHOs. Where there is a close collaboration between the CHC and the CHOs, the implementation of the programme is very smooth with the CHOs receiving support from the community. In addition, bye laws are enacted at the community level to help implement community level activities.

For instance Tamapala, the CHCs has initiated a penalty for pregnant women (See Case study Box A) who deliver in their homes while a special fund (proceeds from communal farming and sale of farm produce) has been set aside for ambulance services. These laws have helped in reducing maternal and infant mortalities in the community. For in the past 8 years no woman in the community has died from child bearing. In communities where the CHSCs are not effective, or non-existence, It has been established that often conflicts ensues between the various communities in that CHPS zone. A case in point is found in Doung in the Nadowli District where as of the time of interview, the CHO was allegedly not working on Fridays, Saturdays and Sundays, thus generating conflict between the community and the Acting CHO. Also in Yorogo in Upper East due to non-functionality of the CHC there is conflict between community members and the CHO because the CHO has refused to stay in the Community.

There is also the issue of late arrival since the CHOs does not stay in the community. In Nyagli in the Upper West region, the CHOs have refused to conduct home visits and prefer to stay outside the community in spite of the availability of accommodation.

In addition, the field survey revealed a number of challenges associated with the CHCs. For instance, most of the committee members lack organizational, mobilization and communication skills. Also, many of the committees do not have women representatives. Out of the ten committee members of the Tampala CHC, none of them is a woman. In instances where women are represented in some committees, their composition is less than 20% of the entire membership. Given the fact that, majority of the clients of the CHPS are women, participation of women in the committees would help gain better appreciation of women health issues and thus meet their needs effectively.

Basic Services Provided by CHPS Compounds

The CHPS Compounds established with the main objective of providing basic services package to clients. These services include the provision of health education related to prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; provision of adequate supply of safe water and basic sanitation; maternal and child healthcare; including family planning; immunization programmes against the major infectious disease; prevention and control of locally endemic diseases;; appropriate management of the minor ailments and injuries; and provision of essential drugs.

About 60.3 % of household respondents indicated that they access services or the compounds provide services to them in all the three broad areas (Health promotion, treatment of minor ailments/referral) on the other hand, 39.7% of the household respondents claim they are getting services in one or two board areas. These findings were confirmed by 69.6% of CHOs interviewed.

Most diseases that cause high rates of illnesses and deaths among Ghanaians are preventable or curable if diagnosed promptly by simple basic and primary healthcare procedures. It is therefore not supervising that, communities where the CHPS compounds are fully operational, infant and maternal mortality have improved. For instance, in the Upper East region, the CHOs contribution to OPD cases increased from five percent in 2009 to 135 in 2011. Also communities such as Kazigu, Yendi and Sabare have been seen reduction in both infant and maternal mortality. A participant in a focused group discussion in Sunson had this to say; "*I can recall that 3 women died during child birth before the compound was established, I do not remember any woman who has died during childbirth since this compound was established"*

Most of the community members however lack understanding of the CHPS concept. This has resulted in a situation where clients refused referrals (which is a key component of the CHPS programme) and insisted that they are treated at the compounds irrespective of the degree and type of ailments afflicting them. Participants at the validation session attributed this state of affairs to the focus of the orientation provided to the community during the introduction of CHPS. For instance, in the local languages, the CHPS compounds are literally translated as smaller hospitals. Therefore community members would not understand why smaller hospital will not perform the duties of bigger hospitals. A chief in one of the communities in the Upper West region insisted that CHOs should provide curative services to his people and failure to do so will lead to "war" in the community.

Regularity of Home Visits

A key requirement of the CHPS implementation is that the CHOs are obliged to take healthcare services to the doorsteps of clients. They are required to pursue a work routine that revolves around home visiting and has its base in outreach by health provided rather than a static service base for the client to attend [3]. The idea is to take services to the client rather than the following the traditional

method of expecting the client to seek out the healthcare provider. CHOs are expected to visit at least 10 homes every day for preventative health education, returning later in the afternoon to attend to clients' health needs.

The study sought to find out the level of compliance with the provision. The results generally show that most of the CHOs conduct house-to-house visits, but the regularity of home visit is not as impressive as originally envisaged in the programme design. As shown in the Fig. 4: over two-thirds (70%) of households interviewed indicated that, the CHOs visit them but on monthly and not on daily nor weekly basis.

"Some of the CHOs at the initial stages of the programme used to visit pur homes but now they do not see the need, they went us to come to their compounds"

A CHO, on average visits a household in a month and discusses issues relating to family planning, immunization, antenatal/ postnatal care and the distribution of mosquito insecticides treated nets. The provision of these services has helped improved the health status of most of the households interviewed. A indicated in Fig 5, 92.2% of households have seen improvement in their health status since the CHOs began home visits. The main reason attributed to this by community members is due to the health education provided by the CHOs during home visits and the distribution of insecticides treated nets to pregnant women. A respondent noted that, "*our main sickness is malaria and with the mosquito net I am free from malaria".*

This assertion is confirmed by GHS 2011 annual report. According to the report, the deployment of CHOs into CHPS zones has greatly improved geographical accessibility in most of the regions contributing to high OPD per capita. The proportion of the outpatients seen by CHOs under CHPS has moved from 4.2% in 2009 to 5.2% in 2011.

The CHOs (24%) who do not organize home visits attributed the challenge to high attendance at the compound by clients and lack of community volunteers to assist them. Given such situations, they prefer to stay at the facility and attend to the clients. This however, defeats the objectives of CHPS focusing on preventative healthcare rather than curative. It also indicates lack of understanding of the CHPS concepts by the community members and even some CHOs

Quality of Service Delivery by CHPS compounds

The effectiveness of CHPS in providing quality primary healthcare to its clients depends on the client's needs. Quality healthcare of partly depends on the state of equipment and the availability and skills level of human resources required for the operation of the CHPS compounds. This study further relies on citizens perspectives for the assessment of the quality of healthcare provided by CHPS compounds. For the purpose of this study quality healthcare is defined to include both client level of satisfaction with the service provided by the CHOs, and the equipment and human resources required to deliver quality healthcare.

Clients' level of satisfaction with services

Clients' level of satisfaction is very important in determining the usage of a health facility. The survey assesses the level of satisfaction of households who have ever used CHPS. The results show that out of the total number of household respondents who visited the CHPS compounds for treatment, 86% indicated that, they were satisfied with the treatments administered by the CHOs shown in the Fig. 6 below

The higher level of satisfaction is informed by the observation that, most of the clients of CHPS received the required essential drugs, treatment and were very happy with how the medical personnel delivered treatment. In addition, the CHPs compounds reduces waiting periods and distances travelled to seek healthcare services. As shown in Fig. 5 below, prior to the establishments of the CHPS compound, 48.3% of respondents travelled between six to ten kilometers while 24.6% travelled between eleven to fifteen kilometers to seek healthcare. This is above the recommended distance of five kilometers radius within which a health facility should be located. One of the major causes of maternal deaths among rural communities is long distance between communities and health centres and the fact that the cost of transportation is very high

Furthermore, the CHPS compounds have reduced waiting periods that, patients have to endure to assess healthcare in other facilities. Almost 93% of respondents indicated that, the main challenge they faced in accessing healthcare in other facilities is long waiting period.

This means that confidence level of clients in seeking healthcare at the CHPS compounds is very high. As indicated by Ghana Health Services, infant mortality is 40% higher among communities with more than 5kilometers away from health facilities. The CHPS therefore has potential of bridging the gap between rural communities and urban areas regarding access to healthcare services particularly maternal healthcare. This assertion is based on the fact that, the CHPS compounds have brought antenatal and post natal services.

In spite of the high level of satisfaction among clients, few households (14%) complain about non availability of essential drug and the fact that some of the CHPS compounds are accredited. About 31% of CHPS compounds sampled are not accredited by the NHIS because they have not yet been assessed for the purpose of accreditation. Thus majority operate on out-of-pocket basis, defending the purpose of the CHPS as pro poor intervention.

Quality of Human Resources

The Effectiveness and efficiency of CHPS compounds depends on the availability and quality of

human resources deployed. The management of CHPS compounds is entrusted to the CHOs. They are trained in the communities. A CHN, enrolled nurses, midwives or field technicians can be appointed as a CHO. They provide a range services including community and compound level education on primary healthcare; immunization and provision of pre and postnatal care delivery; supervision and monitoring of community volunteers, TBA, sanitation efforts at home; provision of nutrition education care, family planning and at home others. CHOs provide these services by focusing on outreach, house-to-house services, and establishing community decision systems using the community register for tracing defaulters and special conditions such as pregnant women. They also organize community child welfare (well child) sessions and school health education [4].

The study observed that 84% of sampled CHOs are CHNs while 10.5% and 55% are enrolled nurse and midwives respectively. Over two-thirds (71.2%) of CHOs have received basic training in management of CHPS compounds while 88.9% have received training on primary healthcare and promotion.

Community Health Officer (CHOs) without midwifery skills

In Ghana, between 1400 to 3900 women of reproductive years die each year due to pregnancy related complications [5]. An estimated two-thirds of these deaths occur in late pregnancy through to 48 hours after delivery. Under normal conditions CHOs are not trained to conduct delivery at the CHPS compounds. CHOs are only permitted to do "emergency" delivery i.e when the baby's head is in the perineum. However, the reality on the ground is that, many of the CHOs have been called upon to assist delivery under emergency circumstances on several occasions. This implies that, the CHOs need to obtain some basic skills in midwifery to administer delivery. In recognition of this reality, the CHPS policy makes it mandatory for CHOs to at least, obtain considerable level of training in midwifery before they are posted to the CHPS compounds.

As evident in fig 8, 68% of CHOs do not have midwifery skills required to effectively deliver pregnant women in emergency situations. According to the field survey, nonetheless, some CHOs conduct normal and routine deliveries at the compounds. For instance, in Sakai CHPS compound in Sissala East district, the CHO conducts five emergency deliveries in 2012. This is also confirmed by a number of studies. A review of the CHPS strategy by a team of researchers from the Ministry of Health noted that CHOs conduct normal deliveries because the community will not understand or believe them if they turn them away and wait for emergencies.

The implication is that maternal mortality is often high in areas where the CHOs have no skills in midwifery. Furthermore, supervision of TBA (which is one of the roles of the CHOs) in the various communities is affected since CHOs do not have skills. TBA is very important when it comes to emergency deliveries given that, 35.6% of CHOs according to the survey; do not stay in their communities.

Availability of Necessary Logistics

"A community Health Officer equipped with a community health compound, a motorbike and a package of essential; drugs' and family planning supplies may provide more services than an entire level B clinic at the fraction of the cost". to ensure effectiveness of the CHPS compound, basic logistics need to be provided by the Sub District Health Management Team to help the CHOs carrying out their normal duties.

With some CHPS lacking basic service delivery logistics such as cold chain, touch lights, communication items, working gears and delivery consumerables; quality healthcare is likely to be compromised. This is because these are the minimum logistics required to deliver basic primary healthcare. Furthermore, the availability of these logistics encourages the CHOs to give off their best and thus motivates them to stay and work in their communities. In the absence of these logistics the likelihood of CHOs staying in their respective communities through the week is minimal.

Community Participation in the Management and Implementation of CHPS

Positive engagement of the community to own their health and commitment to planning, organization, implementing and monitoring healthcare services impacts positively on health outcomes and health status of the population. It has need empirically proven that; programmes with citizens participation coordinated by community level officials have generally been more successful than those without it.

Participation, both at the governance and the operational levels is very important in achieving positive health outcomes. Therefore, the key component of CHPS is community-based service delivery point that focuses on improved partnership with households, community leaders and social groups. Where there is strong community participation, traditional leaders and community members provide resources – both financial and non-financial incentives to support implementation of the programme. A CHO is expected to work in partnership with the community, households and district assemblies to ensure that, citizens are able to access services and health information as and when they need them. On the other hand, the communities are required to exercise some levels of accountability of health providers. This session looks at the level of involvement of communities in setting up CHPS compounds and the level of collections with health professionals.

Contribution by communities to the establishment of CHPS compounds

The CHPS strategy relies on community resources for the labour, delivery of services and programme oversights. Almost all the communities sampled have contributed greatly to the construction of CHPS compounds as shown in fig 10. Evident from the focused group discussions is that, community contributions largely took the form of provision of labour and construction materials (such as roofing sheets, sand and stones). In some communities where water supply is a major hindrance for the smooth operation of the CHPS compounds, the community members, largely women, take turn to supply water to the CHPS compound. This normally happens in the Upper East, Upper West and Northern Regions. In the Tamaplala in Upper West Region, for instance, the women fetch water on weekly basis for the CHPS compound and the men farm for the two CHOs. The community of Sabare in the Northern Region sometimes provides food stuff to the CHOs and weed around the compound to prevent bushfires in the dry season. Most communities, through the health volunteers committees, have provided security for the compounds. This has brought some relief to CHOs whose compounds are isolated.

Collaboration between Community Health Officers and community members

The study observed that generally the level of collaboration between communities and CHPS compounds is high. About 59% of households interviewed indicated that they were involved in the preparation of the community work plans and its implementation. This was confirmed by 93.5% of VHO interviewed and during focused group discussion with key community stakeholders. At the community level, 92.9% of the respondents confirmed the existence of cordial relationship between them and staff of the CHPS compounds

Table 1. Number of Functional CHPS by Regions in Ghana 2010- 2013

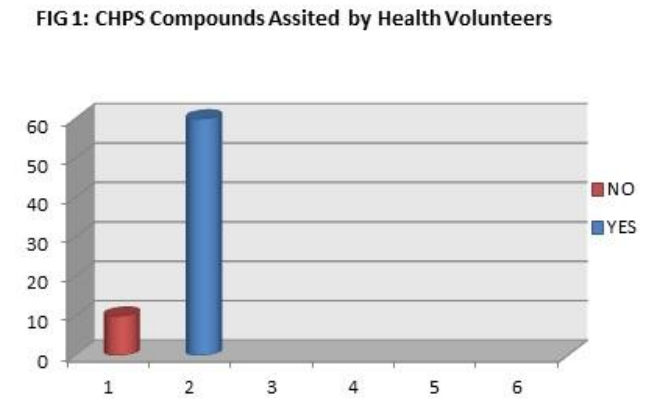
REGIONS	2010	2011	2012
Ashanti	8	36	198
Brong Ahafo	63	46	102
Central	68	93	134
Estern	298	315	368
Greater Accra	20	83	66
Northern	75	78	182
Upper East	104	96	120
Upper West	85	93	105
Volta	50	71	225
Western	114	123	176
Total	869	1034	1675
Percentage Increase		19.1%	62%

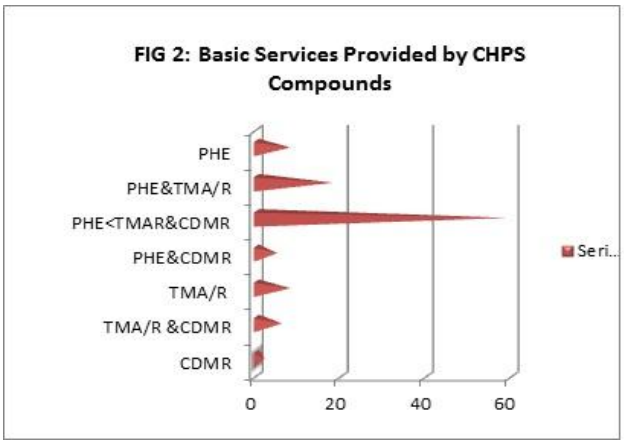
Source: GHS, 2012 Annual Report.

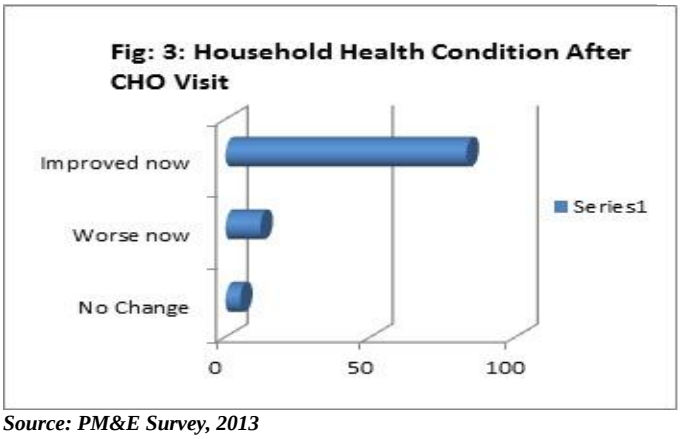
Table 2. Logistics in the various CHPS

Logistics	Yes	No
Cold chain	50.7	40.3
Delivery Consumerable	59.2	40.8
Working Gear	47.3	56.7
Communication items	18.8	81.2
PDA	13.0	78.0
Motor bicycles	75.0	25.0
Accommodation	58.4	46.6
Bed	51.4	48.6
Furniture	55.6	44.4
TV	13.7	86.3
Kitchenware	21.4	78.6
Electricity/solar	58.3	41.7
Thermometer	84.5	15.5
Touch light	26.8	71.4
Vaccine Carrier	85.9	14.1
Weighing scale	98.6	1.4
Stethoscope	82.6	17.4

Source: PM&E Survey, 2013







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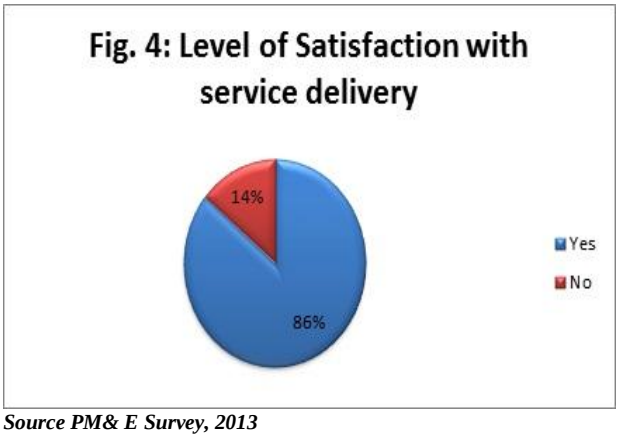

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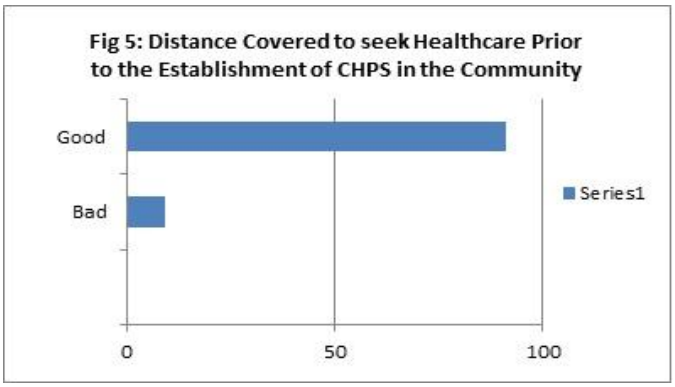

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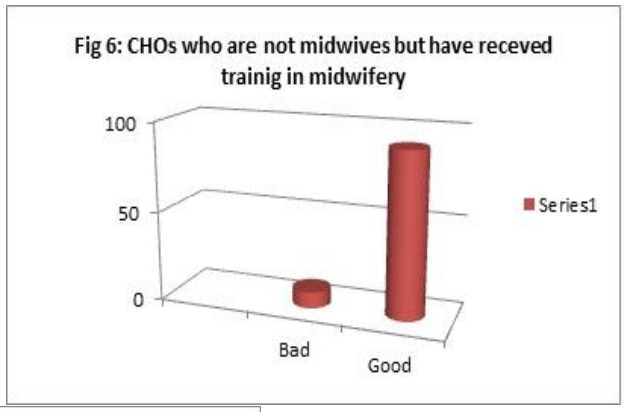

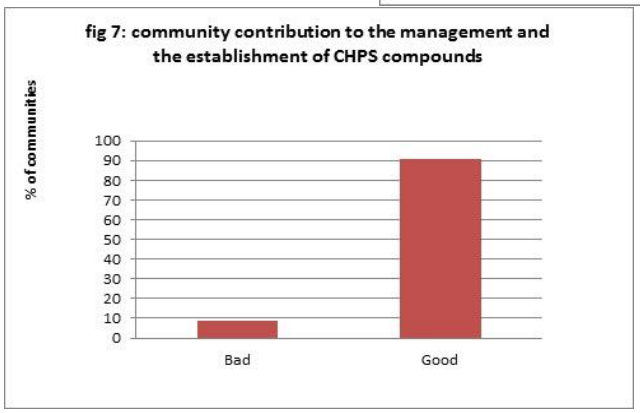

CONCLUSION AND RECOMMENDATIONS

The introduction of the Community-based Health Planning and Services by the Ghana Health Services has received a lot of commendation by stakeholders. It has been recognized as strategy to bridge the health gap between the rural poor and the urban centre. The strategy, since its implementation has increased access to healthcare services and has improved health outcomes in the communities where they exist. There is lots of empirical evidence indicating that where the programme has properly been managed, infant and maternal mortality have reduced drastically. In addition, the CHPS programme has contributed greatly to improve the life of rural dwellers, especially in the area of preventative healthcare and involvement of communities in the mobilization of resources for the implementation of health programmes.

However, the success attained with the implementation of the CHPS strategy could be eroded or become unsustainable when implementation guidelines and structures put in place do not work effectively and efficiently. Currently most of the CHPS compounds do not have basic logistics such as touch lights, motorbikes etc to work with. CHV and CHC are not motivated enough to continue playing their roles as volunteers as most of them lack transportation and communication logistics. More importantly, many CHOs who are mandated by the policy to have some level of training in midwifery to assist in emergency deliveries do not possess these skills, yet a greater number of them conduct normal deliveries do not possess these skills, yet a greater number of them conduct normal deliveries as part of their routine duties. Potentially this puts the lives of pregnant women in danger and can reverse the gains the programme has made in the reduction of maternal mortality.

There is the need to give practical meaning to policy strategies and objectives. The mere establishment of CHPS compounds in communities without the corresponding provision of the needed logistics, motivation and skills demand-side constraints wills likely lead to regressive health outcomes.

Recommendations

The findings of the research have policy implications and therefore the study recommends the following:

- Government as a matter of urgency should increase budgetary allocations and disbursements to the health sector and also ensure that funds are transferred to the districts as well as the SDHMTs. The GHS should take a second look at the issue of management of impress and address the capacity constraints rather than discontinuing with the practice of advantage impress to CHOs
- CHOs who do not have midwifery skills are to be trained by the GHS. This will enable them to perform emergency delivery when the need arises. The added advantage will be that, supervision of TBAs become much easier when the CHOs have the required skills to do so. This could be done through in-service training and attachment to other midwives

- Effort should be made by the SDHMTs and CHOs to work with communities to establish the CHSs where they do not exist and equip them with necessary logistics. This is necessitated by the strong correlation between active health committees and improved health indicators.
- The SDHMTs and CHOs should ensure that communities go beyond the provision of land and other building materials and participate actively in the management and monitoring of the CHPS programme. They should participated fully in the implementation of work plans and monitor the activities of the community volunteers and Community Health Officers.

REFERENCES

1. Ghana Health Service. Community-based Health Planning and Services (CHPS), Handbook, December 1999.
2. Nyanator, FK; Awoonor-Williams, K; Philips, JF; Jones, TC and Miller, RA. The Ghana Community-based Health Planning and Services Initiative for scaling up delivery innovation. *Health Policy and Planning,* 20(1), 2005, 25-34. Oxford University Press, 2005
3. Ghana Health Service. Community-based Health Planning and Services (CHPS). The Operational Policy. Policy Document No. 20, May 2005.
4. Ghana Health Service. The Health Sector of Ghana, Facts and Figures, Accra, 2010.
5. Sakeah Evelyn, McCloskey Lois, Bernstein Judith, Doctor Henry. The Role of Community Members in the Skilled Delivery Program in Rural Northern Ghana, 2013.