Section: Health Care and Public Health Integration

Community Health Services in Building a Resilient Health System

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“Resilient Health Systems” (Kruk, et al. 2015)

According to this article, a RHS is...

1) Capacity to engage a full range of actors in the system in times of crisis or need.
2) A legal and policy foundation to guide responses to emergencies and challenges, including provision for engagement of the private sector as needed.
3) The existence of a strong and committed workforce who function effectively at each level of the system with mechanisms for effective political and community engagement.
A resilient system has five elements

1) Capability of being *aware* of human, physical, and information assets required to detect need and respond to challenges.
2) **Strategic diversity** is needed so that systems can respond to a wide range of challenges that may arise.
3) RHS are **self-regulating** in that they have capacity to isolate and respond to challenges. This involves i) Ability to identify and isolate threats, ii) minimize disruption when threats occur, iii) the existence of redundant capacity that can be marshaled in times of crisis.
4) RHS are **integrated**, with capacity to marshal inter-sectoral action of diverse actors, ideas, and groups to formulate coherent responses to need.
5) RHS are **adaptive**. When crises arise or even in normal times, RHS have a capacity to change operations, respond to unanticipated needs, and revise plans and actions according to reality.
In Ghana, the elements of resilient health systems have been created by CHPS and this represent a platform for developing such capabilities elsewhere.
The Policy Direction

In 1977 Ghana MoH Policy stated...

- ‘..Most disease problems that cause the high rates of illness and deaths among Ghanaians are preventable or curable...

- ...If diagnosed promptly by simple basic and primary health care procedures’

- ....That a major objective (of the Ministry) will be to extend coverage of basic and primary health services to the most people possible during the next ten years”
“In order to provide this extent of coverage it will be necessary to engage the co-operation and authorization of the people themselves at the community level...

.... It will involve virtual curtailment of the sophisticated hospital construction and renovation and...

.... Will require a re-orientation and re-deployment of at least some of the health personnel from hospital-based activities to community-oriented activities”

Ghana MoH Policy Document: July 1977
There is a longstanding goal in Ghana to solve the health access problem:

<table>
<thead>
<tr>
<th>In seeking clientele...</th>
<th>In seeking care...</th>
<th>The problem</th>
<th>Developing demand</th>
<th>The desired program outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>...the program is passive.</td>
<td>...clients are passive.</td>
<td>Developer demand</td>
<td>Supply</td>
<td>Mobilizing demand</td>
</tr>
</tbody>
</table>
Why CHPS?

Increased Access to health services
Increased Access to Information
Community-centred services and increased Economic Access

= CHPS as a key strategy for achieving the goal of universal access to care
CHPS within the context of Dist. Health Systems...
What is CHPS?

The Community-based Health Planning and Services (CHPS) Initiative is the national scale up of the lessons learned from the Navrongo Experiment

- Piloted in 1994 and launched in 1996, the project explored alternative strategies for developing effective community-based services.
What is CHPS?

Worker dimension

Community Health Officers

Clinical system

Health management system

CHC & Volunteers

Social dimension

Mothers, Children & others

Familial Gatekeepers

Community leadership system

Social Structure, & Tradition
From the beginning, the Navrongo project was designed with scale-up as a goal:

- **Qualitative systems research** with micro-piloting
- **Quantitative experimental or plausibility trial**
- **Replication implementation research**

The table below shows the mobilization strategies used in the project:

<table>
<thead>
<tr>
<th>Mobilizing Ministry of Health outreach</th>
<th>Mobilizing traditional community organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No, Comparison 4, Zurugelu 1</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes, Nurse outreach 2, Zurugelu &amp; nurse 3</td>
</tr>
</tbody>
</table>
Events leading to the creation of CHPS

1978
Alma Ata Global Conference

1980
Ghana launches a Primary health care policy

1988
Creation of the Health Research Unit

1989
Navrongo Vitamin A Supplementation Trial

1994-1996
Navrongo CHFP pilot

1996-2003
Navrongo Trial

“Health for All” in Ghana through expansion of fixed facility care (district and sub-districts)

Creation of 3 Health Research Centres
Evidence that “health for all” will not be possible

Creation of The Navrongo Health Research Centre from the VAST system of work

CHPS developed as a Strategy for providing health for all

Results show that CHPS saves lives and reduces fertility

“Health for All by the Year 2000” is a global priority
1998
Nkwanta Replicates Navrongo implementation

1998
National Health Forum calls for replication evidence

1999
CHPS is declared a national policy

1999
National implementation uses Navrongo and Nkwanta as “lead districts.” More lead district created

2000
CHPS Implementation begins

2000
Evidence from monitoring shows that implementation is too slow

2008
MoH CHPS Review

2008
GEHIP is launched to develop and test ways to strengthen the PHC system

2010
GEHIP is launched

2013
SERC is added to GEHIP

2014
GEHIP produces results

2013
Emergency referral is added to the GEHIP agenda

2014
Results show that GEHIP Accelerates CHPS
Navrongo Pilot

- Culturally appropriate System
- Open-systems micro pilot

Navrongo Experiment

- Mortality and fertility impact
- Plausibility trial

Replication (Nkwanta)

- Replicable strategy
- Implementation research
- Is the system replicable and sustainable?

National Scale-up

- Coverage
- Organizational change and development
- Is coverage expanding?

Qualitative research starts with micro implementation

Protocol, research utilization plans and scale up developed with policy makers
Phase I: Develop “people-centred” programming
The community health service dimension

- Health infrastructure
- Community-constructed health centers
- Relocated nurses
- Essential equipment
CHPS-- a major health reform strategy

• Community-based service delivery strategy
• Improved partnerships with community leadership and social groups
• Provides ‘close-to-client’ doorstep health delivery
  • A Process of engaging communities to improve upon their health status.
Key Stakeholders in CHPS

The Ghana Health Service

The L/G District Assembly

The Community
CHPS...the key elements

- The *Community* (as Social Capital)
- The *Households* and Individuals (as Target)
- *Plan* with them (community participation)
- *Service delivery* with them (client focused)
CHPS, a new paradigm shift: taking health services provision close to clients

- Improve equity in access to basic health services.
- Improve efficiency and responsiveness to client needs.
- Develop effective community engagement systems to support service delivery.
- Develop effective inter-sectoral collaboration.
At the Centre of CHPS delivery

The Community Health Officer (CHO)

The Community Health Volunteer (CHV)
CHOs are the community-based front-line health workers who visit households, organise community health services, and conduct CHC clinics. These cadre of health workers provide services which represent the backbone of the Navrongo experiment and the CHPS programme.

- **Role within the National Health Strategy**
- Recognized as a formal part of the National Health Strategy and are on the pay-roll of the Ghana Health Services:
  - Cadres primarily created to address workforce shortages in rural areas of Ghana
  - Promote effective primary health care, family planning and prevention services
  - Strategic policy direction of the Ghana Health Service for a three-tier level of health service provision within a district:
    - District (Hospital) Level
    - Sub-District (Health Centre) Level
    - Community-based - linked with a functioning referral system
## CHO/CHW Utilization Goals

<table>
<thead>
<tr>
<th>Specific tasks performed by CHO/Cs towards achieving National MDGs</th>
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</thead>
<tbody>
<tr>
<td><strong>Tasks related to MDG 4</strong></td>
</tr>
<tr>
<td>✓ House to house visits coverage (including sick child contact, follow-up visits, health checks)</td>
</tr>
<tr>
<td>✓ Provision of Expanded Programme in Immunization (EPI) services</td>
</tr>
<tr>
<td>✓ Treatment of simple diarrhea</td>
</tr>
<tr>
<td>✓ First Aid for burns, cuts, toxic inhalations and consumptions (Home Accidents)</td>
</tr>
<tr>
<td><strong>Tasks related to MDG 5</strong></td>
</tr>
<tr>
<td>✓ Blood pressure monitoring</td>
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<tr>
<td>✓ First Aid for spontaneous delivery</td>
</tr>
<tr>
<td>✓ Distribution of condoms and FP devices</td>
</tr>
<tr>
<td>✓ Counseling on STIs/Family Planning services, counseling and advice</td>
</tr>
<tr>
<td>✓ Counseling on ante-natal and post-natal care</td>
</tr>
<tr>
<td><strong>Tasks related to MDG 6</strong></td>
</tr>
<tr>
<td>✓ Provide and support community based DOTS</td>
</tr>
<tr>
<td>✓ Advocacy on community sanitation</td>
</tr>
<tr>
<td>✓ Community directed treatments</td>
</tr>
<tr>
<td>✓ Distribution of insecticide treated nets (ITNs)</td>
</tr>
<tr>
<td>✓ Treatment of uncomplicated malaria and fevers</td>
</tr>
<tr>
<td>✓ Treatment of simple cough and URTIs</td>
</tr>
</tbody>
</table>
IDSR, Case Detection, Mobilization and Referrals

- Reporting of unusual conditions (IDRS)
- Referral of all conditions beyond the scope
- Mobilization of communities for health talks – creating community awareness
- Mobilization of communities for outreach services
- Providing support for Community Decision Making Systems
- Availability and completeness of community register
- Embrace Mobile health initiatives to compliment paper-base and increase effectiveness of health delivery
CHPS - Key Strategy in Achieving the MDGs
CHPS as Strategy

- Home-grown evidence based approach of mobilising both the health sector & communities to meet basic health needs:
  - Demarcating Sub-districts into CHPS zones
  - Mobilisation Community systems – CHMCs & volunteer system
  - Preparation & placement of CHOos in zones
  - Building DHMT & SDHT support systems for CHPS
  - Building Partnerships with Govt, communities & Dev partners/NGOs
  - Mainstreaming all Community health programs into CHPS
CHPS as Process

15 interactive & dynamic steps and six milestones, including

- Community entry & dialogue,
- Partnership building & resources mobilisation
- leading to the placement of a trained health worker in zone to work with communities to meet their basic health needs.
CHPS Increases Access

- 24-hour availability of services including family planning

- Routine door-step visits

- Active outreach strategy for family planning and immunization (CHPS nurses track down clients)

- Reduction in wait time

- Flexible and confidential arrangements for service provision (in comfortable and safe environment of clients’ choosing)
CHPS Increases Access

- Health education and communication at both community and individual levels
- Information access includes: symptom recognition, provision of needed care, and referral services
- Disease surveillance and Response (IDSR)
- Treatment of minor ailments
CHPS Increases Access

- Community-based nurses understand cultural fears, local superstitions and practices
- Clients are more comfortable with nurses who live in community
- CHPS mobilizes local traditions/systems for communication, planning and action
CHPS Increases Economic Access

Trust-based payment schemes (deferment, installment, or transfers in-kind)

Decreases transportation and opportunity costs

CHPS services are less expensive than hospital or clinic care (home consultations are free)
Phase 4: Challenges to national scale up: Slow pace of CHPS scale up

Community-based health planning and services scaled up most rapidly in Ghana’s poorest Regions

Scaling up was virtually non-existent in the most populous and prosperous regions: Greater Accra, Ashanti, Brong Ahafo
In 2010 the Ghana Essential Health Intervention Program (GEHIP) was launched

- GEHIP aims to address operational flaws and systems constraints that prevent CHPS from achieving its full potential.
- An *implementation research project* that seeks to strengthen elements of the six WHO pillars of health systems development.

- GEHIP is a *plausibility trial* for testing the hypothesis that health systems strengthening will accelerate achievement of MDG4, MGD5 and MGD6.
The GEHIP Approach

Develop enabling sub-system inputs...

- Integrated service components
- Health workforce size, composition & training
- Information for decision-making
- Essential drug supply & logistics
- Health financing & resource allocation
- Leadership & governance

...that generate system outcomes,

- Enhanced access to services and technologies
- Extended range of services and technologies
- Improved quality of services
- Improved efficiency

...alter the climate of demand for services,

- Improved equity
- Reduced social costs

...and impact on health behaviour, in ways that...

- Enhanced Health Service Utilization

Improve survival

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GEHIP Impact on CHPS Coverage
Revitalize the role of community mobilization through interactions with chiefs, local governance, and opinion-leaders. In addition, promote community engagement through CHPS-development focused durbars and community gatherings.
GEHIP engage outside the health sector through promoting continuous dialogue with District Assemblies & local NGOs to leverage support for CHPS implementation activities.

“You have to dialogue with the District Assembly always to let them understand the issue at hand. Before, they always said that when we are planning we don’t involve them – then when we are implementing we shouldn’t come to them. They want to be part of the planning process so that when the implementation comes they will be part. But if you finish your planning and just go, “Oh, we are doing this”, then they will not buy into it. So they all want to be recognized – recognition. Just know that they are the political head, give them that respect, dialogue with them. Then when you have your programme then they will be part of it.
GEHIP impact on CHPS/health service coverage

Community Health Officer Training

Ensure that CHPS trainings are provided to all new CHOIs and refresher trainings provided to all existing CHOIs
Actively coach CHO’s to promote volunteerism by engaging with local chiefs and establishing/or enhancing the volunteer cadre serving their CHPS zone. This include supporting the selection of new volunteers and providing routine orientations.
GEHIP impact on CHPS coverage
Basic Equipment

• Ensured that basic equipment, fuel for motorbikes, and supplies are available.
• Provided routine maintenance to motorbikes and equipment to enhance durability.

“Like what I said the fuel is a challenge, if you have more CHPS compounds it means more motorbikes and then you have to provide fuel so that has also been helped by the GEHIP support.”
GEHIP impact on CHPS Service coverage
Simplified Registers

Improve the quality and use of information for decision-making
Reinstate the ‘learning by doing’ model, which included exchange visits and the promotion of information sharing of best practices.
Sustainable Emergency Referral Care

SERC Hypothesis

• Context-specific, community- and sub-district level interventions designed to strengthen emergency referral systems will improve access to emergency health care in rural, impoverished communities in the region.
## SERC Design

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes (short term)</th>
<th>Outcomes (medium term)</th>
<th>Outcomes (long term)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access barriers to care (distance and transport)</td>
<td>Transportation and communication equipment</td>
<td>Functioning emergency transport and communication system</td>
<td>Increased access to services</td>
<td>Reduced delays in reaching care</td>
<td>Survival</td>
</tr>
<tr>
<td>Financial barriers to care</td>
<td>District and community support for fuel costs</td>
<td>Affordable fee structure established</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge and socio-cultural barriers</td>
<td>Community engagement</td>
<td>Community education activities</td>
<td>Increased knowledge and awareness</td>
<td>Reduced delays in seeking care</td>
<td></td>
</tr>
</tbody>
</table>

**Outcomes**

- **(short term)**: Increased access to services
- **(medium term)**: Reduced delays in reaching care
- **(long term)**: Reduced delays in seeking care

**Survival**
GEHIP impact on CHPS coverage
Sustainable Emergency referral Care (SERC)

Emergency transportation system:

- Strategically deployed 24 modified Motorking ambulances to:
  - 9 sub-district health centres
  - 12 CHPS facilities
  - 3 communities

- Used GIS data to determine ambulance catchment areas based on geography and proximity to health facility
- 2 community-selected volunteer drivers per ambulance
- Vehicles routinely serviced by RHD mechanics

Community Acceptance: SERC has been well-received by community members despite some preferring a four wheeled vehicle.
GEHIP impact on CHPS coverage
Sustainable Emergency referral Care (SERC)

Emergency communication system:
➢ Developed an emergency communication system using dual SIM mobile phones to facilitate rapid communication among: Health workers, Volunteer drivers, and Community health volunteers

Fee structure:
➢ Pregnant women and children under 5 transported free
➢ All other cases charged a pre-determined fee

Effective Transport: Motorkings have been able to withstand rough terrain and can navigate through narrow pathways.
% CHPS Contribution - Clinical care

- Referral
- Malaria
- Diarrhoea
- Upper Respiratory Tract Infection

- GEHIP Intervention
- Non-Intervention
Lessons/Conclusion

• Engaging local political system/community mobilization
• Improved dialogue with Municipal/District Assemblies
• Targeted capacity building for frontline health workers
• Making basic equipment available
• ‘Improved documentation practices and evidence-based decision making
• Strengthening public health and clinical services by posting midwives to CHPS zones
• Promoting “learning by doing”
• Access to emergency transportation and referral service