# National Community Health Planning and Services (CHPS) Policy

*Theme*: Accelerating attainment of Universal Health Coverage and bridging the access inequity gap

**WORKING DRAFT FOR VALIDATION**

November 2014

# FOREWORD BY HIS EXCELLENCY THE PRESIDENT

## STATEMENT BY THE HON MINISTER OF HEALTH

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## Abbreviations

| | |
|---|---|
| CDS | Community Decision System |
| CHFP | Community Health and Family Planning Project |
| CHMC | Community Health Management Committee |
| CHN | Community Health Nurse |
| CHO | Community Health Officer |
| CHPS | Community-based Health Planning and Services |
| CHV | Community Health Volunteer |
| CZ | CHPS Zone |
| DDHS | District Director of Health Services |
| DHMT | District Health Management Team |
| EPI | Expanded Programme of Immunization |
| GHS | Ghana Health Service |
| MDG | Millennium Development Goal |
| MMDA | Metropolitan, Municipal, District Assembly |
| MoH | Ministry of Health |
| OPD | Out Patient Department |
| PMTCT | Prevention of Mother to Child Transmission |
| PR | Performance Review |
| SDHT | Sub-District Health Team |
| SDMT | Sub-District Management Team |
| SMM | Senior Management Meeting |
| TBA | Traditional Birth Attendant |
| UHC | Universal Health Coverage |
| VHC | Village Health Committee |

# 1. National context

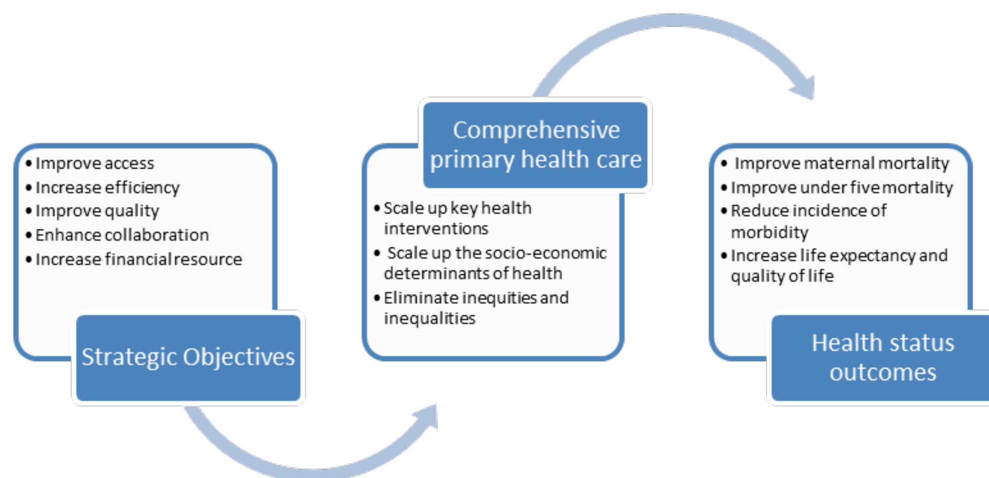
1. The Ghana Shared Growth and Development Agenda contain five Policy Objectives that are relevant to the Ministry of Health. These are:

    a. Bridge the equity gaps in access to health care and nutrition services and ensure sustainable financing arrangements that protect the poor
    b. Improve governance and strengthen efficiency and effectiveness in health service delivery
    c. Improve access to quality maternal, neonatal, child and adolescent health services
    d. Prevent and control the spread of communicable and non-communicable diseases and promote healthy lifestyles
    e. Expand access to and improve the quality of institutional care, including mental health service delivery

2. Ghana's health system has over the years been premised on the basic healthcare model with a network of health posts and dispensaries at the lowest level, linked to health centers, polyclinics and hospitals. In 1977 Ghana adopted a strategy of service delivery at the community level using Community Health Workers called Community Clinic Attendants and Traditional Birth Attendants. This preceded the Alma Ata Declaration in 1978 of 'Health for All by year 2000' that focused on Primary Health care (PHC).

3. The 1996 Health Sector Reform was launched with focus on health system development especially at the district level. A Medium Term Health Strategy: Towards vision 2020 and the first of a series of Five Year Program of Work and Common Management Arrangement were produced. The conceptual framework for this reform has guided the health sector up to date and is shown in figure 1 below.

**Figure 1** Conceptual Framework for the Five year medium term plans towards 2020



4. PHC was the bedrock of the first Medium Term Health Strategy and the Sector-wide Approach leading to over 40% of the discretionary sector budget consistently being allocated to the district and sub-district levels. Since then the Ghana health sector has continuously worked on strategies for delivering care direct to communities. Over time CHPS has emerged as the main strategy for doing this.

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

6. The proportion of OPD attendance by insured clients increased from 55.81% in 2010 to 82.11% in 20.11, OPD per capita increased from 0.98 in 2010 to 1.07 in 2011, with CHPS contributing approximately 5% to the total OPD attendance countrywide. There has been a corresponding progressive and significant increase in IGF from increasing attendance of insured clients at GHS facilities. During 2011, attendance of insured clients at GHS facilities contributed to more than 80% of their total IGF after suffering a dip in 2010 (72%) in comparison to 77.9% in 2009.

7. The safe motherhood indicators show fairly sustained ANC coverage over the three - year period being reviewed that is, 92.1% (2009); 93.3% (2010) and 94.4% (2011). This has been in spite of the proportion of clients achieving the 4+ visits, which has continued to decline from 88% (2009); 82.4%(2010) and 74.9% (2011). The national rate of skilled delivery has continued to improve from 45.6% (2009), 49.5% (2010) to 52.2% (2011).

8. With the national target at 90%, national performance in immunization, as measured by Penta-3 coverage, continued its decline for a second year running, dropped from 89.3%(2009) and 87.1% (2010) to 85.8% (2011).

9. It estimated that up to 80% of illnesses could be prevented by the combination of improved nutrition, adequate clean water supplies, education on personal hygiene, family planning, vaccination services, treatment of common ailments and injuries. These are the main activities of the Primary Health Care (PHC) System. However, there exists significant inequity in access to health services between the rural and urban population. CHPS is a national strategy to improve access and utilization and reduce inequities.

## 2. CHPS as a primary healthcare strategy

10. Ghana has been implementing the Community-based Health Planning and Services (CHPS) program for 10 years. Considered one of the pragmatic strategies for achieving universal health coverage of a basic package of essential primary health services, CHPS has gained international recognition. Led by a Community Health Officer and supported by volunteers drawn from the area of service, the CHPS strategy is a breakthrough in enhancing community involvement and ownership of primary health care interventions towards achieving universal health coverage (UHC).

11. CHPS began as a Community Health and Family Planning (CHFP) project based on lessons learnt from Bangladesh (Phillips, 1988). The project was launched in Navrongo as an operations research in 1994 piloted in three sub-districts. Four different models of delivering community services were experimented to treat malaria, acute respiratory infections, diarrheal disease and other childhood illness and providing family planning services and immunization outreach. Each experiment location was referred to as a Cell with different configurations of organisation of services as in figure 1 below.

Figure 1: Conceptual framework of Navrongo Community Health and Family Planning Project

| Constant: Health Centres in all cells upgraded equally | Traditional community not mobilised | Traditional Community Mobilised – entry, CHMC formed and volunteers engaged |
|---|---|---|
| No nurses trained and deployed for home visits | **Cell 4**: Upgraded Health Centre | **Cell 1:**Upgraded Health Centre with community mobilised |
| Nurses trained and deployed- residency, with services available and home visits | **Cell 2:** Upgraded Health Centre with nurse trained and deployed in communities | **Cell 3:** Upgraded Health Centre with communities mobilised and nurse trained and deployed |

**Source**: Adapted from Nazzar et al 1994

12. The option that proved most successful was **Cell 3** which had three components **-** (i) a compound where the CHNs lived and could be reached in emergency and a courtyard for delivering ANC and services when required; (ii) volunteer assisted outreach program that encouraged case tracing and referral, health education and confidential counselling and (iii) and the Community Health Management Committees who oversee community mobilisation and participation, service delivery and welfare of both the Community Health Nurse and the Volunteers. Medical Assistants from the Health Centre provided support for community entry and establishment, supervisory support and held zonal meetings to provide feedback on implementation. With this option child mortality was reduced by 38% and total fertility was reduced by one birth (Pence et al., 2001). It was also demonstrated that in the study area, the case load increased eightfold, immunization and family planning coverage improved and fertility and mortality rates declined (Debpuur et al., 2002).

13. In 1999, consensus was reached to adopt and scale up the Cell 3 model as a national strategy to improve access, efficiency and quality of health care (Ghana Health Services, 2003). Fifteen steps were developed to guide the implementation process. Community Health Nurses were

provided further training and designated Community Health Officers (CHOs) as resident health care providers in a CHPS zone. Zones were geographical coverage areas for community services. The CHOs would provide reproductive, maternal and child health services, manage diarrhoea, treat malaria, acute respiratory infections and childhood illness and provide comprehensive family planning and childhood immunization 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 mobilization. These services were mainly delivered through home visits. Treatment would be provided for those who come to the CHOs at their residence. The 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.

## 3. Scaling-up CHPS: Where are we?

14. In 2000 work began on scaling up the CHPS concept, 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 barrier to access to care. The national health insurance scheme was seen as the social intervention to address the financial challenge and CHPS was to make basic services available "close to client".

15. The GMHI focused attention on community health services emphasising the importance of the entire district health system in PHC. The emphasised on construction of compounds as the basis for scaling up CHPS diverted effort and attention from community mobilisation to CHPS compound construction.

16. In line with the expected roll out of CHPS strategy, every CHPS zone was to have a CHPS compound comprising CHO accommodation and a service delivery point. Patients who could not be handled at this level were referred to a Health Centre, district hospital and regional hospital in that order of upward referral. The gap between need and what is required across the various categories of facilities were estimated as follows: 4475 Community Health Compounds, 346 additional Health Centres at the sub-district and 67 district hospitals. With the kind of health systems outlined, each Region will need a referral hospital. It was estimated that realistically only 300 of the CHPS facilities could be built in a year.

17. It was unclear what the prototype of the facility was to be. Nyonator and others (2005) suggested that what was required was a simple facility, comprising ‘a room for the CHO living area and a room for a community clinic. Experience over the years has shown that this standard facility is not suitable for long term living and comfort of the CHO. In 2011 new designs were suggested. The new design is a two bedroom, living room, kitchen and toilet and washroom facilities for two person occupancy and a single room for consultation with a court yard.

18. The Ministry of Health since the revision of the CHPS Compound design in 2012 has funded the construction and completion of 16 CHPS compounds with an additional 28 under construction country wide.

19. Different development partners and District Assemblies have also supported the building of CHPS compounds using different designs and standards at varying costs. In practice the sizes vary from simple two-room structures to complex facilities the size of some health centers. The varying specifications make it difficult to equip, maintain and manage these facilities.

20. Planning with communities, effective community entry and mobilisation, deploying the CHO supported by volunteers to deliver services, and the acquisition the CHPS compound (may be donated or constructed), and the provision of essential equipment and supplies are essential components of the CHPS concept.

21. In 2008 a new terminology "functional" was defined and added to the demarcation of CHPS zones. This definition stated: *'where all the milestones have not been completed… but a community health officer has been assigned and provides a defined package of services to the catchment population, from house to house in the unit area'*. In practice the definition was open to different interpretations. It was then generally accepted that it is not mandatory to have a purpose built CHPS compound in implementing CHPS (GHS, 2013).

22. The geographical demarcation for a CHPS zone was changed in 2010 from size of population or Unit Committees to be conterminous with electoral areas. This reduced the number of CHPS zones from 5280 to 2840. In 2013 and because of the increase in electoral areas the new figure put out by the Ghana Health Service (GHS, 2014) is 5487. To date 1189 CHPS zones are reported to be functional.

23. In 2003 the Ministry of Health set out to significantly increase the production of Community Health Nurses for CHPS. It directed that all nursing training institutions should train this cadre. New training schools were also opened. By 2008/2009 the CHN numbers started increasing reaching over 6300 in 2010. Current estimates of staff in the system are almost 12,000 for only CHNs (MoH, 2014b). Given the ratio between available CHPS zones and CHNs there appears to be an over-production of this cadre.

Table 2: Trend in growth of CHNs

| Category | Staff Population | | | |
|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2010 |
| Community Health Nurse (CHN) | 3732 | 4502 | 6303 | 6343 |

24. The 2005 CHPS operational policy indicated that CHOs will be assisted by community health volunteers who are supervised by Community Health Management Committees (CHMCs). However the effort in developing volunteers (CHMC and Health Volunteers) has not been as consistent as that in developing the CHO component of the strategy.

## 4. Implementation challenges

25. 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 were also issues in relation to effective leadership and technical direction. Planning and budgeting for CHPS at the national, regional and district levels. Planning as a process at the community level is also inadequate.

26. At the implementation level technical health and local government officers referred severally to the confusion in directives received from the centre. Written guidelines were not adequately disseminated, and were difficult to understand and implement. While local government and district assemblies are willing to take on the challenge of scale up there is still no clarity in roles and responsibilities. It is also unclear whether CHPS should be implemented in urban areas given its origin as a strategy for reaching deprived rural areas.

27. The term 'functional CHPS zone' introduced further complication to the concept. Under the functional CHPS zone concept compounds were no longer a mandatory requirement. Zones were now ranked on a scale of fractional degrees of partial or incomplete depending on how many of the six steps have been completed. Under the new definition it was difficult to determine precisely what 'functional' meant (Awoonor-Williams et al., 2013; Baatiema et al., 2013).

28. In rapid assessments in both the Western and Central Region about 77% of CHPS compounds were found to be in a poor state of repair. Some districts have commissioned CHPs compounds which have not as yet started operations after several years of commissioning. Most of the compounds (about 60%) are partially equipped and without accommodation. Most CHOs also complain of lack of operations running budget (MoH, 2014).

29. Service delivery was in a constant flux with ever changing definitions of the standard basic package of interventions to be delivered in a CHPS zone (MoH, 1999, GHS, 2005, GHS, 2010 and GHS, 2013). New services are constantly layered onto existing ones with supervisors and communities coming to expect an increasing variety and complexity of clinical services to be delivered at the CHPS level. All disease specific programmes see the CHPS platform as an opportunity to reach the communities with their programmes. There was also push for CHOs to include deliveries in the CHPS portfolio of services. Lack of communication and engagement has led to community members not understanding the distinction between community-based health service and services at a higher level health facility (Tierozie, 2011). Communities expect a facility to should deliver clinical care when required.

30. The current population reached with CHPS services is 5% (GHS, 2012). Considering investment to output this might be considered low. This raises the question as to whether we are optimally implementing the strategy and whether CHPS is value for money. Another issue raised by this low coverage is to examine the methods and indicators for measuring CHPS performance. CHOs are required to fill different forms for various programme specific activities. The result is an overload in reporting requirements and little use of data.

31. The ratio of functional CHPS zone to CHN points to an over production of CHNs. Currently the ratio is about 1:11. The initial assumption was to have one CHO per CHPS zone. It is now considered to have at least two CHOs per zone. This presents logistic challenges in terms of accommodation and amenities resulting in many CHNs not residing in CHPS zones. The CHN training program was developed with no prospects of career progression while in service. Many CHNs desire to continue their education, leading to dissatisfaction with the location and length of their current placement. There is no policy on how long a CHN can remain in a deprived community or incentives in place to reward those serving in deprived areas.

32. The selection, training and retention of volunteers have received the least attention in the CHPS deployment framework. It is estimated that 55% of CHPS zones have no regularly trained active volunteers working with CHOs on a regular basis (MoH, 2014). Volunteers provide a bridge for the services between patients and the CHNs without affecting the national wage bill. The low availability can be attributed to several factors. Different programs drawing on volunteer services have led to volunteers implementing different uncoordinated services. There is no policy on reward and incentives for these volunteers leading to volunteer fatigue and various programs introducing cash incentives. This has distorted the volunteer system in several communities resulting in some volunteers demanding cash for services. Some sub-districts are waiting for funding to become available for hiring community members to perform volunteer services (Awoonor-Williams et al., 2013, Seddoh et al 2014). There are proposals from the Ministry of Health to retool existing volunteers and regularise the payment system by providing some monetary payment.

33. Another issue that cut across all regions was Community Health Management Committees (CHMCs). Though they were formed in most CHPS zones, members were inactive or not trained in 65% of the CHPS zones (MoH, 2014). Community entry and appropriate community mobilisation to support the CHPS programme were hardly done.

34. There are issues of inappropriate siting of CHPS compounds. In some instance land allocated for CHPS are either in sacred groves, insanitary environments and not sensitive to the cultural setting and taboos. There are also issues of security and availability of water and electricity.

35. Financing CHPS is not clear. Different development partners have funds for supporting the development and scale up of CHPs but there is no coordination and harmonisation of the various funds. The NHIA does not reimburse for CHPS services directly. Where services are provided and qualify for NHIA reimbursement, the cost is claimed through the Health Centres as part of the services provided by the Health Centre. Under capitation, individuals will prefer to select health centres and hospitals as their preferred primary provider.

# 4. The CHPS Policy: definition and directives

## 4.1 Definition of CHPS

36. CHPS is a national mechanism to deliver essential community based health services involving planning and service delivery with the communities. Its primary focus is communities in deprived subdistricts and in general bringing health services close to the community.

The following constitute the components of CHPS implementation

a. A CHPS Zone refers to a demarcated geographical area of a 4 kilometre radius and between 4500-5000 persons or 750 households in densely populated areas and may be conterminous with electoral areas where feasible
b. A CHPS Community is a town, part of a town or a group of villages or settlements grouped together and designated as such by the district assembly as sub-units of a CHPS Zone. These are mapped for ease of planning of itinerant services and assignment of CHOs and CHVs. A CHPS Community in a densely populated area shall be approximately 1500 persons or 250 households.
c. A CHPS Compound refers to an approved structure consisting of a service delivery point and accommodation complex both of which must be present
d. A Community Health Officer (CHO) is a trained and oriented Community Health Nurse working in a CHPS zone and may be assigned to a Community within the zone
e. Community Health Volunteers (CHVs) are non-salaried community members identified and trained persons supporting CHOs in a Community within the CHPS zone
f. Community Health Management Committees are community leaders drawn from the CHPS Community with different competencies and responsibilities who volunteer to provide community level guidance and mobilisation for the planning and delivery of health activities and see to the welfare of CHOs in their community

37. The aim of this policy is to:

    a. Attain the goal of reaching every community with a basic package of essential health services towards attaining Universal Health Coverage and bridging the access inequity gap 2020

## 4.2 General principles

38. The general principles guiding the development and implementation of CHPS are
    **a.** Community participation, empowerment, ownership and volunteerism
    **b.** Focus on community health needs to determine the package of CHPS services
    **c.** Task shifting to achieve universal access
    **d.** Communities as social and human capital for health system development and delivery
    **e.** Health services delivered using systems approach.

## 4.3 Policy directives

39. The following policy directives shall apply and guide the implementation of this National CHPS Policy. Implementation guidelines will be developed to provide more detailed information to guide implementation.

### 4.3.1 Policy directive 1: Duty of care and minimum package of services

40. Package will include:
    - Maternal and reproductive health ( emphasising FP, ANC+, providing relevant information and motivating pregnant women to seek appropriate services including PMTCT and ANC, and to deliver under trained health worker supervision) and ASRH)
    - Child Health services (EPI, nutrition education and support and Growth monitoring and promotion, Community Integrated Management of Childhood Illnesses
    - Treatment of minor ailments, including fever control, first aid for cuts, burns and domestic accidents, and referrals
    - Health education, sanitation and counselling on healthy lifestyles and good nutrition
    - Follow up on defaulters and discharged patients

41. Information and Surveillance: CHOs will keep records and report regularly according to standard protocols. The reports will include vital events in the CHPS zone and prompt notification of strange diseases or deaths and increased occurrence of known diseases such as diarrhoea, neglected tropical diseases and jaundice.

42. Deliveries may not be performed by CHOs. They are expected to refer all delivery cases to a higher level of care. Based on need, the District Director of Health Services may include midwifery services in the package of services for a specific CHPS zone and post a qualified resident midwife to the zone.

43. Where there is already a competent midwife operating in an accredited private maternity home within the zone, such a facility shall be the referral point for the CHPS zone.

44. Any earmarked or project services to be implemented at the community level and directly financed by any persons, institutions or development partners should be implemented on the CHPS platform according the laid down

### 4.3.2 Policy directive 2: Human resources for CHPS

45. CHN is a professionally classified cadre by the Nurses and Midwives Council for persons qualified and issued with the recognised specific license. A CHN who undergoes the prescribed in-service training and orientation and posted as a staff in a CHPS zone is designated as a CHO. There shall be established a CHO grading system for the purpose of providing career progression.

46. Any Community Health Nurse acquiring a professional nursing grade or a degree level qualification shall migrate onto the new profession grade categories for their promotions. For avoidance of doubt a CHN acquiring a professional qualification and licensed to practice in a nursing profession above a CHN licensure shall move from the CHN category onto the new qualification and license and progress from there. The professional may continue to serve at the CHPS level where appropriate as in for example a CHN being designated a midwife.

47. There shall be at least three (3) CHOs to a CHPS zone who may serve for specified periods depending on the level of deprivation and shall rotate out. No CHN shall however serve in the same zone for more than four years.

48. An appropriate incentives scheme shall be developed and instituted to reward CHOs depending on performance, duration of stay and category of deprivation of the CHPS zone. The incentive scheme will recognise staff opting to serve in very deprived areas. See a proposed incentive scheme in annex 1.

49. Community Health Volunteers shall continue to be an integral part of CHPS zone service delivery. Each CHPS Community shall have at least two volunteers selected by the community and trained by the sub-district health team. These will be the recognised volunteers for the CHPS platform.

50. An appropriate incentives scheme shall be developed and instituted to reward Volunteers depending on performance, duration of stay and category of deprivation of the CHPS zone. See suggested incentive scheme in annex

### 4.3.3 Policy directive 3: Infrastructure and equipment for CHPS

51. A CHPS compound is a basic structure consisting of accommodation of CHOs and a service delivery point which may also be referred to as a health post. To promote efficiency and cost effectiveness in the construction, maintenance and management of CHPS compounds across country, all CHPS compounds shall be standardised across the country using approved design options. For the purpose of consistency in nomenclature, the complex of residence and health post shall be referred to as a 'CHPS Compound'.

52. Where a community has provided a temporary structure to serve as a CHPS compound, this should be replaced in due course with the standard approved design

53. 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 a standard design approved by the Minister of Health

54. A CHPS compound shall be equipped and furnished in accordance to the standard list defined for the approved designs as attached in annex 2. CHPS compounds located in deprived areas without power grid or safe water shall have solar power and boreholes as part of the standard requirements

55. All on-going construction of CHPS compounds shall be completed with their planned design; or modified to the new design where applicable except that the cost due to modifications shall not be more than 15% of the suggested cost of construction of the new prototype. All CHPS compounds not started shall comply with the approved prototype and constructed in line with the principles set out in this policy

56. The establishment of CHPS zones and location of CHPS compounds shall be determined by the District Assembly on the advice of the District Director of Health Services and consistent with the District Strategic Health plan

57. The land for the construction of CHPS Compounds shall be provided by the host community as a free hold with appropriate documentation sealed at the land title registry. The government on receipt shall have a right to vest the land in a third party for the sole purpose of achieving the objective of establishing a CHPS Compound.

58. In urban areas and around hospitals and health centres, the CHPS concept is applicable, except that the services will be provided from an existing facility as the host facility. The accommodation component may be provided to the CHOs if no accommodation already exists for the CHOs

59. CHPS compound construction will be prioritised for rural and deprived areas

### 4.3.4 Policy directive 4: Financing

60. The primary responsibility for financing the scale up of CHPS rests with government. Government shall allocate dedicated resources for the scaled up operations of the CHPS

61. Additional funds may be mobilized from the following sources:

    a. 10% levy on salaries of the Executive and the Legislature already committed by the ruling government
    b. Allocation of the National Health Insurance Fund to the Ministry of Health
    c. Development partner contributions including establishment of a common funding basket
    d. Contributions from benefactors and philanthropists

62. All services delivered in CHPS compounds shall be delivered free of charge at the point of use. All CHPS services on the NHIS benefit package shall be reimbursed. CHOs and their volunteers will facilitate the registration of their populations onto the NHIS.

### 4.3.5 Policy directive 5: Supervision, monitoring and evaluation

63. The District Director of Health Services being the technical lead in the District and reporting to the District Chief Executive and the district assembly shall have overall responsibility for guiding service delivery in the CHPS zones in the district.

64. Direct supervision of CHOs shall be the responsibility of the Officer in charge of the health centre in the sub-district. Where there is no public health centre, The District Director shall delegate an appropriate officer to be responsible.

65. Medical officers in the District Hospital shall be assigned a number of sub-districts for which they shall have mentoring and technical supervision responsibility and shall visit a CHPS zone in their assigned sub-district at least once every quarter.

66. The District Chief Executive shall in collaboration with the District Director of Health Services commission annual reviews of progress in CHPS implementation in the district and make the report available to be discussed by the District Assembly. The report and recommendations of the district assembly shall be made available to the Director General of the Health Service and the Minister of Health by June of the reviewing year.

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# Annex 1 Proposed incentives for CHOs and CHVs

**Proposed Incentives for CHOs in deprived areas**

| Category | 1st to 3rd Year | 4th to 6th Year | 7th to 9th Year |
|---|---|---|---|
| D eprived | 15% salary top up per month with half year five working days rest and recuperation paid off days –standard return bus fare paid by district assembly to preferred destination in Ghana | Automatic promotion to next grade; 20% salary top up per month with half year five working days rest and recuperation paid off days –standard return bus fare paid by district assembly to preferred destination in Ghana. Mandatory rotation out on request of CHO | Automatic promotion to next grade; 20% salary top up per month with half year five working days rest and recuperation paid off days –standard return bus fare paid by district assembly to preferred destination in Ghana. Mandatory rotation out on request of CHO |
| Most Deprived | 30% salary top up per month with half year five working days rest and recuperation paid off days –standard return bus fare paid by district assembly to preferred destination in Ghana. | Automatic promotion to next grade; 30% salary top up per month with half year five working days rest and recuperation paid off days –standard return bus fare paid by district assembly to preferred destination in Ghana. Guaranteed leave with pay to health related degree program. Mandatory rotation out on request of CHO at anytime | Automatic promotion to next grade; 25% salary top up per month with half year five working days rest and recuperation paid off days –standard return bus fare paid by district assembly to preferred destination in Ghana – automatic rotation out to a deprived or better endowed area. In this case the conditions for the new area shall apply at the continuing incentive level if applicable at end of period. |
| Severely Deprived | 40% salary top up per month with bi-monthly five working days rest and recuperation paid off days – standard return bus fare paid by district assembly to preferred destination in Ghana- Mandatory rotation out on request of CHO after one year | Automatic promotion to next grade after second year of service; 40% salary top up per month plus, guaranteed paid educational leave and fees paid to an approved health degree after 3rd Year or guaranteed paid six months leave and move to better endowed urban area of choice after period. Retain allocated motorbike for personal use- Mandatory rotation out on request of CHO at anytime | **Not allowed** – compulsory rotation out to better endowed urban area and revert to standard salary on new grade if acquired new degree or automatic promotion to next grade with two incremental point jump on salary scale for either |

**Proposed incentive system for volunteers**

| Up to one-year | 2nd and 3rd Year | 4th and 5th Year | 6th to 10th Year |
|---|---|---|---|
| Two pieces of made in Ghana cloths | Retain allocated bicycle, two pieces of cloths annually and certificate of service | Three pieces of cloth from 4th year, 24" television in 5th year, certified as trainer of volunteers | Retain allocated bicycle in 6th year, three pieces of cloth annually, 36" television in 8th year, combination fridge and freezer in 10th year with certificate of long service award and rotated out |

# Annex 2 Basic equipment, tools, supplies, drugs for CHPS zones

**For CHPS compound**

| | |
|---|---|
| **Equipment** | |
| | Resuscitation Kit: NeoNatalie |
| | Salter Weighing Scale |
| | Blood Pressure Apparatus |
| | Bowl to receive placenta |
| | Couch |
| | Demonstration tray, family planning |
| | Fetoscope |
| | Forceps, dressing |
| | Galipots |
| | Screen or curtain |
| | Refrigerator |
| | Refrigerator thermometer |
| | Adult weighing Scale |
| | Vaccine carrier |
| | Clock/watch with second hand |
| **Logistics** | |
| | Cup with 100ml/50ml mark for tasting ORS solution (ORT) |
| | Bucket, container for 0.5% chlorine |
| | Bucket, container for contaminated waste |
| | Mackintosh sheet |
| | Benches and chairs at waiting area |
| | Tape measure |
| | Weighing pant |
| **Supplies** | |
| | Information, Education and Communication materials |
| | Methylated Spirit |
| | Alcohol Hand Rub |
| | Plastic apron |

| | |
|---|---|
| | Bandages / plaster |
| | Chlorine solution or powder |
| | Cotton swabs / gauze |
| | Disposable syringes, 1 cc |
| | Disposable syringes, 5 cc |
| | Gloves, disposable |
| | Gloves, sterile |
| | Gloves, utility |
| | Malaria Rapid Diagnostic Test |
| | Scissors |
| | Sheets, linen |
| | Liquid soap |
| | Thermometer |
| | Waste containers: puncture proof for needles/syringes |
| | Water, clean |
| **Midwifery Kits – if approved** | |
| | ITEM |
| | Plastic sheet |
| | Disposable gloves |
| | Cord Ligatures (twine) |
| | New Blade |
| | Methylated spirit |
| | Oxytocin |
| | Soap (wrapped in Polybag) |
| | Gauze Swabs |
| | Cotton wool swabs |
| | Polythene bag for waste |
| | Plastic bowl (as galipot) |
| | ORS |
| | Thick Plastic bag (to wrap items) |
| | FP job aid |
| **Monitoring and Evaluation tools** | |
| | Antenatal Care register |
| | Child Health Record Book/weighing card |

| | |
|---|---|
| | Consulting Room register (OPD) |
| | Daily log |
| | Delivery Register |
| | Drug register |
| | Drug Bin cards |
| | Family Planning register |
| | Family planning client record books |
| | Family planning monthly reporting format |
| | Immunization register |
| | IMNCI chart booklet |
| | Maternal Health Record Book |
| | MCH quartery reporting format |
| | Monthly Morbidity Report forms |
| | Post Natal Care Register |
| | Refrigerator temperature sheet |
| | School Health Registration Notebook |
| | TT Cards |
| | Vaccine logistics register |
| **Medications** | |
| | Albendazone |
| | 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 |
| | Paracetamol |
| | Sulfadoxine + Pyrimethamine |
| | Tetanus Toxoid |
| | Vitamin A |

**For Home Visit for CHO and CHW**

***(1) For CHO***

| | Item | Quantity |
|---|---|---|
| | Back pack | 1 |
| | Dressings (Bandage, Gauze swabs, Cotton Wool swabs, Plaster 1"&2", Crip bandage, Vaseline Gauze etc.) | 5 |
| | Raincoat | 1 |
| | Cup & Spoon | 2 |
| | Soap dish & Soap | 1 |
| | Hand towels | 6 |
| | Notebook | 2 |
| | Pen & Pencil | 2 |
| | Torch Light and batteries | 1 |
| | Wellington Boots | 1 |
| | Family Planning methods | Samples & For sale |
| | Oral Rehydration salts (ORS) | Samples & For sale |
| | Insecticide Treated Nets (ITNs) | 1 |
| | Methylated Spirit/Glycerin (Alcohol Rub) | 1 |
| | Penis Model | 1 |
| | Health education<br>-Maternal Health Record Book<br>-Breastfeeding Care<br>-Complementary Feeding<br>-Malaria Prevention etc. | 1 each |
| | Brochures (Assorted) | 1 each |
| | Community Register | NIL |
| | Volunteer T-shirt (Lacoste) | NIL |
| | Plastic sheet 2 yards | 1 |
| | First Aid items (Parafin, Mecurochrome, Activated charcoal, | 1 |
| | Tape measure | 1 |
| | Drugs – Anti-malarials | |
| | Artesunate Amodiaquine (various age groups) | 5 each |
| | Artemeter Lumifantrine (Ionart, coaterm) | 2 |

| | | |
|---|---|---|
| | Sulphadoxine Pyremethame (SP) | 10 |
| | Paracetamol | 2 sachet |
| | Disposable gloves | 2 pairs or more |
| | Methylated spirit | 1 |
| | Data Management tools | Various in Plastic wallet |
| | Blood Pressure kit (digital) | 1 |

***(2) For CHV***

| | Item | Quantity |
|---|---|---|
| | Knapsack | 1 |
| | Plastic file | 2 |
| | Community book | 1 |
| | Data tools | 4 |
| | Stationery | 1 |
| | Plaster | 1 |
| | Bandage | 1 |
| | Cotton Wool swabs | 5 |
| | Guaze swabs | 5 |
| | Small notebook | 1 |
| | Contraceptive methods | 3 |
| | Anti malarials (Green leaf) | 2 |
| | Plastic sheet | 1 |
| | ORS | 5 |
| | Scissors | 1 |
| | Health education material | 4 |
| | Gloves | 1 |
| | Torch with Batteries | 1 |
| | Wellington books | 1 |
| | Plastic bowl ( as galipot) | 2 |
| | Rain Coat | 1 |