Appendix 1-1 : PDM Version 0

Project Design Matrix
Project Title: Strengthening community-based health services focusing on the life-course approach in the Upper West, Upper East and Northern Regions
Implementing Agency: Ghana Health Service (GHS)
Beneficiaries: People of all ages in the Upper West, Upper East and Northern Regions
Target Group: CHOs and other health staff in the Upper West, Upper East and Northern Regions
Period of Project: 2017 - 2022 (5 years)
Project Site: Output 1-3: Upper West, Upper East and Northern Regions* (*: selected districts in Northern Region), Output 4: Upper West Region

Narrative Summary	Objectively Verifiable Indicators Ver.0	Means of Verification Ver.0	Important Assumption	Achievement	Remarks
Overall Goal Universal health coverage is promoted by improving access and utilization of primary health care through Community-based Health Planning and Services (CHPS) in Upper West, Upper East and Northern Regions	1. (By the end of 2025), more people within the 3 northern regions are covered by functional CHPS zones UWR XX% (2025) UER XX% (2025) NR XX% (2025)	1. Records from regional/district health directorates/Annual Performance Review Report			
Project purpose Community-based health services focusing on the life-course approach are strengthened in Upper West, Upper East and Northern Regions	1. The percentage of people who has access to functional CHPS UWR XX% (2016) → XX% (2021) UER XX% (2016) → XX% (2021) NR XX% (2016) → XX% (2021) 2. The level (score) of CHPS implementation is increased by XX% UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) 3. The level (score) of CHPS implementation with life course approach in UWR is increased by XX% UWR XX% (2017) → XX% (2021)	1. Records from regional/district health directorates/Annual Performance Review Report 2. Project Score Card 3. Project Score Card	A financially sustainable mechanism is established to operate CHPS		

Outputs					
0. (Project Management) The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ for scaling-up.	0-1. The number of Joint Coordinating Committee meetings conducted 0-2. The number of technical exchange events 0-3. Results of evaluation submitted to GHS-HQ	0-1. Project reports 0-2. Project reports 0-3. Project reports			
1. The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.	1-1. The number of CHOs who are trained and deployed at CHPS 1-2. The number of FSVs implemented as planned at each level RHMT→DHMT (UWR: twice/yr, NR & UER: 4 times/yr) DHMT→SDHT (4 times/yr) SDHT→CHO (4 times/yr) 1-3. The number of issues identified and the number of issues solved through FSV	1-1. Project reports 1-2. FSV reports 1-3. FSV reports			
2. Community activities of CHPS are strengthened.	2-1. Number of active CHMCs for Community activities 2-2. Proportion of CHAPs developed and implemented 2-3. Proportion of pregnant women receiving first trimester ANC, Skilled Delivery, PNC within 23 hours	2-1. FSV reports/ CHPS Database/ DHIMS2 2-2. FSV reports/ CHPS Database/ DHIMS2 2-3. FSV reports/ CHPS Database/ DHIMS1			

3. Governance of CHPS by local government and stakeholders is strengthened.	3-1. Number of health integrated annual plans of DAs including CHPS implementation	3-1. Annual Plans of DAs/ Signed agreements			
4. Life-course approach is addressed in the minimum package of CHPS	4-1. Evidence of district action plan implemented 4-2. Evidence of feedback to GHS-HQ	4-1. Project Report/ Annual Performance Review Report 4-2. Project Report/ Annual Performance Review Report			

Activities	**Inputs**		**Important Assumption**
Project Management	**The Japanese Side**	**The Ghanaian Side**	
0-1. Conduct baseline survey 0-2. Monitor the progress and review the effectiveness of CHPS implementation periodically 0-3. Conduct field visit for technical exchange among regions and GHS-HQ 0-4. Inform MoH/GHS-HQ and modify the project approach (strategy) when necessary 0-5. Conduct end-line survey 0-6. Compile evaluation report reviewed by MoH/GHS-HQ and disseminate it nationwide	1. Experts: Chief Advisor Project Coordinator/Training Management Experts on Community Health, Helath Promotion/IEC, Nutrition, NCD, Ageing, Health Financing 2. Training in Japan 3. Equipment Basic medical equipment Training equipment Vehicles	1. Counterparts • GHS-HQ • Regional health directorate of UWR, UER, NR • District health directorate of UWR, UER, NR • Sub district health teams of UWR, UER, NR • Community Health Officers of UWR, UER, NR • Regional/district hospitals of UWR, UER, NR	1. CHPS Policy remains to be a main health policy within Ghana. 2. The macroeconomy of the country does not get extremely worse compared to the current state. 3. Epidemiological outbreak does not occur unexpectedly. 4. Socio-political stability is ensured. 5. Decentralization is smoothly implemented without

1-1. Develop assessment tool (e.g. score card) by utilizing available tools to review progress of CHPS implementation 1-2. Assess and score the current progress of CHPS implementation 1-3. Plan trainings for CHOs, SDHT and DHMT, referral and FSV 1-4. Modify the training materials 1-5. Assign/train the trainers for trainings 1-6. Conduct the trainings 1-7. Conduct follow-up of the trainings 1-8. Conduct standardized FSV regularly (RHMT→DHMT, DHMT→SDHT, SDHT→CHPS) 1-9. Conduct quarterly DHMT review meetings, and share reports among stakeholders 1-10. Plan and conduct intra/extra joint learning among target districts/regions (e.g. develop videos of good practices) 1-11. Standardize training materials to be shared for national scaling-up 2-1. Develop standardized community level data capturing tools 2-2. Assess and score current community health activities by the community 2-3. Plan and conduct CHO's community outreach and home visit 2-4. Plan and implement community engagement activities with the support of SDHT, DHMT and DA 2-5. Modify/produce training materials for CHMC/CHV 2-6. Conduct training for CHMC/CHV 2-7. Implement community health activities by the community (e.g. referral system using CETS) 2-8. Create sustainable non-monetary incentive mechanism for the CHO/CHV and community 2-9. Plan and conduct intra/extra joint learning among target districts/regions 2-10. Review/standardize/develop training materials to be shared for national scaling-up	Office equipment 4. Budget for operation	2. Office Spaces 3. Others Budget for operation Utility fees	interrupting the health system. Pre-Conditions 1. Capable local consultants are available for project implementation 2. All stakeholders of the project (MOH, GHS-HQ, Regional, district, subdistrict and community level) agree on the design of the project and cooperate together. ⬇ <Issues and countermeasures>

3-1. Assess and score the current level of governance of CHPS by DA and stakeholders				
3-2. RCC, RHMT, DA, DHMT and stakeholders conduct a joint stakeholder meeting and discuss on CHPS planning (HRH, equipment, logistics), budgeting and monitoring.				
3-3. DHMT and DA develop health integrated annual plans including CHPS implementation				
3-4. Plan and conduct intra/extra joint learning among target districts/regions				
4-1. Review the current CHPS services focusing on life-course approach between the GHS-HQ and three northern Regions				
4-2. Three northern Regions propose to GHS-HQ "minimum package of services focusing on life-course approach at community level (minimum package)" based on the review of 4.1				
4-3. Plan minimum package between GHS-HQ and Upper West Region				
4-4. Develop regional action plan for minimum package at Upper West Region				
4-5. Integrate life-course approach into the trainings and currently used training materials for CHPS implementation at Upper West Region				
4-6. Life-course approach team develops action plan for minimum package at Upper West Region				
4-7. Life-course approach team conducts and monitors district action plan for minimum package at Upper West Region				
4-8. Share the results of the action plan among GHS-HQ and three northern Regions				

Note: A life-course approach to health stresses the importance of all ages and stages of life, and sets goals of investment in health capital through health promotion and prevention ("A life Course Approach to Health", WHO, 2000).

Appendix 1-2 : PDM Version 1

Project Design Matrix Ver 1 (Approved 28 November, 2017)

Project Title: Strengthening community-based health services focusing on the life-course approach in the Upper West, Upper East and Northern Regions

Implementing Agency: Ghana Health Service (GHS)

Beneficiaries: People of all ages in the Upper West, Upper East and Northern Regions

Target Group: CHOs and other health staff in the Upper West, Upper East and Northern Regions

Period of Project: 2017 - 2022 (5 years)

Project Site: Output 1-3: Upper West, Upper East and Northern Regions* (*: selected districts in Northern Region), Output 4: Upper West Region

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumption	Achievement	Remarks
Overall Goal Universal health coverage is promoted by improving access and utilization of primary health care through Community-based Health Planning and Services (CHPS) in Upper West, Upper East and Northern Regions	Coverage of the population in the functional CHPS zones of three northern regions is reached by the end of 2022 as follows UWR XX% UER XX% NR XX%	CHPS database and other CHPS data collection systems used by UE and NR			
Project purpose Community-based health services focusing on the life-course approach are strengthened in Upper West, Upper East and Northern Regions	1. The percentage of people who have access to functional CHPS UWR XX% (2016) → XX% (2021) UER XX% (2016) → XX% (2021) NR XX% (2016) → XX% (2021) 2. The level (score) of CHPS implementation is increased by XX% UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) 3. The level (score) of CHPS implementation with life course approach in UWR is increased by XX% UWR XX% (2017) → XX% (2021)	CHPS database CHPS database To be determined	A financially sustainable mechanism is established to operate CHPS		

Outputs					
0. (Project Management) The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ for scaling-up.	0-1 Joint Coordinating Committee meeting is conducted for at least once per year. 0-2. The number of technical exchange events achieved to XX times during the whole project period. 0-3 GHS-HQ receives monitoring sheet (twice per fiscal) and progress reports (as determined in R/D).	Monitoring Sheet Monitoring Sheet Monitoring Sheet			
1. The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.	1-1 Number of trained beneficiaries is increased to following targets by the end of the project. Community Health Nurse: XX Enrolled Nurse: XX Midwives: XX Nurse Assistant Clinical Students: XX Nurse Assistant Preventive Students: XX 1-2 Number of trained CHOs in the functional CHPS zones is increased to XX 1-3 The numbers of implemented FSVs maintain following frequencies over the project period. RHMT -> DHMT (**2** times / year) DHMT->SDHT (4 times / year) SDHT -> CHO (4 times / year) 1-4 FSV score is increased as follows. RHMT -> DHMT (XX%) DHMT->SDHT (XX%) SDHT -> CHO (XX%)	CHPS database CHPS database FSV database/ Hard copies of monitoring tools FSV database/ FSV Performance Standard			

2. Community activities of CHPS are strengthened.	2-1 The number of active CHMCs for community activities is increased to XX. 2-2 The proportion of CHPS zone with at least one CHAP is increased to XX%. 2-3 Proportion of active CHAPs is increased to XX% 2-4 Proportion of pregnant women receiving first trimester ANC, Skilled delivery, PNC within **48** hours is increased to XX%.	FSV reports/ CHPS database/ DHIMS 2 DHIMS 2 CHPS database/ DHIMS 2 DHIMS 2			
3. Governance of CHPS by local government and stakeholders is strengthened.	3-1 Number of districts with health integrated annual plans developed and costed is increased to XX. 3-2 Proportion of projects/activities implemented in the health integrated annual plans is increased to XX%.	Health Integrated Annual Plan Health Integrated Annual Plan			
4. Life-course approach is addressed in the minimum package of CHPS	4-1The minimum package of services under the LCA is developed and implemented. 4-2 The life course approach is integrated into the revised CHPS training materials. 4-3 Proportion of community activities for life course approach is increased to XX%.	Project documents or materials developed by the project CHPS training materials Annual Performance Review Report			

Activities			Important Assumption	
Project Management 0-1. Conduct baseline survey 0-2. Monitor the progress and review the effectiveness of CHPS implementation periodically 0-3. Conduct field visit for technical exchange among regions and GHS-HQ 0-4. Inform MoH/GHS-HQ and modify the project approach (strategy) when necessary 0-5. Conduct end-line survey 0-6. Compile evaluation report reviewed by MoH/GHS-HQ and disseminate it nationwide 1-1. Develop assessment tool (e.g. score card) by utilizing available tools to review progress of CHPS implementation 1-2. Assess and score the current progress of CHPS implementation 1-3. Plan trainings for CHOs, SDHT and DHMT, referral and FSV 1-4. Modify the training materials 1-5. Assign/train the trainers for trainings 1-6. Conduct the trainings 1-7. Conduct follow-up of the trainings 1-8. Conduct standardized FSV regularly (RHMT→DHMT, DHMT→SDHT, SDHT→CHPS) 1-9. Conduct quarterly DHMT review meetings, and share reports among stakeholders 1-10. Plan and conduct intra/extra joint learning among target districts/regions (e.g. develop videos of good practices) 1-11. Standardize training materials to be shared for national scaling-up 2-1. Develop standardized community level data capturing tools 2-2. Assess and score current community health activities by the community 2-3. Plan and conduct CHO's community outreach and home visit 2-4. Plan and implement community engagement activities with the support of SDHT, DHMT and DA 2-5. Modify/produce training materials for CHMC/CHV 2-6. Conduct training for CHMC/CHV 2-7. Implement community health activities by the community (e.g. referral system using CETS) 2-8. Create sustainable non-monetary incentive mechanism for the CHO/CHV and community 2-9. Plan and conduct intra/extra joint learning among target districts/regions 2-10. Review/standardize/develop training materials to be shared for national scaling-up			1. CHPS Policy remains to be a main health policy within Ghana. 2. The macroeconomy of the country does not get extremely worse compared to the current state. 3. Epidemiological outbreak does not occur unexpectedly. 4. Socio-political stability is ensured. 5. Decentralization is smoothly implemented without interrupting the health system. Pre-Conditions 1. Capable local consultants are available for project implementation 2. All stakeholders of the project (MOH, GHS-HQ, Regional, district, subdistrict and community level) agree on the design of the project and cooperate together. ▼ <Issues and countermeasures>	

3-1. Assess and score the current level of governance of CHPS by DA and stakeholders 3-2. RCC, RHMT, DA, DHMT and stakeholders conduct a joint stakeholder meeting and discuss on CHPS planning (HRH, equipment, logistics), budgeting and monitoring. 3-3. DHMT and DA develop health integrated annual plans including CHPS implementation 3-4. Plan and conduct intra/extra joint learning among target districts/regions 4-1. Review the current CHPS services focusing on life-course approach between the GHS-HQ and three northern Regions 4-2. Three northern Regions propose to GHS-HQ "minimum package of services focusing on life-course approach at community level (minimum package)" based on the review of 4.1 4-3. Plan minimum package between GHS-HQ and Upper West Region 4-4. Develop regional action plan for minimum package at Upper West Region 4-5. Integrate life-course approach into the trainings and currently used training materials for CHPS implementation at Upper West Region 4-6. Life-course approach team develops action plan for minimum package at Upper West Region 4-7. Life-course approach team conducts and monitors district action plan for minimum package at Upper West Region 4-8. Share the results of the action plan among GHS-HQ and three northern Regions				

Note: A life-course approach to health stresses the importance of all ages and stages of life, and sets goals of investment in health capital through health promotion and prevention ("A life Course Approach to Health", WHO, 2000).

Appendix 1-3 : PDM Version 2

Project Design Matrix Ver 2 (Approved 10 May, 2019)
Project Title: Strengthening community-based health services focusing on the life-course approach
Implementing Agency: Ghana Health Service (GHS)
Beneficiaries: People of all ages **in the Upper West, Upper East, Northern, North East and Savannah Regions**
Target Group: CHOs and other health staff **in the Upper West, Upper East, Northern, North East and Savannah Regions.**
Period of Project: 2017 - 2022 (5 years)
Project Site: Output 1-3: **Upper West, Upper East , Northern, North East and Savannah Regions* (*: selected districts in Northern, North East and Savannah Regions), Output 4: Upper West Region**

Narrative Summary	Abjectively Verifiable Indicators	Means of verification	Important Assumption
Oveall goal			
Universal health coverage is promoted by improving access and utilization of primary health care through Community-based Health Planning and Services (CHPS)	Coverage of the population in the functional CHPS zones of northern regions is reached by the end of 2025 as follows UWR XX% UER XX% NR XX% NER XX% SR XX%	CHPS database	
Project Purpose			
Community-based health services focusing on the life-course approach are strengthened	1. The percentage of people who have access to functional CHPS UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) NER XX% (2017) → XX% (2021) SR XX% (2017) → XX% (2021)	CHPS database	A financially sustainable mechanism is established to operate CHPS
	2. The level of CHPS implementation is increased. 2-1.Coverage of CHPS zone with assigned staff per total population UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) NER XX% (2017) → XX% (2021) SR XX% (2017) → XX% (2021) 2-2 Coverage of functional CHPS zone per total population UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) NER XX% (2017) → XX% (2021) SR XX% (2017) → XX% (2021)	CHPS database	
	3. The level of CHPS implementation with life course approach in UWR is increased . 3-1. Proportion of functional CHPS zones which provide LCA related services. UWR XX% (2019) → XX% (2021) 3-2. The minimum package of services focusing on the LCA is developed and proposed as national standard.	3-1. LCA activity record 3-2. CHPS National Implementation Guidelines	

Output			
0. (Project Management) The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ for scaling-up.	0-1 Joint Coordinating Committee meeting is conducted for at least once per year.	Minutes of Meeting	
	0-2. The number of technical exchange events conducted during the whole project period.	Activity report	
	0-3 GHS-HQ receives monitoring sheet (twice per fiscal) and progress reports (as determined in R/D).	Monitoring Sheet	
1. The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.	1-1 Number of trained beneficiaries is increased to following targets by the end of the project. 1) Beneficiaries of Harmonized CHO Training Community Health Nurse: XX Enrolled Nurse: XX Midwives: XX 2) Beneficiaries of pre-service training Nurse Assistant Clinical students: XX Nurse Assistant Preventive students: XX Midwifery Training School students: XX Registered Community Health Nurse: XX	Training report	
	1-2 Number of CHOs trained through "Harmonized CHO Training" is increased. UWR XX (2017) → XX (2021) UER XX (2017) → XX (2021) NR XX (2017) → XX (2021) NER XX (2017) → XX (2021) SR XX(2017) → XX (2021)	Training report	
	1-3 Referral system is strengthened 1) Number of beneficiaries of referral training 2)Number of Referral from CHPS zone done according to the protocol 3) Number of Feedbacks sent back to CHPS zones according to the protocol. UWR 0 (2017) → XX (2021) UER 0 (2017) → XX (2021) NR 0 (2017) → XX (2021) NER 0 (2017) → XX (2021)	1) Developed Training Materials 2) Training report 3)Referral register Referral forms Feedback forms	
	1-4 Monitoring system are strengthened. XX Region (2017) → XX regions (2021) 1) Number of Beneficiaries of FSV/SSV training XX Region: XX (2017) →XX (2021) 2) The number of implemented FSV/SSV maintaining the frequencies according to the guidelines over the project period. XX region. XX% (2017)→XX% (2021) 3) DHMT FSV/SSV review meeting is implemented quarterly XX Region: XX% (2017)→ XX% (2021)	1)Training report 2) Regional data(FSV/SV record) 3) Minutes of meeting	
	1-5 CHPS database system are established at least five regions and disseminated nationally. Number of regions in which CHPS database is established.	CHPS database	

2. Community activities of CHPS are strengthened.	2-1 The number of active CHMCs for community activities is increased . UWR XX (2017) → XX (2021) UER XX(2017) → XX (2021) NR XX (2017) → XX (2021) NER XX (2017) → XX (2021) SR XX (2017) → XX (2021)	CHPS database	
	2-2. Proportion of CHPS zones wih CHAP updated quarterly is increased. UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) NER XX% (2017) → XX% (2021) SR XX% (2017) → XX% (2021)	CHPS database	
	2-3. proportion of CHPS zones with CHAP updated quarterly on Life Course Approach (LCA) activities is increased. UWR XX% (2017) → XX% (2021)	CHPS database	
3. Governance of CHPS by local government and stakeholders is strengthened.	3-1 Proporation of districts with health integrated annual action plans developed and costed is increased. UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX %(2017) → XX %(2021) NER XX% (2017) → XX %(2021)	Health Integrated Annual Action Plan (Action Plan Format)	
	3-2 Proportion of districts in which Regional Planning Coordinating Unit (RPCU) and District Planning Coordinating Unit (DPCU) monitor implementation of health integrated annual action plans in 3-1 on a quarterly base (four times a year) is increased. UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX %(2017) → XX %(2021) NER XX% (2017) → XX %(2021)	Health Integrated Annual Action Plan (Monitoring Format)	
	3-3 Proportion of activities implemented in the health integrated annual plans is increased. UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX %(2017) → XX %(2021) NER XX% (2017) → XX %(2021)	Health Integrated Annual Action Plan (Assessment Format)	

4. Life-course approach is addressed in the minimum package of CHPS	4-1. The minimum package of services focusing on the LCA is developed.	Materials developed by the project.	
	4-2 The life course approach is integrated into the training on CHPS services.	CHO/SDHT training	
	4-3. Health service delivery focusing on the LCA is strengthened at CHPS level. 1) Training materials developed 2) Number of beneficiaries of LCA training for SDHT and CHO in UWR, CHO XX, SDHT staff XX 3)% of pregnant women who received nutrition counselling. 4)% of mothers with < 5 children who received nutrition counselling. 5) Percentage of CHPS zones providing adolesent friendly services. 6) % of CHO who used the healthy lifestyle assessment questionnaire for school-aged children, adolescent, adults and aged in the past one month.	1) Developed training materials 2) Training report 3),4) Record of MCHRB 5),6) LCA Activity record	
	4-4 Proportion of pregnant women receiving first trimester ANC, Skilled delivery, PNC within 48 hours is increased to XX% in UWR. 1) % of pregnant women receiving first trimester ANC 2) % of pregnant women making at least 4 ANC visits. 3) % skilled delivery 4) % of women who received postnatal care from health personnel within 48 hours since delivery UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) NER XX %(2017) → XX% (2021) SR XX % (2017) → XX% (2021)	DHIMS 2	

Activities			Important Assumption
0-1. Conduct baseline survey			1. CHPS Policy remains to be a main health policy within Ghana. 2. The macroeconomy of the country does not get extremely worse compared to the current state. 3. Epidemiological outbreak does not occur unexpectedly. 4. Socio-political stability is ensured. 5. Decentralization is smoothly implemented without interrupting the health system.
0-2. Monitor the progress and review the effectiveness of CHPS implementation periodically			
0-3. Conduct field visit for technical exchange among regions and GHS-HQ			
0-4. Inform MoH/GHS-HQ and modify the project approach (strategy) when necessary			
0-5. Conduct end-line survey			
0-6. Compile evaluation report reviewed by MoH/GHS-HQ and disseminate it nationwide			
1-1. Establish CHPS database system to assess progress of CHPS implementation			
1-2 Assess the current progress of CHPS implementation			
1-3. Plan trainings for CHOs, SDHT and DHMT, referral and FSV			Pre-Conditions
1-4. Modify the training materials			1. Capable local consultants are available for project implementation 2. All stakeholders of the project (MOH, GHS-HQ, Regional, district, subdistrict and community level) agree on the design of the project and cooperate together.
1-5. Assign/train the trainers for trainings			
1-6. Conduct the trainings			
1-7. Conduct follow-up of the trainings			
1-8. Support standardized supervision regularly			
1-9. Plan and conduct intra/extra joint learning among target districts/regions (e.g. develop videos of good practices)			
1-10. Standardize training materials to be shared for national scaling-up			
2-1. Develop standardized community level data capturing tools			
2-2. Assess and score current community health activities by the community			
2-3. Plan and conduct CHO's community outreach and home visit			<Issues and countermeasures>
2-4. Plan and implement community engagement activities with the support of SDHT, DHMT and DA			
2-5. Modify/produce training materials for CHMC/CHV			
2-6. Conduct training for CHMC/CHV			
2-7. Implement community health activities by the community (e.g. referral system using CETS)			
2-8. Create sustainable non-monetary incentive mechanism for the CHO/CHV and community			
2-9. Plan and conduct intra/extra joint learning among target districts/regions			
2-10. Review/standardize/develop training materials to be shared for national scaling-up			
3-1. Assess and score the current level of governance of CHPS by DA and stakeholders			
3-2. RCC, RHMT, DA, DHMT and stakeholders conduct a joint stakeholder meeting and discuss on CHPS planning (HRH, equipment, logistics), budgeting and monitoring.			
3-3. DHMT and DA develop health integrated annual action plans with budgets for implementation			
3-4. DHMT and DA monitor health integrated annual action plans developed in Activity 3-3.			
3-5. Plan and conduct intra/inter joint learning among target districts/regions			
4-1. Define the concept of LCA in CHPS implementation in Ghana			
4-2. Review the current CHPS services focusing on life-course approach between the GHS-HQ and northern regions			
4-3. Develop the CHO/SDHT and CHMC/CHV training materials in UWR			
4-4. Build the capacity of CHO/SDHT and CHMC/CHV on the LCA in UWR			
4-5. Integrate life-course approach into the trainings and currently used training materials for CHPS implementation at Upper West Region			
4-6. Life-course approach team develops action plan for minimum package at Upper West Region			
4-7. Life-course approach team conducts and monitors district action plan for minimum package at Upper West Region			
4-8. Share the results of the action plan among GHS-HQ and northern Regions			

Appendix 1-4 : PDM Version 3

Overall goal, Project Purpose **Version 3**

Project Design Matrix Ver 3(Approved 8 July, 2021)

Project Title: Strengthening community-based health services focusing on the life-course approach

Implementing Agency: Ghana Health Service (GHS)

Beneficiaries: People of all ages **in the Upper West, Upper East, Northern, North East and Savannah Regions**

Target Group: CHOs and other health staff **in the Upper West, Upper East, Northern, North East and Savannah Regions.**

Period of Project: 2017 - 2023 (6 years)

Project Site: Output 1-3: **Upper West, Upper East , Northern, North East and Savannah Regions* (*: selected districts in Northern, North East and Savannah Regions), Output 4: Upper West Region**

Narrative Summary	Abjectively Verifiable Indicators	Means of verification	Important Assumption
Oveall goal			
Universal health coverage is promoted by improving access and utilization of primary health care through Community-based Health Planning and Services (CHPS)	Coverage of the population in the functional CHPS zones of northern regions is reached by the end of 2026 as follows UWR: 100 % UER: 100 % NR:75 % NER: 100 % SR: 100 %	CHPS database	
Project Purpose			
Community-based health services focusing on the life-course approach are strengthened	1. The percentage of people who have access to functional CHPS UWR: 55.2% (2017) →100 % (2023) UER: 31.1% (2017) →100 % (2023) NR: 9.6% (2017) → 60 % (2023) NER: NA (2017) → 75 % (2023) SR : NA (2017) → 80 % (2023)	CHPS database	A financially sustainable mechanism is established to operate CHPS
	2-1.Coverage of CHPS zone with assigned staff per total population UWR: 60.8% (2017) → 100 % (2023) UER: 61.9% (2017) → 100 % (2023) NR: 75.7% (2017) → 100% (2023) NER: NA (2017) → 100 % (2023) SR: NA (2017) → 100 % (2023) 2-2. Coverage of functional CHPS zone per total population UWR: 55.2% (2017) → 100 % (2023) UER: 31.1% (2017) →100 % (2023) NR: 9.6% (2017) → 60 % (2023) NER: NA (2017) → 75 % (2023) SR: NA (2017) → 80 % (2023)	CHPS database	

	3. The level of CHPS implementation with life-course approach in UWR is increased. 3-1. The proportion of functional CHPS zones which provide LCA related services. (1) The number of staff trained on the LCA training package to provide LCA related services is increased. CHO 0→ 192, SDHT：0→48 (2) The percentage of CHPS zones which conduct health screening in all schools in CHPS zone at least once a year in the last 1 year. NA (2019)→40 % (2023) (3) The percentage of CHPS zone which conduct health screening in all communities at least once a year in the last 1 year. NA (2019)→40 % (2023) (4) The percentage of CHO who appropriately record the result and followed up in the LCA register in the last 1 year - Accuracy of calculation of BMI - Accuracy of classification of dada BMI,BS,BP,WC - Appropriate follow up NA (2019)→100 % (2023) 3-2. The minimum package of services focusing on the LCA is developed and proposed as national standard. (1) LCA training package is developed and submitted to GHS. (2) LCA training materials are integrated into pre-service training (3) LCA training materials are integrated into district CHO orientation field guide.	3-1. LCA training report, LCA register 3-2. CHPS National Implementation Guidelines, Pre-service training materials, District CHO Orientation Filed Guide	

Output			
0. (Project Management) The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ for scaling-up.	0-1 Joint Coordinating Committee meeting is conducted for at least once per year.	Minutes of Meeting	
	0-2. The number of technical exchange events conducted during the whole project period.	Activity report	
	0-3 GHS-HQ receives monitoring sheet (twice per fiscal) and progress reports (as determined in R/D).	Monitoring Sheet	
1. The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.	1-1. The number of trained beneficiaries is increased. 1) Beneficiaries of Harmonized CHO Training Community Health Nurse: 2) Beneficiaries of pre-service training Nurse Assistant Clinical students: Nurse Assistant Preventive students: Midwifery Training School students: Tutors:	Training report	
	1-2. Beneficiaries of district CHO orientation (1) The number of districts which conduct district CHO Orientation at least once. UWR 0 (2017) → 11 (2023) UER 0 (2017) → 15 (2023) NR 0 (2017) → 16(2023) NER 0 (2017) → 6 (2023) SR 0 (2017) → 7 (2023) (2).The number of CHO trained through district CHO Orientation. UWR 0 (2017) → 102 (2023) UER 0 (2017) → 186 (2023) NR 0 (2017) → 112(2023) NER 0 (2017) → 60 (2023) SR 0 (2017) → 70 (2023)	Training report	

	1-3. Referral system is strengthened in pilot districts 1) The number of health facilities whose staff were trained on referral protocols: UER: 0 (2017) → 355 (2023) NR/NER: 0 (2017) → 65 (2023) UWR: 0 (2017) → 376 (2023) 2) The number of referrals from CHPS zones done according to the protocol/guidelines N/A (2017) → 75% (2023) 3) The number of feedbacks sent to CHPS zones is increased. N/A (2017) → 60% (2023)	1) Developed Training Materials 2) Training report 3)Referral register Referral forms Feedback forms	
	1-4. Monitoring system is strengthened in target districts. 1) Harmonized SS training materials and tools for CHPS supervision is developed, introduced and incorporated into national SS program. 2) The average implementation rate of SS from SDHTs to CHPS. UWR: 0(2017) → 80 % (2023) UER: 0(2017) → 80 % (2023) NR/NER: 0(2017) → 75 % (2023) 3) The standardized reference guide for District Health Quarterly Performance Review Meeting is developed and introduced to all districts of the project target regions. 4) All districts conduct District Health Quarterly Performance Review Meeting with the standardized reference guide at least twice per year over the project period.	1)Training report 2) Regional data(FSV/SV record) 3) Minutes of meeting	
	1-5. CHPS database system is established at least in five regions and disseminated nationally. ・The Nnumber of regions in which CHPS database is established. 1 (2017)→16 (2023)	CHPS database	

2. Community activities of CHPS are strengthened.	2-1. The number of active CHMCs for community activities is increased . UWR: 183 (2017)→ 496 (2023) UER: 147 (2017)→ 523 (2023) NR: 127(2017)→ 322 (2023) NER: NA (2017)→ 116 (2023) SR: NA (2017)→ 140 (2023)	CHPS database	
	2-2. The proportion of CHPS zones with CHAP updated quarterly is increased. UWR: 56.7% (2017)→100% (2023) UER: 36.2% (2017)→100% (2023) NR: 19.8% (2017)→ 60% (2023) NER: NA (2017)→ 75% (2023) SR: NA (2017)→ 80% (2023)	CHPS database	
	2-3. The proportion of CHPS zones with CHAP updated quarterly on Life Course Approach (LCA) activities is increased in UWR. UWR: 0%(2017)→ 40% (2023)	CHPS database	
3. Governance of CHPS by local government and stakeholders is strengthened.	3-1. The proportion of districts with health integrated annual action plans developed and costed is increased. UWR 0% (2017) → 100 % (2023) UER 0% (2017) → 100 % (2023) NR 0 %(2017) → 100 % (2023) NER 0% (2017) → 100 % (2023) SR 0% (2017) → 100 % (2023)	Health Integrated Annual Action Plan (Action Plan Format)	
	3-2. The proportion of districts in which Regional Planning Coordinating Unit (RPCU) and District Planning Coordinating Unit (DPCU) monitor implementation of health integrated annual action plans in 3-1 on a quarterly bases (four times a year) is increased. UWR 45% (2017) → 70 % (2023) UER NA (2017) → 80 % (2023) NR NA(2017) → 85 % (2023) NER NA (2017) → 100 % (2023) SR NA (2017) → 100 % (2023)	Health Integrated Annual Action Plan (Monitoring Format)	
	3-3. The proportion of activities implemented in the health integrated annual plans is increased. UWR 0% (2017) → 50 % (2023) UER NA (2017) → 50 % (2023) NR NA(2017) → 65 % (2023) NER NA (2017) → 60 % (2023) SR NA (2017) → 60 % (2023)	Health Integrated Annual Action Plan (Assessment Format)	

4. Life-course approach is addressed in the minimum package of CHPS	4-1. The minimum package of services focusing on the LCA is developed.	Materials developed by the project.	
	4-2 The life course approach is integrated into the training on CHPS services.	CHO/SDHT training	
	4-3. Health service delivery focusing on the LCA is strengthened at CHPS level. (1) The number of staff trained on the LCA training package to provide LCA related services is increased; CHO 0→192, SDHT：0→ 48 (2) The percentage of CHPS zones which conduct health screening in all schools in CHPS zone at least once a year in the last 1 year. NA (2019)→ 40 % (2023) (3) The percentage of CHPS zone which conduct health screening in all communities at least once a year in the last 1 year. NA (2019)→ 40 % (2023) (4) The percentage of CHO who appropriately record the result and followed up in the LCA register in the last 1 year - Accuracy of calculation of BMI - Accuracy of classification of dada BMI,BS,BP,WC - Appropriate follow up. NA (2019)→100 % (2023)	1) Developed training materials 2) Training report 3),4) Record of MCHRB 5),6) LCA Activity record	
	4-4. The proportion of pregnant women receiving first trimester ANC, Skilled delivery, PNC within 48 hours is increased to XX% in all regions. 1) % of pregnant women receiving first trimester ANC UWR: 62.3 % (2017) → 85 % (2023) UER: 51.1 % (2017) → 75 % (2023) NR: 36.9 % (2017) → 85 % (2023) NER: NA (2017) → 50 % (2023) SR: NA (2017) → 85 % (2023) 2) % of pregnant women making at least 4 ANC visits. UWR: 85.6 % (2017) → 90 % (2023) UER: 82.3 % (2017) → 85 % (2023) NR: 68.5 % (2017) → 80 % (2023) NER: NA (2017) → 80 % (2023) SR: NA (2017)→ 85 % (2023) 3) % skilled delivery UWR: 68.7 % (2017) → 80 % (2023) UER: 69.8 % (2017) → 60 %(2023) NR: 64.5 % (2017) → 90 % (2023) NER: NA (2017) → 85 % (2023) SR: NA (2017) → 75 % (2023) 4) % of women who received postnatal care from health personnel within 48 hours since delivery UWR: 93.9 % (2017) → 100 % (2023) UER: 97.0 % (2017) → 100 % (2023) NR: 57.9 % (2017) → 95 % (2023) NER: NA (2017) → 80 % (2023) SR NA (2017) → 85 % (2023)	DHIMS 2	

Activities			Important Assumption
0-1. Conduct baseline survey			1. CHPS Policy remains to be a main health policy within Ghana. 2. The macroeconomy of the country does not get extremely worse compared to the current state. 3. Epidemiological outbreak does not occur unexpectedly. 4. Socio-political stability is ensured. 5. Decentralization is smoothly implemented without interrupting the health system.
0-2. Monitor the progress and review the effectiveness of CHPS implementation periodically			
0-3. Conduct field visit for technical exchange among regions and GHS-HQ			
0-4. Inform MoH/GHS-HQ and modify the project approach (strategy) when necessary			
0-5. Conduct end-line survey			
0-6. Compile evaluation report reviewed by MoH/GHS-HQ and disseminate it nationwide			
1-1. Establish CHPS database system to assess progress of CHPS implementation			
1-2 Assess the current progress of CHPS implementation			
1-3. Plan trainings for CHOs, SDHT and DHMT, referral and SS			Pre-Conditions
1-4. Modify the training materials			1. Capable local consultants are available for project implementation 2. All stakeholders of the project (MOH, GHS-HQ, Regional, district, subdistrict and community level) agree on the design of the project and cooperate together.
1-5. Assign/train the trainers for trainings			
1-6. Conduct the trainings			
1-7. Conduct follow-up of the trainings			
1-8. Support standardized supervision regularly			
1-9. Plan and conduct intra/extra joint learning among target districts/regions (e.g. develop videos of			
1-10. Standardize training materials to be shared for national scaling-up			
2-1. Develop standardized community level data capturing tools			
2-2. Assess and score current community health activities by the community			
2-3. Plan and conduct CHO's community outreach and home visit			<Issues and countermeasures>
2-4. Plan and implement community engagement activities with the support of SDHT, DHMT and DA			
2-5. Modify/produce training materials for CHMC/CHV			
2-6. Conduct training for CHMC/CHV			
2-7. Implement community health activities by the community (e.g. referral system using CETS)			
2-8. Create sustainable non-monetary incentive mechanism for the CHO/CHV and community			
2-9. Plan and conduct intra/extra joint learning among target districts/regions			
2-10. Review/standardize/develop training materials to be shared for national scaling-up			
3-1. Assess and score the current level of governance of CHPS by DA and stakeholders			
3-2. RCC, RHMT, DA, DHMT and stakeholders conduct a joint stakeholder meeting and discuss on CHPS planning (HRH, equipment, logistics), budgeting and monitoring.			
3-3. DHMT and DA develop health integrated annual action plans with budgets for implementation			
3-4. DHMT and DA monitor health integrated annual action plans developed in Activity 3-3.			
3-5. Plan and conduct intra/inter joint learning among target districts/regions			
4-1. Define the concept of LCA in CHPS implementation in Ghana			
4-2. Review the current CHPS services focusing on life-course approach between the GHS-HQ and			
4-3. Develop the CHO/SDHT and CHMC/CHV training materials in Upper West Region			
4-4. Build the capacity of CHO/SDHT and CHMC/CHV on the LCA in Upper West Region			
4-5. Integrate life-course approach into the trainings and currently used training materials for CHPS implementation at Upper West Region			
4-6. Life-course approach team develops action plan for minimum package at Upper West Region			
4-7. Life-course approach team conducts and monitors district action plan for minimum package at Upper			
4-8. Share the results of the action plan among GHS-HQ and northern regions			

Appendix 1-5 : PDM History of Changes

Project Design Matrix

Project Title: Strengthening community-based health services focusing on the life-course approach in the Upper West, Upper East and Northern Regions

	Ver 0	Ver 1	Ver 2	Ver 3
Date of change		**1st JCC on 28 November, 2017**	**2nd JCC on 10 May, 2019**	**6th JCC on 8th July, 2021**
Project Title	Strengthening community-based health services focusing on the life-course approach in the Upper West, Upper East and Northern Regions	Strengthening community-based health services focusing on the life-course approach in the Upper West, Upper East and Northern Regions	Strengthening community-based health services focusing on the life-course approach in the Upper West, Upper East and Northern Regions	Strengthening community-based health services focusing on the life-course approach in the Upper West, Upper East and Northern Regions
Implementing Agency	Ghana Health Service (GHS)	Ghana Health Service (GHS)	Ghana Health Service (GHS)	Ghana Health Service (GHS)
Beneficiaries	People of all ages in the Upper West, Upper East and Northern Regions	People of all ages in the Upper West, Upper East and Northern Regions	People of all ages in the Upper West, Upper East, Northern, North East and Savannah Regions	People of all ages in the Upper West, Upper East, Northern, North East and Savannah Regions
Target Group	CHOs and other health staff in the Upper West, Upper East and Northern Regions	CHOs and other health staff in the Upper West, Upper East and Northern Regions	CHOs and other health staff in the Upper West, Upper East, Northern, North East and Savannah Regions.	CHOs and other health staff in the Upper West, Upper East, Northern, North East and Savannah Regions.
Period of Project	2017 - 2022 (5 years)	2017 - 2022 (5 years)	2017 - 2022 (5 years)	2017 - 2026 (6 years)
Project Site	Output 1-3: Upper West, Upper East and Northern Regions* (*: selected districts in Northern Region), Output 4: Upper West Region	Output 1-3: Upper West, Upper East and Northern Regions* (*: selected districts in Northern Region), Output 4: Upper West Region	Output 1-3: Upper West, Upper East , Northern, North East and Savannah Regions* (* selected districts in Northern, North East and Savannah Regions), Output 4: Upper West Region	Output 1-3: Upper West, Upper East , Northern, North East and Savannah Regions* (* selected districts in Northern, North East and Savannah Regions), Output 4: Upper West Region
Overall goal	Universal health coverage is promoted by improving access and utilization of primary health care through Community-based Health Planning and Services (CHPS) in Upper West, Upper East and Northern Regions	Universal health coverage is promoted by improving access and utilization of primary health care through Community-based Health Planning and Services (CHPS) in Upper West, Upper East and Northern Regions	Universal health coverage is promoted by improving access and utilization of primary health care through Community-based Health Planning and Services (CHPS)	Universal health coverage is promoted by improving access and utilization of primary health care through Community-based Health Planning and Services (CHPS)
Objectively Verifiable Indicators	1. (By the end of 2025), more people within the 3 northern regions are covered by functional CHPS zones UWR XX% (2025) UER XX% (2025) NR XX% (2025)	Coverage of the population in the functional CHPS zones of three northern regions is reached by the end of 2025 as follows UWR XX% UER XX% NR XX%	Coverage of the population in the functional CHPS zones of northern regions is reached by the end of 2025 as follows UWR XX% UER XX% NR XX% NER XX% SR XX%	Coverage of the population in the functional CHPS zones of northern regions is reached by the end of 2026 as follows UWR: 100 % UER: 100 % NR:75 % NER: 100 % SR: 100 %
Means of Verification	1. Records from regional/district health directorates/Annual Performance Review Report	CHPS database and other CHPS data collection systems used by UE and NR	CHPS database	CHPS database
Project Purpose	Community-based health services focusing on the life-course approach are strengthened in Upper West, Upper East and Northern Regions	Community-based health services focusing on the life-course approach are strengthened in Upper West, Upper East and Northern Regions	Community-based health services focusing on the life-course approach are strengthened	Community-based health services focusing on the life-course approach are strengthened
Objectively Verifiable Indicators	1. The percentage of people who has access to functional CHPS UWR XX% (2016) → XX% (2021) UER XX% (2016) → XX% (2021) NR XX% (2016) → XX% (2021)	1. The percentage of people who have access to functional CHPS UWR XX% (2016) → XX% (2021) UER XX% (2016) → XX% (2021) NR XX% (2016) → XX% (2021)	1. The percentage of people who have access to functional CHPS is increased UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) NER XX% (2017) → XX% (2021) SR XX% (2017) → XX% (2021)	1. The percentage of people who have access to functional CHPS is increased UWR: 55.2% (2017) →100 % (2023) UER: 31.1% (2017) →100 % (2023) NR: 9.6% (2017) → 60 % (2023) NER: NA (2017) → 75 % (2023) SR : NA (2017) → 80 % (2023)
	2. The level (score) of CHPS implementation is increased by XX% UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021)	2. The level (score) of CHPS implementation is increased by XX% UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021)	2. The level of CHPS implementation is increased. 2-1.Coverage of CHPS zone with assigned staff per total population UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) NER XX% (2017) → XX% (2021) SR XX% (2017) → XX% (2021)	2. The level of CHPS implementation is increased. 2-1.Coverage of CHPS zone with assigned staff per total population UWR: 60.8% (2017) → 100 % (2023) UER: 61.9% (2017) → 100 % (2023) NR: 75.7% (2017) → 100% (2023) NER: NA (2017) → 100 % (2023) SR: NA (2017) → 100 % (2023)
	3. The level (score) of CHPS implementation with life course approach in UWR is increased by XX% UWR XX% (2017) → XX% (2021)	3. The level (score) of CHPS implementation with life course approach in UWR is increased by XX% UWR XX% (2017) → XX% (2021)	3. The level of CHPS implementation with life course approach in UWR is increased. 3-1. The proportion of functional CHPS zones which provide LCA related services. UWR XX% (2019) → XX% (2021)	3. The level of CHPS implementation with life-course approach in UWR is increased. 3-1. The proportion of functional CHPS zones which provide LCA related services. (1)The number of staff trained on the LCA training package to provide LCA related services is increased. CHO 0→192, SDHT：0→48 (2)The percentage of CHPS zones which conduct health screening in all schools in CHPS zone at least once a year in the last 1 year. NA (2019)→40 % (2023) (3)The percentage of CHPS zone which conduct health screening in all communities at least once a year in the last 1 year. NA (2019)→40 % (2023) (4)The percentage of CHO who appropriately record the result and followed up in the LCA register in the last 1 year - Accuracy of calculation of BMI - Accuracy of classification of dada BMI,BS,BP,WC - Appropriate follow up NA (2019)→100 % (2023)
			3-2. The minimum package of services focusing on the LCA is developed and proposed as national standard.	3-2. The minimum package of services focusing on the LCA is developed and proposed as national standard. (1) LCA training package is developed and submitted to GHS. (2) LCA training materials are integrated into pre-service training (3) LCA training materials are integrated into district CHO orientation field guide.
Means of Verification	1. Records from regional/district health directorates/Annual Performance Review Report	1. CHPS database and other CHPS data collection systems used by UE and NR	1. CHPS database	1. CHPS database
	2. Project Score Card	2. CHPS database	2. CHPS database	2. CHPS database
	3. Project Score Card	3. To be determined	3-1. LCA activity record	3-1. LCA training report, LCA register
			3-2. CHPS National Implementation Guidelines	3-2. CHPS National Implementation Guidelines, Pre-service training materials, District CHO Orientation Filed Guide

	Ver 0	Ver 1	Ver 2	Ver 3
Output				
Output 0	0. (Project Management) The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ for scaling-up.	0. (Project Management) The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ for scaling-up.	0. (Project Management) The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ for scaling-up.	0. (Project Management) The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ for scaling-up.
Objectively Verifiable Indicators	0-1. The number of Joint Coordinating Committee meetings conducted	0-1 Joint Coordinating Committee meeting is conducted for at least once per year.	0-1 Joint Coordinating Committee meeting is conducted for at least once per year.	0-1 Joint Coordinating Committee meeting is conducted for at least once per year.
	0-2. The number of technical exchange events	0-2. The number of technical exchange events achieved to XX times during the whole project period.	0-2. The number of technical exchange events conducted during the whole project period.	0-2. The number of technical exchange events conducted during the whole project period.
	0-3. Results of evaluation submitted to GHS-HQ	0-3 GHS-HQ receives monitoring sheet (twice per fiscal) and progress reports (as determined in R/D).	0-3 GHS-HQ receives monitoring sheet (twice per fiscal year) and progress reports (as determined in R/D).	0-3 GHS-HQ receives monitoring sheet (twice per fiscal) and progress reports (as determined in R/D).
Means of Verification	0-1. Project reports	0-1. Monitoring Sheet	0-1. Minutes of Meeting	0-1. Minutes of Meeting
	0-2. Project reports	0-2. Monitoring Sheet	0-2. Activity report	0-2. Activity report
	0-3. Project reports	0-3. Monitoring Sheet	0-3. Monitoring Sheet	0-3. Monitoring Sheet

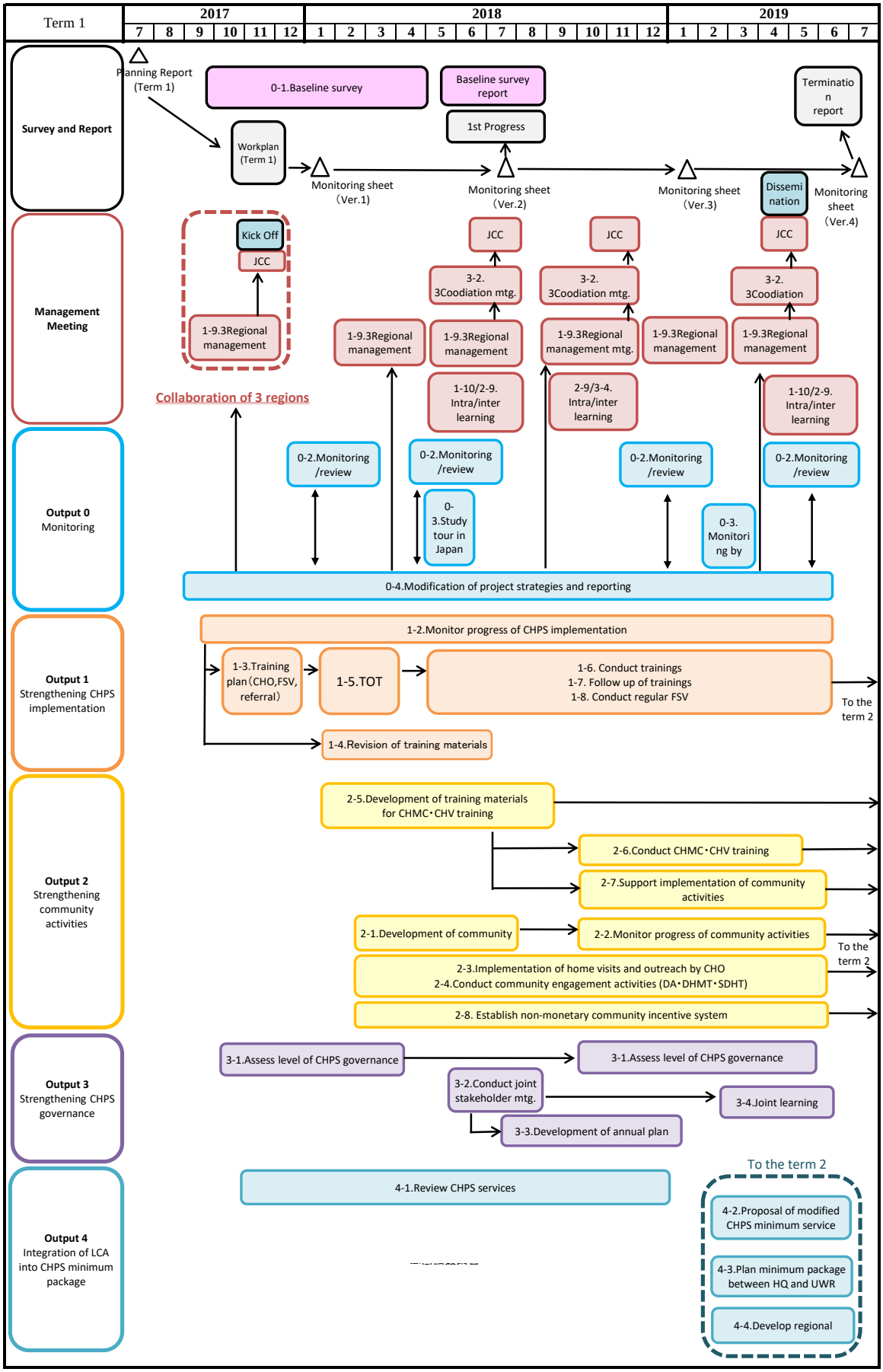
	Ver 0	Ver 1	Ver 2	Ver 3
Output 1	1. The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.	1. The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.	1.The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.	1.The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.
		1-5 CHPS database system are established at least five regions and disseminated nationally. Number of regions in which CHPS database is established.	1-5 CHPS database system are established at least five regions and disseminated nationally. Number of regions in which CHPS database is established.	1-5 CHPS database system are established at least five regions and disseminated nationally. Number of regions in which CHPS database is established.
Objectively Verifiable Indicators	1-1. The number of CHOs who are trained and deployed at CHPS	1-1 Number of trained beneficiaries is increased to following targets by the end of the project. Community Health Nurse: XX Enrolled Nurse: XX Midwives: XX Nurse Assistant Clinical Students: XX Nurse Assistant Preventive Students: XX	1-1 Number of trained beneficiaries is increased to the following targets by the end of the project. 1) Beneficiaries of Harmonized CHO Training Community Health Nurse: XX Enrolled Nurse: XX Midwives: XX 2) Beneficiaries of pre-service training Nurse Assistant Clinical students: XX Nurse Assistant Preventive students: XX Midwifery Training School students: XX Registered Community Health Nurse: XX	1-1. The number of trained beneficiaries is increased. 1) Beneficiaries of Harmonized CHO Training Community Health Nurse: 2) Beneficiaries of pre-service training Nurse Assistant Clinical students: Nurse Assistant Preventive students: Midwifery Training School students: Tutors:
	1-2. The number of FSVs implemented as planned at each level RHMT→DHMT (UWR: twice/yr, NR & UER: 4 times/yr) DHMT→SDHT (4 times/yr) SDHT→CHO (4 times/yr)	1-2 Number of trained CHOs in the functional CHPS zones is increased to XX	1-2 Number of CHOs trained through "Harmonized CHO Training" is increased. UWR XX (2017) → XX (2021) UER XX (2017) → XX (2021) NR XX (2017) → XX (2021) NER XX (2017) → XX (2021) SR XX(2017) → XX (2021)	1-2. Beneficiaries of district CHO orientation (1) The number of districts which conduct the district CHO Orientation at least once. UWR 0 (2017) → 11 (2023) UER 0 (2017) → 15 (2023) NR 0 (2017) → 16(2023) NER 0 (2017) → 6 (2023) SR 0 (2017) → 7 (2023) (2) The number of CHO trained through the district CHO Orientation. UWR 0 (2017) → 102 (2023) UER 0 (2017) → 186 (2023) NR 0 (2017) → 112(2023) NER 0 (2017) → 60 (2023) SR 0 (2017) → 70 (2023)
	1-3. The number of issues identified and the number of issues solved through FSV	1-3 The numbers of implemented FSVs maintain following frequencies over the project period. RHMT -> DHMT (**2** times / year) DHMT->SDHT (4 times / year) SDHT -> CHO (4 times / year)	1-3 Referral system is strengthened 1) Number of beneficiaries of referral training 2)Number of Referral from CHPS zone done according to the protocol 3) Number of Feedbacks sent back to CHPS zones according to the protocol. UWR 0 (2017) → XX (2021) UER 0 (2017) → XX (2021) NR 0 (2017) → XX (2021) NER 0 (2017) → XX (2021)	1-3 Referral system is strengthened in pilot districts 1) The number of health facilities whose staff were trained on referral protocols: UER: 0 (2017) → 355 (2023) NR/NER: 0 (2017) → 65 (2023) UWR: 0 (2017) → 376 (2023) 2) The number of referrals from CHPS zones done according to the protocol/guidelines N/A (2017) → 75% (2023) 3) The number of feedbacks sent to CHPS zones is increased. N/A (2017) → 60% (2023)
		1-4 FSV score is increased as follows. RHMT -> DHMT (XX%) DHMT->SDHT (XX%) SDHT -> CHO (XX%)	1-4 Monitoring system is strengthened. XX Region (2017) → XX regions (2021) 1) Number of Beneficiaries of FSV/SSV training XX Region: XX (2017) →XX (2021) 2) The number of implemented FSV/SSV maintaining the frequencies according to the guidelines over the project period. XX region. XX% (2017)→XX% (2021) 3) DHMT FSV/SSV review meeting is implemented quarterly XX Region: XX% (2017)→ XX% (2021)	1-4. Monitoring system is strengthened in the target districts. 1) Harmonized SS training materials and tools for CHPS supervision is developed, introduced and incorporated into national SS program. 2) The average implementation rate of SS from SDHTs to CHPS. UWR: 0(2017) → 80 % (2023) UER: 0(2017) → 80 % (2023) NR/NER: 0(2017) → 75 % (2023) 3) The standardized reference guide for the District Health Quarterly Performance Review Meeting is developed and introduced to all districts of the project target regions. 4) All districts conduct the District Health Quarterly Performance Review Meeting with the standardized reference guide at least twice per year over the project period.
			1-5 CHPS database system are established at least five regions and disseminated nationally. Number of regions in which CHPS database is established.	1-5. CHPS database system is established at least in five regions and disseminated nationally. ・The number of regions in which CHPS database is established. 1 (2017)→16 (2023)
Means of Verification	1-1. Project reports	1-1. CHPS database	1-1. Training report	1-1. Training report
	1-2. FSV reports	1-2. CHPS database	1-2. Training report	1-2. Training report
	1-3. FSV reports	1-3. FSV database/ Hard copies of monitoring tools	1-3. 1) Developed Training Materials 2) Training report 3)Referral register Referral forms Feedback forms	1-3. 1) Developed Training Materials 2) Training report 3)Referral register Referral forms Feedback forms
		1-4. FSV database/ FSV Performance Standard	1-4. 1)Training report 2) Regional data(FSV/SV record) 3) Minutes of meeting	1-4. 1)Training report 2) Regional data(FSV/SV record) 3) Minutes of meeting
			1-5. CHPS database	1-5. CHPS database

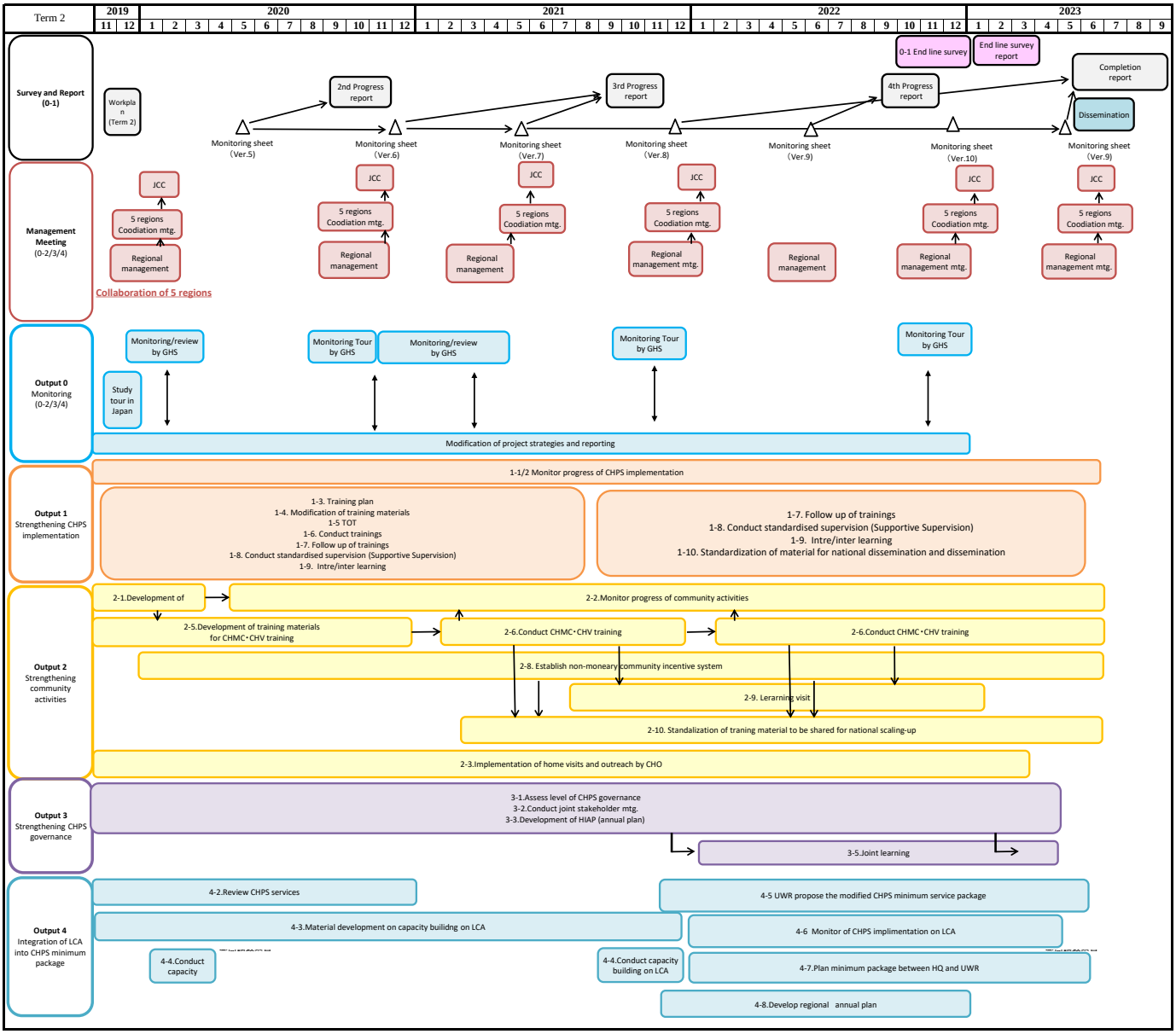
	Ver 0	Ver 1	Ver 2	Ver 3
Output 2	2. Community activities of CHPS are strengthened.	2. Community activities of CHPS are strengthened.	2. Community activities of CHPS are strengthened.	2. Community activities of CHPS are strengthened.
Objectively Verifiable Indicators	2-1. Number of active CHMCs for Community activities	2-1 The number of active CHMCs for community activities is increased to XX.	2-1 The number of active CHMCs for community activities is increased . UWR XX (2017) → XX (2021) UER XX(2017) → XX (2021) NR XX (2017) → XX (2021) NER XX (2017) → XX (2021) SR XX (2017) → XX (2021)	2-1 The number of active CHMCs for community activities is increased . UWR: 183 (2017)→ 496 (2023) UER: 147 (2017)→ 523 (2023) NR: 127(2017)→ 322 (2023) NER: NA (2017)→ 116 (2023) SR: NA (2017)→ 140 (2023)
	2-2. Proportion of CHAPs developed and implemented	2-2 The proportion of CHPS zone with at least one CHAP is increased to XX%.	2-2. Proportion of CHPS zones wih CHAP updated quarterly is increased. UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) NER XX% (2017) → XX% (2021) SR XX% (2017) → XX% (2021)	2-2. The proportion of CHPS zones with CHAP updated quarterly is increased. UWR: 56.7% (2017)→100% (2023) UER: 36.2% (2017)→100% (2023) NR: 19.8% (2017)→ 60% (2023) NER: NA (2017)→ 75% (2023) SR: NA (2017)→ 80% (2023)
	2-3. Proportion of pregnant women receiving first trimester ANC, Skilled Delivery, PNC within 23 hours	2-3 Proportion of active CHAPs is increased to XX%	2-3. Proportion of CHPS zones with CHAP updated quarterly on Life Course Approach (LCA) activities is increased. UWR XX% (2017) → XX% (2021)	2-3. The proportion of CHPS zones with CHAP updated quarterly on Life Course Approach (LCA) activities is increased in UWR. UWR: 0%(2017)→ 40% (2023)
		2-4 Proportion of pregnant women receiving first trimester ANC, Skilled delivery, PNC within **48** hours is increased to XX%.	Delated	
Means of Verification	2-1. FSV reports/ CHPS Database/ DHIMS2	2-1. FSV reports/ CHPS database/ DHIMS 2	2-1. CHPS database	2-1. CHPS database
	2-2. FSV reports/ CHPS Database/ DHIMS2	2-2. DHIMS 2	2-2. CHPS database	2-2. CHPS database
	2-3. FSV reports/ CHPS Database/ DHIMS1	2-3. CHPS database/ DHIMS 2	2-3. CHPS database/ DHIMS2	2-3. CHPS database
		2-4. DHIMS 2	Delated	
Output 3	3. Governance of CHPS by local government and stakeholders is strengthened.	3. Governance of CHPS by local government and stakeholders is strengthened.	3. Governance of CHPS by local government and stakeholders is strengthened.	3. Governance of CHPS by local government and stakeholders is strengthened.
Objectively Verifiable Indicators	3-1. Number of health integrated annual plans of DAs including CHPS implementation	3-1 Number of districts with health integrated annual plans developed and costed is increased to XX.	3-1 Proporation of districts with health integrated annual action plans developed and costed is increased. UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX %(2017) → XX %(2021) NER XX% (2017) → XX %(2021)	3-1 The proportion of districts with health integrated annual action plans developed and costed is increased. UWR 0% (2017) → 100 % (2023) UER 0% (2017) → 100 % (2023) NR 0 %(2017) → 100 % (2023) NER 0% (2017) → 100 % (2023) SR 0% (2017) → 100 % (2023)
		3-2 Proportion of projects/activities implemented in the health integrated annual plans is increased to XX%.	3-2 Proportion of districts in which Regional Planning Coordinating Unit (RPCU) and District Planning Coordinating Unit (DPCU) monitor implementation of health integrated annual action plans in 3-1 on a quarterly base (four times a year) is increased. UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX %(2017) → XX %(2021) NER XX% (2017) → XX %(2021) SR XX% (2017) → XX % (2023)	3-2 The proportion of districts in which Regional Planning Coordinating Unit (RPCU) and District Planning Coordinating Unit (DPCU) monitor implementation of health integrated annual action plans in 3-1 on a quarterly bases (four times a year) is increased. UWR 45% (2017) → 70 % (2023) UER NA (2017) → 80 % (2023) NR NA(2017) → 85 % (2023) NER NA (2017) → 100 % (2023) SR NA (2017) → 100 % (2023)
			3-3 Proportion of activities implemented in the health integrated annual plans is increased. UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX %(2017) → XX %(2021) NER XX% (2017) → XX %(2021)	3-3 The proportion of activities implemented in the health integrated annual plans is increased. UWR 0% (2017) → 50 % (2023) UER NA (2017) → 50 % (2023) NR NA(2017) → 65 % (2023) NER NA (2017) → 60 % (2023) SR NA (2017) → 60 % (2023)
Means of Verification	3-1. Annual Plans of DAs/ Signed agreements	3-1. Health Integrated Annual Plan	3-1. Health Integrated Annual Action Plan (Monitoring Format)	3-1. Health Integrated Annual Action Plan (Monitoring Format)
		3-2. Health Integrated Annual Plan	3-2. Health Integrated Annual Action Plan (Assessment Format)	3-2. Health Integrated Annual Action Plan (Assessment Format)
				3-3. Health Integrated Annual Action Plan (Assessment Format)

	Ver 0	Ver 1	Ver 2	Ver 3
Output 4	4. Life-course approach is addressed in the minimum package of CHPS	4. Life-course approach is addressed in the minimum package of CHPS	4. Life-course approach is addressed in the minimum package of CHPS	4. Life-course approach is addressed in the minimum package of CHPS
Objectively Verifiable Indicators	4-1. Evidence of district action plan implemented	4-1The minimum package of services under the LCA is developed and implemented.	4-1. The minimum package of services focusing on the LCA is developed.	4-1. The minimum package of services focusing on the LCA is developed.
	4-2. Evidence of feedback to GHS-HQ	4-2 The life course approach is integrated into the revised CHPS training materials.	4-2 The life course approach is integrated into the training on CHPS services.	4-2 The life course approach is integrated into the training on CHPS services.
		4-3 Proportion of community activities for life course approach is increased to XX%.	4-3. Health service delivery focusing on the LCA is strengthened at CHPS level. 1) Training materials developed 2) Number of beneficiaries of LCA training for SDHT and CHO in UWR, CHO XX, SDHT staff XX 3)% of pregnant women who received nutrition counselling. 4)% of mothers with < 5 children who received nutrition counselling. 5) Percentage of CHPS zones providing adolesent friendly services. 6) % of CHO who used the healthy lifestyle assessment questionnaire for school-aged children, adolescent, adults and aged in the past one month.	4-3. Health service delivery focusing on the LCA is strengthened at CHPS level. (1) The number of staff trained on the LCA training package to provide LCA related services is increased; CHO 0→192, SDHT：0→ 48 (2) The percentage of CHPS zones which conduct health screening in all schools in CHPS zone at least once a year in the last 1 year. NA (2019)→ 40 % (2023) (3)The percentage of CHPS zone which conduct health screening in all communities at least once a year in the last 1 year. NA (2019)→ 40 % (2023) (4) The percentage of CHO who appropriately record the result and followed up in the LCA register in the last 1 year - Accuracy of calculation of BMI - Accuracy of classification of dada BMI,BS,BP,WC - Appropriate follow up. NA (2019)→100 % (2023)
			4-4 The proportion of pregnant women receiving first trimester ANC, Skilled delivery, PNC within 48 hours is increased to XX% in UWR. 1) % of pregnant women receiving first trimester ANC 2) % of pregnant women making at least 4 ANC visits. 3) % skilled delivery 4) % of women who received postnatal care from health personnel within 48 hours since delivery UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) NER XX %(2017) → XX% (2021) SR XX % (2017) → XX% (2021)	4-4 The proportion of pregnant women receiving first trimester ANC, Skilled delivery, PNC within 48 hours is increased to XX% in all regions. Discuss in the annual review 1) % of pregnant women receiving first trimester ANC UWR: 62.3 % (2017) → 85 % (2023) UER: 51.1 % (2017) → 75 % (2023) NR: 36.9 % (2017) → 85 % (2023) NER: NA (2017) → 50 % (2023) SR: NA (2017) → 85 % (2023) 2) % of pregnant women making at least 4 ANC visits. UWR: 85.6 % (2017) → 90 % (2023) UER: 82.3 % (2017) → 85 % (2023) NR: 68.5 % (2017) → 80 % (2023) NER: NA (2017) → 80 % (2023) SR: NA (2017)→ 85 % (2023)
				3) % skilled delivery UWR: 68.7 % (2017) → 80 % (2023) UER: 69.8 % (2017) → 60 %(2023) NR: 64.5 % (2017) → 90 % (2023) NER: NA (2017) → 85 % (2023) SR: NA (2017) → 75 % (2023) 4) % of women who received postnatal care from health personnel within 48 hours since delivery UWR: 93.9 % (2017) → 100 % (2023) UER: 97.0 % (2017) → 100 % (2023) NR: 57.9 % (2017) → 95 % (2023) NER: NA (2017) → 80 % (2023) SR NA (2017) → 85 % (2023)
Means of Verification	4-1. Project Report/ Annual Performance Review Report	4-1. Project documents or materials developed by the project	4-1. Materials developed by the project.	4-1. Materials developed by the project.
	4-2. Project Report/ Annual Performance Review Report	4-2. CHPS training materials	4-2. CHO/SDHT training	4-2. CHO/SDHT training
		4-3. Annual Performance Review Report	4-3. 1) Developed training materials 2) Training report 3),4) Record of MCHRB 5),6) LCA Activity record	4-3. 1) Developed training materials 2) Training report 3),4) Record of MCHRB 5),6) LCA Activity record
			4-4. DHIMS 2	4-4. DHIMS 2

	Ver 0	Ver 1	Ver 2	Ver 3
Points of modification		Overall goal: Description is changed to be clearer than Ver.0. Output 0: 1 and 2: Description is changed to focus on the targets. 3: Means of evaluation are clearly described. Output 1: 1: Indicators on the Project intervention (training) was added. 2: Not only the number but the improvement (increase) is emphasized. 3: Not only the number but the improvement (frequency) was emphasized. The frequency of FSV from RHMT to DHMT is changed from 4 to 2 based on the current reality. Output 2: 1 and 2: Not only the number but the improvement (increase) was emphasized. 3: Another indicator is added to measure if CHAP is updated. 4: The changed of PNC within 23 to 48 hours according to the national guideline. Output 3: 1:Not only the number of planned activities/projects but emphasized on both the plan and the cost to promote implementation. 2: An indicator was added to measure the implementation rate of HIAP. Output 4: 1-3: Indicators are changed based on detailed activities which were developed through TWG meeting .	Overall goal: NER and SR are added. Project purpose:1 and 2: NER and SR are added. 3: Detail indicators are developed according to the Project intervention. Output 1: 1: Beneficiaries are classified according to the planned target. Pre-service training is added as part of the CHO Fresher training according to the Project interventions. 2: NER and SR are added. 3: Indicators on the referral related interventions are added. 4. Due to the change of a supervision method from FSV to SS, indicators are changed to be appopriate for the SS related activities; training and implementation of SS. 5: Indicator on the CHPS database related activities is added. Output 2: 1 and 2: All regions are added as targeted regions. 3: Indicator is clarified by describing it in detail as quarterly CHAP to include the LCA related activities. 4: This indicator is moved to Output 4 as it is an indicator to evaluate the total result of health services. Output 3: 1: To evaluate the result as a region, number is changed to proportion in each region accordingly. Four pilot regions are targeted. 2: Monitoring of HIAP is added as an indicator. 3: To evaluate the result as a region, four pilot regions are added. Output 4: 1-2: Description is changed according to the Project intervention. Integration of the materials developed by the project should be done by GHS. 3: Indicators are changed to measure the main interventions of the Project such as CHO's capacity building. Indicators on the training materials' development, target beneficiaries and improvement of service delivery skills are moved from Output 2 to ouput 4.	Overall goal: Target value was set. Project purpose: 1 and 2: Target value was set. 3: The indicators and target value to evacuate LCA services are set. Three ways to integrate LCA service nationally are described as indicators. Output 1: 1: 1) Target beneficiaries is chaged to CHN as CHN is recognized as an official candidate to be CHO according to the national policy. Target the schools which the Project willl conduct pilot. 2: District CHO orientation is introduced as a new CHO production system. Indicators are changed and target value is set accordingly. 3: Indicator is changed to only training beneficiaries but also improvement of the result. Beneficiaries are changed from individual to facility base. Target value is set. 4: Indicators are changed according to the change of Project intervention such as modification of SS monitoring sheet from SDHT to CHPS and commencement of DHQPR meeting. 5: Target value is set. Output 2: 1,2and 3: Target value are set. Output 3: 1,2and 3: Target value are set. Output 4:1-3: The indicators are changed based on the main focus of the services to be strengthened and on the LCA register record. 4: Target value is set.
		Most of the means of verifications for ver.0 are not available or not detailed. In Ver.1, MoV are detailed and changed to the existing available report/data.	According to the change of the indicators, means of verification are also changed to the most appropriate sources.	Means are added to show the materials on pre-service training and District CHO orientation.
		The PDM was modified once as version 1 and approved during the first JCC on 28 November 2017. Major points of modifications are; ・Means of verification were revised to focus on areas where data is obtainable from available sources. ・Revision of indicators to make them measurable while including new ones as and when necessary. ・Alignment of some data and/or standards in line with prevailing national guidelines. These figures include frequencies of Facilitative Supervision (FSV) from region to district, and the deadline of the first Post-natal Care (PNC).	The modification of the PDM was completed and approved during the second JCC on 10 May 2019. Major points of modifications are; ・Narrative summary: Overall goal and Project purpose. Newly created regions, NER and SR are added as traget regions, the names of the regions is deleted in the description of the overall goal and Project purpose. ・The description that limited the project target area to three regions is deleted. Two new regions are added in the description. ・Indicators that were unclear are given clearer descriptions, and new indicators are added. ・The Project does not develop a scorecard as the CHPS database system has been introduced to all target areas and accurate data is available. Therefore, “Score” is deleted. ・ Output 4 indicators are changed to conform with activities related to the Life-course Approach (LCA). ・Means of verification has also been modified in line with both the modified and additional indicators. ・The level of performance of the Project indicators depends on the Project resources. Therefore, the Project did not set a target this time. At the beginning of the second term, a Project meeting will be held to set the targets.	The PDM version 2 was modified to version 3 and it got approved at the 6th Joint Coordination Committee (JCC) meeting held on 8th July, 2021. Mayor points of modifications are: ・Definite article are added to correct some sentences grammatically. ・Traget year of overall goal is changed to 2026 based on the one yera extension of the Project. ・Duration of the project changed based on the 1-year extension plan. ・Apart from the overall goal, the target year of assessment was reset 2023 based on the extension plan. Many data can be obtained not by the survey but the regular dataset such as the CHPS database and DHIMS 2.Therefore, the year is set as 2023. ・The criteria for assessing the level of achievement of each indicator was determined. ・Indicators that were not in synchronize with the project intervention were changed to more appropriate ones. This is especially the case for Output 1: Supportive Supervision, Referral and Output 4 related indicators. ・The target trainees of the Harmonized CHO training was changed in line with the national policy. ・The target schools of the Pre-service training were changed to the ones in which the project plans to intervene.

Appendix 2 : Flow Chart of the Project Activities




Term 2
2019
11 12
2020
1 2 3 4 5 6 7 8 9 10 11 12
2021
1 2 3 4 5 6 7 8 9 10 11 12
2022
1 2 3 4 5 6 7 8 9 10 11 12
2023
1 2 3 4 5 6 7 8 9
Survey and Report (0-1)
Workpla n (Term 2)
Monitoring sheet (Ver.5)
2nd Progress report
Monitoring sheet (Ver.6)
3rd Progress report
Monitoring sheet (Ver.7)
Monitoring sheet (Ver.8)
Monitoring sheet (Ver.9)
4th Progress report
Monitoring sheet (Ver.10)
0-1 End line survey
End line survey report
Completion report
Dissemination
Monitoring sheet (Ver.9)
Management Meeting (0-2/3/4)
JCC
5 regions Coodiation mtg.
Regional management
Regional management mtg.
Collaboration of 5 regions
Output 0 Monitoring (0-2/3/4)
Monitoring/review by GHS
Monitoring Tour by GHS
Study tour in Japan
Modification of project strategies and reporting
Output 1 Strengthening CHPS implementation
1-1/2 Monitor progress of CHPS implementation
1-3. Training plan
1-4. Modification of training materials
1-5 TOT
1-6. Conduct trainings
1-7. Follow up of trainings
1-8. Conduct standardised supervision (Supportive Supervision)
1-9. Intre/inter learning
1-10. Standardization of material for national dissemination and dissemination
Output 2 Strengthening community activities
2-1.Development of
2-2.Monitor progress of community activities
2-5.Development of training materials for CHMC･CHV training
2-6.Conduct CHMC･CHV training
2-8. Establish non-moneary community incentive system
2-9. Lerarning visit
2-10. Standalization of traning material to be shared for national scaling-up
2-3.Implementation of home visits and outreach by CHO
Output 3 Strengthening CHPS governance
3-1.Assess level of CHPS governance
3-2.Conduct joint stakeholder mtg.
3-3.Development of HIAP (annual plan)
3-5.Joint learning
Output 4 Integration of LCA into CHPS minimum package
4-2.Review CHPS services
4-3.Material development on capacity builidng on LCA
4-4.Conduct capacity
4-4.Conduct capacity building on LCA
4-5 UWR propose the modified CHPS minimum service package
4-6 Monitor of CHPS implimentation on LCA
4-7.Plan minimum package between HQ and UWR
4-8.Develop regional annual plan

Appendix 3 : Work Breakdown Structure (WBS)

No. of activities \ Timing of activities (Year)	FIRST TERM																											
	2017						2018												2019									
	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7			
【Activities througout the project term 】																												
(1) Pre-mission meeting with JICA	■																											
(2) Development of monitoring sheet							■						■						■					■				
(3) Conduct JCC					■							■					■						■					
(4) Study tour and visits by three regions and GHS					■							■					■					■	■					
(5) Follow up after CHO, FSV and other trainings													■	■	■	■	■	■	■	■	■	■	■	■				
(6) Plan and implementation of interactive visits among districts and regions					■							■					■						■					
(7) Promote outreach by CHO and implementation of CHAP by community													■	■	■	■	■	■	■	■	■	■	■	■				
(8) DA related activity and interactive visits																												
【Activities in the first term : July 2017-July 2019】																												
(1) Development of workplan or the first term and approval					■																	■	■					
Activities related to Output 0																												
(2) Preparation of baseline				■	■		■	■																				
(3) Kick off meeting and the first JCC					■																							
(4) Implementation of baseline survey					■	■	■	■	■	■																		
(5) Follow-up activities for baseline survey																						■	■	■				
(6) Development of workplan by each region				■																		■	■					
(7) Conduct JCC												■					■						■					
(8) Implementation of the training in Japan (including preparatory activities and post study meeting)											■	■					■						■					
Activities related to Output 1																												
(8) Development and introduction of CHPS database					■				■				■	■	■	■	■	■	■	■	■	■	■	■				
(9) Assign and train trainers of training for CHO, FSV and referral training				■									■	■		■				■								
(10) Develop training plan, implementation and follow up of CHO, FSV and referral training.							■						■				■	■	■	■	■	■	■	■				
(11) Follow up of the training and implementation of FSV							■	■	■	■	■	■	■															
(12) Conduct DHMT review meeting on CHPS enhancement (Regional management meeting)																												
(13) Create opportunity such as a study tour for three regions and districts to exchange information and experiences													■	■		■	■	■	■	■			■					
Activities related to Output 2																												
(14) Develop standardized community data capturing tools									■				■		■			■	■									
(15) Assess and score current community health activities by the community									■				■	■	■	■	■	■	■	■	■	■	■	■				
(16) Plan and conduct CHO's community outreach and home visit								■	■			■	■		■	■	■	■	■	■	■	■	■	■				
(17) Modify/produce training materials for CHMC/CHV								■	■				■	■	■	■	■	■	■	■	■	■	■	■				
(18) Conduct training for CHMC/CHV																												
(19) Implement community health activities by the community (e.g. referral system using CETS)								■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■				
(20) Create sustainable non-monetary incentive mechanism for the CHO/CHV and community																												
(21) Plan and conduct intra/extra joint learning among target districts/regions																												
Activities related to Output 3																												
(22) Assess and score the current level of governance of CHPS by DA, DHMT and stakeholders			■	■	■	■	■	■	■	■	■	■	■						■	■								
(23) RCC, RHMT, DA, DHMT and stakeholders conduct a joint stakeholder meeting and discuss on CHPS planning (HRH, equipment, logistics), budgeting and monitoring.			■							■	■					■			■								
(24) DHMT and DA develop health integrated annual plans including CHPS implementation			■													■	■	■	■								
(25) DHMT and DA monitor health integrated annual action plans																					■							
(26) Plan and conduct intra/extra joint learning among target districts/regions										■					■				■									
Activities related to Output 4																												
(27) Define the concept of LCA at CHPS level in Ghana				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■								
(28) Review the current CHPS services focusing on life-course approach between the GHS HQ and three northern Regions				■	■	■	■	■	■	■	■	■	■	■	■	■	■											
(29) (28)Develop the CHO/SDHT and CHMC/CHV training materials in UWR based on the review, and integrate life-course approach into the trainings and currently used training materials for CHPS implementation at Upper West Region																	■	■	■	■	■	■						
(30) Build the capacity of CHO/SDHT and CHMC/CHV on the LCA in UWR																						■						
(31) Upper West Region proposes to GHS HQ" minimum package of services focusing on life-course approach at community level (minimum package)" ⇒Second Term																												
(32) Plan minimum package between GHS HQ and Upper West Region ⇒Second Term																												
(33) Develop regional action plan for minimum package in Upper West Region ⇒Second Term																												
(34) (33)Share the results of the action plan among GHS HQ and three northern Regions ⇒Second Term																												

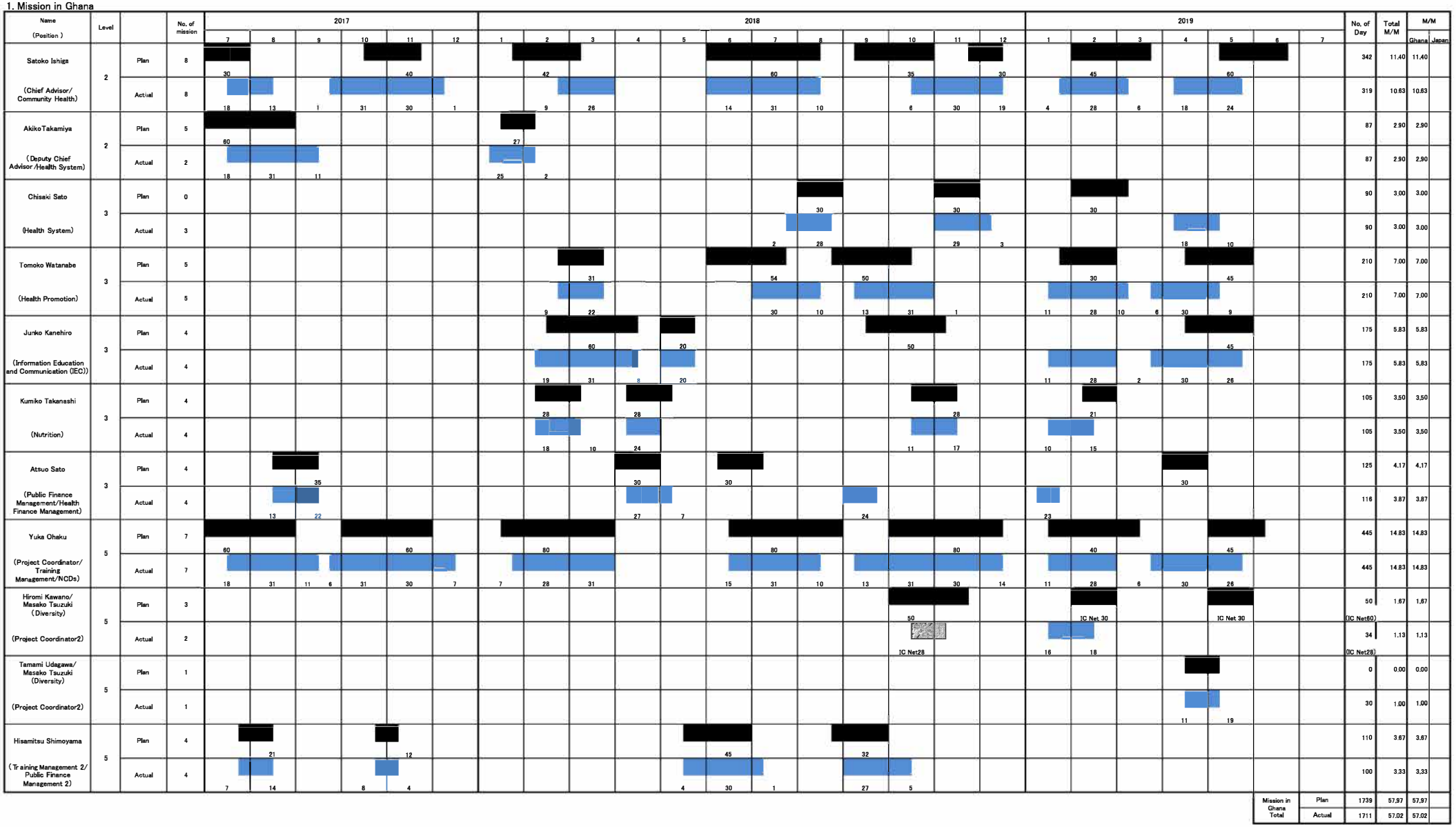
■ Implemented

Timing of activities (Year) / No. of activities	2019		2020												2021												2022												2023								
	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
【Activities througout the project term 】																																															
(1) Pre-mission briefing with JICA	■	■	■	■	■																																										
(2) Development of monitoring sheet						■							■	■					■													■												■			
(3) Conduct JCC			■																		■						■													■				■			
(4) Study tour and monitorig by GHS and regions																								■																							
(5) CHO training and Supervision training and follow-up after the training	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■			
(6) Create opportunities for mutual visits among regions and districts																			■						■	■																					
(7) Conduct outreach and community health activities			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■																												
(8) Assess the progress of CHPS governance by DA and stakeholders; support DHMT and DA to develop Health-Integrated Annual Plan and conduct mutual visits among regions and district				■							■	■					■		■	■					■	■																					
(9) Public Relations			■									■		■			■	■								■							■							■			■	■			
【Activities in the second term (Expected): November 2019-July 2023】																																															
Activities related to Output 0																																															
(1) Development of workplan for the second term and approval	■	■	■																■				■																								
(2) Conduct 5th JCC (Kick off of the second term)			■																																												
(3) Conduct JCC (6th-)																					■						■													■				■			
(4) Support CPs to attend training in Japan	■		■																																												
(5) Conduct end line survey and present evaluation report for dissemination of Project activities																					■	■														■	■										
(29) Develop Project Completion Report																																													■	■	■
Activities related to Output 1																																															
(6) Implementation of CHO Fresher Training, SSV and Referral training	■	■	■	■	■				■	■			■						■	■	■	■	■	■																		■					
(7) Follow up on CHO Fresher Training, SSV and Referral training	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■			
(8) Support regular implementation of standardized SSV						■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■			
(9) Create opportunity such as a study tours for five regions and districts to exchange information and experience																			■					■		■					■																
(10) Standardize the training materials for nationwide dissemination			■	■	■	■										■	■	■	■					■	■		■		■	■	■		■	■	■	■			■	■	■	■	■				
Activities related to Output 2																																															
(11) Measure the progress of community health activities by using assessment tools	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■										
(12) Implementation of outreach activities by CHOs	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■										
(13) Develop training materials and conduct training for CHMC/CHV	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■										
(14) Implementation of community health activities by the community	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■										
(15) Create sustainable non-monetary incentive mechanism for the CHMC/CHV and community				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■										
(16) Plan and conduct intra/extra joint learning visits among target districts/regions																																															
(17) Develop and review the training material to make them nationally recognized standard material					■																																										
Activities related to Output 3																																															
(18) Assess and score the current level of governance of CHPS by DA, DHMT and stakeholders	■																■		■										■	■											■	■					
(19) RCC, RHMT, DA, DHMT and stakeholders conduct joint stakeholder meetings and discuss CHPS planning (HRH, equipment, logistics), budgeting and monitoring.	■	■		■							■	■					■		■	■					■	■			■	■	■										■	■	■					
(20) DHMT and DA develop health integrated annual plans including CHPS implementation	■	■	■	■	■						■	■	■		■	■									■	■	■	■									■	■	■	■								
(21) DHMT and DA monitor health integrated annual action plans	■	■	■					■	■		■	■			■	■		■			■			■			■			■			■			■			■			■					
(22) Plan and conduct intra/extra joint learning among target districts/regions																																									■					
Activities related to Output 4																																															
(23) Develop CHO/SDHT training materials in UWR based on the review of the current CHPS services focusing on life-course approach	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■			■	■	■	■																						
(24) Conduct capacity building for CHO,SDHT, CHV and CHMC in UWR			■	■	■															■			■	■																							
(25) Integrate LCA into the trainings and currently used training materials for CHPS implementation in UWR																				■	■	■	■	■	■								■														
(26) Life-course approach team develops action plan for minimum package in Upper West Region																							■	■	■																			■			
(27) Life-course approach team monitors action plan for minimum package in Upper West Region																								■	■					■												■	■	■			
(28) Share the results of the action plan with GHS-HQ and the five northern Regions																																					■										

■ Implemented

Appendix 4 : Dispatch of Japanese Experts

1. Mission in Ghana



Name (Position)	Level		No. of mission	2017						2018												2019							No. of Day	Total M/M	M/M Ghana	M/M Japan
				7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7				
Satoko Ishiga	2	Plan	8																										342	11.40	11.40	
(Chief Advisor/ Community Health)		Actual	8	30 18	13	1	40 31	30	1		42 9	26			60 14	31	10		35 6	30	19		45 4	28	6	60 18	24			319	10.63	10.63	
AkikoTakamiya	2	Plan	5	60						27																			87	2.90	2.90	
(Deputy Chief Advisor/Health System)		Actual	2	18	31	11				25	2																		87	2.90	2.90	
Chisaki Sato	3	Plan	0														30			30			30						90	3.00	3.00	
(Health System)		Actual	3													2	28			29	3					18	10		90	3.00	3.00	
Tomoko Watanabe	3	Plan	5								31				54			50					30			45			210	7.00	7.00	
(Health Promotion)		Actual	5													30	10		13	31	1		11 28	10	6	30	9		210	7.00	7.00	
Junko Kanehiro	3	Plan	4								60		20							50						45			175	5.83	5.83	
(Information Education and Communication (IEC))		Actual	4							19	31	8	20										11 28	2	30	26			175	5.83	5.83	
Kumiko Takanashi	3	Plan	4								28		28							28			21						105	3.50	3.50	
(Nutrition)		Actual	4							18	10		24							11	17		10	15					105	3.50	3.50	
Atsuo Sato	3	Plan	4																										125	4.17	4.17	
(Public Finance Management/Health Finance Management)		Actual	4		13	35 22							30 27	7		30			24				23			30			116	3.87	3.87	
Yuka Ohaku	5	Plan	7																										445	14.83	14.83	
(Project Coordinator/ Training Management/NCDs)		Actual	7	60 18	31	11 6	60 31	30	7	80 7	28	31			80 15	31	10	80 13	31	30	14		40 11	28	6	45 30	26			445	14.83	14.83	
Hiromi Kawano/ Masako Tsuzuki (Diversity)	5	Plan	3																	50			IC Net 30			IC Net 30			50 (IC Net80)	1.67	1.67	
(Project Coordinator2)		Actual	2																	IC Net28			16	18					34 (IC Net28)	1.13	1.13	
Tamami Udagawa/ Masako Tsuzuki (Diversity)	5	Plan	1																										0	0.00	0.00	
(Project Coordinator2)		Actual	1																							11	19		30	1.00	1.00	
Hisamitsu Shimoyama	5	Plan	4		21			12							45				32										110	3.67	3.67	
(Training Management 2/ Public Finance Management 2)		Actual	4	7	14		8	4						4	30	1			27	5									100	3.33	3.33	
Mission in Ghana Total		Plan																											1739	57.97	57.97	
		Actual																											1711	57.02	57.02	

2. Mission in Japan

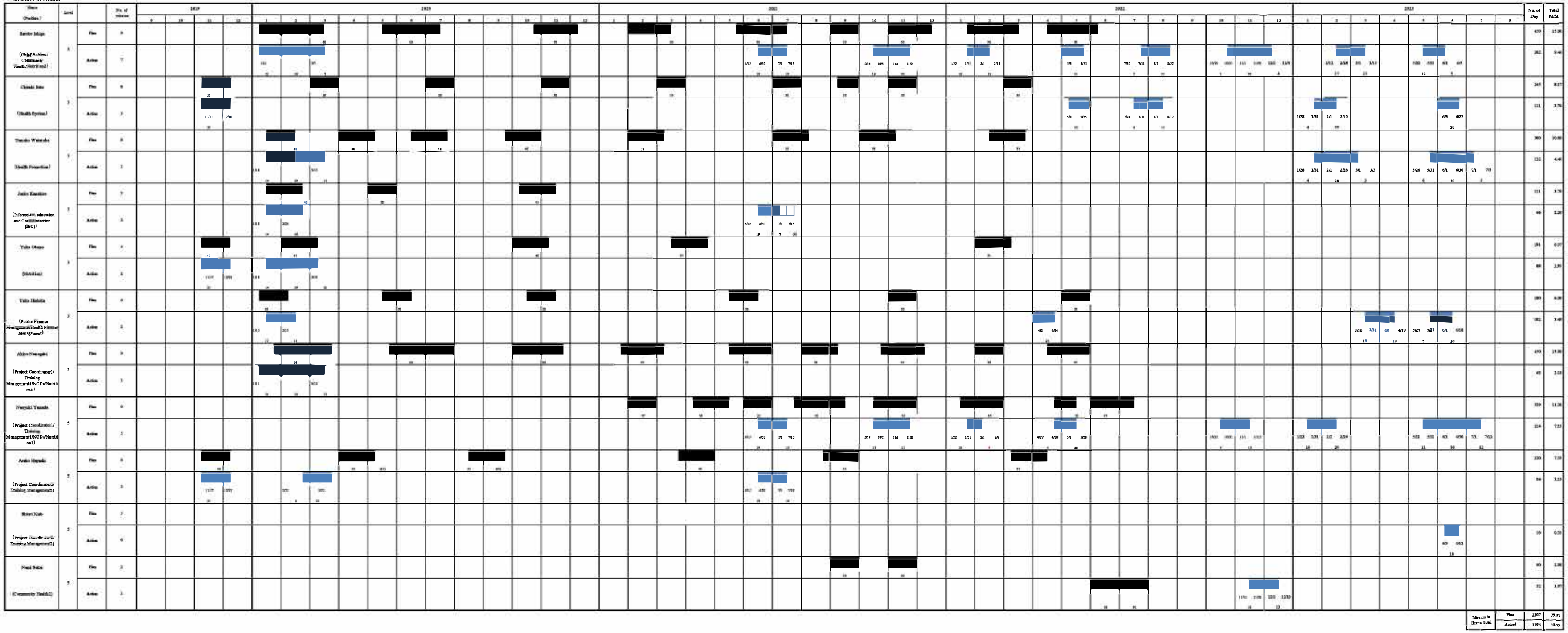
Name	Grade	Plan/Actual	No.	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12	T13	T14	T15	T16	T17	T18	T19	T20	T21	T22	T23	T24	T25	Days	M/M		M/M Total
Satoko Ishiga	2	当初計画	1											6															6	0.30		0.30
(Chief Advisor/ Community Health)		実績及び最新計画	3											3					5.3								3.4		11.7	0.59		0.59
Akiko Takamiya	2	当初計画	1											6															6	0.30		0.30
(Deputy Chief Advisor/Health System)		実績及び最新計画	0																										0	0.00		0.00
Tomoko Watanabe	3	計画	2										16	10															26	1.30		1.30
(Health Promotion)		実績及び最新計画	2				1																						1	0.05		0.05
Junko Kanehiro	3	計画	1										16																16	0.80		0.80
(Information Education and Communication (IEC))		実績及び最新計画	1				3																						3	0.15		0.15
Atsuo Sato	3	計画	0																										0	0.00		0.00
(Public Finance Management/Health Finance Management)		実績及び最新計画	2									5		6															11	0.55		0.55
Yuka Ohaku	5	計画	0																										0	0.00		0.00
(Project Coordinator/ Training Management/NCDs)		実績及び最新計画	5										8	2		4										2	11		27	1.35		1.35
Hisamitsu Shimoyama	5	計画	0																										0	0.00		0.00
(Training Management 2/ Public Finance Management 2)		実績及び最新計画	3											14											3		2		19	0.95		0.95

Mission in Japan Total	Plan	54	2.70		2.70
	Actual	72.7	3.64		3.64

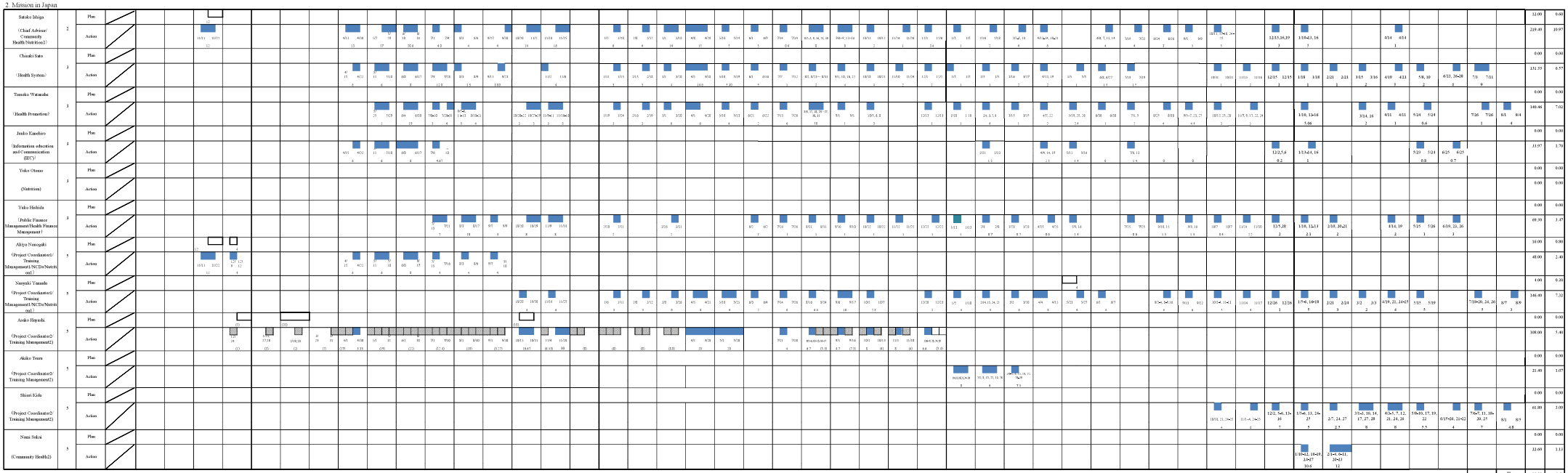
Remarks: Original Plan / Actual Mission / Latest Plan / IC Net Mission

Total	Plan	1793	60.67	57.97	2.70
	Actual	1784	60.66	60.67	

1 Mission in Ghana



2. Mission in Japan



Satoko Ishiga (Chief Advisor/ Community Health/Nutrition2)	2	Plan	12.00	0.00
		Actual	219.40	10.97
Chiaki Sato (Health System1)	3	Plan	0.00	0.00
		Actual	131.33	6.57
Tomoko Watanabe (Health Promotion)	3	Plan	0.00	0.00
		Actual	140.46	7.02
Junko Kanehiro (Information education and Communication (IEC))	3	Plan	0.00	0.00
		Actual	33.97	1.70
Yuko Otomo (Nutrition)	3	Plan	0.00	0.00
		Actual	0.00	0.00
Yuko Hishida (Public Finance Management/Health Finance Management)	3	Plan	0.00	0.00
		Actual	69.30	3.47
Akiyo Nonogaki (Project Coordinator1/ Training Management1(NCTeNutrition))	5	Plan	16.00	0.80
		Actual	48.00	2.40
Naoyuki Yamada (Project Coordinator1/ Training Management1(NCTeNutrition))	5	Plan	1.00	0.20
		Actual	146.40	7.32
Asako Hayashi (Project Coordinator2/ Training Management2)	5	Plan	0.00	0.00
		Actual	108.00	5.40
Akiko Tezen (Project Coordinator2/ Training Management2)	5	Plan	0.00	0.00
		Actual	21.40	1.07
Shiori Kido (Project Coordinator2/ Training Management2)	5	Plan	0.00	0.00
		Actual	61.80	3.09
Nami Sakai (Community Health2)	5	Plan	0.00	0.00
		Actual	22.60	1.13
		Mission in Japan Total Plan	12.00	1.6
		Mission in Japan Total Actual	1002.66	50.14

Remarks : Original Plan Actual Mission IC Net Mission

* It is based on the latest plan in the monthly plan which submitted to JICA as of 30th of November, 2022.

Total	Plan	22.0	77.17
	Actual	2196.7	109.93

Appendix 5 : List of Trainees of the Training in Japan

1st batch

No.	Term	Name	Position	Organisation	Type of Training	Course Title	Period of Training	
							Starting Date	Ending Date
1	1st	Ms. Gladys Brew	Safe Motherhood Coordinator	Family Health Division, Ghana Health Service	Country Focused	Life-Course Approach and the Community Health	15 May 2018	26 May 2018
2	1st	Dr. Winfred Komla Ofosu	Regional Director of Health Services	Upper East Regional Health Directorate, Ghana Health Service	Country Focused	Life-Course Approach and the Community Health	15 May 2018	26 May 2018
3	1st	Mr. Barnabas Kwame Yeboah	National CHPS Coordinator	Policy Planning, Monitoring & Evaluation Unit – Accra, Ministry of Health	Country Focused	Life-Course Approach and the Community Health	15 May 2018	26 May 2018
4	1st	Dr. John Wetu Abenyeri	Deputy Director	Public Health/Regional Health Directorate, Public Health Unit – Tamale, Ghana Health Service	Country Focused	Life-Course Approach and the Community Health	15 May 2018	26 May 2018
5	1st	Dr. Matthias Pogvi Tengan	Acting District Director of Health	Wa East District Health Administration, Ghana Health Service	Country Focused	Life-Course Approach and the Community Health	15 May 2018	26 May 2018
6	1st	Ms. Esther Adu	Senior Health Promotion Officer	Health Promotion/Family Health Division – Accra, Ghana Health Service	Country Focused	Life-Course Approach and the Community Health	15 May 2018	26 May 2018

2nd batch

No.	Term	Name	Position	Organisation	Type of Training	Course Title	Period of Training	
							Starting Date	Ending Date
1	1st	Dr. Kwabena Boateng BOAKYE	Head of Clinical Information	GHS HQ, Institutional Care Division	Country Focused	Life-Course Approach and the Community Health	09 November 2019	22 November 2019
2	1st	Mrs. Felecia BABANAWO	CHPS Coordinator	GHS HQ, Policy Planning Monitoring & Evaluation Division	Country Focused	Life-Course Approach and the Community Health	09 November 2019	22 November 2019
3	1st	Mrs. Eleanor SEY	Acting Director	GHS HQ, Health Promotion Division	Country Focused	Life-Course Approach and the Community Health	09 November 2019	22 November 2019
4	1st	Dr. John ELEEZA	Regional Director of Health Services	GHS Northern Region	Country Focused	Life-Course Approach and the Community Health	09 November 2019	22 November 2019
5	1st	Dr. Osei Kuffour AFREH	Regional Director of Health Services	GHS Upper West Region	Country Focused	Life-Course Approach and the Community Health	09 November 2019	22 November 2019
6	1st	Dr. Josephat NYUZAGHL	Deputy Director	GHS Upper East Region	Country Focused	Life-Course Approach and the Community Health	09 November 2019	22 November 2019

Appendix 6 : List of Training Sessions and Workshops Implemented

Related Output	Organization involved in the training	Training title	Date	Content of Training/Meeting	Main Participants (Project members are excluded)	No. of participants (Project members are excluded)	Remarks
						2nd Term	
Output 0	RHMT, DHMT	First workshop to develop workplan	26th and 27th, October 2017	Development and finalization of the workplan for the first term of the Project	UWR RHMT/DHMT, UER RHMT, NR RHMT, JICA Ghana office	62	First day 30 people, Sedond day 32 people. Workplan was submitted.
	UWR, NR, UER RHMT	Briefing on the baseline survey	20th, September 2017	・Confirming the tools of the baseline survey ・Sharing the PDM draft and the data to verify the indicators	UWR RHMT, UER RHMT, and NR RHMT	6	
	Subcontractors	Training to the subcontractors	1st batch: 30th and 31st October, 2017 2nd batch: 26th and 27th March, 2018	・Briefing on the baseline survey ・Instructing baseline survey tools	Researchers of the subcontractors	20	Batch1: 10 people, Batch2: 10 people.
	UER RHMT, SDHT	Sub-District Orientation for BLS in UER	13th December, 2017	Requesting SDHTs to answer BLS questionnaire	RHMT, SDHT	49	
	GHS-HQ and main stakeholders of the Project	Kick off meeting	28th November, 2017	Official launching of the Project	GHS DG, Directors of GHS-HQ's main divisions, Embassy of Japan,UWR RHMT/DDHS, UER RHMT, NR RHMT, Media, Development partners, JICA Ghana office	71	
	GHS-HQ, RHMT,DHMT	First Joint Coordination Committee	28th November, 2017	・Introduction of the Project workplan and approval ・Introduction of the Project outlines ・Approval of PDM ver.1	GHS DG, Directors of GHS-HQ's main divisions, UWR RHMT/DM|HMT, UWR RHMT/DDHS, UER RHMT/DDHS, NR RHMT/DDHS,CHNTS principal, JICA Ghana office	36	
	RHMT	First Coordination meeting for three regions	26th June, 2018	Sharing the progress of the progress of the Project activities in three regions Coordination with three regions on the coming activities	UWR RHMT/DHMT, UER RHMT, NR RHMT	21	
	GHS-HQ,RHMT, DHMT	First study tour	27th June, 2018	Field visit to three CHPS zones in UWR, Jirapa CHNTS, health centre, DHMT, DA and DHMT	Main division directors of GHS-HQ, UWR RHMT/DM|HMT, UWR RHMT/DDHS, UER RHMT/DDHS, NR RHMT/DDHS,UWR CHNTS principal, UWR Regional Hospital Director, UWR DA, Embassy of Ghana, JICA Ghana office	62	
	GHS-HQ, RHMT, DHMT	Second Joint Coordinatiion Committee	28th June, 2018	・Presentation of the Project progress and approval of the plan ・Presentation on the training in Japan, plan and follow up ・Presentation of the result of baseline survey ・Presentation of the lesson learnt on the study tour in UWR ・Approval of the Project concept of Life Course Approach	Directors of GHS-HQ's main divisions, UWR RHMT/DM|HMT, UWR RHMT/DDHS, UER RHMT/DDHS, NR RHMT/DDHS,UWR CHNTS principal, UWR Regional Hospital Director, UWR RCC, Embassy of Ghana, JICA Ghana office	55	
	GHS-HQ, RHMT	First follow up meeting of training in Japan	28th June, 2018	Confirmation of action plan and agreement on the follow up method	Participants of training in Japan, in total 6 people (MOH 1, GHS-HQ 2, each 1 from three regions)	6	
	UER RHMT	UER management meeting	1st meeting: 1st August, 2017 2nd meeting: 22nd March, 2018	First meeting: Introduction of the outline and activities of the Project . Organization on the establishment of the Project office Second meeting: Briefing of the Project activities in UER to the new Regional Director and organization.	UER RHMT	34	First meeting 20 people, second meeting 14 people
	NR RHMT	NR management meeting	1st meeting: 31st July, 2017 2nd meeting: 20th March, 2018	First meeting: Introduction of the outline and activities of the Project . Organization on the establishment of the Project office Second meeting: Briefing of the Project activities in NR to the new Regional Director and organization.	NR RHMT	29	First meeting 12people, second meeting 17 people
	UWR RHMT	UWR management meeting	24th May, 2018	Briefing of the Project activities in UER to the new Regional Director and organization.	UWR RHMT	10	First meeting 10 people
	RHMT, DHMT	Workshop to analyse the result of baseline survey Review meeting of baseline survey report	11th-14th June, 2018	・Data analysis of the baseline survey ・Review of the baseline survey and receiving comments	RHMT, DHMT	13	
	RHMT of UER, UWR and NR	Second Coordination meeting for three regions	27th November, 2018	・Project briefing for newly assigned regional directors ・Presentation on the status of CHPS implementation ・Presentation of the progress of the Project and workplan ・Presentation of the result of baseline survey ・Presentation on findings of training in Japan	UWR RHMT/DHMT, UER RHMT, NR RHMT	23	
	RHMT of UER, UWR and NR	Third Coordination meeting for three regions	8th May, 2019	・Presentation on the status of CHPS implementation ・Presentation of the workplan of the second year ・Presentation of the modified PDM Ver.2 ・Information sharing on the management of Project office during the break between the first term and the second term	UWR RHMT/DHMT, UER RHMT, NR RHMT	26	
	GHS HQ, Training schools, UER, UWR, NR	Second study tour	28th November, 2018	Field visit to three CHPS zones in NR, CHNTS, Health Center, DHMT and DA	GHS HQ, UWR RHMT/DM/HMT, UWR RHMT/DDHS, UER RHMT/DDHS, NR RHMT/DDHS, UWR CHNTS principal, UWR Regional Hospital Director, UWR DA, Embassy of Ghana, JICA Ghana office	75	
	GHS HQ, Training schools, UER, UWR, NR	Third study tour	9th May, 2019	Field visit to three CHPS zones in UER, CHNTS, Health Center, DHMT and DA	GHS HQ, UWR RHMT/DM/HMT, UWR RHMT/DDHS, UER RHMT/DDHS, NR RHMT/DDHS, UWR CHNTS principal, UWR Regional Hospital Director, UWR DA, Embassy of Ghana, JICA Ghana office	63	
	GHS HQ, RHMT, DHMT	Third Joint Coordination Committee	29th November, 2018	・Presentation and confirmation of progress ・Reporting progress of the activities by participants of Training in Japan Presentation of the findings Study Tour in NR ・Discussion on issues and concerns ・Confirmation of the plan of the rest of the first Project term	GHS DG, Directors of GHS HQ's main divisions, UWR RHMT/DM/HMT, UWR RHMT/DDHS, UER RHMT/DDHS, NR RHMT/DDHS, CHNTS principal, JICA Ghana office	70	
	GHS HQ, RHMT, DHMT	Fourth Joint Coordination Committee	10th May, 2019	・Presentation and confirmation of progress ・Presentation of the findings GHS monitoring ・Presentation of the findings Study Tour in UER ・Discussion on issues and concerns ・Approval of the plan of the second term of the Project and modified PDM	GHS DG, Directors of GHS HQ's main divisions, UWR RHMT/DM/HMT, UWR RHMT/DDHS, UER RHMT/DDHS, NR RHMT/DDHS, CHNTS principal, JICA Ghana office	75	
	GHS HQ, MOH, RHMT, DHMT, Development partners	First dissemination forum	10th May, 2019	Presentation of the outputs and progress at the end of the first term	GHS HQ, MOH CHPS Coordinator, RHMT, DHMT, KOICA	85	
	UER DHMT	DHMT meeting on CHPS implementation	18th February, 2019	・Information sharing on CHPS database ・Capacitate DHMT on CHPS implementation	DHMT (DDHS, PHN, HIO, CHPS Coordinator), RHMT	61	

Output 0	NR DHMT	DHMT meeting on CHPS implementation	27th March, 2019	・Information sharing on CHPS database ・Capacitate DHMT on CHPS implementation	DHMT (DDHS, PHN, HIO, CHPS Coordinator), RHMT	109	
	UER RHMT	UER management meeting (3rd, 4th, 5th)	3rd December, 2018 18th February, 2019	・Establishment of office and arrangement ・Progress of CHPS implementation ・Challenges on CHPS implementation ・Progress and plan of project activities	UER RHMT	32	3rd 15 people, 4th 17 people
	NR RHMT	NR management meeting (3rd, 4th, 5th)	22nd November, 2018 28th February, 2019 20th May, 2019	・Briefing for new Regional Director ・Progress of CHPS implementation ・Challenges on CHPS implementation ・Progress and plan of project activities	NR RHMT	23	3rd 5 people, 4th 12 people, 5th 6 people
	UWR RHMT	UWR management meeting (2nd, 3rd, 4th, 5th)	19th November, 2018 5th February, 2019 28th February, 2019 14th May, 2019	・Briefing for new Regional Director ・Progress of CHPS implementation ・Challenges on CHPS implementation ・Progress and plan of project activities	UWR RHMT	50	2nd 14 people, 3rd 15 people, 4th 15 people, 5th 6 people
	GHS HQ, MOH, RHMT	Follow up of Training in Japan	29th November, 2018	・Follow up of implementation of the action plan ・Plan of collaboration with the project	Participants of training in Japan from GHS HQ, MOH, RHMT	5	
	GHS HQ, RHMT, DHMT	GHS Monitoring visits	6th - 13th April, 2019	・Confirm the project activities' progress ・Evaluate the achievement of project	GHS HQ's (PPMED, ICD, PHD, FHD) UWR RHMT/DM/HMT, UER RHMT/DHMT, NR RHMT/DHMT	27	GHS HQ 8, RHMT/DHMT 19
	UWR, NR, UER RHMT, GHS HQ, JICA Ghana Office	PDM modification meeting	15th April, 2019	Modification of PDM Ver.1 to Ver.2	UWR RHMT, UER RHMT, and NR RHMT	34	
	RHMT and DHMT of three regions, GHS HQ	Second workshop to develop workplan	16th and 17th April, 2019	Development and finalization of the workplan for the first term of the Project	UWR RHMT/DHMT, UER RHMT, NR RHMT, JICA Ghana office, NAP	45	
	Regional Management Health Team (RHMT) of 5 regions, Training school	Workplan review meeting	29th, November , 2019	Sharing the workplan of the second term and agreement	Main RHMT members of 5 regions, Principals of training schools	25	
	RHMT	The 4th coordination meeting of 5 regions	21st January, 2020	・Introduction of new members (NER and SR) and status of establishment of administrative office ・Approval of the workplan of the each region in the 2nd term ・Sharing the status of CHPS implementation ・Confirmation of the contents of JCC presentation ・Discussion of modification of PDM and value setting on indicators	RHMT of 5 regions	31	
	GHS HQ, RHMT, District Health Management Team (DHMT), JICA Ghana office etc.	The 4th study tout	22nd January,2020	Field visits to three districts, training school, health center, DA and DHMT of UWR	GHS HQ staff, RHMT,DHMT, UWR District Assembly(DA), members, UWR training school, JICA Ghana office	87	
	GHS HQ, RHMT, DHMT, JICA Ghana office+B8:I12B8:I14B8:I16E8B8:I11E8B8:I11B8:I19E8B8:I11B8:I22E8B8:I11B8:I24E8B8:I1B8:I27	The 5th JCC	23rd January, 2020	・Approval for the workplan of the second term ・Sharing the findings of UWR study tour ・Sharing the status of CHPS implementation ・Sharing findings of the 2nd Training in Japan ・Discussion on issues and concerns	GHS DG, Directors of GHS-HQ's main divisions RHMT/DDHS, UER RHMT, NR/NER/SRRHMT, Media, JICA Ghana office	46	
	UWR RHMT	UWR Regional Management Meeting	1st: 28th January 2020 2nd: 6th October ,2020	1st:Progres of the Project, Agreement on the workplan of the 2nd term, setting of indicator value of PDM 2nd: Progress of the Project and introduction of the modified plan. Discussion on COVID-19 related issues	UWR RHMT	!st:8 2nd:9	
	UER RHMT	UER Regional Management Meeting	1st: 3rd February 2020 2nd: 30th September ,2020	1st:Progres of the Project, Agreement on the workplan of the 2nd term, setting of indicator value of PDM 2nd: Progress of the Project and introduction of the modified plan. Discussion on COVID-19 related issues	UER RHMT	!st: 15 2nd:12	
	NR/NER/SR RHMT	NR/NER/SR Regional Management Meeting	1st: 2nd March, 2020 2nd: 30th September ,2020	1st:Progres of the Project, Agreement on the workplan of the 2nd term, setting of indicator value of PDM, Agreement on meeting style (Joint meeting for 3 regions) 2nd: Progress of the Project and introduction of the modified plan. Discussion on COVID-19 related issues	NR/NER/SR RHMT	1st:13 2nd: 15	
	UER RHMT, DHMT	The 2nd DHMT meeting	4th February, 2020	Sharing the status of CHPS implementation and confirmation of regional strategy. Explanation of rationales of necessity of district Cho orientation and request of collaboration	UER ,RHMT,DHMT	70	
	NR/NER/SR ,RHMT, DHMT	The 2nd DHMT meeting	9th March, 2020	Sharing the status of CHPS implementation and confirmation of regional strategy. Explanation of rationales of necessity of district Cho orientation and request of collaboration	NR/NER/SR RHMT,DHMT	73	
	GHS-HQ, RHMT	GHS monitoring tour	From 22nd to 29th August, 2020	Confirmation of the Project progress by GHS HQ	Participants of training in Japan, in total 6 people (MOH 1, GHS-HQ 2, each 1 from three regions)	GHS HQ 8 people	
	RHMT	The 5th coordination meeting of 5 regions	7th July, 2021	・Validation and setting of indicator value for the PDM ver.3 ・Sharing the status of CHPS implementation ・Sharing the progress of activities ・Sharing workplan and approval ・Confirmation of the contents of JCC presentation ・Discussion on issues and concerns	RHMT of 5 regions	29	
	GHS HQ, RHMT, DHMT, JICA Ghana office	The 6th JCC	8th July, 2021	・Approval for th PDM ver.3 ・Sharing the status of CHPS implementation ・Sharing the progress of activities ・Sharing workplan and approval ・Sharing NCD data ・Discussion on issues and concerns	GHS DG, Directors of GHS-HQ's main divisions RHMT/DDHS, UER RHMT, NR/NER/SR RHMT, Media, JICA Ghana office	58	
	UWR RHMT	UWR Regional Management Meeting	11st March ,2021	Progress of the Project,Workplan and change of operation style	UWR RHMT	20	
	UER RHMT	UER Regional Management Meeting	1st: 18th February 2021 2nd: 25th May ,2021	1st: Workplan and change of operation style 2nd: Progress of the Project, coming activities, challenges and solution	UER RHMT	!st: 11 2nd: 16	
	NR/NER/SR RHMT	NR/NER/SR Regional Management Meeting	1st: 9th February 2021 2nd: 11th May ,2021	1st: Workplan and change of operation style 2nd: Progress of the Project, coming activities, challenges and solution	NR/NER/SR RHMT	1st: 16 2nd: 20	
	GHS-HQ, RHMT	GHS monitoring tour	From 11 to 15 October, 2021	・Confirmation of the Project progress by GHS HQ ・Examine tool and training materials of each output	GHS HQ, ICD, PHD, FHD、RHMT of 5 regions, DHMT of visited site	GHS HQ 10 people	
	UER RHMT/DHMT	The third district meeting on CHO Orientation meeting	From 12th to 13th November, 2021	・CHPS concept and role of each level ・Orientation of Distrcict CHO Orientation ・Orientation of utilization of Distrcist CHO Orientation tool	RHMT, DHMT (DDHS, CHPS Coordiator, HIO) of 16 districts	122	Conducted three venues
	RHMT	The 6th coordination meeting of 5 regions	25th January, 2022	・Information sharing of on the status of CHPS implementation ・Presentation on the status of the progress ・Information on the achievement to PDM indicators value ・Issues and concerns on challenges	RHMT of 5 regions	31	
	GHS HQ, RHMT, DHMT, JICA Ghana office	The 7th JCC	26th January, 2022	・Presentation on the status of CHPS implementation ・Presentation of the progress of the Project ・Presentation on the achievement on PDM ・Discussion on issues and concerns	GHS DG, Directors of GHS-HQ's main divisions RHMT/DDHS, UER RHMT, NR/NER/SR RHMT, Media, JICA Ghana office	58	

Output 0	UWR RHMT	UWR Regional Management Meeting	22nd October ,2022	Progress of the Project, coming activities, challenges and solution	UWR RHMT	17	
	NR/NER/SR RHMT	NR/NER/SR Regional Management Meeting	22nd September 2022	Progress of the Project, coming activities, challenges and solution	NR/NER/SR RHMT	14	
	RHMT	End-line Survey Review Meeting	14th – 15th February, 2023	・Purpose of Report ・Purpose of end-line survey ・Program and how to review the report ・Background information of the Project ・Characters of regions ・Framework of Endline survey	RHMT of 5 regions	17	
	RHMT, DHMT	The 7th coordination meeting of 5 regions	15th February, 2023	・Information sharing of on the status of CHPS implementation ・Presentation on the status of the progress ・Information on the achievement to PDM indicators value ・Issues and concerns on challenges	RHMT of 5 regions	35	
	GHS HQ, RHMT, DHMT, JICA Ghana office	The 8th JCC	16th February, 2023	・Presentation on the status of CHPS implementation ・Presentation of the progress of the Project ・Presentation on the achievement on PDM ・Discussion on issues and concerns	GHS DG, Directors of GHS-HQ's main divisions, UWR RHMT/DDHS, UER RHMT, NR/NER/SR RHMT, JICA Ghana office	43	
	UER RHMT	UER Regional Management Meeting	28th February, 2023	Progress of the Project, plan for the remaining period, status of CHPS implementation as at the end of Q4 2022, comparison of the performance of CHPS implementation among the five regions, challenges and solution	UER RHMT	20	
	GHS HQ, RHMT, DHMT, RCC, DA, JICA Ghana office	Dissemination Forum for Five Regions	31st May 2023	・Brief Overview of the Project and Introductory Slide Show ・Project Activities, Results, Achievements and Lessons Learnt ・ Presentation on the results of the endline survey ・Panel Discussion 1; DCHOO: a sustainable approach to the training of CHO ・Panel discussion 2 ;Integrating Life-course Approach (LCA) into Primary Health Systems (CHPS)	GHS DG, Directors of GHS-HQ's main divisions RHMT/DDHS, UER RHMT, NR/NER/SR RHMT, RCC/DA, JICA Ghana office	97	
	GHS HQ, RHMT, DHMT, RCC, DA, JICA Ghana office	National Dissemination Forum	14th June, 2023	・Brief Overview of the Project and Introductory Slide Show ・Project Activities, Results, Achievements and Lessons Learnt ・Panel Discussion 1; DCHOO: a sustainable approach to the training of CHO	GHS DG, Directors of GHS-HQ's main divisions RHMT/DDHS, UER RHMT, NR/NER/SR RHMT, RCC/DA, JICA Ghana office	132	
	GHS HQ, RHMT, DHMT, JICA Ghana office	The 9th JCC	14th June, 2023	・Presentation on the achievement of PDM indicators and sustainability plans ・Project closure and brief remarks from CHPS for Life. ・Remarks & Way forward from five regions and HQ ・Closing remarks and dissolution of JCC	GHS DG, Directors of GHS-HQ's main divisions RHMT/DDHS, UER RHMT, NR/NER/SR RHMT, JICA Ghana office	79	
	GHS HQ, RHMT, DHMT	Feedback meeting on final output and project dissemination	15th June, 2023	・Discussion of outputs ・Remarks/Feedback from GHS Counterparts	RHMT of 5 regions	13	
	GHS HQ, RHMT, DHMT, JICA Ghana office	DG VIP dissemination/Feedback meeting	19th June, 2023	・Presentation of Project Activities, Results, Achievements and Lessons Learnt ・Remarks from Rep. of Regional Directors	GHS DG, Directors of GHS-HQ's main divisions RHMT/DDHS, UER RHMT, NR/NER/SR RHMT, JICA Ghana office	15	

Related Output	Organization involved in the training	Training title	Date	Content of Training/Meeting	Main Participants (Project members are excluded)	No. of participants (Project members are excluded)	Remarks
						2nd Term	
Output 1	UWR RHMT, DHMT	UWR CHPS database meeting	9th March, 2018	Presentation of the result of CHPS data as of Dec. 2017 Presentation of the current challenges and capacity building on data validation	Regional CHPS coordinator/Health Information Officer (HIO) , District CHPS Coordinator and HIO	25	Every 6 months, First meeting 25 people.
	UER RHMT, DHMT	UER CHPS database meeting	1st meeting: 1st November, 2017 2nd meeting: 1st February.2018 3rd meeting: 22nd March, 2018(Regional) 4th meeting: 11th July, 2018	1st meeting: Introduction on CHPS database and tool and capacity building on data collection 2nd meeting: Presentation on the CHPS data as of Dec. 2017 and capacity building on data validation. Supports on the data collection for 2018. 3rd meeting: Capacity building of regional CHPS unit on integration and validation of data 4th meeting: Presentation on challenges on data validation and capacity building	Regional CHPS coordinator/Health Information Officer (HIO) , District CHPS Coordinator and HIO, GHS-HQ	104	Quarterly, First meeting 34 people, Second meeting 29 people, Third meeting 14 people, Fourth meeting 27 people.
	NR RHMT, DHMT	NR CHPS database meeting	1st meeting: 2nd November,2017 2nd meeting: 6th February, 2018 3rd meeting:20th March, 2018(Regional) 4th meeting: 29th June, 2018 5th meeting:13th July, 2018	1st meeting: Introduction on CHPS database and tool and capacity building on data collection 2nd meeting: Presentation on the CHPS data as of Dec. 2017 and capacity building on data validation. Supports on the data collection for 2018. 3rd meeting: Capacity building of regional CHPS unit on integration and validation of data 4th meeting: capacity buildinh of regional CHPS unit on utilization of data 5th meeting:Presentation on challenges on data validation and capacity building	Regional CHPS coordinator/Health Information Officer (HIO) , District CHPS Coordinator and HIO, GHS-HQ	188	Quarterly, First meeting 55 people, Second meeting 63 people, Third meeting 17 people, Fourth meeting 2 people , Fifth meeting 51 people.
	RHMT, DHMT, CHNTS	Strategic meeting on pre-service training and district CHO orientation	13th November, 2017	Strategy meeting on improvement of the program of pre-service training and introduction of district CHO orientation and standardization	RHMT(CHPS unit), DHMT	16	
	RHMT	Strategic meeting on CHO fresher training	13th July, 2018	Planning of CHO fresher training Listing of candidates of facilitators and planning TOT	CHPS unit staff of three regions	8	
	RHMT, DHMT, Hospital, CHNTS	First CHO fresher training in UWR	Preparatory meeting: 20th July, 2018 Training: 23rd July to 3rd August, 2018	CHO fresher training for the candidates of CHO in UWR capacity building of facilitators of UER and NR	Preparatory meeting 25 Candidates of CHO 70, UER facilitators 10、NR facilitators 20, UWR facilitators 19	Preparatory meeting: 25 CHO fresher training: 119	
	RHMT, DHMT	Strategic meeting on FSV	23rd January, 2018	Sharing the status of FSV implementation and data. Agreement to change monitoring from FSV to nationally recommended SSV	GHS-HQ, UWR Regional hospital, UWR RHMT/DHMT	42	
	RHMT, DHMT	Strategic meeting on referral in UWR	22nd January, 2018	Planning referral training Confirmation of training materials on the part of modification.	GHS-HQ,UWR Regional hospital/ district hospital,/polyclinic, UW RHMT/DHMT	31	
	RHMT, DHMT	Strategic meeting on referral in UER and NR	10th, April, 2018	Planning referral training Confirmation of training materials on the part of modification.	GHS-HQ, UER and NR Regional hospital/ district hospital,/polyclinic, UER and NR RHMT/DHMT	41	
	RHMT, DHMT	Review meeting on referral training materials	1st meeting: 26th January 2nd meeting: 4th and 5th June, 2018	Modification and finalization of referral training materials	GHS-HQ, UWR Regional hospital/district hospitals, UWR RHMT/DHMT	27	Quarterly, First meeting 14 people, Second meeting 13 people.
	RHMT, DHMT	ToT on referral training	9th and 10th July, 2018	Capacity building of facilitators for district referral training	RHMT, DHMT, District hospitals, regional hospitals、	35	
	UWR RHMT, DHMT	UWR CHPS database meeting	9th March, 2018 22nd May, 2019	Presentation of the result of CHPS data as of December, 2017 Presentation of the current challenges and capacity building on data validation	Regional CHPS coordinator/Health Information Officer (HIO), District CHPS Coordinator and HIO	About 25/meeting Total 50	
	UER RHMT, DHMT	UER CHPS database meeting (4th to 6th)	3rd December, 2018 19th February, 2019 3rd May, 2019	Review and feedback of data of previous quarter Data collection of the quarter Share regional data with district Training of newly assigned staff Capacity building on utilization of data	Regional CHPS coordinator/Health Information Officer (HIO), District CHPS Coordinator and HIO	About 34/meeting Total 102	
	NR RHMT, DHMT	NR CHPS database meeting (6th to 8th)	6th December, 2018 19th February, 2019 14th April, 2019	Review and feedback of data of previous quarter Data collection of the quarter Share regional data with district Training of newly assigned staff Capacity building on utilization of data	Regional CHPS coordinator/Health Information Officer (HIO), District CHPS Coordinator and HIO, GHS HQ	About 55/meeting, Total 165	
	UWR, UER and NR, GHS HQ	CHPS database modification meeting	22nd February, 2019	Review the modified CHPS database for finalization Clarify definition of CHO	CHPS unit of UWR, UWR and UER, GHS HQ	8	
	UWR, UER and NR	The first CHO fresher training (UWR)	23rd July - 3rd August, 2018	Capacity building of facilitators on Harmonized CHO Training Produce CHO	UER, UWR and NR facilitators Trainees (CHN, EN, MW) from UWR	122	
	UWR, UER and NR, GHS HQ	The second CHO fresher training (NR)	3rd - 24th August, 2018	Capacity building of facilitators on Harmonized CHO Training Produce CHO Familiarize training school tutors on CHO fresher training	UER, UWR and NR facilitators NAP tutors Trainees (CHN, EN, MW) from NR	78	
	UWR, UER and NR, GHS HQ	The third CHO fresher trainin (NR)	29th October - 9th November, 2018	Capacity building of facilitators on Harmonized CHO Training Produce CHO Familiarize training school tutors on CHO fresher training	UER, UWR and NR facilitators NAP tutors Trainees (CHN, EN, MW) from NR	117	
	UWR, UER and NR, GHS HQ	The fourth CHO fresher training (UER)	4th - 15th February, 2019	Capacity building of facilitators on Harmonized CHO Training Produce CHO Familiarize training school tutors on CHO fresher training Capacity building of SDHT	UER, UWR and NR facilitators NAP, NAC, MTC tutors SDHT Trainees (CHN) from UER	129	
	Training schools of UWR, UER and NR, RHMT	Orientation of pre-service training for UER and NR	5th December, 2018	Status of CHPS implementation and challenges on CHO production Introduction of modified model of pre-service training Share experiences of Jirapa NAC	Training schools (NAP, NAC, MTC) of UWR, UER and NR, CHPS unit of RHMT	43	
	NAP of 3 regions, UWR RHMT	Study visit to Jirapa NAP (Theory)	17th-21st December, 2018	Establish network among schools Learn the conducts of pre-service training	Tutors of NAP of 3 regions, CHPS unit of RHMT	27	
	NAP of 3 regions, UIWR RHMT	Study visit to Jirapa NAP (Field)	21st - 25th January, 2019	Establish network among schools Learn the conducts of pre-service training	Tutors of NAP of 3 regions, CHPS unit of RHMT	17	
	Training schools of UWR, UER and NR, RHMT	Strategic meeting on pre-service training	25th April, 2019	Selection of module to be integrated Review duration and contents of the Harmonized CHO training and curriculum	RHMT, NAC, NAP, MTC of UWR, UER and NR, CHPS unit of RHMT	46	
	UWR, NAP, NAC and MTC of UWR	Strategic meeting on District CHO Orientation	13th December, 2018	Review of orientation program and materials Selection of pilot districts	UWR DRHMT, DHMT, NAP, NAC and MTC	36	
	UWR, Wa Municipal DHMT, Jirapa DHMT	Preparatory meeting on pilot District CHO Orientation	26th February, 2019	Planning of detailed orientation (candidates, monitoring, program and venue etc.)	Jirapa DHMT, Wa Municipal DHMT	13	
	UWR RHMT, DHMT	Joint feedback meeting on pilot District CHO Orientation	23th May, 2019	Joint feedback on pilot District CHO orientation Plan of District Cho orientation in the 9 districts	UWR RHMT, DHMT	40	

	RHMT, DHMT, Hospital	Health System Strengthening Technical Working Group Meeting (UWR)	1st meeting: 21st November, 2018 2nd meeting: 26th Feb, 2019 3rd meeting: 16th May, 2019	To develop strategies and monitor actvitities related to referrals and SSV in the region	TWG members consisting from RHMT/DHMT and Hospitals	(1st) 10 (2nd) 10 (3rd) 9	
	RHMT, DHMT, Hospital	Health System Strengthening Technical Working Group Meeting (UER)	1st meeting: 10th December, 2018 2nd meeting: 21st February, 2019 3rd meeting: 24th April, 2019	To develop strategies and monitor actvitities related to referrals and SSV in the region	TWG members consisting from RHMT/DHMT and Hospitals	(1st) 12 (2nd) 9 (3rd) 10	
	RHMT, DHMT, Hospital	Health System Strengthening Technical Working Group Meeting (NR)	1st meeting: 10th January, 2019 2nd meeting: 26th April, 2019	To develop strategies and monitor actvitities related to referrals and SSV in the region	TWG members consisting from RHMT/DHMT and Hospitals	(1st) 10 (2nd) 10	
	Hospital, Polyclinic, Health Center, DHMT	TOT/Preparatory training for Referral training (UWR)	27th February, 2019	To review the referral training materials, assign modules to the various facilitators and also review the pre/post test questions and conduct mock presentations by the various facilitators	Staff from Hospital, Polyclinic, Health Center, DHMT	38	
	RHMT, DHMT, SDHT, Hospital	TOT/Preparatory training for Referral training (UER)	21st February, 2019	To review the referral training materials, assign modules to the various facilitators and also review the pre/post test questions and conduct mock presentations by the various facilitators	Staff from Hospital, RHMT, DHMT and Health Center	39	
	RHA, Hospital	TOT/Preparatory training for Referral training (NR)	16th January, 2019	To review the referral training materials, assign modules to the various facilitators and also review the pre/post test questions and conduct mock presentations by the various facilitators	Officers from RHA and Hospitals	7	
	DHMT, SDHT, CHPS, Hospital	Referral Training (UWR)	12th March - 2nd April, 2019 (9 days within the period)	Training on national referral guidelines, referral procedures and documentation, and customer care	Health officers at CHPS, Health Center, Hospital, DHMT	344	
	DHMT, SDHT, CHPS, Hospital	Referral Training (UER)	1st Batch: 12th September - 27th September, 2018 (13 days within the period) 2nd Batch: 26th Feburary - 19th March, 2019 (11 days within the period)	Training on national referral guidelines, referral procedures and documentation, and customer care	Health officers at CHPS, Health Center, Hospital, DHMT	954	
	DHMT, SDHT, CHPS, Hospital	Referral Training (NR)	1st Batch: 4th September - 11th September, 2018 (3 days within the period) 2nd Batch: 17th January - 30th January, 2019 (4 days within the period)	Training on national referral guidelines, referral procedures and documentation, and customer care	Health officers at CHPS, Health Center, Hospital, DHMT	264	
	RHMT, Hospitals (regional, district and private), DHMT, NAS	Regionwide Stake Holder meeting (UWR)	23rd November, 2018	To share the current status of referral activities and challenges in the region To strengthen referral service delivery network within the region	Doctors and staff from hospitals and clinics, District Directors, Officers at DHMT and RHMT	103	
	NR/NER/SR RHMT	CHPS database meeting	12th February, 2020	Capacity building on CHPS database for regional CHPS unit	Regional CHPS unit staff and Health Information Officer (HIO)	104	
	UER RHMT	CHPS database meeting	25th February, 2020	Capacity building on CHPS database for regional CHPS unit	Regional CHPS unit staff and Health Information Officer (HIO)	25	
Output 1	UWR RHMT, DHMT,Training schools	UWR CHO fresher raining	From 25th November to 6th December , 2019	Production of CHO, new facilitators and SDHT	UWR RHMT, DHMT,Training school , SDHT and CHN	Trainees:(SDHT. CHN):110 Facilitators:22	One-day preparatory meeting for facilitators prior to the training.
	UER RHMT, DHMT,Training schools	UER CHO fresher training	From 17th to 28th February , 2020	Production of CHO, new facilitators and SDHT	UER RHMT, DHMT,Training school , SDHT and CHN	Trainees:(SDHT. CHN):120 Facilitators:16	One-day preparatory meeting for facilitators prior to the training.
	NR/NER/SR RHMT, DHMT, Training schools	NR/NER/SR CHO fresher training	From 31st August to 25th September, 2020	Production of CHO, new facilitators and SDHT	NR/NER/SR RHMT, DHMT,Training school , SDHT and CHN	Trainees:(SDHT. CHN):119 Facilitators:28	One-day preparatory meeting for facilitators prior to the training.
	NR/NER/SR RHMT, DHMT of pilot districts	Preparatory meeting on district CHO orientation for NR/NER/SR	From 8st to 22nd September, 2020	Planning meeting on district CHO orientation	NR/NER/SR RHMT, DHMT of pilots districts	Nanton 22 East Mamprusi 33 Savelugu 28 Sawla Tuna Kalba 28 **Total 111**	It was conducted in pilot district of each region
	GHS HQ, RHMT, DHMT	SS Material Review Meeting	From January 13 to 14, 2020	Reviewing and revising SS checklists and training materials for the pilot implementation of SS from SDHT to CHPS	National SS TWG members, HSS-TWG members from UWR, UER and NR	17	
	RHMT, DHMT	HSS-TWG Meeting	March 10, 2020 (UWR) July 14, 2020 (NR) July 28, 2020 (UER)	Sharing the status of SS and referral in the region and discussing the strategy and plans for future operation	Members of HSS-TWG in the region	UWR: 9 NR: 9 UER: 12	
	RHMT, DHMT, SDHT	SS Training (UWR)	From 17th March to 20th, 2020	Capacity Building of the Staff at SDHT in implementation of SS	Preparatory Meeting: DHMT, HSS-TWG members Training: SDHT staff	26	Two-day preparatory meeting for facilitators prior to the training.
	RHMT, DHMT, SDHT	SS Training (NR)	From 21st to 24th July, 2020	Capacity Building of the Staff at SDHT in implementation of SS	Preparatory Meeting: DHMT, HSS-TWG members Training: SDHT staff	27	Two-day preparatory meeting for facilitators prior to the training.
	RHMT, DHMT, SDHT	SS Training (UER)	From 4th to 7th August , 2020	Capacity Building of the Staff at SDHT in implementation of SS	Preparatory Meeting: DHMT, HSS-TWG members Training: SDHT staff	27	Two-day preparatory meeting for facilitators prior to the training.
	NR RHMT/DHMT	NR CHPS database meeting	13th April, 2021	・Orienttaion on the modified CHPS database. ・Sharing the crrent CHPS implementation status	Regional and district CHPS unit staff and Health Information Officer (HIO)	50	
	SR RHMT/DHMT	SR CHPS database meeting	22nd March, 2021	・Orienttaion on the modified CHPS database. ・Sharing the crrent CHPS implementation status	Regional and district CHPS unit staff and Health Information Officer (HIO)	25	
	NER RHMT/DHMT	NER CHPS database meeting	6th April, 2021	・Orienttaion on the modified CHPS database. ・Sharing the crrent CHPS implementation status	Regional and district CHPS unit staff and Health Information Officer (HIO)	20	
	UER RHMT/DHMT	UER CHPS database meeting	18th February, 2021	・Orienttaion on the modified CHPS database. ・Sharing the crrent CHPS implementation status	Regional CHPS unit staff and Health Information Officer (HIO)	11	
	UWR RHMT/DHMT	UWR CHPS database meeting	14th and 15th April, 2021	・Orienttaion on the modified CHPS database. ・Sharing the crrent CHPS implementation status	Regional and district CHPS unit staff and Health Information Officer (HIO)	41	
	GHS HQ,RHMT/DHMT of 16 regions	National CHPS Disseination Meeting	From 16th to 18th November. 2021	・Dissemination of CHPS database to the remaining 10 regions. ・Orientation of CHPS database on concept, introduction of tools and how to use it.	GHS Director General, Director of PPMED, Deputy Director of PPMED, 14 regional directrs/deputy directors, RHMT, DHMT of 16 regions, UNDP	1st day: 70 2nd day:101 3rd day;100	Launching of CHPS database manual
	GS HQ, RHMT/DHMT of Eastern region, RHMT of Northern five regions	CHPS Disseination Meeting in Eastern Region	1st: 23rd and 24th September,2021 2nd: 9th an 10th November, 2021	1st: Orientation on CHPS database to RHMT and DHMT 2nd: Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO of 33 districts	1st: 150 2nd: 142	
	UWR RHMT, DHMT,Training schools	UWR CHO fresher raining (Theory)	From 16th to 22nd May, 2021	Production of CHO and new facilitators on theory part of Harmonized CHO training	UWR RHMT, DHMT,Training school and CHN	Trainees:(CHN):81 Facilitators:19	One-day preparatory meeting for facilitators prior to the training.
	NR/NER/SR RHMT, DHMT, Training schools	NR/NER/SR CHO fresher training (Theory)	From17th to 22nd May, 2021 From 24th to 29th May, 2021	Production of CHO and new facilitators on theory part of Harmonized CHO training	NR/NER/SR RHMT, DHMT,Training school , and CHN	Trainees:(CHN、EN):127 Facilitators:28	One-day preparatory meeting for facilitators prior to the training.
	UWR RHMT, DHMT、SDHT、CHPS staff	Pilot District CHO orientation in UWR (11 districts)	From September to October, 2020	Pilot implementattion of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	331 (CHN to be CHO:79)	It was conducted in pilot district of each region
	UER RHMT,DHMT,SDHT、CHPS staff	Pilot District CHO orientation in UER (5 districts)	From December 2020 to Febraury 2021	Pilot implementattion of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	237 (CHN to be CHO:71)	It was conducted in pilot district of each region

	NR RHMT, DHMT, SDHT、CHPS staff	Pilot District CHO orientation in NR(2 districts)	From September to October, 2020	Pilot implementattion of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	50 (CHN to be CHO:18)	It was conducted in pilot district of each region
	NER RHMT, DHMT, SDHT、CHPS staff	Pilot District CHO orientation in NER (1 district)	From September to November, 2020	Pilot implementattion of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	26 (CHN to be CHO:10)	It was conducted in pilot district of each region
	SR RHMT, DHMT,SDHT、CHPS staff	Pilot District CHO orientation in SR (1 district)	From September to October, 2020	Pilot implementattion of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	28 (CHN to be CHO:8)	It was conducted in pilot district of each region
	UWR RHMT, DHMT、SDHT、CHPS staff	District CHO orientation in UWR (11 districts)	From May to JUne, 2021	Implementation of Distrct CHO Orientation	RHMT, DHMT, SDHT, CHO, CHN	246 (CHN to be CHO:81)	The second implementation by all districts
	UER RHMT,DHMT,SDHT、CHPS staff	District CHO orientation in UER (10 non-pilot districts)	From May to July 2021	Implementation of Distrct CHO Orientation	RHMT, DHMT, SDHT, CHO, CHN	378 (CHN to be CHO:158)	
	NR RHMT, DHMT, SDHT、CHPS staff	District CHO orientation in NR(14 non pilot districts, 2 districts,total 16 districts)	From May to June 2021	Implementation of Distrct CHO Orientation	RHMT, DHMT, SDHT, CHO, CHN	261 (CHN to be CHO:66)	The second implementation by Savelugu,Nanton
	NER RHMT, DHMT, SDHT、CHPS staff	District CHO orientation in NER (5 non-pilot districts)	From May to June 2021	Implementation of Distrct CHO Orientation	RHMT, DHMT, SDHT, CHO, CHN	85 (CHN to be CHO:25)	
	SR RHMT, DHMT,SDHT、CHPS staff	District CHO orientation in SR (6 non pilot districts)	June 2021	Implementation of Distrct CHO Orientation	RHMT, DHMT, SDHT, CHO, CHN	96 (CHN to be CHO:30)	
	UWR RHMT, DHMT,SDHT、CHPS staff	NR/NER/SR Distrct CHO Orientation, Joint feedback meeting	17th March, 2021	Feedback meeting of District CHO orientation	RHMT, DHMT	30	
	UER RHMT, DHMT,SDHT、CHPS staff	NR/NER/SR Distrct CHO Orientation, Joint feedback meeting	11th May, 2021	Feedback meeting of District CHO orientation	RHMT, DHMT	50	
	NR/NER/SR RHMT, DHMT,SDHT、CHPS staff	NR/NER/SR Distrct CHO Orientation, Joint feedback meeting	17th February, 2021	Feedback meeting of District CHO orientation	RHMT, DHMT	43	
	RHMT, DHMT	Health System Stregthening Techinical Working Team Meeting	20th October, 2020, April 16, 2021 (UWR) 18th Feburary, 2021 (NR) 22nd April, 2021 (UER)	Confirmation and discussion SS and Referral Status, Project strategy, and future schedule of the activity.	TWG members selected from RHMT and DHMT	UWR: 7、8 NR: 10 UER 13	
	RHMT, DHMT, Hospital	Joint HSS-TWG Taskforce Meeting	20th October , 2020 25th Feburary, 2021 30th-31st March , 2021 7th May, 2021	Discussion and development of Referral monitoring tools and standard telephone directory, reference guide for DHQPR meeting and startegy for implementation.	Selected members of HSS-TWG from each region	14 13 14 18	
	RHMT, DHMT, SDHT, Hospital and CHPS	Orientation on Referral Monitoring Tools	12th January, 2021 (UER) 14th January, 2021 (NR) 19th January, 2021 (UWR)	Orientation on Monthly Referral Returns, Standard Telephone Directory	Staff from DHMT, SDHT, CHPS of the Pilot District, and RHMT and Hospitals in each regions	NR: 27 UER: 37 UWR: 57	
	Regional and District Hospital	Referral Trainining	From 16th to 20th June , 2021 (5 batches)	Referral training (process, forms and tools) for newly assinged staff at UW Regional hospital	Preparatory Meeting: Selected TWG-HSS members from RHMT and Hospitals Training: Health Staff at Regional and District Hospitals	135	Preparatory meeting was conducted prior to the training
	RHMT, DHMT, Hospital and DA	Orientation for District Health Quarterly Perofrmance Review Meeting	From 16th to 27th May, 2021 (UER) 10th June, 2021 (UWR) From 10th to 11th June, 2021 (NR) 6th August, 2021 (SR) 25th August, 2021 (NER)	Orientation and Capacity Development of the staff on implementation of DHQPR meeting	RHMT, DHMT and DA in each region	NR: 122 NER: 33 SR: 44 UER: 99 UWR: 83	
	RHMT, DHMT, SDHT, Hospital and others	UER Referral Stakeholde Meeting	27th October, 2021	Referral Stakeholder meeting to improve the status of referrals in the region	UE-RHMT, DHMT, SDHT and Hospital	43	Participating districts are Talensi DHMT, Bolgatanga DHMT, Kasena-Nankana DHMT and Bawku DHMT only.
Output 1	UER RHMT/DHMT	UER CHPS database meeting	22nd July, 2022	・Capacity building of CHPS unit members ・Capacity building of district	Regional CHPS unit staff and Health Information Officer (HIO)	54	
	UWR RHMT/DHMT	UWR CHPS database meeting	4th March, 2022	・Capacity building of CHPS unit members ・Capacity building of district	Regional and district CHPS unit staff and Health Information Officer (HIO)	40	
	GHS HQ, RHMT/DHMT , RHMT of Ahafo	CHPS Dissemination Meeting in Ahafo Region	Orientation: 2nd February,2022 Feedback : 17th May, 2022	Orientation: Orientation on CHPS database to RHMT and DHMT Feedback Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO	Orientation: 30 Feedback 10	No financial support by the Project
	GHS HQ, RHMT/DHMT , RHMT of Bono	CHPS Dissemination Meeting in Bono Region	Orientation: 4th February,2022 Feedback : 18th May, 2022	Orientation: Orientation on CHPS database to RHMT and DHMT Feedback Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO	Orientation: 50 Feedback 12	Tehe Project support only lunch
	GHS HQ, RHMT/DHMT , RHMT of Bono East	CHPS Dissemination Meeting in Bono East Region	Orientation: 10th March,2022 Feedback : 10th May, 2022	Orientation: Orientation on CHPS database to RHMT and DHMT Feedback Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO	Orientation: 48 Feedback 12	No financial support by the Project
	GHS HQ, RHMT/DHMT , RHMT of Central	CHPS Dissemination Meeting in Central Region	Orientation: 21st and 22nd July,2022 Feedback :	Orientation: Orientation on CHPS database to RHMT and DHMT Feedback Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO	Orientation: 96 Feedback	No financial support by the Project
	GHS HQ, RHMT/DHMT , RHMT of Greater Accra	CHPS Dissemination Meeting in Greater Accra Region	Orientation: 25th,26th, 27th May,2022 Feedback : 8th November, 2022	Orientation: Orientation on CHPS database to RHMT and DHMT Feedback Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO	Orientation: 120 Feedback 8	No financial support by the Project
	GHS HQ, RHMT/DHMT , RHMT of Oti	CHPS Dissemination Meeting in Oti Region	Orientaion:6th June,2022 Feedback : 29th November, 2022	Orientation: Orientation on CHPS database to RHMT and DHMT Feedback Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO	Orientation:40 Feedback 10	No financial support by the Project
	GHS HQ, RHMT/DHMT , RHMT of Volta	CHPS Dissemination Meeting in Volta Region	Orientation: 2nd June,2022 Feedback : 2nd November, 2022	Orientation: Orientation on CHPS database to RHMT and DHMT Feedback Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO	Orientation: 80 Feedback 13	No financial support by the Project
	GHS HQ, RHMT/DHMT , RHMT of Western	CHPS Dissemination Meeting in Western Region	Orientation: 6th May,2022 Feedback : 9th August, 2022	Orientation: Orientation on CHPS database to RHMT and DHMT Feedback Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO	Orientation: 60 Feedback 12	No financial support by the Project
	GHS HQ, RHMT/DHMT , RHMT of Western North	CHPS Dissemination Meeting in Western North Region	Orientation: 4th May,2022 Feedback : 11th August, 2022	Orientation: Orientation on CHPS database to RHMT and DHMT Feedback Feedback on data collection and development of regional dataset.	Regional Director, Regional CHPS Coordinator and HIO, DDHS, District Director, CHPS focal person and HIO	Orientation: 40 Feedback 10	No financial support by the Project
	GHS HQ, RHMT 8 regions	Joint CHPS Database feedback meeting for 8 regions	17th August,2022	Comparison of CHPS database Consistency check with DHIMS2 Feedback from GHS HQ Orientation: Challenges and countermeasure	Regional CHPS Coordinator and HIO, PPMED	35	
	GHS HQ, RHMT 5 regions	Joint CHPS Database feedback meeting for 5 regions	26th January,2022	Consistency check with DHIMS2 Plan of CHO to be produced to achieve PDM target value	Regional CHPS Coordinator, RHMT staff	8	
	5 regions RHMT, DHMT,Training schools	5 regions pre-service training orientation	From 10th to 13th May, 2022	Progress of pre-service training progress and introduction of modules developed Review of the presentation Planning of pre-service training at schools	UWR RHMT, DHMT,Training school and CHN	133	
	MOH, UWR RHMT,DHMT, Training schools	National pre-service training orientation	From 15th to 16th September, 2022	Rationales of pre-service training and introduction of modules developed Introduction of the presentation Planning of pre-service training at schools	MOH, UWR RHMT, DHMT, Training schools	122	Virtual meeting
	UWR RHMT,DHMT,SDHT、CHPS staff	District CHO orientation in UWR (11 districts)	From January to November 2022	Implementation of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	CHN to be CHO:148	

	UER RHMT,DHMT,SDHT、CHPS staff	District CHO orientation in UER (4 districts)	From January to November 2022	Implementation of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	CHN to be CHO:76	
	NR RHMT、DHMT, SDHT、CHPS staff	District CHO orientation in NR(3 districts)	From January to November 2022	Implementation of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	CHN to be CHO:52	
	NER RHMT, DHMT, SDHT、CHPS staff	District CHO orientation in NER (1 district)	From January to November 2022	Implementation of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	CHN to be CHO:15	
	SR RHMT, DHMT,SDHT、CHPS staff	District CHO orientation in SR (7 district)	From January to November 2022	Implementation of district CHO orientation	RHMT, DHMT, SDHT, CHO, CHN	CHN to be CHO:75	
	GHSHQ, RHMT, DHMT	Referral Review Meeting	8th December 2021	Review of Referral activities in each region and discussion on Monthly Referral Returns and its impact	GHS-ICD, PPMED, selected members from HSS-TWG in 3 regions	38	
	GHSHQ, RHMT, DHMT	ISS Lesson Learned Meeting	9th December 2021	Sharing the experiences and lessons learnt from ISS implementation in 3 regions and discuss future strategies	GHS-SS TWG members, selected members from HSS-TWG in 3 regions	39	
	RHMT, DHMT, Regional/District Hospitals, District Assembly	District Health Quarterly Performance Review Meeting (Nadowli, Savelugu)	14th December, 2021 (UWR: Nadowli) 15th December, 2021 (NR: Savelugu)	District's health performance review based on the DHQPR reference guide	RHMT, DHMT, SDHT, CHO, Hospital and DA staff	75 43	
	GHSHQ, RHMT, DHMT	(DHIMS2) BootCamp for MRR development	From 4th to 6th January, 2022	Technical Work on integration of MRR onto the DHIMS2 format	GHS-PPMED, RHMT, DHMT	7	
	GHSHQ, RHMT, DHMT	(DHIMS2) Finalization meeting on MRR on DHIMS2	13th June, 2022	Finalization of the format after pre-testing	GHS-PPMED, ICD, RHMT, DHMT	22	
	DHMT, Regional/District Hospital, SDHTs	Family Clinical Meeting: Nadowli	28th March, 2022 5th October, 2022	Referral Follow-up activities: Quartely meeting among referral network facilities to improve referral situation	DHMT、District Hospital, Health Centers	60 54	
	RHMT, DHMT, Hospitals	Joint HSS-TWG Taskforce Meeting	19th May, 2022	Sharing of activities, experiences and good practices on Referral, SS and DHQPR meeting in each regions, and discussing the final strategies for activities and the endline survey	Selected TWG members from each region	19	Participants include NER and SR
	RHMT, DHMT	HSS-TWG Taskforce Meeting	NR：6th April, 2022, 2nd August, 2022 UER：3rd August, 2022 UWR:18th March, 2022, 5th August, 2022	Review the status of SS, Referral and DHQPR meeting and develop final strategies and action plans for the remaining period.	Selected TWG members from the region	NR: 2, 6 UER: 7 UWR: 10, 8	
	RHMT, DHMT, Regional/District Hospitals, DA	(5 Regions) DHQPR meeting	From April to May, 2022	District's health performance review based on the DHQPR reference guide	RHMT, DHMT, Hospitals and DA	NR (16 districts):886 NER (6districts): 281 SR (7districts): 377 UER (15 districts):945 UWR (11 districts) : 822	Project supported the 1st implementation of DHQPR meeting
	GHSHQ, RHMT, DHMT	ISS Technical working meeting for the digitization of SS checklist for CHPS	8th to 11th August, 2022	ISS TWG meeting to review Sub-district tools on the HNQIS platform	GHS-ISS TWG members, selected members of HSS-TWG in three regions, a technical officer from Impact Malaria	19	
	RHMT, DHMT, Hospitals	(UWR) Referral Orientation for Referral Coordinator/Health Information Officer	13th October, 2022	Orientation on referral flows and referral formats for referral coordinators and HIOs in the region	RHMT, DHMT, Regional/District Hospitals, Polyclinics	36	
	RHMT, DHMT, SDHT, Hospitals	UER Referral Stakeholder Meeting	13th May, 2022 4th to 5th October, 2022	District and Region-wide Referral Stakeholder meeting to monitor, share the status of referral activities. Region-wide meeting includes sharing of lesson learned and good practices with other districts.	RHMT, DHMT, SDHT, Regional and District hospitals	39 48 (1st batch)； 32 (2nd batch)	4th to 5th October, 2022(1st batch):the meeting was conducted by batch due to large volume of the participants
	RHMT, DHMT, SDHT and District Hospital	NR District-wide Stakeholder Meeting	27th September, 2022	Referral Stakeholder meeting to share and strengthen the referral activities in the pilot district	RHMT, DHMT, SDHT, Regional and District Hospitals and NAS	48	
Output 1	GHS HQ, RHMT	Joint CHPS Database Feedback Meeting	27th June, 2023	Purpose, overview and implementation of CHPS database in Ghana Presentation of Regional comparison of CHPS data Frequent district data errors Validation of data Work (cleaning Regional datasets) Sustainability and way forward for CHPS database	GHS HQ, RHMT	37	
	GHS HQ, RHMT, DHMT	DCHOO review meeting	19th April 2023	Rationale, Strategy and progress of DCHOO Findings from EDS on DCHOO District experiences implementing DCHOO Regional presentations on: •Introduction of DCHOO in the region •Confirmation of DCHOO numbers trained •Best practices in rolling out DCHOO •Success stories in DCHOO implementation •Challenges and lessons learnt •Way forward/sustainability plan Review DCHOO fieldwork guide and practice areas, suggest modifications	GHS HQ, RHMT, DHMT	34	
	UER RHMT/DHMT	District CHO Orientation Sustainability Meeting	24th May, 2023	•To Share experiences on DCHOO Implementation in UER •To Develop a Sustainable plan for the DCHOO Strategy To Discuss discrepancies in CHPS database	RHMT, DDHS, CHPS Coordinator, HIO & PHN	70	
	NER RHMT/DHMT	CHPS Database Meeting	25th May, 2023	•Review the CHPS Database and address data quality issues •Provide orientation to newly posted Health Information Officers to better position them to support the CHPS database at the district level	RHMT, DDHS, CHPS Coordinator, HIO	22	
	SR RHMT/DHMT	CHPS Database / District CHO Orientation Meeting	1st June, 2023	iReview the CHPS Database and address data quality-related issues iiProvide orientation to newly posted officers especially CHPS coordinators and Health Information Officers to support the CHPS database compilation and submission at the district level iiiOrient Districts on the DCHOO approach in training CHOs	RHMT, DDHS, CHPS Coordinator, HIO	25	
	NR RHMT/DHMT	District CHO Orientation/CHPS Database Meeting	7th June, 2023	•Review the CHPS Database and address data quality issues •Provide orientation to newly appointed CHPS Coordinators and Health Information Officers to better position them to support the CHPS database at the district level	RHMT, DDHS, CHPS Coordinator, HIO & PHN	70	
	GHSHQ, RHMT, DHMT	Technical Meeting To Review HNQIS Inline With The Gaps Identified	19th January, 2023			31	
	RHMT of 5 Regions	JOINT HEALTH SYSTEM STRENGTHENING TECHNICAL WORKING GROUP MEETING	8th February, 2023	1To share the results of the endline survey and confirm the current achievement of HSS activities in comparison to the Project targets (Referral/SS/DHQPR) 2To discuss the issues concerning sustainability in each area 3To agree on the final activities to take place to the end of the Project	RHMT	28	
	DHMT, SDHT	Feedback on HNQIS use in Nadowli	27th June, 2023	Feedback meetijng to share lessons for HNQIS use in various sub-districts in the district	DHMT, SDHT, CHOs	19	
	MoH, PPME-MoH, Development Partners.	Referral Technical Guidelines Meeting	23rd to 26th of May, 2023	Technical work on developing guidelines to include referral documentations developed by project	MOH, PUC, Development Partners, PPME-MoH	40	
	RHMT, DHMT, SDHT	Referral Scale-up in UWR	4th May, 2023	Meeting to develop strategies to scale-up referral activities in the region	RHMT, DHMT, SDHT, Regional and District Hospitals	55	
	RHMT, DHMT, SDHT	HNQIS Training in Nadowli	19th April, 2023	Training of Sub-district In-charges on how to use HNQIS in conducting SS	DHMT, SDHT	40	
	RHMT, DHMT, SDHT	HNQIS Training of Traininers	6th April, 2023	Traing of Trainers from the 3 pilot districts, the regions and project staff.	RHMTs NR, UER, UWR, Ipact Malaria, GHS-HQ	13	

Related Output	Organization involved in the training	Training title	Date	Content of Training/Meeting	Main Participants (Project members are excluded)	No. of participants (Project members are excluded)	Remarks
						2nd Term	
Output 2	UWR, RHMT, DHMT	First Community Mobilization taskforce meeting	16th March, 2018	Confirmation of criteria to select pilot CHPS zone Confirmation of modules on CHO training and CHMC/CHV training Sharing plan of community mobilization related activities.	UWR RHMT CHPS coordinator, Health promotion officer, Nutrition officer, DDHS	8	
	GHS-HQ, UWR, RHMT, DHMT, SDHT, CHPS	First Community Scorecard taskforce meeting	24th July, 2018	Discuss and develop a framework of the Community Scorecard and indicator for monitoring	GHS-HQ FHD Program officer, UWR Regional CHPS Coordinator, Health Promotion Offcer, Disease Control Officer, District Director, Health Information Officer, Disease Control Officer, SDHT staff, CHO	11	
	UWR RHMT, DHMT	First IEC working group meeting	10th May, 2018	LCA video screened Sharing LCA media strategy	GHS/HQ HP officer, UWR CHPS coordinator/Health promotion officer, Nutrition officer, DDHS	8	
	UWR, RHMT, DHMT	First Community Mobilization taskforce meeting	16th March, 2018	Confirmation of criteria to select pilot CHPS zone Confirmation of modules on CHO training and CHMC/CHV training Sharing plan of community mobilization related activities	UWR RHMT CHPS coordinator, Health promotion officer, Nutrition officer, DDHS	8	
	GHS HQ, UWR, RHMT, DHMT, SDHT, CHPS	First Community Scorecard taskforce meeting	24th July, 2018	Discuss and develop a framework of the Community Scorecard and indicator for monitoring	GHS HQ FHD Program officer, UWR Regional CHPS Coordinator, Health Promotion Offcer, Disease Control Officer, District Director, Health Information Officer, Disease Control Officer, SDHT staff, CHO	11	
	UWR, RHMT, DHMT, SDHT, CHPS	First Facilitators' meeting	4th October, 2018	Formation of facilitator's team (DHMT staff, SDHT staff and CHO) to support the activities of the pilot CHPS zones Capacity development of the facilitators on orientation workshop in the pilot CHPS zone and community assessment tools	UWR RHMT staff, DHMT directors and staff, SDHT staff and CHO	35	
	UWR, RHMT, DHMT, SDHT, CHPS, Community	First Orientation Workshop	10th October - 2nd November, 2018 (12 days withing the period)	Capacity development of CHMC, CHV and community leaders on the pilot CHPS zones and community assessment tools	UWR RHMT staff, DHMT directors and staff, SDHT staff, CHOs, CHMC members, CHVs and community leaders	396	
	UWR, RHMT, DHMT, SDHT, CHPS	Second Facilitators' meeting	6th December, 2018	Capacity development of the facilitators of the pilot CHPS zone on community assessment tools Presentation of progress of activities in the pilot CHPS zones	UWR RHMT director and staff, DHMT directors and staff, SDHT staff and CHO	57	
	UWR, RHMT, DHMT, SDHT, CHPS, Community	Second Orientation Workshop	17th December, 2018 - 18th January, 2019 (12 days within the period)	Capacity development of CHMC, CHV and community leaders on community assessment tools and Life-Course Approach	UWR RHMT staff, DHMT directors and staff, SDHT staff, CHOs, CHMC members, CHVs and community leaders	437	
	UWR, RHMT, DHMT, SDHT, CHPS	Third Facilitatos' meeting	26th April, 2019 (as part of the CHO/SDHT refresher training)	Presentation of progress of activities in the pilot CHPS zones	UWR RHMT staff, DHMT directors and staff, SDHT staff and CHO	CHO:36 Facilitators:19 Candidates of the facilitators (Observers):11	It was conducted at the moment of the CHO/SDHT refresher training
	UWR, RHMT, DHMT, SDHT, CHPS	Training on Mobilizing Community on First CHO/SDHT refresher training on Life-Course Approach	26th and 27th April, 2019 (as part of the CHO/SDHT refresher training)	Capacitiy development of CHOs and SDHT staff on the community assessment tools	UWR RHMT staff, DHMT directors and staff, SDHT staff and CHO	CHO:36 Facilitators:19 Candidates of the facilitators (Observers):11	It was conducted as one of module of the CHO/SDHT refresher training
	GHS HQ, UWR, RHMT, DHMT, CHPS	First CHMC/CHV training material discussion meeting	12th April, 2019	Discussion on illustration concept of flipchart for CHMC/CHV training	GHS HQ FHD, ICD officer, UWR RHMT staff, DHMT director and staff, CHO	24	It was couducted at the moment of the GHS monitoring meeting
	GHS HQ, UWR, RHMT, DHMT, CHPS	Secound CHMC/CHV training material discussion meeting	2nd and 3rd May, 2019	Discussion on illustration concept of flipchart for CHMC/CHV training	GHS HQ HP officer, UWR RHMT staff, DHMT director and staff, CHO	17	It was conducted at the moment of the feedback meeting on CHO/SDHT refresher training on 2nd May, and the SBCC TWG meeting on 3rd May
	UWR RHMT, DHMT	Fist SBCC TWG meeting	19th Feb, 2019	Discuss modifying and additional video scripts in accordance with outcomes of SBCC TRC in May 2018 and other LCA meetings	GHS HQ HP officer, UWR CHPS coordinator/Health promotion officer, Nutrition officer, DDHS	23	
	GHS HQ, Health Promotion	SBCC TRC meeting	10th April, 2019	Submit modifying and additional video scripts	GHS HQ FHD Director, HP officer, UWR Health promotion officer, WHO	26	
	UWR RHMT, DHMT	2nd SBCC TWG meeting	3rd May, 2019	Screening 2 modified videos, discuss two modified scripts for 2 new videos and concept of flipchart	GHS HQ HP officer, UWR CHPS coordinator/Health promotion officer, Nutrition officer, DDHS	17	
	GHS HQ, Health Promotion	SBCC TRC meeting	21st May, 2018	Submit 2 modified videos and modifies scripts for 2 new videos to get approval	GHS HQ FHD Director, HP officer, UWR Health promotion office	25	
	UWR RHMT, DHMT, District Assembly	First Non-monetary incentive core team meeting	12th February, 2020	Discussion on non-monetary incentive activities and development of activity list	DDHS, DCO, DA district planning officer, district coordinating director	5	
	UWR RHMT, DHMT	Third SBCC TWG meeting	13th February 2020	Review edited LCA videos CHMC/CHO training material (flip-chart) concept	GHS HQ HP officer, UWR CHPS coordinator/Health promotion officer, Nutrition officer, DDHS	22	
	GHS HQ Health Promotion Division, Accra	Third SBCC TRC meeting	21st February 2020	Submit and obtain approval of edited LCA videos and submit CHMC/CHO training material (flip-chart) concept	GHS HQ HP Director, officer, Regional HPO	25	
	GHS HQ Health Promotion Division, Accra	Forth SBCC TRC meeting	10th March 2020	Submit revised CHMC/CHO training material (flip-chart) concept and approved	GHS HQ HP Director, officer, Regional HPO	18	
	UWR RHMT, DHMT, DA, Zonal/Area Council, Hospital, Nursing Training School (NTS), National Health Insurance Scheme (NHIS), Department of Social Welfare (DSW)	First Non-monetary incentive stakeholder meeting	25th August, 2020	Feedback of the feasibility study on non-monetary incentive activity Proposal on pilot implementation of non-monetary incentive activity	UWR RDHS, CHPS coordinator, DDHS, DA district Coordinating Director, Zonal/Area Council chairman, assembly man, Hospital administrator, NTS principal, NHIS manager, DSW director	28	
	UWR RHA, DHMT	Preparation meeting of CHMC/CHV training	6th August 2021	Orientation and planning of CHMC/CHV training	UWR-RHMT, DHMT	27	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation of CHMC/CHV training	13th August 2021	Orientation and planning of CHMC/CHV training	UWR-RHMT, DHMT, SDHT, CHO	Trainee(CHO/SDHT): 41 Facilitator (RHMT): 6	
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT／Sissala East, Sakalu CHPS	19, 20 August 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	36	The number including RHMT Staff

	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT/Sissala West, Tiwii CHPS	19th and 20th Septemeber,2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	36	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT/Lawra, Tongo/Zagpee CHPS	31st August and 1st September 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	36	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT/Wa Municipal Sombo CHPS	1st and 2nd September, 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	36	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT/Nandom, Guri CHPS	6th and 7th Septembe,r 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	34	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV Training/TOT/Wa West, Domangyli CHPS	6th and 7th September, 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	33	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV Training/TOT/Jirapa/Tampala CHPS	7th and 8th September, 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	33	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT/Lambussie, Bognuo CHPS	7th and 8th September,2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	37	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT/DBI, WoguCHPS	8th and 9th September, 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	35	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT/Wa East-East, Tiniabe CHPS	13th and 14th September, 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	30	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT/Wa East-West, Jeyiri CHPS	15th and 16th September 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	33	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/TOT/Nadowli/Kaleo, Kpagadigna CHPS	8th and 9th November, 2021	Training for CHMC and CHV in the pilot CHPS zone and TOT for CHO from other CHPS zones	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	29	The number including RHMT Staff
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training, in 21 CHPS zones	From August to November, 2021	Training for CHMC/CHV	UWR-RHMT, DHMT,SDHT,CHO, CHMC, CHV, Community leader	N/C (9 districts, 21 CHPS zones)	
	UWR RHMT, DHMT, SDHT, CHPS	First CHMC/CHV training feedback meeeting (Non-monetary incentive feedback meeting)	23rd November,2021	Feedback of CHMC/CHV training and discussion on training in other CHPS zones	UWR RHMT, DHMT, SDHT, CHO	56	
	GHS HQ Health Promotion Division, Accra	Fifth SBCC TRC meeting	22nd December, 2020	Submit and obtain approval of CHMC/CHO training material (flip-chart) design and submit concept of Ghanaian Radio Exercise Video	GHS HQ HP Director, officer, Regional HPO	29	
	GHS HQ Health Promotion Division, Accra	Forth SBCC TRC meeting	25th August, 2021	Submit and obtain approval of Ghanaian Radio Exercise Video	GHS HQ HP Director, officer, Regional HPO	27	
	UWR RHMT, DHMT, DA, Zonal/Area Council, Hospital, Nursing Training School (NTS), National Health Insurance Scheme (NHIS), Department of Social Welfare (DSW)	Non-monetary incentive feedback meeting (1 fase)	18th March, 2021	Feedback of the pilot implementation of non-monetary incentive activity	UWR RDHS, CHPS coordinator, DDHS, DA district Coordinating Director, Zonal/Area Council chairman, assembly man, Hospital administrator, NTS principal, NHIS manager, DSW director	40	
	UWR RHMT, DHMT, SDHT, CHPS	Non-monetary incentive feedback meeting (1st phase) (First CHMC/CHV training feedback meeting)	23rd November,2021	Sharing of progress of pilot implementation of non-monetary incentive activity	DHMT, SDHT, CHO	56	
Output 2	UWR RHMT, DHMT, SDHT, CHPS	Preparatory Meeting on Orientation for CHO on CHMC/CHV training	9th February, 2022	Preparation for the orientation for CHO on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	44	
	UWR RHMT, DHMT, SDHT, CHPS	Training for trainers for Orientation for CHO on CHMC/CHV training	9th February, 2022	Training for trainers for CHO orientation on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	44	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ DBI	22nd February, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	18	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Nandom	23rd February, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	34	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Sissala West	23rd February, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	28	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Lawra	25th February, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	33	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Sissala East	25th February, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	48	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Wa East	8th March, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	26	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Jirapa	9th March, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	66	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Wa Municipal	9th March, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	56	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Lambussie	10th March, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	23	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Wa West	15th March, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	36	
	UWR RHMT, DHMT, SDHT, CHPS	Orientation for CHO on CHMC/CHV training/ Nadowli/Kaleo	21st June, 2022	Orientation for CHOs on CHMC/CHV training	RHMT, DHMT, SDHT, CHO	41	
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Jirapa	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	35	No financial support by the Project
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Lambussie	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	12	No financial support by the Project
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Lawra	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	19	No financial support by the Project
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Nadowli/Kaleo	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	4	No financial support by the Project
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in DBI	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	8	No financial support by the Project
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Nandom	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	24	No financial support by the Project

	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Sissala East	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	11	No financial support by the Project
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Sissala West	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	18	No financial support by the Project
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Wa East	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	11	No financial support by the Project
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Wa Municipal	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	45	No financial support by the Project
	UWR RHMT, DHMT, SDHT, CHPS	CHMC/CHV training/ CHPS zones in Wa West	February to October, 2022	CHMC/CHV training in CHPS zones	DHMT,SDHT,CHO, CHMC, CHV, Community leader	16	No financial support by the Project
	UWR RHMT, DHMT, Selected Media Houses	LCA Orientation/ Media and Audio Dissemination Meeting	8th August, 2022	Discussing details of health promotion on LCA activities to use audio version of LCA videos to broadcast on local radio stations in UWR.	Journalists on 11 local radio stations in UWR, CHPS Coordinator, RHPO, DDHS, DHPO	32	
Output 2	UWR RHMT, DHMT, Nursing Training School (NTS)	Preparatory Meeting for Evaluation of pilot implementation of Non-monetary incentive	10th February, 2022	Preparation for evaluation of pilot implementation of non-monetary incentive activities	RHMT, DHMT, NTS principal	8	
	UWR RHMT, DHMT, Zonal/Area Council, Nursing Training School (NTS), Department of Social Welfare (DSW)	Meeting for sharing the results of Evaluation of pilot implementation of Non-monetary incentive	31st August, 2022	Sharing the evaluation results of non-monetary incentive activities	RHMT, DHMT, Zonal/Area Council chairman, NTS principal, DSW director	41	
	UWR RHMT, DHMT, NHIS, NTS, DSWCD	NMI Reference Material Development Meeting	22nd February, 2023	Development of NMI Reference Material	RHMT, DHMT, HTS principal, NHIS, DSWCD director	11	
	UWR RHMT, DHMT	Preparatory meeting on CHAP utilization and CHMC/CHV training sustainability	23 February, 2023	Preparation of the meeting on CHAP utilization and CHMC/CHV training sustainability	RHMT, DHMT	8	
	UWR RHMT, DHMT, Hospital, NTS, DSWCD, NHIS	Meeting for the Dissemiation of NMI Implementation Reference Material	31st March, 2023	Dissemiation of NMI Implementation Reference Material	RHMT, DHMT, Hospital, HTS, DSWCD, NHIS	81	
	UWR RHMT, DHMT, CHO, Development Partners	Meeting on CHAP Utilization and CHMC/CHV Training Sustainability	17th April, 2023	Sharing the experience and discuss on CHAP Utilization and CHMC/CHV Training Sustainability	RHMT, DHMT, SDHT, CHO, UER, NR, NER, SR, Development Partners	51	

Related Output	Organization involved in the training	Training title	Date	Content of Training/Meeting	Main Participants (Project members are excluded)	No. of participants (Project members are excluded)	Remarks
						2nd Term	
	UWR RCC, RHMT, DA, DHMT	First RCC meeting (UWR)	18th September, 2017	Introduction of the Project Progress of DA engagement Improving planning, budgeting, monitoring on CHPS governance Way forward	Planning Officer of RCC, Regional Director of Health Services, District Planning Officer, District Budget Officer, DDHS etc.	66	
	UWR RCC, RHMT, DA, DHMT	Second joint stakeholder meeting (RCC/DA engagement meeting) (UWR)	3rd October, 2018	Decision of formulation of HIAP for 2019 using Action Plan Format in UWR	RCC planning officer, acting RDHS, district planning officer, district budget officer and DDHS	47	
	UWR RCC, RHMT, DA, DHMT	Third RCC/ DA Engagement meeting (UWR)	22nd March, 2019	Formulation of checklist to be used by RPCU and DPCU for HIAP for 2019, based on HIAP monitoring format Confirmation of monitoring schedule	RCC Planning Officer, RHMT CHPS coordinator, district planning officer of UWR	46	
	UWR RCC, RHMT, DA, DHMT	Fourth RCC/ DA Engagement meeting (UWR)	6th February, 2020	Sharing of results of HIAP 2019 in 11 Districts confirmation of HIAP formulation format, actors' roles Sharing of CHPS facility / equipment status Collecting opinions on non-monetary incentive mechanisms for health volunteers	RCC Chief Director Regional Health Director, CHPS Coordinator of RHMT, District Chief Director, District Health Director, etc.	66	
	UWR RCC, RHMT, DA, DHMT	Fifth RCC/ DA Engagement meeting (UWR)	24th and 25th September, 2020	Progress report for the first half of 2020 in 11 Dissects HIAP 2021 formulation Sharing the status of consideration of non-monetary incentives for health volunteers	RCC Planning officer, Deputy Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	61	
	UWR RCC, RHMT, DA, DHMT	Sixth RCC/ DA Engagement meeting (UWR)	25th and 26th March, 2021	Sharing of results of HIAP 2020 monitoring in 11 Districts Sharing of results of HIAP 2020 in 11 Districts Sharing of HIAP 2021 (Final draft) in 11 Distracts Confirmation of HIAP formulation format, actors' roles	RCC Dipty Director, Regional Health Director, CHPS Coordinator of RHMT, District Chief Director, District Health Director	50	
	UWR RCC, RHMT, DA, DHMT	Seventh RCC/DA engagement meeting (UWR)	25th and 26th Octubre, 2021	Sharing of results of HIAP 2021 monitoring in 11 Districts Formulation of Draft HIAP 2022 in 11 Distracts Confirmation of HIAP formulation format, actors' roles	RCC Planning officer, Representative Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director,	66	
	UWR RCC, RHMT, DA, DHMT	Eighth RCC/DA engagement meeting (UWR)	6th and 7th April, 2022	Sharing of results of HIAP 2021 monitoring in11 Districts Sharing of results of HIAP 2021 in 11 Districts Sharing of HIAP 2022 (Final draft) in 11 Distracts Confirmation of HIAP formulation format, actors' roles	RCC Chief Director, Planning officer, Budget officer, Health officer Deputy Regional Health Director, CHPS Coordinator of RHMT District Chief Director, Planning officer District Health Director, CHPS Coordinator	69	
	UWR RCC, RHMT, DA, DHMT	Nineth RCC/DA engagement meeting (UWR)	23th and 24th March, 2023	Sharing of results of HIAP 2022 monitoring in11 Districts Sharing the progress and issues of the HIAP as a result of the endline survey. Discussion and agreement on the continuation of the HIAP after the project completion	RCC Chief Director, Planning officer, Budget officer, Health officer Deputy Regional Health Directors, CHPS Coordinator of RHMT, Information officer District Chief Director, Planning officer District Health Director, CHPS Coordinator	69	
	UER RCC, RHMT, DA, DHMT	First RCC meeting (UER)	20th April, 2018	Introduction of the Project Explanation on DA's role of CHPS implementation Promotion of understanding of CHPS governance strengthening	UER Minister, RDHS, Municipal/District Chief Executive, District Coordinating Director DDHS etc.	67	
	UER RCC, RHMT, DA, DHMT	Second RCC/DA engagement meeting (UER)	25th and 25th November, 2019	Explanation of HIAP Formulation Format Formulation of the 2020 HIAP Role of each actor Sharing of good practices in the UWR	RCC Planning officer, Deputy Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	101	
	UER RCC, RHMT, DA, DHMT	Third RCC/DA engagement meeting (UER)	15th 16th and 17th September, 2020	Progress report for the first half of 2020 for the 15 districts Formulation of the draft HIAP 2021	RCC Planning officer, Deputy Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	88	
	UER RCC, RHMT, DA, DHMT	Fourth RCC/DA engagement meeting (UER)	24th and 25th June, 2021	Sharing of results of HIAP 2020 monitoring in 15 Districts Sharing of results of HIAP 2020 in 15 Districts Sharing of HIAP 2021 (Final draft) in 15 Distracts Confirmation of HIAP formulation format, actors' roles	RCC Deputy Director, Coordinating Director, Regional Health Director, CHPS Coordinator of RHMT, District Chief Director, District Health Director	93	
	UER RCC, RHMT, DA, DHMT	Fifth RCC/ DA Engagement meeting (UER)	3rd and 4th February 2022	Sharing of results of HIAP 2021 monitoring in 15 Districts Sharing of results of HIAP 2021 in 15 Districts Sharing of HIAP 2022 (Final draft) in 15 Distracts Confirmation of HIAP formulation format, actors' roles	RCC Chief Director, RCC Coordinating Director Planning officer Regional Health Director, CHPS Coordinator of RHMT District Chief Director, District planning officer District Health Director, CHPS Coordinator	86	
	UER RCC, RHMT, DA, DHMT	Sixth RCC/ DA Engagement meeting (UER)	15th and 16th March 2023	Sharing of results of HIAP 2022 in 15 Districts Discussion of HIAP issues and improvement measures Discussion and agreement on continuation of HIAP after project completion	RCC Chief Director, Planning officer Regional Health Director, CHPS Coordinator of RHMT District Chief Director, District planning officer District Health Director, CHPS Coordinator	89	
	NR RCC, RHMT, DA, DHMT	First RCC/DA engagement meeting	2nd May, 2018	Explanation of MMDA's role in CHPS implementation Project overview Explanation of HIAP formulation and monitoring	Acting RCC Coordinating Director, RCC Economic Planning officer, Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	86	
Output 3	NR RCC, RHMT, DA, DHMT	Second RCC/DA engagement meeting (NR, NER, and SR)	22nd November, 2019	Explanation of HIAP formulation format HIAP 2020 Formulation Role of each actor Sharing of good practices in UWR	RCC Planning officer, Deputy Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	25	
	NR RCC, RHMT, DA, DHMT	Third RCC/DA engagement meeting (NR, NER, and SR)	21st October, 2020	Progress report of the first half year of HIAP 2020 in 4 Districts Sharing of HIAP 2021 (Final draft) in 4 Distracts Sharing the experiences of 4 Districts with SR.	RCC Director, Planning officer, Deputy Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	41	
	NR RCC, RHMT, DA, DHMT	Fourth RCC/DA engagement meeting (NR, NER, and SR)	4th May, 2021	Sharing of results of HIAP 2020 monitoring in 4 Districts Sharing of results of HIAP 2020 in 4 Districts Sharing of HIAP 2021 (Final draft) in 5 Distracts Confirmation of HIAP formulation format, actors' roles	RCC Coordinating Director, Planning officer, Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	46	

	NR RCC, RHMT, DA, DHMT	Fifth RCC/DA engagement meeting (NR, NER, and SR)	30th November, 2021	Sharing of results of HIAP 2021 monitoring in 11 Districts Sustaining project innovations: Ideas for consideration in 2022 HIAP and beyond Confirmation of HIAP formulation format, actors' roles	RCC Director, Planning officer, Regional Health Director, CHPS Coordinator of RHMT, District Chief Director, District/ Municipal Coordinating Director, planning officer, District Health Director, CHPS Coordinator, etc.	42	
	NR, NER and SR RCC, RHMT, DA, DHMT	Sixth RCC/ DA Engagement meeting (NR, NER and SR)	25th March, 2022	Sharing of results of HIAP 2021 monitoring in 5 Districts Sharing of results of HIAP 2021 in 5 Districts Sharing of HIAP 2022 (Final draft) in 5 Distracts Confirmation of HIAP formulation format, actors' roles	RCC Coordinating Director, Planning officer Regional Health Director/Deputy Director, Information officer, CHPS Coordinator of RHMT Planning officer, etc. District Health Director, etc.	47	
	NR, NER and SR RCC, RHMT, DA, DHMT	Seventh RCC/ DA Engagement meeting (NR, NER and SR)	14th December, 2022	Sharing the status and results of HIAP monitoring in the five districts up to the third quarter of 2022. Discussions and recommendations on issues and improvement measures to improve and sustain the formulation, monitoring and implementation of the HIAP and their reporting Sharing of the final draft of the 2023 HIAP for the five districts Confirmation of HIAP development format and roles of actors	RCC Coordinating Director, Planning officer Acting Regional Health Director, Deputy Director, Information officer, CHPS Coordinator of RHMT Planning officer, etc. District Health Director, etc.	52	
	NR, NER and SR RCC, RHMT, DA, DHMT	Eighth RCC/ DA Engagement meeting (NR, NER and SR)	3rd April, 2023	Sharing the status of 2022 HIAP formulation and monitoring implementation in the five districts Sharing of HIAP progress and issues as a result of the endline survey Discussion and agreement on the sustainability of the HIAP after the completion of the project	RCC Coordinating Director, Planning officer Regional Health Director/Deputy Director, Information officer, CHPS Coordinator of RHMT Planning officer, etc. District Health Director, etc.	50	
	UER RCC, RHMT, DA, DHMT	HIAP monitoring raining	15th, 16th and 17th July, 2020	Explanation on monitoring format of HIAP implementation • Explanation of HIAP monitoring / results presentation template at the RCC/DA Engagement meeting Explanation of check sheet for confirmation of monitoring Confirmation of HIAP formulation /monitoring schedule	Representative of Chief Director of RCC Chief, Deputy Regional Health Director, CHPS Coordinator of RHMT, District Chief Director etc.	90	
	NR, NER, SR RCC, RHMT, DA, DHMT	HIAP monitoring raining	25th June, 2020	Explanation on monitoring format of HIAP implementation • Explanation of HIAP monitoring / results presentation template at the RCC/DA Engagement meeting Explanation of check sheet for confirmation of monitoring Confirmation of HIAP formulation /monitoring schedule	Representative of Chief Director of RCC Chief, Deputy Regional Health Director, CHPS Coordinator of RHMT, District Chief Director, District Health Director, etc.	29	
	NER RCC, RHMT, DA, DHMT	HIAP Orientation (NER)	15th July, 2022	Sharing of CHPS implementation status in NER Explanation of HIAP process, implementation and monitoring Experience sharing on HIAP implementation in the Project target district, East Mamprusi Municipal Development of draft HIAP for 2022	RCC Planning officer, Deputy Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	46	
	UWR RCC, RHMT, DA, DHMT	First TWG meeting (UW)	18th April, 2018	Improving the flow of Health-integrated Annual Action Plan (HIAP) formulation Improving the HIAP format Necessity of reference document on CHPS governance and discussion on the structure of HIAP Feedback on a draft CHPS governance checklist	Deputy Director of RCC, CHPS Coordinator of RHMT, District Planning Officer, DDHS etc. in UWR	12	
	UWR RCC, RHMT, DA and DHMT, NR RHMT, UER RCC and RHMT	Second TWG meeting (UWR, NR, and UER jointly)	20th September, 2018	Improving HIAP formats (Action Plan Format and Monitoring Format) Improving flow and schedule of HIAP formulation	RCC planning officer, acting Regional Director of Health Services (RDHS) , CHPS coordinator of RHMT, district planning officer, District Director of Health Services (DDHS) of UWR, CHPS coordinator of NR and UER, budget analyst of UER	19	
	UWR RCC, RHMT, DA and DHMT, NR RHMT, UER RCC and RHMT	Third TWG meeting (UWR)	17th January, 2019	Confirmation of the status of HIAP for 2019 planning in each DA and DHMT Drafting reference materials (handbook) on HIAP	RCC planning officer, RDHS, CHPS coordinator of RHMT, district planning officer, District Director of Health Services (DDHS) of UWR, CHPS coordinator of NR and UER, budget analyst of UER	28	
	UWR, UER, NR, NER and SR RCC, RHMT, DA, DHMT	Fourth Technical Working Group meeting (UWR, UER, NR, NER and SR)	14th April, 2022	Review, discuss, revise, and agree on HIAP reference material Confirmation of approver of HIAP reference material	RCC Planning officer, Deputy Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	19	
	UWR, UER, NR, NER and SR RCC, RHMT, DA, DHMT	5 region joint RCC/ DA Engagement meeting	5th April, 2023	Sharing of 5 regions experiences Sharing of endline survey results Confirmation of each Region's commitment agreement	RCC Director, Planning officer Regional Health Director, CHPS Coordinator of RHMT, District planning officer, District Health Director, etc.	47	

Related Output	Organization involved in the training	Training title	Date	Content of Training/Meeting	Main Participants (Project members are excluded)	No. of participants (Project members are excluded)	Remarks
						2nd Term	
Output 4	GHS-HQ,RHMT, DHMT	First Life Course Approach (LCA) meeting	17th October, 2017	Introduction of the Project Proposal on the concept of LCA and the Project activities to GHS-HQ and exchange opinions	Directors of GHS-HQ's main divisions RHMT/DHMT, UER RHMT, NR RHMT, JICA Ghana office, JICA MC Book project members	30	
		Second LCA meeting	29th November, 2018	Listing of LCA-related health activities and program through workshop	Directors of GHS-HQ's main divisions RHMT/DHMT, UER RHMT, NR RHMT . JICA Ghana office	25	
		Third LCA meeting	13th March, 2018	Presentation on organization of listed activities Presentation on the Project concept on LCA and agreement with stakeholders in UWR	GHS-HQ, UWR RHMT/DHMT, UER RHMT, NR RHMT	21	
		Fourth LCA meeting	26th April, 2018	Finalization of the concept and key definitions of the Life-Course Approach within the project	GHS-HQ, RHMT, MC Book project members, JICA Ghana office	13	
	RHMT, DHMT	Nutrition Strategic Meeting	17th April, 2018	Review of the nutrition component of existing training module and to discuss possible units to be added into the module in the context of LCA	Nutrition officers from 3 northern regions	10	
	RHMT, DHMT	LCA preparation meeting (nutrition, NCDs, community mobilization & IEC) in UWR	2nd March, 2018	Discussion of the key activities and approaches of nutrition, non-communicable diseases, community mobilization, and IEC	UWR RHMT CHPS coordinator, Health promotion officer, Nutrition officer, DDHS	5	
	GHS HQ, RHMT, DHMT	5th Life-Course Approach (LCA) meeting	30th November, 2018	Discussed the Structure and Content of CHO/SDHT refresher training Discussed the Structure and Content of CHMC/CHV training Re-discussion about the LCA concept	GHS HQ Directors of main divisions, MoH, UWR: RHMT and DHMT, UER: RHMT, NR: RHMT, JICA Ghana office, MCHRB project team	26	
		6th LCA meeting	19th February, 2019	Developed the draft materials for CHO/SDHT refresher training Developed the draft materials for CHMC/CHV training Finalisation and Agreement on the revised LCA concept	GHS HQ Directors of main divisions, MoH, UWR: RHMT and DHMT, UER: RHMT, NR: RHMT, JICA Ghana office	36	
	RHMT, DHMT	LCA-TWG meeting	7th November, 2018	Discussed the Structure and Content of CHO/SDHT refresher training Discussed the Structure and Content of CHMC/CHV training	UWR RHMT, DHMT	16	
	RHMT, DHMT, CHPS	Material development meeting	6th and 7th Februry, 2019	Developed the draft materials for CHO/SDHT refresher training Developed the draft materials for CHMC/CHV training	UWR RHMT, DHMT, CHO	24	
	UWR RHMT, DHMT, CHPS	LCA-TWG meeting	8th and 14th Februry, 2019	Reviewed the draft materials for CHO/SDHT refresher training Reviewed the draft materials for CHMC/CHV training	UWR RHMT, DHMT, CHO	21	
	UWR RHMT, DHMT, CHPS	LCA-TWG meeting	9th and 10th April, 2019	Finalised the draft materials for CHO/SDHT refresher training	UWR RHMT, DHMT, CHO	22	
	UWR RHMT, DHMT, CHPS	Preparatory meeting on 1st CHO/SDHT refresher training	11th April, 2019	Confirmed the training schedule, assignments of facilitators, facilitators' schedule and preparation of the materials and/or medical instruments which facilitators needed to use in the training	UWR RHMT, DHMT, CHO	18	
	GHS HQ, UWR RHMT, DHMT	First CHMC/CHV training material discussion meeting	12th April, 2019	Discussed the illustration concept of flipchart for CHMC/CHV training on LCA	GHS HQ Directors of main divisions, UWR: RHMT and DHMT	24	It was couducted at the moment of the GHS monitoring meeting
	UWR RHMT, DHMT, SDHT, CHPS	1st CHO/SDHT refresher training	23rd to 27th April, 2019 (5days)	Built the capacity of CHO/SDHT on LCA	GHS HQ HP officer, UWR RHMT staff, DHMT director and staff, CHO	CHO:36 Facilitators:19 Candidates of the facilitators (Observers):11	
	UWR RHMT, DHMT, SDHT, CHPS	CHO/SDHT refresher training feedback meeting	2nd May, 2019	Discussed and shared the issues and lessons learnt from the first CHO/SDHT refresher training	UWR RHMT, DHMT, CHO	14	
	UWR RHMT, DHMT	The 7th LCA meeting	12th December , 2019	Review and modification of the CHO/SDHT refresher training materials	The members of technical working group	14	
	Training schools and RHMT of 5 regions	Review meeting on CHO/SDHT training materials on LCA	11th February , 2020	Review of the CHO/SDHT refresher training materials by school tutors for integrating pre-service training materials as exit strategy	Nutrition officers from 3 northern regions	40	
	UWR RHMT, DHMT , SDHT, CHO	The 2nd CHO/SDHT refresher training on LCA	From 2nd to 5th March, 2020	Capacity building of facilitators, CHO and SDHT on LCA and development of training materials	Facilitators of RHMT, DHMT, SDHT and CHO	60	One-day preparatory meeting for facilitators prior to the training.
	UWR RHMT, DHMT	The facilitators' preparatory meeting for 3rd CHO/SDHT refresher training on LCA	23rd June, 2021	Strategy/structure of LCA Refresher training, updates on LCA training materials review, review of training schedule, confirmation of facilitators, listing of learning aids	Facilitators of RHMT, DHMT, Municipal Health Directorate	15	
	UWR RHMT, DHMT, SDHT, CHO, GHS HQ	The 3rd CHO/SDHT refresher training on LCA	From 28th June to 1st July, 2021	Capacity building of CHO and SDHT on LCA, demonstrations with practices, development and revision of training materials, orientation on flipchart	Facilitators of RHMT, DHMT, SDHT and CHO, GHS HQ (PPMED)	CHD/SDHT 63 Observers (GHS HQ) 2 RDHS (UWR) 1	Conducted at Techiman due to security issues in northern regions
	UWR RHMT, DHMT, Municipal Health Directorate	The facilitators' preparatory meeting for 4th CHO/SDHT refresher training on LCA	28th October, 2021	Purposes and strategy, updates on LCA training materials, review of training schedule, confirmation of facilitators and preparations, follow up monitoring, review of LCA register and LCA monthly reporting form	Facilitators of RHMT, DHMT, Municipal Health Directorate	16	
	UWR RHMT, DHMT, SDHT, CHO, GHS HQ	The 4th CHO/SDHT refresher training on LCA	From 1st to 4th November, 2021	Capacity building of CHO and SDHT on LCA with demonstration, review of training materials Review of Pre-Post test Review and finalization of monitoring tool	Facilitators of RHMT, DHMT, SDHT and CHO, Nutrition officers, GHS HQ (FHD)	CHD/SDHT 63 Nutrition Officers (UWR) 9 Observers 10 (GHS HQ, RHMT in UWR/NR/SR/NER/UER)	Field visit to CHPS compound after the training
	GHS HQ, UWR RHMT, DHMT	LCA Technical Working Group meeting	2nd August, 2022	Reporting progress of LCA related activities Review of LCA training materials Agreement on national dissemination Review of standardization on registers	Facilitators of RHMT, DHMT, Municipal Health Directorate	23	
	UWR RHMT, DHMT	The 1st feedback meeting on LCA training follow up	7th July, 2022	Sharing the result of the training follow up Challenges in LCE related services by CHO Coming follow up activities and planning	Facilitators of RHMT, DHMT, SDHT and CHO, GHS HQ (PPMED)	44	Several meetings to develop monitoring tools for monitoring were conducted previously

Output 4	UWR RHMT, DHMT, SDHT, CHPS	District-based LCA orientation for CHO	7th September - 4th October, 2022	Introduction of LCA concept at CHPS level Sharing the issues and challenges in providing LCA services Practical session for records of LCA register etc. Sharing the findings obtained after the 1st feedback meeting on LCA training follow up	UWR RHMT, DHMT, SDHT, CHPS, CHPS coordinator, Nutrition officer, SDHT, CHO/CHN, Concermed party for LCA service delivery	Trainees: 482 facilitators: 48	The Project covered only lunch.
	UWR and NR RHMT, DHMT	LCA dissemination for NR	17th November, 2022	Concept, definition, necessity and background of LCA Introduction of developed training materials and tools LCE and preservice training and district CHO orientation Challenges and lesson learnt through implementation	UWR Facilitators, NR(CHPS coordinator, Nutrition officer, health promotion officer, MCH officer, NCD person in charge	60	
	UWR, NER and SR RHMT, DHMT	LCA dissemination for NER and SR	18th November, 2022	Concept, definition, necessity and background of LCA Introduction of developed training materials and tools LCE and preservice training and district CHO orientation Challenges and lesson learnt through implementation	UWR Facilitators, NER and SR (CHPS coordinator, Nutrition officer, health promotion officer, MCH officer, NCD person in charge	57	Field visit to CHPS compound after the training
	UWR RHMT and DHMT	Preparatory meeting for second LCA monitoring	25th April, 2023	To re-review monitoring checklist for second LCA post-training follow-up To prepare, confirm schedule and assign roles for the second post training follow-up.	UWR Facilitators of LCA training	11	
	UWR RHMT, DHMT, SDHT, CHPS	LCApost-training follow-up monitoring	26th April to 1st May 2023	Follow-up on performance of CHOs after training on LCA. Identify gaps and provide OJT for CHOs. Monitor implementation of action plans developred districts	UWR Facilitators	9	
	UWR RHMT, DHMT, SDHT, CHPS	LCA monitoring feedback meetings in the districts	19th to 30th June, 2023	Provide feedback to districts on the results of monitoring. Confirm post-project follow-up monitoring strategy with districts	UWR Faciliators, DHMT, SDHT, CHPS	885	Several meetings to develop monitoring tools for monitoring were conducted previously

Appendix 7 : List of Equipment Provided and Equipment that Accompanied Expert Dispatch

No.	Item Name	Standard/Parts number	Qty	Price			Day of	Place	Status	Remarks	Handling at the end of the Project
				Price	Currency	Price in JPY					
P1	Satellite phone	Thuraya XT-Lite/ 177077-5	1	70,000	Yen	-	2017/7/10	UE	In use	GN 4056-17(UE:Adams)	Return to JICA
P2	Satellite phone	Thuraya XT-Lite/ 178623-5	1	70,000	Yen	-	2017/7/10	UW	In use	GN 4055-17(UW:Razak)	Return to JICA
P3	Satellite phone	Thuraya XT-Lite/ 177078-3	1	70,000	Yen	-	2017/7/10	UW	In use	GN 4053-17(UW:Vincent)	Return to JICA
P4	Satellite phone	Thuraya XT-Lite/ 178140-0	1	70,000	Yen	-	2017/7/10	N	In use	GN 4054-17(NR:Andani)	Return to JICA
P5	LCD Projector	EPSON EB-S31/ WDUK6YO4347	1	2,000	GHc	51,200	2017/7/20	N	Disposed	Fatally broken (Screen lump malfunctioned) and disposed on 8th Sep 2021	Disposed
P6	Micro office Pro 2016	Office Professional 2016	1	2,100	GHc	53,761	2017/7/20	UW	Expired	The date has been expired	Disposed
P7	Desktop PC	Dell Inspiron 3650/ 28541280998	1	3,150	GHc	80,641	2017/7/20	UW	In use	User: Ben	Handing-over
P8	Safety Box	LEECO NSD	1	3,000	GHc	76,801	2017/7/21	UW	In use		Handing-over
P9	Air Conditioner	TCL 11002WH4450H51800070	1	2,550	GHc	61,393	2018/2/7	N	In use		Handing-over
P10	Air Conditioner	TCL 11002WH4450H51800193	1	2,550	GHc	61,393	2018/2/7	N	In use		Handing-over
P11	Lap Top PC	UX550VD-730D/H7HDCX151313299	1	129,800	Yen	-	2018/4/10	UW	In use	Cabinet: Used for projection	Handing-over
P12	Lap Top PC	HP PROBOOK 640 G2 I5 8GB 500GB WIN 10/2TK73800KT	1	3,592.23	GHc	86,486	2018/4/27	UW	Stored	Stored in Office Carbinet	Handing-over
P13	Lap Top PC	HP PROBOOK 640 G2 I5 8GB 500GB WIN 10/2TK73802LT	1	3,592.23	GHc	86,486	2018/4/27	N	Disposed	Not in use due to defects. Transfering data into a new PC (P. 50, Lap Top PC) Disposed from list of JICA Ghana office	Disposed
P14	Lap Top PC	HP PROBOOK 640 G2 I5 8GB 500GB WIN 10/2TK73802CM	1	3,592.23	GHc	86,486	2018/4/27	UE	Disposed	Not in use due to defects. Transfering data into a new PC (P. 51, Lap Top PC) Disposed from list of JICA Ghana office	Disposed
P15	Lap Top PC	HP PROBOOK 640 G2 I5 8GB 500GB WIN 10/2TK73802M1	1	3,592.23	GHc	86,486	2018/4/27	UW	Stored	Stored in Office Carbinet	Handing-over
P16	Safety Box	BOOIL SAFE BS-K670	1	2,500.00	GHc	58,248	2018/8/6	N	In use		Handing-over
P17	Lap Top PC	HP IS-BS 060 WM INTEL CORE I3 8GB RAM 1TB HDD 15.6" / CND 7313QYN	1	2,550.00	GHc	59,877	2018/9/20	UE	In use	User: Adams, activities	Handing-over
P18	Lap Top PC	HP IS-BS 060 WM INTEL CORE I3 8GB RAM 1TB HDD 15.6" / CND 7510RGY	1	2,550.00	GHc	59,877	2018/9/20	N	Stored		Handing-over
P19	Lap Top PC	HP IS-BS 060 WM INTEL CORE I3 8GB RAM 1TB HDD 15.6" / CND 7430WG3	1	2,550.00	GHc	59,877	2018/9/20	UW	Stored		Handing-over
P20	LCD Projector	EPSON EB SO5 / X4GB8301046	1	2,150.00	GHc	50,485	2018/9/20	UW	In use		Handing-over
P21	LCD Projector	EPSON EB SO5 / X4GB8201131	1	2,150.00	GHc	50,485	2018/9/20	UW	In use		Handing-over
P22	LCD Projector	EPSON EB SO5 / X4GB8300971	1	2,150.00	GHc	50,485	2018/9/20	UE	In use		Handing-over
P23	Safety Box	DAXING GANGGUI	1	3,400.00	GHc	77,720	2019/1/10	UE	In use		Handing-over
P24	Fuser Unit	CANON 33251	1	3,062.00	GHc	67,552	2019/1/10	UW	Disposed	It was replaced by new fuser unit and the new fuser unit has been equipped with Copier Machine (J7, Canon C3325i) Disposed from list of JICA Ghana office	Disposed
P25	Printer	Pro HP Colour LaserJet MFP M281 FDW / VNBNLBQ4S8	1	2,754.37	GHc	56,222	2019/3/25	N	Disposed	Not in use due to decline in print quality. (Awaiting assessment results) Disposed from list of JICA Ghana office	Disposed
P26	Printer	Pro HP Colour LaserJet MFP M281 FDW / VNBNLBQ4H7	1	2,754.37	GHc	56,222	2019/3/25	UE	In use	There are faulties in some parts	Handing-over
P27	Lap Top PC	HP ProBook 440 G5 I5 8GB RAM 500 HDD 14" WIN 10/5CD8368L82	1	4,945.00	GHc	106,113	2019/4/9	N	Lost	The new Laptop PC(P39) was compensated for the lost PC in May 2021.	Disposed
P28	Lap Top PC	HP ProBook 440 G5 I5 8GB RAM 500 HDD 14" WIN 10/5CD8484LVY	1	4,945.00	GHc	106,113	2019/4/9	UW	In use	User: Ambrose (UWR CHPS Unit)	Handing-over
P29	Lap Top PC	HP ProBook 440 G5 I5 8GB RAM 500 HDD 14" WIN 10/5CD8368L8R	1	4,945.00	GHc	106,113	2019/4/9	Savannah	In use	User: Sarfo (SR CHPS Unit)	Handing-over
P30	2.5 HP Bruhm Air conditioner	BAS-24CCFW/M5H004191	1	3,050.00	GHc	58,932	2020/1/15	UW	In use		Handing-over
P31	2.5 HP Bruhm Air conditioner	BAS-24CCFW/M5H004213	1	3,050.00	GHc	58,932	2020/1/15	UW	In use		Handing-over
P32	Dell 22 Inche Monitor	CNC3080DPV	1	300.00	GHc	5,797	2020/1/15	UW	In use	User: Ben	Handing-over
P33	Solid UPS	2000VA/E1909024670	1	1,300.00	GHc	25,119	2020/1/16	UW	In use		Handing-over
P34	Vodafone Router	Huawei Mobile WiFi/SCK7S18B07002483	1	485.00	GHc	9,371	2020/1/24	UW	In use		Handing-over
P35	MTN MiFi Router	Huawei Mobile WiFi/4RP7S19222004211	1	475.00	GHc	9,178	2020/1/28	UW	In use		Handing-over
P36	HP Color LaserJet Printer	Color LaserJet Pro MFP M281 Fdw	1	2,800.00	GHc	54,102	2020/2/17	UW	Disposed	It could not print out because of no function of core unit. The part is not available. Disposed from list of JICA Ghana office	Disposed
P37	Public Address System	JBC-EN15W	1	1,700.00	GHc	32,848	2020/2/21	UW	In use		Handing-over
P38	Lap Top PC	HP ProBook 440 G6 I7 8GB RAM 1TB HDD 14" WIN 10/5CD9416SL4	1	5,200.00	GHc	99,167	2021/5/12	NE	In use	NR CHPS Unit	Handing-over
P39	Lap Top PC	HP ProBook 440 G6 I7 8GB RAM 1TB HDD 14" WIN 11/5CD9416SCV	1	5,200.00	GHc	99,167	2021/5/12	N	In use	User: Mabel	Handing-over
P40	Lap Top PC	HP ProBook 440 G6 I7 8GB RAM 1TB HDD 14" WIN 12/5CD9416SLB	1	5,200.00	GHc	99,167	2021/5/12	N	In use	User: Roger	Handing-over
P41	Lap Top PC	HP Laptop Core i7 Model 14-dq2045cl / 5CD043X9TQ	1	5,200.00	GHc	99,167	2021/10/1	UW	In Use	User: Anita	Handing-over
P42	Lap Top PC	HP Laptop Core i7 Model 14-dq2045cl / 5CD043X7R6	1	5,200.00	GHc	99,167	2021/10/1	UW	In use	User: Zacchi	Handing-over
P43	Lap Top PC	Lenovo Yoga i7 11th Gen. 12/512 SSD 14 Inches / PF2FLEGY	1	5,700.00	GHc	108,702	2021/10/1	UW	In use	User: Sharif	Handing-over
P44	Printer	HP color Lasejet Pro MFP M479dw/ CNCRP2S3TQ	1	3,450.00	GHc	64,671	2021/11/25	N	In use		Handing-over
P45	Printer	HP color Lasejet Pro MFP M479dw/ CNCRP2S8MN	1	3,450.00	GHc	64,671	2021/11/25	UE	In use		Handing-over
P46	Printer	HP color Lasejet Pro MFP M479dw/ CNCRP258HF	1	3,450.00	GHc	64,671	2021/11/25	UW	In use		Handing-over
P47	Copier Machine	Canon iR-ADV C5740i/ 3BE03020	1	60,000.00	GHc	1,111,158	2022/2/7	UW	In use		Handing-over
P48	UPS	UPS Solid UPS 6K VA	1	9,800.00	GHc	161,477	2022/6/13	UW	In use		Handing-over
P49	Lap Top PC	HP Pavilion Laptop/Model 15-eg0070wm/5CD1347F8P	1	10,800.00	GHc	152,079	2022/10/31	UW	In use	User: Abu	Handing-over
P50	Lap Top PC	HP Pavilion Laptop/Model 15-eg0070wm/5CD1347X79	1	10,800.00	GHc	152,079	2022/10/31	N	In use	User: Kassim	Handing-over
P51	Lap Top PC	HP Pavilion Laptop/Model 15-eg0070wm/5CD134H44Z	1	10,800.00	GHc	152,079	2022/10/31	UE	In use	User: Raymond	Handing-over
	【Equipment rented by JICA】										
J1	Lap Top PC	HP HQ-TRE71025/ CND6496MZ6	1				2017/7/24	N	Disposed	To dispose from the equipment list of JICA Ghana office due to deterioration over time	Disposed
J2	Lap Top PC	HP HQ-TRE71025/ CND6496NXG	1				2017/7/24	UW	Disposed		Disposed
J3	Lap Top PC	HP HQ-TRE71025/ CND6495PYJ	1				2017/7/24	UW	Disposed		Disposed
J4	Lap Top PC	HP HQ-TRE71025/ CND6496MZN	1				2017/7/24	UW	In use	User: Razak/Vincent	Handing-over
J5	Printer	HP color Lasejet Pro M277dw/ VNB8J6V5V1	1				2017/8/8	UW	Disposed	The printer have been deteriorated Disposed from list of JICA Ghana office	Disposed
J6	Printer	HP color Lasejet Pro M277dw/ VNB8J6LHWV	1				2017/8/8	N	Disposed	Malfunction Disposed from list of JICA Ghana office	Disposed
J7	Copier Machine	Canon C3325i/ QTS22871	1				2017/8/8	UW	Disposed	To dispose from the equipment list of JICA Ghana office due to deterioration over time Disposed from list of JICA Ghana office	Disposed
J8	Car	GN 4053-17	1				2017/8/10	UW	In use		Handing-over
J9	Car	GN 4054-17	1				2017/8/10	N	In use		Handing-over
J10	Car	GN 4055-17	1				2017/8/10	UW	In use		Handing-over
J11	Car	GN 4056-17	1				2017/8/10	UE	In use		Handing-over

List of CHPS Equipment

No	Description	Actual needs			Total Quantity
		UWR	UER	NR, SR, NER	
1	Sphygmomanometer	302	186	462	**950**
2	Stethoscope	279	118	449	**846**
3	Weighing Scale (adult)	366	214	366	**946**
4	Height Scale (adult)	265	80	95	**440**
5	Weighing Scale (baby, flat type)	38	51	62	**151**
6	Height Scale (baby)	264	175	125	**564**
7	Calibrated measuring tape	279	276	491	**1,046**
8	Digital Thermometer	603	305	733	**1,641**
9	Sterilizing drum (Medium)	674	653	652	**1,979**
10	Bucket, container for 0.5% chlorine	200	215	0	**415**
11	Bucket, container for contaminated waste	723	580	311	**1,614**
12	Weighing scale (hanging type) & pants	0	11	40	**51**
13	Dressing instrument set	40	278	296	**614**
14	Veronika bucket (small	633	514	648	**1,795**
15	Veronika bucket (large)	252	143	203	**598**
16	Vaccine carreer	99	0	0	**99**
17	Glucometer & strips	174	360	213	**747**
18	Pulse oximeter (portable)	187	267	222	**676**
19	Hb meter & strips	368	267	116	**751**

Appendix 8. JCC minutes (1st to 9th)

Strengthening Community-based Health Services Focusing on the Life-course Approach in the Upper West, Upper East and Northern Regions (CHPS for Life)

Minutes of 1st Joint Co-ordinating Committee (JCC) Meeting
Date: 28th November, 2017
Venue: Accra City Hotel, Accra

1. Introduction

The 1st JCC meeting was held on 28th November, 2017 from 14:00 to 16:15. It was chaired by Dr. Anthony Nsiah Asare, Director General (DG) of the Ghana Health Service who is also the Project Director. Forty-two (42) persons were in attendance. The breakdown is as follows:

- 7 staff of the Ghana Health Service Headquarters (including DG and Divisional Directors),
- 2 staff of JICA Ghana Office,
- 6 key members of Upper West Regional Health Administration,
- 5 key members of the Upper East Regional Health Administration,
- 4 key members of the Northern Regional Health Administration,
- 9 District Directors comprising 3 each from the Upper West, Upper East and Northern Regions,
- 1 staff of the Upper West Regional Coordinating Council,
- 2 heads of training schools; and
- 6 project staff.

The detailed list of participants and the agenda of the meeting are attached as annexes 1& 2 respectively.

2. Opening remarks – Dr. Anthony Nsiah Asare (Project Director)

In his opening remarks, the Project Director welcomed participants to the first JCC meeting as a key activity of the project during which major decisions are taken and entreated all to participate actively. He noted that although the meeting was now being held, some activities have already been carried out but it was necessary to discuss the progress of those activities, discuss and approve the project work plan and also share information on other key project issues.

3. Purpose of the meeting and management related activities – Mr. Zacchi Sabogu

In a PowerPoint presentation, he took the house through the purpose, arrangement of the project office, vehicles & staffs, work plan development and opportunities for modifying the project work plan.

3.1 Purpose of the 1st JCC meeting:

Mr. Sabogu stated that the 1st JCC meeting was organized to achieve the following:

i. To approve the strategies, steps and work plan of the project.
ii. To share the progress of the project activities.
iii. To plan for upcoming events
iv. To clarify roles and responsibilities of each level and region.

3.2 Arrangement of project office (s), vehicles & staffs

Mr. Sabogu informed the house that the headquarters of the project is hosted at the UW RHMT and that 4-local staff are currently engaged there. There are also 4 drivers and 4 cars. In the future, 2 cars and 2 drivers will be moved; 1 each to the Upper East and Northern Regions. In the UER, the project will share office with KOICA while in the NR, the project has been assigned a portion of the training unit of the RHA. Refurbishment of the office is underway and would be ready for use by end of January 2018. One or two more local staff will be recruited and placed in each of the Upper East and Northern Region offices.

3.3 Development of project work plan

Mr. Sabogu explained that a workshop was organized on 26th and 27th October, 2017 at the UDS campus in Tamale to develop the work plan for the first term of the project. Solid teams from all the 3 regions including RDHS, DDPH, DDCC and other RHMT members as well as 3 DDHS from each region participated in the workshop. They discussed, reviewed and finalized the strategies, steps, activities and target groups for each output of the project. They also discussed the venues of meetings involving the three regions. As part of the workshop, the modified PDM and baseline survey were also discussed.

3.4 Modification of project work plan

In this section, Mr. Sabogu stressed that the work plan is for the first term of the project that is 2017 to June 2019. And that, as implementation progresses, the progress will be presented at subsequent JCC meetings. Modifications will be possible given that there is enough justification to do so. Besides, if on account of budget limitations and schedule challenges, some activities are not implemented, they will be moved to the second term of the project.

4. Plan and progress of activities – Mr. Zacchi Sabogu & Ms. Satoko Ishiga

With the use of a PowerPoint presentation Mr. Sabogu explained the outputs of the project. He also explained in detail the output zero (management activities) of the project outlining timelines, persons responsible for organizing each activity and progress made in each of them so far.
Ms. Ishiga on her part explained in a sequential manner the strategies and activities contained in the work plan and progress made so far in respect of each output.
The outputs, activities and progress made so far in respect of each output are summarized in the following tables:

4.1 Outputs of the project

Output 0: The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ for scaling-up.
Output 1: The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.
Output 2: Community activities of CHPS are strengthened.
1. Output 3: Local government and stakeholder support in planning and implementing CHPS is strengthened
Output 4: Life-course approach is addressed in the minimum package of CHPS

4.1 Output 0 activities and progress:

Name of activity	Progress
1. Joint Coordination Committee + Study tour	• 1st meeting on November 28, 2017 • Study tour will start from March 2018
2. Coordination meeting of three regions	• To be decided
3. Regional management meeting	• Visits to UER (1 time) and NR (2 times) • 1 time for UW with ex-RD but not with new RD
4. Monitoring visits by GHS	• To be planned
5. Review of Project Termination report	
6. Study Tour in Japan on Life-course Approach	• To be planned
7. Baseline survey	• Approval by Ethical Committee (Oct. 2017) • Selection of sub-contractor (Oct. 2017)

4.1.1 Key management meetings and persons responsible:

Title & responsible person	Members	Timing/Frequency
1. Joint Coordination Committee meeting	Responsible: Director General GHS, RHMT, DHMT, GHS, Development partners, JICA 50 persons	4 times, November 2017, March 2018, Oct.2018, March 2019
2. Coordination meeting of three regions	Responsible: Director General RHMT of three regions, GHS, JICA 30 persons	4 times, November 2017, March 2018, Oct.2018, March 2019
3. Regional management meeting	Responsible: 3 RDHS for UW, UE & N Regions RHMT (DHMT), 20 persons	4 times, November 2017, March 2018, Oct.2018, March 2019

4.2. Output 1 activities and progress:

Name of activity	Progress
1. CHPS database training	• 1st meeting was conducted in UER and NR on Nov. 1 & 2, 2017 • Initial CHPS data are under collection. It will be summarized in December.
2. CHO fresher training	Nil
3. Pre-service training (UWR only)	• 1st strategic meeting was conducted on Nov. 13, 2017
4. FSV training	Nil
5. Referral training	Nil
6. Conduct DHMT review meeting on CHPS enhancement	Nil
7. Learning visits	Nil

4.3 Output 2 activities and progress:

Name of activity	Progress
1. Development of community score card (UWR)	Nil
2. CHV/CHMC training(UWR)	Nil
3. LCA related community activities (UWR)	Nil
4. Development of IEC materials (UWR)	Nil
5. Promote intra/inter learning visits	Nil

4.4 Output 3 activities and progress:

Name of activity	Contents
1. Assess the level of involvement of DA, DHMT and stakeholders in CHPS	• Assessment of UWR was conducted in Oct. 2017
2. Conduct Joint stakeholder meeting	Nil
3. Development of health-integrated annual action plans	Nil
4. Joint learning	Nil

4.5 Output 4 activities and progress:

Name of activity	Contents
1. NCD	Nil
2. Nutrition	Nil
3. Capacity building of SDHT/CHO on LCA	Nil
4. Review of LCA activities by GHS HQ and region	• 1st LCA concept meeting was held on Oct.17, 2017 • 2nd LCA concept meeting will be held on Nov. 29, 2017.
5. Integration of LCA into CHPS minimum package and budgeting	Nil

4.6 Discussions after presentation of the project work plan:

Key issues/questions raised	Discussions and conclusions
The role of district hospitals in the activities	The district hospitals are involved in the referral activities. Some clinical staff are also facilitators of some modules especially modules on referral
Is there any thinking around linking telemedicine with CHPS	In the midst of inadequate human resources, there is the need to consider the use of telemedicine both as a way of building capacity at the CHPS level and reducing the number of referrals. DG informed the house that the GHS is setting teleconsultation centres in 5 regions, with one in Bolgatanga. This process will slowly develop into telemedicine including consultation for psychiatry. He advised that teleconsultation should be considered in the activities of the project in the future.
How would the project ensure	The project will use manuals that have been developed at the

that the training materials that it will be using are nationally recognized as the standard?	national level. Where non-existent materials have to be developed, the GHS HQ and others would be deeply involved so that all materials are generally accepted nationally. Further, For CHO training in particular, the GHS HQ is standardizing all the CHO training materials but those materials have not been shared with all stakeholders. The Project has the original materials that the GHS working to standardize. However, for new areas such as the LCA, a team would need to be put together to pull the materials together. In concluding the subject, DG explained that if the project is about developing any materials it should work with the GHS HQ to have it done. If there is any budget for that purpose, the project should give it to the GHS HQ to do it. He stressed that the project should work very closely with the GHS HQ to ensure that all materials including supportive supervision tools originate from the GHS HQ.
The need to collaborate with GHS PPMED to link up with the e-tracker system	Charles Acquah called on the project to collaborate closely with the PPMED to be able to benefit from the e-tracker that is being rolled out to reduce paper work in the system. According to him, some key CHPS records such as the Home Visiting Register are in the e-tracker which is linked to DHIMS. As such, it makes it possible for CHPS data to be collected and transmitted through a virtual platform.
The need to strengthen the sub-district level	The sub-district level is already weak, and so any effort at strengthening CHPS should not consciously or unconsciously weaken that level any further. There is the need therefore to pay attention and build capacity at that level. Trainings targeting CHOs should not leave out the sub-districts. In addition, interventions such as the CHPS database could be referred to as the Sub-District Database. Such things are needed in order not to weaken the sub-districts further. During FSV, efforts should be made to identify and address challenges at that level. In order for this to be effective, clinicians should be involved in FSV.
Budget allocation for each of the activities in the work plan	There were no discussions on this subject
Focus of the regional coordinating meetings	The meetings will be used to share progress and harmonize activities among the three regions.
Referral Coordinators	DG emphasized that he does not endorse the concept of 'Referral Coordinators' as anything good to practice. In his view, the designation of people for everything contributes to inefficiency on the part of managers entrusted with overall responsibility. He discouraged others from learning from it and insisted that the nomenclature should be changed. People can be assigned responsibilities but they should not be called coordinators
DG to consider working on bridging the lag between the	DG advised regional directors to put in the necessary steps to ensure that trainees feel attracted to stay in their regions. He

time nurses complete school and the time they are deployed to facilities. This is needed in order to reduce the loss of investments made in them through the pre-service training. And also consider reposting staff back to regions where they were trained.	also said the GHS will engage the NMCG to ensure that CHPS becomes a crucial and examinable part of the training school curricula.
It is useful to include technical working groups in strategic meetings	The technical working groups who will be responsible for each aspect of the project will be involved in strategic meetings to deepen their understanding of the issues. This in fact is the approach used by the project.
How will CHPS zones not selected as model CHPS zones benefit from LCA activities?	CHPS zones not selected as model ones for LCA will be covered through training and peer learning/support among CHOs. The model communities will serve as the nucleus in conducting the LCA community interventions, all adjourning CHPS zones will learn and practice LCA in their respective CHPS zones.
The involvement of Community Health Workers in trainings.	DG explained that CHWs will be there whether we like it or not. It was explained that their payment is irregular, and their attrition for school does not make them readily available for trainings. DG advised district directors to screen them and make it possible for the committed ones to be trained. Once the African Union has signed a declaration to use CHWs, Ghana cannot do otherwise. Conclusion was that, the responsibility of selecting people for trainings is with the health managers, so if the health managers select CHWs, the project will train them as part of trainings targeting levels where they work.

5. Proposed modification to PDM and progress of baseline study - Ms. Satoko Ishiga & Mr. Zacchi Sabogu

During this session, a proposal for modification of the original PDM (version 0) was shared with the house. Also, purpose and progress of the project baseline study was also shared.

5.1 Proposed modified PDM (version 1):

The points of modification were presented as follows:

- Change of "Objectively Verifiable Indicators" and "Means of Verification" to appropriate indicators and available means of data verification.
- Change of target of FSV implementation rate (FSV from RHMT to DHMT)
- Change of definition of the 1st PNC

5.2 Purpose and progress of baseline study:

The purpose of the baseline was presented as follows:

- To collect baseline data to set targets

- To track the performance of the project indicators over time
- To collect baseline data to support activity planning and implementation.
- To collect baseline information in order to harmonize systems in the three regions

The progress made so far include the following:

- Ethical clearance was obtained from GHS-ERC at the end of October 2017
- Preparatory work to conduct study ongoing
- Data collection from December 2017 to January 2018
- Analysis and report writing from January to February 2018
- Sharing of results in March 2019 at the 2nd JCC

6. Issues and Concerns - Dr. Anthony Nsiah Asare

6.1 Approval of project work plan (2017 – 2019):

Led by the Project Director, the house unanimously approved the project work plan for the first term.

6.2 Approval of modified PDM (version 1):

Again led by the Project Director, the modified PDM (version 1) was approved. The modified PDM is attached as annex 3.

6.3 Planning of study tour in Japan

Up to six people will be sent to Japan to understudy LCA in Japan. It is DG who will select the six participants.

6.4 Monitoring plan by GHS HQ

The monitoring will be done 3 times in between JCC/Study tour. DG will decide the timing and the team members.

6.5 Protocols for the approval of monitoring sheet

The submission timelines are January and July of each year. DG is expected to firm up the protocol for the review and approval of the monitoring sheet each time it is drafted. Sample template of the monitoring is attached as annex 4.

6.6 Security issues on Wa-Tamale road

The rising incidence of armed robbery cases on the Wa-Tamale road, which happens to be one of the roads that the project staffs use regularly, was raised as a concern to the project. It was said that once the RCCs are the heads of Regional Security Councils and there was a representative from the UW RCC, he should take it.

6.6 Next JCC meeting:

Tentatively, the next JCC meeting was slated for either 28th or 29th March 2018. As the days draws closer, DG will decide the appropriate date and communicate to members in writing.

7. Remarks by JICA Representative – Ms. Maki Ozawa

Ms. Maki said JICA hopes that GHS can use this project to improve CHPS services. The LCA meeting planned for 29th November to firm up the actual package for that aspect of the project. She expects a lot of participation in discussions during the LCA meeting.

8. **Closure – Dr. Anthony Nsiah Asare**
In his closing remarks, DG thanked participants for travelling from long distances for the meeting. He wished participants travelling mercies back to their posts and charged the regional directors for UWR, UWR and NR to be up to the task and do better than the 7 other regions that are not fortunate enough to benefit from the CHPS for Life project. The meeting ended with a prayer said by Mr.Charles Acquah.

Annex 1: Participants List for the 1st JCC meeting

No.	Name	Organization	Position
1	Dr. Anthony Nsiah Asare	GHS	Director General
2	Dr. Patrick Kuma-Aboagye	GHS	Director, Family Health Division
3	Dr. Jacob Abebrese	GHS	Dep. Director, Institutional Care Division
4	Dr. David Opare	GHS	Director, Public Health Division
5	Dr. Abraham Hodgson	GHS	Director, Research and Development Division
6	Ms. Rebecca Ackwonu	GHS	Public Relations Officer
7	Mr. Tsunenori Aoki	GHS/JICA	Policy Advisor
8	Dr. Joseph Teye Nuertey	RHMT UW	Regional Director of Health Service
9	Mr. Theophilus Owusu-Ansah	RHMT UWR	DDCC
10	Mr. Prosper Tang	RHMT UWR	Regional CHPS Coordinator
11	Mr. Marcelinus Welber	RHMT UWR	DDA
12	Mr. Ali Musah	RHMT UWR	Asst. Regional CHPS Coordinatot
13	Mr. Anthony Kullah	RHMT UWR	Nutrion Officer
14	Ms. Basilia Saalia	Wa MHMT	MDHS
15	Ms. Pheobe Bala	Nadowli-Kaleo DHMT	DDHS
16	Mr. Emmanuel Sanwouk	DBI DHMT	DDHS
17	Mr. Yango Crispin	RCC UWR	Planning Officer
18	Ms. Christina Nyewala	Jirapa CHNTC	Principal
19	Dr. Winfred Ofosu	RHMT UER	Regional Director of Health Service
20	Dr. Abdul-Razak Dokurugu Isaac	RHMT UER	Deputy Director of Public Health/Clinical Care
21	Mr. Bimpeh Kwame Amankwah	RHMT UER	Regional Health Information Officer
22	Mr. Peter Boateng	RHMT UER	Reg. CHPS Coordinator
23	Mr. Emmanuel Ansu-Abina	RHMT UER	CHPS Unit Member
24	Mad. Mary Stella Adapesa	Bawku MHMT	MDHS
25	Mr. James Naabil Tobiga	Builsa South DHMT	DDHS

26	Mad. Rosemond Azure	Bongo DHMT	DDHS
27	Dr. Samuel T. Kwashie	RHMT NR	Regional Director of Health Service
28	Ms. Abiba Iddi	RHMT NR	PNO(PH)
29	Mr. Isaac Lartey	RHMT NR	Regional Health Information Officer
30	Mr. Dubik Daniel Dindiok	RHMT NR	Regional CHPS Coordinator
31	Ms. Charity Azantilow	Tolon DHMT	DDHS
32	Mr. Bukari Adam	Savelugu-Nanton DHMT	DDHS Rep.
33	Mr. Anas Adam	East Mamprusi DHMT	DDHS Rep.
34	Ms. Comfort Kona	HTS- NR	Principal- Tamale CHNTS
35	Ms. Maki Ozawa	JICA Ghana	Senior Representative
36	Mr. Enoch Oti Agyekum	JICA Ghana	Programme Officer
37	Ms. Satoko Ishiga	JICA Project	Chief Advisor/ Community Health
38	Ms. Yuka Ohaku	JICA Project	Project Coordinator
39	Mr. Zacchi Sabogu	JICA Project	Project Advisor
40	Mr. Abu Dokuwie Alhassan	JICA Project	Senior Project Coordinator
41	Mr. Samuel D. Daguah	JICA Project	Junior Project Coordinator
42	Mr. Sharifdeen Amadu	JICA Project	Junior Project Coordinator/Adm.

Annex 2: Agenda of 1st JCC Meeting

No.	Time	Activity	Person Responsible
1	13:30 -13:40	Registration	GHS/JICA
2	13:40-13:45	Introduction of Participants	**Madam Rebecca Ackwonu** PRO, GHS HQ
3	13:45-13:50	Opening remarks	**Dr. Anthony Nsiah Asare** Director General, GHS/Project Director
4	13:50-14:00	Purposes and management related activities	**Mr. Zacchi Sabogu** **Project** Advisor, Project Team
5	14:00- 14:45	Plan and progress of activities	**Ms. Satoko Ishiga** Chief Advisor, Project Team **Mr. Zacchi Sabogu** **Project** Advisor, Project Team
6	14:45-15:00	Introduction of modified PDM version 1 and brief introduction of the baseline study	**Ms. Satoko Ishiga** Project Advisor, Project Team **Mr. Zacchi Sabogu** **Project** Advisor, Project Team
7	15:00-15:30	Discussion	**Madam Rebecca Ackwonu** PRO, GHS HQ
8	15:30-15:45	Issues and Concerns ● Approval of modified PDM ● Approval of workplan (2017-2019) ● Plan of the next JCC etc.	**Dr. Anthony Nsiah Asare** Director General, GHS/Project Director
9	15:45-15:50	Remarks by JICA Representative	**Mr. Hirofumi Hoshi** Chief Representative, JICA Ghana Office
10	15:50-15:55	Way Forward	**Dr. Koku Awoonor Williams** Director of PPMED, GHS/ Project Coordinator
11	15:55-16:00	Closing Remarks	**Dr. Anthony Nsiah Asare** Director General, GHS /Project Director
12	16:00-16:05	Closing Prayer	To be selected
13	16:05-16:10	Photo taking	All

MC: **Madam Rebecca Ackwonu,** PRO, GHS HQ

Annex 3: Modified PDM (Version 1)

Project Title: Strengthening community-based health services focusing on the life-course approach in the Upper West, Upper East and Northern Regions

Implementing Agency: Ghana Health Service (GHS)

Beneficiaries: People of all ages in the Upper West, Upper East and Northern Regions

Target Group: CHOs and other health staff in the Upper West, Upper East and Northern Regions

Period of Project: 2017 - 2022 (5 years)

Project Site: Output 1-3: Upper West, Upper East and Northern Regions* (*: selected districts in Northern Region), Output 4: Upper West Region

Narrative Summary	Objectively Verifiable Indicators		Means of Verification		Important Assumption	Achievement	Remarks
	Ver.0	Proposed modification for Ver. 1	Ver.0	Proposed modification for Ver. 1			
Overall Goal Universal health coverage is promoted by improving access and utilization of primary health care through Community-based Health Planning and Services (CHPS) in Upper West, Upper East and Northern Regions	1. (By the end of 2025), more people within the 3 northern regions are covered by functional CHPS zones UWR XX% (2025) UER XX% (2025) NR XX% (2025)	Coverage of the population in the functional CHPS zones of three northern regions is reached by the end of 2022 as follows UWR XX% UER XX% NR XX%	1. Records from regional/district health directorates/Annual Performance Review Report	CHPS database and other CHPS data collection systems used by UE and NR			
Project purpose							

Community-based health services focusing on the life-course approach are strengthened in Upper West, Upper East and Northern Regions	1. The percentage of people who has access to functional CHPS UWR XX% (2016) → XX% (2021) UER XX% (2016) → XX% (2021) NR XX% (2016) → XX% (2021) 2. The level (score) of CHPS implementation is increased by XX% UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) 3. The level (score) of CHPS implementation with life course approach in UWR is increased by XX% UWR XX% (2017) → XX% (2021)	1. The percentage of people who have access to functional CHPS UWR XX% (2016) → XX% (2021) UER XX% (2016) → XX% (2021) NR XX% (2016) → XX% (2021) 2. The level (score) of CHPS implementation is increased by XX% UWR XX% (2017) → XX% (2021) UER XX% (2017) → XX% (2021) NR XX% (2017) → XX% (2021) 3. The level (score) of CHPS implementation with life course approach in UWR is increased by XX% UWR XX% (2017) → XX% (2021)	1. Records from regional/district health directorates/Annual Performance Review Report 2. Project Score Card 3. Project Score Card	CHPS database CHPS database To be determined	A financially sustainable mechanism is established to operate CHPS		
Outputs							
0. (Project Management) The project is monitored and evaluated periodically, and good practices and	0-1. The number of Joint Coordinating Committee meetings conducted	0-1 Joint Coordinating Committee meeting is conducted for at least once per year.	0-1. Project reports	Monitoring Sheet			

lessons learned are shared with other regions and GHS-HQ for scaling-up.	0-2. The number of technical exchange events 0-3. Results of evaluation submitted to GHS-HQ	0-2. The number of technical exchange events achieved to XX times during the whole project period. 0-3 GHS-HQ receives monitoring sheet (twice per fiscal) and progress reports (as determined in R/D).	0-2. Project reports 0-3. Project reports	Monitoring Sheet Monitoring Sheet			
1. The capacity of CHOs and health management teams (SDHT, DHMT and RHMT) to plan and implement CHPS policy by national standards is strengthened.	1-1. The number of CHOs who are trained and deployed at CHPS 1-2. The number of FSVs implemented as planned at each level RHMT→DHMT (UWR: twice/yr, NR & UER: 4 times/yr) DHMT→SDHT (4 times/yr) SDHT→CHO (4 times/yr)	1-1 Number of trained beneficiaries is increased to following targets by the end of the project. Community Health Nurse: XX Enrolled Nurse: XX Midwives: XX Nurse Assistant Clinical Students: XX Nurse Assistant Preventive Students: XX 1-2 Number of trained CHOs in the functional CHPS zones is increased to XX	1-1. Project reports 1-2. FSV reports	CHPS database CHPS database			

	1-3. The number of issues identified and the number of issues solved through FSV	1-3 The numbers of implemented FSVs maintain following frequencies over the project period. RHMT -> DHMT (2 times / year) DHMT->SDHT (4 times / year) SDHT -> CHO (4 times / year) 1-4 FSV score is increased as follows. RHMT -> DHMT (XX%) DHMT->SDHT (XX%) SDHT -> CHO (XX%)	1-3. FSV reports	FSV database/ Hard copies of monitoring tools FSV database/ FSV Performance Standard			
2. Community activities of CHPS are strengthened.	2-1. Number of active CHMCs for Community activities 2-2. Proportion of CHAPs developed and implemented 2-3. Proportion of pregnant women receiving first trimester ANC, Skilled Delivery, PNC within 23 hours	2-1 The number of active CHMCs for community activities is increased to XX. 2-2 The proportion of CHPS zone with at least one CHAP is increased to XX%. 2-3 Proportion of active CHAPs is increased to XX% 2-4 Proportion of pregnant women receiving first trimester ANC, Skilled delivery,	2-1. FSV reports/ CHPS Database/ DHIMS2 2-2. FSV reports/ CHPS Database/ DHIMS2 2-3. FSV reports/ CHPS Database/ DHIMS1	FSV reports/ CHPS database/ DHIMS 2 DHIMS 2 CHPS database/ DHIMS 2 DHIMS 2			

		PNC within 48 hours is increased to XX%.					
3. Governance of CHPS by local government and stakeholders is strengthened.	3-1. Number of health integrated annual plans of DAs including CHPS implementation	3-1 Number of districts with health integrated annual plans developed and costed is increased to XX. 3-2 Proportion of projects/activities implemented in the health integrated annual plans is increased to XX%.	3-1. Annual Plans of DAs/ Signed agreements	Health Integrated Annual Plan Health Integrated Annual Plan			
4. Life-course approach is addressed in the minimum package of CHPS	4-1. Evidence of district action plan implemented 4-2. Evidence of feedback to GHS-HQ	4-1The minimum package of services under the LCA is developed and implemented. 4-2 The life course approach is integrated into the revised CHPS training materials. 4-3 Proportion of community activities for life course approach is increased to XX%.	4-1. Project Report/ Annual Performance Review Report 4-2. Project Report/ Annual Performance Review Report	Project documents or materials developed by the project CHPS training materials Annual Performance Review Report			
Activities	**Inputs**				**Important Assumption**		

Project Management	**The Japanese Side**	**The Ghanaian Side**	
0-1. Conduct baseline survey 0-2. Monitor the progress and review the effectiveness of CHPS implementation periodically 0-3. Conduct field visit for technical exchange among regions and GHS-HQ 0-4. Inform MoH/GHS-HQ and modify the project approach (strategy) when necessary 0-5. Conduct end-line survey 0-6. Compile evaluation report reviewed by MoH/GHS-HQ and disseminate it nationwide 1-1. Develop assessment tool (e.g. score card) by utilizing available tools to review progress of CHPS implementation 1-2. Assess and score the current progress of CHPS implementation 1-3. Plan trainings for CHOs, SDHT and DHMT,	1. Experts: Chief Advisor Project Coordinator/Training Management Experts on Community Health, Helath Promotion/IEC, Nutrition, NCD, Ageing, Health Financing 2. Training in Japan 3. Equipment Basic medical equipment Training equipment Vehicles Office equipment 4. Budget for operation	1.Counterparts □ GHS-HQ □ Regional health directorate of UWR, UER, NR □ District health directorate of UWR, UER, NR □ Sub district health teams of UWR, UER, NR □ Community Health Officers of UWR, UER, NR □ Regional/district hospitals of UWR, UER, NR 2. Office Spaces 3. Others Budget for operation Utility fees	1. CHPS Policy remains to be a main health policy within Ghana. 2. The macroeconomy of the country does not get extremely worse compared to the current state. 3.Epidemiological outbreak does not occur unexpectedly. 4. Socio-political stability is ensured. 5.Decentralization is smoothly implemented without interrupting the health system. **Pre-Conditions**

referral and FSV 1-4. Modify the training materials 1-5. Assign/train the trainers for trainings 1-6. Conduct the trainings 1-7. Conduct follow-up of the trainings 1-8. Conduct standardized FSV regularly (RHMT→DHMT, DHMT→SDHT, SDHT→CHPS) 1-9. Conduct quarterly DHMT review meetings, and share reports among stakeholders 1-10. Plan and conduct intra/extra joint learning among target districts/regions (e.g. develop videos of good practices) 1-11. Standardize training materials to be shared for national scaling-up 2-1. Develop standardized community level data capturing tools 2-2. Assess and score current community health				1. Capable local consultants are available for project implementation 2. All stakeholders of the project (MOH, GHS-HQ, Regional, district, subdistrict and community level) agree on the design of the project and cooperate together.

activities by the community 2-3. Plan and conduct CHO's community outreach and home visit 2-4. Plan and implement community engagement activities with the support of SDHT, DHMT and DA 2-5. Modify/produce training materials for CHMC/CHV 2-6. Conduct training for CHMC/CHV 2-7. Implement community health activities by the community (e.g. referral system using CETS) 2-8. Create sustainable non-monetary incentive mechanism for the CHO/CHV and community 2-9. Plan and conduct intra/extra joint learning among target districts/regions 2-10. Review/standardize/develop training materials to be shared for national scaling-up 3-1. Assess and score the current level of governance of CHPS by DA and				<Issues and countermeasures>

stakeholders 3-2. RCC, RHMT, DA, DHMT and stakeholders conduct a joint stakeholder meeting and discuss on CHPS planning (HRH, equipment, logistics), budgeting and monitoring. 3-3. DHMT and DA develop health integrated annual plans including CHPS implementation 3-4. Plan and conduct intra/extra joint learning among target districts/regions 4-1. Review the current CHPS services focusing on life-course approach between the GHS-HQ and three northern Regions 4-2. Three northern Regions propose to GHS-HQ "minimum package of services focusing on life-course approach at community level (minimum package)" based on the review of 4.1 4-3. Plan minimum package between GHS-HQ and Upper West Region					

4-4. Develop regional action plan for minimum package at Upper West Region						
4-5. Integrate life-course approach into the trainings and currently used training materials for CHPS implementation at Upper West Region						
4-6. Life-course approach team develops action plan for minimum package at Upper West Region						
4-7. Life-course approach team conducts and monitors district action plan for minimum package at Upper West Region						
4-8. Share the results of the action plan among GHS-HQ and three northern Regions						

Note: A life-course approach to health stresses the importance of all ages and stages of life, and sets goals of investment in health capital through health promotion and prev
Course Approach to Health", WHO, 2000).

Annex 4: Sample of monitoring sheet

TO CR of JICA GHANA OFFICE

PROJECT MONITORING SHEET

Project Title :
Version of the Sheet: Ver.●● (Term: Month, Year - Month, Year)
Name:
Title: Chief Advisor
Submission Date:

I. Summary

1 Progress
1-1 Progress of Inputs
1-2 Progress of Activities
1-3 Achievement of Output
1-4 Achievement of the Project Purpose
1-5 Changes of Risks and Actions for Mitigation
1-6 Progress of Actions undertaken by JICA
1-7 Progress of Actions undertaken by Gov. of ●●
1-8 Progress of Environmental and Social Considerations (if applicable)
1-9 Progress of Considerations on Gender/Peace Building/Poverty Reduction (if applicable)
1-10 Other remarkable/considerable issues related/affect to the project (such as other JICA's projects, activities of counterparts, other donors, private sectors, NGOs etc.)
2 Delay of Work Schedule and/or Problems (if any)
2-1 Detail
2-2 Cause
2-3 Action to be taken
2-4 Roles of Responsible Persons/Organization (JICA, Gov. of●●,etc.)

3 Modification of the Project Implementation Plan
3-1 PO
3-2 Other modifications on detailed implementation plan
(Remarks: The amendment of R/D and PDM (title of the project, duration, project site(s), target group(s), implementation structure, overall goal, project purpose, outputs, activities, and input) should be authorized by JICA HDQs. If the project team deems it necessary to modify any part of R/D and PDM, the team may propose the draft.)

4 Preparation of Gov. of●● toward after completion of the Project

II. Project Monitoring Sheet I & II *as Attached*

Compiled by:

Abu Dokuwie Alhassan.....
(Senior Project Coordinator)

Reviewed by:

Zacchi Nolan Sabogu.....
(Project Advisor)

Endorsed by:

Ms. Satoko Ishiga .....
(Project Chief Advisor, IC Net)

Ms. Maki Ozawa.....
(Senior Representative, JICA Ghana Office)

Dr. Anthony Nsiah Asare.....
(Director General, Ghana Health Service)

Strengthening Community-based Health Services Focusing on the Life-course Approach in the Upper West, Upper East and Northern Regions (CHPS for Life)

Minutes of 2nd Joint Co-ordination Committee (JCC) Meeting
Date: 28th June
Venue: Upland Hotel, Wa

1. Introduction

The 2nd JCC meeting was held on 28th June 2018 from 9:45 to 14:30 at the Upland Hotel in Wa. It was chaired by Dr. Patrick Kuma-Aboagye, Director, Family Health Division of GHS, on behalf of Dr. Anthony Nsiah-Asare, Director General (DG) of the Ghana Health Service. In all, sixty-five (65) persons were in attendance. The breakdown is as follows:

- 1 representative from the Ministry of Health (MoH);
- 1 representative from the Embassy of Japan (EoJ);
- 7 staff of the Ghana Health Service Headquarters (including 2 divisional directors);
- 2 staff of JICA Ghana Office;
- 22 members from the three Regional Health Directorates comprising 13 from Upper West, 6 from Upper East and 3 from Northern;
- 16 District Directors of Health Services comprising 11 from Upper West, 3 from Upper East region and 2 from Northern;
- 2 heads of hospitals – the Upper West Regional Hospital and St. Joseph Hospital in Jirapa.
- 1 representative of the Upper West Regional Coordinating Council
- 2 staff of training schools – Jirapa and Tamale CHN training schools; and
- 11 project staff.

The detailed list of participants and the agenda of the meeting are attached as annexes 1& 2 respectively.

2. Summary of key issues

- ***Confirmation of plan and progress of the project;*** the progress of activities and plan in respect of each output area were shared by the project team and confirmed by the house.
- ***Demonstration of ownership;*** in subsequent JCC meetings, participants from the 3 regions should make the presentations on issues pertaining to their regions whilst the project team presents cross-cutting issues.
- ***Addressing identified gaps in CHPS implementation;*** having identified gaps in CHPS implementation e.g CHO training, equipment etc across the 3 regions through the CHPS database, it will be useful for the project to clarify what proportion of the gap that the project will fill. Such information will assist managers in the three regions to approach other partners for support in addressing identified gaps.
- ***Support to organize District Annual CHPS Forums;*** the CHPS policy requires districts to organize District Annual CHPS forums with District Assemblies leading the process with technical advice by the District Director of Health Services but that activity is not being implemented. Therefore, it was proposed that the project advocates for the organization of the Annual CHPS forums by the District Assemblies. The forum, if possible to organize, should be christened Annual District CHPS forums as per the new CHPS policy but should be used as platforms to discuss all health service issues including CHPS as a vehicle for delivering the services close to clients.
- ***Capacity building for sub-districts to adequately support LCA activities;*** the project should make conscious efforts to strengthen the sub-district level to provide oversight or support LCA activities at the community level.

- ***Development of community scorecard;*** the project might need to develop an updated version based on the one introduced by the GHS.
- ***Linking CHPS database to the national level;*** to create recognition for the CHPS database, it is imperative to take steps to make it known and acceptable. Meetings have already been held by the project in Accra with PPMED/GHS and the database introduced to some of the key people at the national level. It is therefore expected that, the GHS HQ having known about the CHPS database, would find a way to make it accessible at the national level and use it as and when needed.
- ***Involvement of the participants of Study Tour in Japan in LCA;*** it was proposed that the staff who participated in the Study Tour in Japan should play active role in the implementation of LCA activities.
- ***Sustainable printing of referral registers and forms;*** the setting up of a revolving fund system needs to be discussed to ensure the continuous availability of the materials after the initial printing by the project. The project will print the referral registers and forms as part of the referral trainings before considering the setting up of the sustainable system.
- ***School health screening as part of LCA;*** the GHS is planning to facilitate 'my first day at school screening' in schools. As such, the project can support the three regions in that direction as part of school health screening under LCA.
- ***Supportive Supervision (SSV) materials;*** the SSV materials developed GHS (ICD, FHD, PPME, PHD) in collaboration with USAID are very good but rather more general. It is currently under revision by the consultant. When it becomes ready, the project would also need to do further adaptation to make it usable at the lower levels. Dr. Patrick Kuma-Aboagye will share the SSV materials with the project.
- ***Injuries and trauma not being addressed under LCA;*** it was great idea that in shaping the scope of the LCA aspect of the project, the focus was broadened to look at both communicable and non-communicable diseases. However, injuries and trauma which are essential for emergency care have still not been considered.
- ***Further editing of IEC video is needed;*** the IEC videos developed by the project need further editing to incorporate inputs and comments made during the SBCC meeting in Accra when the clips were shown.
- ***Sustainability measures;*** the project stakeholders should already start thinking about sustainability arrangements for the project. Sustainability arrangements should not be deferred to the end of the project.
- ***Next JCC meeting;*** the next JCC meeting plus study tour was slated for December 2018 in Tamale. The DG will decide the appropriate date and communicate to members in writing.

3. Welcome Address – Dr. Joseph Teye Nuertey, RHDS & Project Manager, UWR

Dr. Nuertey welcomed participants to the UWR and specially those who participated in the study tour the previous day. He said the study tour and JCC meeting offered an opportunity for participants to pick up useful lessons in the UWR to assist in the full operation of the project in the Upper East and Northern regions. He concluded by calling on all participants to participate actively.

4. Opening remarks

(i) Dr. Patrick Kuma-Aboagye, Director, FHD, GHS HQ (Chairperson)

He expressed delight that he was participating in the JCC meeting and apologized for the absence of the DG. He informed members that the DG really wished to have participated in the meeting, was on his way but had to be called back to Accra because of other urgent tasks.

He said the CHPS for Life project is of great interest to the GHS because it mirrors an ideal approach to achieving Universal Health Coverage (UHC) in Ghana. He expressed optimism that the meeting was going to be a successful one.

(ii) Maki Ozawa, Senior Representative, JICA Ghana Office

Ms. Ozawa expressed gratitude to stakeholders of the project for demonstrating ownership so far. According to her, CHPS for Life is the flagship project supported by JICA that seeks to serve as a model of how UHC can be achieved in African country. She said the project depicts the current global approach to achieving UHC across the globe. She concluded that the meeting was meant to galvanize constructive inputs to enrich the project strategy and implementation.

(iii) Anna Shimpo, Economic Cooperation Coordinator, Embassy of Japan in Ghana

Ms. Anna expressed excitement for her participation in the study tour the previous day. She said that as far as the Government of Japan is concerned, Ghana together with Senegal and Kenya are the 3 countries that have been prioritized for improving UHC. She added that CHPS for Life project can help to accelerate the achievement of UHC that many can learn from. She expressed confidence that everything will work out very well. She assured that the Embassy of Japan will do everything within its means to ensure the project succeeds.

5. Plan and progress of the project

With the use a PowerPoint presentation, Ms. Ishiga and Mr. Sabogu took the house through the plan and progress of activities in respect of each output of the project. The summary of the status of the project in each output is as follows:

(i) Output 0 (management related activities) – Ms. Satoko Ishiga

The status of output 0 activities and challenges so far are summarized as follows:

Status of activities:

Activities	Progress & plan
1. Joint coordination committee (JCC) meeting	o 1st meeting conducted in November 2017 to approve workplan and 1st modification of PDM. o 2nd meeting to report the progress of project activities, the findings of baseline survey and study tour in Japan in May 2018. o 3rd meeting planned in December 2018
2. Coordination meeting of three regions	o 1st meeting was conducted in June 2018 to discuss resource sharing for training and report the findings of baseline survey o Next meeting The same date as JCC
3. Regional management meeting	o UER: 2 meetings, in July 2017 and March 2018. o NR: 3 meetings, in July and November, 2017 and March 2018. o UWR: 1st meeting was conducted in May 2018. o Plan: September 2018 and January 2 019 for all regions.
4. Monitoring tour by GHS	o It is yet to be conducted. It should be planned with the involvement and participation of the various divisions of the GHS HQ. o Plan: To be discussed with GHS HQ

5. Review of Project Monitoring, Progress and Completion Reports	o The persons in charge of report review in NR and UWR have been nominated. o UER and GHS HQ need to nominate the persons in charge o Plan: Review of Progress report in July/August 2018, Termination report in June 2019
6. Study tour in Japan on Life-course approach	o 6 persons (1 from MOH, 2 from GHS HQ, 1 each from UW, UE & N regions) participated in the study tour from 15th to 25th May 2018. o Presentation of lessons at JCC and first follow-up meeting were done in June 2018. Subsequent follow up meetings will be organized quarterly. The next follow up meeting will be in September 2018 in Tamale.
7. Baseline survey	o Survey in UER and NR was conducted from November 2017 to February 2018, and in UWR from February to May 2018. o Plan: Review of report in June/July and submission in July.

Challenges

- Delay of monitoring visits by GHS HQ; the timing has to be harmonized with project/national events. Team composition should also consider relevant divisions.
- Delay in organizing coordination meeting of three regions due to the reshuffling of RDHS and conflicting schedules; the1st meeting was conducted a day before JCC.
- Joint review of progress reports, monitoring sheet and baseline survey report by the project team and GHS; there is need to assign persons in charge

(ii) Output 1 (strengthening CHPS implementation and systems)

Status of activities:

Activities	Progress & plan
1. CHPS database training	o CHPS data as of 2017 was summarized in 3 regions through introduction of CHPS database in UER and NR. o Three meetings for each region were conducted in UER and NR in November 2017 and in February 2018. o Planned activities: - Next meeting in UWR in October 2018. - Next meeting in UER in July 2018, October 2018, January 2019. - Next meeting in NR in July 2018, October 2018, January 2019
2. CHO fresher training	o Not conducted yet o Important points to note: • Analysis of the CHPS database revealed the urgent need for CHO fresher training in the NR. • The rollout of the training delayed because of the delay in the release of modified national CHO fresher training materials (released in June 2018). • Training will be conducted intensively from July to December 2018. • UER: trainees to be selected by UER according to their role-out plan. The project does not target any CHPS zones.

	• NR: Trainees can be selected from the 4 target districts. If resources allow, trainees from other districts can be considered. o Planned activities: - Strategic meeting will be conducted in July 2018 to confirm strategy, plan the training and finalize program based on the modified national training materials. - Orientation on CHO fresher training in July/August 2018 to introduce modified national training materials and program to trainers, RHA, DHMT, CHPS unit of 3 regions. - ToT for 81 target trainers (NR 30, UER 28 & UWR 23). - Capacity building of trainers through the conduct of CHO fresher training.
3. Pre-service training (UWR only)	o 1st strategic meeting was conducted on November 13, 2017. o Planned activities: - Invite UER and NR to the pre-service training; 1st meeting in July 2018 to plan the visits. Timing of visit to be discussed with training schools. - Review meeting for district CHO orientation materials. Materials will be developed based on the modified CHO fresher training materials. - Review meeting will be conducted in October 2018. - Trial CHO orientation in two districts; timing of orientation to be discussed with 2 districts. - Feedback meeting and modification of materials in early 2019. - Conduct district CHO orientation in nine districts from February to June 2019. Timing to be discussed with 9 districts according to their CHO assignment plan. - Joint feedback meeting on district CHO orientation): In June 2019
4. FSV training	o Not conducted yet o Important points to note: - Strategic meeting for UWR organized in November 2017. - Review and modification of FSV training materials; waiting for the release of national SSV materials. - FSV activities in the UER and NR will be rolled out as soon as materials are received.
5. Referral training	o Two (2) strategic meetings were held on referral, in UWR in November 2017 and in Bolgatanga for both UER and NR in April 2018. o Final training materials review meeting was held in June 2018 with participation of ICD of GHS-HQ. o ToT is planned in July for UER and NR and in August for UWR. Trainings will commence in August.
6. Conduct DHMT review meeting on CHPS enhancement	o Not yet conducted o Planned activities: • Review of the program and meeting tools, and orientation on CHPS review meeting to be conducted in October 2018. • Joint review meeting on CHPS enhancement to be conducted

	in February 2019.
7. Learning visits	o Study tour by JCC participants was done a day before JCC. Experience sharing was done as part of JCC proceedings. o Planned activities • Study tour for three regions will be conducted in November 2018 and April 2019. • Dissemination for three regions will be done in April 2019.

Challenges:

- Urgent need to conduct CHO fresher training; effective plan of the training and appropriate resource sharing need further discussion.
- Delay of SSV training due to delay in the release of national SSV training materials; waiting for the national SSV materials by GHS-HQ, ICD to roll out SSV activities.
- Inadequate referral forms and registers; allocation of annual budget for registers and setting up of revolving fund system for referral and feedback forms.

(iii) Output 2 (strengthening community activities)

Status of activities:

Activities	Progress & plan
1. Development of community score card (UWR)	o Meeting with FHD in February 2018 (to confirm framework of the current Community Score Card) o Planned activities: - Strategic meeting in UWR involving GHS HQ (PPME & FHD) to discuss the concept and purpose of the score card by project in July 2018. - Sharing the framework of the score card with FHD in August 2018. - Development of the tool in August-September 2018. - Review of the tool by GHS HQ in September 2018 - Orientation on score card to be discussed during the strategic meeting. - Monitoring, feedback and modification of tool to be discussed during the strategic meeting.
2. CHV/CHMC training (UWR)	o 1st Taskforce meeting on community mobilization was conducted on March 16, 2018 to discuss the training content. o Planned activities: - Field visits to guide the development of materials will be conducted in July and August 2018. - Review meeting by Taskforce in August 2018 and the development of the training contents in October-November 2018. - Development of the materials (e.g. Flipchart) in February-March 2019. - TOT on CHO refresher training in April 2019. - CHMC/CHV training from April-June 2019 in the pilot CHPS zones as field practice of post-CHO refresher training - Joint review meetings to be conducted in term 2.

3. LCA related community activities (UWR)	o The 1st Taskforce meeting was held in March 2018. o Selection of pilot CHPS zones was done in April-May 2018. o Planned activities: - Field visits to assess the selected Pilot CHPS zones per district in July 2018. - List up LCA related community activities in July-August 2018. - Feedback/orientation to the Pilot CHPS zones in September-October 2018. - TWG meetings to review existing incentive system for CHMC and CHV in July-October 2018, discuss possible incentive system in February-March 2019 and develop proposal of the incentive system in May-June 2019. - Joint review meeting to be conducted in May-June 2019.
4. Development of IEC materials (UWR)	• 4 of 5/6 video clips targeting the public have been developed and editing is ongoing. • Videos for the CHO/CHV/CHMC training will be in 2019 in harmonization with the timing of the training
5. Promote intra/inter learning visits	Not conducted yet

Challenges:

- o Project Community Scorecard and the scorecard introduced by the GHS should be harmonized; the project would need to explain the purpose of its scorecard and agree with GHS on what additional issues to feature on the national scorecard.
- o The project needs to consider the appropriate way to introduce the scorecard.

(iv) Output 3 (strengthening governance of CHPS)

Status of activities:

Activities	Progress & plan
1. Conduct survey to assess the current CHPS governance in UWR and UER	o Survey was conducted in UWR in September 2017 and UER in April 2018. Involvement of DA, DHMT and stakeholders in CHPS planning and monitoring were found in all districts in UWR but not in UER.
2. Preparation of CHPS governance checklist	o The contents of the CHPS governance checklist was discussed in the 1st TWG meeting in April 2018
3. Development of reference materials on CHPS Governance by TWG	o Necessity and the structure of reference materials were discussed in 1st TWG meeting in April 2018. o Planned activities: - 2nd TWG involving participants from all three regions will be conducted in September 2018.
4. Stakeholder meeting in each region	o The 1st RCC meeting was conducted in UWR in September 2017, UER (April 2018), and NR (May 2018) respectively.
5. Development of health integrated	o Promoted the preparation of the health integrated annual action plans for 2018 in 1st RCC meeting in UWR in

annual action plans	September 2017 o Planned activities: - Workshops will be conducted on the development of health integrated annual action plans in NR and UWR in September 2018 and UER in March 2019.
6. Joint learning meeting among target districts/regions	o Joint learning meeting among target districts/regions will be organized in March 2019

(v) Output 4 (Introduction and integration of LCA into CHPS service package)

Status of activities:

Activities	Progress & plan
1. Nutrition	o The first strategic meeting was organized to review the potential nutrition topics to be included in the CHO training materials. o Community visits were conducted in February and April 2018. o Study on the necessary services on Nutrition at CHPS level is on-going till November 2018 through the review of existing documents and field visits. o Planned activities: - Additional community visits are planned in October 2018 as part of situational analysis of LCA. - Another strategic meeting is planned in February 2019. - Material review meeting will be conducted in February 2019.
2. School health, Adolescent Health, Aged Health, Communicable and NCD	o Study on the necessary services at CHPS level is on-going till November 2018 through the review of existing documents and field visits o Planned activities: - Strategic meeting to discuss screening at CHPS zone and material development is planned to be held in November 2018. - TWG meeting to review existing materials including materials on screening for NCDs (as part of CHO refresher training material) will be held in February 2019. - Materials review meeting to be held in February 2019. - Study visit to UER and strategic meeting on workplace screening to be done in the 2nd term.
3. Capacity building of SDHT/CHO on LCA	o Training materials are under development. o Planned activities: - Strategic meeting on LCA training for CHO and SDHT to be conducted around October 2018. - TWG meeting on development of training materials to be held in February 2019.

	- ToT, training for SDHT and CHO to be conducted from April 2019 onwards. - Joint feedback and strategic meeting to be conducted in the 2nd term.
4. Review of LCA activities by GHS HQ and region	o The concept of LCA in the project was developed and agreed through 4 meetings from November to April 2018. o Planned activities: - Orientation on LCA to integrate into CHPS services, LCA review meeting and Meeting to finalize the proposal to be conducted in the 2nd term.
5. Integration of LCA into CHPS minimum package and budgeting	o Study on the current CHPS minimum package of services is on-going till November 2018 through the study of modified national CHO fresher training materials and field visits. o Planned activities: - Proposal review meeting and Budget planning meeting for LCA to be conducted in the 2nd term.

Challenges:

- The situational analysis based on the determined concept and definition needs to be conducted. The timeline of the situational analysis is between July and November 2018 with slight delay.
- The outline of the situational analysis needs to be developed and agreed among stakeholders prior to the execution.

(vi) Key discussion points on presentations of the plan and progress of the project

- For issues from the regions, it is important for each region to make the presentations as a sign of ownership.
- The design of the project is seeking to strengthen the community level structures to make it possible for Ghana to achieve UHC earlier than other African countries.
- It is great that the LCA is looking at both communicable and NCDs but injuries and trauma need to be considered.
- A lot of materials and activities are available in the system and should not be left in the silos but harmonized together to improve the system.
- It will be important to know what proportion of the gap identified in the CHPS database, as far as CHPS implementation is concerned, that the project can fill. Such information will provide a good starting point for counterparts to start approaching other partners.
- In designating CHPS zones as fully or partially equipped as contained in the CHPS database, the criteria are based on the list of standard equipment contained in the CHPS implementation guidelines.
- In prioritizing CHPS zones for CHO fresher training there is no recourse to whether there is a compound or not. Emphasis is on service provision.
- There is the need to link the CHPS database to the national level. Meetings have already been held in this regard and the CHPS database introduced to the national level.
- IEC video needs further editing based on comments made at the SBCC meeting in Accra in May 2018.
- Printing of referral materials (registers & forms) needs to be discussed to devise a sustainable way of replenishing the stocks after the first printing by the project.

- SSV documents developed by ICD are very good but more general. So, the project might have to tailor them for use. The consultant is relooking at them to improve them.
- PPMED has a small input they would love to make into the SSV materials. It will be great for an opportunity for these needed inputs to be made to make the materials ready for use.
- Conscious efforts should be made to strengthen the sub-district level to control or at least support LCA activities at the community level.
- The project should consider supporting the districts to organize District CHPS Forums which is part of the CHPS policy but has been left. The forums should be christened as Health Forums to discuss general health issues including CHPS.
- The project might need to do an abridged and harmonized version of the community scorecard that has been introduced by the GHS for use.
- School health screening – 'my first day at school' screening will be facilitated by the GHS. So, the project can consider supporting the 3 regions to organize it as part of LCA.
- The three regions are expected to take advantage of the processes outlined by the project to improve health outcomes.

6. Presentation on findings of baseline survey – Mr. Hitsamitsu Shimoyama

Mr. Shimoyama took the house through the baseline survey results. The details of his presentation are attached as annex 3. He highlighted the purpose, timelines, survey design, sampling methodology and size and the PDM indicators on which data was collected by the baseline survey. Summary of key findings of the baseline survey are as follows:

- Functional CHPS zones; UWR 74%, UER 43% and NR 10.7%.
- Percentage of people with access to functional CHPS zones; UWR 55.2%, UER 31% and NR 9.6%.

7. Presentations on study tour in Japan

7.1 Ms. Gladys Brew, Safe Motherhood Coordinator, Family Health Division of GHS HQ (on behalf of GHS HQ participants):

Ms. Brew's presentation focused on the findings made in Japan, challenges in applying the practices in Ghana, area of intervention and action plans.

(i) Findings in Japan

- Provision of MCH services is backed by law and this includes system for notification of pregnancy.
- Public Health Centres provide mandatory health checks for children and optional health checks for adults ("Papa and mama checks").
- Good dietary habit is promoted in schools, at Public Health Centres and in communities, in collaboration with communities ("Shokai San").
- A system of mandatory annual health screening in schools.
- Clinicians, in addition to clinical work, are involved in health promotion activities eg theatrical events and clinics (SMART Clinic).
- Care of the elderly is an essential part of health visiting to homes.
- Strong public/private partnership exists for the provision of health services, including MCH services.

(ii) Challenges to applying practices in Ghana

- Although a Public Health Act exists, there is no Legislative Instrument guiding the provision of MCH services which would include pregnancy notification.
- MCH services have been traditionally known to apply to pregnant and postpartum women and children and not men or other caregivers.
- Even though male involvement is encouraged in MCH services such as ANC, pregnancy schools and CWC, no services exist for them and other caregivers.

(iii) Area of intervention

- Providing Basic Adult Health Care within the Life-course Approach using MCH as Entry Point.

Background, Justification and Rationale

- Hypertension is listed among the top 10 Causes of Mortality in Ghana
- Hypertension and diabetes are life-style diseases
- Carbohydrates form a relatively large proportion of Ghanaian diet and some local dishes tend to have high salt content.
- Although there is general awareness of balanced diet there is ignorance on the required daily salt intake
- Limited availability of basic adult check-up facilities at community level
- Opportunity exists for promotion of good dietary habits and basic health checks for adults at MCH entry points such as Child Welfare Clinics, Pregnancy Schools and Home Visits.

(iv) Action Plan

Objective:

Disseminate Concept Paper on Providing Basic Adult Health Care within the Life-course Approach using MCH as Entry Point.

Outputs:

- Concept paper on Providing Basic Adult Health Care within the Life-course Approach using MCH as Entry Point.
- Dissemination sessions on Providing Adult Health Care within the Life-course Approach using MCH as Entry Point

Activities:

- De-briefing of Director, Family Health Division and colleagues on proposed action plan
- Development of draft concept paper using reference materials from study tour
- Submission to Director of Family Health Division for review
- Sharing at CHPS for Life project meetings
- Modification and finalization of concept paper
- Dissemination at various national meetings.

7.2 Dr. John Abenyiri, DDPH, NR (on behalf of participants from 3 regions)

Dr. Abenyeri's presentation looked at the organization of LCA activities in Japan, challenges of implementation in Ghana, points to note and LCA in the Ghanaian context.

(i) Organization of LCA activities in Japan

- Comprehensive deliberate system of health promotion/preventive activities
- Starts with newborn through school-age to adulthood and elderly
- There is a seamless flow of human resources from private to public sector and vice versa
- Good referral system anchored on smooth interpersonal relationship
- Orientation of clinical staff to public health approach to patient care and management

- Significant involvement of local authorities in health care delivery
- Community participation in service delivery at all levels exemplary
- High level of volunteerism and commitment to social good.

(ii) Challenges to implementation in Ghana
- Poor legal and regulatory framework for the operationalization of programmes
- Low literacy level (particularly on health)
- Little community/local government ownership of health-related activities
- Few numbers/mal-distribution of specialised clinical/health promotion personnel
- Weak collaboration of public-private health sector
- Challenges of multi-sectoral collaboration to service delivery

(iii) Points to note
- Planning, organisation and delivery of health care services should be contextualised to local needs.
- Ownership of activities by residents is key to patronage and sustainability
- Systems must work based on clearly defined roles for service integration to yield reasonable results.

(iv) LCA in Ghanaian context
- CHPS is the strategy and vehicle for pilot and scale up
- DA engagement must be enhanced from the inception
- Community and stakeholder participation
- Staff (CHOs/MWs) orientation on technical and community-centred service delivery skills [CHAP/CHMC as avenues]
- Formalisation of health volunteer status at each district level
- Integration of basic health check-ups into CWC sessions for pre-schoolers
- Consider specialised education sessions in pregnancy classes

(v) Application in the Ghanaian context
- CHPS is the strategy and vehicle for pilot and scale up
- DA engagement must be enhanced from the inception
- Community and stakeholder participation
- Staff (CHOs/MWs) orientation on technical and community-centred service delivery skills [CHAP/CHMC as avenues]
- Formalisation of health volunteer status at each district level
- Integration of basic health check-ups into CWC sessions for pre-schoolers
- Consider specialised education sessions in pregnancy classes

7.3 ***Mr. Banabas Kwame Yeboah, National CHPS Coordinator, MoH***

In Mr. Yeboah' presentation, he catalogued the findings in Japan, challenges to apply practices in Ghana, area of your intervention and his action plan.

(i) Findings in Japan
- LCA has been legislated
- Japan has the MCH Act which is among another legal framework
- Structures for Public Health activities are not integrated into the mainstream clinical services
- 5-year action plan on development of next generation

- Healthcare services are under the Decentralized authorities (local authorities)
- 90% of facilities are private
- Ministry of Health, Social Welfare and Labour in-charge of Health Promotion

(ii) Challenges to applying practices in Ghana
- Leadership Buy-in
- Financial resources
- Bureaucracies

(iii) Area of intervention
- Advocacy and Policy Influencing
- Legislation of Life Course Approach/MCH
- Establishment of Public Health Centres under
- Establishment of Health Promotion Directorate separate from Health facilities to be under MoH
- Private Participation and Management of public facilities--Legislation

(iv) Action plan
- Briefing of the Minister and MoH Management
- Stakeholder engagement on LCA legislation
- Sensitization of Cabinet by HM on LCA/MCH law
- Establishment of NSC and TWG committee for MCH
- Preparation and Submission of Cabinet Memo for approval
- Organize stakeholder meetings on MCH Act and LI
- Sensitization of Parliamentary Select Committee on Health
- Drafting of MCH law by Attorney General Department.
- Submission of draft MCH Act and LI to cabinet and Parliament.

8. Observations of study tour in UWR

Observations made by participants of study tour in UWR were shared representatives of UER, NR and GHS HQ. Summary of their observations is the following:

(i) Emmanuel Ansu-Abina (on behalf of UER)
- Full understanding of CHPS by both CHOs and communities
- Community profile prepared and displayed
- CHAPs and community maps available and displayed
- Great complementarity between CHOs and midwives in the CHPS zones
- Best practice - DCEs show great interest in health activities
- Challenges - Lack of delivery room in CHPS zones

(ii) Welbeck Akplu (on behalf of NR)
- Strength of SDHT demonstrated in the supervision to CHOs.
- Confidence level of staff is high

(iii)Mr. Chares Acquah (on behalf GHS HQ)
- Strong collaboration among the key actors – CHO, community etc
- Strong activism of SDHT

- Mobile CHPS alien to the policy

9. Key discussion points on results of baseline and study tours in Japan and UWR

Few comments and inputs were made on the baseline and study presentations. They are summarized as follows:

- Although Ghana has a Public Health Act, Act 851 (2012), it does not deal with LCA and MCH
- Study tour in Japan team should be a good resource in shaping the content and direction of LCA activities in CHPS for Life project.
- The use of the term 'mobile CHPS' should not be understood as another kind of CHPS zone but one where outreach services being provided without a compound that makes the CHO resident in the CHPS zone.

10. Issues and concerns – Satoko Ishiga

The following issues and concerns needing redress were shared and under directions of the chairperson, considered the way forward after the JCC meeting:

- Modification of PDM and work plan;
  - Proposal for the modification of PDM and workplan will be done in November 2018 through TWG meetings.
  - The modifications will bother on setting target for project indicators, agreeing on LCA related indicators, changes in the number of districts etc.
  - Approval of the modified PDM would be done in the next JCC.
- Strengthening joint review of monitoring sheet and progress reports;
  - GHS HQ and UER need to nominate the persons in charge.
  - Timing of review: progress report (July/August 2018).
  - Monitoring sheet (July 2018).
- Transitioning from FSV to SSV
  - There are delays in starting SSV due to unavailability of materials.
- Monitoring plan by GHS HQ
  - Originally, it was planned as study tour of JCC and quarterly monitoring visits. The quarterly monitoring has not yet happened.
  - GHS HQ has to assign persons from relevant divisions in charge to plan and organize the monitoring visits.
- Next JCC (with Study Tour and Coordination meeting for 3 regions);
  - Proposed date: December 2018.
  - Venue: Tamale, NR.

11. Closure - Dr. Patrick Kuma-Aboagye & Dr. Joseph Teye Nuertey

Dr. Kuma-Aboagye closed the meeting by thanking all for their active participation. Dr. Nuertey on his part, pledged the readiness of the UWR to work with other regions to improve CHPS systems.

Annex 1: Participants List for the 2nd JCC meeting

No.	Category	Name	Organization	Position
1	Ghanaian side	Dr. Patrick Kuma-Aboagye	GHS HQ	Director, Family Health Division
2	Ghanaian side	Mr. John Ayivase	GHS HQ	Member, ICD, rep. of Dr. Abebrese
3	Ghanaian side	Dr. Badu Sarkodie	GHS HQ	Director, Public Health Division
4	Ghanaian side	Mr. Jacob Acquah Andoh	GHS HQ	Public Relations Officer
5	Ghanaian side	Mr. Charles Agyei Acquah	GHS HQ	Deputy Director, Policy
6	Ghanaian side	Ms. Gladys Brew	GHS-HQ	Safe Motherhood Coordinator, FHD
7	Ghanaian side	Ms. Esther Adu	GHS-HQ	Senior Health Promotion Officer, FHD
8	Ghanaian side	Mr. Barnabas K. Yeboah	MoH	National CHPS Coordinator
9	Ghanaian side	Dr. Joseph Teye Nuertey	RHMT UW	Regional Director of Health Service
10	Ghanaian side	Dr. Abdulai Abubakari	RHMT UWR	DDPH
11	Ghanaian side	Mr. Marcelinus Welber	RHMT UWR	DDA
12	Ghanaian side	Mr. Prosper Tang	RHMT UWR	Regional CHPS Coordinator
13	Ghanaian side	Mr. Ali Musah	RHMT UWR	Asst. Regional CHPS Coordinator
14	Ghanaian side	Mr. Nani Tengey	RHMT UWR	RHIO
15	Ghanaian side	Mr. Anthony Kullah	RHMT UWR	Regional Nutrition Officer
16	Ghanaian side	Mr. Dudu Philip Naah	RHMT UWR	Health Promotion
17	Ghanaian side	Mrs. Cecilia Tuo	RHMT UWR	Ag. CNO
18	Ghanaian side	Mrs. Rosemary Banzie	RHMT UWR	School and Adolescent Health
19	Ghanaian side	Mr. Kelvin F. Tengekyebe	RHMT UWR	Regional HR Officer
20	Ghanaian side	Mr. Michael Kamal Seidu	RHMT UWR	Nutrition Officer
21	Ghanaian side	Ms. Rukaya Wumnaya	Wa East DHA	Ag. DDHS
22	Ghanaian side	Ms. Basilia Saalia	Wa MHMT	MDHS
23	Ghanaian side	Ms. Pheobe Bala	Nadowli-Kaleo DHMT	DDHS
24	Ghanaian side	Mr. Emmanuel Sanwouk	DBI DHMT	DDHS
25	Ghanaian side	Mr. Saani Nyuasun	SE-MHMT	Ag. MDHS
26	Ghanaian side	Mrs. Cecilia Kakariba	SW-DHMT	DDHS
27	Ghanaian side	Mrs. Florence Angsomwine	Jirapa MHMT	MDHS
28	Ghanaian side	Mrs. Genevieve Yiripaare	Nandom DMTH	DDHS
29	Ghanaian side	Mrs. Rebecca Alalbilla	Lamb. DHMT	DDHS
30	Ghanaian side	Dr. Mathias Pogvi Tengan	Medical Officer in UWR	Medical Officer
31	Ghanaian side	Mr. Clifford Vengkumwine	WW DHMT	Ag. DDHS
32	Ghanaian side	Ms. Doris Nigre	Lawra MHMT	Ag. DDHS
33	Ghanaian side	Mr. Mohammed Tahiru	Jirapa CHNTC	Tutor
34	Ghanaian side	Dr. Barnabas Naa Gandau	UWR Hosp.	Medical Director
35	Ghanaian side	Dr. Richard Wodah-Seme	St. Joseph Hosp, Jirapa	Medical Superintendent

36	Ghanaian side	Mr. Nii Adjaye Laryea	RCC UWR	Development Planning Officer
37	Ghanaian side	Dr. Winfred Ofosu	RHMT UER	Regional Director of Health Services
38	Ghanaian side	Dr. Abdul-Razak Dokurugu Isaac	RHMT UER	Deputy Director Clinical Care
39	Ghanaian side	Dr. Josephat I. Nyuzaghi	RHMT UER	DDPH
40	Ghanaian side	Mr. James Tobiga	RHMT UER	Regional Health Mgt. Team
41	Ghanaian side	Ms. Gillian Anabah	RHMT UER	CHPS Unit Member
42	Ghanaian side	Mr. Emmanuel Ans-Abina	RHMT UER	CHPS Unit Member
43	Ghanaian side	Mr. Edmund Mohammed Nyenyuwa	Bolgatanga MHMT	MDHS
44	Ghanaian side	Ms. Juliana Anam-erime	KSN West DHMT	DDHS
45	Ghanaian side	Mr. Benson Azure	Pusiga DHMT	DDHS
46	Ghanaian side	Mr. Welbeck Akplu	RHMT NR	Health Information Officer
47	Ghanaian side	Mr. Dubik Daniel Dindiok	RHMT NR	Regional CHPS Coordinator
48	Ghanaian side	Dr. John Abenyeri	RHMT NR	DDPH
49	Ghanaian side	Ms. Charity Azantilow	Tolon DHMT	DDHS
50	Ghanaian side	Mr. Bukari Adam	Savelugu-Nanton DHMT	DDHS
51	Ghanaian side	Mr. Amin Dramani Mahama	Tamale CHNTS	Health Tutor
52	Japanese side	Ms. Anna Shimpo	Embassy of Japan	Economic Cooperation Coordinator
53	Japanese side	Ms. Maki Ozawa	JICA Ghana	Senior Representative
54	Japanese side	Mr. Enoch Oti Agyekum	JICA Ghana	Programme Officer
55	Japanese side	Ms. Satoko Ishiga	JICA Project	Chief Advisor/ Community Health
56	Japanese side	Mr. Hisamitsu Shimoyama	JICA Project	Baseline Expert
57	Japanese side	Ms. Yuka Ohaku	JICA Project	Project Coordinator
58	Project staff	Mr. Zacchi Sabogu	JICA Project	Project Advisor
59	Project staff	Mr. Abu Dokuwie Alhassan	JICA Project	Senior Project Coordinator
60	Project staff	Mr. Kassim Abdul-Basit	JICA Project	Senior Project Coordinator
61	Project staff	Mr. Sharifdeen Amadu	JICA Project	Junior Project Coordinator/ Adm.
62	Project staff	Mr. Ernest Zieni Manson	JICA Project	Junior Project Coordinator
63	Project staff	Mr. Gamuo Roger	JICA Project	Administrative Officer
64	Project staff	Mr. Ngmenenbang David	JICA Project	Administrative Officer
65	Project staff	Mr. Raymond Alirigia	JICA Project	Junior Project Coordinator

Annex 2: Agenda of 2nd JCC Meeting

No.	Time	Activity	Person Responsible
1	9:30 -9:40	Registration	GHS/JICA
2	9:40-9:45	Opening prayer	**Mr. Anthony Kullah** Regional Nutrition Officer
3	9:45-9:50	Introduction of Participants	**Ms. Phoebe Balagumyetime** District Director, Nadowli-Kaleo District
4	9:50-9:55	Welcome address	**Dr. Joseph Teye Nuertey** Regional Director, GHS/Project Manager
5	9:55-10:00	Opening remarks and purpose of the JCC	**Dr. Anthony Nsiah Asare** Director General, GHS/Project Director
6	10:20- 11:00	Plan and progress of activities	**Ms. Satoko Ishiga** Chief Advisor, Project Team **Mr. Zacchi Sabogu** Project Advisor, Project Team
7	**11:00-11:15**	**Coffee break**	**All**
8	11:15-11:55	Presentation of the result of baseline survey	**Mr. Hisamitsu Shimoyama** Japanese expert, Project Team
9	11:55-12:30	Discussion	**Mr. Prosper Tang** Regional CHPS Coordinator
10	12:30-13:00	Presentation on study tour in Japan	**To be selected**
11	13:00-13:30	Issues and Concerns	**Ms. Satoko Ishiga** Chief Advisor, Project Team **Mr. Zacchi Sabogu** Project Advisor, Project Team **Mr. Prosper Tang** Regional CHPS focal person
12	13:30-13:35	Remarks by JICA Representative	**Ms. Ozawa Maki** Chief Representative, JICA Ghana Office
13	13:35-13:40	Remarks by Embassy of Japan in Ghana	**Ms. Anna Shimpo,** Coordinator for Economic Cooperation, Embassy of Japan in Ghana
14	13:40-13:50	Way Forward	**Dr. Koku Awoonor Williams** Director of PPMED, GHS/ Project Coordinator
15	13:50-14:00	Closing Remarks	**Dr. Anthony Nsiah Asare** Director General, GHS /Project Director
16	14:00-14:05	Closing Prayer	To be selected
17	14:05-14:10	Photo taking	All

MC: Prosper Tang, GHS UWR

Annex 3: Details of baseline survey results

(i) General information:

Indicator	Northern Region		Upper East Region		Upper West Region	
	No	%	No	%	No	%
Total Population	2,925,831	100	1,216,680	100	811,124	100
Pop. Under demarcated CHPS zones	2,923,021	99.9	864,231	71	523,409	64.5
Population covered by Functional CHPS	279,263	9.6	378,778	31.1	447,927	55.2
Demarcated CHPS zones	704	100	406	100	324	100
Demarcated CHPS zones with health staff	535	76	328	80	274	85
Functional CHPS zones	75	10.7	160	43.0	240	74.0
Total staff assigned to CHPS	1230	6.7	1012	21.0	635	51.0
CHO assigned to CHPS	82	6.6	181	17.7	324	51.3

(ii) Overall Goal: Indicator 1, Project Purpose: Indicator 1 (Percentage of people who have access to functional CHPS zones)

	Baseline (%)
Upper West Region	55.2
Upper East Region	31.0
Northern Region	9.6

(iii) *Output 1, Indicator 1-3: (The frequency of FSV/SSV carried out as per standard is attained)*

S/N	Indicator	Northern Region	Upper East Region	Upper West Region
1	RHMT->DHMT	0 (0%)	3 (75.0%)	2 (100.0%)
2	DHMT->SDHT	2 (50.0%)	3 (75.0%)	3.6 (91.0%)
3	SDHT -> CHO	1.7 (42.6%)	2.7 (66.9%)	2.8 (69.4%)

(iv) Output 2, Indicator 2-1: (The number of active CHMCs implementing community activities)

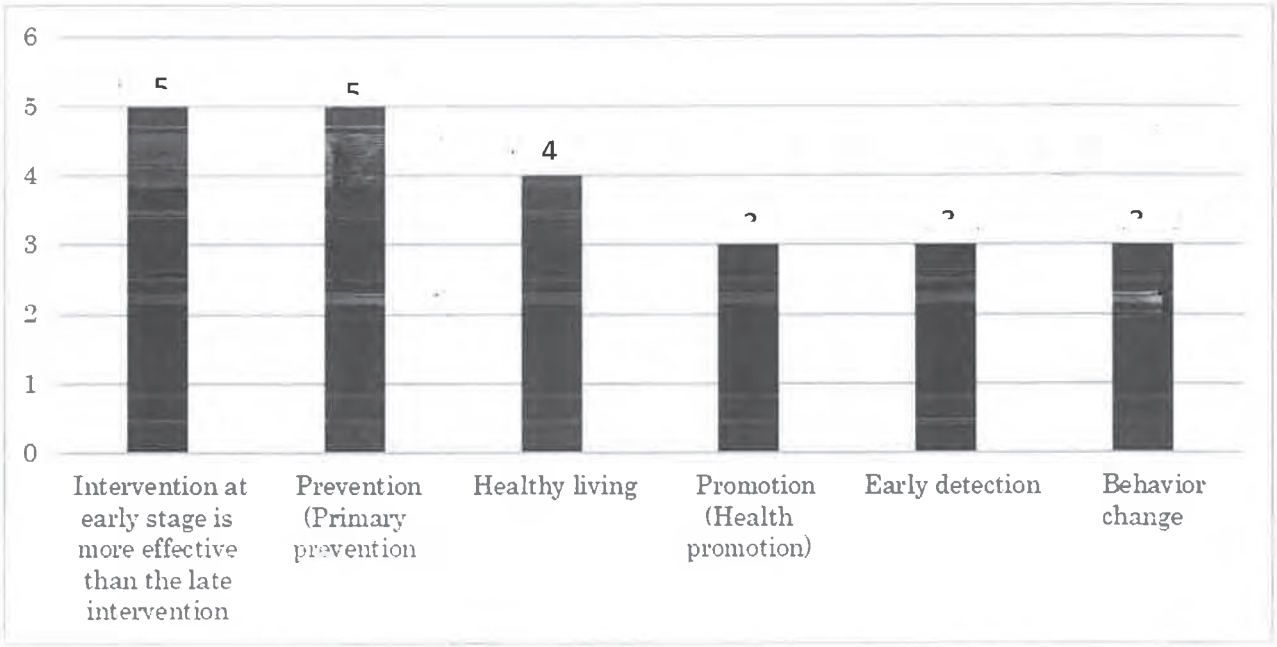
S/N	Indicator	Northern Region		Upper East Region		Upper West Region		Source
		No	%	No	%	No	%	
a) CHPS zones								
1	Demarcated CHPS zones	643	100	407	100	323	100	DB
2	Functional CHPS zones	75	11.7	160	39.3	240	74.3	DB
b) Community Health Management Committees (CHMC)								
3	CHPS zones with CHMC	478	74.3	301	74.0	272	84.2	DB
4	CHMCs who met within the last six months	478	74.3	301	74.0	272	84.2	DB

c) Community Health Action Plans (CHAP)								
5	CHPS zones with CHAP	238	37.1	237	58.4	218	67.5	DB
6	CHAPs reviewed within the last quarter	127	2.5	147	14.0	183	45.8	DB

(v) Output 3, Indicator 3-1: (Number of districts with health integrated annual plans developed and costed)

Category	Districts		
	Northern Region, 3	Upper East Region, 13	Upper West Region, 11
Baseline for the districts with the health integrated action plan	0	0	11

(vi) Opinions of CHPS zones on keys defining LCA



Strengthening Community-based Health Services Focusing on the Life-course Approach in the Upper West, Upper East and Northern Regions (CHPS for Life)

Compiled by:

Abu Dokuwie Alhassan.....
(Senior Project Coordinator)

Reviewed by:

Zacchi Nolan Sabogu.....
(Project Advisor)

Endorsed by:

Ms. Satoko Ishiga .....
(Project Chief Advisor, IC Net)

Ms. Maki Ozawa.....
(Senior Representative, JICA Ghana Office)

Dr. Patrick Kuma-Aboagye.....
(Director, Family Health Division. Ghana Health Service)
On behalf of Director General

Strengthening Community-based Health Services Focusing on the Life-course Approach in the Upper West, Upper East and Northern Regions (CHPS for Life)

Minutes of 3rd Joint Co-ordination Committee (JCC) Meeting
Date: 29th November 2018
Venue: Modern City Hotel, Tamale

1. Introduction

The 3rd JCC meeting was held on 29th November 2018 from 9:20 to 14:50 at the Modern City Hotel in Tamale. It was chaired by the Project Director, Dr. Anthony Nsiah-Asare, Director General (DG) of the Ghana Health Service. In all, eighty-two (82) persons were in attendance. The breakdown is as follows:

- 1 representative of the Ministry of Health (MoH);
- 10 staff of the Ghana Health Service Headquarters (including the Director General);
- 3 staff of JICA Ghana Office;
- 19 members from the three Regional Health Directorates comprising 13 from Upper West, 6 from Upper East and 35 from Northern;
- 30 District Directors of Health comprising 3 from the Upper West, 3 from the Upper East and 24 from the Northern region;
- 1 Medical Officer of a Polyclinic – the Lambussie Polyclinic in the Upper West Region;
- 2 representatives of Regional Coordinating Councils, 1 each from Upper West and Upper East regions;
- 4 staff of Community Health Nurses Training Schools in the 3 regions; and
- 12 project staff.

The detailed list of participants and the agenda of the meeting are attached as annexes 1& 2 respectively.

2. Summary of key issues

❖ ***Output 0 related: Management activities:***

- ***GHS HQ monitoring***; Charles Acquah of PPMED reported that a checklist for the monitoring has been developed. The challenge has been where to source logistics to carry out the monitoring. The Project Director directed that the monitoring unit should prepare and conduct the monitoring not later than January 2019. If there are any concerns about logistics, the monitoring team should contact him (DG).
- ***Focal person for CHPS for Life in GHS HQ;*** DG will discuss with the PPMED to nominate a focal person for the project.

❖ ***Output 1 related: Strengthening CHPS implementation and systems:***

- ***Making the CHPS database more useful;*** the database was extensively used by the regions during the CHPS verification exercise undertaken by GHS HQ. However, in its current form, it is not user-friendly. To make it more user-friendly and ensure effective utilization, the project should consider moving it to a platform that has tools/applications for running queries with ease. In addition, it will greatly help if the database could capture data on the number of CHNs available in a region and the facilities where the CHNs are working.
- ***Using the CHPS database to inform staff selection for training and deployment;*** it has emerged that District Directors do not use the CHPS database to determine the training needs and deployment of staff. This is attributable to the fact that District Directors of Health Services (DDHS) have not been very well involved in the database trainings to understand the use of the database as a management tool.

Integrating CHO training into pre-service training of schools; given the cost associated with the training of CHOs and the widespread complaints about the gap between what students are taught in the schools and the services they are expected to provide after their training, there is the urgent need to look at the pre-service training curricula of the schools. DG will take immediate steps to organize an intersectoral meeting to discuss and find the way forward on this subject. In the meantime, the steps the project is taking to move the CHO training to pre-service training as exit strategy is laudable. It is therefore important to increase the momentum by involving not just the Community Health Nurses Training Schools (CHNTS) in the 3 regions, but involve all CHNTS countrywide or at least their principals, if the schools cannot be brought on board. The project should also involve the leadership of the Nursing and Midwifery Council of Ghana (NMCG) in the pre-service activities. It is hope that if these steps are taken, the CHO training package would have been fully integrated into CHNTS curricula by the time the project ends.

- ***Increasing number of demarcated CHPS zones;*** it is a worrying trend that the number of demarcated CHPS zones keeps increasing overtime. With increasing number of trained CHOs or functional CHPS zones, progress cannot be seen in improving CHPS implementation because of the increasing number of demarcated CHPS zones. The CHPS implementation guidelines makes it clear that all regions and districts should have, by this time, demarcated their entire jurisdictions and made known the target number of demarcated CHPS zones that they are planning to make functional over a given timeframe. Regional and District Directors of Health Service were therefore charged to demarcate and cover all grounds based on the guidelines.
- ***Implementation of supervision activities;*** as soon as possible the districts should be supported with monitoring and supervision tools to conduct supervision to ensure that CHOs who have been trained are appropriately applying the knowledge acquired. The project will proceed to use the available FSV materials and then harmonize when SSV materials become available.
- ***Unavailability of home visit register in CHPS zones;*** although CHOs have been trained, they do not have registers to keep records of their activities. There is currently a draft register in place. Inputs to improve the draft register should be sent to Dr. Osei Kuffour Afreh, RDHS, UWR. The project needs to take up the register issue and constitute a technical team to harmonize the various kinds of home visit registers in the system. After that, any one of the three regions can pilot it. These steps are expected to be taken early next year. After it is finalized, DG will then take it up for replication in other areas.
- ***Organization of Annual CHPS forum;*** organizing annual CHPS forum is an important aspect of the CHPS policy. This should be considered as part of CHPS governance activities.

❖ ***Output 3 related: CHPS governance***

- ***Widening stakeholder engagement in CHPS implementation;*** the involvement of MPs does not appear to be strong in the DA engagement activities. MPs should be considered as important stakeholders in CHPS activities.
- ***Other possible interventions that can create the right environment for CHPS to thrive;***
  i) Engaging DAs to organize annual CHPS forum in collaboration with the GHS.
  ii) Deepening engagement with the DA sub-structures - Area/Urban/Town Councils as the case may be, Unit Committees and Assembly members to support CHPS.

❖ ***Output 4 related: Introduction and integration of LCA into CHPS service package***

- ***Documentation of LCA process;*** as the LCA is a new concept, it is important to appropriately document all the processes regarding its planning and implementation. The documentation will make replicability easy.

3. **Welcome Address – Dr. John Eleeza, RHDS & Project Manager, NR**

Dr. Eleeza said he was privileged to be in the meeting. He thanked the project for taking time to give him and the RDHS for UWR briefing on the project since they have just been assigned. He added that although he was yet to visit the UWR, he was convinced through the last Senior Managers Meeting and presentations made during the 2nd coordination meeting for the 3 regions that the UWR continues to show the way in the area of CHPS service delivery. He particularly found the use of the locomotive approach in CHPS implementation as very useful in building a strong CHPS system. The life-course approach aspect of the project is also something he is enthusiastic about.

4. **Opening remarks and purpose of the JCC – Dr. Anthony Nsiah-Asare, Director General, GHS & Project Director**

The Project Director noted that the purpose of the meeting was to witness the collaboration between JICA and GHS. The meeting was the 3rd of ICC meetings, although he could not be present in the 2nd meeting that took place in the UWR in June 2018. DG proceeded to add that, the 3rd JCC meeting was important because it was taking place at a time when CHPS verification has been completed by the GHS. In his bid to share some of the findings of the CHPS verification, he noted that:

- Earlier reports showed that there are over 6,000 CHPS zones but the verification has shown that there is little below 6000 CHPS zones nationwide.
- He was recently at the Astana Declaration and he, took together with the Health Minister, reaffirmed CHPS as the vehicle for achieving UHC in Ghana.

DG proceeded and shared some details of the findings of the CHPS verification as follows:

- Weak community involvement was observed in many CHPS zones.
- Some CHPS zones do have staffs that have received orientation on CHPS.
- There is still limited understanding about CHPS even among DDHS.
- Several CHPS zones do not have midwives although the GHS is making efforts to have a midwife in every CHPS zone.
- About 35% of CHPS zones have no operating site – in this case a compound.
- About only 34% have properly built compounds.
- More than half of CHPS compounds have no full set of equipment. In that direction, GHS is procuring equipment through the support of World Bank, DFID and JICA for distribution to CHPS zones.
- Half of the CHPS zones have no registers.
- 9 out of 10 CHPS zones do not receive any supervision from the sub-district or district. From next year on, the GHS will put in a lot of effort to ensure the sub-districts are strengthened and are supervising CHPS zones appropriately.
- Up to 5% of CHPS zones have never received MNCHP funds.
- Only 6.5% of CHPS zones completed all the 15 implementation steps. The UWR and UER did very well in that regard.

In what appears to be recommended actions the GHS is taking or will take to improve CHPS implementation, the DG said:

- In addressing the unavailability of standard treatment guidelines in CHPS zones, the GHS is working to have treatment guidelines specific to each level of healthcare service.
- The CHPS concept needs to be slightly modified to adapt to different contexts - rural, peri-urban and urban areas should be implementing CHPS based on their unique characteristics.
- Payment for home visit activities – the GHS is working out modalities to have it paid for by NHIS to support the operations of CHPS better.
- CHNs are reporting gaps between what they are taught in school and what they practice in the service. To address this, there is the need to properly align the training with the practices of the GHS. An inter-agency meeting will be organized by DG to address this concern.
- Health managers do not mentor staff. The District Directors should take steps and do it.

He concluded his opening remarks by giving further details about the purpose of the meeting by stating that it was meant to share progress of implementation of activities, presentation on study tour in Japan, findings of study tour in NR and to discuss issues and concerns. He called on participants also endeavour to hold mini JCC meetings in their districts to share the knowledge gained through the CHPS for Life project.

5. <u>Progress, plan and challenges of the project</u>

With the use a PowerPoint presentation, Ms. Satoko Ishiga and Mr. Zacchi Sabogu took the house through the progress, plan and challenges in respect of each output of the project. The summary of the status of the project in each output area is as follows:

(i) Output 0 (management related activities) – Ms. Satoko Ishiga

The status of output 0 activities and challenges so far are summarized as follows:

Status of activities:

Activities	Progress & plan
1. Joint coordination committee (JCC) meeting	o 3rd JCC on November 29, 2018 in NR and study tour on November 28, 2018 o Next meeting planned in May 2019
2. Coordination meeting of three regions	o 2nd meeting was conducted on November 27 2018 o Next meeting is being planned in April/May 2019
3. Regional management meeting	o UER: 3rd meeting on December 3, 2018 o NR: 4th meeting on November 27, 2018 o UWR: 2nd meeting on November 27, 2018 o Next meetings will be held in February and April/May 2019
4. Monitoring tour by GHS	o It is yet to be conducted. o Plan: To be planned with GHS HQ
5. Reports	o 1st Progress report submitted in August 2018, o Plan: Monitoring sheet (version 3) and termination report in June 2019

Challenges

- Delay of monitoring visits by GHS HQ
  - There is the need for the appointment of focal persons by related GHS divisions
- Communication with GHS HQ
  - DG needs to appoint a focal person for the project.
- Delay in opening the Project office in UER

- The office is planned to be opened in January 2019

(ii) Output 1 (strengthening CHPS implementation and systems) – Ms. Satoko Ishiga

Status of activities:

Activities	Progress & plan
1. CHPS database	o CHPS data is summarized regularly in the 3 regions. o Capacity building continues quarterly (UER, NR) and bi-annually (UWR). Next training in December 2018
2. Harmonized CHO fresher training	o 3 CHO Fresher trainings (and TOT) were conducted.
3. Pre-service training	o There is a slight delay. o Orientation for tutors of UER and NR on December 5, 2018 o District CHO Orientation: Materials review meeting on December 13 and 14, 2018
4. FSV related activities	o Suspended
5. Referral related activities	o Referral training in 3 districts in NR and 13 districts in UER. o Region-wide stakeholder meeting on referral in UWR
6. Conduct DHMT review meeting on CHPS enhancement	o Materials to standardize the quality of meeting is under development
7. Learning visits	o Coming in December for pre-service training

Challenges:

- o The target number of demarcated CHPS zones keeps increasing.
  - Synchronization with electoral areas and analysis on current strategy on CHPS demarcation is needed.
- o Effective utilization of data at district level is required.
  - It is important to use CHPS database as guide in selecting staff for training and in the deployment of CHOs.
  - It is imperative to use CHPS database as the basic data in analyzing the status of demarcated zones
- o Slow improvements in the status of equipment and compounds
  - Advocacy to DA and development partners using evidence will be helpful.
- o Delayed FSV/SSV training wing to the delay in the development of national SSV tools.
  - The Project will start SSV training using existing FSV training materials in NR.
  - When SSV training materials are released, the project will harmonize the content with the existing checklist.
- o Lack of registers (home visit register, community register, school health register)
  - There is urgent need to set up a revolving fund system to ensure the continuous availability of these registers.
  - Lack of national format for home visit register

(iii) Output 2 (strengthening community activities) – Mr. Zacchi Sabogu

Status of activities:

Activities	Progress & plan
1. Development of	o Scorecard related tools were developed and introduced to

community score card	communities of 12 CHPS zones in October 2018. Trial implementation is underway. o Reflection/preparatory meeting of facilitators and 2nd orientation to community members of 12 pilot CHPS in December 2018 o Trial of community scorecard from October 2018 o Feedback meeting on community scorecard in April 2019
2. CHV/CHMC training	o Structure of the training was developed in October 2018. o Development of training materials in February 2019 o Conduct TOT of CHMC/CHV training as part of CHO/SDHT staff refresher training in April 2019 Feedback meeting to be conducted in April 2018
3. LCA related community activities	o 12 pilot CHPS zones were selected and community members oriented between September and November 2018 o Facilitators (DHMT, SDHT, CHO) teams per district were formed and oriented in October 2018. o 2nd orientation in December 2018 o Feedback meeting with facilitators in December 2018/April 2019 o Monitoring of pilot CHPS activities to be conducted from October 2018 o TWG meeting to establish sustainable incentive system to be conducted in the 2nd term
4. Development of IEC materials	o Videos for the CHO/CHV/CHMC training will be done in 2019 in harmonization with the timing of the training o Modification of clips and development of new clips of video for public education from January to March 2019 o Production of video for LCA related trainings will be from April to June 2019 o Development of flipchart in 2019 o Strategic meeting on video promotion in May 2019
5. Promote intra/inter learning visits	o Nil

(iv) Output 3 (strengthening governance of CHPS) – Mr. Zacchi Sabogu

Status of activities:

Activities	Progress & plan
1. Conduct survey to assess the current CHPS governance in UWR and UER	o Done in UWR and UER
2. Preparation of CHPS governance checklist	o Discussed in the 1st and 2nd TWG meetings in April and October 2018 o To be completed in 3rd TWG meeting in January 2019
3. Development of reference materials	o Developed new format for HIAP o Review of draft reference materials on procedures of HIAP

on CHPS Governance	preparation o Finalize reference materials through 3rd TWG meeting in January 2019
4. Stakeholder meeting in each region	o 2nd RCC/DA engagement meeting in UWR in October 2018 o Strategic meeting in January 2019, o Continue in the 2nd term
5. Development of health-integrated annual action plans	o Monitoring of the development of HIAP for 2019 by DA and DHMT in UWR from October 2018 o Repeat the same process in the 2nd term
6. Joint learning meeting among target districts/regions	o Invite UER and NR to 3rd TWG meeting in UWR in January 2019

Challenges

- The RCC (in UWR) has not been swift enough in transmitting information about activities to the Municipal and District Assemblies (MDAs).
- The changes in leadership at the MDAs has given rise to declining levels of commitment to the HIAP formulation and implementation processes.

(v) Output 4 (Introduction and integration of LCA into CHPS service package) – Mr. Zacchi Sabogu

Status of activities:

Activities	Progress & plan
1. Review the current CHPS services focusing on the LCA in UWR (Situation analysis on the LCA)	o Completed in November 2018 and the results were shared with C/Ps.
2. Develop the CHO/SDHT and CHMC/CHV training materials in UWR	o Content structure of the CHO/SDHT and CHMC/CHV training were developed and shared in November 2018. o Discussion and finalization of the structure of CHO/SDHT and CHMC/CHV training materials on 30 November 2018 o Materials development in February 2019 and pilot training in April 2019 o LCA meeting on material development to be conducted in February 2019 o Development of flip chart from February - May 2019
3. Capacity building of SDHT/CHO on LCA	o ToT and pilot training for SDHT and CHO to be conducted in April 2019. o Joint feedback and strategic meeting to be conducted in the 2nd term.

Challenges:

- Extra time is needed to go through the approval process of materials and this may affect the timing of the first(pilot) CHO refresher training
  e.g. Social Behavior Change Communication materials such as flip chart need to go through an approval process of the SBCC Technical Review Committee.

(vi) Key discussion points on presentations of the Progress, Plan and Challenges of the project

- Managers do not use the CHPS database for taking decisions on training needs and deployment of staff; This is partly because many of DDHS have not been very well involved to appreciate the use of the CHPS database as a management tool.
- Documenting LCA activities; it is important for the project and all concerned to appropriately document everything that is taking place under the LCA to make replicability possible.
- Refocusing CHO training as part of pre-service training; there is the need to take a closer look at the training schools' curricula. If possible, the project should involve at least the principals of all CHNTS nationwide, and the leadership of the Nursing and Midwifery Council in the pre-service CHO training activities, such that by the time the project ends, the CHO training package would have been fully integrated into the schools' curricula. DG on his part, will organize an intersectoral meeting to discuss and chart the way forward.
- CHPS database; it is a very useful tool and the UER has used it effectively in the CHPS verification undertaken by GHS HQ. It is however not user-friendly in its current form. To make it more user-friendly, it can be moved to a platform that has tools for running queries on it with ease. This can be done as part of the future modifications that will be done. Furthermore, it will be very helpful for the CHPS database to also gather data for comparing the number of CHNs available in a region and where they have been deployed to.
- Change in government affecting DA commitment to HIAP; this should not have been happening, since the District Coordinating Directors and Planning Officers are those leading the process and the change in leadership does not have to affect those positions. It is happening all the same.
- GHS HQ monitoring; the GHS HQ has gathered a lot of information from the project and has developed a monitoring checklist. The challenge however has been the issue of logistics for the monitoring given that the project resources are in the UWR while the monitoring team is based in Accra. DG concluded that the monitoring team should inform when they are ready, and he will make the logistics available, and that the first monitoring should be done not later than January 2019.
- CHPS demarcation; it is worrying that number of demarcated CHPS zones keeps changing. Given the guidelines as contained in the CHPS manual, all regions should have by this time come out with permanent number of demarcated CHPS zones to make planning easy.
- Annual CHPS forum; this can be considered as part of CHPS governance, as it is an important aspect of the CHPS policy.

6. Presentation on implementation of project activities in the regions

(i) Northern Region – Mr. Dubik Daniel Dindiok

Mr. Dubik enumerated several things the CHPS for Life Project has already done to strengthen CHPS in the Northern Region and then concluded with some challenges and the way forward. The details of his presentation are as follows:

- Held management meetings aimed at getting the RHMT understand the project and what it stands for.

- Facilitated participation in JCC meetings and Coordination meeting in Accra and in Wa.
- Hosting of the 2nd Coordination meeting for 3 regions and 3rd Joint Coordination Committee meeting.
- Established a CHPS unit at the RHD – in the In-service Training Unit for project staff and the Regional CHPS Coordinator and his assistant.
- Supported the region to establish regional CHPS Database system through capacity building of District CHPS Coordinators and District Health Information Officers and sustaining the gains through quarterly CHPS Database review meetings.
- Given orientation to District Directors of Health Service in the region on the CHPS Database and its relevance in CHPS implementation.
- Trained staff on referral management and supplied referral tools to the implementing districts.
- Supported the region to train a total of 35 facilitators on the harmonized materials on CHO fresher training.
- Trained a total of 116 CHOs in 2 sessions in July/August & in October 2018.

Challenges

- Weak sub-district level capacity to supervise and monitor CHPS implementation.
- No form of SSV/FSV to the 116 newly trained CHOs and the staff trained on referral.
- Inadequate logistics and transport for CHPS implementation, thereby weakening the gains.

Way forward:

- There is the need to build capacity of sub-district staff to support CHPS Implementation.
- There is the need to develop SSV/FSV plan and implement it as early as possible.
- Step up advocacy for logistics supply to support CHPS Implementation.

(ii) Upper East Region – Mr. Emmanuel Ansu-Abina

Mr. Ansu-Abina gave a brief profile of the region and proceeded to talk about the activities carried out by the project. He concluded with the challenges and way forward. Details are as follows:

- Referral and training activities:
  - TOT on Referral training for 42 facilitators was conducted in July 2018 (4 RHMT and 38 DHMT);
  - District level training conducted from 12th September to 27th September 2018;
  - A total of 508 participants were trained; 335 health facilities (309 Government and 26 Private);
  - Distribution of Referral Registers and forms to health facilities
- Introduction of CHPS database:
  - District CHPS Coordinators and District Health Information Officers were trained on the Database
    - ❖ Impact
      - Has improved consistency of CHPS data
      - It has Streamlined data analysis for meaningful interpretation for decision making.

Challenges:

- Some district officers do not understand the database template and have difficulty in filling it.
- Late submission of database report from districts.

Recommendation/way forward:

- Project should continue to build the capacity of District HIOs on the database.
- CHPS unit should ensure monitoring of the data and its compilation.

- CHPS database meeting with CHPS Coordinators and HIOs is scheduled on 3rd December 2018.
- CHOs training is slated for 4th to 16th February 2019.

(iii) Upper West Region – Mr. Prosper Tang

Mr. Tang on his part gave an overview of JICA support to the UWR and proceeded to highlight the key activities undertaken under the project outputs and then concluded with challenges and the way forward. The details of his presentation are below:

Output 0: management related:

- Organised 2nd JCC of the project together with the Coordination meeting and study tour.
- The region has also organised 2 regional management meetings.

Output 1: enhancing CHPS implementation related:

- Strategic meeting organised with key stakeholders such as the RHMT, DHMTs, Training schools etc.
- Supported the revision of the harmonised CHO training materials involving the UER & NR.
- Conducted CHO training using harmonised materials and on the back of that got the following outputs:
  - Refresher for facilitators in UWR.
  - ToT for facilitators in both Northern and Upper East regions.
  - Training of 70 CHOs in the UWR.

FSV/SSV

- Strategic meeting on Health System strengthening has been held with health managers.
- Region continues to run FSV system.
- Ensures adequate availability of monitoring tools through revolving fund system.

Referral

- Organized a strategic meeting on referral with health managers.
- Supported in the revision and standardization of training materials.
- Organised a region-wide referral stakeholder forum to galvanize information on strengthening the referral system and deepen collaboration among the public and private service providers

Output 2: strengthening community related activities:

- Organized strategic meetings with health managers and other stakeholders on community mobilization.
- The region supported in the development of tools such as the community assessment scorecard, revised CHAP format and CHAP assessment tools.
- Identified 12 pilot zones and orientated DHMTS, SDHTs and CHOs for the implementation of the pilot CHPS activities.
- Conducted follow-up on some pilot zones to assess progress and support

Output 3: CHPS governance (DA engagement):

- Stakeholder meeting was organized with the RMHT, RCC, DHMTs and MDAs.
- Formation of a technical working group (with membership from GHS/RCC/DA).
- Development of health integrated annual action plans. Some districts have submitted their copies for RDHS to sign before a formal witnessing by Regional Minister.
- The region also supported in the development of a reference document to guide the DA engagement implementation process/advocacy.

Output 4: integration of LCA into CHPS package:

- Several meetings were organized with the support of the region to define the scope and direction of the LCA component of the project. These included

- Technical working group meetings
- LCA meetings to define the concept
- Proposed the refresher training framework which places the SDHTs as the pivot of the training

Challenges/bottlenecks:

- Poor transport situation
- Over aged vehicles for monitoring
- Over aged/weak motorbikes for service delivery
- Inadequate equipment to facilitate effective service delivery-BP apparatus, scales etc
- Most facilities are partially equipped and thus limited to provide the full scope of care of a CHPS zone
- Inadequate and weak supportive supervision especially from the sub districts to CHPS
- Unavailability of some logistics such as standard home visits register affects documentation of core CHO activities

Way forward:

- Deep involvement of SDHTs in all CHPS related trainings. This is to strengthen their capacity to effectively supervise and support CHOs.
- Engage stakeholders such as the MDAs to establish a balance between constructing and equipping/furnishing compounds.
- Work towards developing a standardized home visit register with inputs from HQ.

Key discussion points after the presentations from the regions:

- Availability and role of Health Promotion Officers and their involvement in project activities; HPOs are available in the regions and deeply involved in the project activities. In UWR for instance, the Health Promotion Unit plays central role in the LCA activities.
- How revolving fund system was established in UWR; it started with a stock of materials printed by the previous project, which materials were kept at the Regional Medical Stores, purchased by facilities and are replenished using proceeds from the sale. FSV tools, referral and feedback forms continuous to be available through the revolving fund.
- Involvement of staffs other than only District Directors as facilitators in trainings; this already the case and shall be strengthened.
- Need to explore other possible interventions under CHPS governance (output 3) to create the right environment for CHPS to thrive; two possible interventions to consider are:
  - i) Engaging DAs to organize annual CHPS forum in collaboration with the GHS.
  - ii) Deepening engagement at the assembly sub-structure levels.
- Opportunity for all DDHS in NR to benefit from the CHPS training package; DDHS who have not benefitted will considered during future CHO trainings.
- Scope of referral training; it is comprehensive involving all aspects of referral. All cadre of health staff are involved.
- Request to involve community leaders in referral training; training community leaders directly in referral system will not be an effective strategy. The effective training of health workers to articulate referral issues appropriately to community members is what is needed. So, what the project is currently doing will have better results.
- Stakeholder engagement in CHPS implementation; the involvement of MPs does not appear to be strong thus far. It is important to engage them as important stakeholders.
- Unavailability of home visit register; there is a draft that can be improved and piloted. The project needs to take up the register issue. A technical team can be put together to harmonize the various kinds of home visit registers, pilot it and then DG can take it up for replication.

Inputs to improve the drafts should sent to Dr Afreh of UWR. These actions should be taken early next year.

7. **Progress of Implementation of Action Plans of Japan Study Tour Team** –
Dr. Mathias Pogvi Tengan

Dr. Tengan prefaced his presentation with the history of JICA projects in the regions, the members of the Japan study tour team, main activities undertaken during the tour and the outputs of the tour. He then shared follow-up actions taken by the project, the current status of action plans developed by the team members and the progress of activities. Summary of his presentation is below:

Follow-up of implementation of action plans:

- 1st meeting with the project: after the 2nd JCC in June 2018.
  - Discussed how to link action plans of participants with the project activities
- Quarterly Follow up
  - Initial post-study tour meeting: June 2018
  - 2nd follow up meeting on November 26, 2018
- Report at JCC
  - Initial report on study tour during the 2nd JCC in November 2018
  - Report on the progress of implementation of action plan: Today

Current status of action plans:

- Challenges of assembling members on a regular basis (distance/schedule).
- Some action areas were not directly linked to current project deliverables.
- Some activities in action plan may go well beyond project tenure.
- Merger of common areas of actions and link to project activities.
- Other non-project specific actions are to be undertaken at the individual level

Progress of activities:

Name of activity	Study tour team role
1. Develop the CHO/SDHT and CHMC/CHV training materials in UWR	o Review content of materials drafted by experts o Serve as resource persons/facilitators of trainings
2. CHMC/CHV training	o Supportive visits to selected training sites
3. LCA related community activities	o To promote best practices for selected communities to adopt and implement o Supervise and monitor actual implementation of proposed activities
4. Development of IEC materials	o 2 members to be involved in the review and selection process

Key discussion point after the presentation

- Learnings from the study tour in Japan that are relevant for policy in Ghana; one of such key learnings is legislating life-course approach using MCH as the entry point. This idea was proposed during the second JCC in Wa, but it became clear that the Legislative Instrument (LI) on the Public Health Act will address that need. However, the lessons to be learnt through the project would serve as a learning curve towards legislating life-course approach in Ghana.

8. **Observations of study tour in Northern Region**

Observations made by participants of study tour in NR were shared by representatives of the three study tour teams. Summary of their observations is the following:

Mr. Zakaria Abdul-Kassim (on behalf of East Mamprusi group)

- All Health Centres are operating as CHPS with midwives due to the absence of PAs.
- There are 12 PAs who are all stationed at the Baptist Medical Centre.
- Low coverage for some indicators.
- Inadequate CHNs (12) against 30 functional CHPS zones.
- Weak transport system to support public health activities.
- Demarcated CHPS zones are more than number of electoral areas.
- Sub-district team leaders are not adequately oriented on the concept of CHPS and so are not able to support and supervise CHPS activities.
- It is imperative to appropriately align what is taught in the training schools to relevant issues at service delivery points.

Mr. Samuel Prah (on behalf of Savelugu group)

- Mal-distribution of midwives in the district has accounted for less numbers being deployed to the CHPS zones. Over 50% of midwives are at the district hospital.
- As a temporal measure to improve the midwives' situation, midwifery task-shifting training for ENs and CHNs should be conducted.
- Low referral feedback from the Teaching Hospital to the district hospital; more staff at the various units/departments should be involved in the training.
- Close support from the SDHT in the operations of CHPS.
- Established CETS to help facilitate referral with the community showing high commitment to sustain the system - a tricycle donated by an individual is used to support.
- TBAs are working as link between the community and facilities to promote facility delivery.
- Management and usage of MCHNP funds is done according to guidelines.
- Training of CHOs has helped increased performance and quality of service delivery.
- SDHT supports CHPS zones in their operations through regular monitoring and technical support visits.
- Slow pace of functionality of CHPS zones as less than 50% of demarcated zones is functional. However, the alignment of zones with electoral areas is very impressive.
- Monitoring is done to the lower levels but not structured as FSV/SSV hence continuous improvement and learning is limited.
- Midwives at the sub district/HC do not conduct outreaches to support CHOs during maternal health related services.

Ms. Victoria Aboyella (on behalf of Tolon group)

- Health staff participating in naming ceremonies of children delivered at the health facility. This is to help trigger positive attitude towards facility delivery.
- Strong advocacy by the assembly man to get an additional compound for the community.
- Creation of Municipal referral platform via WhatsApp. This is positive but requires group members to ensure confidentiality.
- Use of labour room platform to discuss and share information related to maternal health and other critical service areas.
- Inadequate number of experienced CHOs to guide and coach trainees during field orientation.
- Lack of preceptors in the service to guide trainees.

- Post field orientation feedback is not shared with health managers hence DDHS are unable to improve grounds for effective orientation

Key contributions after the presentation of study tour group reports

- CHPS should not be viewed as revenue generation facilities but preventive primary healthcare points.
- The disconnect between training and practice has come about as a result of the creation of a directorate by the Ministry of Health. This has limited the extent of inputs the GHS makes into the training schools' curricula.
- GHS HQ has proto-type drawings for all levels of health facilities – any party interested in putting up a structure, be it a compound, HC, polyclinic or hospital, should contact the GHS HQ and obtain the structural designs.

9. **Issues and concerns – Ms. Satoko Ishiga**

- Supportive supervision; as agreed, the FSV materials will be used as the supervision tools to enable the districts conduct supervision.
- Monitoring plan by GHS HQ; PPMED and other divisions that have developed the monitoring checklist should contact DG for the needed logistics. By the end of January 2019, the monitoring should have been conducted.
- Focal person at GHS HQ; DG will talk to the PPMED and to get a focal person for the project.
- Next JCC meeting; 1st or 2nd week of May 2019 is suitable. 19th of May onward is unsuitable because it is usually the period for the World Health Assembly. November is not also good for meetings involving DG. Late October is preferable.

10. **Closure**

Remarks by JICA representative – Ms. Maki Ozawa

Ms. Ozawa made the following points in her remarks:

- Even within a year of implementation of the project, so much progress has been made.
- She was excited to know that the issues being driven by the project are in line with the national standards.
- JICA has provided budget support to address the logistics challenges in implementing CHPS in the 3 regions. She was hopeful that the logistics will soon be distributed.
- A lot of attention is coming to this project, as such, it is hoped that you increase your effort in making further impactful progress.
- She called for contributions and suggestions to review the project design, particularly Output 3, for the term 2 as the 1st term draws to a close.

Remarks – Dr. Anthony Nsiah-Asare, DG, GHS

The DG made the following comments in his closing remarks:

- He thanked all for active participation and contributions.
- He also thanked JICA for continuous support to improve health service delivery in the country.
- The GHS is committed to using the LCA and health promotion as tool for making health services accessible to every segment of the population. CHPS for Life project is assisting greatly in that regard.
- The Health Promotion Department of the GHS will be elevated to a divisional status as part of steps being taken to make health promotion contribute strongly to health service delivery in the Ghana.

Annex 1: Participants list for the 3rd JCC meeting

No.	Category	Name	Organization	Position
Greater Accra				
1	Ghanaian side	Dr. Anthony Nsiah-Asare	GHS HQ	Director General
2	Ghanaian side	Dr. Patrick Kuma-Aboagye	GHS HQ	Director, Family Health Division
3	Ghanaian side	Mr. Martin Ankomah	GHS HQ	Deputy Director, Administration
4	Ghanaian side	Dr. Boateng Boakye	GHS HQ	Director, ICD
5	Ghanaian side	Dr. Maxwell Dalabu	GHS HQ/Navrongo	Reseach Fellow
6	Ghanaian side	Ms. Gifty Amadu	GHS HQ	Secretary, ODG
7	Ghanaian side	Mr. Charles Agyei Acquah	GHS HQ	Deputy Director, Policy
8	Ghanaian side	Mr. Isaac Ankumah	GHS HQ	National CHPS Coordinator, GHS
9	Ghanaian side	Ms. Gladys Brew	GHS-HQ	Safe Motherhood Coordinator,
10	Ghanaian side	Alhaji Abubakari Sufyan	GHS-HQ	Health Promotion Officer, FHD
11	Ghanaian side	Mr. Barnabas K. Yeboah	MoH	National CHPS Coordinator
Upper West				
12	Ghanaian side	Dr. Osei Kuffour Afreh	RHMT UWR	Regional Director of Health
13	Ghanaian side	Dr. Abdulai Abukari	RHMT UWR	Deputy Director, PH
14	Ghanaian side	Mr. Prosper Tang	RHMT UWR	Regional CHPS Coordinator
15	Ghanaian side	Mr. Anthony Kullah	RHMT UWR	Regional Nutrition Officer
16	Ghanaian side	Mr. Musah B. Ali	RHMT UWR	Asst. Reg. CHPS Coordinators
17	Ghanaian side	Dr. Mathias Pogvi	Lambussie Polyclinic	Principal Medical Officer
18	Ghanaian side	Ms. Christina Nyewela	Jirapa CHNTC	Prinicipal
19	Ghanaian side	Mr. Oswald Baloo	RCC UWR	Desk Officer for Health
20	Ghanaian side	Ms. Genevieve Yiripaåre	DHMT-UWR	DDHS, Nandom
21	Ghanaian side	Mr. Alex Bapula	DHMT-UWR	DDHS, Sissala East Municipal
22	Ghanaian side	Mr. Clifford Vengkumwine	DHMT-UWR	DDHS, Wa West
23	Ghanaian side	Mr. John Maakpe	RHMT UWR	Health Promotion Officer
24	Ghanaian side	Ms. Rose-Mary Banzie	RHMT UWR	Adolescent Health Coordinator
Upper East				
25	Ghanaian side	Dr. Winfred Ofosu	RHMT UER	Regional Director of Health
26	Ghanaian side	Dr. Abdul-Razak Dokurugu	RHMT UER	Deputy Director Clinical Care
27	Ghanaian side	Mr. Emmanuel Ansa Aabina	RHMT UER	Regional CHPS Coordinator
28	Ghanaian side	Alhaji Abdul Rafiu Agboola	Navrongo CHNTC	Principal
29	Ghanaian side	Mr. Andrews Akumbutum	RCC UER	Desk Officer for Health
30	Ghanaian side	Ms. Meiri Seidu	DHMT-UER-	DDHS-Nabdam
31	Ghanaian side	Mr.Estella Abazesi	DHMT-UER-Talensi	DDHS-Talensi
32	Ghanaian side	Mr. Lawal Alhassan	DHMT-UER-Bawku	DDHS-Bawku West
Northern Region				
33	Ghanaian side	Dr. John Eleeza	RHMT NR	Regional Director of Health
34	Ghanaian side	Dr. John Abenyeri	RHMT NR	Ag. Regional Director of Health
35	Ghanaian side	Dr. Baba Braimah Abubakari	RHMT NR	Deputy Director Clinical Care
36	Ghanaian side	Mr. Isaac Lartey	RHMT NR	Regional Health Information
37	Ghanaian side	Mr. Dubik Daniel Dindiok	RHMT NR/Central	Reg. CHPS Coord./DDHS -
38	Ghanaian side	Mr. Welbeck Akplu	RHMT NR	Dep. Regional CHPS Coordinator
39	Ghanaian side	Mr. David Bukari	Bole DHMT	DDHS
40	Ghanaian side	Mr. Mbabila Awuni	Bunkpurungu	DDHS
41	Ghanaian side	Mr. Samuel Prah	Chereponi DHMT	DDHS
42	Ghanaian side	Ms. Gertrude Yentumi	East Gonja DHMT	DDHS
43	Ghanaian side	Mr. Mark A. Abugri	East Mamprusi	DDHS
44	Ghanaian side	Alhaji A. B. Yakubu	Gushegu DHMT	DDHS
45	Ghanaian side	Dr. Chrysantus Kubio	Karaga DHMT	DDHS
46	Ghanaian side	Ms Vida Vuoche	Kpandai DHMT	DDHS
47	Ghanaian side	Ms. Joana Quarcoo	Kumbungu DHMT	DDHS
48	Ghanaian side	Mr. Titus Mwini	Maprugu Moaduri	DDHS
49	Ghanaian side	Ms. Maria Ayichuru	Mion DHMT	DDHS
50	Ghanaian side	Mr. Stephen Dadia	Nanumba North	DDHS
51	Ghanaian side	Ms. Victoria T. Aboyella	Nanumba South	DDHS
52	Ghanaian side	Mr. Abukari Alhassan	North Gonja DHMT	DDHS
53	Ghanaian side	Mr. Braimah Mustapha Farouk	Saboba DHMT	DDHS

54	Ghanaian side	Mr. George Abraham	Sagnarigu DHMT	DDHS
55	Ghanaian side	Ms. Denisia L. Agong	Savelugu-Nanton	DDHS
56	Ghanaian side	Mr. Zakaria Abdul Kassim	Sawla-Tuna Kalba	DDHS
57	Ghanaian side	Dr. Francis S. Ali	Tamale MHMT	DDHS
58	Ghanaian side	Mr. Abdulai Mohammed	Tatale DHMT	DDHS
59	Ghanaian side	Ms. Charity Azantilow	Tolon DHMT	DDHS
60	Ghanaian side	Ms. Fuseina Sulemana	West Gonja DHMT	DDHS
61	Ghanaian side	Hajia Haruna Hadjara	Yendi DHMT	DDHS
62	Ghanaian side	Mr. Ewuntomah E. Mahama	Zabzugu DHMT	DDHS
63	Ghanaian side	Ms Comfort Kona	HTS- NR	Principal- Tamale CHNTS
64	Ghanaian side	Ms. Christina Terborbri	HTS- NR	Principal-Bole CHNTS
65	Ghanaian side	Patricia S Amadu	RHMT-NR	Regional Nutrition Officer
66	Ghanaian side	Hon Rahinatu Yakubu	RHMT-NR	Regional Health Information
67	Ghanaian side	Mr. Clement Atampugre	RHMT-NR	Regional Accountant
JICA				
68	Japanese side	Ms Maki Ozawa	JICA Ghana	Senior Representative
69	Japanese side	Mr. Kazunori Miyasaka	JICA Ghana	Representative
70	Japanese side	Mr. Enoch Oti Agyekum	JICA Ghana	Programme Officer
71	Japanese side	Ms. Satoko Ishiga	JICA Project	Chief Advisor/ Community Health
72	Japanese side	Ms. Yuka Ohaku	JICA Project	Project Coordinator
73	Japanese side	Ms. Chisaki Sato	JICA Project	Expert-HSS
74	Project staff	Mr. Zacchi Sabogu	JICA Project	Project Advisor
75	Project staff	Mr. Abu Dokuwie Alhassan	JICA Project	Senior Project Coordinator
76	Project staff	Mr. Kassim Abdul-Basit	JICA Project	Senior Project Coordinator
77	Project staff	Mr. Sharifdeen Amadu	JICA Project	Junior Project Coordinator/Adm.
78	Project staff	Mr. Raymond Alirigia	JICA Project	Junior Project Coordinator
79	Project staff	Mr. Ernest Ziem Manson	JICA Project	Junior Project Coordinator
80	Project staff	Mr. Gamuo Roger	JICA Project	Administrative Officer
81	Project staff	Mr. Ngmenenbang David	JICA Project	Administrative Officer
82	Project staff	Mr. Mpuan Benjamin	JICA Project	Administrative Officer

Annex 2: Agenda of 3rd JCC Meeting

No.	Time	Activity	Person Responsible
1	9:30 -9:40	Registration	GHS/JICA
2	9:40-9:45	Opening prayer	**Mr. Welbeck Akplu** Regional CHPS Unit
3	9:45-9:50	Introduction of Participants	**Mr. Dubik Daniel Dindiok** Regional CHPS Coordinator /District Director, Central Gonja
4	9:50-9:55	Welcome address	**Dr. John Eleeza** Regional Director, GHS/Project Manager
5	9:55-10:00	Opening remarks and purpose of the JCC	**Dr. Anthony Nsiah Asare** Director General, GHS/Project Director
6	10:00- 10:40	Progress, plan and challenges of the project	**Ms. Satoko Ishiga** Chief Advisor, Project Team **Mr. Zacchi Sabogu** Project Advisor, Project Team
7	**10:40-10:55**	**Coffee break**	**All**
8	10:55-11:40	Presentation on implementation of Project activities in the regions	**Project Managers/Rep** RDHS/Rep (UWR, UER and NR)
9	11:40-12:20	Discussion	**Mr. Dubik Daniel Dindiok** Regional CHPS Coordinator /District Director, Central Gonja
10	12:20-12:50	Presentation on study tour in Japan	**Ms. Gladys Brew,** Safe Motherhood Coordinator, FHD
11	12:50-13:20	Lessons learnt from study tour visit to health facilities in the region	**Study tour team leaders or representative**
12	13:20-13:50	Issues and Concerns	**Ms. Satoko Ishiga** Chief Advisor, Project Team **Mr. Zacchi Sabogu** Project Advisor, Project Team
13	13:50-13:55	Remarks by JICA Representative	**Ms. Ozawa Maki** Senior Representative, JICA Ghana Office
14	13:55-14:05	Way Forward	**Dr. Koku Awoonor Williams** Director of PPMED, GHS/ Project Coordinator
15	14:05- 14:10	Closing Remarks	**Dr. Anthony Nsiah Asare** Director General, GHS /Project Director
16	14:10-14:15	Closing Prayer	To be selected
17	14:15-14:30	Photo taking	All

MC: Mr Dubik Daniel Dindiok, DDHS- Central Gonja and Regional CHPS Coordinator

Strengthening Community-based Health Services Focusing on the Life-course Approach in the Upper West, Upper East and Northern Regions
(CHPS for Life)

Compiled by:

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Reviewed by:

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(Project Advisor)

Endorsed by:

Ms. Satoko Ishiga .....
(Project Chief Advisor, IC Net)

Ms. Maki Ozawa.....
(Senior Representative, JICA Ghana Office)

Dr. Anthony Nsiah-Asare.....
(Director General, Ghana Health Service)

Strengthening Community-based Health Services Focusing on the Life-course Approach in the Upper West, Upper East and Northern Regions (CHPS for Life)

Minutes of 4th Joint Co-ordination Committee (JCC) Meeting
Date: 10th May 2019
Venue: Blue Sky Hotel, Bolgatanga

1. Introduction

The Joint Coordination Committee meeting of the CHPS for Life Project is the highest decision-making body of the project. It is a biannual meeting that brings together key stakeholders of the project to take stock of project activities, approve strategic decisions and documents developed during the period. The fourth in the series of JCC meetings and one that heralded the end of the first term of the project, was held on the 10th May 2019 at the Blue Sky Hotel in Bolgatanga in the Upper East Region.

The Project Director and Director General of the Ghana Health Service, Dr. Nsiah Asare chaired the meeting. In attendance were eighty-six (86) participants drawn from the Ministry of Health, Ghana Health Service headquarters, JICA Ghana, Regional Coordinating Councils, Regional Health Directorates, District Health Directorates, training schools and the media.

The detailed list of participants and the agenda of the meeting are attached as annexes 1& 2 respectively.

2. Key Outputs of JCC

- The project's workplan for the second term was approved by JCC.
- The modified Project Design Matrix was also approved. However, it was indicated that the project is yet to set targets for the PDM indicators. These targets will be discussed in some of the management meetings and JCC for approval.
- The CHPS database was approved for national dissemination. It should be viewed as a data gathering tool that will enable districts collate accurate CHPS data for entry into DHIMS2.
- The definition and structure of the LCA concept as pertains to the CHPS level in Ghana was accepted. LCA training materials will however need to be integrated into CHO training.
- The project has been given the green light to proceed with its plan for pre-service training of CHOs.

3. Summary of key issues

✧ ***Output 0: Management activities:***

GHS HQ monitoring; Dr. Kyei Faried of the PHD of GHS reported of the successfully monitoring of project's activities in April 2019 by GHS-HQ. The DG lauded the approach used in the definition of CHPS functionality and called for its adoption by the Service.

- ***Focal person for CHPS for Life Project from GHS HQ;*** The DG stated that, he has directed the director of PPMED to nominate a focal person for the project. The project should make a follow-up to DG's office on the nomination of a focal person.

✧ ***Output 1: Strengthening CHPS implementation and health systems:***

- ***Modifications of the CHPS database;*** The CHPS database has been modified to reflect the CHPS policy. In addition, indices on availability of basic equipment and amenities have been added.
- ***Nationwide deployment of CHPS database;*** The project's developed CHPS database has been found to be an effective tool for collecting accurate CHPS data. As a result, it is being planned for a nationwide dissemination.
- ***Pre-service training of CHOs;*** Considering that it costs an estimated amount of GHS 5,000.00 to train a CHO and given the urgent need to train large numbers of CHOs in the

three regions, there is the need to consider pre-service training which is much more cost effective. The project as a result has held series of strategic meetings with NAP, NAC and midwifery training schools. Following these meetings, the schools have proposed the modules from the harmonized CHO training materials to be integrated into the curricula to enable them train CHOs through the pre-service training arrangements. In addition, Nurses and Midwives Council of Ghana (N & MC) has given an initial approval for the project to collaborate with the training schools to implement the proposed training structure and modules while awaiting final approval.

- ***Unavailability of equipment and standardized registers in CHPS zones;*** Although CHOs have been trained, they do not have registers to keep records of their activities. It has also been established that most facilities have inadequate equipment for rendering basic health care. The DG stated that several equipment have been procured with funding from JICA and will be distributed to the regions in due course.

- ***Output 3 : CHPS governance***
  - ***Improving DA support for health using HIAP;*** The use of the Health integrated Annual Action Plan has led to an increased involvement of District Assemblies in Health. Several materials including a HIAP formulation and monitoring formats have been developed. In addition, a handbook on HIAP planning and monitoring has been compiled to share the processes and formats for formulating, monitoring and reporting on HIAP

- ***Output 4: Introduction and integration of LCA into CHPS service package***
  - ***Definition of LCA and situational analysis;*** Implementing LCA in the context of CHPS is entirely new in the country, as a result, the project has partnered with GHS to come up with a clear concept and a working definition of the LCA. In addition to the concept and definition, a situational analysis was also conducted in the UWR to determine the knowledge and skills gap in service delivery by CHO.
  - ***LCA materials development and training:*** Following the definition of the LCA and how it will be applied in CHPS setting, a training structure and training materials have been developed. An initial round of training for SDHTs and CHOs have been conducted using the developed materials.

3. **Welcome Address – Dr. Winfred Ofosu, RDHS & Project Manager, UER**

The RDHS of UER, Dr. Winfred Ofosu in welcoming participants indicated that, this JCC is of particular importance as it coincides with the end of the first term of the project. He called on all to participate actively in order to have a fruitful and a successful meeting.

4. **Achievements and plan for second term – Dr. Winfred Ofosu, RDHS and project Manager UER.**

The Project Manager for the UER made a presentation on the achievements of the project in the first term as well as the plan for the second term.

(i) Output 0 Management

Activities	Summary
1. Joint Coordination Committee (JCC) meeting	• 4 times(twice/year), kick-off 1 time, study tour 3 times
2. Coordination meeting of three regions	• 3 times, delayed start due to the reshuffling of

	regional directors
3. Regional management meeting	• 4 times in UER, 4 times in NR, 3 times in UWR • 1 meeting in UWR and NR in May 2019 • Advocacy meeting of DHMTs in NR and UER
4. Monitoring tour by GHS	• 1 time in April 2019
5. Reports	• 1st Progress report, Monitoring sheet Ver.1-2 • Monitoring sheet (ver.3) and Completion report in June 2019

Challenges

- After several follow-ups, GHS headquarters is yet to appoint a focal person for the project.
  - The DG indicated that, he has directed PPMED to nominate an officer as the focal person. There is the need for a follow-up.
- Northern Region has been divided into 3 regions with the addition of North East and Savannah Regions.
  - The management structure of the project including the way management meetings are held, will be to changed.

Plan for second term

- The management structure of the project will change to include the 2 new regions. A joint meeting among the three regional directors will be held.
- A second study tour on LCA in Japan is being planned.

(ii) Output 1

Main Activities	Progress
1. CHPS database	• CHPS database system has been implemented successfully in the 3 regions. • Quarterly CHPS database meetings have been organised to build capacity of HIOs and CHPS coordinators • Joint DHMT meetings held in regions to use the CHPS database for advocacy and decision making
2. CHO fresher training "Harmonized CHO Training"	• Four trainings were conducted. (2 NR and 1 each in UWR and UER) • 257 CHOs, 26 SDHT leaders 80 facilitators and 6 training school tutors trained using harmonized CHO training materials.
3. Pre-service training	• Developed a modified pre-service training model. • Conducted strategic meetings with NAP, NAC and MTC tutors in 3 regions to come up with the content for pre-service training. • Developed proposals for N&MC curricula review.
4. Supervision	• Regional TWGs have been formed in each region and are ready to support the program. • Awaiting outcomes of national SSV ToT to plan next steps.
5. Referral	• Reviewed and revised referral training materials. • Trained 1556 health staff on referral and referral documentation. • Distributed 1316 referral booklets, 749 feedback booklets, 706 large referral registers and 879 small referral registers to health

	facilities in the 3 regions. • Established revolving systems in all 3 regions to prevent stock out of referral materials
6. DHMT review meeting	• Materials to standardize the quality of review meetings is under development
7. Learning visits	• Organized one study tour to Japan to understudy LCA. • 3 study tour visits have been organised. • One learning visit to Jirapa for tutors of training schools in UE and NR.

Challenges

- Low demarcation and inadequate number of CHNs to be trained as CHOs especially in the UWR.
  In the NR and UER, low improvement in equipping CHPS compounds, weak supervision of CHOs and weak DA involvement.

Plans for second term

- After national SSV training, the project will support regional SSV trainings and strengthen the SSV program with technical support in the 2nd term
- In the 2nd term, the project intends to disseminate the CHPS database nationwide.
- The project intends to continue CHO training. This will however be based on the needs of the specific region.
- Finalize the pre-service training program and build capacity of tutors.
- As part of the exit strategies, the project will support to establish a system for CHPS database trainings, pre-service training and standardize district review meetings among others.

(iii) Output 2

Main activity	Summary
1. Implementation of community assessment tools	• Conduct CHO/SDHT refresher training • Monitor and support 12 Pilot CHPS zones in the implementation of tools
2. CHMC/CHV/CHW training	• Train CHOs to in turn train CHMC/CHV/CHW • Start CHMC/CHV training in pilot CHPS zones in 2020 and disseminate to other CHPS zones
3. LCA related community activities	• Train CHO and SDHT to support communities on LCA activities • Conduct CHMC/CHV/CHW training • Monitor and support 12 Pilot CHPS zones
4. Development of IEC materials	• Finalize LCA video clips in 2019 • Develop flipchart and Videos for the CHO/CHV/CHMC in 2019
5. Promote intra/inter learning visits	• Facilitate learning visits to pilot CHPS zones

Challenges

- The community assessment tools are currently under trial, hence will need to be disseminated to other communities.

Plans for second term

- Conduct CHO/SDHT refresher training,
- Start CHMC/CHV training,
- Finalize LCA videos
- Facilitate intra/inter learning visits to CHPS zones.

As an exit strategy for output 2, the project intends;

- Integrating the developed materials (CHAP format, training materials and IE&C materials) into national CHO training materials.
- Strengthening pilot CHPS through capacity building of CHOs.
- Identifying a non-monetary incentive package for volunteers that can be shared with GHS.

(iv) Output 3

Main activity	Summary
1. Developed formats for HIAP formulation, monitoring and reporting	• Modified existing HIAP format to include clear indicators, information on cost and timelines. • Developed a HIAP quarterly monitoring format. • Developed an annual HIAP implementation assessment format. • Developed a HIAP reporting format.
2. Compiled reference material on HIAP formulation, monitoring and reporting	• Compiled a handbook on HIAP planning, monitoring and reporting.
3. HIAP implementation and monitoring	• All districts in UWR have developed HIAPs for 2019 • HIAP implementation monitoring on-going in the UWR

Plans for second term

- In the 2nd term, the project will assess the current level of involvement of DA in CHPS activities and support the development of HIAPs.
- The project will also conduct joint stakeholder meetings for experience sharing on the HIAP in the 2nd term.
- As an exit strategy in output 3, the project hopes to integrate the HIAP formulation and monitoring system into existing planning and monitoring systems of the assemblies and disseminate the HIAP formats for use by DHMTs and Das

(v) Output 4

Activities	Progress & plan
1. Review the current CHPS services focusing on the LCA in UWR	• Situational analysis conducted to determine the focus of LCA in CHPS

(Situation analysis on the LCA)	
2. Develop the CHO/SDHT and CHMC/CHV training materials in UWR	• Content structure of the CHO/SDHT and CHMC/CHV training have been developed • Developed a first edition of LCA training materials for CHO/SDHT and CHMC/CHV • Developed a key messages flip chart for training CHMC/CHV and CHW on LCA
3. Capacity building of SDHT/CHO on LCA	• ToT and pilot training for SDHT and CHO conducted in April 2019. • Conducted refresher training for CHO/SDHT on LCA in UWR

Challenges

- Inadequate basic equipment (BP apparatus, height boards etc) at the CHPS zones affects the delivery of LCA related services.
- The duration of the LCA training makes it practically impossible to integrate into the CHO training.

Plans for second term

- In the 2nd term, the project will integrate the LCA into training materials and share the results of LCA action planning with GHS-HQ.
- CHO and subdistrict training will be conducted in the 2nd term.
- CHMC and CHV training/orientation will also be conducted in the 2nd term.
- As an exit strategy, LCA user manual and guidelines will be developed.

5. Discussion/approval of workplan for second term.

- Supervisors of the CHOs (SDHT and DHMT) in the focus districts of the NR need to be trained on the CHPS concept.
- DG has directed the PPMED to nominate a focal person for the project. There is a need to make a follow-up on.
- About 275 ambulances are being procured for deployment in all 275 constituencies. A central management system to be based in Accra, will be used for managing the ambulances.
- CHO training should be integrated into the training of NAP training Schools and should be made examinable.
- There is a need to involve SDHTs in CHPS database activities. Preferably DHMTs can give SDHTs feedback on the outputs of the CHPS database. This will keep them updated on CHPS activities in their respective SDHTs.
- RDHS of UER moved for the adoption of the project workplan for the 2nd term. He was seconded by the CHPS coordinator of the UER. JCC approved the 2nd term workplan by popular acclamation.

6. Regional presentations

UWR- Mr. Prosper Tang

- The challenges of capping demarcated CHPS zones in being addressed.

- An improvement in referral from lower level facilities to the higher levels has been observed. However, feedback continues to be a challenge.

- Training on the GHS community score card has not been conducted in the UWR though it is being implemented.
- All districts have developed and signed their HIAPs for 2019. District level monitoring is ongoing to assess the level of implementation of the 2019 HIAPs.
- Though DA engagement is great, there is a need to go beyond the DA to engage other Community-based Organisations for greater support to health care delivery
- Lack of equipment (infantometers, weighing scales and BP apparatuses) is affecting the roll out of LCA activities.
- Community wellness clinics are being promoted in the UWR; social groupings are being targeted.

UER- Mr. Emmanuel Ansu-Abina

- Two batches of referral training were conducted, targeting all levels of facilities. 42 regional facilitators and 488 health staff have been trained on referral systems and documentation in the region.
- 901 referral booklets, 410 feedback booklets, 569 small referral registers and 332 large referral registers have been distributed in the region.
- There has been improved documentation of referral activities and feedback following the trainings.
- CHPS database has been introduced in the regions and has led to improvements in CHPS data.
- 71 CHOs, 26 SDHT leaders and 6 tutors have been trained on CHPS using the harmonized CHO training materials. This has increased the proportion of functional CHPS zones.
- Late submission of CHPS database and difficulty with understanding the CHPS database are some of the challenges being encountered.

NR- Mr. Dubik Daniel Dindiok

- In terms of advocacy, regional management meetings are organised regularly, 1 officer went on study tour to Japan to understudy LCA and regional teams have participated in regional study tours.
- CHPS concept is now quite clearer to most of the managers in the regions following the various engagements.
- Two sets of CHO training were conducted in NR, 35 facilitators including 14 DDHS and 116 CHOs were trained.
- The region has recorded a marked improvement in proportion of functional CHPS zones.
- Population data in the region continues to be a challenge in addition to weak sub-district systems and increasing staff attrition at the CHPS level.
- 264 health staff have been trained on referral systems and documentation in the region.
- A revolving fund has been established in the NR to ensure continuous supply of referral materials in the region.

Discussions from regional presentations

- GHS council has advertised for suitable candidates to apply for appointment as managers of the new regions. Savannah and North East Regions will soon have RDHS and regional

management teams. The NR RHMT must support in building the capacity of the appointed persons.

- GHS headquarters shared some equipment procured through MNCHP to CHPS compounds. It has however been realised that the equipment are being used at health centers. DG directed that DDHS retrieve these equipment from health centers and deliver them to CHPS zones.
- With support from JICA, GHS has procured several equipment and logistics including motorbikes and bicycles. These will soon be distributed to the 3 regions.

7. **Modification of PDM**

Ms. Satoko Ishiga, Chief Advisor of the project made a presentation on modifications that have been made to the Project Design Matrix (PDM). She indicated that at the start of the project, some activities were not clearly spelt out, in addition, some indicators did not have baseline data. As a result, the PDM has been modified. The following modifications have been made

- Modification of number and names of target regions and districts due to the division of districts and regions.
- Modification or addition of indicators
- Modification of the means of verification according to the change in some indicators.
- Modification of some activities in line with current activities.
- Targets will be set after the financial resource envelop is determined.

Discussion of modifications to PDM

- Project should consider adding outcome indicators to the PDM. For a start, diseases and death can be tracked as a proxy outcome indicator.
- Mr. Zacchi Sabogu tabled the PDM for adoption as a working document for the 2nd term of the project and was seconded by Dr. Winfred Ofosu.
- The house unanimously approved the PDM as a working document for the 2nd term.

8. GHS Headquarters Monitoring

Dr Kyei-Faried of the PHD presented the findings of a GHS headquarters monitoring that was carried out in April 2019. Among their findings, the following best practices and gaps were observed.

Best practices observed

- CHPS data management is excellent in the areas that were visited
- Deployment of CHAP has been very good and is yielding positive results
- The pre-service training plan by the project is positive as it leads to the production of CHOs
- HIAP has enhanced accountability of the District Assemblies

Gaps observed

- Facilities and districts are not using CHPS data for decision making
- Assessment of the functionality of CHPS using the 15 steps is problematic and needs to be reviewed. The team proposed a new assessment model.
- No motorbikes for service delivery at most CHPS zones as staff were seen using their personal motorbikes.
- Weak community-based surveillance and an attendant inadequate tracking of community health outcomes including births, disease and deaths.
- Poor referral feedback from the regional hospital.

Recommendations

- Modified CHAP should be rolled out nationwide
- Facilitative supervision needs to be strengthened

Discussions from GHS HQ monitoring

- DG requested that the headquarters monitoring team shares the report of the monitoring with his office.
- In addition, the team should share their proposed CHPS functionality assessment model with GHS HQ and other stakeholders.
- Various cadres of staff including 10 medical officers, enrolled Nurses and others have been posted to the Upper West Regional Hospital. The hospital management should support these staff with accommodation.
- There are plans to use the Upper West Regional hospital as a fellowship training center. A lot will however depend on the reception the regional hospital management gives to the team that will come to support in that endeavour.

9. Report of study tour

Rapporteurs for the study tour groups made presentations on the activities in the field, the best practices observed, lessons learnt and the experiences shared.

Nabdam group - Ms. Cecilia Kakariba

Key Issues

- High rates of teenage pregnancy
- The district has underestimated population that affects service coverages.
- Low participation of males in health activities.

Best practices observed

- Cordial relations exist between the DHMT and the DA leading to increased DA support for Health.
- High level of community involvement and participation in health activities
- Community ownership of CHPS
- Monthly CHMC meetings instituted instead of the quarterly CHMC meetings.

Lessons learnt

- Stakeholder involvement in health leads to high success of health interventions.
- Availability of CHO at the CHPS zone facilitates CHPS implementation.
- Respect for community members leads to change of people's health seeking behaviour.

Experiences shared

- Stakeholder support in early detection of pregnancies to reduce/prevent maternal and neonatal deaths.
- Parents and stakeholders to encourage girl child education to reduce teenage pregnancies.
- DDHS should link up with PPMED through RHD to get accurate population data.

Bolga group – Mr. Welbeck K. Akplu

Key issues observed

- Inadequate CHOs to increase functionality of CHPS zones. There are five CHPS zones that do not have a CHO. This indicates that five (5) more CHOs are needed to make all CHPS zones functional.
- Inadequate motorbikes at facilities.

- Inadequate drugs for mental health cases in the facilities.
- No referral feedback from regional hospitals.

Best practices observed

- Breastfeeding policy transcribed into local language and displayed at facilities.
- Close collaboration between midwives and TBAs which leads to increase in supervised deliveries.
- Well mobilized communities at the CHPS zones.

Lessons learnt

- Providing hot drinks after delivery increases skilled delivery rates
- Involving males in community activities leads to high male involvement.

Experiences shared

- Use non-monetary incentives to motivate security man at the CHPS compound
- Domiciliary midwifery should be promoted to improve on skilled delivery rates.

Bongo group- Mr. Anthony Kullah

Best practices observed

- DHD provides enough fuel for health activities at the CHPS zone level through KOICA and MNCHP.
- CHAP very well implemented at the CHPS level

Lessons learnt

- Engaging communities at all levels leads to higher community participation in health
- Training staff on use of data promotes better evidence-based decision making
- Demarcating and obtaining title-hold of health facility lands to prevent encroachment.
- Tree planting around facilities can be used to protect facility lands.

Experiences shared

- Use of CHAP to improve community participation in CHPS activities.

10. Issues and concerns – Ms. Satoko Ishiga

The Chief Advisor, Ms. Satoko Ishiga in presenting issues and concerns of the project stated that;

- High cost of CHO training: it costs an estimated amount of GHS 5,000.00 to train a single CHO. The need therefore exists to adopt other cost-effective strategies. GHS should work towards pre-service training and district CHO orientation.
- Home visit, community population and school health registers are not standardized and not available at most facilities. GHS should standardize and supply these registers for effective service delivery.
- Inadequate equipment at most CHPS zones affects service delivery. GHS should strategize and provide basic equipment to CHPS zones.
- Non-reimbursement on some services to CHPS zones by NHIS/Long process in accreditation of CHPS zones by NHIS – GHS needs to engage NHIS.
- Next JCC meeting; 1st or 2nd week of October 2019 is suitable. November is not good for meetings involving DG.

11. Closure

Remarks by JICA representative – Mr. Miyasaka Kazunori

Mr. Miyasaka Kazunori made the following points in his remarks:

- JICA Ghana is appreciative of the cooperation with Ghana Health Service at all levels.
- This JCC meeting has clearly stated what has been done and what can still be done. JICA Ghana appreciates what lies ahead especially the national dissemination of the CHPS database.
- The focus on sustainability of the project's successes by all regions has been noticed and is of great interest to JICA.
- Consideration should be given to integrating developed materials into national training guidelines and materials to ensure they are used effectively.
- Though majority of the project's activities are based in the Upper West Region, the four other regions should also be involved and participate actively to learn the best practices for possible replication.

Way forward – Mr. Charles Acquah, PPMED GHS

Mr. Charles Acquah of the GHS headquarters presented the way forward. In his presentation, he stated that;

- He is happy with the approval of the project's PDM and workplan for the second term.
- The project should finalize the targets for indicators and the budgets for the workplan for consideration. Focus should be placed on building the capacity of SDHTs to enable them support the delivery of quality CHPS services.
- Include DDHS as facilitators of CHO training and other CHPS related activities to build their capacities to better support CHPS implementation.
- Three more rounds of HQ monitoring of the project are planned for the second term. The monitoring team have come out with a tool for assessing CHPS functionality. The tool will be shared with all regions.

Remarks – Dr. Anthony Nsiah-Asare, DG, GHS

The DG made the following comments in his closing remarks:

- A focal person will soon be nominated for the project.
- GHS is working with the NHIA to ensure non-clinical services such as home visits and school health are re-imbursed. This will improve the quality of these activities.
- NHIS unit has been established under the office of the DG to handle issues relating to NHIS accreditation among others. Districts that wish to accredit facilities should write through their regional Directors to the office of the Director General.
- District Directors and teams should ensure their health facilities renew their PINs annually.
- The National Health Facilities Regulatory Authority is registering all health facilities in the country. Though there is a registration fee, GHS HQ has negotiated with the authority to register CHPS compounds for free.
- DHMTs should continue to engage District Assemblies to support health activities.
- Next JCC is proposed for late September or early October 2019.

Annex 1: Participants list for the 4th JCC meeting

List of participants for JCC meeting in Bolgatanga, Upper East Region on 10 May 2019

No.	Category	Name	Organization	Position
Greater Accra (MoH, GHS and NMCG)				
1	Ghanaian side	Dr. Anthony Nsiah Asare	GHS HQ	Director General
2	Ghanaian side	Dr. Barnabas K. Yeboah	MOH	National CHPS Coordinator
3	Ghanaian side	Mr. Gaetan Adangabey	GHS HQ	Rep Director, Institutional Care Division
4	Ghanaian side	Mr. Charles Acquah	GHS HQ	Deputy Director, PPMED
5	Ghanaian side	Ms. Ruby Arthur	GHS HQ	Dietician
6	Ghanaian side	Mr. Martin Ankomah	GHS HQ	Administrator, ODG
7	Ghanaian side	Mr. Isaac Ankomah	GHS HQ	Administrator, FHD
8	Ghanaian side	Mr. Abubakari Sufyan	GHS-HQ	Health Promotion Officer, FHD
9	Ghanaian side	Dr. Kyei-Faried Sardick	GHS-HQ	Deputy Director, DCD PHD
Upper East Region				
10	Ghanaian side	Dr. Winfred Ofosu	RHMT UER	Regional Director of Health Services
11	Ghanaian side	Dr. Josephat I. Nyuzaghi	RHMT UER	Deputy Director, Public Health
12	Ghanaian side	Mr. Adjei Frimpong	RHMT UER	Deputy Director, Clinical Care
13	Ghanaian side	Mrs. Salamatu Seidu	RHMT UER	Regional Public Health Nurse
14	Ghanaian side	Mr. Emmanuel Ansu Abina	RHMT UER	Regional CHPS Coordinator
15	Ghanaian side	Mr. Abdul Rafiu Agboola	Navrongo CHNTC	Principal
16	Ghanaian side	Ms. Teshiayio Muhammed	Bolga, Midwifery Training Sch.	Principal
17	Ghanaian side	Mr. Michael Yidana	Zuarungu, NTS	Principal
18	Ghanaian side	Mr. Andrew Akumbutum	RCC UER	Desk Officer for Health
19	Ghanaian side	Ms. Gillian Anabah	RHMT UER	CHPS unit
20	Ghanaian side	Mr. Osei Kwadwo	RHMT UER	CHPS unit
21	Ghanaian side	Mr. Rexford King James Adjei	RHMT UER	Regional Health Promotion Officer
22	Ghanaian side	Mr. Adjei Agyeman	RHMT UER	Regional Health Information Officer
23	Ghanaian side	Mrs. Amidu Latifatu	RHMT UER	Regional Nutrition Officer
24	Ghanaian side	Mr Yukubu Mahama	DHMT, Bawku	DDHS Rep
25	Ghanaian side	Mr. Lawal Alhassan	DHMT, Bawku West	DDHS
26	Ghanaian side	Mr. Hypolite Yeleduor	DHMT, Binduri	DDHS
27	Ghanaian side	Ms. Rosemond Azure	DHMT, Bongo	DDHS
28	Ghanaian side	Mr. Samuel Angyogdem	DHMT, Builsa North	DDHS
29	Ghanaian side	Mr. Gabriel Kofi Appiah	DHMT, Builsa South	CHPS Coordinator
30	Ghanaian side	Mr. Imelda A. Agoo	DHMT, Garu Tempane	CHPS Coordinator
31	Ghanaian side	Mr. Benjamin Aggrey	DHMT, Kasena Nankana Muni	DDHS
32	Ghanaian side	Ms. Meiri Seidu	DHMT, Nabdam	DDHS
33	Ghanaian side	Ms. Estella Abazesi	DHMT, Talensi	DDHS
34	Ghanaian side	Mr. Nellic Edmund Nyanwura	MHMT, Bolga	DDHS
35	Ghanaian side	Ms. Lamise Kwagia	RHMT UER	PHN/CHPS Unit
36	Ghanaian side	Ms. Rebecca Kpare	Bolga, NMCG	

37	Ghanaian side	Ms. Akolba Georina	Bolga Muni	MNO
38	Ghanaian side	Alhaji Saeed Hussein Yakubu	RHMT UER	Regional Accountant
39	Ghanaian side	Dr Maxwell Dalaba	Navrongo Research, UER	Ref of Dr Hodgson
40	Ghanaian side	Mr. Edmund Edem Tsogbey	RHMT UER	Regional HR Manager
41	Ghanaian side	Ms. Sulemana Bawa Hikima	RHMT UER	HR Unit
42	Ghanaian side	Ms. Awini Susuna Awinpoaka	RHMT UER	HR Unit
43	Ghanaian side	Ms. Atinsia Ayinbono Juliana	RHMT UER	HR Unit
Northen Region				
44	Ghanaian side	Dr. John Bertson Eleeza	RHMT NR	Regional Director of Health Service
45	Ghanaian side	Mr. Jeremiah Timob	RHMT NR	Deputy Director, Administration
46	Ghanaian side	Mr. Dubik Daniel Dindiok	Central Gonja	District Director of Health Services
47	Ghanaian side	Mr Welbeck Akplu	RHMT NR	Dep. Regional CHPS Coordinator
48	Ghanaian side	Mr. Marcel Baumah	RHMT NR	Health Information Officer
49	Ghanaian side	Mrs. Yakubu Rahinatu	RHMT NR	Regional Health Promotion offiecr
50	Ghanaian side	Mr. Mark A. Abugri	DHMT, East Mamprusi	DDHS
51	Ghanaian side	Ms. Denisia L Agong	DHMT, Savelugu-Nanton	DDHS
52	Ghanaian side	Ms. Charity Azantilow	DHMT, Tolon	DDHS
53	Ghanaian side	Mr. Abdul Majeed Mahama	N RCC	Economic Planning Officer
54	Ghanaian side	Mrs. Christiana A Amalba	MTS, Tamale	Principal
55	Ghanaian side	Mr. Alhassan Sukerazu	CHNTS, Tamale CHNTS	Vice Principal
56	Ghanaian side	Hajia Patricia Amadu	NR RHMT	Nutrition Officer
Upper West Region				
57	Ghanaian side	Dr. Osei Kuffour Afreh	RHMT UWR	Regional Director of Health Services
58	Ghanaian side	Dr. Abdulai Abukari	RHMT UWR	Deputy Director, PH
59	Ghanaian side	Mr. Prosper Tang	RHMT UWR	Regional CHPS Coordinator
60	Ghanaian side	Mr Anthony Kullah	RHMT UWR	Regional Nutrition Officer
61	Ghanaian side	Mr. Musah B Ali	RHMT UWR	Asst. Reg CHPS Coordinators
62	Ghanaian side	Dr. Mathias Pogvi Tengan	Lambussie Polyclinic	Principal Medical Officer
63	Ghanaian side	Ms. Christina Nyewela	Jirapa CHNTC	Prinicipal
64	Ghanaian side	Mr. George Segnitome	NTS	Principal, Wa
65	Ghanaian side	Mr. John Maakpe	RHMT UWR	Regional Health Promotion Officer
66	Ghanaian side	Mrs Rose Mary Banzie	RHMT UWR	School Health Coordinator
67	Ghanaian side	Mr. Marcelinus Welber	RHMT UWR	DDA
68	Ghanaian side	Mr. Oswald Baloo	RCC UWR	Economic Planning Officer
69	Ghanaian side	Mr. Godfred K. Bambah	Jirapa Municipal	Economic Planning Officer
70	Ghanaian side	Ms. Florence Angsomwine	MHMT, Jirapa	DDHS
71	Ghanaian side	Ms. Cecilia Kakariba	DHMT, Sissala West	DDHS
72	Ghanaian side	Ms. Rukaya Wumnaya	DHMT, Wa East	DDHS
73	Ghanaian side	Mr. Alhassan Bagaree	Tampala CHPS (Jirapa)	CHO
EoJ, JICA and CHPS for Life Project staff				
74	Japanese side	Mr. Kazunori Miyasaka	JICA Ghana	Representative
75	Japanese side	Ms. Satoko Ishiga	JICA Project	Chief Advisor/ Community

				Health
76	Japanese side	Ms. Yuka Ohaku	JICA Project	Project Coordinator
77	Japanese side	Ms. Tamami Udagawa	JICA Project	Project Coordintaor
78	Project staff	Mr. Zacchi Sabogu	JICA Project	Project Advisor
79	Project staff	Mr. Abu Dokuwie Alhassan	JICA Project	Senior Project Coordinator
80	Project staff	Mr. Kassim Abdul-Basit	JICA Project	Senior Project Coordinator
81	Project staff	Mr. Raymond Alirigia	JICA Project	Junior Project Coordinator
82	Project staff	Mr. Gamuo Roger	JICA Project	Administrative Officer
83	Project staff	Mr. Ngmenenbang David	JICA Project	Administrative Officer
84	Project staff	Mr Razak Iddrisu	JICA Project	Driver/Mechanic
85	Project staff	Mr Adams Noegaaba	JICA Project	Driver/Logistics
86	Project staff	Mr Vincent Y. Botah	JICA Project	Driver/Logistics

Annex 2: Agenda of 4th JCC Meeting

Chairperson: **Dr. Anthony Nsiah Asare**, Director General, GHS

No.	Time	Activity	Person Responsible
1	13:30 -14:15	Registration	GHS/JICA
2	14:15-14:25	Introduction of Participants	**Mr. Emmanuel Ansu-Abina** Regional CHPS Focal Person
3	14:25-14:30	Welcome address	**Dr. Winfred Ofosu** Regional Director, UER/Project Manager
4	14:30-14:35	Opening remarks and purpose of the JCC	**Dr. Anthony Nsiah Asare** Director General, GHS/Project Director
5	14:35- 15:15	Achievement and plan of the project Discussion/ Approval of workplan	**Dr. Winfred Ofosu** Regional Director, GHS/Project Manager
6	15:15-15:50	Presentation on implementation of Project activities in the regions (Q&A)	**Representatives of regions** UWR, UER and NR
7	15:50-16:10	Modification of PDM Discussion and approval Discussion/ Approval of modified PDM	**Ms. Satoko Ishiga** Chief Advisor, Project Team
8	16:10-16:30	Presentation on GHS-HQ monitoring of the project activities in the three regions Discussion	**Dr.Kyei-Faried Sardick** Deputy Director, DCD, PHD, GHS
9	16:30-16:45	Report of study tour in UER	**Representative from three groups**
10	16:45-17:00	Issues and Concerns	**Ms. Satoko Ishiga** Chief Advisor, Project Team
11	17:00-17:05	Remarks by JICA Representative	**Mr. Kazunori Miyasaka** Representative, JICA Ghana Office
12	17:05-17:15	Way Forward	**Mr. Charles Acquah** Deputy Director, PPMED, GHS
13	17:15- 17:20	Closing Remarks	**Dr. Anthony Nsiah Asare** Director General, GHS /Project Director
14	17:20-17:25	Closing Prayer	To be selected

MC: **Mr. Rexford King James Adjei**, Regional Health Promotion Officer, UER

Compiled by:
Kassim Abdul-Basit.....
(Senior Project Coordinator)

Reviewed by:
Zacchi Nolaan Sabogu.....
(Project Advisor)

Satoko Ishiga.....
(Chief Advisor)

Mr. Kazunori Miyasaka .....
(Representative, JICA Ghana)

Dr. Anthony Nsiah Asare .....
(Director General, GHS)

Strengthening Community-based Health Services Focusing on the Life-course Approach in the Upper West, Upper East and Northern Regions (CHPS for Life)

Minutes of 5th Joint Co-ordination Committee (JCC) Meeting
Date: 23rd January, 2020
Venue: Blue Hill Hotel, Wa

1. Introduction

The 5th JCC meeting was held on 23rd January 2020 from 9:00 to 14:20 at the Blue Hill Hotel in Wa. It was chaired by the Project Director, Dr. Patrick Kuma-Aboagye, Director General (DG) of the Ghana Health Service. In all, ninety-six (96) persons were in attendance. The breakdown is as follows:

- 17 from Accra drawn from the MoH and GHS HQ;
- 19 staff members from the UE RCC, RHA, DHMTs and Health Training Institutions;
- 26 members from the UW RCC, RHA, DHMTs and Health Training Institutions;
- 9 from the Northern RCC, RHA, DHMTs and Health Training institutions;
- 5 from the Savanah Regional Health Directorate, DHMT and Training School;
- 4 from the North East RHA, DHMT and Training School; and
- 16 members from JICA Ghana Office and the project.

The detailed list of participants and the agenda of the meeting are attached as annexes 1&2 respectively.

2. Summary of key project related issues

❖ ***Output 0 related: Management activities:***

- ***Possibility of accomplishing all activities:*** Given the activities contained in the workplan and the reduction in budget and time lost between the 1st and 2nd terms, it was asked if it is possible to implement all the activities. It was explained that the budget is not reduced, however the overall amount approved at the beginning is fixed. As implementation progresses, it would be assessed to see if additional time is needed to execute all activities.

❖ ***Output 1 related: Strengthening CHPS implementation and systems:***

- ***CHO fresher training:*** The target number of CHOs to be trained puts the SR, NR and NER in a disadvantaged position. Given that they are three regions sharing one quota, they should be given a quota higher than those of UWR and UER. It was explained that an effort to train more CHOs means all project budget will be used for only CHO fresher training. It is for this reason that emphasis has shifted to pre-service training and District CHO orientation. However, the project would, if possible, increase the number of trainees for the SR, NR and NER.
- ***Pre-service training:*** It will be most appropriate to limit pre-service activities to 2 to 3 schools to learn some lessons before scaling up.
- ***Supervision tool for supervision from SDHT to CHPS:*** Even though supportive supervision has been tolled out as the national standard, it is not suitable for supervising CHPS zones. For this reason, the project is working to develop a pilot tool that will be applicable at the CHPS level.
- ***CHPS policy definitions:*** At all material moments, the appropriate CHPS policy definitions should be used.

❖ ***Output 4 related: Introduction and integration of LCA into CHPS service package***

- ***CHO/SDHT Refresher training*:** All SDHT heads where model CHPS zones are located should be trained. Already, the strategy of the project strategy is to always include SDHT in the trainings.
- ***Waist circumference measurement:*** The measurements used are WHO standards. There is the need to look at it again and consider proposing a standard that is suitable to the local context.

3. **Introduction of participants – Mr. Jacob Acquah Andoh (Master of Ceremony)**
The MC introduced key personalities who were in attendance to the house. They included Dr. Da Costa Aboagye, Director of Health Promotion Division of the Ghana Health Service; Dr. John Bertson Eleeza, RDHS for Northern Region; Dr. Osei Kuffour Afreh, RDHS for UWR, Ms. Maki Ozawa, Senior Representative of JICA Ghana Office, Dr. Banabas K. Yeboah, National CHPS Coordinator at the Ministry of Health and Ms. Satoko Ishiga, Chief Advisor of CHPS for Life Project. Further, participants from the various departments and organizations were acknowledged.

4. **Introduction of chairperson - Mr. Jacob Acquah Andoh (Master of Ceremony)**
Dr. Patrick Kuma-Aboagye was introduced as the Acting Director General of The Ghana Health Service. Until his latest appointment was the Director of the Family Health Division of the Ghana Health Service. He was the chairman of the occasion.

4. **Chairperson's opening remarks and purpose of the JCC – Dr. Patrick Kuma-Aboagye, Director General, GHS & Project Director**
The chairman recalled that the last time the JCC meeting was held, it involved only three regions. Now, the regions are five following the creation of two new regions in the then Northern Region. He expressed delight about the presence of the Health Ministry, in that, the Ministry is the agency that will make it possible to scale up any successes that will emerge from the project interventions. He then concluded by highlighting the purpose of the 5th JCC meeting as follows: To share the strategy and plan of activities for the 2nd term of the project, to share and give inputs on the draft of the modification of PDM, to share the current situation of regions (especially SR and NER), to share and discuss the findings of study tour in UWR, to share the findings, lessons learnt and activity plan of the 2nd term study tour in Japan and finally to discuss issues and concerns.

5. **Welcome remarks – Dr. Osei Kuffour Afreh, RHDS & Project Manager, UWR**
Dr. Afreh said he was delighted to welcome all to the 5th JCC of the CHPS for Life Project. He recounted that JICA's support to the health sector in the UWR dates back to 2006 and gave a vivid account of the technical cooperation projects as well as the progress of current 3rd phase project thus far. He stressed the need to start mapping out sustainability mechanisms for the interventions rolled out by the project. He urged all to see LCA as the pivot to improve health delivery system in Ghana and called for stronger commitment to the cause of the project.

6. **Presentation of workplan, discussions and approval- Ms. Satoko Ishiga**
With the use a PowerPoint presentation, Ms. Satoko Ishiga took the house through the rationale for modifying the workplan for the 2nd term as well as current target areas and major changes from the original plan. The summary of the information she shared is as follows:

(i) Rationale for workplan modification

- The project lost about 3 months due to the delayed commencement of the 2nd term.
- Fixed amount of resources with rising inflation affect cost of general supplies, transportation, hotel cost, etc.
- Tightened security protocol by JICA

(ii) Major changes from previous workplan

- Reduced number/frequency of some activities e.g. management meetings, LCA training, CHPS database meetings, etc.
- Reduced number of attendees of some trainings e.g. CHO fresher training.
- Changes in approach of some interventions from large scale rollout to a pilot approach e.g. Supportive Supervision training

(iii)Major changes by intervention area

Intervention area	Change
Harmonized CHO training	Minimize the number of trainings so as to shift focus to pre-service training
Pre-service training	• Prioritize the schools on pre-service training introduction (NAP→NAC→MTC) • Use TOT method to train tutors (who in turn will train other tutors) • Conduct training for all NAP, but pilot in 3 NAC and 3 MTC
SS related activities	• No region wide implementation of SS but in the selected pilot districts to submit feedback and recommendations to GHS HQ • Target will be from SDHT to CHPS level
Life-course approach	• No region wide dissemination of LCA in UWR • Pilot training to finalize training materials to share with GHS HQ for national dissemination • Conduct orientation in other northern regions

(iv) Project target area by output

CHPS implementation and systems

Activity	UWR	UER	NR	NER	SR
No. of districts	**11**	**15**	**16**	**6**	7
CHO Fresher	50 trainees	50 trainees	50 trainees		
CHPS database	11	15	16	6	7
Pre-service	1 NAP 1 NAC 1 MTC	1 NAP 1 NAC 1 MTC	2 NAPS, 1 NAC, 1 MTC		
District Orientation	11	2	2	1	1
Referral	11	15	2	0	0
Supportive Supervision	1	1	1	0	0
DHMT Review	11	15	2	0*	0*

Community mobilization, CHPS governance & Life-course approach

Activity	UWR	UER	NR	NER	SR
CHV/CHMC Training	11	0	0	0	0
CHAP on LCA	11	0	0	0	0
Introduction of score card	11	0	0	0	0
Non- monetary Incentive	11	0	0	0	0
HIAP Plan	11	15	3	1	0
HIAP Monitor	11	15	3	1	0
HIAP Implementation	11	15	3	1	0
CHO SDHT Training	11	0	0	0	0
LCA monitoring	11	0	0	0	0
Orientation on LCA	11	15	16	6	7

(v) Possible change in plan

- Include some pilot districts from SR (The Project does not have any targeted districts in SR)
- Increase the number of trainees/attendees of various trainings/meetings by controlling the cost (within the budget)
- Budget review around the end of 2020

7. **Strategy and plan of the project, discussion/approval of workplan – Dr. Osei Kuffour Afreh**
He started by presenting a summary of the exit strategy and then proceeded to make a detailed presentation of the main strategy, challenges and plan of the second term for key intervention areas of the project. The details of his presentation are as follows:

Exit strategy:

Subject	Exit strategy
CHO Production	Establish a more sustainable CHO production system by infusing the current Harmonized CHO training into pre-service curriculum (theory) and standardized District CHO Orientation (Practicum)
CHPS database	Disseminate nationally as a standardized system
SS/Referral	Establishment of DHMT review meeting system as an alternative/complementary measure of monitoring
Community mobilization	Modification of CHAP tool and integration into national material Incorporate into the District CHO Orientation (Practicum)
DA	Standardize RCC meeting as monitoring measure on HIAP
LCA	Develop LCA training materials to serve as national materials for LCA training Incorporate CHO/SDHT training into pre-service training curriculum

Main strategy, challenges and plan of the second term:

(i) Output 0 (management activities)

Main strategy:

- Establish an effective management meeting system in Northern Region (NR), Savannah Region (SR) and North East Region (NER)
- Collaboration with GHS HQ for the future dissemination of the Project's good practices

Plan of the 2nd term:

Activities	Summary
Joint Coordination Committee (JCC) meeting	• 6 times (Twice/year), 1 time with Dissemination • Study Tour 5 times
Coordination meeting of three regions	• 6 times (Twice/year)
Regional management meeting	• 9 times (quarterly) in UER, UWR, NR+SR+NER
Monitoring visits by GHS	• 2 times 、 May/June 2020 & 2021
Modification of PDM	• 1 time in January 2020
Study tour in Japan	• 1 time in November 2019: Done
Reports	• Workplan of the 2nd term in February 2020 • 2nd Progress report, 2nd Completion report • Monitoring sheet Ver.5-9 • End-line survey report

Challenges:

- Appointment of focal person for the Project at GHS HQ is not yet done.
- Administrative staff of Savannah Region and North East Region are yet to be assigned.
- Regional management meeting: As joint meeting for NR, Savannah Region and North East Region.
- Coordination meeting with 5 northern regions: UWR, UER, NR, SR and NER.

(ii) Output 1 (strengthening CHPS implementation and systems)

Main strategy:

Main activities	Main strategy
CHO fresher training	• Adopt Pre-service training and District CHO Orientation as the most sustainable system for effective CHO production as compared to the CHO Fresher Training. • Include SDHT to strengthen their capacity as supervisors • Establish collaborative training system among NR, SR and NER
Pre-service training	• Integration of CHO fresher training and LCA training for CHOs into national curriculum (Pre-service training) • Engage all NAP in project regions to start pre-service training for trainees • Conduct Pilot training in selected NAC and MTC in Project regions as

	a basis for future training
District CHO orientation	• Prioritize dissemination of District CHO orientation in UWR as model region • Conduct orientation and Pilot implementation in UER, NR, SR and NER as preparation for dissemination in those regions
CHPS database	• Establish district/region focused CHPS data management system in 5 regions • Strengthen capacity of CHPS unit for verification and training of districts • Strengthen data collection on quality of CHPS • National dissemination
Referral	• Emphasize ownership of referral monitoring by CPs • Create complementary system of referral monitoring by including referral issues into DHMT review meeting • Focus on the improvement of referral procedure between CHPS and SDHT while continuing advocacy at hospital levels
Supportive supervision	• Pilot implementation of SS at CHPS level and submit recommendations and lessons learnt • Support GHS HQ to finalize SS training materials and a checklist for SDHT level • Focus on implementation of SS at SDHT level (S to C supervision).
DHMT review meeting	• Establish a standardized regular review system on general CHPS implementation as a complementary measure for monitoring.

Challenges:

Main Activities	Challenges
CHO fresher training "Harmonized CHO Training"	• High training cost to continue or conduct many trainings • No strategy on career path for CHO leads to high turnover or attrition of CHOs
Pre-service training	• Integration of CHO training into national curriculum should be sped up. • Developing an effective strategy to train tutors
District CHO Orientation	• Need for strong ownership and commitment by DDHS • Budgeting issue by the districts • Orientation and pre-service training should be harmonized as complementary activity
CHPS database	• Needs of strong ownership and responsibilities both by region and district focal persons • Re-modification of database before national dissemination • Organization of data of NR during transition time
Referral	• Need for continuous supervision • Challenges in conducting facility-level cascade training or information sharing by staff who are trained. • Factors outside of the Project scope (e.g. ambulance services) impede the improvement of referrals • Poor participation of the hospitals (especially managers) in

	referral training leads to weak collaboration (such as referral feedback)
Supportive supervision	• Delay in implementation of the Project activity due to the coordination with national SS program which was officially introduced at the end of the first term of the Project
DHMT review meeting	• Delay in implementation of DHMT Review Meeting as it is planned to be implemented after SS training.

Plan of the 2nd term:

(Plan of CHO fresher training):

1st term	Plan and progress in 2nd term
UWR: 1 training • UER facilitators 10, NR facilitators 21m UWR facilitators 21 (DDHS 5) • Trainees 70	UWR: 1 training (November-December 2019) • Facilitators 10 • SDHT + CHN 50
NR: 2 trainings • NR facilitators 31+26 (DDHS 14+14), UWR facilitators 5+5, NAP tutors 2 • Trainees 40 +76	NR: 1 training (February 2020) • Facilitators 10 • SDHT + CHN 50
UER: 1 training • UER facilitators 23 (DDHS 10), NR facilitators 2, UWR facilitators 3, tutors 4, SDHT 26 • Trainees 71	UER: 1 training (2020) • Facilitators 10 • SDHT + CHN 50
Total: 4 trainings Trained 257 of targeted 147 trainees -231 CHN+ 26 SDHT Trained 80 of targeted 86 facilitators (incl. 29 DDHS, 6 tutors)	Total: 3 trainings Trained 110 of targeted 150 trainees (CHN + SDHT) - 85 CHN & 25 SDHT Involved 22 facilitators of targeted 30 facilitators.

(Plan of pre-service training)

Activity	Timing
Orientation to schools on the plan of the 2nd term	January-March 2020
Training in 4 NAP: Capacity building of tutors for the training in 4 NAP →Conduct pre-service training in 3 NAP→Feedback meeting	February－August 2020
Pilot training at 3 NAC: Capacity building of tutors, Pilot in 3 NAC →Conduct pre-service training in 3 NAC→Feedback meeting	September 2020-August 2021
Pilot training at 3 MTC: Capacity building of tutors, Pilot in 3 MTC →Conduct pre-service training in 3 MTC →Feedback meeting	May –August 2021

Joint feedback meeting on pre-service training	October 2021

(Plan of District CHO orientation)

Activity	Timing
Material review meeting	January 2020
UWR: • Pilot: Done in 2 districts • Dissemination: Plan District CHO Orientation for 9 districts →Conduct District CHO orientation in 9 districts →Feedback mtg	January-April 2020
UER, NR (SR, NER): • Orientation: Give orientation to all districts • Pilot: Plan the pilot in pilot districts→conduct the District CHO orientation in pilot districts→Feedback meeting • Dissemination to all districts: Plan the District CHO Orientation in all districts (the rest) →Conduct district CHO orientation in all districts	February 2020 June－August 2020 July-December 2020
Joint Feedback meeting	January2021
Follow up and exit strategy meeting	February 2021

(Plan of CHPS database)

Activity	Timing
• Capacity building of key persons (25, 5 per 5 region)	3 times April, October 2020 April 2021
UWR, UER, NR (SR, NER): • Regional CHPS database meeting	4 times February & June 2020 February & June 2021
National dissemination: Details should be discussed • Manual development and review meeting • National orientation in Accra • Capacity building of some regions • Regional HIOs and CHPS coordinators' meeting	January 2020-January 2021 March 2021 April –December 2021 December 2021, April 2022

(Plan of referral and Supportive Supervision)

Main Activities	Details
Health System Strengthening-Technical Working Group Meeting: • For monitoring the activity • For compiling lessons learnt and recommendation for SS	Quarterly from January 2020 to July 2022
Referral	
Region-wide/district-wide stakeholder meetings on referral	Once a year from 2020 to 2021

Supportive supervision	
Preparatory and Facilitators Meeting on SS Training • Observers from SR, NER and Central Office	1 time (UWR/UER/NR) March to April 2020:
SS Training for SDHT (SDHT to CHPS supervision)	1 time per region (pilot districts) April to May 2020:

(Plan of DHMT review meeting)

Main Activities	Details
Preparation Meeting for DHMT Review • For development of standard materials for quarterly DHMT review meeting	3 times per region April to June 2020
Orientation on standardized DHMT Review Meeting in NR, UWR and UER	1 time per region June 2020
Monitoring of DHMT Review Meeting in NR, UWR, UER	August 2020 to June 2021

(iii) Output 2 (strengthening community activities)

Main strategy:

- Create "Model CHPS Zones" through the Project intervention in the Pilot CHPS zones
- Strengthen self-assessment capacity of community on CHAP
- Create sustainable training opportunity for CHMC/CHV/CHW by using District CHO orientation
- Advocate communities on application of LCA concept in CHAP
- Develop coordination system with District Assembly to create non-monetary incentive mechanism

Challenges:

- Lack of understanding of communities on LCA and importance of the CHAP assessment
- Insufficient capacity of the pilot CHPS zones to serve as learning centers
- Weak involvement of District Assembly in the community health activities

Plan of the 2nd term: Training:

Activity	Timing
CHO/SDHT refresher training (Strengthening CHAP assessment and material development)	3 times: February 2020 - December 2020
Finalize developing LCA video	February 2020
Develop LCA flip chart	March 2020
Post-training monitoring in the Pilot CHPS zones	February 2020-
CHMC/CHV/CHW training in pilot CHPS • Planning and Preparatory meeting • Conduct the training • Feedback Meeting	3 times: April & August 2020, March 2021
Integration of CHMC/CHV/CHW training into the District CHO Orientation	January 2020-

Plan of the 2nd term: Non-monetary incentive activities:

Contents	Timing
Create the incentive mechanism • Taskforce team meeting • Meeting with District Assembly • Regional level meeting	February-July 2020
Pilot Implementation in 2 pilot districts of UWR	April 2020-
Implementation in all districts of UWR	August 2020-
Share the experience with UER and NR (SR, NER)	July 2021

Plan of the 2nd term: Learning visits:

Contents	Timing
Visit for staff members of CHPS zones in UWR Leaning visit→Feedback Meeting	1st: July-August 2020 2nd: March-April 2021
Visit for officials from UER and NR (SR, NER) Planning and Preparatory meeting →Leaning visit, →Feedback Meeting	June- August 2021

(iv) Output 3 (strengthening governance of CHPS)

Main strategy:

- Scale up effective PDCA (Plan-Do-Check-Action) cycle/system for HIAP
- Promote learning among RCC, RHMT, DA, and DHMT through RCC meeting
- Standardize RCC meeting for effective HIAP implementation and monitoring
- Disseminate experiences in UWR to UER, NER and NR through inter-regional learning visits.

Challenges:

- UER, NER and NR have just started HIAP
- Poor understanding of DA to plan health activities according to the community health situation/needs.
- Unrealistic and unactionable HIAP.
- Strong system to monitor the implementation of HIAP yet to be established.

Plan for the 2nd term

Activity	Timing
Assess the current level of involvement of DA, DHMT and stakeholders in UER, NER and NR	1 time per region Nov.2019, Oct. 2020, and 2021
Conduct RCC meetings (RCC, RHMT, DA, and DHMT)	3 times per region Nov. 2019, Oct. 2020, and 2021

Strengthen development of health-integrated annual action plans (HIAP) • Disseminate HIAP tools to UER, NER and NR. • Capacity building on HIAP formulation and monitoring for DA and DHMT staff. • Capacity on HIAP implementation and monitoring for DPCU/ RPCU, DA and DHMT staff.	1-time pe region: Nov. 2019 1 time per region: Nov. 2019 1 time: Mar. 2020
Strengthen development, implementation and monitoring of health-integrated annual action plans (HIAP) • Conduct review meetings on HIAP formulation and monitoring. • Conduct 4th TWG meeting to finalize reference material.	2 time per region UWR: Jan. or Feb. 2020 and 2021 UER, NER and NR: Jan. or Feb. 2021 and 2022 1 time: Mar. 2020
Conduct joint stakeholder meeting for experience sharing and sustenance of HIAP.	1 time: Mar. 2022

(v) *Output 4 (Introduction and integration of LCA into CHPS service package)*

Main strategy:

- Develop manual (Textbook) for effective dissemination of LCA activities.
- Integrate LCA training into national curriculum (Pre-service training) to ensure sustainability of LCA services at CHPS level.
- Strength capacity of facilitators in 3 regions through their participation in CHO/SDHT training in UWR.
- Strength capacity of SDHT through their participation in CHO/SDHT training for effective collaboration and supervision to CHPS on LCA activities.

Challenges:

- Delay in development of LCA manual (Textbook).
- Detailed steps to integrate LCA materials into existing CHO training materials is yet to be discussed.

Plan of LCA related activities: Development of Training materials:

Activity	Timing
Development of Flip chart on LCA • Meeting on flipchart development	4 times December 2019-February 2020
Development of materials for CHO/SDHT refresher training and manual of LCA • Material review of CHO/SDHT training on LCA • Review meeting for development of LCA manual in UWR • Review meeting for finalization of LCA manual in Accra	3 times December 2019-February 2021 3 times October 2020-April 2021 3 times April – December 2021

Plan of LCA related activities: Training:

Activity	Timing

Implementation of training • Preparatory meeting for CHO/SDHT refresher training • Conduct CHO/SDHT training (5 days) • Feedback meeting on training • Review and feedback meeting on action plan for minimum package • Post training follow up	3 times: Jan. 2020-Apr. 2021 3 times: Feb. 2020-April 2021 3 times: Feb. 2020-Apr. 2021 1 time (UWR): October 2020 11 times (1-day X 11 districts) Oct. 2020 –Apr. 2021

Plan of LCA related activities: Integration of LCA:

Activity	Timing
The LCA meeting in Accra -Share the re-organized CHPS basic service package and action plan with GHS-HQ and the five northern regions	1 time April 2021
The LCA meeting in Accra -Discuss the strategy of dissemination - Dissemination of manual/guideline of LCA training	1 time February 2022

(vi) Key discussions on presentations of the Workplan, Strategy, Challenges and Plan of the 2nd term

- *CHO/SDHT Refresher training*: All SDHT heads where model CHPS zones are located should be trained. Already, the strategy of the project strategy is to always include SDHT in the trainings.
- *Pre-service training:* It was asked if it is possible to extend the training beyond the schools in the project target regions to involve schools in other regions. It was explained that a review of the curricula is ongoing and may be completed by July 2020. The harmonized CHO training contents will be included in the curricula. To the that extend, the feasible thing to do is to train tutors of other schools but given the limitation of project budget, it is not possible to train all tutors. In the circumstances, it may be better to restrict it to just 2 or 3 schools so we can see the lessons and scale up.
- *Supervision tool for supervision from SDHT to CHPS:* Given that there is a tool for monitoring CHPS in the implementation guidelines, it was quizzed whether it is necessary to develop another tool for supervision. It was explained SS that has been deployed as the national standard is not suitable for supervising CHPS zones. For that reason, the project is working to develop a pilot tool that will be applicable at the CHPS level.
- *Possibility of accomplishing all activities:* Given the activities contained in the workplan and the reduction in budget and time lost between the 1st and 2nd terms, it was asked if it possible to implement all the activities. It was explained that the budget is not reduced but the overall amount approved at the beginning is fixed. As implementation progresses, it would be assessed to see if additional time is needed to execute all activities.
- *Strong involvement of sub-districts in all CHPS projects*: It was discussed that every project on CHPS must involve the sub-district in its entirety.
- *CHO fresher training:* The target number of CHOs to be trained puts the SR, NR and NER in a disadvantaged position. Given that that they are three regions sharing one allocation, they should be given a quota higher than those of UWR and UER. It was explained that an effort to train more CHOs means all project budget will be used for only

CHO fresher training. It is for this reason that emphasis has shifted to pre-service training and District CHO orientation. However, the project should, if possible, increase the number of trainees for the SR, NR and NER.

- *Inclusion of eye care services for the aged in LCA service*: It was explained that a further expansion of the services CHOs have to provide in the face of lack of equipment will end up making the CHOs ineffective. Besides, the CHO's work is more of early identification and referral.
- *Sustaining the innovations in the project:* The GHS HQ was implored to take steps to ensure that all the good things being introduced by the project are scaled up nationwide.

8. Report on the status of activities in each region from June to December 2019

(i) Upper West Region – Mr. Prosper Tang

Mr. Tang gave an overview of key activities implemented over the period, the status of CHPS implementation and concluded with some challenges.

Activities implemented:

Main Activities	Details of Activities
CHPS database	• Capping of the regions roll-out plan/demarcation • Promoting OJT on managing CHPS database • CHPS database being used as a source for improving data quality on both DHIMs and the CHPS tracker tool • Availability of database has improved planning on CHPS implementation and also informed management decision making
CHO F training	• Bridging the regions functionality gap has been enhanced through the fresher training & Pilot of District-based orientation • All DDHS has been involved as observers and deepened their understanding of the duties of CHOs • Solid foundation has been laid for the roll-out of the District-based CHO orientation through the successful pilot and high interest of DDHS.
Referral	• Revolving system has ensured availability of referral and feedback forms. Registers have been included in the revolving funding scheme.
Community mobilization	• Revised CHAP format(measurable) is now being used to address specific community health needs and improve community feedback durbars. • Effective Planning & Measuring progress is highlighted
Supportive supervision	• Continuous implementation of FSV was encouraged in anticipation for the official roll-out of the SS approach • Engaging SS National TWG on a proposed checklist for the CHPS level (This is a gap in the current SS approach)

DA engagement	• Well-structured engagement process has been developed with all stakeholders committed to executing agreed plans • Preparations underway for 2020 HIAP development • Using CHPS database as basis for advocacy especially with Das
LCA	• Training on the LCA & Community mobilization has re-energized communities to deepen their involvement in PLANNING health activities using the revised CHAP format • Deep involvement of the DHD and SDHT is helping bridge the capacity gap between CHPS zones & supervisors • Training materials needs further modification and standardization with inputs from Japan study tour group (Shifting from Theory to Practice)

Summary of CHPS implementation

Availability of accommodation for 2 staff at CHPS compound	**55.8%**
Availability of full equipment	12.8%
Availability of EPI refrigerator	28.6%
Availability of official motor bike	47.8%
Availability of GRID (Electricity)	48.1%
Availability of portable water	47.1%
Availability of Toilet (Staff & clients)	36.8%

Challenges:

Main Activities	Details of Challenges
CHPS database	• Capacity of DDHS on the database is weak and thus limits them from using it as basis for informed decision making e.g. staff re-distribution • Mal-distribution of CHOs affects functionality
CHO Fresher training	• High cost of training • It requires that trainees stay away from post for 2weeks
Referral	• Feedback remains a challenge especially from the hospitals to the Community lower level facilities • Attention should be on creating a robust referral system at the new regional hospital
Supportive supervision	• Absence of a checklist for the CHPS level • Creating complimentary opportunities in using both SS and FSV checklist especially at the CHPS level
Community mobilization	Scorecard system is non-existent
DA engagement	Inadequate inflow to MDAs and priority of district/govt determines commitment to implement HIAP

LCA	Inadequate equipment such as infantometers, portable weighing scales, BP apparatus etc affects the effectiveness of conducting screening and LCA related activities

Other issues:

- Creating "community wellness clinics" at CHPS zones to promote LCA should be envisioned
- Sustainability mechanisms are introduced alongside implementation
  - Seamless uptake of activities by counterparts to promote ownership and continuity
  - Quality of services provided at CHPS zone should be major focus for all.

(ii) Upper East Region – Mr. Emmanuel Ansu-Abina

Mr. Ansu-Abina gave a brief of activities implemented, summary of CHPS implementation and challenges encountered.

Activities implemented:

Main Activities	Details of Activities
CHPS database	Database for Q3, 2019 will be presented below Data for Q4, 2019 is being compiled
CHO Fresher training	▪ Conducted training in June (45 CHO supported by KOICA) ▪ Training would be held in February, 2020 by JICA
Referral	▪ Revolving system has been established to sustain the referral process with an initial stock of materials provided by the project. ▪ Letters from the RHA have been written to all districts informing them of the availability of referral materials at the RHD stores. ▪ Purchases and utilisation is very encouraging i.e. from both private and public health institution. ▪ Plans are advance to restock the initial quantities.
Supportive supervision	▪ Training for regional and district supervisors has taken place. ▪ First round of district supervision has been conducted. ▪ Currently, a review of FSV and SS materials is underway to finetune it with CHPS facilities.
DA engagement	▪ All 15 district have been introduced and trained on the formulation of HIAP. ▪ First round of project support to DAs and DHMTs to formulate their HIAPs is complete. ▪ Districts have started submitting their final drafts to the region for endorsement.

Summary of CHPS implementation:

Availability of accommodation for 2 staff at CHPS compound	37.7%
Availability of full equipment	9.4%
Availability of EPI refrigerator	13. 2%
Availability of official motor bike	48.9%
Availability of GRID (Electricity)	31.0%

Availability of portable water	38.8%
Availability of Toilet (Staff & clients)	19.3%

Challenges:

Main Activities	Details of Challenges
CHPS database	▪ Late submission of district reports. ▪ Some Districts still have difficulties in the usage the database template ▪ Reshuffling of staff especially district CHPS coordinators.
CHO Fresher training	
Referral	▪ Low feedback rates from receiving facilities.
SS	▪ Blending FSV and SS
DA	▪ Due to conflicting activities, not much commitment was exhibited by some DHMTs to engage the DAs on their priorities.

(iii)Northern, North East and Savanah Regions – Mr. Welbeck Akplu

Activities implemented:

Main Activities	Details of Activities
CHPS database	▪ Q1, Q2 and Q3 2019 data worked on and used for DHIMS II ▪ Q4 2019 data in being compiled
CHO Fresher training	▪ No CHO F training held in 2019. ▪ One planned for Q2 2020.
Referral	▪ All trainings completed. ▪ Revolving system established and functional. ▪ Facilities and districts procuring materials from RMS
SS	▪ TWG meetings held to discuss SS plan ▪ Pilot districts for SS selected awaiting confirmation.
DA	▪ HIAP formulation meetings held ▪ DA's and DHMTS have all formulated and submitted HIAPS

Challenges:

Main Activities	Details of Challenges
CHPS database	• Slow improvement of CHPS database system. No data of 2019 is available. • Late submission of District Data • Inability of some district teams to use Dropbox • Some districts still do not use CHPS database for decision making. • Staff attrition and frequent replacement of focal persons.
CHO Fresher training	• No structured follow-ups to trained CHOs to assess their work and offer them support. (SS stalled) • Low CHPS functionality due to low number of CHOs
Referral	• Higher level facilities not regularly giving feedback on referral issues. • No avenue for districts and facilities to share issues relating to

	referrals
Supportive supervision	• Delay in the release of National tools affected SS • The released tools did not address issues at the CHPS level into detail

(iv) Key discussions after the presentations from the regions:

- *Coverage of CHPS population:* The project is using the policy definition of functional where a CHPS with CHO is only considered.
- *CHPS database in NR:* Why data was collected for DHIMS but still reported to be unavailable. It was explained that it is the summary data from the region that is not available, district data are available and used for DHIMS data.
- *SBCC promotion is not clear:* There is the need to let the SBCC promotion activities stand out clearly in the project.
- *Redistribution of CHNs by UWR:* The region was commended for redistributing CHNs in the region. The region needs to document the lessons and strategies to sustain it.
- *Situational of referral feedback:* There are real challenges with referral feedback in the service.
- *Access to potable water and toilet facilities:* Regions need to take action to ensure that facilities without these amenities are provided.
- *CHPS demarcation in NR:* The region used the number of electoral areas as the denominator, resulting in more 100% demarcation. It was advised that the region should work further to correct this anomaly, because CHPS demarcation cannot be more than 100% under any circumstance.
- *CHPS classification for planning purposes:* It was suggested that for planning purposes, districts are entreated to use service provision as the criterion for determining functionality hen feeding data into DHIMS. It was further suggested that given flexibility of the CHPS database, focal persons can take the extract the needed data from the CHPS database for DHIMS, as all relevant parameters are available in it.
- *Basic equipment for pilot CHPS zones*: It was asked if it is possible for the project to consider providing relevant equipment to pilot CHPS zones to support LCA service delivery. It was explained that it did not form part of the project budget and so difficult to handle.
- *Home visit as a major CHPS service:* It was stressed that home visits should be reemphasized as central to all CHO activities.

9. <u>Modification of PDM</u> – Mr. Zacchi Sabogu

Mr. Sabogu explained that a workshop was organized through which targets for indicators in PDM were set. However, targets could not be set for some indicators especially those relating to LCA because those ones needed to be discussed and decided by the technical working group. As such the PDM modification process was going to continue and hoped that the PDM version 3 will be adopted in the next JCC. The following are the timelines for the modification of the PDM. The schedule for the PDM modification is as follows:

PDM Modification meeting	January 29,2020 in Tamale
Finalization and further meeting	February 2020
Circulation of draft and modification	March 2020
Approval of PDM Version 3	May /June/July 2020 through the next JCC

Comments by participants

- Dr. Banabas Yeaboah of MOH called for an accelerated implementation of activities because only 2 years is left to get to project completion. Added that the project is full of lessons and that those lessons should be domesticated. He was also looking to see some slides on innovations on the presentations that were made.
- Mr. Charles Acquah of GHS PPMED was concerned about how the MOH and GHS will demonstrate commitment to ensure sustainability of the interventions.
- The Director General on his part was concerned about reimbursement by NHIS for home visit services. He said actions will be initiated to have a more structured way of providing CHPS services particularly home visits so that NHIS can easily agree to reimburse the cost of home visits.

10. <u>Presentation on second Japan Study Tour</u> – Dr. John Eleeza

Among other things, Dr. Eleeza explained the objectives of the tour, the key issues, outputs, lessons learnt and action plans developed by the participants.

Summary of key lessons learnt:

- All interventions are backed by legislation which is strictly adhered to
- A fully decentralized health system
- Mayors and Governors are elected which makes them accountable to the people
- Strong collaboration between health and other sectors (education)
- School health screening is comprehensive with timely feedback to parents and teachers
- There is a deliberate effort to prevent infection in all facilities visited
- Most of the volunteers are retired active persons, they have time and are fully committed to serve the community
- There are volunteers for specific health interventions
- Health Guidance Assistants (HGA) have specific term of 2years
- Volunteers (HGA) have a budget to organize their activities with an annual stipend
- Health promotion decisions and interventions are data driven
- Well established interventions for all age cohorts
- Quality health and longevity is owned by the community and people

Action plans developed by participants:

Participants	Theme	Target and details
GHS HQ group (Ms, Sey, Dr. BB, Ms. Felicia)	Integrating the prevention and control of Hypertension and Diabetes in LCA at the CHPS level.	Ghana Health Service managers, and at the CHPS level and hospital in the 5 regions of the North • Advocacy of managers (ICD, PPMED, HP) • Define health promotional package • Establishment of functional HPT and DM clinics in all District Hospitals
Dr. John Eleeza	Management of Obesity with Nutrition (food power) and Exercise ("Smart OPD	Establish pilot of Smart OPD at Tamale Regional Hospital • Establishment of obesity clinic • Public awareness on obesity and BMI

	concept).	
Dr. Osei Kuffour Afreh	Improving Holistic Health Check/ Assessment through wellness clinics in the Wa Municipality	Conduct pilot in Wa Municipal • Staff training on LCA counseling • Increase facilities for health check for early detection • Increase public awareness through HP officers, CHO training
Dr. Josephat Nyuzaghl	Introduction of Papa Mama Classes (MAP concept)	Conduct pilot in Bolgatanga Municipal, then dissemination to the rest UER • Training of DDHS, MWs and CHOs on Papa Mama class • Development of questionnaire • Provide necessary equipment for the class

11. Sharing the findings of study tour in UWR

Observations made by participants of study tour in UWR were shared by representatives of the three study tour teams. Summary of their observations is the following:

Mr. Kwame Aboagye (on behalf of Jirapa group)

- Community ownership in CHPS activities was good
- High level of community involvement and participation
- Cordial relationship among stakeholders
- District Assembly has key interest in health activities
- High philanthropy support (e.g. Dr. Bacheyie)
- Regular CHMC meetings with support from SDHT
- Updated CHAP
- Care for the aged at the community
- Pregnancy schools taking place in CHPS zone
- Stakeholders involvement has contributed to high participation

Mr. Rexford King James (on behalf of Nadowli-Kaleo group)

- Good collaboration between the GHS and DCE, traditional authorities, assembly man etc
- The environment was very clean and relevant health indicators displayed
- Hepatitis B screening is being done at the wellness clinic established at the health centre
- Active community participation in health service delivery.
- Kpagadigna CHPS mobilizes funds to pay security man, built a garage for emergency transport tricycle and a delivery room.
- Adaptation of relevant tools for assessment (holistic assessment check list) for more effective home visiting by CHOs
- Data capturing tool developed and used at the wellness clinic

Mr. Alhassan Abukari (on behalf of Wa East group)

- Community is enthusiastic about health issues
- CHAPS and CETS in place

- LCA service provision was under way during the visit
- Age groups that are usually neglected in routine services are taken care of in LCA
- CHMC play an active role in health service delivery
- Good collaboration between the facility and GPRTU/PROTOA has strengthened referral system
- Good collaboration between the community and the health facility has addressed a lot of the health challenges

Key discussions after the presentation of study tour group reports

- Dr. Wodah-Seme spoke about the action plans developed by the Japan Study Tour team. He suggested that as they execute their plans there should not lose sight of the aged.
- Dr. Wodah-Seme also suggested that it would have been helpful to share the situation of a rural area in Japan not just a city area as seen in the presentation of the study tour team.
- Mr Charles Acquah was concerned about the appropriate use of equipment especially height scales. He recommended that user training should always form a part of the equipment procurement chain to avoid such gaps.

12. Project related issues – Ms. Satoko Ishiga

- *Introduction of the new JCC members;* Ms Ishiga introduced the RDHS for NER and the RDHS for SR (who was not personally present at the meeting) and members of the Japan study tour;
- *Introduction of new Japanese experts;* she also introduced new Japanese members including Dr. Yuko Otomo, Ms. Yuko Hishida, Ms. Akiyo Nonogaki and Ms. Asako Hayashi who have joined the project.
- *Activities in SR and NER;* she requested the NER and SR to give information to the project about the start of full operations. She also talked about the need to include a pilot district from SR.
- *Appointment of focal person at GHS HQ;* the issue was raised in the last JCC during the first term but no one has been nominated yet. He requested DG to take action on that.
- Security issues; she informed the house that JICA has tightened security protocol and measures which restrict the entry of project team and vehicles into districts that are within 10km to the border. So, the project would need the strong support of counterparts to carry out interventions in the affected districts.
- *Timing of next JCC;* next JCC will take place in mid-July, 2020. The project will liaise with DG to confirm the date an communicate to members.

13. Closure

Remarks by JICA representative – Ms. Maki Ozawa

Ms. Ozawa made the following points in her remarks:

- She appreciated all for participation and valuable contributions to the discussions.
- She further introduced Mr. Shizume as the new representative for health in JICA Ghana.
- The SDHTs have been strongly involved right from the first term of this project up to this time.
- She reiterated the importance of the security concerns that were shared by Satoko Ishiga, and added that JICA has been observing with concern the security threats from neighbouring countries.
- She was particularly enthused that the exit strategy is being discussed at this point of project implementation. It is particularly important that steps are taken to ensure the sustainability of the interventions especially the LCA.
- She concluded by thanking all for hard work and commitment so far.

Remarks – Dr. Patrick Kuma-Aboagye, DG, GHS

The DG made the following comments in his closing remarks:

- It is good to see the different perspectives from different regions so it should be encouraged.
- A limited number of schools should be used for the pre-service so that lessons can be learnt from it before scale up.
- He recommended the continuation of fresher training as a stop gap measure to soar up the number of trained CHOs providing services.
- The engagement with the NMCG together with the health training unit of MOH should continue to ensure the smooth integration of CHO training modules into the training school curricula.
- SDHTs must be continually involved in the project activities to build their capacity.
- It is important for health managers to institutionalize wellness clinics in the scheme of things within the service.
- Waist measurement needs to be relooked at to see if it is okay to use one standard for everyone or many be contextualized to suit people of varied backgrounds.
- He advised all to stick to CHPS policy definitions to avoid any confusion.
- If possible, the number of CHO fresher training quota for the NR, NER and SR should be increased.
- Health managers should properly institutionalize home visits and strengthen it.
- He called on regions to conduct equipment needs assessment and make known their equipment gaps.
- He informed the house about some funding coming in from the Global Financing Facility – hoping that small resources will be available as part of extension of MNCHP
- Audit issues within the GHS; he urged all to be patient for the full facts to be uncovered.

Annex 1: Participants list for the 5th JCC meeting

No.	Category	Name	Organization	Position
Greater Accra (MoH, GHS and NMCG)				
1	Ghanaian side	Dr. Patrick Kuma-Aboagye	GHS HQ	Director General, Chairperson
2	Ghanaian side	Dr. Cornelius Debpuur	GHS HQ	Director, Research and Development
3	Ghanaian side	Mr. Seth Adjei	GHS HQ	Health Promotion Officer
4	Ghanaian side	Mr. John Ayivase	GHS HQ	Rep. Director, Institutional Care
5	Ghanaian side	Dr. Da Costa Aboagye	GHS HQ	Director, Health Promotion Div.
6	Ghanaian side	Mr. Emma Antwi	GHS HQ	Rep. for Chief Nursing Officer, ODG
7	Ghanaian side	Ms. Mavis Apatu	MoH	DDNS, Rep. CNS
8	Ghanaian side	Mr. Zanu Dassah	GHS HQ	Deputy Director, Human Resource
9	Ghanaian side	Mr. Charles Acquah	GHS HQ	Deputy Director, PPMED
10	Ghanaian side	Mr. Martin Ankomah	GHS HQ	Dep.Director, Administration, ODG
11	Ghanaian side	Ms. Catherine Adu Asare	GHS-HQ	Office Director General
12	Ghanaian side	Ms. Ruby Arthur	GHS HQ	Dietician, ICD
13	Ghanaian side	Mr. Jacob Acquah Andoh	GHS HQ	Public Relations Office
14	Ghanaian side	Ms. Gifty Amadu	GHS HQ	Dep. Chief Admin Manager, ODG
15	Ghanaian side	Dr. Barnabas K. Yeboah	MOH	National CHPS Coordinator
16	Ghanaian side	Ms. Felecia Babanawo	GHS HQ	National CHPS Coordinator, GHS
17	Ghanaian side	Ms. Gladys Brew	GHS-HQ	Safe Motherhood Coordinator, FHD
Upper East Region				
1	Ghanaian side	Dr. Winfred Ofosu	RHMT UER	Regional Director of Health Services
2	Ghanaian side	Dr. Josephat A. Nyuzaghl	RHMT UER	Deputy Director, Public Health
3	Ghanaian side	Mr. Emmanuel Adjei Frimpong	RHMT UER	Deputy Director, Administration
4	Ghanaian side	Dr. Abdul Razak Dukurugu	RHMT UER	Deputy Director, Clinical Care
5	Ghanaian side	Ms. Kulariba Dora	RHMT UER	Regional Public Health Nurse
6	Ghanaian side	Mr. Emmanuel Ansu Abina	RHMT UER	Regional CHPS Coordinator
7	Ghanaian side	Alhaji Abdul Rafiu Agboola	Navrongo CHNTC	Principal
8	Ghanaian side	Ms. Mabel Kanyomse	Bolga, Midwifery Training Sch	Principal
9	Ghanaian side	Mr. Michael Yidana	Zuarungu, NTS	Principal
10	Ghanaian side	Mr. Muizdeen Saaka	RCC UER	Desk Officer for Health
11	Ghanaian side	Ms. Lamise Kwogia	RHMT UER	CHPS unit
12	Ghanaian side	Mr. Osei Kwadwo	RHMT UER	CHPS unit
13	Ghanaian side	Mr. Rexford King James Adjei	RHMT UER	Regional Health Promotion Officer
14	Ghanaian side	Ms. Adjatu Tiamiyu	RHMT UER	Regional Health Information Officer
15	Ghanaian side	Mr. Ayamga Emmanuel	RHMT UER	Rep. for Regional Nutrition Officer
16	Ghanaian side	Mr. Stephen Bodosia	DHMT, Bongo	DDHS
17	Ghanaian side	Mr. Lawal Alhassan	DHMT, Bawku West	DDHS
18	Ghanaian side	Mr. Hypolite Yeleduor	DHMT, Binduri	DDHS

19	Ghanaian side	Mr. Philip Addo Aboagye	RHMT, UER	Regional Referral Coordinator
Northern Region				
1	Ghanaian side	Dr. John Bertson Eleeza	RHMT NR	Regional Director of Health Service
2	Ghanaian side	Ms. Benedict Ofori Appiah	RHMT NR	Rep. Deputy Director, Public Health
3	Ghanaian side	Dr. Baba Braimah Abubakari	RHMT NR	Deputy Director Clinical Care
4	Ghanaian side	Mr. Welbeck Akplu	RHMT NR	Dep. Regional CHPS Coordinator
5	Ghanaian side	Mr. Boye Yakubu	RHMT NR	Regional Health Information Officer
6	Ghanaian side	Ms. Charity Azantilow	DHMT, Tolon	DDHS
7	Ghanaian side	Ms. Denisia L. Agong.	DHMT, Savelugu	DDHS
8	Ghanaian side	Ms. Leticia Akum	Tamale CHNTS	Rep. for Principal
9	Ghanaian side	Ms.Sophia Kpebu	RCC NR	Budget Officer
Upper West Region				
1	Ghanaian side	Dr. Osei Kuffour Afreh	RHMT UWR	Regional Director of Health Services
2	Ghanaian side	Mr. Baatima Linus	RHMT UWR	CHPS unit
3	Ghanaian side	Mr. Prosper Tang	RHMT UWR	Regional CHPS Coordinator
4	Ghanaian side	Mr. Anthony Kullah	RHMT UWR	Nutrition Officer
5	Ghanaian side	Mr. John Maakpe	RHMT UWR	Health Promotion Officer
6	Ghanaian side	Mrs Rose Mary Banzie	RHMT UWR	Adolescent and Reproductive Health
7	Ghanaian side	Mr. Bob-Milliar Gordon	RCC UWR	Regional Economic Planning Officer
8	Ghanaian side	Ms. Beatrice Tengan	DHMT, Wa Municipal	Ag. DDHS
9	Ghanaian side	Ms. Phoebe Balagumyetime	DHMT, Nadowli	DDHS
10	Ghanaian side	Mr. Clifford Veng	DHMT, Wa West	DDHS
11	Ghanaian side	Mr. Emmanuel Sanwuok	DHMT, DBI	DDHS
12	Ghanaian side	Ms. Florence Angsomwine	DHMT, Jirapa	DDHS
13	Ghanaian side	Alhaji Haruna Tiraah	Jirapa CHNTC	Principal
14	Ghanaian side	Dr. Bernard Ziem	DHMT, Lawra	DDHS
15	Ghanaian side	Ms. Rukaya Wumnaya	DHMT, Wa East	DDHS
16	Ghanaian side	Ms. Genevieve Yiripaare	DHMT, Nandom	DDHS
17	Ghanaian side	Dr. Mathias Pogvi Tengan	Lambussie Polyclinic	Principal Medical Officer
18	Ghanaian side	Ms. Cecilia Kakariba	DHMT, Sissala West	DDHS
19	Ghanaian side	Mr. Alex Bapula	DHMT, Sissala East	DDHS
20	Ghanaian side	Mr. Richard Ambrose Darko	RHMT, UWR	Regional Health Information Officer
21	Ghanaian side	Mr. Naawa Ambrose	RHMT, UWR	Research Officer
22	Ghanaian side	Mr. Jerdu Nuhu	DHMT, Lambussie	Ag. DDHS
23	Ghanaian side	Mr. Felix Berewono	RHMT, UWR	Public Health Officer
24	Ghanaian side	Mr. Bukari Mohammed	Wa East	CHPS Coordinator
25	Ghanaian side	Mr. Nang Eric	DHMT, Nadowli-Kaleo	Nutrition Officer
26	Ghanaian side	Edward Tioh	Nadowli-Kaleo	Dist. CHPS Coordinator
North East Region				

1	Ghanaian side	Dr. Abdulai Abukari	RHMT, NER	Regional Director of Health Services
2	Ghanaian side	Mr. Adams Anas	RHMT, NER	Regional CHPS Coordinator
3	Ghanaian side	Mr. Valentine Ayamba	HTS, Nalerigu	Principal
4	Ghanaian side	Mr. Mark Abugri	DHMT, East Mamprusi	DDHS
Savannah Region				
1	Ghanaian side	Mr. Zakariah Abdul-Kassim	RHMT, SR	Rep. for Regional Director of Health Services
2	Ghanaian side	Mr. Marcel Boamah	RHMT, SR	RHIO
3	Ghanaian side	Mr. Dubik Daniel Dindiok	DHMT, Central Gonja	District Director of Health Services
4	Ghanaian side	Ms. Christiana Terbobri	CHNTS, Bole	Principal
5	Ghanaian side	Mr. Alhassan Abukari	DHMT, North Gonja	DDHS
EoJ, JICA and CHPS for Life Project staff				
1	Japanese side	Ms. Maki Ozawa	JICA Ghana	Senior Representative
2	Japanese side	Mr. Takuya Shizume	JICA Ghana	Representative
3	Japanese side	Ms. Satoko Ishiga	JICA Project	Chief Advisor, Community Health Expert
4	Japanese side	Ms. Tomoko Watanabe	JICA Project	Expert, Health Promotion
5	Japanese side	Ms. Junko Kanehiro	JICA Project	Expert, IEC
6	Japanese side	Dr. Otomo Yuko	JICA Project	Public Health Expert
7	Japanese side	Ms. Yuko Hishida	JICA Project	Expert, Public Finance Management
8	Japanese side	Ms. Akiyo Nonogaki	JICA Project	Project Coordintaor
9	Project staff	Mr. Zacchi Sabogu	JICA Project	Project Advisor
10	Project staff	Mr. Abu Dokuwie Alhassan	JICA Project	Senior Project Coordinator
11	Project staff	Mr. Kassim Abdul-Basit	JICA Project	Senior Project Coordinator
12	Project staff	Mr. Raymond Alirigia	JICA Project	Junior Project Coordinator
13	Project staff	Mr. Sharifdeen Amadu	JICA Project	Junior Project Coordinator
14	Project staff	Mr. Gamuo Roger	JICA Project	Administrative Officer
15	Project staff	Mr. Ngmenenbang David	JICA Project	Administrative Officer
16	Project staff	Mr. Mpuan Benjamin Binipom	JICA Project	Administrative Officer

Annex 2: Agenda of 5th JCC Meeting

No.	Time	Activity	Person Responsible
1	09:00 -09:30	Registration	GHS/JICA
2	09:30 -09:40	Introduction of participants	**Mr. Prosper Tang** Regional CHPS Focal Person
3	09:40 -09:45	Introduction of Chairperson	**Mr. Jacob Acquah Andoh** PRO, GHS-HQ
4	09:45 -09:55	Chairperson's opening remarks and purpose of the JCC	**Dr. Patrick Kuma-Aboagye** Director General, GHS/Project Director
5	09:55-10:10	Welcome remarks	**Dr. Osei Kuffour Afreh** Regional Director, UWR/Project Manager
6	10:10-10:35	Presentation of work plan, discussions and approval	**Ms. Satoko Ishiga** Chief Advisor, Project Team
7	10:35- 11:05	Strategy and plan of the project, Discussion/ Approval of workplan	**Dr. Osei Kuffour. Afreh** Regional Director, UWR/Project Manager
8	11:05-11:50	Presentation on implementation of Project activities and situation in the regions. Q&A	**Representatives of regions** UWR, UER and NR
9	11:50-12:00	Modification of PDM Background and timeline	**Mr. Zacchi Sabogu** Project Advisor, Project team
10	12:00-12:10	Comments by participants	**MoH/GHS**
11	12:10-12:30	Presentation on Study Tour in Japan and action plan	**Dr. John Bertson Eleeza Regional Director, NR/Project Manager Participants of study tour**
12	12:30-13:00	Report of study tour in UWR	**Representative from three groups**
13	13:00-13:15	Project Related Issues	**Ms. Satoko Ishiga Chief Advisor, Project Team**
14	13:15-13:20	Remarks by JICA Representative	**Ms. Ozawa Maki Snr. Representative, JICA Ghana Office**
15	13:20-13:30	Way Forward	**Dr. Winfred Ofosu Regional Director, UER/Project Manager**
16	13:30- 13:35	Closing Remarks	**Dr. Patrick Kuma-Aboagye Director General, GHS/Project Director**
17	13:35-13:40	Closing Prayer	**To be selected**

MC: Mr. Jacob Acquah Andoh, PRO, GHS HQ

Compiled by:

Abu Dokuwie Alhassan.....
(Senior Project Coordinator)

Reviewed by:

Zacchi Nolan Sabogu.....
(Project Advisor)

Endorsed by:

Ms. Satoko Ishiga .....
(Project Chief Advisor, IC Net)

Ms. Maki Ozawa.....
(Senior Representative, JICA Ghana Office)

Dr. Patrick Kuma-Aboagye.....
(Director General, Ghana Health Service)

Strengthening Community-based Health Services Focusing on the Life-course Approach in the Upper West, Upper East and Northern Regions (CHPS for Life)

Minutes of 6th Joint Co-ordination Committee (JCC) Meeting
Date: 9th July 2021
Venue: Accra City Hotel, Accra

1. Introduction

The 6th in the series of Joint Coordination Committee meetings of the CHPS for Life Project came off on the 9th of July 2021 at the Accra City Hotel.
In attendance were fifty-eight (58) participants drawn from the Ministry of Health, Ghana Health Service headquarters, JICA/project, Regional Coordinating Councils, Regional Health Directorates, District Health Directorates, and training schools.
The detailed list of participants and the agenda of the meeting are attached as annexes 1 & 2 respectively.

2. Summary of key issues

✧ ***Progress of project activities:***

- Contributory factors such as covid-19, delay in return of Japanese Experts, delay in the release of the revised curriculum for training nurses and security threats from neighbouring Burkina-Faso had significant effect on project activities These factors did not only caused the delay in the implementation of key activities but also the need to re-strategize the organization of some activities. Members therefore agreed that, the one-year extension proposed by the project was needful and appropriate.
- Despite these challenges, implementation of some project activities continued except for activities that required the presence of the Experts. The ingenuity of the project to use the Regional Management Meetings for decision making to support these activities was commendable.

✧ ***Current situation of the regions***

- Even though the project has rolled out innovative activities such as the DCHOO, Supportive Supervision, HIAP amongst others, inadequate funding to supervise these activities and to fully support pilot activities were of major concern to the regions and the pilot districts. It was therefore discussed that members of parliament need to be brought on board in order to explore other funding mechanisms.
- Inadequate registers to capture data during service delivery was another concern for the regions and it was agreed that the project should engage PPMED to standardize and integrate the LCA register into a national NCD register and to explore opportunities of making the existing registers into electronic registers. In addition, it was agreed that the project should work with PPMED and the SS Coordinator to adopt the revised CHAP format and to adapt the SS checklists to be uploaded onto the online platforms.

✧ ***Modification of PDM***

- The modified PDM was approved by popular acclamation on the basis that all the assumptions considered in developing the PDM will not change significantly within the project period.

3. Opening/Welcome Address – Dr. Anthony Adofo Ofosu, Deputy Director General, GHS HQ

The Deputy Director General of the Ghana Health Services, Dr, Addo Ofosu in his opening remarks, commended the regional teams and the project for continuing project activities even in the face of the Covid-19 Pandemic. He indicated that system-strengthening activities are

particularly important during these times, as the healthcare system has become saddled with quite a number of challenges following the Covid-19 pandemic. He thanked all for making time to participate in the JCC and asked for effective participation.

4. **Achievements and plans for second term – Dr. Damien Punguyire, RDHS and project Manager UWR.**

The RDHS and project Manager of the Upper West Region made a presentation on the progress and plan of project activities. He stated that the Covid-19 Pandemic, delay in return of Japanese experts and a delay in the release of the revised curriculum for training schools have all contributed to a delay in some project activities. As a result, he added that the possibility exists for an extension of the project by a year.

He proceeded to present the progress and plan of activities by output areas.

Output 0 Management

Activities	Progress and Plan
1. Joint Coordination Committee(JCC) meeting	• Conducted 6 times • Suspended since January 2020, conducted in July 2021 • Planned for December 2021/January 2022, June and November 2022, June 2023
2. Coordination meeting of three regions	• Conducted 5 times • Suspended since January 2021, conducted in July 2021 • Planned in December 2021/January 2022, June and November 2022, June 2023
3. Regional management meeting	• Conducted in November 2020 and February 2021 • Decision making meeting of regions during the suspension period of JCC. • Planned to continue quarterly in between JCCs
4. Monitoring visits by GHS	• 2 times • Suspended since August 2020 • To be conducted once in 2021 and 2022
5. Modification of PDM	• 1 time in January 2020 • Conducted in June 2021 by Zoom
6. Reports	• 2nd Progress report was submitted in January 2021 • Monitoring sheet versions 6 and 7 were submitted • 3rd progress report to be submitted in Jan. 2022 and the 4th in Jan. 2023 • Completion report in June 2023 • Three monitoring sheet versions 8, 9 & 10 to be submitted in January and June each year until June. 2023

(i) Output 1

Main Activities	Progress
1. CHPS database	• Regular update of quarterly CHPS database and utilization in all five regions. • Capacity building of DHMT on utilization of CHPS database for the development of CHPS implementation strategy(UER, NR/NER/SER) • Defined Basic CHPS equipment in collaboration with PPMED • Modification of CHPS database and Development of CHPS database manual for dissemination • Preparation for national dissemination in November 2021

2. CHO production (Harmonized CHO training and District CHO Orientation)	• Conducted two extra **Harmonized CHO trainings (Theory)** for UWR 81, NR /NER /SR 120: 201 CHO were trained. • Completed the introduction of **District CHO orientation** in all districts in UWR, NER, NE, SR and 12 districts in UER. • **Established alternative model of low cost CHO production** by combining Harmonized CHO training (Theory only) and District CHO orientation (Practicum) • **Trained 546 CHOs (UWR 160, NR 84, NER 35, SR 38, UER 229) using the DCHOO**
3. Pre-service training	• Developed a modified pre-service training model. • Conducted strategic meetings with NAP, NAC and MTC tutors in 3 regions to come up with content for pre-service training. • Developed proposals for N&MC curriculum review. • **Suspension of pilot pre-service training**; it will commence between October –December 2021 with the launch of new training schools curriculum
4. Supervision	• Customized a national **SS tool for supervision at CHPS level. Pilot utilization** is ongoing at Nadowli, Savelugu-Nanton and Talensi. • SS implementation rate (as of Q1-2021): **90.9 %(UWR), 83.97% (UER), 55.57% (NR).** • **All SS trainings were completed** in the districts by August 2020. • Regularly conducts monitoring and technical support to the pilot districts in their SS implementation. • **SS review meetings** were held in all pilot districts, except Savelugu-NR, to share the result of supervision and discuss areas for improvement.
5. Referral	• **Developed "Referral Monitoring tools"** to monitor referral and feedback at facility and district levels. • Conducted **referral orientation on new tools *in pilot districts*** (including hospitals) in January 2021. The pilot activity is currently ongoing. • **Developed a format of "Standard Referral Telephone Directory"** with a mechanism of regular updates. • Conducted **referral systems training for about 140 staff of the new UW Regional hospital staff**. Selected staff were also trained on the referral monitoring tools.
6. DHMT review mtg	• **Developed a Standard reference guide for the DHQPR meeting** through piloting and three joint taskforce meetings with 3 regions • **Organized DHQPR Orientation meetings in all** districts (DHMT and hospital staff) of UWR, UER and NR • **Planned to support one round of DHQPR in selected districts**

Challenges

- Delay in release of updated curriculum affecting the roll out of pre-service activities.
- Low commitment to the use of CHPS database by some districts and regions.
- Poor Referral Feedback Rate: 7.6% (UWR), 36.5% (UER), 18% (NR) as of Jan. 2021 at CHPS.
- Inadequate funding of districts affecting their ability to implement some activities including DCHOO, Supportive Supervision and DHQPR

Plan for output 1 activities

- National dissemination and establishment of CHPS database in all districts between November 2021 and June 2023
- Finalisation of DCHOO materials by November 2021

- Development of pre-service training materials and deployment of pre service training in schools.
- Conduct DHQPR orientation in NER and SR in August 2021

(ii) Output 2

Main activity	Summary
1. Strengthening of CHAP implementation	• Conducted the second training on CHAP tools for CHO/SDHT in March 2020 • Conducted quarterly monitoring of CHAP tools utilization • Modified CHAP tools will be integrated into the CHPS National Implementation guidelines
2. Capacity development of CHMC/CHVs on LCA	• Finalization of LCA Video clip in February 2020 • Finalized the CHMC/CHV training material • Producing a Ghanaian version of exercise video • The project intends to incorporate the CHMC/CHV training into the District CHO Orientation and pre-service training.
3. Implementation of Non-Monetary Incentive activities	• Selection of incentive items/activities and pilot implementation since September 2020. • Completion of the first round of the pilot from Sep. 2020 to Feb. 2021. • The second round pilot is ongoing from March to August 2021 • The project will propose a package on Non-monetary Incentive to the GHS HQ.

Challenges

- Modified CHAP format yet to be approved as a national standard.
- Use of IGF as a source of funding for NMI activities not very reliable. There is a need to explore alternative funding sources.
- CHVs in non-pilot communities have expressed their displeasure for not being included in the NMI activities.

(iii)Output 3

Main activity	Summary
1. HIAP formulation	• Project provided the necessary technical support to districts in the formulation of HIAP with budgets in 2020 • 100% of DAs (11 DAs of UWR, 15 of UER, 3 of NR and 1 of NER) formulated HIAP with budget for 2020. • RCC/DA engagement meeting in UWR, UER and NR (with NER &SR) for HIAP formulation • Finalization of reference material at TWG meeting
2. HIAP Monitoring	• The project provided enhanced support to DPCU to write monitoring reports and submit to RPCU. • 65% of DAs of UWR, 67% of UER and 33% of NR implemented HIAP quality monitoring in 2020
3. HIAP implementation	• Implementation rate of plans: 45% in UWR, 57% in UER, 63% in NR and 75% in NER, implemented plan in 2020.

Challenges

- HIAP endorsements at the RCC sometimes delays, leading to a delay of the entire process
- Irregular flow of funds to DAs' affects their ability to implement some of the activities.
- Delay in the finalization of the reference material for HIAP due to the Covid-19 pandemic.

(iv) Output 4

Activities	Progress & plan
1. CHO/SDHT training on LCA	• Modified the training package on LCA to include a new module on Covid-19 • Development of LCA manual in May 2021 • Conducted the 2nd and 3rd trainings in March 2020 and June 2021 • Preparation of post training follow up (development of monitoring tool etc.) • Plan to incorporate the contents of CHO/SDHT training on LCA into pre-service training materials (theory) and District CHO Orientation (Practicum)
2. Development of LCA register	• Finalization of LCA register to capture data (BMI, BS, BP and WC and follow up.) • Collaborative work with GHS HQ to integrate NCD data into DHIMS 2. • Analyzed data on NCDs in the register • Standardization of LCA register as national data collection tool. • Integration of the NCD risk data into DHIMS 2
3. Integrating LCA into basic package of CHPS services	• The project will promote the incorporation of LCA service package into national CHPS implementation guidelines

Challenges

- Covid-19 pandemic affected the roll-out of the 3rd and 4th batches of the CHO/SDHT training on LCA
- A delay in starting pre-service training pilot activities has also affected the integration of LCA into the basic services of CHPS.

Discussions from progress and plan presentation

- There is a need to engage the HR division of GHS to review the scope of work and training needs of CHOs due to the increasing number of activities being added to their work.
- The project should consider completely funding pilot activities to ensure that they are implemented fully. This will enable the full implementation of these activities and lessons can be drawn from them.
- To support HIAP activities, the various members of parliament in the districts need to be brought on board. This will make it possible for the NHIS allocation to districts to be used to support HIAP activities.

5. Regional presentations

UER- Mr. Emmanuel Aabina

- The region has recorded marked improvements in CHPS indicators including an increase in functional CHPS from 337 in Q1 2020 to 427 in Q1 2021
- The DCHOO concept has been adopted by the region, leading to the training of 71 new CHOs.

Challenges;

- Inadequate funds to effectively supervise the DCHOO activity
- Staff attrition affecting the quality of CHPS data captured in the CHPS database
- Referral feedback from higher to lower facilities challenging.
- Inadequate registers to capture data during service delivery.
- Unrealistic planning and budgeting affecting HIAP activities.

NR- Mr. Anthony Sopaal

- Sixty-three CHOs are being trained using the DCHOO approach. All districts in the region have adopted the approach and are implementing it effectively.
- RHMT supported the Kpandai district to implement the DCHOO activity as a model district.
- CHPS zones demarcation in the region has not attained the targeted 100% due to a number of data capture issues in Tamale Metro and Nanton.

Challenges;

- Poor equipment status at CHPS zones affecting CHPS service delivery
- Staff attrition is affecting CHPS functionality.
- District Assemblies not adhering to the nationally approved prototype for CHPS construction. This leads to some facilities lacking basic components such as washrooms.

SR- Mr. Sarfo Adjei Kwabena

- Number of functional CHPS zones in the region has increased due to the roll-out of District CHO Orientation in the region. RHMT has directed and supported all districts to adopt the approach
- Thirty-two (32) staff of the region were supported by the project to undertake a study tour to the Upper West Region where they understudied the implementation of CHPS and the Life Course Approach by the UWR team. .
- With an increase in number of demarcated CHPS from 166 in Q1 2020 to 176 in Q1 2021, the region has attained 100% CHPS demarcation.

Challenges;

- Poor equipment status at CHPS zones affecting CHPS service delivery
- Unavailability of service delivery registers is also a challenge at the CHPS level.

NER- Mr. Adam Anas

- Number of functional CHPS zones in the region has increased due to the roll-out of District CHO Orientation in the region.
- Two (2) CHPS zones in the region are now fully equipped and can now be used as model zones for CHO production.
- The DA engagement approach (HIAP) has led to greater investments in CHPS compound construction in the East Mamprusi district. The district has gone ahead to start equipping the compounds to support service delivery.

Challenges;

- The North East Region is often allocated very few numbers of CHNs, as a result, even if the region had enough support to train CHOs, they would not have enough CHNs to train.
- Inadequate basic equipment for service delivery including motorbikes
- Although the DA is supporting in compound construction, it is not adhering to the GHS approved CHPS compound design. This leads to the construction of CHPS without accompanying accommodation facilities for the staff.

UWR- Mr. Ambrose Naawaa

- The region with the support of the World Bank has procured some equipment and medicines for the CHPS zones

- UNICEF has supported the region to conduct community score card training for 8 of the 11 districts.
- A reclassification of the basic equipment at CHPS zones has seen the number of completed CHPS zones in the region drop from 80 in Q1 2020 to 16 in Q2 2021

Challenges;

- There is high attrition of CHOs in the region leading to fluctuations in CHPS functionality in the region.
- Frequent changes in CHPS coordinators affect their ability to utilize the CHPS database. Currently, 45% of the CHPS coordinators are new and do not know how to navigate through the CHPS database.
- Referral feedback from hospitals to lower facilities remains a challenge.
- Inability to conduct joint DA/DHMT monitoring of HIAP activities leads to poor implementation of some of the activities.

Discussions from regional presentations

- Project should consider extending pilot activities to the non-pilot districts.
- SR requests the project to share the adapted SDHT to CHPS checklists with the non-pilot districts to implement it on their own.
- The project should consider funding the pilot activities so that the best lessons can be learnt from these activities.

6. Presentation on NCDs related Data captured in the LCA register

Ms. Satoko Ishiga project Chief Advisor made a presentation on NCD related data that had been captured using the LCA registers. The data was captured from the CHPS zones (community data) between March and November 2020.

- About 254 people were screened within the period, comprising 147 (58%) females and 107(43%) males.
- In terms of age distribution, majority (52%) of those screened were between 20-30 years, whilst the aged (60+) accounted for 19%.
- Majority (57%) of those screened, had their screening done at home (during home visits).
- In relation to blood pressure readings, 17% had a high blood pressure (>140 or >90). For BMI, 68% had normal BMI whilst 4% were obese (BMI >30kgm^2)
- Waist circumference readings showed 8% with reading above the normal cut-off point and 62% with normal waist circumferences.
- A healthy lifestyle assessment questionnaire was also used to assess the lifestyles of those screened. About 85% were found to be healthy whilst 1% were unhealthy.
- The ability of health workers to correctly calculate and assess screening results and proffer appropriate follow-up actions was also assessed. Only 26% of health workers assessed could accurately calculate BMI whilst 59% could assess BMI accurately.

7. Modification of PDM

Mr. Zacchi Sabogu, the Project Advisor, made a presentation on modifications to the Project Design Matrix (PDM). He stated the rationale of the PDM modification as;

1. Target values of indicators in PDM are not yet fixed. Those previously agreed were based on 2020 data. They have to be decided based on the current status.

2. The Project is preparing for 1 year extension. The target values should be fixed based on the new project completion date i.e. June 2023.

The following modifications have therefore been made;

- Overall goal of the project be modified to read " population covered by functional CHPS zones in the five northern regions reached by the end of 2025 as follows:
- Target values have been set for the project purposes (Purpose 1, 2 and 3).
- Under output 1, an indicator "number of CHO trained through district CHO orientation" has been added.
- Output 1-3, on referrals; indicator 1 has been changed to "number of facilities" instead of "number of beneficiaries". Target values have also been set for the indicators 1, 2 and 3.
- Indicators 1, 2, 3 and 4 of output 1-4 have been changed and target values set for indicator 2.
- Output 1-5 on CHPS database has the indicator 1 (number of regions in which CHPS database is established) has changed from 5 to 16.
- Target values have been set for all indicators in output 2, 3 and 4

Discussion of modifications to PDM

- Pre-service education for the Life Course Approach (LCA) should not focus on only Community Health Nurses (CHNs) but should include other cadres such as Midwives, RCNs and Staff Nurses.
- Dr. John Bertson Eleeza, RDHS for NR, moved for the adoption of the modified PDM. Dr. Emmanuel Dzotsi, RDHS of UER, seconded the adoption of the PDM.
- The modified PDM was then adopted by popular acclamation.

8. Issues and concerns – Ms. Satoko Ishiga

The Project Chief Advisor, Ms. Satoko Ishiga in presenting issues and concerns of the project stated that;

- New members of JCC have been added, including Dr. Damien Punguyire, the RDHS of UWR and Dr. Emmanuel Kofi Dzotsi the RDHS of UER. She added that the project has recruited two new officers in the persons of Mr. Naoyuki Yamada, a project Coordinator and Mr. Yakubu Abdulai Andani, a driver for the NR office of the project.
- JICA has taken strict security measures, barring Japanese experts from entry into the five Northern Regions. As a result, activities involving Japanese experts will be conducted in Accra and other regions. Local staff will continue activities in the Northern Regions.
- National dissemination of the CHPS database is tentatively planned for 10-12 November 2021. The meeting will be facilitated by PPMED and officers from the 5 Regions of the North.
- JICA has purchased basic equipment for CHPS service delivery. The equipment were purchased based on gaps identified by the regional teams and from data on the CHPS database.
- Next JCC meeting; November 2021 or January 2022

9. Closure

***Remarks by JICA representative – Mr* Yasumichi Araki**

The JICA Ghana Senior Representative, Mr. Yasumichi Araki in his remarks; stated the following;

- Expressed appreciation to the DG and GHS for continuously supporting the CHPS for Life Project and other JICA projects particularly during these pandemic times.

- Indicated the need for building stronger and more resilient health systems considering the impact of the pandemic. He added that JICA is happy to collaborate with the GHS and other stakeholders in building these systems.
- Expressed his understanding and appreciation of the various challenges that currently bedevil the health system including inadequate equipment and the funding gaps. Called for broader stakeholder engagements to address these challenges.
- Stated that JICA working with the GHS is procuring equipment worth $1.2 million to support CHPS services in the five regions of the North.

Remarks – Dr. Addo Ofosu Deputy DG, GHS

The Deputy DG made the following comments in his closing remarks:

- Appreciated JICA for all the support offered the GHS especially the CHPS for Life Project that seeks to implement the Life Course Approach in Ghana.
- Directed the National SS Coordinator/Director of nursing to work with the project to integrate the adapted SDHT to CHPS SS checklists into the national SS checklists and to upload it to the online platforms.
- Asked that the project engage PPMED to standardize and integrate the LCA register into a national NCD register. He also asked that the project work with PPMED towards making the existing registers into electronic forms to reduce the cost of production.
- Directed PPMED to consider the issue of inadequate registers in the various facilities. He indicated that data is very important in the healthcare delivery and as a result, registers have to be available to capture the data.
- Stated that from the national EMONC study and the presentations made, serious equipment gaps exist in the system, he therefore expressed appreciation to JICA for the equipment being supplied to the five regions. He asked that similar attention be paid to the rest of the regions.
- He thanked all participants for the efforts that have been put in place to address the set objectives.

Compiled by:
Kassim Abdul-Basit.....
(Senior Project Coordinator)

Reviewed by
Zacchi Nolan Sabohu.....
(Project Advisor)

Satoko Ishiga.....
(Chief Advisor)

Mr. Takuya Shizume .....
(Health Sector Representative)

Dr. Anthony Adofo Ofosu.....
(Deputy Director General, GHS)

Annex 1: List of Participants

No	Name	Sub District/Facility	Background/Position
Greater Accra (MoH, GHS and NMCG)			
1	Dr. Anthony Adofo Ofosu	GHS HQ	Deputy Director General
2	Dr. Kofi Issah	GHS HQ	Director, Family Health Division
3	Dr. Da-cosata Aboagye	GHS HQ	Director, Health Promotion Division
4	Dr. Andrews Ayim	GHS HQ	Deouty Director, Policy
5	Ms. Eva Mensah	GHS-HQ	Chief Nursing Officer, ODG
6	Mr. Jacob Acquah Andoh	GHS HQ	Public Relations Officer
7	Ms. Aseye Afi Kpodotsi	GHS HQ	CHPS for Life Focal Person, PPMED
8	Ms. Esther Afari	GHS HQ	Secretary, PPMED
9	Ms Rachael Quartey Papafro	GHS HQ	Admin Manager
Japan study tour team			
10	Dr. John Bertson Eleeza	RHMT NR	Regional Director of Health Service
11	Dr. Josephat A. Nyuzaghl	RHMT UER	Deputy Director, Public Health
12	Dr. Mathias Pogvi Tengan	Lambussie Polyclinic, UWR	Principal Medical Officer
Upper West Region			
13	Dr. Damien Punguyire	RHMT UWR	Regional Director of Health Services
14	Dr. Richard Wodah-Seme	RHMT UWR	Deputy Director, Public Health
15	Mr. Ambrose Naawa	RHMT UWR	Regional CHPS Coordinator
16	Mr. Anthony Kullah	RHMT UWR	Nutrition Officer
17	Alh. Haruna Tiraah	Jirapa CHNTC, UWR	Principal
18	Ms. Phoebe Balagumyetime	DHMT, Nadowli, UWR	DDHS
19	Mr. Clifford Yeng	DHMT, Wa West, UWR	DDHS
20	Mr. Nii Adjaye Laryea	RCC UWR	Regional Economic Planning Officer
Northen Region			
21	Dr. Baba Braimah Abubakari	RHMT NR	Deputy Director Clinical Care
22	Dr. Hilarius Abiwu	RHMT NR	Deputy Director, Public Health
23	Mr. Jeremiah Tiimob	RHMT NR	Deputy Director, Administration
24	Mr. Anthony Sopaal	RHMT NR	Regional CHPS Coordinator.
25	Mr. James Aglah	RHMT NR	Health Information Officer
26	Ms Rahinatu Fuseini	RCC NR	Chief Economic Planning Officer
27	Mr Musah Bashiru	DHMT, Savelugu, NR	DDHS
28	Ms. Comfort Kona	Tamale CHNTS, NR	Principal
29	Dr. Abdulai Abukari	RIIMT, NER	Regional Director of Health Services
30	Mr. Adams Anas	RHMT, NER	Regional CHPS Coordinator
31	Mr. Mark Abugri	DHMT, East Mamprusi, NER	DDHS
Savannah Region			
32	Dr. Chrysantus Kubio	RHMT, SR	Regional Director of Health Services
33	Mr. Sarfo Adjei	RHMT, SR	Reg. CHPS Coordinator
34	Mr. Dubik Daniel Dindiok	DHMT, Central Gonja, SR	District Director of Health Services

Upper East Region			
35	Dr. Emmanuel Dzotsi	RHMT UER	Regional Director of Health Services
36	Dr. Razak Dukurugu	RHMT UER	Deputy Director, Clinical Care
37	Mr. Emmanuel Ansu Abina	RHMT UER	Regional CHPS Coordinator
38	Mr. Alhaji Abdul Rafiu Agboola	Navrongo(Kasena Nankana Municipal) CHNTC, UER	Principal
39	Mr. Andrews Akumbutum	RCC UER	Desk Officer for Health
40	Ms. Estella Abazesi	DHMT, Talensi, UER	DDHS
EoJ, JICA and CHPS for Life Project staff			
1	Mr. Yasumichi Araki	JICA Ghana	Chief Representative
2	Ms. Maki Ozawa	JICA Ghana	Senior Representative
3	Mr. Takuya Shizume	JICA Ghana	Health Sector Representative
5	Ms. Satoko Ishiga	JICA Project	Chief Advisor, Community Health Expert
6	Ms. Junko Kanehiro	JICA Project	IEC/SBCC Expert
7	Mr. Naoyuki Yamada	JICA Project	Project Coordinator
8	Ms. Asako Hayashi	JICA Project	Project Coordinator
9	Mr. Zacchi Sabogu	JICA Project	Project Advisor
10	Mr. Kassim Abdul-Basit	JICA Project	Senior Project Officer
11	Mr. Abu Dokuwie Alhassan	JICA Project	Senior Project Officer
12	Mr. Raymond Alirigia	JICA Project	Project Officer
13	Mr. Sharifdeen Amadu	JICA Project	Junior Project Coordinator
14	Mr. David Ngmenebang	JICA Project	Junior Project Coordinator
15	Mr. Gamuo Roger	JICA Project	Project Officer/Administrative Officer
16	Mr. Benjamin Mpuan	JICA Project	Project Officer/Administrative Officer
17	Ms. Nasagrey Mma Mabel	JICA Project	Administrative Assistant
18	Mr. Iddrisu Razak	JICA Project	Driver/Mechanic
19	Mr. Vincent Botah	JICA Project	Driver/Logistics

Annex 2: Agenda for the 6th JCC Meeting

Venue: Accra City Hotel, Accra

No.	Time	Activity	Person Responsible
1	09:30 -10:00	Registration	GHS/JICA
2	10:00 -10:10	Introduction of participants	**Mr. Jacob Acquah Andoh** PRO, GHS-HQ
3	10:10 -10:15	Introduction of Chairperson	**Mr. Jacob Acquah Andoh** PRO, GHS-HQ
4	10:15 -10:25	Chairperson's opening remarks and purpose of the JCC	**Dr. Patrick Kuma-Aboagye** Director General, GHS/Project Director
5	10:25-11:00	Progress and plan of the project, Discussion	**Dr. Damien Punguyire** Regional Director, UWR/Project Manager
6	11:00- 12:00	Presentation on implementation of Project activities and situation in the regions, Q&A	**Representatives of regions UWR, UER ,NR, NER, SR**
7	12:00-12:15	Tea break	
8	12:15-12:25	Summary data on NCD and referral	**Ms. Satoko Ishiga** Chief Advisor, Project team
9	12:25-12:45	Modification of PDM Approval	**Mr. Zacchi Sabogu** Project Advisor, Project team
10	12:45 - 12:50	Issues and Concerns	**Ms. Satoko Ishiga** Chief Advisor, Project Team
12	12:55-13:00	Remarks by JICA Representative	**Mr. Yasumichi Araki** Chief Representative, JICA Ghana Office
14	13:15- 13:25	Closing Remarks	**Dr. Patrick Kuma-Aboagye** Director General, GHS/Project Director
15	13:25-13:30	Closing Prayer	To be selected
16	13:30-14:30	Lunch	All

Strengthening Community-based Health Services Focusing on the Life-course Approach in the Upper West, Upper East and Northern Regions (CHPS for Life)

Minutes of 7th Joint Co-ordination Committee (JCC) Meeting
Date: 26th January 2022
Venue: Miklin Hotel, Kumasi

1. Introduction

On January 26, 2022, the GHS/JICA CHPS for Life Project successfully held the 7th Joint Coordination Committee meeting at the Miklin Hotel in Kumasi. A total of fifty-eight (58) participants, comprising staff from the Ghana Health Service headquarters, Ministry of Health, JICA/Project, Regional Coordination Councils, Regional Health Directorates and training schools attended the meeting. Dr. Kofi Issah, Director, FHD at the Ghana Health Service Headquarters, chaired the meeting on behalf of the Director General.

The detailed list of participants and the agenda of the meeting are attached as annexes 1 & 2 respectively.

2. Summary of key issues

i. *Sustainable funding for CHPS*: the Deputy Director Policy, PPMED- GHS-HQ, outlined two key sources of funds for CHPS activities. It was explained that there is an overall plan to secure funds from the World Bank to enhance the attainment of UHC in the country for which CHPS is a major component. In addition, funds will be allotted to support CHPS operations as part of the Network of Practice.

ii. *Career path for CHNs*: There was the concern that many community health nurses did not return to carry out duties they originally performed after they completed a higher education course but wanted to be assigned new roles. Additionally, other community health nurses were moving out of the CHN role to other professional groups after the attainment of higher education qualifications. This has caused high numbers of attrition and the tendency for community based services to suffer. A need has therefore arisen to devise a career path for health staff providing community based services to attain the highest academic levels whilst maintaining their core mandate. MoH/GHS must consider defining clear higher education and career paths for CHNs with appropriate incentives for those working in deprived communities. The current situation pertaining to the carrier path for CHNs is quite unclear. In response, Dr. Barnabas Yeboah announced that Diploma level trainees in community health nursing would soon be awarded certificates as PHNs. This is to align with degree programmes offered in universities so that CHNs can pursue higher education. He added that certificate level CHNs can also upgrade to become midwives or obtain diploma certificates that permit them to pursue degrees. Again, he noted that access or mature student opportunities can also be explored by CHNs.

iii. *Data sharing on LCA*: Having piloted the LCA in UWR over the past few years, the Project was requested to share data on the implementation and relevance of the approach thus far. The rural-urban dichotomy in CHPS especially in relation to LCA implementation will be particularly helpful.

iv. *Inclusion of blood sugar in NHIS benefit package*: GHS-HQ agreed to engage NHIS on the need to cover the cost of Blood Sugar Test as the current cost prevents clients from accessing the service as part of LCA screening undertaken in CHPS Zones.

v. *Integrating SS at CHPS into the national SS framework:* The CHPS for Life Project is working with GHS-HQ and Impact Malaria to migrate Sub district-CHPS SS checklist onto Health Network Quality

Improvement System (HNQIS) to be used to conduct supportive supervision from the Sub-district to the CHPS level.

3. *Revision of National CHPS Implementation Guidelines:* There is an urgent need to revise the National CHPS Implementation Guideline given that the last revision was in September 2016. The Deputy Director of Policy, PPMED of GHS, Dr. Andrews Ayim indicated that GHS considers the revision eminent. *He added that GHS, Ghana College of Surgeons and Physicians (GCSP) and the York University, Toronto are currently conducting a study on urban CHPS and other related issues and their findings would be useful in the review process.*

4. **Opening/Welcome Address – Dr. Kofi Issah, Director - FHD, GHS HQ**

In his opening remarks, Dr. Kofi Issah, Director- FHD, GHS HQ, appreciated all participants for continuously prioritizing the JCC amidst their busy schedules. He further commended the various RDHS and their teams for their crucial support in piloting and implementing various Project interventions in their respective regions. Given that the Project is nearing completion, he called on members to consider discussions on sustainability approaches for the various interventions. He also mentioned that he expected discussions to focus on progress of key project activities, notable challenges as well as collectively forging a way forward. He then proceeded to welcome all members to the meeting.

5. **Presentation on Progress and Plan of Activities - Dr. Emmanuel Dzotsi, RDHS, UER**

On behalf of all RDHS' of implementing regions and the Project, Dr. Emmanuel Dzotsi made a presentation on the progress and plan of project activities. He appreciated efforts by the Project to strengthen health service delivery in the respective regions and then proceeded to present the progress and plan of activities by output areas.

(1) Output 0: Management activities

Activities	Progress and Plan
1. Joint Coordination Committee (JCC) meeting	• Conducted 7 times (including the 7th JCC on January 26, 2022) • Planned in June and November 2022, and May 2023
2. Coordination meeting of three regions	• Conducted 6 times (including the 6th Coordination meeting on January 25, 2022) • Next Coordination meeting will precede the next JCC
3. Regional management meeting	• Conducted in May/June 2021 • The next set of Regional Management Meetings is scheduled for April 2022 • Continue in between JCC
4. Monitoring visits by GHS	• 3 times (including the 3rd, one conducted in October 2021) • Next monitoring is scheduled for October, 2022
5. Modification of PDM	• Modified PDM Version 3 was approved by JCC in July 2021 • (Modification by R/D is ongoing)
6. Reports	• 3rd Progress report was submitted in January 2022 • Monitoring sheet version 8 was submitted in Dec. 2021 • 4th progress report in January 2023 • Completion report in June 2023 • Three monitoring sheets: version 9 & 10 in June and December 2022 respectively.

(2) Output 1: Strengthening CHPS implementation and systems

Main Activities	Progress
1. CHPS database	• National Dissemination of CHPS database conducted in November 2021 (79 RHMT, HQ for Day 1, 119 RHMT, HQ and DHMT for Day 2) • Introduction of CHPS database in Eastern Region done in November 2021 • Plan of regional CHPS database orientation in Bono and Ahafo Region in February 2022.
1. CHO production (District CHO Orientation)	• At least one orientation was conducted in all districts in the 5 regions • Selected some CHPS zones for DCHOO
3. Pre-service training	• The revised curriculum was launched in December 2021 by N&MC.
4. Supervision	• The Project customized a national SS tool for supervision at CHPS level. Pilot utilization has been ongoing since August 2020. • Conducted a Joint SS Review Meeting with NR, UER, UWR and national SS coordinators. • Discussion with national level for the incorporation of the SS checklist (CHPS level) into the national SS platform
5. Referral	• Conducted the first District-wide Referral Stakeholder Meeting in Talensi, UER in October 2021. • Held a Joint Referral Review Meeting with NR, UER and UWR in December 2021. • Held a booth camp meeting to review and finalize the Monthly Referral Returns and Referral Feedback Forms to upload onto DHIMS2 Platform.
6. DHMT review mtg	• First DHQPR meeting after the orientation in UWR, UER and NR.

Challenges

- Inclusion of theory part of Harmonized CHO training into the orientation session of DCHOO (Time and Budget)
- Poor quality of DCHOO due to lack of equipment and skilled CHO in CHPS zones
- Most referrals from CHPS sent directly to the hospital have low referral feedback. There is the need to review the Project target to within the remaining Project period.
- Continuous need for referral training due to staff movement
- Conflicting activities and unavailability of funds to conduct quarterly SS
- Lack of funds for conducting regular quarterly meetings
- Difficult to involve District Assemblies to participate in the DHQPR meetings

Plan for output 1 activities

- Establishment of CHPS database system in 8 regions (2022 - 2023)
- Finalization of District CHO Orientation program and tool, ccontinuous implementation to produce CHOs, strengthen capacity of 136 selected CHPS zones for DCHOO (2022)
- Development of pre-service training materials (early 2022), TOT for school tutors (Mar - Apr. 2022) and ssupport to pilot the training in 3 NAC, 3 NAP and 3 MTC in 5 regions (2022 - 2023)
- Review of Referral Monitoring Tools through TWG(Q2-2022) and conduct Referral Stakeholders Meeting (UWR, UER, NR) (Q3-2022)
- SS review meeting with National level (Q3-2022)

- Technical monitoring of DHQPR Meeting (Pilot) (Q3-2022) and conduct Joint Review of DHQPR Meeting (2022 -2023).

(3) Output 2: Strengthening community activities

	Main activity	Summary
1.	Strengthening of CHAP implementation	The "CHAP implementation assessment tool" (revised CHAP format and CHAP assessment tool) has been developed. - The tool has been integrated into the LCA flipchart. - It has also been introduced to CHO, SDHT, CHMC, CHV through trainings (in at least 33 CHPS zones to more than 426 trainees)
2.	Capacity development of CHMC/CHVs on LCA	• LCA video clip was finalized in February 2020 and ready to be released • Finalization and distribution of 228 flipchart in UWR since June 2021 • 1st CHMC/CHV training in 12 pilot CHPS zones • CHO of 21 non-pilot CHPS zones who attended the training replicated same in their CHPS zones • Production of Ghanaian version of radio exercise video in July 2021.
3.	Implementation of Non-Monetary Incentive activities	• The 2nd Pilot implementation of the non-monetary incentive activities has been going on since March 2021. • Experience sharing on the pilot implementation among DHMTs in November 2021.

Challenges

- Sustainability of continuous capacity building for untrained CHOs as facilitators of CHMC/CHV training.
- Identification of appropriate way to disseminate LCA and exercise videos.

Plan for Output 2 activities

- Conduct the 2nd and 3rd CHMC/CHV training (February - April, 2022)
- Meeting on standardization of the CHAP Implementation Assessment Tool with GHS-HQ PPMED (August 2022)
- Learning visit to UWR by RHMT and DHMT of UER, NR, SR and NER on CHAP implementation (October, 2022)
- Disseminate LCA and radio exercise video using broadcasting, SNS or other media (March - May, 2022)
- Meeting with GHS HQ on the CHMC/CHV training (April - October, 2022)
- Evaluation to identify very effective non-monetary incentive activities and sharing the results with UWR (February-March, 2022)
- Meeting with stakeholders (DA, AC/ZC, NHIS, DSW) (March-April, 2022)
- Selecting and proposing a package of non-monetary incentive activities (March-June, 2022)

(4) Output 3: Strengthening governance of CHPS

Main activity	Summary

1. HIAP formulation	• Supported formulation of HIAP with budgets in 2021 • 100% of DAs formulated HIAP with budget for 2021. All RCC except SR endorsed HIAP.
2. HIAP Monitoring	• Supported DPCU to write monitoring reports and submit to RPCU. • The Q2 HIAP 2021 monitoring was implemented by 1/3 of targeted districts in the NR, and by 2 /15 in the UER. The Q3 monitoring was done by 2 /11 districts in the UWR.
3. HIAP implementation	• Sharing implementation status of each DA at the RCC/DA engagement meeting. • Implementation rate of plans: 58% in UWR, 12% in UER, 33% in NR

Challenges

- Delay in endorsement by RCC to start implementation of activities.
- Delay and non-submission of quarterly HIAP monitoring reports to the RCC
- Difficulty in budget allocation from central government
- Delay in the finalization of reference material for HIAP due to COVID-19 pandemic.

Plan of Output 3 activities

- RCC/DA engagement meeting in UWR, UER and NR (with NER & SR) for HIAP formulation (August, 2022)
- Quarterly monitoring and reporting (April, July and October, 2022)
- RCC/DA engagement meeting in UWR, UER and NR (with NER & SR) for annual review of HIAP implementation and monitoring (February, 2022 & 2023)
- Finalization of reference material at TWG meeting (March, 2022)

(5) Output 4: Introduction and Integration of LCA into CHPS Service Package

Activities	Progress & plan
1. CHO/SDHT training on LCA	• The 3rd and 4th CHO/SDHT training on LCA were done. • Finalization of training materials and addition of new module on COVID-19 was done in December 2021. • Development of post training follow up tool in December 2021
2. LCA register	• Modification of LCA register (BMI, BS, BP and WC and follow up) is ongoing.
3. Integrating LCA into basic package of CHPS services	• It will start in February 2022.

(6) Summary of Exit Strategies

Intervention	Exit Strategy
CHPS Database	• Adoption of CHPS database in all regions in Ghana
CHO Production	• Incorporation of the theory part of the Harmonized CHO training into Pre-service training • Incorporation of the practices of the Harmonized CHO training into District CHO Orientation
Referral	• Integration of referral/feedback format into DHIMS 2
SS	• Integration of the modified SS tool for CHPS level into national SS tool
Strengthening of CHAP Implementation	• Promote integration of the "CHAP implementation assessment tool" into the "CHPS national implementation guidelines".
Capacity development of CHMC/CHV on	• Propose and promote the standardization of the CHMC/CHV training as part of activities during the CHMC meeting

LCA	
Implementation of NMI activities	• Propose a package on non-monetary incentive activities to the UWR-RHMT and GHS-HQ
HIAP	• Incorporate HIAP formulation/monitoring into the DA annual planning/monitoring. • Establishment of a mutual learning opportunity among RCC, RHMT, DA, and DHMT by leveraging on existing RCC/DA meetings. • Public display of HIAP results for the information of local communities and stakeholders.
Development of LCA service package	• Promote the incorporation of LCA service package into national CHPS implementation guidelines
CHO/SDHT training on LCA	• Incorporation of the contents of CHO/SDHT training on LCA into pre-service training materials (theory) and District CHO Orientation (Practicum)
LCA Register	• Standardization of LCA register as recording tool for Wellness Clinics

(7) Discussions on the presentation on progress and plan of the project:

- The UER team explained that donor support in procuring equipment, roll out of the District CHO Orientation (DCHOO) and the effective use of the CHPS Database for decision making by managers accounted for the noticeable increase in CHPS functionality and improvement in equipment status in their region as highlighted in the presentation.
- Although the situation of direct referrals from CHPS zones to Hospitals defeats the gate-keeper system, the chairperson explained that peculiar contexts of districts and geographical distribution of health facilities within districts do not allow for strict adherence to the protocol. All members agreed however that, to improve upon referral feedback, hospitals should be impressed upon to provide feedbacks regularly and in a timely manner.

5. Regional presentations

The regional presentations focused on specific outputs or interventions being implemented by the regions.

(1) Savanah Region - Study Tour to UWR and CHPS Contribution by Mr. Adjei Sarfo

- A delegation of 30 health staff led by RDHS, SR, Dr. Chrysantus Kubio, visited UWR specifically to learn about LCA and how LCA services are rendered as well as to learn best practices of CHPS implementation in that region.
- Following the tour, SR has replicated the strong involvement of SDHT leaders in CHPS implementation through the orientation of CHNS (32) as CHOs using the DCHOO approach.
- SR has since observed an increase in CHPS functionality as well as an appreciation in CHPS contribution to selected indicators like ANC registrants, BCG, etc.

Challenges;

- Inadequate knowledge of some DHMT members on the CHPS strategy and the CHPS database.
- Inconsistency of DHIMS 2 data and CHPS database.
- Lack of funds for HIAP activities.

(2) North East Region - HIAP Implementation; successes and future plans by Mr. Adams Anas

- Since 2019 when HIAP started in East Mamprusi Municipality, 3 HIAPs have been developed with most projects completed and others at various stages of completion. These HIAPs are monitored on quarterly basis and review meetings are held annually.
- HIAP has contributed to the construction of several CHPS compounds in the municipality. Motorbikes and equipment have also been procured for some CHPS compounds as a result of HIAP.

Challenges;

- Late execution of planned projects due limited funds or delay in release of funds from government.
- Lack of funds for monitoring
- Limited control over some contractors

(3) Northern Region - Challenges of CHPS Implementation by Mr. Anthony Sopaal

Key challenges observed in CHPS implementation in NR include;

- NR is yet to be fully demarcated into CHPS Zones
- Inadequate CHOs (210) to man demarcated (466) CHPS zones. Staff mix in some CHPS zones seem to focus on curative services.
- Inadequate CHPS compounds with requisite amenities. The situation has forced most staff to provide mobile services to CHPS Zones while residing at Sub-districts.
- There is still a deficit in equipment/logistics as only 5.3% of demarcated CHPS zones have the full set of basic equipment, and 38.6% have no equipment at all. 57.9% of demarcated CHPS zones do not have functioning motorbikes.
- Community mobilization still needs strengthening as only 31.9% of CHPS zones had CHAP which was updated in the last quarter and 37% of the demarcated CHPS Zones are without CHMC.

Recommendations to address the challenges;;

- Status of CHPS implementation should be a key component of the appraisal of district managers.
- HIAP needs to be introduced to all District Assemblies to obtain their support.
- Use on-the-job training methodologies including DCHOO and SS to train more people.

(4) Upper East Region - Referral, SS, DCHOO by Mr. Emmanuel Ansu-Abina

- A model for effective referral system is being piloted in Talensi in UER. The model comes with four key components i.e. Full use of existing referral tools, strengthening intra-district Referral Network, functioning Referral Teams and Transportation.
- Using the DCHOO strategy, UER has trained 556 CHOs to man the 524 demarcated CHPS Zones. The region intends training more CHNs using the strategy so as to ensure 2 CHOs are assigned to each demarcated CHPS zone.

Challenges;

- Referral feedback rate in the region is still low.
- Inadequate accommodation facilities in some CHPS zones
- Inadequate funds to conduct DCHOO at the district level

- SS checklists currently being piloted are bulky

(5) Upper West Region - LCA, Community Mobilization and NMI by Mr. Ambrose Naawaa

- A total of 168 CHOs and 38 SDHT leaders have been trained to render LCA services in their communities. These staff were equipped with tools including the Healthy Lifestyle Assessment Questionnaire (HLAQ), WC tape for adults, holistic assessment checklists, etc. and have been rendering the desired LCA services.
- LCA registers and monthly summary sheets were also provided for documentation.
- To strengthen the capacity of CHMCs, CHVs and community leaders to participate actively in their health, orientation on LCA flipchart developed jointly by the Project and GHS was conducted across the region. About 426 CHMC/CHV/Community leaders and 33 CHOs were trained during the pilot training.
- UWR identified sustainable and non-monetary ways to duly appreciate and motivate community health volunteers. These Non-Monetary Incentive packages are currently being piloted in all districts in the region to standardize a package to become a national strategy for motivating volunteers. These include; support in NHIS subscription, admission of wards into Health Training Schools, Priority attention with ID cards, annual awards for CHMC and Volunteers, etc

Challenges;

- Difficulty in documenting information on repeated visits into the LCA register
- Inability of most staff to calculate BMI
- Inability of clients to pay for blood sugar test
- CHOs who observed the pilot training on LCA using the flipchart could not organize the training in their zones due to lack of funds
- Language barrier impeded the use of the flipchart in some communities
- There are cost elements associated with all the NMIs being piloted
- Difficulty in lobbying for admission for wards into some institutions

(6) Discussions on regional presentations

- According to Dr. Andrews Ayim, Deputy Director of Policy at PPMED, there is an overall plan to secure funds from the World Bank to further UHC in the country for which CHPS is a major component. The funding arrangements will be based on agreed indicators (***Disbursement Linked Indicators***) and funds will be released based on progress with those indicators. It was also noted that proper reporting and documentation is a pre-requisite for soliciting funds.
- Aside from defining a clear career path for CHNs, it was argued that providing enabling work environments with the right infrastructure and equipment as well as incentives would help reduce staff attrition and turnover at the CHPS level.
- MoH and GHS were called upon to provide immediate clearance for the backlog of CHNs who have not been posted to lessen the pressure on staff in CHPS zones. It was explained that there seem to be a shift in focus from EPI service to COVID-19 vaccination and other related issues since the same staff

are required to provide both services concurrently.

MoH Representative, Dr. Barnabas Yeboah indicated that the Ministry of Finance has been engaged and clearance has been given to recruit more staff into the system. He however mentioned that the maldistribution of staff at the district level should be critically examined.

- As part of strategies to incentivize CHNs working in CHPS Zones, GHS should readily approve study leave requests by CHNs in rural areas when they are due. Special concessions should also be given to staff who have worked in rural communities for several years and have earned degrees on their own. The chairperson promised to engage the directors of HRD from both GHS and MoH to relook at the deprivation associated with 'CHNs' and to come up with solutions.
- There is the need to evaluate the difficulty or ease with which community level staff can complete reporting formats and registers so as to manage the continuous deployment of registers into the system.
- RDHS and DDHS were called upon to take full responsibility and become somewhat self-reliant and innovative in raising funds to run the system as the GHS-HQ is also beset with financial challenges.
- To ensure sustainability, volunteer incentive packages should be community driven and managed.
- Care for the aged under LCA is a laudable activity in UWR. The Project, however, needs to make data available to explain how the LCA concept fits into urban CHPS.
- The Project needs to disseminate and air the Ghanaian version of the Physical exercise video and other LCA videos approved by the Health Promotion Division of GHS.
- An appeal was made for the Project, through JICA, to procure some more motorbikes to improve upon the motorbike situation in the various CHPS zones.

6. <u>Presentation on GHS Monitoring</u> – Ms. Aseye Afi Kpodotsi

Ms. Aseye Afi Kpodotsi, CHPS for Life Project Focal Person, GHS-HQ, presented the findings of the 3rd GHS monitoring visit to the Project sites on behalf of the team. The following issues were noted;

- The team monitored the implementation of all Project interventions in selected sites in NR, SR, UWR and UER.
- Although the implementation of interventions were progressing smoothly, a few challenges were observed which informed the following recommendations by the team;
  1. The LCA flip chart should be designed with a stand for easy handling
  2. The Project should procure standard tape measures for height to reduce errors in BMI calculation.

7. <u>Issues and concerns</u> – Ms. Satoko Ishiga

Ms. Satoko Ishiga, Chief Advisor of the Project, in presenting issues and concerns of the project highlighted the following;

- JICA Ghana's restrictions due to security concerns still stand. However, JICA Ghana in consultation with Ghana Police and National Security will grant permission to Japanese Experts to enter restricted zones on case-by-case basis. Dr. Damien Punguyire, RDHS of UWR, added that his team has

arranged with the Police command in UWR to provide escort services to donor partners, experts, visitors and even staff where necessary and at no cost to GHS.

- It has become necessary to define clear funding arrangements for CHPS activities in the country. Dr. Andrews Ayim, Deputy Director of Policy of PPMED at GHS hinted that there are ongoing engagements with the World Bank to fund the network of practice with focus on model health centres. Since CHPS is crucial in the network, budget allocations will be made available for CHPS activities.
- A strong proposition was made for MoH and GHS to define a clear career path for CHNs to curb the high incidence of attrition and turnover. Representative from MoH, Dr. Barnabas Yeboah announced that Diploma level community health nurse trainees will soon be awarded certificates as PHNs. This is to align with degree programmes offered in universities so that CHNs can pursue higher education. He added that certificate level CHNs can also upgrade to become midwives or obtain diploma certificates that permit them to pursue degrees. Again, he noted that access or mature student opportunities can also be explored by CHNs.

  He explained however that, the main challenge relates to the fact that CHNs divert to other cadres or decline to return to serve at the community level once they obtain higher certificates.
- In relation to NCD, it was noted that because NHIS does not cover blood sugar tests, clients in CHPS Zones are unable to access that service. GHS-HQ agreed to engage NHIA on the matter.
- Given that the National CHPS Implementation Guideline was last revised in 2016, members called for another revision of the guideline. In response, Deputy Director of Policy, PPMED of GHS, Dr. Andrews Ayim indicated that GHS considers the revision eminent. He added that GHS, UNDP and the York University, Toronto are currently conducting a study on urban CHPS and other related issues and their findings would be useful in the review process.
- Next JCC meeting is tentatively scheduled for August, 2022. In consultation with DG, the actual date will be communicated to members.

8. Way Forward

Dr. Andrews Ayim

- Network of Practice with Model Health Centres is another policy direction that aims at strengthening CHPS and support systems. *The network of practice strategy is to strengthen the sub-district health system.*
- Aside the CHPS Database, there is a move to use e-tracker to capture data at the CHPS level. Currently, funds are being solicited to procure tablets for facilities.
- Reforms are under way to reduce indicators for programs so that data compilation and usage of registers are not cumbersome processes at the CHPS level.
- To ensure CHPS activities are properly funded, CHPS compounds should be accredited under the network of practice system so that budget is made available for CHPS operations under the network.
- All CHPS for Life Project interventions proposed for adoption will be critically considered and subsequently endorsed in policy.

9. Closure

(1) Remarks by Senior Representative, JICA-Ghana – Ms. Maki Ozawa

In her remarks, Ms. Maki Ozawa stated the following;

- Expressed profound gratitude to GHS, MoH and the Project team for their unrelenting commitment to achieving the various outputs of the Project particularly in the midst of COVID-19 and other security related issues.
- Explained that under JICA's Initiative for Global Health and Medicine, Ghana has become one of the biggest beneficiaries as the agency focused on strengthening CHPS implementation in the country since 2006. She noted that several milestones have been accomplished and particularly, the CHPS Database developed by the Project was crucial in churning out reliable data for the procurement of CHPS equipment for the 5 Northern regions.
- Indicated that JICA looks forward to tangible outcomes and requested the Project to share strategies on how LCA could really work in the country given that it preceded the Wellness Clinic idea. In order to popularize LCA and obtain CP buy-in and sustainability, she called on the team to showcase experiences and best practices from the implementation of LCA in the next JCC.
- Concluded by assuring GHS and MoH of JICA's unflinching support in building a robust health system in the country.

(2) Remarks – Dr. Barnabas Yeboah, Representative, MoH

The Representative from MoH made the following comments in his closing remarks:

- Commended JICA for their support to GHS and MoH over the years and applauded the commitment of RDHS/DDHS and their teams.
- Clearly stated that LCA and other key interventions introduced by the Project have come to stay. As a sustainability mechanism, he proposed that managers should leverage the Network of Practice to make resources available to strengthen CHPS implementation.
- Noted that CHPS functionality is good across the respective regions but asked NER to work harder to improve functionality with the help of the other regions.
- Advised that managers should take advantage of the several e-learning platforms to conduct training for staff as the associated costs are relatively lower.
- Called on all to continue to work together towards the attainment of UHC in the country.

(3) Remarks – Dr. Kofi Issah, Director FHD, Chairperson

Among other issues, the chairperson highlighted the following in his closing remarks:

- The CHPS for Life Project and its interventions are indispensable. There is therefore the need for all counterparts to own the interventions to ensure sustainability.
- Key interventions of the Project should be well packaged and mainstreamed to ensure sustainability. Teams currently introducing the CHPS Database system to new regions were cautioned to take the task seriously.

- RDHS/DDHS and their teams were commended for their contribution to the Project's output so far. Managers were encouraged to be mindful and mentor younger staff and get them involved so as to ensure sustainability.
- Appreciated all members for participating actively in the 7th JCC meeting.

Compiled by:
David Ngmenenbang.....
(Project Officer)

Reviewed by:
Abu Dokuwie Alhassan.....
(Senior Project Coordinator)

Endorsed by:
Satoko Ishiga.....
(Chief Advisor, CHPS for Life Project)

Ms. Maki Ozawa.....
(Senior Representative, JICA Ghana Office)

Dr. Kofi Issah.....
(Director, FHD, GHS HQ)

Annex 1: List of Participants

No	Name	Organization/ District	Background/Position
1	Dr. Kofi Issah	GHS HQ	Director, Family Health Division
2	Ms. Bridget Anim	GHS HQ	Deputy Director, Health Promotion Division
3	Dr. Andrews Ayim	GHS HQ	Deputy Director, Policy
4	Mr. Jacob Acquah Andoh	GHS HQ	Public Relations Officer
5	Ms. Aseye Afi Kpodotsi	GHS HQ	CHPS for Life Focal Person, PPMED
6	Mr. Kwame Bimpeh	GHS HQ	Head, CHIM
7	Ms. Vivian Aubyn	GHS HQ	HRD (Representative)
8	Ms. Winifred Addo-Cobbiah	GHS HQ	PPMED
9	Dr. Barnabas Yeboah	MoH	PPMED
10	Mrs. Emma Hammond	GHS-HQ	PPMED
11	Dr. Horlali Gudjinu	GHS-HQ	PHD
12	Dr. Damien Punguyire	RHMT UWR	Regional Director of Health Services
13	Dr. Richard Wodah-Seme	RHMT UWR	Deputy Director, Public Health
14	Mr. Mohammed Tahir Abarry	RHMT UWR	Deputy Director, Clinical Care
15	Alh. Haruna Tiraah	Jirapa CHNTC	Principal
16	Ms. Phoebe Balagumyetime	DHMT, Nadowli	DDHS
17	Mr. Gordon Bob-Milliar	RCC, UWR	Development Planning Officer
18	Dr. John Bertson Eleeza	RHMT NR	Regional Director of Health Service
19	Dr. Baba Braimah Abubakari	RHMT NR	Deputy Director Clinical Care
20	Dr. Hilarius Abiwu	RHMT NR	Deputy Director, Public Health
21	Mr. Jeremiah Timob	RHMT NR	Deputy Director, Administration
22	Ms. Denisia L. Agong.	DHMT, Savelugu	DDHS
23	Ms. Comfort Kona	Tamale CHNTS	Principal
24	Dr. Abdulai Abukari	RHMT, NER	Regional Director of Health Services
25	Mr. Mark Abugri	DHMT, East Mamprusi	DDHS
26	Dr. Chrysantus Kubio	RHMT, SR	Regional Director of Health Services
27	Mr. Alhassan Abukari	DHMT, STK	District Director of Health Services
28	Dr. Emmanuel Dzotsi	RHMT UER	Regional Director of Health Services
29	Dr. Razak Dukurugu	RHMT UER	Deputy Director, Clinical Care
30	Dr. Josephat I. Nyuzaghl	RHMT UER	Deputy Director, Public Health
31	Mr.Alhaji Abdul Rafiu Agboola	Navrongo CHNTC	Principal
32	Mr. Michael Awuni	RCC, UER	Deputy Director, RCC
33	Ms. Estella Abazesi	DHMT, Talensi	DDHS
34	Mr. Stephen Bordotsiah	DHMT, Bongo	DDHS
35	Mr. Ambrose Naawa	RHMT UWR	Regional CHPS Coordinator
36	Mr. Anthony Kullah	RHMT UWR	Nutrition Officer
37	Mr. Michael Kamal Seidu	RHMT UWR	Nutrition Officer
38	Dr. Matthias Pogvi Tengan	DHMT, Lambussie	DDHS
39	Mr. Musah Ali	RHMT UWR	CHPS Unit
40	Mr. Anthony Sopaal	RHMT NR	Regional CHPS Coordinator.
41	Mr. Adams Anas	RHMT, NER	Regional CHPS Coordinator
42	Mr. Sarfo Adjei	RHMT, SR	Reg. CHPS Coordinator

43	Mr. Emmanuel Ansu Abina	RHMT UER	Regional CHPS Coordinator
44	Ms. Maki Ozawa	JICA Ghana	Senior Representative
45	Mr. Takuya Shizume	JICA Ghana	Health Sector Representative
46	Mr. Prosper N. Tang	JICA Ghana	Program Officer, Health
47	Ms. Satoko Ishiga	JICA Project	Chief Advisor, Community Health Expert
48	Mr. Naoyuki Yamada	JICA Project	Project Coordintaor
49	Mr. Zacchi Sabogu	JICA Project	Project Advisor
50	Mr. Kassim Abdul-Basit	JICA Project	Senior Project Officer
51	Mr. Abu Dokuwie Alhassan	JICA Project	Senior Project Officer
52	Mr. Raymond Alirigia	JICA Project	Project Officer
53	Mr. Sharifdeen Amadu	JICA Project	Junior Project Coordintaor
54	Mr. David Ngmenebang	JICA Project	Junior Project Coordintaor
55	Ms. Anita Aba Wobil	JICA Project	Junior Project Coordintaor
56	Mr. Gamuo Roger	JICA Project	Project Officer/Administrative Officer
57	Mr. Benjamin Mpuan	JICA Project	Project Officer/Administrative Officer
58	Ms. Nasagrey Mma Mabel	JICA Project	Administrative Assistant

Annex 2: Agenda for the 7th JCC Meeting

Venue: Miklin Hotel, Kumasi

No.	Time	Activity	Person Responsible
1	09:30 -10:00	Registration	GHS/JICA
2	10:00 -10:10	Introduction of participants	**Mr. Jacob Acquah Andoh** PRO, GHS-HQ
3	10:10 -10:15	Introduction of Chairperson	**Mr. Jacob Acquah Andoh** PRO, GHS-HQ
4	10:15 -10:25	Chairperson's opening remarks and purpose of the JCC	**Dr. Kofi Issah** Director, FHD
5	10:25-11:15	Progress and plan of the project, Discussion	**Dr. Emmanuel Dzotsi** Regional Director, UER/Project Manager
6	11:15-11:35	Tea break	
7	11:35- 12:15	Findings of GHS Monitoring Tour	**Ms. Aseye Afi Kpodotsi** CHPS for Life Project Focal Person, PPMED, GHS
8	12:15-12:35	Issues and Concerns	**Ms. Satoko Ishiga** Chief Advisor, Project Team
9	12:35 - 12:40	Remarks by JICA Representative	**Ms. Maki Ozawa** Senior Representative, JICA Ghana Office
10	12:40-12:50	Photo taking	All
11	12:50-13:50	Lunch Break	
12	13:50 - 14:40	Presentation on implementation of Project activities and situation in the regions Q&A	**Representatives of regions SR, NER, NR, UWR and UER**
13	14:40 - 14:45	Remarks by MoH Representative	**Dr. Barnabas K. Yeboah** National CHPS Coordinator
14	14:45-14:55	Way Forward	**Dr. Andrews Ayim** **Dep[uty** Director, Policy - PPMED
15	14:55- 15:00	Closing Remarks	**Dr. Kofi Issah** Director, FHD
16	15:00-15:05	Closing Prayer	**Mr. Adams Anas** Regional CHPS Coordinator, NER

Minutes of 8th Joint Coordination Committee (JCC) Meeting
Date: February 16, 2023; Time: 09:25am – 15:00pm
Venue: Noda Hotel, Kumasi

1. **Introduction**

The GHS/JICA CHPS for Life project held its eighth Joint Coordination Committee (JCC) meeting on 16th February 2023 at the Noda Hotel in Kumasi. Among other things, the purpose of the eighth JCC meeting was to share the results of project interventions and achievement of PDM indicators and the plan for upcoming activities. As it is the practice, the meeting brought together participants from the Ghana Health Service (GHS) Headquarters, the Ministry of Health, and leadership of the GHS in the five target regions of the project as well as representatives from the Regional Coordinating Councils (RCCs), District Assemblies and Health Training Institutions (HTIs). In all fifty-eight (58) including JICA Ghana office and project staff participated in the meeting. Dr. Ofori Boadu, on behalf of the Director General (DG), chaired the event. See annexes 1 & 2 for the detailed list of participants and agenda of the meeting.

2. **Summary of key issues**

- ***Calls for a repackaged program for new regions:*** The Regional Director of Health Services (RDHS) for the Savannah Region (SR), Dr. Chrysantus Kubio noted that there is the need for a repackaged program to extend project activities, especially to the new regions of Ghana on the back of the successes highlighted. In line with this, the chairperson, Dr. Ofori Boadu observed that it was a good call and hinted at taking the matter up with the DG.
- ***Plans for Health Network Quality Improvement System (HNQIS) scale-up:*** Following a presentation on using Integrated Supportive Supervision (ISS) to facilitate Network of Practice (NoP) in Nadowli-Kaleo District, Ms. Eva Mensah (Director of Nursing and Midwifery Services) enquired to know whether access to tablets did not come up as a challenge. She noted that it was necessary to know because as part of plans to scale up HNQIS, provision of tablets has come up for consideration. Further, Dr Andrews Ayim, Deputy Director, Policy at the GHS HQ in contributing to the subject noted tablets would form part of the budget of the NoP program. Again, Ms. Eva Mensah hinted that the HNQIS is being finalized following which it will be handed over to PPMED.
- ***Implementation of CHPS database:*** There were concerns why the project was yet to introduce the CHPS database in the Ashanti Region. To that extent, there was a call to delve into the operational challenges preventing that region from coming on board and if there are any issues requiring the action of the GHS HQ, the project could get them involved.
- ***Challenges in the provision of LCA services:*** In providing LCA services, certain challenges came to the fore, notably calculations and classification for certain indicators such as Body Mass Index (BMI). Concerns were raised as to whether the challenges were due to capacity of staff or the calibration of the tools used. In response, Mr. Kullah Anthony, Regional Nutrition Officer of the Upper West Regional Health Administration indicated that although accuracy of calculation was a bit challenging, classification was generally not.

- ***Career progression for CHOs:*** The subject of career progression for CHOs generated significant interest among participants. Contributing to the issue, Mr. Zanu Dassah, a Deputy Director of Human Resource Division (HRD) of the GHS HQ indicated that as far as career progression for CHOs is concerned, more institutions are mounting degree programs to cater for the needs of Community Health Officers (CHOs). Notable among them are the University of Health and Allied Sciences (UHAS), University for Development Studies (UDS) and Wisconsin University. He further noted that the service is making deliberate efforts to ensure that CHOs are retained in the public health space. He further indicated that there are opportunities for Community Health Nurses (CHNs) to pursue diplomas and degrees in community health nursing. In a related contribution by Dr. Hilarius Abiwu, Deputy Director, Public Health at the Northern Regional Health Administration made the point that CHOs who upgrade themselves tend to be apathetic towards working at the community level owing among other things to the level of respect and recognition for community level work. He therefore submitted that until this is addressed, such CHOs will always prioritize working at the district level.
- ***New referral policy and technical guidelines:*** Dr. Lawrence Ofori Boadu observed that a new referral policy has been drafted and validated albeit yet to be disseminated. What remains to be done is the technical guideline. To this end, he was optimistic that some of the materials developed by the CHPS for Life project such as the Referral Register and Monthly Referral Returns (MRR) will be considered for adoption.
- ***Integration of CHPS for Life activities into NoP:*** The Deputy Director, Policy, PPMED, Dr. Andrews Ayim noted that the activities implemented by the CHPS for Life project especially at the CHPS and sub-district levels will be integrated into the NoP. This, he argued was necessary to ensure that the service leverages on the successes to improve service delivery under the NoP.
- ***Calls for training of Enrolled (ENs) and Midwives (MWs) as CHOs:*** The CHPS for Life project Chief Advisor, Ms. Satoko Ishiga contended that there was a shortage of CHNs for training as CHOs, a position supported by the presentations made by the CHPS focal persons of the 5 regions of the north. To that extent, she urged the GHS to consider training other cadre of staff (notably ENs and MWs) as CHOs to shore up the numbers. However, Dr. Ayim argued that the distinct nature of trainings given to these different cadres makes it extremely difficult to convert for instance ENs into CHOs.
- ***Costing of project interventions will help inform sustaining project gains with the GHS:*** The PPMED requested that projects should be in a position to provide the cost of its major and innovative interventions to help engender well-guided discussions and planning towards sustaining project gains leveraging other funding streams. This request is based on the GHS inability to effectively provide appropriate estimates to other DPs that are interested in carrying-on some good initiatives of the GHS that were financed through other DPs.

3. **<u>Opening prayer</u> - Mr. Stephen Bordotsiah**

The meeting commenced at 9:25am with an opening prayer by Mr. Stephen Bordotsiah, District Director of Health Services (DDHS), Bolgatanga Municipal, Upper East Region.

4. **Introduction of participants – Mr. Jabob Acquah Andoh**
The MC, Mr. Jacob Acquah Andoh, Public Relations Officer of GHS who was the Master of Ceremony took the opportunity to introduce participants from GHS HQ as well as Regional Directors and other representatives from the participating regions.

5. **Opening remarks by chairperson – Dr. Lawrence Ofori Boadu**
The chairperson, Dr. Lawrence Ofori Boadu, Ag. Director, Institutional Care Division (ICD), GHS HQ standing in for the DG indicated that the DG was unavailable for the meeting due to other equally pressing needs elsewhere. He noted that the meeting was crucial as it demonstrated how firmly rooted the activities of CHPS for Life have been over the years. He also observed that key decisions were taken during the last JCC, citing discussions on career path for CHOs, sustainability of CHPS among others. Further, he indicated that he was looking forward to how lessons learned from the project including the monthly referral returns (MRR) can be considered for inclusion in the referral policy and technical guidelines.

6. **Remarks by JICA Ghana – Mr. Shizume Takuya**
JICA's Representative for Health, Mr. Shizume Takuya, conveyed greetings from JICA Ghana to all participants. He pointed out that JICA has high expectations as far as scaling up of the CHPS for Life project is concerned owing to its years of experience. He called for continuity of project activities such as CHPS database, District CHO orientation especially in other regions. Further, he submitted that as the project prepares for a closeout, it will offer an opportunity to reflect on the lessons learned. He added that JICA remains committed amid the current global challenges to support the MoH and GHS to consolidate the gains made in the country.

7. **Presentations on achievement, progress and plan of activities – Dr. Damien Punguyire & Dr. Chrysantu Kubio**
The RDHS for UWR, Dr. Damien Punguyire and the RDHS for SR, Dr. Chrysantus Kubio took turns to apprise participants of the status of achievement of project targets, exit strategy and sustainability actions for each intervention. The key points of their presentations are summarized as follows:

Project purpose: CHPS implementation & integration of LCA into CHPS services:

Exit Strategy	Progress
CHPS database • Establishment of the standardized CHPS database system in all regions in Ghana • Strengthening regional capacity through buddy system • Promoting utilization of data for resource management in CHPS implementation	• Database was established in 15 of 16 regions (Ashanti region outstanding) • Buddy system among regions was established. • Strengthening utilization of data through information sharing
CHO training approaches • Establishment of cost-effective CHO training system (District CHO	• Dissemination of new training system was 5 regions are continuously conducting DCHOO.

orientation and pre-service training) and dissemination	• National orientation approved by GHS for training schools was conducted by MOH.
LCA services • Integration of LCA related services into CHO training materials. • Improvement of CHO skills through monitoring	• LCA contents are integrated into CHO training materials (DCHOO & Pre-service training materials) therefore ensuring sustainability of the LCA training. • 1st monitoring was done. • 2nd monitoring is under preparation.

Project purpose: Status of achievement of PDM targets:

1. The percentage of people who have access to functional CHPS; 2017→2022 (Target value in parenthesis) UWR 55.2% → 93.0% (100%), UER 31.1% → 96.5% (100%), NR 9.5% → 38.2% (60%), NER N/A→ 44.2% (75%) 、SR N/A → 67.6% (80%)
2-1. Coverage of CHPS zones with assigned staff per total population UWR 60.8%→ 95.6% (100%), UER61.9% → 99.7% (100%) , NR 75.7%→ 71.2% (75%) NER N/A→ 77.7% (100%), SR N/A→ 79.0% (100%) 2-2. Coverage of functional CHPS zones per total population. The same as 1.
3. The level of CHPS implementation with life-course approach in UWR is increased. 3-1. The proportion of functional CHPS zones which provide LCA related services. • The number of staff trained on the LCA training package to provide LCA related services is increased; CHO: 688 (2022), SDHT 48 (2022). • The percentage of CHPS zones which conduct health screening in all schools in the CHPS zone at least once a year in the last 1 year. 94.7 % (40%) Endline survey (N=150). • The percentage of CHPS zones which conduct health screening in all communities at least once a year in the last 1 year. 94% (40%), Endline survey (N=150). • The percentage of CHOs who appropriately record health screening results and followed up in the LCA register in the last 1 year. - Accuracy of calculation of Body Mass Index (BMI): 59.7% - Accuracy of classification of data: BMI 90.9%, BS 80.5%, BP 94.4%, WC 93.8% - Appropriate follow up: Education and counselling 49.8%, Referral 57.6% (Denominator is the number of recorded cases)
3-2. The minimum package of services focusing on LCA is developed and proposed as national standard. 1) LCA training package is developed and submitted to GHS: Materials were developed and GHS has approved for use in LCA training. 2) LCA training materials are integrated into pre-service training: Theory part of LCA training for CHOs was integrated into Pre-service training materials. 3) LCA training materials are integrated into district CHO orientation field guide: Practice part of LCA training for CHOs was integrated into DCHOO.

Project purpose: Strategy for the remaining period:

• Target setting for districts to conduct CHO training to increase functional CHPS zones. • Promoting monitoring of CHO's skills on LCA services at CHPS zones

Output 0: Management

Exit Strategy	Progress
• Promotion of dissemination of Project activities	• Project outputs and suggestion are shared through regular JCC and Coordination meetings
• Sharing Project output and suggestions with GHS for improvement of national tools and systems	• Joint meetings with GHS were conducted on each activity to give suggestions
• Sharing good practices with other regions	• Study tours from Bono East Region to UWR • Technical support from 5 northern regions to other regions on CHPS database

***Management: Status of achievement of PDM targets*:**

0-1: Joint Coordinating Committee (JCC) meetings are conducted at least once per year; · 8 times (9th JCC will be the last). 0-2: The number of technical exchanges conducted during the project period; · 11 times (Mainly on output 1, including study tour from Bono East Region to UWR). 0-3. GHS-HQ receives monitoring sheet (twice per fiscal year) and progress reports (as determined in the R/D); · All are regularly submitted

Management: Strategy for the remaining period:

• Further dissemination of the tools and systems developed • Study tours, mutual visits, development of good practices document, joint feedback meetings for each output and dissemination forum.

Output 1: CHPS implementation

Exit Strategy	Progress
<u>CHPS Database:</u> • Completion of national dissemination • Promoting mutual supporting system among regions. • Strengthening data utilization	• Completion of introduction in 14 regions • Establishment of mutual supporting system (Buddy regions) for regions • Strengthened utilization through joint feedback meeting
<u>CHO training system approaches</u>: • Support MOH on pre-service training monitoring • Support implementation of District CHO orientation (DCHOO)	• Completion of Pre-service training orientation for tutors of 5 regions • Completion of the national orientation by MOH • Planning on DCHOO for remaining 6 months

Referral: • Scaling up of the use of the referral tools within 5 regions and national level • Strengthening the utilization of referral tools in the pilot districts	• Revolving system has been in place to ensure the supply of tools in UWR/UER/NR • Monthly Referral Returns are uploaded onto DHIMS2 • Discussion with the ICD (GHS-HQ) on the possible inclusion of the tools in the New Referral policy and technical guideline
SS: • Inclusion of the SS checklist at the CHPS level into the national SS platform (HNQIS). • Scaling up of SS implementation at the CHPS level	• Finalization of digitized SS checklist is on-going and to be completed by the end of February 2023 (with support from Impact Malaria). GHS-HQ and IM/USAID is ongoing hand over of the server.
DHQPR: • Establishment of DHPQR meeting in all districts by maximizing the opportunities and existing resources in the district.	• Orientation conducted in all 55 districts of JICA target regions. • The RHA issued the letter to request the district to harmonize the activity into coming annual review meeting. • The sustainability strategy was discussed and ideas were exchanged in HSS-TWG meeting of Feb 2023.

Output 1: Status of achievement of PDM targets:

1-1. The number of trained beneficiaries is increased.

- Beneficiaries of Harmonized CHO Training: 729 personnel working in CHPS zones have been trained, Community health nurses (CHNs) 649.
- Beneficiaries of pre-service training: NAC Students: 1573, NAP Students: 803, MTS Students: 1010, Tutors: 113 (for 5 regions) + Beneficiaries of national orientation (Sep. 2022) will be added.

1-2. Beneficiaries of DCHOO

- The number of districts which conduct district CHO Orientation at least once.
  UWR: 11 (11), UER:15 (15), NR:16 (16), NER: 6 (6), SR:7 (7)
- Number of trained CHOs through DCHOO: UWR:308, UER: 388, NR:136, NER:60, SR:115

1-3. Referral system is strengthened in pilot districts.

- The number of health facilities whose staff were trained on referral protocols.
  UER: 355, NR and NER: 65, UWR: 376
- The number of referrals from CHPS zones done according to the protocol/guidelines.
  (Target is 75%): The assessment is done as part of the endline survey
  UER: 73.3% (11/15), NR: 63.6% (7/11), UWR: 100.0% (21/21)
- The number of feedbacks sent to CHPS zones is increased.
  (Target is 60%): The data is from DHIMS2-MRR 2022
  UER: 54.7%, NR: 32.5%, UWR: 53.9%.

1-4. Monitoring system is strengthened in target districts.

- Harmonized SS training materials and tools for CHPS supervision is developed, introduced and incorporated into national SS program: Finalization of the digitized SS checklist is on-going with GHS-HQ and USAID through IM
- The average implementation rate of SS from SDHTs to CHPS. (Target: 80% in UWR and UER, 75% in NR): UER: 94.8%, UWR: 92.4 %, NR-Savelugu: 72.4%, NR-Nanton: 60.0% *as of Q4-2022
- The standardized reference guide for District Health Quarterly Performance Review (DHQPR) Meeting is developed and introduced to all districts of the Project target regions: All 55 districts received orientation and a reference guide.
- All districts conduct the DHQPR meeting with the standardized reference guide at least *twice per year* over the project period: UER: 97%, UWR: 100%, NR: 84%, NER: 50%, SR: 50%

1-5. CHPS database system is established at least in five regions and disseminated nationally.

- Number of regions in which CHPS database is established: 15 (16 regions). Ashanti region remains, orientation was done in Central Region, but feedback meeting is incomplete.)

Output 1: Strategy for the remaining period:

CHO training system
- Establishment of a firm pre-service training system for the training schools through the end orientation.
- Sharing good practices to promote implementation of DCHOO.
- Implementation of DCHOO in NR, NER and SR to achieve the target.

Referral
- Discussion with the GHS-HQ and MOH to harmonize the Project developed referral tools (registers, referral form and Monthly Referral Returns) with new Referral Policy/Guideline
- Sharing good practices and strategies to strengthen referrals within the Region

SS
- Harmonization of the SS checklist at the CHPS level into the national SS platform
- Scaling up of SS implementation with HNQIS at the CHPS level in JICA target regions

DHQPR
- Harmonizing the components of the DHQPR meeting with an existing regular meeting system to enhance the quality and sustainability of the meeting.

Output 2: Community mobilization (UWR only)

Exit Strategy	Progress
Improved CHAP tools • Approval for dissemination of CHAP assessment tools by the GHS	• Ongoing analysis of End-line survey data to assess the effectiveness of the CHAP assessment tools for discussions with GHS-HQ
Strengthening the capacity of community • Promote the implementation of CHMC/CHV training using CHMC meetings.	• Ongoing integration of CHMC/CHV training into CHMC meeting. • Follow up visits conducted by RHMT and DHMT to pilot CHPS zones.

• Establish a system for the RHMT and DHMT to monitor and follow-up on the training	• Timing and methods of regular monitoring and follow-up discussed.
Dissemination of IEC materials • Promoting the continuous use of IEC materials within the UWR • Supporting the use of IEC materials in other regions	• End-line survey summary to assess the effectiveness of the IEC materials in facilities is on going • Checking status of availability of flip chart for re-distribution. • Regular dissemination of IEC materials to community at CHMC meetings and at durbar.
Non-monetary incentives • Institutionalization of non-monetary incentive activities for CHVs	• The incentive activities to be introduced in DHMT in UWR have selected • A reference material for the institutionalization by RHMT of the UWR is under development

***Output 2: Status of achievement of PDM targets*:**

2-1. The number of active CHMCs for community activities is increased.

- UWR: 435 (496),UER: 507 (523), NR: 327 (322), NER: 77 (116), SR: 145 (140)

2-2. Proportion of CHPS zones with CHAP updated quarterly is increased.

- UWR: 77.8% (100%) UER: 77.5% (100%)、NR: 43.4% (60%) NER: 16.1% (75%) SR: 48.2% (80%)

2-3. Proportion of CHPS zones with CHAP updated quarterly on Life Course Approach (LCA) activities is increased in UWR: UWR: 64.3% (40.0%)

Output 2: Strategy for the remaining period:

- Improve the rate of update of CHAP and frequency of CHMC meeting through CHO training of Output 1 and monitoring and follow up of CHMC/CHV meeting.
- Promote the implementation of CHMC/CHV meeting in the CHPS zones in collaboration with DHMT.
- Institutionalize NMI scheme in UWR

Output 3: Governance/DA engagement (HIAP formulation, monitoring & implementation

Exit Strategy	Progress
HIAP formulation/monitoring • Encourage RCC /DA to incorporate timely HIAP formulation and monitoring into existing activities • Encourage timely monitoring report submission • Disseminate HIAP in non-implementing districts in focus regions collaboration with their RCCs	• HIAP formulation has already been incorporated into DA's activities in implementing areas. • Incorporation of agenda into the existing meetings was verbally confirmed with the RCC. • HIAP was introduced in 4 non-implementing districts in NER. • Submission of digitized (Soft) reports instead of hard copies was proposed.

HIAP implementation • Encourage the continuous implementation at RCC/DA meetings. • Sharing the HIAP implementation status during existing meeting at regional and district level.	• Continuation of RCC/DA meetings including presentation of implementation status of HIAP was verbally confirmed by RCC.

***Output 3: Status of achievement of PDM targets*:**

3-1 The proportion of districts with health integrated annual action plans developed and costed is increased. Actual (Target)

- UWR: 100 %(100 %), UER: 100% (100 %), NR: 100 %(100 %), NER: 100 % (100 %), SR: 100 % (100%)

3-2 The proportion of districts in which Regional Planning Coordinating Unit (RPCU) and District Planning Coordinating Unit (DPCU) monitor implementation of health integrated annual action plans in 3-1 on a quarterly bases (four times a year) is increased.

- UWR: 91 % (70 %), UER: 70 % (80 %), NR: 33 % (85%), NER: 0 % (100 %), SR: 0 % (100%)

3-3 The proportion of activities implemented in the health integrated annual plans is increased.

- UWR: 40%(50 %) UER: 11 % (50 %) , NR: 18 %(65 %), NER: 0%(60 %) , SR: 0%(60%)

Output 3: Strategy for the remaining period:

- Ensuring the sustainability of RCC/DA meetings.
- Improve quarterly HIAP monitoring through the promotion of timely report submission and Securement of budget for monitoring.
- Improve HIAP implementation through appropriate target setting (realistic target according to feasible budget)

Output 4: Introduction of LCA

Exit Strategy	Progress
• Approval of LCA training materials as standardized materials by GHS HQ • Integration of LCA contents into CHO training materials	• Approved through LCA- TWG meeting • LCA contents integrated into Pre-service training and District CHO orientation (DCHOO) materials. • Nationwide dissemination of DCHOO ongoing
• Integration of LCA related activities into regional/district annual plan in UWR	• Development of LCA integrated annual plan in UWR
• Development of health Screening record tool and approval by GHS	• Development of health screening record tool and pilot use in UWR.

***Output 4: Status of achievement of PDM targets*:**

4-1. The minimum package of services focusing on the LCA is developed

- It was finalized and approved as materials for national dissemination through the meeting with GHS HQ in July 2022.

4-2. The life course approach is integrated into the training on CHPS services

- The practices of the LCA related services were integrated into the training materials of District CHO orientation, Nationwide dissemination is ongoing.
- The theory parts of the LCA related services were integrated into the pre-service training materials. Nationwide orientation of materials was done.

4-3. Health service delivery focusing on the LCA is strengthened at CHPS level.

- Data is the same as "Project Purpose 3-1.

4-4: The proportion of pregnant women receiving first trimester ANC, Skilled delivery, PNC within 48 hours is increased in all regions. *Actual (Target)*

4) % of pregnant women receiving first trimester ANC

UWR: 71.1% (85%), UER: 55.5% (75%), NR: 48.7% (85%) ,NER: 41.9% (50%), SR:44.8% (85%)

(2) % of pregnant women making at least 4 ANC visits

UWR: 96.1% (90%), UER: 85% (85 %), NR: 82.1% (80%) , NER: 65.4% (80%), SR:58.1 % (85%)

(3) % of skilled delivery

UWR: 66.4% (80%), UER: 63%(60%), NR: 68.8% (90%),NER: 63.9% (85%),SR: 58.1% (75%)

(4) % of women who received postnatal care from health personnel within 48 hours since delivery

UWR: 96.7% (100%),UER: 97.4% (100%) ,NR: 82.7% (95%), NER:87.2%(80%),SR: 85.6%(85%)

Output 4: Strategy for the remaining period:

- Strengthening CHO's skills through monitoring of LCA related services.
- Improvement of MCH data

8. Discussions on presentations on the achievement, progress and plan of activities

- As part of plans to roll out HNQIS, Ms. Eva Mensah enquired whether access to tablets did not come up as a challenge. The Nadowli-Kaleo team in response affirmed that the issue of tablets was indeed a challenge. Dr Ayim in contributing noted that tablets will be catered for as part of the budget of the NoP program.
- It is crucial to follow and understand if there are any operational reasons why Ashanti Region has not implemented the CHPS database.
- Mr. Nicholas Nyagblornu enquired to know if there are different definitions for CHPS functionality in the context of the CHPS for Life project relative to the policy position. It was clarified that there are no differences. The project simply works with the policy definitions.
- Mr. Nicholas Nyagblornu also queried if there are any plans by JICA Ghana to conduct endline evaluation to document lessons learned. He also asked whether the challenges in the measurement and calculation of some of the LCA data were due to capacity of staff or calibration of the tools used. In response, Mr. Shizume took

the opportunity to explain the evaluation process that will take place some few years after the end of project particularly on the overall goal of the project. In a similar response to the latter, Mr. Kullah Anthony indicated that although accuracy of calculation was a bit challenging, classification was not.

- Dr. Ofori Boadu, on his part wanted to know why NER's implementation of HIAP reduced from 75% in 2020 to 25% in 2021 and to a further 0% in 2022? On the subject of a repacked project for the new regions, he observed that the call was a good one and hinted on discussing it with the DG.

9. Regional presentations on strategies to achieve PDM targets

In this section, the **highlights** of the presentations made by each region are summarized below:

Upper West Region (Mr. Ambrose Nawa)

- The UWR is fully demarcated (100% demarcation)
- Gaps in CHPS functionality exist in Lawra, Nadowli and Wa West
- 153 CHNs are available in facilities including polyclinics, health centers, hospitals for training as CHOs through DCHOO
- Redistribution of CHOs and posting of more CHNs to Lawra and Wa West for training as CHOs are priority strategies
- Most CHOs in the region have been trained on LCA and post-training follow ups conducted
- Weaknesses observed in the provision of LCA services include BMI calculation and classification, inadequate equipment in some CHPS zones, inadequate follow ups etc.
- Regional orientation for districts, compilation of referral telephone directory and development of district-specific action plans are key strategies to improve feedback

Upper East Region (Nana Dr. Emmanuel Ansu-Abina)

- The region has set 1st quarter of 2023 to achieve 100% functionality
- Ongoing security issues in Bawku adversely affecting the CHO situation in the district and by extension the regional performance
- Total of 321 CHOs trained using the DCHOO approach
- The region has developed a model for effective referral system using the Talensi experience
- As part of strengthening intra-district referral network, facility mapping, referral pathways and flow charts have been developed in Talensi
- Region has put in measures to ensure the constant availability of referral materials at the medical stores

Northern Region (Mr. Benedict Ofori Appiah)

- The region has achieved 100% demarcation with CHPS with services limited to about half of the districts in the region.
- Referral feedback is a major problem
- To increase functionality, CHO audits and re-assignment of CHOs are planned among other measures

- Continuous engagement with stakeholders and adjoining facilities earmarked as a key strategy to improve the referral feedback situation
- Prioritization of DCHOO and HIAP implementation and scale up are key going forward

North-East Region (Mr. Adams Anas)

- The region is fully demarcated (100%). However, the 75% functionality target has not been achieved
- Equipment situation has drastically improved due to JICA's support
- A total of 74 CHOs needed to fill existing gaps and as a consequence functionalize all CHPS zones. In line with this, fifty (50) CHOs are planned to be trained via DCHOO
- To address the gaps in CHPS with service, CHPS zone staff will be redistributed at the district levels

Savannah Region (Mr. Jonas Abodoo)

- The region lobbied partners for DCHOO leading to 76 CHOs trained, bringing the current number of CHOs to 143 in the region.
- Demarcated CHPS zones moved to 193 from 175 with functional CHPS zones increasing from 75 to 143.
- Seventy (70) CHOs planned to be trained by August 2023
- Staff audits and subsequent redistribution have been identified to ensure that all demarcated zones have assigned staff
- Region will continue to lobby DAs and other partners for construction of CHPS compounds while liaising with the RCC for prompt release of funds for HIAP activities.

10. Discussions on regional presentations

- Dr. Ayim observed that the strengths and weaknesses of the project have come out clearly which is relevant for subsequent support.
- He also noted that in view of the high CHO attrition rate, on-the-job training (OJT) will be very important.
- Dr. Ayim further observed that soft skills such as lobbying, knowledge transfer among CHOs that affect project implementation did not come out strongly from the presentations.
- Ms. Eva also remarked that the presentation on SS focused more on the process with no highlights on action plans.
- Mr. Zanu Dassah also opined that as far as career progression for CHOs is concerned, more institutions (notably UHAS, UDS, Wisconsin) are mounting degree programs to cater for the needs of CHOs. He noted that deliberate efforts are being made to ensure that CHOs are retained in the public health space. He further indicated that there are opportunities for CHNs to pursue diplomas and degrees in community health nursing.
- What new strategies will NER put in place to tackle the pressing challenge of mal-distribution of CHOs given that the phenomenon is a result of the system of staff allocation?

- In a submission by Dr. Hilarius, he made the point that CHOs who upgrade themselves tend to be apathetic towards working at the community level owing among other things to the level of respect and recognition for community level work. He therefore submitted that until this is addressed, such CHOs will always prioritize working at the district level.
- Mr. Prosper Tang also noted that apart from the presentation by NER, the other regions failed to demonstrate how the investment/provision of equipment by JICA has resulted in measurable outcomes (e.g. number of functional CHPS zones). Again, he indicated that beyond reporting on the increasing CHMC involvement in activities, there is the need to demonstrate how this translates into tangible health care outputs or outcomes on the ground.

11. <u>Presentation on using ISS to facilitate NoP in Nadowli/Kaleo district</u>

Speaking on the subject above, Mr. Linus Angwelba, the In-Charge of Sombo Sub-district, UWR, highlighted the following;

- JICA adapted ISS checklist for Sub-district→CHPS supportive supervision
- JICA/GHS and Impact Malaria have developed digital checklist hosted on a demo HNQIS server
- Among other strengths, the HNQIS app is user-friendly and can be used on normal android phones
- Immediate sharing of action plans however remains a major challenge
- ISS has improved communication among staff as well as interpersonal relationships as expected of NoP
- Through ISS, gaps were identified and counteractions taken in the NoP to address same.
- Migration of HNQIS onto the national ISS server is strongly recommended
- Procurement of quality tablets and orientation for SDHT level staff are crucial for scale up

12. <u>Presentation on using LCA for early NCD detection; Data from UWR</u>

The regional Nutrition Officer, UWR, Mr. Anthony Kullah, in his delivery put forward the following;

- Data was extracted from health screening registers of 105 CHPS zones from July 2019 to June 2022
- Uptake of LCA services appear to be higher in females than males
- Higher proportion of women screened normal for blood pressure and blood sugar whilst more males were normal for BMI and waist circumference measurements. Additionally, less than half of the males and females screened using the HLAQ were normal
- Further analysis showed that weight and waist circumference on one hand and BMI and waist circumference on another hand were positively correlated albeit moderate.

13. <u>General discussions</u>

- Ms. Eva Mensah hinted that the HNQIS is being finalized following which it will be handed over to PPMED

- There appears to be a clear correlation between the amount of investment and results as demonstrated by the presentation on SS and NoP
- Data presented on LCA shows that men are healthier than women. However, in the case of HLAQ which assesses certain lifestyles, more men than women appeared to be living unhealthy lifestyles.
- The quality of presentation by the Sombo sub-district is commendable
- Areas targeted for intervention by projects should always go beyond the problems identified by partners to the larger problems in the specific locations
- Screening on LCA is very crucial in the context of the current NCD outlook in the country and the measures being taken to address same.
- The CHPS for Life project should look at how the data presented on LCA fits into the MoH's NCD policy and guidelines as part of plans for sustainability going forward
- GHS and local government have different planning periods. As such, there is the need to harmonize the planning periods especially because both entities work towards a common goal.
- CHPS for Life project has proven to be an eye opener as far as the attainment of UHC is concerned.
- Dr. Lawrence hinted that he will engage DG on the subject of a repacked program and also to explore other partners with the view to ensuring continuity in project activities.

14. <u>Issues and concerns (Ms. Satoko Ishiga)</u>

- Endline survey report and dissemination are planned for June, 2023.
- Project activities to be completed by May, 2023.
- In view of the shortage of CHNs for training as CHOs, GHS should consider training ENs and MWs as CHOs
- There is a need to create a career path for CHOs to ensure that they are retained in the public health space

15. <u>Remarks by MoH</u>

- Presentations have been quite insightful
- Operational research is needed to investigate some of the issues reported such as the unwillingness of CHOs to take up CHPS level duties after acquiring higher certificates/degrees
- MoH is concerned about resource harmonization at all levels. In line with this, the MoH believes that a system approach should be adopted.

16. <u>Remarks and way forward by Dr. Ayim</u>

- The CHPS for Life project needs to be commended for showcasing evidence on a lot of things that work for communities
- Costing of project activities is important to estimate additional activities needed to sustain the gains. To this end, he urged the project to make available such information, especially on equipment

- The distinct training given to CHNs and ENs constitutes an inherent challenge for converting ENs to CHOs
- Dr. Ayim also noted that there is the need to promote sub-district leadership in networking, considering that networking with the CHPS zones (spokes) will be critical in the NoP.
- Interventions by JICA at the CHPS and sub-district levels to be integrated into the NoP as a way of building on the successes.

17. Remarks by chairperson

- Presentations by the RDHS for UWR & SR demonstrate that significant achievements have been made by the project
- Foundation laid by the CHPS for Life project should be used to improve the NoP
- Investment in infrastructure is as important as investing in soft issues like capacity building
- Referral policy has been drafted and validated albeit yet to be disseminated. What remains to be done is the technical guideline.
- GHS will continue to work with the local government
- Finally, he thanked JICA and the team for creating an opportunity to share the progress of project activities with participants.

18. Closing prayer

The meeting ended at 15:00 with a closing prayer by Rev. Sr. Genevieve Nen-nome, Principal, Jirapa Community Health Nurses Training School.

Compiled by:
Dr. Ernest Ziem Manson.....
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Confirmed by:
Zacchi Sabogu.....
(Project Advisor)

Endorsed by:
Satoko Ishiga.....
(Chief Advisor, CHPS for Life Project)

Mr. Shizume Takuya……鎭目琢也……

(Health Representative, JICA Ghana Office)

Dr. Lawrence Ofori Boadu……

(Ag. Director, ICD, GHS HQ)

Annex 1: List of participants

No	Name	Organization/District	Background/Position
A. Participants, GHS-HQ, Accra			
1	Dr. Lawrence Ofori Boadu	GHS HQ	Ag. Director, ICD
2	Mr. Isaac Tandoh	GHS HQ	NCD
3	Dr. Andrews Ayim	GHS HQ	Deputy Director, PPMED, Policy
4	Ms. Eva Mensah	GHS-HQ	Director of Nursing & Midwifery, ODG
5	Mr. Jacob Acquah Andoh	GHS HQ	Public Relations Officer
6	Ms. Aseye Afi Kpodotsi	GHS HQ	CHPS for Life Focal Person, PPMED
7	Mr. Zanu Dassah	GHS HQ	HRD
8	Mr. Nicholas Nyagblornu	MoH	Health Planner, MoH, PPMED
9	Ms. Esther Effah Afari	GHS HQ	Secretary, PPMED
B. Participants, UWR			
10	Dr. Damien Punguyire	RHD, UWR	Regional Director of Health Services
11	Mr. Prosper M. Lana	RHD, UWR	Deputy Director, Administration
12	Mr. Mohammed Tahir Abarry	RHD, UWR	Deputy Director, Clinical Care
13	Mr. Ambrose Naawa	RHD, UWR	Regional CHPS Coordinator
14	Mr. Anthony Kullah	RHD, UWR	Regional Nutrition Officer
15	Mr. Linus Baatiema	RHD, UWR	Deputy CHPS Coordinator
16	Mr. Richard Ambrose Darko	RHD, UWR	Regional Health Information Officer
17	Mr. Musah Ali	RHD, UWR	Field Epidemiologist
18	Mr. Nii Adjaye Laryea	RCC, UWR	Economic Planning Officer
19	Ms. Phoebe Balagumyetime	DHD, Nadowli-Kaleo	DDHS
20	Mr. Linus Angwelba	Sombo SDHT, Nadowli-Kaleo	Principal Physician Assistant
21	Rev. Sr. Genevieve Nen-nome	CHN Training College, Jirapa	Principal
22	Dr. Mathias Pogvi Tengan	DHD, Sissala West	DDHS
C. Participants, NER, SR,NR,UER			
23	Dr. Abdulai Abukari	RHD, NER	Regional Director of Health Services
24	Mr. Mark Abugri	DHD, East Mamprusi	DDHS
25	Mr. Salifu Issifu	DA, East Mamprusi	District Planning Officer
26	Mr. Adams Anas	RHD, NER	Regional CHPS Coordinator
27	Dr. Chrysantus Kubio	RHD, SR	Regional Director of Health Services
28	Mr. Alhassan Abukari	DHD, STK	District Director of Health Services
29	Mr. Abodoo Jonas	RHD, SR	Reg. CHPS Coordinator
30	Dr. Hilarius Abiwu	RHD, NR	Deputy Director, Public Health
31	Mr. Jeremiah Timob	RHD, NR	Deputy Director, Administration
32	Ms. Rahinatu Abdulai	RCC, NR	Economic Planning Officer
33	Mr. Benedict Ofori Apiah	RHD, NR	Regional CHPS Coordinator.
34	Mr. Matthew Konlan	RHD, NR	Research Officer
35	Ms. Comfort Kona	CHN Training School, Tamale	Principal
36	Dr. Abdul-Razak Dokurugu	RHD, UER	Deputy Director, Clinical Care
37	Dr. Josephat A. Nyuzaghl	RHD, UER	Deputy Director, Public Health
38	Dr. Emmanuel Ansu-Abina	RHD, UER	Regional CHPS Coordinator
39	Mr. Stephen Bodotsia	DHD, Bolgatanga Municipal	DDHS
40	Mr. Philip Addo-Aboagye	RHD, UER	Asst. CHPS Coordinator
41	Mr. Manzuk Ebenezer	CHN Trg. College, Navrongo	Principal
D. JICA Ghana/Project Staff			
42	Mr. Shizume Takuya	JICA Ghana	Representative, Health
43	Mr. Prosper Tang	JICA Ghana	Health Specialist
44	Ms. Satoko Ishiga	JICA Project, CHPS For Life	Chief Advisor
45	Ms. Tomoko Watanabe	JICA Project, CHPS For Life	Expert, Community Health
46	Ms. Chisaki Sato Makabenta	JICA Project, CHPS For Life	Expert, Health Systems Strengthening
47	Mr. Naoyuki Yamada	JICA Project, CHPS For Life	Project Coordintaor

48	Mr. Zacchi Nolan Sabogu	JICA Project, CHPS For Life	Project Advisor
49	Ms. Salia Basilia	JICA Project, CHPS For Life	Resource Person
50	Mr. Abu Dokuwie Alhassan	JICA Project, CHPS For Life	Senior Project Coordinator
51	Mr. Sharifdeen Amadu	JICA Project, CHPS For Life	Junior Project Coordinator
52	Dr. Ernest Ziem Manson	JICA Project, CHPS For Life	Senior Project Coordinator
53	Ms. Anita Aba Wobil	JICA Project, CHPS For Life	Junior Project Coordinator
54	Mr. Benjamin Mpuan	JICA Project, CHPS For Life	Administrative Officer
55	Mr. Kassim Abdul-Basit	JICA Project, CHPS For Life	Senior Project Coordinator
56	Mr. Gamuo Roger	JICA Project, CHPS For Life	Senior Administrative Officer
57	Ms. Mabel Mma Nasagrey	JICA Project, CHPS For Life	Administrative Officer
58	Mr. Raymond Alirigia	JICA Project, CHPS For Life	Junior Project Coordintaor

Minutes of the 9th Joint Coordination Committee (JCC) Meeting
Date: June 14, 2023; Time: 05:18pm – 16:33
Venue: Labadi Beach Hotel, Accra

1. Introduction

The GHS/JICA CHPS for Life project held its ninth and final Joint Coordination Committee (JCC) meeting on 14th June 2023, at the plush Labadi Beach Hotel in Accra. The JCC, which immediately followed the project's final dissemination at the same venue, was to share the project's achievements and bring the project's activities to a close. Participants of the JCC included JICA Ghana officials, staff of the Ghana Health Service (GHS) Headquarters, the Ministry of Health, and leadership of the GHS in the five target regions of the project as well as representatives from the Regional Coordinating Councils (RCCs). District Assemblies, Health Training Institutions (HTIs), and project staff. The event was chaired by Dr. Kofi Issah, the Director of the Family Health Division of the Ghana Health Service.
See annexes 1 & 2 for the detailed list of participants and agenda of the meeting.

2. Summary of key issues

- ***Calls for Staff rationalization to make the most qualified staff work in the rural areas:*** It was mentioned that most of the disease burden experienced in the country comes from the rural areas. In addition, it is in these areas that much of the work of public health is needed. However, it is observed that most CHPS zones are manned by CHNs and other least-qualified cadres such as Enrolled Nurses. It is also observed that staff who attain degree certificates or other specialized qualifications are moved from rural areas to towns and cities. Steps, therefore, have to be taken to ensure that the most qualified staff are assigned to the rural areas to handle the myriad of problems faced at that level.
- ***Utilizing the World Banks SOCO project to support HIAP activities in the intervention areas:*** It was mentioned that the World Bank group is providing funding for a project known as the Gulf of Guinea Northern Regions Social Cohesion Project (SOCO) in the five regions of Northern Ghana and Oti Region. The project will support health, education and social protection interventions in the catchment areas. It was mentioned that the regional health teams in the catchment areas should work hand in hand with their RCCs and District Assemblies to ensure that they support healthcare infrastructure. It was also suggested that the HIAP process can be used to ensure that these agreements are binding.
- ***Call for a project to extend some of the CHPS for Life Project interventions piloted in the Upper West Region, to other regions.:*** It was mentioned that a number of the interventions of the CHPS for Life project, such as LCA, and supportive supervision components, were piloted in selected areas. The Regional Director of Health of UWR called on JICA Ghana to develop a project that will extend the learnings from the pilot activities such as the Life Course Approach, to the other regions
- ***Developing a standardized wellness clinic register:*** A program Officer with the National NCD program office, mentioned that the NCD program, with support from the World Health Organization, is piloting a health screening project in some areas in Greater Accra. As part of the pilot project, the wellness clinic screening register has been developed and uploaded onto DHIMS II to capture health screening data. She

mentioned that they will take a look at the projects' health screening register developed as part of LCA activities and merge them into a standardized register for health screening activities at the wellness clinics.

3. **Opening remarks by chairperson – Dr. Kofi Issah**
The chairperson, Dr. Kofi Issah, Director, Family Health Division (FHD), GHS HQ standing in for the DG indicated that this was the final JCC of the project and was intended to highlight the key achievements of the project and also discuss issues of sustainability. He called on all to participate actively to ensure a successful final JCC.

4. **Presentations on achievement, progress and plan of activities – Dr. Damien Punguyire**
The RDHS for UWR, Dr. Damien Punguyire made a presentation on the achievement of the project's PDM indicators and the sustainability plans developed by the various regional teams. His presentation covered the four outputs of the project and summarized below;

Status of attainment of project indicators – Project Goal and Purpose

Indicator	Status of Achievement
Indicator 1 The percentage of people who have access to functional CHPS	• Only Upper East Region met their target of 100%. • Upper West region was within 5% of reaching the target (98.9%/100%) • NR and SR were within 20% of reaching their targets (45.6%/60% and 66.5%/80% respectively) • NER was beyond 20% of reaching their set target (47.5%/75%)
Indicator 2 Coverage of CHPS zones with assigned staff per total population	• All regions except SR met their targets set for coverage of CHPs zones with assigned staff. •
Indicator 3 The level of CHPS implementation with LCA in UWR is increased. 3-1 The proportion of functional CHPS zones which provide LCA-related services	• Target of CHOs trained on LCA services was exceeded (650/192) • Target of SDHTs trained on LCA was not met (39/48) • Both targets of health screening in schools and health screening in communities were exceeded (94.7%/40% and 94%/40% respectively) • None of the targets set for CHOs who appropriately recorded LCA services in registers were met.
Indicator 3	• All targets for this indicator, including developing LCA training package,

The level of CHPS implementation with LCA in UWR is increased. 3-2 The minimum package of services focusing on the LCA is developed and proposed as national standard.	integrating the materials into pre-service education, and integrating the materials into DCHOO field guide have been met
Challenges in meeting PDM indicators	Indicator 1 • Delay in commencement of interventions due to division of regions • Shortage of supervising CHOs in NR, NER and SR • Shortage in allocation of CHNs for training as CHOs Indicator 2 • Delay in implementation of activities in SR Indicator 3 • Inadequate skills of CHOs • Lack of standardized documentation for LCA services • Poor utilization of LCA data • Inadequate supervision of LCA services by SDHTs.
Recommendations for sustainability	• Mobilize resources from stakeholders to support CHPS implementation • Establish model CHPS zones in NR, NER and SR to support CHO training • GHS should recruit and deploy CHNs • Continuous capacity building needed for CHOs on LCA service provision • Develop standardized register for health screening • Introduce system to facilitate utilization of the LCA service data
	•

Output 0: Management

Indicator	Status of Achievement
• 0-1 Joint Coordination Committee meeting conducted at least once per year	• Target exceeded (9 meetings conducted out of a targeted 6)
• 0-2 Number of technical exchange events conducted during project period	• 11 exchange events conducted. (No target was set for this indicator)
• GHS HQ receives monitoring sheet (twice a year) and progress report (as determined in R/D)	• All targets achieved (11 monitoring sheets, 4 progress reports and 2 completion reports have been submitted within the project period)

Output 1: CHPS implementation

Indicator	Status of Achievement
Indicator 1-1 • Beneficiaries of Harmonized CHO Training: • Benefitted students of pre-service training NAC, NAP, MTS, Tutors	• 520 CHNs trained as CHOs (no target) • 1,573 NAC, 803 NAP, 1,010 MTC trained through preservice • 113/1125 tutors trained across the NAP, NAC and MTCs. (no target)
• Indicator 1-2 The number of districts which conduct district CHO Orientation at least once. • The number of CHO trained through district CHO Orientation	• The target was achieved (55 of 55 districts conducted DCHOO at least once) • 1,129 CHNs trained through DCHOO (no target set)
Indicator 1-3 Referral system is strengthened in pilot districts	• All pilot districts achieved the indicator on number of health facilities whose staff are trained on referrals • Nadowli Kaleo met the target set for number referrals done according to protocol (100%). Talensi was within 10% of the target (73.3%/75%), whilst Savelugu was beyond 10% of the target (63.6%/75%) • Only Talensi met the target for the indicator on feedbacks sent to CHPS zones (60.8%/60%). Nadowli was within 10% to the target (56.3%/60%) whilst Savelugu did not meet the target (32.3%/60%)
Indicator 1-4 Monitoring system is strengthened in target districts The standardized reference guide for District Health Quarterly Performance Review (DHQPR) Meeting is developed and introduced to all districts of the Project target regions. All districts conduct District Health Quarterly Performance Review Meeting	• The target for development of SS materials was met. • The targets for implementation rate of SS was met by Nadolwi and Talensi (93.1%/80% and 95.3%/80% respectively). Savelugu was within 55 of the target (73%/75%) whilst Nanton was beyond 10% of the target (62.5%/75%) • The target for this indicator was achieved. • UWR met the target (11/11 districts all conducted 2 rounds of DHQPR), UER

with the standardized reference guide at least twice per year over the project period. Indicator 1-5 CHPS database system is established at least in five regions and disseminated nationally.	and NR were within 5% of their targets (93.3% and 93.8% respectively) NER was within 50% of the target (50%/100%) whereas SR was below 50% of the target (42.(5?100%) • Target for this indicator has been achieved. (16/16)
Challenges of Output 1	• Inadequate number of CHNs • Inadequate number of supervising CHOs • Inadequate and incomplete referral documentation • Non-compliance with referral; processes • Delayed start of SS program due to delay in start of national SS programme • Conflicting activities affects staff ability to conduct SS
Recommendations	• Establish model CHPS zones • Training of staff on documentation of referrals. • Review revolving fund system in districts • Scale ISS using HNQIS to non pilot districts • RHMTs should harmonize DHQPR guide with national review meeting guides

Output 2 : *Community mobilization (UWR only)*

Indicator	Status of Achievement
Indicator 2-1 • 2-1. The number of **active CHMCs** for community activities is increased.	• All regions except NER met the targets of this indicator
2-2. The proportion of CHPS zones with **CHAP updated quarterly** is increased.	• With the exception of UER that was close to their target)86.5%/100%) , all other regions missed the target
2-3. The proportion of CHPS zones with **CHAP updated quarterly on Life Course Approach (LCA)** activities is increased in UWR. •	• Target achieved (76.1%/40%)

Challenges of Output 2	• Financial burden of being community volunteers affected their motivation for work. • The level of interest and the capacity of CHOs affect the success of community mobilization in the CHPS zone. • The shortage of CHOs in NR, NER and SR cause poor intervention on community mobilization, such as implementing CHAP. • Delayed implementation of training for CHMC members and CHVs.
Recommendations •	• Train CHOs to implement CHMC/CHV training effectively through the District CHO Orientation (DCHOO). • Implement non-monetary incentive activities to maintain the motivation of community health volunteers for health activities.

Output 3: CHPS Governance

Indicator	Status of Achievement
Indicator 3-1 Indicator 3-1. The proportion of districts with health-integrated annual action plans (HIAP) developed and the cost is increased.	• All regions except met the targets of this indicator
3-2. The proportion of districts in which the Regional/district Planning Coordinating Unit monitor the implementation of HIAP	• All regions met the targets set except Savannah region which had 05/100%)
3-3. The proportion of activities implemented in the HIAP is increased. •	• Only NER achieved the target. NR was within 3% to the target (37.5%/40%). UWR, UER and SR were not near their set targets.
Challenges of Output 2	• Inadequate commitment of DDHS, DCE, Regional Director, Regional Minister, RCC person in charge. • Ambitious planning based on uncertain budget for monitoring and implementation.

	• Political influence sometimes prioritizes the activity which is not part of the HIAP. • Aligning HIAP to DACF affects HIAP implementation • Target implementation (completion) rate may not represent the true status of progress when the plan includes the multiple-years activities.
Recommendations •	• Ensure implementation of the commitment agreement signed by Regional Minister and Regional Director of Health Services • Ensure stronger commitment and leadership at District and Regional levels • Leadership to devote resources for quarterly monitoring: for RPCU by RCC, and for DPCU by DCE and DCD. • Use RPCU/DCPU engagement meetings to discuss HIAP issues. • Develop more realistic plans based on reliable budget sources.

Output 4: Life-Course Approach

Indicator	Status of Achievement
Indicators 4-1 to 4-3 are same as the project purpose	• Same as project purpose
Indicator 4-4: The proportion of pregnant women receiving first trimester ANC, skilled delivery, PNC within 48 hours is increased in all regions.	• No region met the set targets. NER was within 10% of their target (43.2%/50%). UWR and UER were within 20% to the target (72.4%/85% and 57.2%/75% respectively). NR and SR were beyond 20% of the set targets (49%/85% and 50.3%/85% respectively)
% of pregnant women making at least 4 Antenatal Care (ANC) visits.	• NR achieved the target for this indicator. UWR and UER were within 10% to their targets whilst NER and SR are beyond 20% to the targets

% skilled delivery % of women who received postnatal care (PNC) from health personnel within 48 hours since delivery	• Only UER met the target for this indicator. All others were within 10% to the indicator • NER and SR attained the target for this indicator. UWR and NR were within 5% to the target and UER was beyond 20% to the target
Challenges of Output 4	• Poor health-seeking behavior. • Inequitable distribution of midwives across the regions
Recommendations •	• 1st ANC: intensify health education on the importance of early reporting. • 4 ANC: Education of mothers during the 1st ANC, booking next visit, home visit for ANC defaulters. • Skilled delivery: Accurate calculation of the expected date of delivery and promotion of birth preparedness planning • PNC within 48 hours: Home visits in case of home delivery • Strengthen the collaboration with CHMC/CHVs, schools and community

Sustainability plans by regions

Region	Sustainability plan
UWR	• The region intends to use the model CHPS zones of each of the districts to train at least 10 CHOs each year. • The region also has a number of organizations including USAID that are working closely with districts at the CHPS level; hence the RHMT will explore the possibility of soliciting their support for the DCHOO. • All districts are equally expected to plan and budget for DCHOO during the HIAP formulation. • Both District and Region will use the CHPS database to advocate for support to the districts on the DCHOO.
UER	• The region will conduct HCT for 60 CHN/- 2/district/year (supported by KOICA) • Each District will conduct at least 1 DCHOO with a least 5 participants
NR	• DDHS to sign KPI with RDHS on the training of CHOs • Lobby partners to support in the DCHOO • Regular feedback on district CHO gap • Evenly distribution of CHO in districts

	•
NER	• The region will train 50 CHOs each in Q3 2023, Q2 2024, and Q2 2025 using DCHOO. • Each year, there will be a refresher training for 50 CHOs till 2025 • Re-align population in CHPS database with the national census data •
SR	• The region will write official letters to all DDHS in the beginning of every year reminding them to incorporate DCHOO approach into their plan of activities • RHMT will provide technical support to districts relating to DCHOO

5. **Discussions on the presentation of project achievements and sustainability plans.**

- There is a need for the Human Resource Division of the Ghana Health Service to re-evaluate staff distribution and ensure that the most qualified staff are assigned to community-level healthcare. The situation where certificate-level health staff are assigned to the community level where the majority of the disease burden comes from, is not good.
- Regional teams should develop action plans addressing the various problems they face. These action plans can then be shared with donors and other funding agencies that come to the regions to implement projects. This will address the issue of donor agencies coming into regions with activities that are not in line with laid down targets.
- The World Bank Group is implementing a project in the five Northern regions and the Oti region known as the Gulf of Guinea Northern Regions Social Cohesion Project (SOCO). RHMTs and DHMTs should take steps to engage their various local government agencies (RCC and District Assemblies) to ensure that they leverage some of the SOCO project funds to support HIAPs. The planning cycle for the SOCO project starts in August.
- The NCD program office of GHS is actively pursuing a program to ensure wellness clinics are available at health facilities to cater to the screening needs of non-sick clients. Guidelines are currently being developed to specify the age groups for screening activities. In addition, data capture forms have been developed and assigned on DHIMS to facilities piloting the WHO NCD project.
- Savannah Region in implementing the wellness clinic concept, adopted the project's health screening register, which has been shared with all facilities. The register has been found to capture the key data of wellness clinics.

6. **Project Closure and remarks from CHPS for Life Project**

The acting Project Chief Advisor made remarks relating to project closure she recounted the activities and learnings that have been made since 2006 when the first project was started.

- Project team over the years has built great relations with GHS staff both in the UWR and the other 4 Northern Regions since the very first inception.
- Expressed confidence in the capacity of the GHS counterparts to carry on and build on the joint successes that have been achieved over the years.

- Thanked all participants for their participation in the dissemination and JCC as well as the support that has been offered the project since the very beginning.

7. **Remarks and way forward from five regions and HQ**

The RDHS UER made remarks on behalf of the other RDHS of the five regions. His remarks also included the commitments of the directors to sustain the gains made by the project. He stated that

- DCHOO will be used to train newly appointed and posted CHNs to ensure that CHOs are always available for service delivery
- RHMTs will work with RCCs to integrate HIAP into their planning systems and cycles
- Implored GHS HQ to incorporate the tools developed and the key learnings in the policies of GHS. This he said will ensure their sustainability.

8. **Remarks by JICA Ghana**

A Senior Representative of JICA Ghana, Mr Yasuaki Momita gave remarks on behalf of JICA Ghana. He stated the following;

- Expressed appreciation to GHS, its regions, divisions, and agencies for owning the project
- There were difficulties faced within the implementation period particularly COVID-19, despite all of these, success was achieved through the collaborative efforts of the project and counterparts.
- The goal of the project has been met despite the number of gaps that still exist. JICA Ghana will therefore continue to commit to Ghana's UHC and PHC roadmaps.
- The commitments made by the Ministry, GHS, RHMTS and DHMTS to sustain the interventions and successes of the project, are duly noted. It is the hope of JICA Ghana that the counterparts will commit to the sustainability plans so that success will be attained by 2026.
- JICA Ghana will continue to collaborate with Ghana for improving health and development even in the face of the global financial crisis,
- Thanked all for the participation and continued support

9. **Closing remarks by the chairperson**

Dr. Damien Punguyire, the RDHS of UWR on behalf of Dr. Kofi Issah, the chairman, gave the following closing remarks.

- The project has been very successful over the years. However, some interventions such as the Life Course Approach are new and have only been implemented in the Upper West region. Further support is needed to strengthen these new interventions and to also extend them to the remaining 4 regions of Northern Ghana.
- In designing future support, JICA Ghana should consider strengthening these new interventions in the regions of Northern Ghana.
- The regional directors of the five regions as well as their team desire to continue to collaborate with JICA Ghana and other development partners for improved health outcomes.

- Finally, he thanked JICA for his continued support.

10. Dissolution of JCC

The Regional Director of Upper West Region and acting chairman of JCC dissolved JCC with the following words "on behalf of the Director General, I declare the 9th JCC duly dissolved."

11. Closing prayer

The meeting ended at 4:33 pm with a closing prayer by Nana Dr. Emmanuel Ansu-Aabina, the CHPS coordinator of the Upper East Region.

Compiled by:
Mr. Kassim Abdul-Basit.....
(Senior Project Coordinator, CHPS for Life Project)

Confirmed by:
Mr. Zacchi Sabogu.....
(Project Advisor, CHPS for Life Project)

Endorsed by:
Ms. Tomoko Watanabe.....
(Health Promotion, CHPS for Life Project)

Mr. Yasuaki Momita.....
(Senior Representative, JICA Ghana Office)

Dr. Kofi Issah.....
(Director, FHD, GHS HQ)

Annex 1: List of participants

JCC meeting for CHPS for Life Project on 14 June 2023 at Labadi Beach Hotel, Accra			
List of Participants			
No	**Name**	**Organization/District**	**Background/Position**
I- GHS-HQ and MoH participants, Accra			
1	Dr. Kofi Issah	GHS HQ	Director, Family Health Division
2	Mr. Isaac Obeng Tandoh	GHS HQ	NCD Data Manager
3	Mr. Kwame Bimpeh	GHS HQ	Head, CHIM
4	Mr. Zanu Dassah	GHS HQ	Deputy Director, Training, HRD
5	Mr. Jacob Acquah Andoh	GHS HQ	Public Relations Officer
6	Mr. Stephen Obeng-Danso	GHS HQ	Administrator, PPMED
7	Ms. Aseye Afi Kpodotsi	GHS HQ	CHPS for Life Focal Person, PPMED
8	Mr. Divine Kwame Amanieh	GHS HQ	CHPS Data Manager, PPMED
9	Ms. Esther Effah Afari	GHS HQ	Administrative Manager, PPMED
II. RCC and MMDA Participants, UWR			
1	Mr. Peter M. Maala	RCC & MMDA – UWR	Chief Director, RCC
2	Mr. Nii Adjaye Laryea	RCC & MMDA – UWR	Regional Development Planning Officer, RCC
3	Mr. Bob-Milliar Gordon	RCC & MMDA – UWR	Development Planning Officer, RCC
III. GHS and Training Schools Participants, UWR			
1	Dr. Damien Punguyire	Regional Health Directorate - UWR	Regional Director of Health Services
2	Mr. Prosper N. Lana	Regional Health Directorate - UWR	Deputy Director, Administration
3	Dr. Collins Boateng Dankwah	Regional Health Directorate - UWR	Deputy Director, Public Health
4	Mr. Mohammed Tahir Abarry	Regional Health Directorate - UWR	Deputy Director, Clinical Care
5	Mr. Ambrose Naawa	Regional Health Directorate - UWR	Regional CHPS Coordinator
6	Mr. Anthony Kullah	Regional Health Directorate - UWR	Regional Nutrition Officer
7	Mr. Linus Baatiema	Regional Health Directorate - UWR	Deputy CHPS Coordinator
8	Mr. John Maakpe	Regional Health Directorate - UWR	Regional Health Promotion Officer

9	Mr. Richard Ambrose Darko	Regional Health Directorate - UWR	Regional Health Information Officer
10	Dr. Matthias Pogvi Tengan	District Health Directorate, Sissala West	DDHS
11	Ms. Phoebe Balagumyetime	District Health Directorate, Nadowli – Kaleo	DDHS
12	Dr. Alex Bapula	District Health Directorate, Wa Municipal	DDHS
13	Ms. Florence Angsowmine	District Health Directorate, Jirapa	DDHS
14	Ms. Genevieve Yirirpaare	District Health Directorate, DBI	DDHS
15	Dr. Paschal Mwine	District Health Directorate, Wa East	DDHS
16	Mr. Clifford Veng	District Health Directorate, Sissala East	DDHS
17	Mr. Denis Allotey	Regional Health Directorate - UWR	HIO
18	Rev. Sr. Genevieve Nen-nome	Community Health Nursing Training College - Jirapa	Principal
19	Mr. Ra-uf Issah	Regional Hospital – UWR	Dietician
20	Mr. Felix Baapiire	Tampaala CHPS, Jirapa Municipal	Community Health Officer
IV. RCC and MMDA Participants, UER			
1	Alhaji Inusah Abubakari	RCC & MMDA - UER	Chief Director
2	Ibrahim Kadir-Alhassan	RCC & MMDA - UER	Regional Economic and Development Officer
3	Ms. Thelma Felicity	RCC & MMDA - UER	Health Desk Officer
V. GHS and Training Schools Participants, UER			
1	Dr Emmanuel Kofi Dotse	Regional Health Directorate - UER	Regional Director of Health Services
2	Dr. Josephat I. Nyuzaghi	Regional Health Directorate - UER	Deputy Director, PH
3	Mr Pascal Dongzuning	Regional Health Directorate - UER	Deputy Director, Administration
4	Dr Abdul-Razak Dokurugu	Regional Health Directorate - UER	Deputy Director, Clinical Care
5	Dr Emmauel Ansu-Abina	Regional Health Directorate - UER	Regional CHPS Coordinator
6	Mr Philip Addo-Aboagye	Regional Health Directorate - UER	Regional Referral Focal Person

9	Ms. Basilia Saalia	JICA Project, CHPS For Life	Resource Person
10	Mr. Abu Dokuwie Alhassan	JICA Project, CHPS For Life	Senior Project Coordinator
11	Mr. Kassim Abdul-Basit	JICA Project, CHPS For Life	Senior Project Coordinator
12	Dr. Ernest Ziem Manson	JICA Project, CHPS For Life	Senior Project Coordinator
13	Mr. Raymond Alirigia	JICA Project, CHPS For Life	Junior Project Coordinator
14	Mr. Sharifdeen Amadu	JICA Project, CHPS For Life	Junior Project Coordinator
15	Ms. Anita Aba Wobil	JICA Project, CHPS For Life	Junior Project Coordinator
16	Mr. Gamuo Roger	JICA Project, CHPS For Life	Jnr Project Coordinator/Snr. Admin. Officer

Annex 2: Agenda

Agenda of Final JCC Meeting

Venue: **Labadi Beach Hotel (Accra, GAR)**
Date: **June 14, 2023**
Time: **From 14:30 to 16:30**
Chairperson **Dr. Kofi Issah, Director, FHD, Accra**

No.	Time	Activity	Person Responsible
1	14:30 – 14:35	Introduction of Participants	**Mr. Jacob Acquah** Public Relations Manager, GHS-HQ
2	14:35 – 14:40	Introduction of the Chairperson	**Mr. Jacob Acquah** Public Relations Manager, GHS-HQ
3	14:40 – 14:50	Chairperson's Remarks and Purpose of JCC Meeting	Chairperson
4	14:50 – 15:20	Presentation on the achievement of PDM indicators and sustainability plans	**Dr. Damien Punguyire** Regional Director of Health Service and Project Manager, UWR, GHS
5	15:20 – 15:35	Discussions	All
6	15:35 – 15:40	Project closure and brief remarks from CHPS for Life.	**Ms. Chisaki Sato** Ag. Chief Advisor, CHPS for Life Project
7	15:40 – 16:05	Remarks & Way forward from five regions and HQ	**Dr. Abdulai Abukari** Regional Director of Health Service and Project Manager, NER, GHS **Dr Emmanuel Kofi Dzotsi** Regional Director of Health Service and Project Manager, UER, GHS **Dr. Braimah Baba Abubakari** Ag. Regional Director of Health Service and Project Manager, NR, GHS **Dr. Damien Punguyire** Regional Director of Health Service and Project Manager, UWR, GHS **Dr. Chrysantus Kubio** Regional Director of Health Service and Project Manager, SR, GHS
8	16:05 – 16:15	Remarks from JICA Ghana	**Mr. Yasuaki Momita** Senior Representative, JICA Ghana

9	16:15 – 16:25	Closing remarks and dissolution of JCC	**Dr. Damien Punguyire** Regional Director of Health Service and Project Manager, UWR, GHS
10	16:25 – 16:30	Closing Prayer	**Dr. Emmanuel Ansu-Abina** Regional CHPS Coordinador, UER, GHS

Appendix 9 : Comparison of CHPS data of northern regions (Year of 2017, 2019 and 2023)

1． Year of 2017

No		NR	%	UWR	%	UER	%
0	**Total Population**	**2,925,489**		**811,124**		**1,216,680**	
1	**Total number of demarcated CHPS**	**643**		**323**		**406**	
2	**Population under demarcated CHPS coverage**	**2,923,021**	**99.9**	**523,409**	**64.5**	**864,231**	**71.0**
3	**Number of CHO**	**82**	**6.6**	**324**	**51.3**	**181**	**17.7**
4	**Number of CHN**	**407**	**32.9**	**63**	**10.0**	**372**	**36.4**
5	**Number of EN**	**472**	**38.1**	**179**	**28.4**	**300**	**29.4**
6	**Number of MW**	**132**	**10.7**	**65**	**10.3**	**98**	**9.6**
7	**Number of Other technical staff**	**145**	**11.7**	**0**	**0.0**	**70**	**6.9**
	Total number of staff at CHPS	**1,238**	**1.9**	**631**	**2.0**	**1,021**	**2.5**
8	**Number of Compound (Constructed)**	**259**	**40.3**	**221**	**68.4**	**166**	**40.9**
9	**Equipment**						
9.1	No equipment	**357**	**55.5**	**71**	**22.0**	**123**	**30.3**
9.2	Partially equipped	**230**	**35.8**	**133**	**41.2**	**260**	**64.0**
9.3	Fully equipped	**53**	**8.2**	**129**	**39.9**	**24**	**5.9**
10	**Service delivery started**						
10.1	No services	**72**	**11.2**	**45**	**13.9**	**78**	**19.2**
10.2	Partially	**346**	**53.8**	**42**	**13.0**	**168**	**41.4**
10.3	Fully	**225**	**35.0**	**235**	**72.8**	**161**	**39.7**
11	**CHAP Status**						
11.1	No CHAP started	**406**	**63.1**	**88**	**27.2**	**181**	**44.6**
11.2	CHAP is not updated last quarter	**111**	**17.3**	**35**	**10.8**	**90**	**22.2**
11.3	CHAP is updated last quarter	**127**	**19.8**	**183**	**56.7**	**147**	**36.2**
12	**Number of active of CHMC**	**478**	**74.3**	**272**	**84.2**	**301**	**74.1**
13	**Number of active CHV**	**3,697**	**5.7**	**1,495**	**4.6**	**1,686**	**4.2**
14	**Heath technical staff (Incl CHO)+ service delivery**	**535**	**83.2**	**274**	**84.8**	**328**	**80.8**
15	**Population covered by CHPS with health worker**	**2,215,685**	**75.7**	**492,938**	**60.8**	**753,621**	**61.9**

	Procssed data for DHIMS 2						
		NR	**%**	**UWR**	**%**	**UER**	**%**
1	Number of demarcared CHPS zone	**643**		**323**		**407**	
2	Number of completed CHPS zone	**11**	**1.7**	**104**	**32.2**	**11**	**2.7**
3	Number of CHPS compounds	**265**	**41.2**	**221**	**68.4**	**181**	**44.5**
4	Number of CHPS zone with full equipment	**14**	**2.2**	**109**	**33.7**	**12**	**2.9**
5	**Population covered by Functional CHPS**	**279,263**	**9.5**	**447,927**	**55.2**	**378,778**	**31.1**
6	**Number of functional CHPS zone**	**75**	**11.7**	**240**	**74.3**	**160**	**39.3**
7	Number of trained CHO	**82**	**0.1**	**324**	**1.0**	**181**	**0.4**
8	Number of active CHMC	**478**	**74.3**	**272**	**84.2**	**301**	**74.0**
9	Number of active CHV	**3,697**	**5.7**	**1,495**	**4.6**	**1,686**	**4.1**
10	Number of functional CHPS zone with CHAP	**45**	**7.0**	**204**	**63.2**	**136**	**33.4**

2. Year of 2019

It is divided in five regions due to the reorganization of Northern Region.

No		unit	UER Q4 2019	%	UWR Q4 2019	%	NR Q4 2019	%	NER Q4 2019	%	SR Q4 2019	%
0			1,273,677		849,123		1,905,623		575,557		581,368	
1	**Total number of demarcated CHPS**		523		391		449		146		167	
2	**Population under demarcated CHPS coverage**	%	1,273,677	100.0	581,955	68.5	1,672,343	87.8	499,550	86.8	533,663	91.8
3	**Number of CHO**	%	319	27.2	380	52.2	84	18.8	26	11.0	19	7.6
4	**Number of CHN**	%	391	33.4	101	13.9	222	49.8	51	21.5	95	38.2
5	**Number of EN**	%	282	24.1	179	24.6	309	69.3	99	41.8	46	18.5
6	**Number of MW**	%	110	9.4	63	8.7	77	17.3	27	11.4	52	20.9
7	**Number of Other technical staff**	%	70	6.0	5	0.7	63	14.1	34	14.3	37	14.9
	Total number of staff at CHPS	Person	1,172	2.2	728	1.9	446	1.0	237	1.6	249	1.5
8	**Number of Compound (Constructed)**	%	210	40.2	250	63.9	159	35.4	54	37.0	84	50.3
9	**Accomodation for staff at compound**											
9.1	0: No accomodation	%	327	62.5	147	37.6	297	66.1	94	64.4	82	49.1
9.2	1: 1 room is available	%	17	3.3	26	6.6	35	7.8	13	8.9	38	22.8
9.3	2: 2 or more rooms available	%	179	34.2	218	55.8	117	26.1	39	26.7	47	28.1
10	**Equipment**											
10.1	0: No equipment	%	138	26.4	64	16.4	210	46.8	100	68.5	68	40.7
10.2	1: Up to 25% (1-10)	%	134	25.6	78	19.9	118	26.3	24	16.4	37	22.2
10.3	2:Up to 50% (11-20)	%	104	19.9	117	29.9	53	11.8	17	11.6	33	19.8
10.4	3: Up to 75% (21-30)	%	104	19.9	82	21.0	48	10.7	5	3.4	25	15.0
10.5	4: Up to 100% (31-40)	%	43	8.2	50	12.8	20	4.5	0	0.0	4	2.4
11	**EPI Refrigirator**											
11.1	0: No EPI refrigirator	%	444	84.9	251	64.2	390	86.9	128	87.7	130	77.8
11.2	1: Refr. is NOT functioning	%	32	6.1	28	7.2	5	1.1	4	2.7	9	5.4
11.3	2:Refr. Is functioning	%	47	9.0	112	28.6	54	12.0	14	9.6	28	16.8
12	**Official Motorbike**											
12.1	0: No official motorbiker	%	228	43.6	167	42.7	261	58.1	90	61.6	62	37.1
12.2	1: Bike is NOT functioning	%	43	8.2	37	9.5	23	5.1	18	12.3	23	13.8
12.3	2:.Bike is functioning	%	252	48.2	187	47.8	165	36.7	38	26.0	82	49.1
13	**Electricity**											
13.1	0: No electricity	%	355	67.9	168	43.0	281	62.6	94	64.4	70	41.9
13.2	1: Generator	%	2	0.4	2	0.5	1	0.2	0	0.0	0	0.0
13.3	2:.Solor	%	25	4.8	33	8.4	14	3.1	5	3.4	18	10.8
13.4	3: GRID	%	141	27.0	188	48.1	153	34.1	47	32.2	79	47.3
14	**Access to portable water**											
14.1	0: No access to portable water	%	317	60.6	207	52.9	360	80.2	111	76.0	129	77.2
14.2	1: Access toi portable water	%	206	39.4	184	47.1	89	19.8	35	24.0	38	22.8
15	**Toilet**											
15.1	0: No toilet	%	336	64.2	153	39.1	305	67.9	107	73.3	90	53.9
15.2	1: Toilet for staff only	%	96	18.4	94	24.0	74	16.5	16	11.0	41	24.6
15.3	**2:.Toilet for staff and client**	%	91	17.4	144	36.8	70	15.6	23	15.8	36	21.6
16	**Service delivery started**											
16.1	No services	%	109	20.8	19	4.9	93	20.7	25	17.1	22	13.2
16.2	Partially	%	208	39.8	127	32.5	217	48.3	91	62.3	72	43.1
16.3	Fully	%	206	39.4	245	62.7	139	31.0	30	20.5	73	43.7
17	**CHAP Status**											
17.1	No CHAP started	%	191	36.5	56	14.3	281	62.6	120	82.2	106	63.5
17.2	CHAP is not updated last quarter	%	43	8.2	55	14.1	73	16.3	16	11.0	23	13.8
17.3	CHAP is updated last quarter	%	289	55.3	280	71.6	95	21.2	10	6.8	38	22.8
18	**Number of active of CHMC**	%	378	72.3	350	89.5	363	80.8	81	55.5	141	84.4
19	**Number of active CHV**	CHV	2,169	4.1	1699	4.3	2,141	4.8	536	3.7	1,046	6.3
20	**Heath technical staff (Incl CHO)+ service delivery**	%	405	77.4	371	94.9	346	77.1	115	78.8	124	74.3
21	**Population covered by CHPS with health worker**	%	1,002,209	78.7	574294	67.6	1,327,539	69.7	364,372	63.3	367,862	63.3

	Procssed data for DHIMS 2											
		unit	**Q3 2019**	**%**	**Q4 2019**	**%**	**Q4 2019**	**%**	**Q4 2019**	**%**	**Q4 2019**	**%**
1	Number of demarcared CHPS zone	**%**	**523**		**391**		**449**		**146**		**167**	
2	Number of completed CHPS zone	**%**	**18**	**3.4**	**70**	**17.9**	**16**	**3.6**	**0**	**0.0**	**0**	**0.0**
3	Number of CHPS compounds	**%**	**210**	**40.2**	**250**	**63.9**	**166**	**37.0**	**54**	**37.0**	**84**	**50.3**
4	**Population covered by Functional CHPS**	**%**	**754,888**	**59.3**	**536,942**	**63.2**	**292,230**	**15.3**	**53,650**	**9.3**	**46,534**	**8.0**
5	**Number of functional CHPS zone**	**%**	**298**	**57.0**	**338**	**86.4**	**66**	**14.7**	**19**	**13.0**	**15**	**9.0**
6	Number of trained CHO	**%**	**319**	**61.0**	**380**	**97.2**	**119**	**26.5**	**26**	**17.8**	**19**	**11.4**
7	Number of active CHMC	**%**	**378**	**72.3**	**350**	**89.5**	**387**	**86.2**	**81**	**55.5**	**141**	**84.4**
8	Number of active CHV	**CHV**	**2,169**	**4.1**	**1,699**	**4.3**	**2,212**	**4.9**	**536**	**3.7**	**1,046**	**6.3**
9	Number of functional CHPS zone with CHAP	**%**	**271**	**51.8**	**324**	**82.9**	**58**	**12.9**	**12**	**8.2**	**10**	**6.0**
10	CHPS with (Basic) equipment	**%**	**33**	**6.3**	**71**	**18.2**	**36**	**8.0**	**1**	**0.7**	**7**	**4.2**

3. Year of 2023

No	Item	unit	UER Q1 2023	%	UWR Q1 2023	%	NR Q1 2023	%	NER Q1 2023	%	SR Q1 2023	%
0	Total Population		1,328,551		939,760		2,359,469		672,784		666,985	
1	Total number of demarcated CHPS		525		496		515		155		195	
2	Population under demarcated CHPS coverage	%	1,353,396	101.9	939,760	100.0	2,330,489	98.8	857,341	127.4	659,684	98.9
3	Number of CHO	%	669	37.6	549	51.9	270	16.6	90	12.9	137	20.9
4	Number of CHN	%	347	19.5	86	8.1	372	22.8	118	16.9	125	19.0
5	Number of EN	%	405	22.8	230	21.8	535	32.8	312	44.8	236	35.9
6	Number of MW	%	251	14.1	177	16.7	191	11.7	76	10.9	90	13.7
7	Number of Other technical staff	%	108	6.1	15	1.4	262	16.1	101	14.5	69	10.5
8	Number of Compound (Constructed)	%	249	47.4	302	60.9	226	43.9	71	45.8	110	56.4
9	**Accomodation for staff at compound**											
9.1	0: No accomodation	%	295	56.2	193	38.9	343	66.6	87	56.1	91	46.7
9.2	1: 1 room is available	%	18	3.4	44	8.9	35	6.8	21	13.5	26	13.3
9.3	2: 2 or more rooms available	%	212	40.4	259	52.2	145	28.2	45	29.0	77	39.5
10	**Equipment**											
10.1	No equipment at all	%	33	6.3	47	9.5	210	40.8	73	47.1	58	29.7
10.2	No. 1 and 29 items of basic eqyuipment	%	255	48.6	190	38.3	172	33.4	38	24.5	51	26.2
10.3	Full basic equipment. (30 items)	%	105	20.0	86	17.3	61	11.8	28	18.1	43	22.1
10.4	Full basic equipment+some other equipment	%	92	17.5	92	18.5	30	5.8	4	2.6	23	11.8
10.5	Full equipment (49 items)	%	40	7.6	81	16.3	49	9.5	12	7.7	20	10.3
11	**EPI Refrigirator**											
11.1	0: No EPI refrigirator	%	399	76.0	300	60.5	383	74.4	106	68.4	135	69.2
11.2	1: Refr. is NOT functioning	%	12	2.3	19	3.8	12	2.3	0	0.0	0	0.0
11.3	2:Refr. Is functioning	%	114	21.7	177	35.7	128	24.9	49	31.6	60	30.8
12	**Official Motorbike**											
12.1	0: No official motorbiker	%	202	38.5	225	45.4	289	56.1	83	53.5	78	40.0
12.2	1: Bike is NOT functioning	%	25	4.8	34	6.9	32	6.2	8	5.2	9	4.6
12.3	2:.Bike is functioning	%	298	56.8	237	47.8	194	37.7	64	41.3	108	55.4
13	**Electricity**											
13.1	0: No electricity	%	319	60.8	206	41.5	287	55.7	89	57.4	63	32.3
13.2	1: Generator	%	3	0.6	2	0.4	1	0.2	0	0.0	2	1.0
13.3	2:.Solor	%	23	4.4	35	7.1	10	1.9	4	2.6	13	6.7
13.4	3: GRID	%	180	34.3	253	51.0	221	42.9	62	40.0	117	60.0
14	**Access to portable water**											
14.1	0: No access to portable water	%	273	52.0	227	45.8	397	77.1	110	71.0	120	61.5
14.2	1: Access toi portable water	%	252	48.0	269	54.2	126	24.5	45	29.0	75	38.5
15	**Toilet**											
15.1	0: No toilet	%	294	56.0	225	45.4	331	64.3	92	59.4	108	55.4
15.2	1: Toilet for staff only	%	109	20.8	100	20.2	90	17.5	24	15.5	43	22.1
15.3	**2:.Toilet for staff and client**	%	122	23.2	171	34.5	96	18.6	39	25.2	44	22.6
16	**Access to Network**											
16.1	0: No access to Network	%	23	4.4	153	30.8			14	9.0	71	36.4
16.2	1: Access to Network	%	502	95.6	343	69.2			79	51.0	124	63.6
16	**Service delivery started**											
16.1	No services	%	0	0.0	0	0.0	85	16.5	18	11.6	16	8.2
16.2	Partially	%	248	47.2	210	42.3	242	47.0	93	60.0	73	37.4
16.3	Fully	%	277	52.8	286	57.7	192	37.3	44	28.4	106	54.4
17	**CHAP Status**											
17.1	No CHAP started	%	36	6.9	36	7.3	206	40.0	92	59.4	59	30.3
17.2	CHAP is not updated last quarter	%	35	6.7	71	14.3	53	10.3	18	11.6	41	21.0
17.3	CHAP is updated last quarter	%	454	86.5	389	78.4	264	51.3	45	29.0	95	48.7
18	**Number of active of CHMC**	%	525	100.0	496	100.0	349	67.8	79	51.0	164	84.1
19	**Number of active CHV**	CHV	2,524	4.8	2,024	4.1	3,243	6.3	527	3.4	1,246	6.4
20	**Number of CHPS with service and staff**	%	525	100.0	496	100.0	429	83.3	135	87.1	169	86.7
21	**Population covered by CHPS with services and staff**	%	1,353,396	101.9	939,760	100.0	2,022,749	85.7	784,314	116.6	555,903	83.3

Procssed data for DHIMS 2

No	Item	unit	UER Q1 2023	%	UWR Q1 2023	%	NR Q1 2023	%	NER Q1 2023	%	SR Q1 2023	SR
1	Number of demarcared CHPS zone	%	525		496		515		155		195	
2	Number of completed CHPS zone	%	35	6.7	61	12.3	38	7.4	9	5.8	12	6.2
3	Number of of CHPS compounds	%	249	47.4	302	60.9	226	43.9	71	45.8	110	56.4
4	Population covered by functional CHPS	%	1,353,396	101.9	929,474	98.9	1,076,452	45.6	319,425	47.5	443,424	66.5
5	**Number of functional CHPS zone**	%	525	100.0	484	97.6	236	45.8	74	47.7	129	66.2
6	Number of trained CHO	%	669	127.4	549	110.7	272	52.8	90	58.1	137	70.3
7	Number of active CHMC with meeting in the last 3 months	%	525	100.0	496	100.0	349	67.8	79	51.0	164	84.1
8	Number of active CHV	CHV	2,524	4.8	2,024	4.1	3,243	6.3	527	3.4	1,246	6.4
9	Number of functional CHPS zone with CHAP	%	489	93.1	460	92.7	226	43.9	38	24.5	118	60.5
10	Number of Functional CHPS zone with basic Equipment	%	237	45.1	184	37.1	138	26.8	44	28.4	83	42.6
11	Number ofCommunities covered by GHS facilities (CHPS or SDHT)		1,425		1,287		3,106		850		149,381	
12	Number of electral area		359		303		430		132		151	

Appendix 10 : Comparison of CHPS data of 15 regions in Ghana (Year 2022)

No	Item	Ahafo Q2 2022	%	Bono Q2 2022	%	Bono East Q2 2022	%	Central Q3 2022	%	Eastern Q2 2022	%
0	**Total Population**	576,526		1,234,031		1,228,672		2,919,877		2,987,092	
1	**Total number of demarcated CHPS**	178		319		301		537		958	
2	**Population under demarcated CHPS coverage**	550,441	95.5	1,108,988	89.9	1,133,290	92.2	1,948,905	66.7	2,708,372	90.7
3	**Number of CHO**	13	1.9	53	4.3	54	4.3	97	6.1	188	7.2
4	**Number of CHN**	463	66.8	537	43.5	643	50.8	854	53.8	1,423	54.8
5	**Number of EN**	163	23.5	377	30.5	362	28.6	315	19.8	616	23.7
6	**Number of MW**	45	6.5	143	11.6	120	9.5	249	15.7	269	10.4
7	**Number of Other technical staff**	9	1.3	125	10.1	86	6.8	73	4.6	103	4.0
	Total number of staff at CHPS	693	3.9	1,235	3.9	1,265	4.2	1,588	3.0	2,599	2.7
8	**Number of Compound (Constructed)**	68	38.2	107	33.5	113	37.5	285	53.1	377	39.4
9	**Accomodation for staff at compound**										
9.1	0: No accomodation	109	61.2	230	72.1	208	69.1	240	44.7	664	69.3
9.2	1: 1 room is available	3	1.7	39	12.2	20	6.6	90	16.8	66	6.9
9.3	2: 2 or more rooms available	66	37.1	50	15.7	73	24.3	207	38.5	221	23.1
10	**Equipment**										
10.1	No equipment at all	69	38.8	98	30.7	110	36.5	69	12.8	207	21.6
10.2	No. 1 and 29 items of basic eqyuipment	96	53.9	191	59.9	160	53.2	360	67.0	585	61.1
10.3	Full basic equipment. (30 items)	1	0.6	18	5.6	4	1.3	86	16.0	88	9.2
10.4	Full basic equipment+some other equipment	11	6.2	10	3.1	27	9.0	15	2.8	59	6.2
10.5	Full equipment (49 items)	1	0.6	2	0.6	0	0.0	7	1.3	19	2.0
11	**EPI Refrigirator**										
11.1	0: No EPI refrigirator	128	71.9	273	85.6	239	79.4	301	56.1	642	67.0
11.2	1: Refr. is NOT functioning	19	10.7	13	4.1	31	10.3	33	6.1	59	6.2
11.3	2:Refr. Is functioning	31	17.4	33	10.3	31	10.3	203	37.8	257	26.8
12	**Official Motorbike**										
12.1	0: No official motorbiker	127	71.3	234	73.4	203	67.4	424	79.0	756	78.9
12.2	1: Bike is NOT functioning	15	8.4	37	11.6	22	7.3	33	6.1	78	8.1
12.3	2:.Bike is functioning	36	20.2	48	15.0	76	25.2	80	14.9	124	12.9
13	**Electricity**										
13.1	0: No electricity	74	41.6	136	42.6	153	50.8	117	21.8	352	36.7
13.2	1: Generator	0	0.0	3	0.9	11	3.7	3	0.6	37	3.9
13.3	2:.Solor	3	1.7	1	0.3	4	1.3	8	1.5	24	2.5
13.4	3: GRID	101	56.7	179	56.1	133	44.2	409	76.2	545	56.9
14	**Access to portable water**										
14.1	0: No access to portable water	77	43.3	184	57.7	164	54.5	227	42.3	639	66.7
14.2	1: Access toi portable water	101	56.7	135	42.3	136	45.2	310	57.7	319	33.3
15	**Toilet**										
15.1	0: No toilet	99	55.6	218	68.3	170	56.5	231	43.0	591	61.7
15.2	1: Toilet for staff only	28	15.7	46	14.4	50	16.6	133	24.8	172	18.0
15.3	**2:.Toilet for staff and client**	51	28.7	55	17.2	81	26.9	173	32.2	195	20.4
14	**Access to Network**										
14.1	0: No access to Network	13	7.3	72	22.6	53	17.6	94	17.5		
14.2	1: Access to Network	157	88.2	247	77.4	248	82.4	443	82.5		
16	**Service delivery started**										
16.1	No services	0	0.0	12	3.8	0	0.0	16	3.0	64	6.7
16.2	Partially	110	61.8	222	69.6	210	69.8	212	39.5	469	49.0
16.3	Fully	68	38.2	85	26.6	91	30.2	309	57.5	425	44.4
17	**CHAP Status**										
17.1	No CHAP started	18	10.1	110	34.5	137	45.5	124	23.1	374	39.0
17.2	CHAP is not updated last quarter	71	39.9	149	46.7	86	28.6	320	59.6	268	28.0
17.3	CHAP is updated last quarter	89	50.0	60	18.8	78	25.9	93	17.3	316	33.0
18	**Number of active of CHMC**	165	92.7	257	80.6	200	66.4	431	80.3	668	69.7
19	**Number of active CHV**	554	3.1	525	1.6	853	2.8	913	1.7	1,179	1.2
20	**Population cverage by CHPS with service and staff**	178	95.5	307	89.4	301	92.2	503	63.1	882	87.0
21	**Population covered by CHPS with services and staff**	550,441	95.5	1,102,779	89.4	1,133,290	92.2	1,843,243	63.1	2,597,725	87.0

Procssed data for DHIMS 2

No	Item	Ahafo Q2 2022	%	Bono Q2 2022	%	Bono East Q2 2022	%	Central Q3 2022	%	Eastern Q2 2022	%
1	Number of demarcared CHPS zone	178		319		301		537		958	
2	Number of completed CHPS zone	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
3	Number of of CHPS compounds	68	38.2	107	33.5	113	37.5	285	53.1	368	38.4
4	Population covered by functional CHPS	49,091	8.5	113,275	9.2	172,524	14.0	439,795	15.1	280,582	9.4
5	**Number of functional CHPS zone**	13	7.3	34	10.7	40	13.3	71	13.2	103	10.8
6	Number of trained CHO	13	7.3	53	16.6	54	17.9	97	18.1	183	19.1
7	Number of active CHMC with meeting in the last 3 months	165	92.7	257	80.6	200	66.4	430	80.1	671	70.0
8	Number of active CHV	554	3.1	525	1.6	853	2.8	913	1.7	1,158	1.2
9	Number of functional CHPS zone with CHAP	13	7.3	34	10.7	29	9.6	68	12.7	84	8.8
10	Number of Functional CHPS zone with basic Equipment	1	0.6	1	0.3	4	1.3	107	19.9	40	4.2
11	Number ofCommunities covered by GHS facilities	178		525		720		643		3,466	
12	Number of electral area	178		292		282		271		0	

No	Item	Greater Accra Q2 2022	%	Northern Q2 2022	%	Nort East Q2 2022	%	Oti Q2 2022	%	Savannah Q2 2022	%
0	**Total Population**	5,570,264		2,359,469		672,784		762,940		666,984	
1	**Total number of demarcated CHPS**	878		465		155		194		190	
2	**Population under demarcated CHPS coverage**	5,176,925	92.9	2,135,102	90.5	612,995	91.1	537,835	70.5	655,140	98.2
3	**Number of CHO**	270	15.1	223	6.5	69	12.3	42	5.2	71	11.7
4	**Number of CHN**	1,287	71.9	76	2.2	96	17.1	299	36.8	133	21.9
5	**Number of EN**	143	8.0	190	5.5	244	43.5	322	39.7	236	38.9
6	**Number of MW**	59	3.3	306	8.9	74	13.2	94	11.6	91	15.0
7	**Number of Other technical staff**	30	1.7	2,645	76.9	78	13.9	55	6.8	75	12.4
	Total number of staff at CHPS	1,789	2.0	3,440	7.4	561	3.6	812	4.2	606	3.2
8	**Number of Compound (Constructed)**	62	7.1	201	43.2	71	45.8	89	45.9	99	52.1
9	**Accomodation for staff at compound**										
9.1	0: No accomodation	820	93.4	298	64.1	88	56.8	107	55.2	86	45.3
9.2	1: 1 room is available	25	2.8	34	7.3	21	13.5	8	4.1	27	14.2
9.3	2: 2 or more rooms available	32	3.6	133	28.6	46	29.7	79	40.7	74	38.9
10	**Equipment**										
10.1	No equipment at all	302	34.4	177	38.1	74	47.7	18	9.3	68	35.8
10.2	No. 1 and 29 items of basic eqyuipment	540	61.5	200	43.0	39	25.2	171	88.1	56	29.5
10.3	Full basic equipment. (30 items)	29	3.3	37	8.0	26	16.8	3	1.5	24	12.6
10.4	Full basic equipment+some other equipment	6	0.7	23	4.9	6	3.9	0	0.0	26	13.7
10.5	Full equipment (49 items)	0	0.0	26	5.6	10	6.5	2	1.0	14	7.4
11	**EPI Refrigirator**										
11.1	0: No EPI refrigirator	811	92.4	343	73.8	107	69.0	88	45.4	123	64.7
11.2	1: Refr. is NOT functioning	17	1.9	23	4.9	0	0.0	14	7.2	0	0.0
11.3	2:Refr. Is functioning	49	5.6	99	21.3	48	31.0	92	47.4	65	34.2
12	**Official Motorbike**										
12.1	0: No official motorbiker	851	96.9	238	51.2	83	53.5	102	52.6	82	43.2
12.2	1: Bike is NOT functioning	9	1.0	35	7.5	7	4.5	23	11.9	10	5.3
12.3	2:.Bike is functioning	17	1.9	192	41.3	65	41.9	69	35.6	96	50.5
13	**Electricity**										
13.1	0: No electricity	784	89.3	263	56.6	92	59.4	65	33.5	64	33.7
13.2	1: Generator	2	0.2	1	0.2	0	0.0	5	2.6	2	1.1
13.3	2:.Solor	0	0.0	14	3.0	4	2.6	12	6.2	14	7.4
13.4	3: GRID	91	10.4	187	40.2	59	38.1	112	57.7	108	56.8
14	**Access to portable water**										
14.1	0: No access to portable water	802	91.3	355	76.3	111	71.6	97	50.0	121	63.7
14.2	1: Access toi portable water	75	8.5	110	23.7	44	28.4	97	50.0	67	35.3
15	**Toilet**										
15.1	0: No toilet	813	92.6	286	61.5	94	60.6	98	50.5	101	53.2
15.2	1: Toilet for staff only	40	4.6	92	19.8	27	17.4	48	24.7	44	23.2
15.3	**2:.Toilet for staff and client**	24	2.7	87	18.7	34	21.9	46	23.7	43	22.6
14	**Access to Network**										
14.1	0: No access to Network	73	8.3			34					
14.2	1: Access to Network	802	91.3			121					
16	**Service delivery started**										
16.1	No services	41	4.7	84	18.1	19	12.3	22	11.3	33	17.4
16.2	Partially	742	84.5	205	44.1	91	58.7	80	41.2	66	34.7
16.3	Fully	94	10.7	176	37.8	45	29.0	92	47.4	89	46.8
17	**CHAP Status**										
17.1	No CHAP started	297	33.8	199	42.8	118	76.1	123	63.4	72	37.9
17.2	CHAP is not updated last quarter	264	30.1	76	16.3	17	11.0	66	34.0	28	14.7
17.3	CHAP is updated last quarter	315	35.9	190	40.9	20	12.9	4	2.1	88	46.3
18	**Number of active of CHMC**	593	67.5	306	65.8	74	47.7	108	55.7	133	70.0
19	**Number of active CHV**	636	0.7	2,645	5.7	522	3.4	530	2.7	1,176	6.2
20	**Population cverage by CHPS with service and staff**	808	92.0	359	70.3	132	77.0	162	63.4	147	77.2
21	**Population covered by CHPS with services and staff**	4,933,604	88.6	1,657,551	70.3	518,018	77.0	483,331	63.4	514,860	77.2

Procssed data for DHIMS 2

No	Item	Greater Accra Q2 2022	%	Northern Q2 2022	%	Nort East Q2 2022	%	Oti Q2 2022	%	Savannah Q2 2022	%
1	Number of demarcared CHPS zone	878		465		155		194		190	
2	Number of completed CHPS zone	0	0.0	24	5.2	8	5.2	0	0.0	11	5.8
3	Number of of CHPS compounds	62	7.1	201	43.2	71	45.8	89	45.9	99	52.1
4	Population covered by functional CHPS	1,120,460	20.1	769,364	32.6	246,427	36.6	99,447	13.0	255,057	38.2
5	**Number of functional CHPS zone**	121	13.8	158	34.0	62	40.0	28	14.4	69	36.3
6	Number of trained CHO	270	30.8	225	48.4	69	44.5	48	24.7	71	37.4
7	Number of active CHMC with meeting in the last 3 months	593	67.5	306	65.8	74	47.7	113	58.2	133	70.0
8	Number of active CHV	636	0.7	2,645	5.7	522	3.4	530	2.7	1,176	6.2
9	Number of functional CHPS zone with CHAP	116	13.2	145	31.2	26	16.8	27	13.9	62	32.6
10	Number of Functional CHPS zone with basic Equipment	0	0.0	82	17.6	42	27.1	5	2.6	63	33.2
11	Number ofCommunities covered by GHS facilities	1,299		2,951		834		753		941	
12	Number of electral area	375		392		133		182		151	

No	Item	Upper East Q2 2022	%	Upper West Q2 2022	%	Volta Q2 2022	%	Western Q2 2022	%	Western North Q2 2022	%
0	**Total Population**	1,328,551		922,236		1,705,838		2,258,953		1,133,492	
1	**Total number of demarcated CHPS**	525		496		436		448		284	
2	**Population under demarcated CHPS coverage**	1,353,333	101.9	922,236	100.0	1,203,646	70.6	1,500,743	66.4	615,471	54.3
3	**Number of CHO**	600	35.9	493	49.9	103	6.9	72	4.3	45	4.1
4	**Number of CHN**	354	21.2	112	11.3	748	50.1	920	54.6	403	37.1
5	**Number of EN**	396	23.7	224	22.7	339	22.7	411	24.4	402	37.1
6	**Number of MW**	226	13.5	152	15.4	214	14.3	186	11.0	144	13.3
7	**Number of Other technical staff**	97	5.8	7	0.7	88	5.9	97	5.8	91	8.4
	Total number of staff at CHPS	1,673	3.2	988	2.0	1,492	3.4	1,686	3.8	1,085	3.8
8	**Number of Compound (Constructed)**	251	47.8	293	59.1	160	36.7	236	52.7	104	36.6
9	**Accomodation for staff at compound**										
9.1	0: No accomodation	280	53.3	200	40.3	281	64.4	239	53.3	141	49.6
9.2	1: 1 room is available	43	8.2	44	8.9	43	9.9	56	12.5	51	18.0
9.3	2: 2 or more rooms available	202	38.5	252	50.8	112	25.7	151	33.7	92	32.4
10	**Equipment**										
10.1	No equipment at all	53	10.1	74	14.9	101	23.2	89	19.9	60	21.1
10.2	No. 1 and 29 items of basic eqyuipment	235	44.8	161	32.5	278	63.8	310	69.2	136	47.9
10.3	Full basic equipment. (30 items)	96	18.3	82	16.5	19	4.4	24	5.4	43	15.1
10.4	Full basic equipment+some other equipment	86	16.4	84	16.9	37	8.5	17	3.8	45	15.8
10.5	Full equipment (49 items)	55	10.5	95	19.2	1	0.2	6	1.3	0	0.0
11	**EPI Refrigirator**										
11.1	0: No EPI refrigirator	403	76.8	308	62.1	226	51.8	282	62.9	178	62.7
11.2	1: Refr. is NOT functioning	19	3.6	16	3.2	7	1.6	28	6.3	23	8.1
11.3	2:Refr. Is functioning	103	19.6	172	34.7	203	46.6	137	30.6	83	29.2
12	**Official Motorbike**										
12.1	0: No official motorbiker	200	38.1	238	48.0	319	73.2	348	77.7	202	71.1
12.2	1: Bike is NOT functioning	28	5.3	27	5.4	21	4.8	40	8.9	32	11.3
12.3	2:.Bike is functioning	297	56.6	231	46.6	96	22.0	58	12.9	50	17.6
13	**Electricity**										
13.1	0: No electricity	327	62.3	227	45.8	178	40.8	83	18.5	55	19.4
13.2	1: Generator	3	0.6	1	0.2	2	0.5	57	12.7	7	2.5
13.3	2:.Solor	24	4.6	28	5.6	15	3.4	7	1.6	7	2.5
13.4	3: GRID	171	32.6	240	48.4	241	55.3	300	67.0	215	75.7
14	**Access to portable water**										
14.1	0: No access to portable water	277	52.8	263	53.0	224	51.4	158	35.3	196	69.0
14.2	1: Access toi portable water	248	47.2	233	47.0	210	48.2	289	64.5	88	31.0
15	**Toilet**										
15.1	0: No toilet	297	56.6	234	47.2	249	57.1	196	43.8	153	53.9
15.2	1: Toilet for staff only	104	19.8	96	19.4	55	12.6	152	33.9	82	28.9
15.3	**2:.Toilet for staff and client**	124	23.6	166	33.5	132	30.3	99	22.1	49	17.3
14	**Access to Network**										
14.1	0: No access to Network	40	7.6	157	31.7	69	15.8	59	13.2	123	43.3
14.2	1: Access to Network	485	92.4	339	68.3	367	84.2	269	60.0	161	56.7
16	**Service delivery started**										
16.1	No services	14	2.7	45	9.1	37	8.5	16	3.6	32	11.3
16.2	Partially	241	45.9	158	31.9	232	53.2	191	42.6	102	35.9
16.3	Fully	270	51.4	293	59.1	167	38.3	240	53.6	150	52.8
17	**CHAP Status**										
17.1	No CHAP started	55	10.5	65	13.1	167	38.3	261	58.3	183	64.4
17.2	CHAP is not updated last quarter	59	11.2	53	10.7	135	31.0	49	10.9	51	18.0
17.3	CHAP is updated last quarter	411	78.3	378	76.2	134	30.7	137	30.6	50	17.6
18	**Number of active of CHMC**	497	94.7	428	86.3	266	61.0	303	67.6	179	63.0
19	**Number of active CHV**	2,552	4.9	1,765	3.6	889	2.0	787	1.8	417	1.5
20	**Population cverage by CHPS with service and staff**	511	99.9	449	94.0	383	64.5	411	62.7	240	51.3
21	**Population covered by CHPS with services and staff**	1,326,817	99.9	867,054	94.0	1,100,726	64.5	1,416,609	62.7	581,663	51.3

Procssed data for DHIMS 2

No	Item	Upper East Q2 2022	%	Upper West Q2 2022	%	Volta Q2 2022	%	Western Q2 2022	%	Western North Q2 2022	%
1	Number of demarcared CHPS zone	525		496		436		448		284	
2	Number of completed CHPS zone	36	6.9	69	13.9	0	0.0	0	0.0	0	0.0
3	Number of of CHPS compounds	251	47.8	293	59.1	160	36.7	236	52.7	104	36.6
4	Population covered by functional CHPS	1,271,203	95.7	839,830	91.1	177,058	10.4	133,531	5.9	65,933	5.8
5	**Number of functional CHPS zone**	487	92.8	422	85.1	68	15.6	36	8.0	21	7.4
6	Number of trained CHO	600	114.3	493	99.4	103	23.6	72	16.1	85	29.9
7	Number of active CHMC with meeting in the last 3 months	497	94.7	428	86.3	258	59.2	303	67.6	179	63.0
8	Number of active CHV	2,552	4.9	1,765	3.6	889	2.0	787	1.8	417	1.5
9	Number of functional CHPS zone with CHAP	456	86.9	422	85.1	58	13.3	20	4.5	17	6.0
10	Number of Functional CHPS zone with basic Equipment	236	45.0	191	38.5	10	2.3	13	2.9	35	12.3
11	Number ofCommunities covered by GHS facilities	1,429		1,275		1,848		1,251		492	
12	Number of electral area	359		305		367		0		174	

Appendix 11 : Implementation of District CHO Orientation

Region	District	No. of Trainees (CHNs)				Total No. of Orientation	Total No. of Trainees
		2020	2021	2022	2023		
UWR	DBI	6	5	15	5	4	31
	Jirapa	6	5	12	16	4	39
	Lambussie	6	7	10	10	4	33
	Lawra	6	8	15	15	4	44
	Nadowli-Kaleo	7	8	9	10	4	34
	Nandom	6	8	15	9	4	38
	Sissala East	10	9	12	10	4	41
	Sissala West	8	5	24	21	4	58
	Wa East	8	7	13	3	4	31
	Wa Municipal	10	7	12	15	4	44
	Wa West	6	12	11	15	4	44
	UWR Total	**79**	**81**	**148**	**129**	**44**	**437**
UER	Bawku Municipal	0	10	10	10	3	20
	Bawku West	0	12	0	0	3	12
	Binduri	0	10	9	10	3	19
	Bolgatanga East	0	12	14	0	3	26
	Bolgatanga Municipal	0	10	0	0	3	10
	Bongo	31	14	0	0	3	45
	Builsa North	0	15	0	0	3	15
	Builsa South	0	17	12	12	3	29
	Garu	17	0	22	0	3	39
	Kassena Nankana Municipal	18	0	0	0	3	18
	Kassena Nankana West	0	19	10	10	3	29
	Nabdam	0	13	0	8	3	13
	Pusiga	0	11	8	0	3	19
	Talensi	0	6	0	0	3	6
	Tempane	10	10	28	0	3	48
	UER Total	**76**	**159**	**113**	**50**	**42**	**398**
NR	Gushegu	0	2	0	0	3	2
	Karaga	0	8	0	0	3	8
	Kpandai	0	5	0	0	3	5
	Kumbungu	0	2	0	0	3	2
	Mion	0	4	0	0	3	4
	Nanton	8	2	0	0	3	10
	Nanumba North	0	3	20	0	3	23
	Nanumba South	0	6	0	0	3	6
	Saboba	0	8	16	0	3	24
	Sagnarigu	0	5	0	0	3	5
	Savelugu	10	2	0	0	3	12
	Tamale	0	6	0	0	3	6
	Tatale	0	3	0	0	3	3
	Tolon	0	2	0	0	3	2
	Yendi	0	6	0	0	3	6
	Zabzugu	0	2	16	0	3	18
	NR total	**18**	**66**	**52**	**0**	**48**	**136**
NER	Bunkprugu	0	5	0	0	3	5
	Cheriponi	0	5	0	0	3	5
	East Mamprusi	10	0	0	0	3	10
	Mampruga Maoduri	0	5	0	0	3	5
	West Mamprusi	0	5	0	0	3	5
	Yunyoo	0	5	15	0	3	20
	NER total	**10**	**25**	**15**	**0**	**18**	**50**
SR	Bole	0	5	10	0	3	15
	Central Gonja	0	5	17	0	3	22
	East Gonja	0	5	8	0	3	13
	North Gonja	0	5	10	0	3	15
	North East Gonja	0	5	6	0	3	11
	Sawla Tuna Kalba	8	2	10	0	3	20
	West Gonja	0	5	14	0	3	19
	SR total	**8**	**32**	**75**	**0**	**21**	**115**
	Total No. of trainees of all districts	**191**	**363**	**403**	**179**	**173**	**1,136**

Overview of JICA project intervention in Referral

- JICA's contribution to the referral system in Ghana-

Objectives of the presentation

- To share the Project activities carried out on Referrals in line with the new referral policy and objectives
- To share the results of the Referral activities by the Project (impact and effectiveness)
- To propose the areas which can be adapted in the referral policy and technical guideline which allows to scale-up the activities nationwide for better sustainability and impact

Brief Background of JICA CHPS Project in Northern Regions

17 years of work in referral

2006-2011
UWR
Scaling up of CHPS Implementation Project (5-9 Districts)

- Ambulances
- Communication equipment
- Training

2011-2016
UWR
Improvement of Maternal and Neonatal Health Services
Utilizing CHPS System (11 Districts)

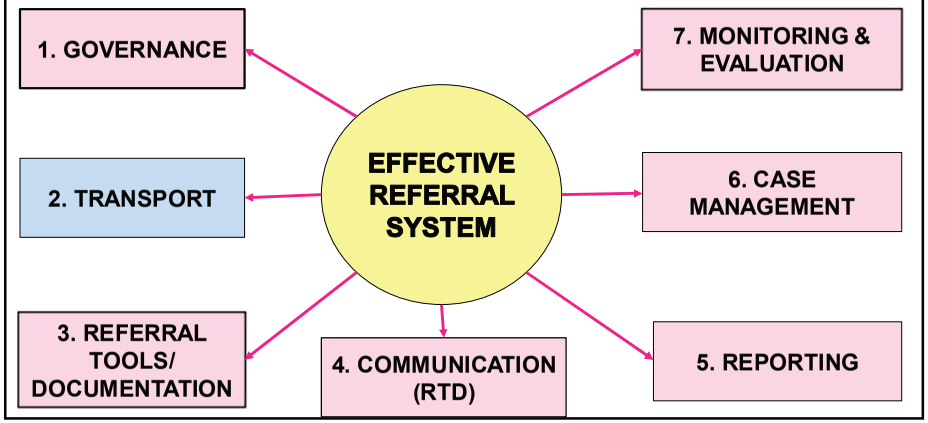
- Referral register
- Referral and feedback forms
- Training

2017-2022
UWR, UER and NR
Strengthening Community-Based Health Services
Focusing on the Life-Course Approach
" CHPS for Life" (55 Districts)

- Scale up of the use of register and forms in northern regions
- Strengthening monitoring system through "Monthly Referral form" (29 District)

Major components of referral work and JICA's intervention

JICA Project worked particularly in the pink colored areas!



Achievements over years

No	Item
1	Development of Referral Training Materials
2.	Training of Health Staff (more than 3, 000 health workers) on Referral in 3 regions
3.	Procurement of Ambulance and Communication Tools
4.	Development of Standardized Referral Tools (Referral forms, Referral Feedback forms, and Register)
5.	Introduction of Revolving Fund System for Referral Tools (in 3 regions)
6.	Introduction of Monthly Referral Returns as a comprehensive monitoring tools for referral and incorporation into DHIMS2
7.	Introduction of the Referral Telephone Directory as a standard resource for communication between facilities
8.	Introduction of sensitization activities of the health workers and communities (Family Clinical Meeting, IEC activities, Referral Stakeholder meeting)

Introduction of Key Materials/Tools developed

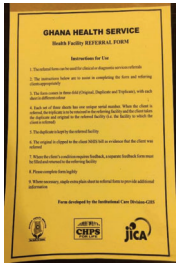
Referral Training Materials

- It consists of **5 modules** and exercises and pre/post tests
- It has good reference to the National Referral Policy and Technical Guidelines
- **Customer Care and Quality Assurance** as essential components to ensure quality of care
- Exercises focusing **on how to fill out referral forms, feedback forms and registers with a case study**
- In addition, the Project has additional training materials for **Monthly Referral Returns**

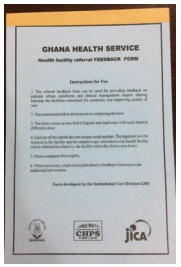
Module
1. Introduction to Referral System and Management
2. Standard Referral Procedure
3. Referral Documentation
4. Customer Care and Quality Assurance
5. Support Services
6. Exercise: Filling out the forms

Referral Documentation – tools developed by the Project

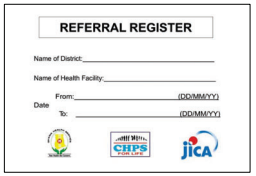
1. National Standard Referral Form



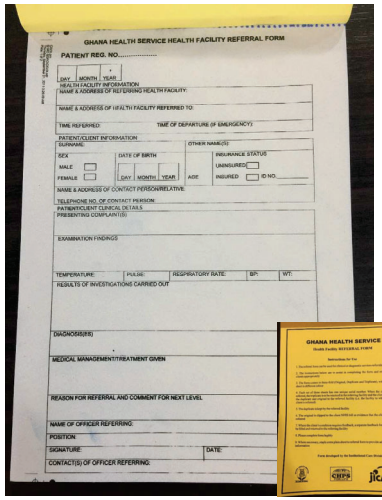
2. National Standard Referral Feedback Form



3. Referral Register



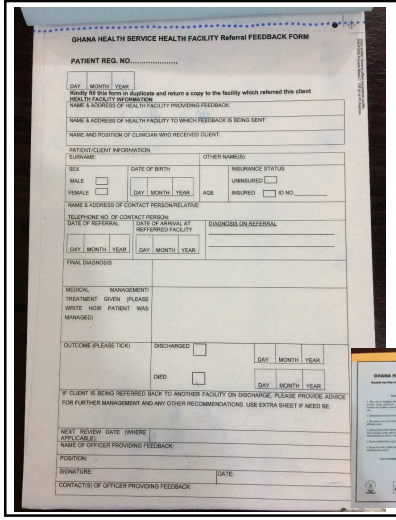
Master data kept at health facilities where all referral activity are recorded.



Referral Forms

1. Comprehensive Forms include;
 (1) information of referring facilities,
 (2) Patient insurance status,
 (3) Clinical details of the patient at admission with examination and treatment done at referring facilities.

2. It comes with triplicate copy. One copy kept at an initiating facility and another used for NHIS bills, and the original kept at a receiving health facility.

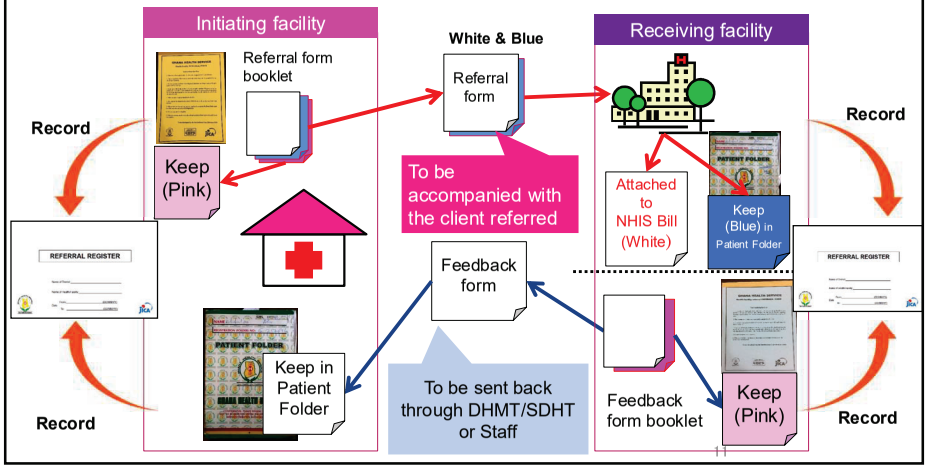


Referral Feedback Forms

1. Comprehensive Forms include;
 (1) information of receiving facility,
 (2) Patient insurance status,
 (3) Final Diagnosis including medical management carried out and the outcome,
 (4) Advice and recommendation for further management

2. It comes with duplicate copy. A copy kept at the receiving facility and original sent to the initiating facility.

Flow of Referral & Documentation



Referral Register

- Referral register is used to record both in and out referral cases
- The register is designed in rows and columns and
- Each row is used for one client whilst each column contains information on the referral
- One page can capture 20 clients, and the whole register can capture over 1000 clients
- The register shows the referral workload of the facility
- The referral register could be placed at OPD, Maternity ward, Children ward

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Referral Register (Content)

MONTH: _____ YEAR: _____

S/N.	DATE	NAME	OPD/FLD #	SEX	AGE	ADDRESS INCL. PHONE NO.	NHIS Y/N	TIME	REFERRED FROM/TO	TYPE OF REFERRAL		PROVISIONAL DIAGNOSIS	FINAL DIAGNOSIS	OUTCOME	FEED BACK
										IN	OUT				

Referral Register (Content)

S.NO.	DATE	NAME	OPD/FLD#	SEX	AGE	ADDRESS INCL PHONE NO.	NHIS Y/N	TIME	REFERRED FROM/TO	TYPE OF REFERRAL		PROVISIONAL DIAGNOSIS	FINAL DIAGNOSIS	OUTCOME	FEEDBACK
										In	Out				
1	7/03/13	Samuel xxxxxx	Gxxxxx	M	17	Nandom 02029xxxx	Y	10:15	Nadowli Hosp.		✓	Snake bite			
2	08/04/13	Mary xxxxxxx	Gxxxxx	F	20	Domwine 0243xxxx	N	9:30	xxxCHPS	✓		Breach	Pre-eclampsia	Discharged	8/15
3	08/04/13	Michel xxxxx	Gxxxx	M		Takpo 054xxxxxx	Y	14:40	Nadowli Hosp.		✓	Severe malaria	Severe malaria	Discharged	8/20

This part will be filled out when sending (initiating) or receiving a client at health facility

This part will be recorded when referral feedback sent or received at health facility

Definition of terms on the register (1/2)

Serial Number (S/N)	A monthly serial number starting with number one at the beginning of every month
Date	The date on which the patient was referred or received. (Write DD/MM/YY)
Name	Full name of the Patient
OPD/FLD#	OPD or Patient folder number of the Patient
Sex	Male =M, Female =F
Age	The age of the patient in years for patients up to 1 year or more. For children less than 1 year, write in months, for children less than a month write in weeks and for children less than a week write in days. (e.g., days, wks, mths, yrs)
Address incl. phone no.	The address on the ID or patient folder (including phone number of patient or close relative)

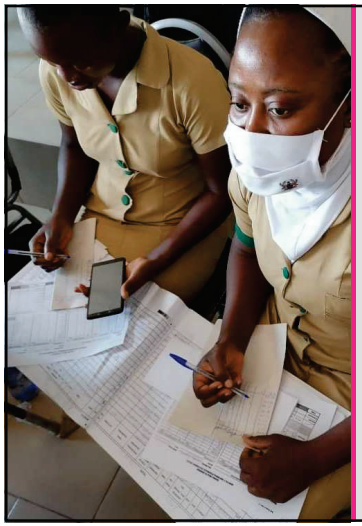
Definition of terms on the register (2/2)

NHIS Status	Insured=Y, Not insured=N
Time	The time referred or received
Referred from/ to	When you receive the patient (**Referral IN**), record the name of facility on the referral form accompanied with the patient. When you send the patient (**Referral OUT**), record the name of facility you send the patient
Type of referral	If you receive the patient, tick✔ on the column "IN". If you send the patient, tick✔ on the column "OUT".
Provisional Diagnosis	Copy the "Diagnosis" in Referral Details on the GHS referral form.
Final Diagnosis	In case of Referral "**IN**", record the final diagnosis on this column before feedback. In case of "**OUT**", record the final diagnosis on the column according to the feedback form/ verbal.
Outcome	Treated and discharged, Absconded, Refused or Dead
Feedback	If you sent or received the feedback, write the "**date**"

Development of Additional Referral Tools

To address the challenges in referral feedback, the following strategy was developed and introduced to the regions.

ROOT CAUSES of Poor Referral Feedback	Improvement Plans
1. No available system in place to monitor "referral feedback "	1. Introduction of Monthly Referral Monitoring Forms
2. Weak Two Way Communication between facilities	2. Standardized Referral Telephone Directory with a mechanism of regular updates



Monthly Referral Returns

- It addresses the problem of poor referral data and limited monitoring of the status of referral and referral feedback on a regular basis.
- It assesses the accurate status of expected feedbacks from the upper facility. It aims to understand "**how many feedbacks the facility was able to receive from those referrals they have sent**".
- After piloting in 3 districts, it has been incorporated in DHIMS2 platform, and the form is available to the entire health facilities in Ghana.

Form A

GHANA HEALTH SERVICE
MONTHLY REFERRAL RETURNS FORM (PILOT)

Region ..... District ..... Facility .....
Section ..... Month ..... Year .....

Age Group	Referral-Out: Maternal: Incured M	F	Non-Incured M	F	Neonatal: Incured M	F	Non-Incured M	F	OPD: Incured M	F	Non-Incured M	F	Referral-In: Maternal: Incured M	F	Non-Incured M	F	Neonatal: Incured M	F	Non-Incured M	F	OPD: Incured M	F	Non-Incured M	F	No of Referral-In by Facility Type: OHPS	Health Ctr/ Clinic	Poly-clinic	Hospital	Clinic	Maternity Home	Other (specify)
0-28 days																															
1-11 months																															
1-4 Years																															
5-9 Years																															
10-14 Years																															
15-17 Years																															
18-19 Years																															
20-34 Years																															
35- 49 Years																															
50-59 Years																															
60-69 Years																															
70 Yrs & Above																															
Total All Ages																															

This form allows us to know the details of the Client referred including age, insurance, facilities involved and outcome per month.
It is especially helpful to understand our partnered health facilities in referral.

Form B

GHANA HEALTH SERVICE
MONTHLY REFERRAL FEEDBACK RETURNS FORM (PILOT)

Region ..... District ..... Facility .....
Section ..... Month ..... Year .....

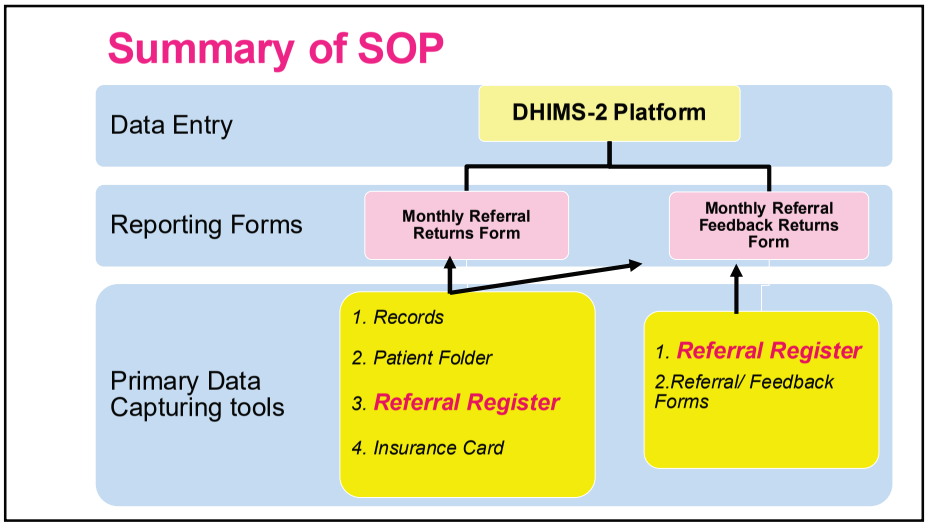
FEEDBACK GIVEN

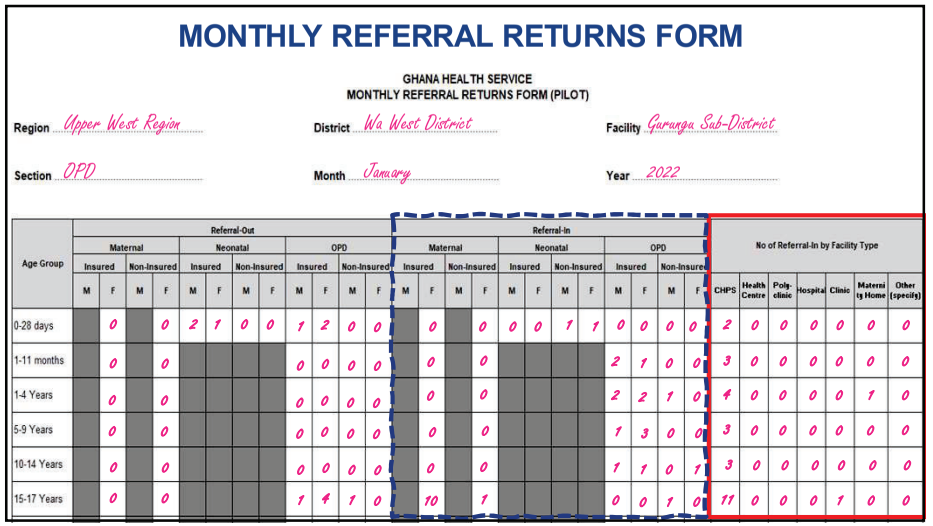
Age Group	Referral: Incured: Verified & Discharged	Absconded	Cases Referred	Dead	Non-Incured: Verified & Discharged	Absconded	Cases referred	Dead	Neonatal: Incured: Verified & Discharged	Absconded	Cases referred	Dead	Non-Incured: Verified & Discharged	Absconded	Cases referred	Dead	OPD: Incured: Verified & Discharged	Absconded	Cases referred	Dead	Non-Incured: Verified & Discharged	Absconded	Cases referred	Dead
	Female: M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0-23 days																								
1-11 months																								
1-4 Years																								
5-9 Years																								
10-14 Years																								
15-17 Years																								
18-19 Years																								
20-34 Years																								
35- 49 Years																								
50-59 Years																								
60-69 Years																								
70 Yrs & Above																								
Total All Ages																								

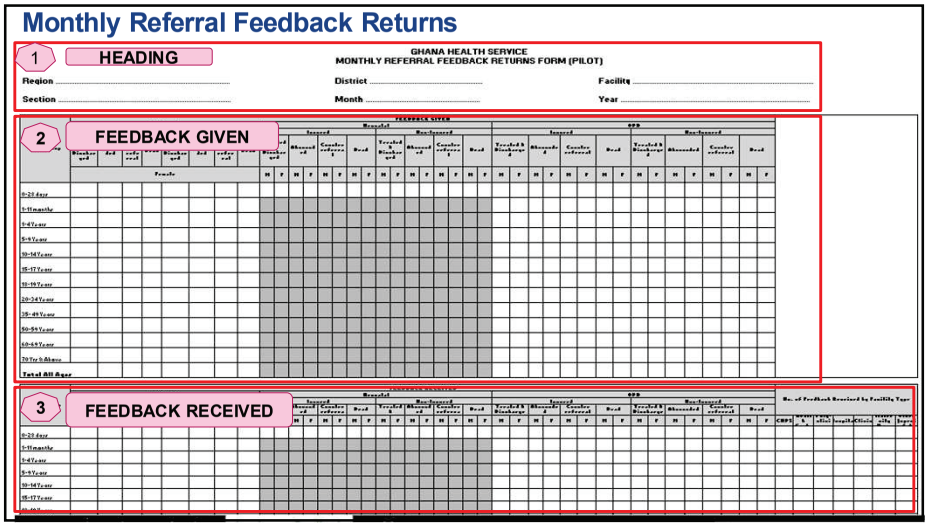
FEEDBACK RECEIVED

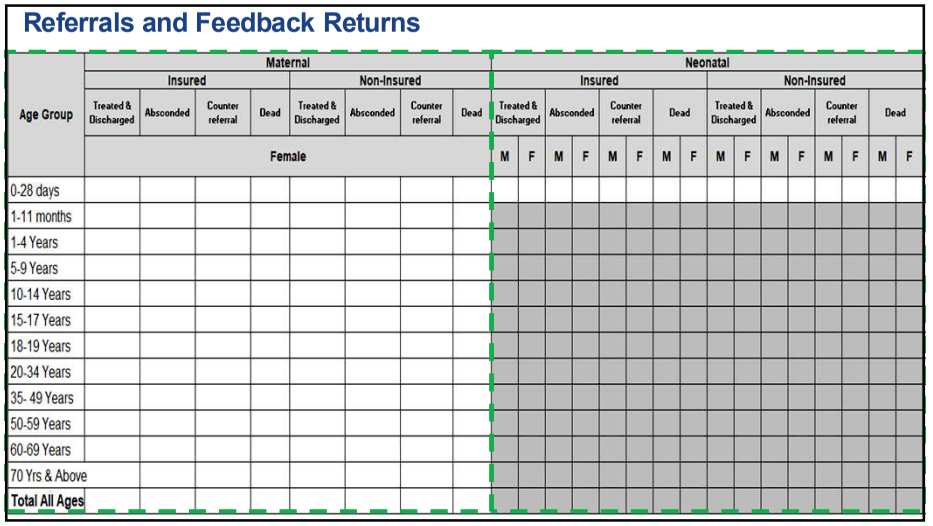
Age Group	Referral: Incured: Verified & Discharged	Absconded	Cases Referred	Dead	Non-Incured: Verified & Discharged	Absconded	Cases referred	Dead	Neonatal: Incured: Verified & Discharged	Absconded	Cases referred	Dead	Non-Incured: Verified & Discharged	Absconded	Cases referred	Dead	OPD: Incured: Verified & Discharged	Absconded	Cases referred	Dead	Non-Incured: Verified & Discharged	Absconded	Cases referred	Dead	No. of Feedback Received by Facility Type: CHPS	Health Ctr/ Clinic	Hospital	Clinic	Maternity Home	Other (specify)
	Female: M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F							
0-23 days																															
1-11 months																															
1-4 Years																															
5-9 Years																															
10-14 Years																															
15-17 Years																															
18-19 Years																															
20-34 Years																															
35- 49 Years																															
50-59 Years																															
60-69 Years																															
70 Yrs & Above																															
Total All Ages																															

This form allows us to know the monthly referral status such as how many referrals sent out and how many "pending" feedbacks to receive/give. You can get **yearly total of referrals and feedback** sent and received. This form is the basis of calculating the referral FB rate.


Summary of SOP
Data Entry
DHIMS-2 Platform
Reporting Forms
Monthly Referral Returns Form
Monthly Referral Feedback Returns Form
Primary Data Capturing tools
1. Records
2. Patient Folder
3. Referral Register
4. Insurance Card
1. Referral Register
2.Referral/ Feedback Forms


MONTHLY REFERRAL RETURNS FORM
GHANA HEALTH SERVICE
MONTHLY REFERRAL RETURNS FORM (PILOT)
Region Upper West Region
District Wa West District
Facility Gurunga Sub-District
Section OPD
Month January
Year 2022
Referral-Out
Referral-In
Maternal
Neonatal
OPD
Insured
Non-Insured
Age Group
No of Referral-In by Facility Type
CHPS
Health Centre
Poly-clinic
Hospital
Clinic
Maternity Home
Other (specify)
0-28 days
1-11 months
1-4 Years
5-9 Years
10-14 Years
15-17 Years


Monthly Referral Feedback Returns
1
HEADING
GHANA HEALTH SERVICE
MONTHLY REFERRAL FEEDBACK RETURNS (PILOT)
Region
District
Facility
Section
Month
Year
2
FEEDBACK GIVEN
3
FEEDBACK RECEIVED


Referrals and Feedback Returns
Age Group
Maternal
Neonatal
Insured
Non-Insured
Treated & Discharged
Absconded
Counter referral
Dead
Female
0-28 days
1-11 months
1-4 Years
5-9 Years
10-14 Years
15-17 Years
18-19 Years
20-34 Years
35- 49 Years
50-59 Years
60-69 Years
70 Yrs & Above
Total All Ages

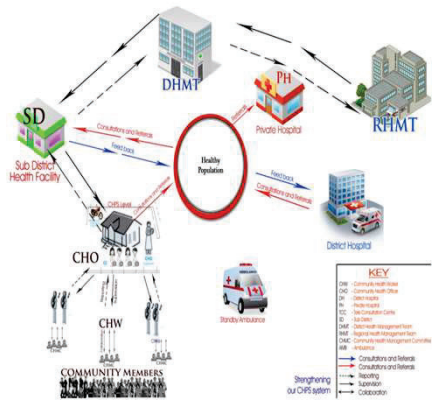
Referrals and Feedback Returns

Age Group	Maternal						OPD													
	Insured				Non-Insu		Insured						Non-Insured							
	Treated & Discharged	Absconded	Counter referral	Dead	Treated & Discharged	Absconded	Treated & Discharged	Absconded	Counter referral	Dead			Treated & Discharged	Absconded	Counter referral	Dead				
	Female						M	F	M	F	M	F	M	F	M	F	M	F	M	F
0-28 days																				
1-11 months																				
1-4 Years																				
5-9 Years																				
10-14 Years																				
15-17 Years																				
18-19 Years																				
20-34 Years																				
35- 49 Years																				
50-59 Years																				
60-69 Years																				
70 Yrs & Above																				
Total All Ages																				

Monthly Referral Feedback Returns

OPD																				
Insured								Non-Insured												
Treated & Discharged		Absconded		Counter referral		Dead		Treated & Discharged		Absconded		Counter referral		Dead						
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F					

No. of Feedback Received by Facility Type						
CHPS	Health Centre	Poly-clinic	Hospital	Clinic	Maternity Home	Other (specify)



Referral Telephone Directory

- Contact number stays in the personal mobile phone, which prohibits proper sharing of important number among the staff or no access to the number during emergency.
- Referral Telephone Directory (RTD) is for External Communication. It aims to communicate between facilities.
- RTD shall be made per district: It contains all referral health facilities (public and private) within the district.
- list only the contact numbers which are related to referral activities. This is to enable the user to identify necessary contact numbers quickly when needed

RTD Format Sample (1)

MUNICIPAL/DISTRICT REFERRAL TELEPHONE DIRECTORATE TEMPLATE

MUNICIPAL/DISTRICT NAME:..... Last Updated (MM/DD/YYYY)

ADDRESS.....

REGION:.....

FACILITY NAME	REFERRAL POINT/PERSON	Name	CONTACT NUMBER ###-###-####
DHMT	District Director of Health Services (DDHS)		
Location:	District Referral Focal Person		
Ambulance Service	National Ambulance Service		
	Private ambulances		

FACILITY NAME	REFERRAL POINT/PERSON	Name	CONTACT NUMBER
Teaching Hospital	Dedicated Contact number		
	Medical Director		
Location: Tamale	Clinical Care Coordinator		
	Referral Focal Person		
	Specialised Units:		
	Cardiothorasic Surgery		
	Cardiovascular Diseases		
	Consultative and Diagnostic Medicine		
	Dermatology		
	General Surgery		
	Neonatal Intensive Care (NICU)		
	Obstetrics and Gynaecology		
	Ophthalmology		
	Paediatrics		
	Urology		
	Telemedicine Room		

Periodical updates is essential!

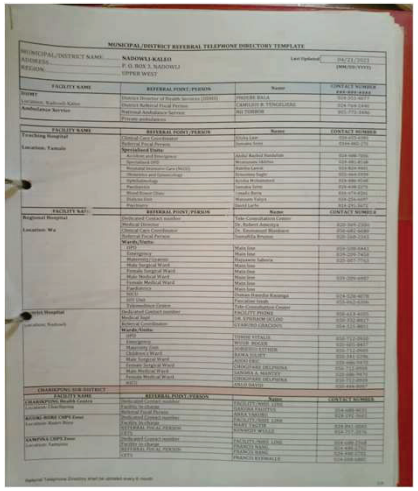
- RTD is managed and distributed to the facility by **the DHMT-Referral Focal Person in collaboration with Hospital Referral Team.**
- Update is done every 6 month or as needed.

RTD Format Sample (2) Regional & District Hospital Portion

FACILITY NAME	REFERRAL POINT/PERSON	Name	CONTACT NUMBER
Regional Hospital	Dedicated Contact number		
	Medical Director		
Location:	Clinical Care Coordinator		
	Referral Focal Person		
	Wards/Units:		
	OPD		
	Emergency		
	Maternity/Gyaenic		
	Male Surgical Ward		
	Female Surgical Ward		
	Male Medical Ward		
	Female Medical Ward		
	Paediatrics		
	NICU		
	Telemedince Centre		
District Hospital	Dedicated Contact number		
	Medical Supt		
Location:	Referral Coordinator		
	Wards/Units:		
	OPD		
	Emergency		
	Maternity Unit		
	Children's Ward		
	Male Surgical Ward		
	Female Surgical Ward		
	Male Medical Ward		
	Female Medical Ward		
	NICU		

RTD Format Sample (3) Sub-District, CHPS and Private

.....SUB-DISTRICT			
FACILITY NAME	REFERRAL POINT/PERSON	Name	CONTACT NUMBER
.....**Polyclinic**	Dedicated Contact number		
Location:	Facility In-charge		
	Referral Focal Person		
.....**Health Centre**	Dedicated Contact number		
Location:	Facility In-charge		
	Referral Focal Person		
.....**CHPS Zone**	Dedicated Contact number		
Location:	Facility In-charge		
	CETS		
.....**CHPS Zone**	Dedicated Contact number		
Location:	Facility In-charge		
	CETS		
PRIVATE FAACILITIES			
.....**Clinic**	Dedicated Contact number		
Location:	Facility in-charge		
	Referral focal person		
.....**Maternity Home**	Dedicated Contact number		
Location:	Facility in-charge		
	Referral focal person		


MUNICIPAL/DISTRICT REFERRAL TELEPHONE DIRECTORY TEMPLATE

Actual Referral telephone directorate at Nadowli District, UWR

Adaptable

Other Practices contribute to the Objectives of the National Policy

Objectives of the National Patient Referral Policy 2022-2030

1. To strengthen community participation and ownership in referral services
2. To improve timely and appropriate referral processes and procedures
3. To strengthen multi-sectoral collaboration for referrals

Next, How JICA Project activities contribute to these…

Example of UER

Referral: Model for Effective Referral System

Sustenance of the Revolving Fund System	Strengthening Intra-District Referral Network	Maintaining Standard of Practice	Referral Stakeholders' meeting
established by JICA in UER • Referral & Feedback Forms • Referral Register • Monthly Referral Returns Forms	• Referral Telephone Directory with regular update • Facility Mapping & networking between key facilities	• Functional referral teams • Feedback tracking system • Technical assistance through SS and DHQPR meeting • Development of IE&C materials	• Strategy to harness ideas on improving referral system • Share results of implemented strategies to stakeholders
Policy Objective 2 1. To ensure availability of forms. 2. To enhance documentation and reporting	**Policy Objective 2 & 3** To enhance communication between stakeholders	**Policy Objective 1** Adherence to referral protocols & processes	**Policy Objective 3** To perfect referral strategies and share lessons

Objective 1: To strengthen community participation and ownership in referral services

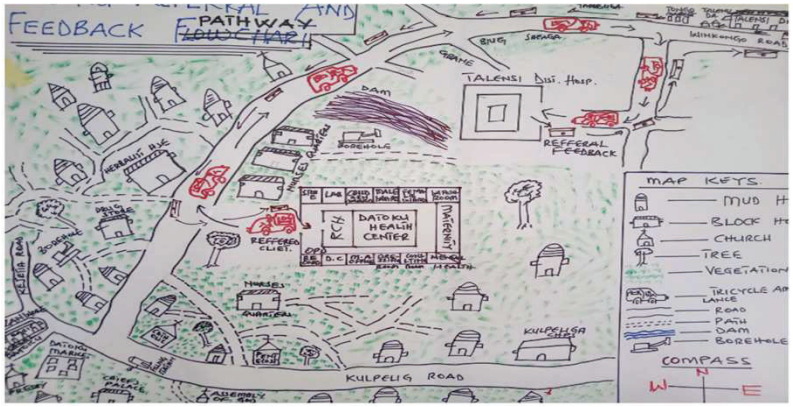
1. **Enhance ownership of the Health Staff on referral procedure**
2. **Sensitize community members to improve Health Seeking Behavior, particularly by increasing awareness of referral system in their area (to increase the compliance rate of the client)**

SDHT staff explaining the Referral Flow to the judges during a referral stakeholder meeting

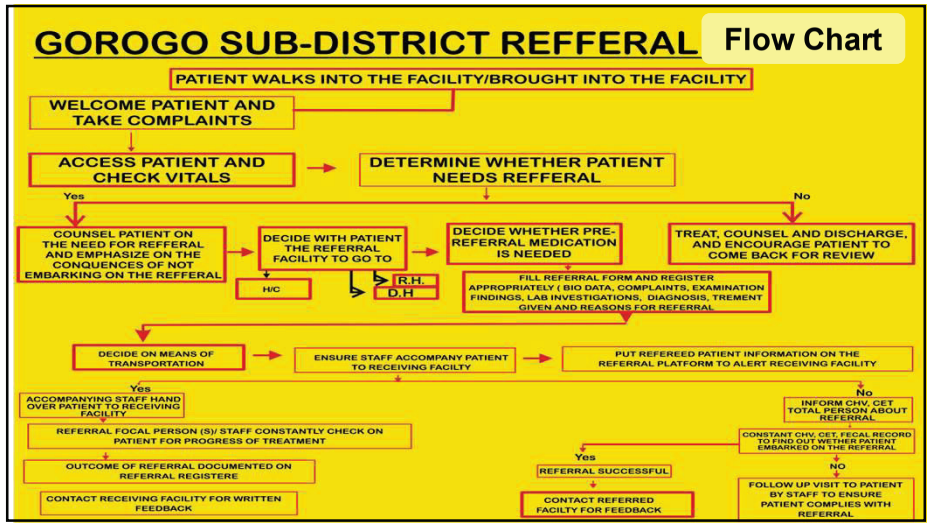
2 types of IEC materials developed by Sub-districts in a competitive way;

1) Referral pathway (community consumption)
2) Referral flow chart (for health staff use).

Referral Pathway: Talensi (DATOKU SD- PATHWAY)



Will be used for community durbar to orient the community how the referral works in their area



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Objective 2: To improve timely and appropriate referral processes and procedures

Referral Facility Mapping through GPS

No.	Sub-District	Facility	Community	Mapping distance traveled in Km		
				Distance from Community to facility	Distance from CHPS to Health Centre/Clinic	Distance from facility to District Hospital
1	DATOKU	Datoku Health Centre	Datuko	1.7KM		20.4KM
2	DATOKU	Datoku Health Centre	Zanware	5.1KM		25.5KM
3	DATOKU	Kejetia CHPS	Kejetia	100M	7.0KM	15.3KM
4	DATOKU	Kejetia CHPS	Obuasi Site	200M	6.8KM	15.3KM
5	DATOKU	Kupilega CHPS	Kulpeliga	100M	3.4KM	27.2KM
6	DATOKU	Kupilega CHPS	Namoranteng	6.8KM	10.2KM	30.6KM

Mapping aided;

1. Determination of distance to the referring facility by case type (Neonatal, OPD or Maternity).
2. Estimationof fuel for referrals (using the constant (1.5) by distance is also generated.

Objective 3: To strengthen multi-sectoral collaboration for referral strategies

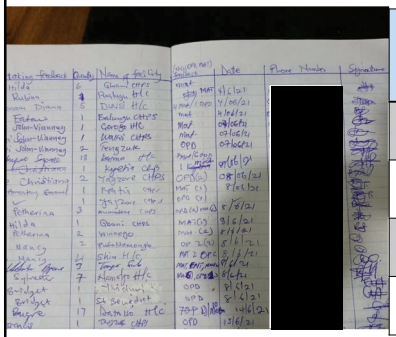
- Leadership and coordination, strategic partnership

1. Implementation of District-/Region-wide Referral Stakeholder meetings (UER/NR/UWR)
2. Conduct of Family Clinical Meeting (UWR)
3. Introduction of Standard Referral Telephone Directory with regular updates/Use of WatsAPP referral platform for better communication

- Referral issues were discussed with stakeholders such as regional/district hospitals and NAS based on the evidence data from MRRs.
- More active involvement by the hospital referral coordinator (e.g., development of referral tracking forms in UER/UWS)

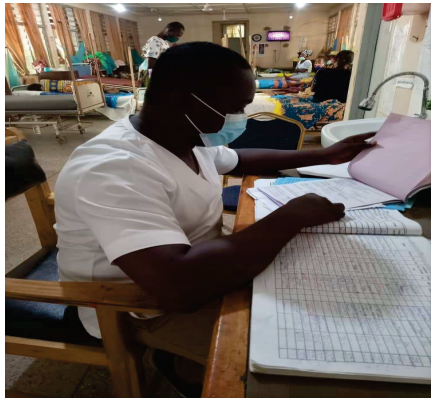
Examples of the outcome through the multi-sectoral collaboration

Referral Feedback Tracker at the DHD, but hospital also has their own tracker



Officer taking Feedback	No. of Feedbacks	Name of Facility	(NICU, OPD, Mat) Feedback	Date	Phone Number	Signature

Daily Ward review and coaching at the Hospital




From Nadowli District Hospital, UWR

Impact of the Referral Activities

How all these activities yield the improvement of referral system?

Impact on Continuum of Care through two-way Communication

-The number of feedbacks sent to CHPS zones is increased-

Project Target: 60%

Performance of the Referral Feedback in 2022

Region (Number of CHPS facilities)	Number of Referrals (Cumulative total for 12 months)	Number of Referral Feedbacks (Cumulative total)	Percentage of FB (Cumulative rate)	Percentage of FB (Monthly Average)
UWR/ Nadowli (36)	651	351	**53.9%**	54.0%
NR/ Savelugu (13)	348	113	**32.5%**	36.6%
UER/ Talensi (30)	688	376	**54.7%**	54.9%

Source: Referral Monthly Returns-DHIMS2 2022

* The cumulative rate is calculated by the total number of FB received divided by the total number of referral cases

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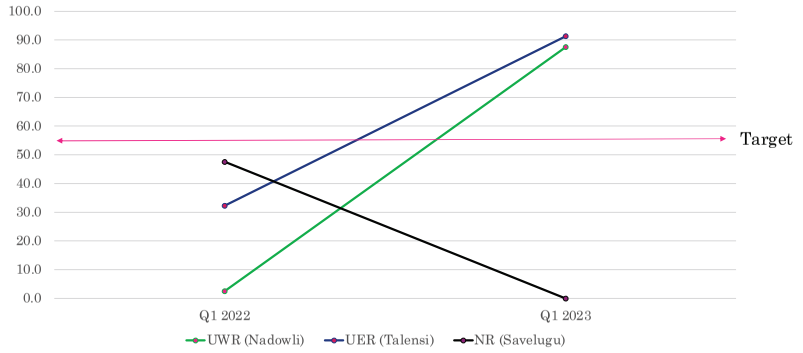
Impact on Continuum of Care through two-way Communication

-Trend analysis of percentage of referral feedback rate (cumulative) for the first quarter 2022 and 2023



Source: Referral Monthly Returns-DHIMS2

* The cumulative rate is calculated by the total number of FB received divided by the total number of referral cases

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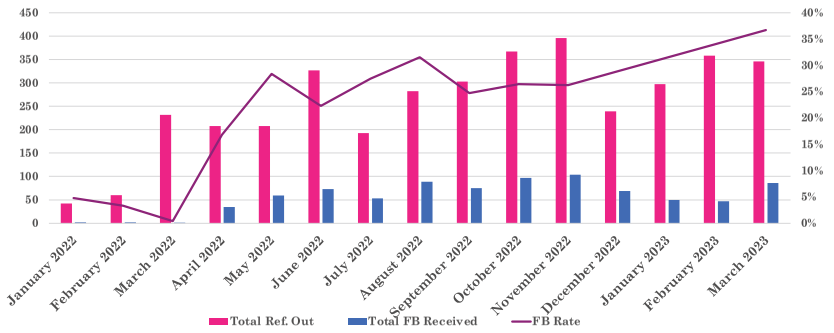
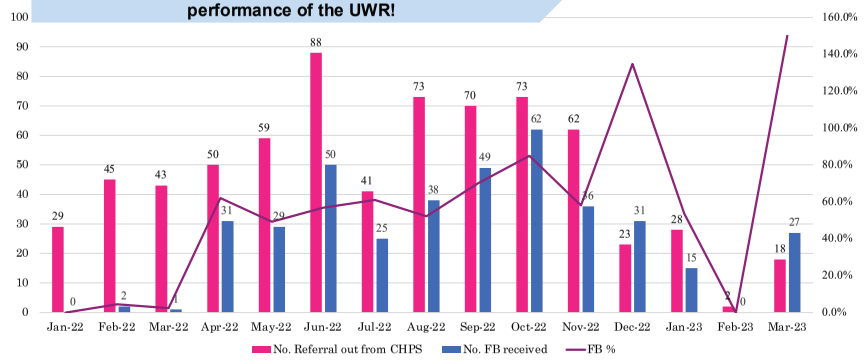
Trend of Referral Out, Feedback Received and Feedback Rate in the UWR (Jan 2022 – March 2023)



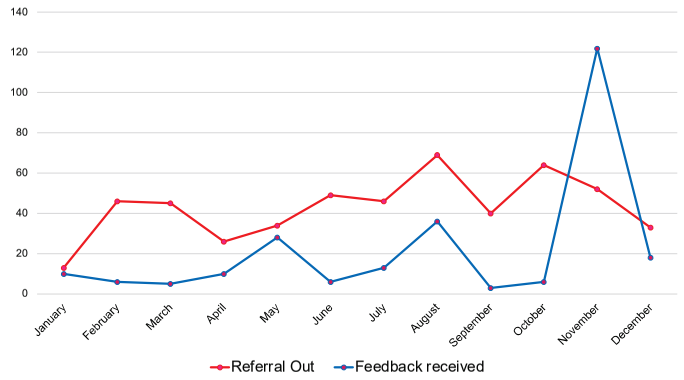
Please compare the data with the next slide of the performance of the Pilot District, Nadowli!

Trend of Referral Out, Feedback Received and Feedback Rate in the Nadowli Kaleo District (Jan 2022 – March 2023)

Nadowli FB Performance is much higher than overall performance of the UWR!



Status of "Two-way communication" on referral at CHPS – Talensi, UER



Total Referral (Cumulative): 517

Total Feedback received (Cumulative): 263

Feedback Rate: 50.9%

Nadowli District Hospital: Status of Referral Feedback rates -2022

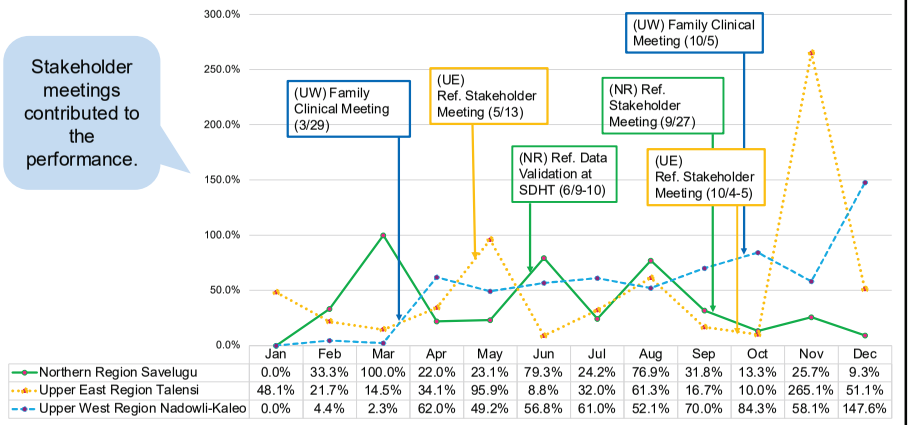
Referral & Referral Feedback Summary		Neonatal			Maternal	General		
		M	F	Total		M	F	Total
Referral Type	Referral In	31	19	50	690	279	272	551
	Referral Out	4	3	7	15	46	24	70
Referral Feedback	Feedback Received	1	1	2	0	1	0	1
	Feedback Given	30	19	49	690	279	272	551
Insurance Status	Insured		50		674		463	
	Uninsured		0		16		88	
	Total		50		690		551	
Referral Feedback rate given to the lower health facility			**98.0%**		**100.0%**		**100.0%**	

Impact on Quality of Referral Activities

Based on the endline assessment of CHPS facility in JICA target area

Region	Availability of essential Referral Resource	Quality of referral Documentation	Appropriateness of filing referral Document
UWR/ Nadowli-Kaleo	90.5%	93.7%	73.8%
NR/ Savelugu	70.9%	82.8%	18.2%
UER/ Talensi	75.7%	74.1%	50.0%
Overall	**81.0%**	**83.5%**	**53.0%**

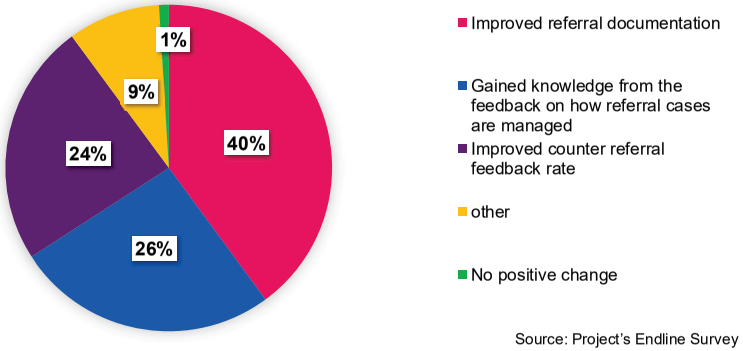
Impact of Referral related activities on referral Feedback at CHPS level (2022)



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Northern Region Savelugu	0.0%	33.3%	100.0%	22.0%	23.1%	79.3%	24.2%	76.9%	31.8%	13.3%	25.7%	9.3%
Upper East Region Talensi	48.1%	21.7%	14.5%	34.1%	95.9%	8.8%	32.0%	61.3%	16.7%	10.0%	265.1%	51.1%
Upper West Region Nadowli-Kaleo	0.0%	4.4%	2.3%	62.0%	49.2%	56.8%	61.0%	52.1%	70.0%	84.3%	58.1%	147.6%

Voice from the field:

Impact of the Project activities on Referral System (N=92) *Multiple Answers

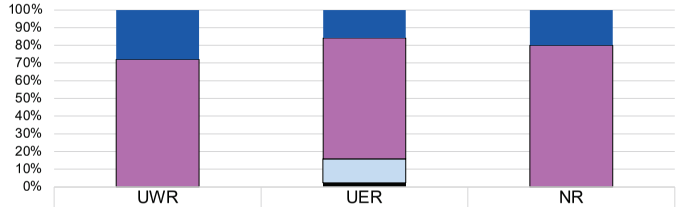


Source: Project's Endline Survey

Voice from the Field (2):

Source: Project's Endline Survey

Level of the Collaboration/Partnership between health facilities (DHMT/SDHT/CHPS) (N=89)



	UWR	UER	NR
Significantly improved	7	7	4
Improved	18	30	16
No change	0	6	0
Poor	0	1	0
Very Poor	0	0	0

Way forwards

- A number of outputs/activities by the Project produced positive impact on referral system in three regions
- Policy support is needed to motivate the staff at health facilities to sustain and enhance the activities in health facilities, particularly at hospitals where reshuffle of the staff occurs quite frequently
- Policy support is also important to scale-up and harmonize the activity within regions and nation.

Thank you very much!

July 2023

GHS/JICA CHPS FOR LIFE PROJECT

GOOD PRACTICES

FOREWORD

It gives me great pleasure to introduce this Good Practices Document, showcasing the remarkable achievements and valuable experiences gained through the implementation of the JICA CHPS for Life project in the five northern regions of Ghana. As we reach the final stage of this transformative initiative, it is essential to reflect upon the outstanding outcomes that have been accomplished and share the lessons learned with a wider audience.

The JICA CHPS for Life project, as the third phase of the JICA Project, has played a pivotal role in strengthening the implementation of the Community-based Health Planning and Services (CHPS) approach and elevating the quality of healthcare services by embracing the Life-Course Approach (LCA). By focusing on the Life-Course Approach, which emphasizes health interventions across all stages of life, this project has made significant strides in improving the overall well-being of communities in the northern regions of Ghana.

As we disseminate this Good Practices Document, I am confident that the experiences and success stories shared within its pages will serve as a source of inspiration for future endeavors in community-based healthcare. The lessons learned and best practices highlighted in this document hold immense value for healthcare professionals, policymakers, and development practitioners who strive to make a positive impact on health systems and the lives of individuals and communities they serve.

I commend the dedication and commitment of all the stakeholders involved in the JICA CHPS for Life project. The success stories shared in this document exemplify their unwavering efforts, passion, and collaborative spirit. I extend my sincere appreciation to the key stakeholders including the Regional Health Management Teams, Regional Coordination Councils (RCCs) District Health Management Teams, District Assemblies (DAs) Sub-District Health Teams (SDHTs), Community Health Officers (CHOs), Community Health Management Committees (CHMCs), Community Health Volunteers (CHVs), and most importantly, the community members. It is through your collective efforts that the JICA CHPS for Life project has achieved outstanding results, leaving a lasting legacy in the five northern regions of Ghana.

May the knowledge and experiences shared in this document guide future initiatives, nurturing sustainable and inclusive health systems that uphold the principles of community participation, equitable access, and the holistic well-being of individuals throughout their life course.

Dr. Patrick Kuma-Aboagye

Director General

Ghana Health Service

ACRONYMS

CHAP	Community Health Action Plan
CHMC	Community Health Management Committee
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community-Based Health Planning and Services
CHV	Community Health Volunteer
DA	District Assembly
DDHS	District Director of Health Service
DHA	District Health Administration
DHMT	District Health Management Team
GHS	Ghana Health Service
HIAP	Health Integrated Annual Action Plan
HTI	Health Training Institution
JICA	Japan International Cooperation Agency
LCA	Life-course Approach
PPMED	Policy Planning, Monitoring & Evaluation Division
RDHS	Regional Director of Health Service
RHA	Regional Health Administration
RHMT	Regional Health Management Team
PHN	Public Health Nurse
SDHT	Sub-District Health Team
UHC	Universal Health Coverage
UWR	Upper West Region

ACKNOWLEDGEMENT

This best practice report was compiled with the support of several key entities. The report would not have been possible without the invaluable support and contribution by the Regional Health Management Teams, District Health Management Teams, and staff of the JICA CHPS for Life Project. In particular, the support of all persons who shared their stories with the project team is greatly appreciated.

TABLE OF CONTENTS

1. Outline of the project

The GHS/JICA Project "CHPS for Life" commenced in 2017 as a 6-year project in the five northern regions. The overall aim of the project is to strengthen CHPS implementation and improve service quality by focusing on the Life-course Approach (LCA), strengthen the capacity of communities and engaging with District Assemblies (DA) for their support towards health activities. The goal of the Project is to strengthen health systems in the five northern regions of Ghana to achieve the objectives of the CHPS policy through the introduction of effective systems and CHPS implementation. Additionally, the Project introduced LCA-related services at the CHPS level in UWR to establish a model to address emerging challenges in PHC delivery.

The Project Matrix Design (PDM) is presented in table 1 below.

Table 1 : PDM of the Project

Overall Goal
Universal health coverage is promoted by improving access and utilization of primary health care through Community-Based Health Planning and Services (CHPS).
Project Purpose
Community-Based health services focusing on the life-course approach are strengthened.
Outputs
Output 0: The project is monitored and evaluated periodically, and good practices and lessons learned are shared with other regions and GHS-HQ (Ghana Health Service Headquarters) for scaling up.
Output 1: The capacity of Community Health Officers (CHO) and health management teams (Sub-District Health Teams (SDHT), District Health Management Teams (DHMT), and Regional Health Management Teams (RHMT)) to plan and implement CHPS policy according to national standards is strengthened.
Output 2: Community activities of CHPS are strengthened.
Output 3: Governance of CHPS by local government and stakeholders is strengthened.
Output 4: Life-course approach is addressed in the minimum package of CHPS.

I. Activities of the project

The list of key activities of the project is described below in table 2. Activities 1 to 6 are related to Output 1 and are meant to strengthen CHPS Implementation. Activities 7 to 8 are related to Output 2 and seek to strengthen community mobilization. Activities 9 and 10 focus on strengthening DA engagement and Life-course Approach (LCA) respectively. All outputs complement each other to strengthen CHPS implementation and to improve the LCA-related services at CHPS zone and community level.

Activities of Output 1 cover all five northern regions, with some covering all regions in Ghana. Activities of output 2 were limited only to UWR. Output 3 covers five northern regions, especially local government units. Output 4 was limited to UWR as a pilot introduction but disseminated in five northern regions.

Table 2: Key Activities of the Project

No	Activities
1	Introduction and establishment of the **CHPS database system**
2	Introduction of quality **CHO training approaches** (introduction of District CHO Orientation)
3	Introduction of sustainable CHO training approaches (Introduction of Pre-service training)
4	Improvement of **Referral** to support CHPS level (Training on referral protocol; Introduction of feedback forms)
5	Promote the implementation of **quality Supportive Supervision** at the CHPS level
6	Introduction of **District Health Quarterly Performance Review** (DHQPR) as a backup system of monitoring and for solving problems
7	Promote the implementation of **CHAP** (Introduction of assessment sheet on CHAP, capacity building of CHO)
8	Promote the implementation of Life Course Approach-related activities in CHAP (capacity building of CHMC/CHV)
9	Promote formulation/monitoring and implementation of Health Integrated Action Plan (HIAP) as a way of strengthening engagement with District Assembly (DA)
10	Strengthen the capacity of CHOs to provide Life Course-related services

II. Criteria in selecting good practices

The World Health Organization (WHO, 2017) in "A guide to identifying and developing best practices in family planning programs" defines a best practice as "a technique or method that, through experience and research has proven reliable to lead to desired results".

The best practices should be proven reliably to lead to the desired result. The WHO criteria and the Development Assistance Committee (DAC) evaluation method were used by the Project in identifying and selecting good practices. Project activities and interventions that met the WHO and DAC criteria were included. Details of each criteria are outlined below.

Table 3 contains the detailed description of each criterion that was used by the project team.

Table 3: **WHO Criteria for evaluating best practice**

Criterion	Description
Effectiveness	This is a fundamental criterion implicit in the definition. The practice must work and achieve results that are measurable
Efficiency	The proposed practice must produce results with a reasonable level of resources and time
Relevance	The proposed practice must address the priority health problems in the intervention areas
Ethical soundness	The practice must respect the current rules of ethics for dealing with human populations
Sustainability	The proposed practice, as carried out, must be implementable over a long period with the use of existing resources
Possibility of duplication	The proposed practice, as carried out, must be replicable elsewhere in the country or region.
Involvement of partnerships	The proposed practice must involve satisfactory collaboration between several stakeholders
Community involvement	The proposed practice must involve the participation of the affected communities
Political involvement	The proposed practice must have support from the relevant national or local authorities

III. Selected Good Practices

The CHPS for Life Project reviewed the activities in accordance with the WHO criteria . The following activities have been selected as good practices which can be disseminated nationwide in terms of effectiveness (data improvement), sustainability (sustainable implementation system), repeatability (standardized manual/tool) and they are bearable to present to other regions and development partners.

Table 4: Selected good practices

No	Selected Good Practices	Implementation Area
1	CHO training approach by using a sustainable low-cost approach	UWR, UER, NR, NER, SR, ER, BER,
2	Improvement of referral system for quality care	UWR, NR, SR, UER
3	Provision of LCA services at CHPS level in UWR	UWR
4	Planning, resource mobilization, and monitoring of CHPS implementation using the CHPS database.	UER, UER, NER, SR,NR

The next pages contain the approach, results/achievements, lessons learned and views as well as direct quotes from the field as far as each good practice area is concerned.

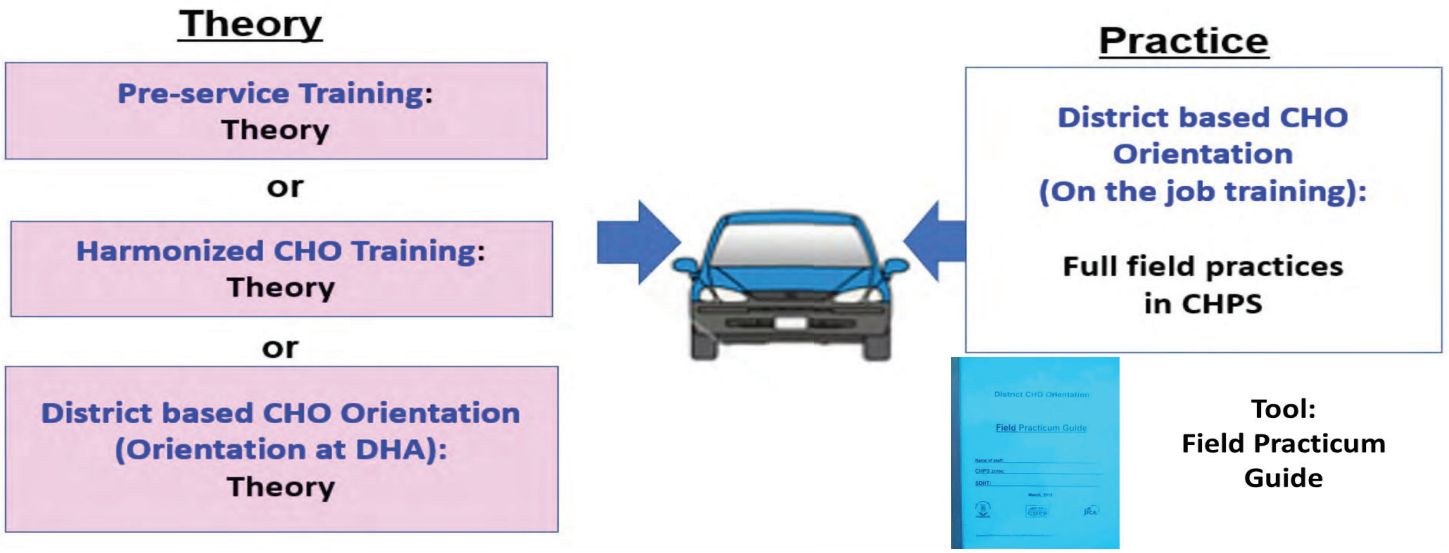
IV. Good Practices

1. TRAINING COMMUNITY HEALTH OFFICERS (CHO) USING A SUSTAINABLE APPROACH

Summary of the Approach	The District CHO Orientation approach is an experience-based learning approach that assigns Community Health Nurses (CHNs) to experienced CHOs for 4-6 weeks. This is done after the CHNs have been taken through a 2 or 3 day orientation session to equip them with technical knowledge on CHPS. Compared to the standard harmonized CHO training, the DCHOO approach is more cost effective and flexible, which ensures intensive field work and provides a relaxed learning experience under the supervising CHO.
Key results Achieved	All districts in the five regions of northern Ghana have used the DCHOO training approach to train CHOs. The approach has also been introduced in Eastern and Bono East regions to train CHOs. So far, 1,136 CHOs have been trained in the seven regions using this approach since 2020 . This has improved CHO availability and CHPS functionality in Ghana.
Lessons learned and replication	• Cost plays a very significant role in the adoption of training approaches, with dwindling funds and reducing donor support, there is the need to explore alternative training approaches. • Decentralizing CHO training to the district level, not only ensures CHOs are trained, but also builds the capacity of the DHMT and SDHT to supervise the CHOs.

What is the District CHO Orientation Approach ?

Harmonized CHO Training consists of one week of theory training and a one-week practical component which is very costly. As a result, the Project developed a new training system called district CHO orientation (DCHOO) to replace the practicum component of harmonized CHO training. The DCHOO is combined with any of the theory sessions such as pre-service training in the school, harmonized CHO training or short theory session at DHA. Main tool of DCHOO is the "Field Practicum Guide" which consists of a manual and worksheet for both supervisor and trainee.



What is the District CHO Orientation Approach ?

DCHOO has three main steps. The first step is an orientation and short theory session at DHA for 2 to 3 days. The second step is field practicum at the CHPS zone of the supervising CHO for 4 to 6 weeks. During the field practicum, SDHT and DHMT conduct monitoring visits. The last step is a feedback meeting at DHA to confirm the completion of the practicum and certify trainees as CHO.

Box 1 District CHO Orientation in Savannah Region : DHMT

"The harmonized CHO training approach is too costly and cannot be carried out by districts on their own. The need for a cost-effective CHO training approach was felt and the CHPS for Life Project came up with DCHOO. Through DCHOO we have increased the number of CHOs in the district which has resulted in a 100% CHPS functionality. Our communities are now better mobilized and are supporting healthcare delivery."

MS. Gertrude Yentumi, DDHS,
West Gonja, DHD, - Savannah Region

The introduction of the DCHOO approach in the West Gonja district in Savannah Region in 2019 has been a major success story in improving community participation in health and community engagement by CHOs.

Prior to the implementation of this approach, the district was faced with a shortage of trained CHOs, which adversely affected community health outcomes. Before the introduction of the DCHOO approach, CHOs used to be trained using the Harmonized CHO Training (HCT). This training approach was however bedeviled with a number of issues, key among them was the issue of cost. The cost per trainee was so high that no district could organize the training on their own and had to rely on donor support which was not forthcoming in most instances. Secondly, HCT training implied that both trainees and facilitators had to be away from work for 2 -week training, a situation which greatly affected work output. Lastly, the HCT had just three (3) days of fieldwork which made it practically impossible for trainees to fully apply what they had learnt in the classroom.

The DCHOO approach has been instrumental in addressing these challenges by providing a practical and experience-based approach to train CHOs. This approach allows for the training of CHOs without the need for the standard two-week training program. Through the approach, trainees in my district are given a day's orientation at the District level, where they are exposed to the theory of CHPS and then assigned to experienced CHOs for four weeks where they undergo fieldwork.

The DCHOO approach enables CHOs to learn on the job, with experienced-based learning modules that emphasizes practical skills and hands-on experience. This approach allows CHOs to acquire the necessary skills and knowledge required for their role, while also enabling them to participate actively in their communities' health initiatives.

Box 2 **District CHO Orientation in Savannah Region: RHMT**

"CHOs are very instrumental in the CHPS strategy. They are the core link between the health service and the community and have the needed skills to mobilize communities for health. However, as a region, we depended solely on development partners to support us organize harmonized CHO trainings. The cost of the harmonized CHO training made it difficult to get this needed support. The District CHO Orientation approach has therefore been very beneficial to us. Through the approach, the region has been able to train CHOs without any donor support. The result is that we have increased the number of CHOs across the region, and also improved our CHPS functionality rate. DCHOO is actually a game changer."

Regional CHPS Coordinator
Savanna Regional Health Directorate

Through the DCHOO approach, the West Gonja district has successfully trained a sufficient number of CHOs to ensure that every CHPS zone has the required number of trained CHOs. This has been instrumental in improving community engagement and participation in health, as community members now have access to trained CHOs who can provide them with adequate health education and guidance.

Moreover, the DCHOO approach has improved community health outcomes by ensuring that trained CHOs are available to provide basic health services and preventive measures in their respective CHPS zones. This has resulted in a significant reduction in the incidence of preventable diseases and illnesses, thereby improving the overall health status of the community.

Box 3 **District CHO Orientation in Savannah Region : CHO**

"The District CHO Orientation is great approach, its benefits are enormous. First of all, we the supervising CHOs get an opportunity to refresh our memories on the things we learnt and are practicing, the trainees get to learn in a more friendly environment where they can ask all the questions they want, and our communities get to participate in the mobilization activities"

Mr. Godwin Deyeni
CHO, Kpiri CHPS, West Gonja District, Savannah

Box 3 **Photos of DCHOO in Savannah Region**

Trainee CHOs engaging community members in drawing their daily activity diagram

Trainee CHOs making a presentation with their certificates at a feedback meeting

Box 4 District CHO Orientation in Upper East Region : RHMT

The DCHOO was initiated by JICA and piloted in 2 districts (Garu & Kassena Nankana Mun) in the Upper East Region in December 2019. The first CHOs who were trained with this strategy were certificated in February 2020. After the pilot in the two districts, it became obvious that the strategy was cost-effective, workable, and sustainable method of training CHOs. Based on that, a letter was written by the Regional Director to all the District Directors to learn and use the strategy to train CHNs to increase the number of CHOs to man the demarcated CHPS zones. This was embraced by all, and a team of trainers was formed at the regional level comprising the CHPS unit and a district director to supervise the training in all the districts.

Districts plans for orientation and supervision of the trainees are done with the regional team for the entire duration of the training. The regional team supports the districts staff to train the CHNs for the two days in a lecture room, then schedule a date for the beginning of the field practicum. The sub-district and district teams ensure regular visits and provide support to the CHPS zones during field practice.

The regional team conducts joint monitoring with the district team to ensure strict adherence and also monitor the conduct of the field work. The team usually interrogate the mentor separately to ascertain the issues and challenges of the training. The mentee is equally met in the same manner. After meeting with the two separately, then both are brought together to further discuss the issues from their points of view.

In a situation where both exhibited good understanding of the training, the team congratulates them and encourages them to continue the good work. On the other flip, they are encouraged to continue but a week or two will be added to the duration of the training for them to polish the deficiencies. This is the reason why the duration of the training in Upper East ranges from 5 weeks to 6 weeks.

" The statistics indicate that 398 CHOs have been trained in the region using DCHOO. This constitutes 54.4% of the total number of CHOs in the region. It is clear that using the DCHOO strategy has contributed tremendously to the number of CHOs in the region. It is recommended that the Ghana Health Service reviews it's CHPS implementation policy and guidelines and incorporates this laudable and cost-effective strategy into the policy."

Dr. Emmanuel Ansu-Abina
Regional CHPS Coordinator, UER

Box 5 District CHO Orientation in Upper East Region : CHO

I worked with a CHO before getting the opportunity to attend a DCHOO. At the time, most of the community mobilization tools were difficult to understand, hence, I could not apply them. During the DCHOO, I spent two days for theory and six weeks for field practical. On the field, I applied all the community mobilization tools with community members. This has equipped me with the requisite knowledge to be able to effectively work with my community.

" I applied all the community mobilization tools with community members. This has equipped me with the requisite knowledge to be able to effectively work with my community."

Mr. Kamal Gado
CHO, Dazongo CHPS ,Bolga Municipal, Upper East Region

Number of trained CHNs through the DCHOO approach

District	No. of Trainees (CHNs)			
	2020	2021	2022	2023
Bawku Municipal	0	10	10	10
Bawku West	0	12	0	0
Binduri	0	10	9	10
Bolgatanga East	0	12	14	0
Bolgatanga Municipal	0	10	0	0
Bongo	31	14	0	0
Builsa North	0	15	0	0
Builsa South	0	17	12	12

District	No. of Trainees (CHNs)			
	2020	2021	2022	2023
Garu	17	0	22	0
Kassena Nankana Mun.	18	0	0	0
Kassena Nankana West	0	19	10	10
Nabdam	0	13	0	8
Pusiga	0	11	8	0
Talensi	0	6	0	0
Tempane	10	10	28	0
UER Total	**76**	**159**	**113**	**50**

2. STRENGTHENING MANAGEMENT OF REFERRAL SERVICE FOR QUALITY HEALTH CARE

Summary of the Approach

CHPS implementation highly depends on a well-functioning referral system since they manage only minor ailments at their level. The situational analysis of the Project revealed gaps such as lack of standard referral forms & registers, inappropriate documentation, non-compliance with referrals and the gate-keeper system, and low referral feedback and communication between higher and lower-tier facilities. This situation affected the referral system and quality of care given to clients, hence was seen as one of grave concern.

Frantic efforts were made by the Project to strengthen referral services for continuity of care and management of clients' health needs. The JICA CHPS approach consists of three major components; 1) standardization of referral documentation, 2) maintaining the standard of practice, and 3) strengthening referral linkage. Aside from referral tools and training provided by the Project, opportunity was given to the Project's target regions and districts to develop innovative ideas to improve their referral system. Such examples include establishing a revolving fund system, developing monthly referral returns and referral tracking system, institutionalizing quarterly family clinical meetings, and developing referral IEC posters.

Strengthening management of referral service for quality health care

Key result Achieved	• Establishment of a revolving system for Referral Forms & Registers at Regional Medical Stores for sustainability: Health centers & hospitals can procure referral forms and registers at an affordable cost using their IGF. • Remarkable improvement in documentation and compliance with national referral protocol: Nadowli-Kaleo (UWR), a pilot district of the JICA project, recorded 100% compliance with referral protocol at the CHPS level during the JICA CHPS project's endline survey. • Increase in referral feedback from higher facilities to CHPS level: 0% to 56.3% (Nadowli-Kaleo, UWR), 60.8% (Talensi, UER), and 32.3% (Savelugu, NR) against the project target of 60%. • National adoption and scale-up of tools: referral forms, referral feedback forms and referral registers were adopted in the National Health Referral Policy and Implementation Guideline 2022-2030. • Monthly Referral Returns (MRR), a monitoring format of referral, has been incorporated into the DHIMS2 platform.
Lessons learned and replication	• Monitoring Referral Feedback with MRR and tracker helps identify the status of two-way communication between health facilities for continuity of care and maintains the gate-keeper system. • Gaps in referral can only be addressed through a collaborative approach between higher and lower-tier facilities. Many gaps are due to communication breakdown. Implementing stakeholder meetings, such as quarterly family clinical meetings, from CHPS to Hospital is critical. • The interest of officers and health workers directly affects the functionality and success of the referral system.

Effectiveness of the Intervention

Compliance of Referral Protocol & Guidelines
at CHPS level

Regions	2023
UWR (Nadowli-k)	100 %
UER (Talensi)	73.3 %
NR (Savelugu)	63.6 %

Based on the Project's endline survey.
Project Target: 75%

Referral Feedback Rates
(FB received from higher facility to CHPS)

Regions	2017 (baseline)	2023
UWR (Nadowli-k)	0%	56.3 %
UER (Talensi)	0%	60.8 %
NR (Savelugu)	0%	32.3 %

Based on the Monthly Referral Returns from 2022 to 2023(Q1).
Project Target: 60%

Box 6 Monthly Referral Returns & Tracking System - UER & UWR

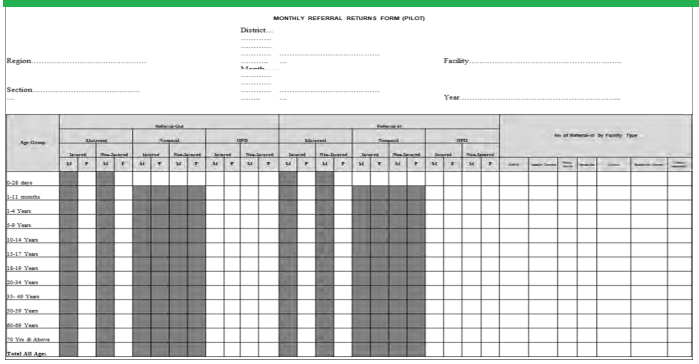
Monthly Referral Return (MRR) was introduced for referral monitoring as a way of tracking clients' status in the continuum of care. Before the intervention, there was no way of tracking and summarizing referral cases at facilities. There was also no means of monitoring a client's status after a referral was made at an initiating health facility. MRR collects data on referrals and referral feedback and helps identify a client's movement, the functionality of the gate-keeper system, and the status of two-way communication between health facilities. With this format, a program manager can easily identify health facilities with gaps. The relevance of MRR was acknowledged by GHS-HQ, and with the support of PPMED, it was accepted and integrated into DHIMS2. MRR has revealed clear gaps in terms of referral feedback to be provided for clients by higher facilities.

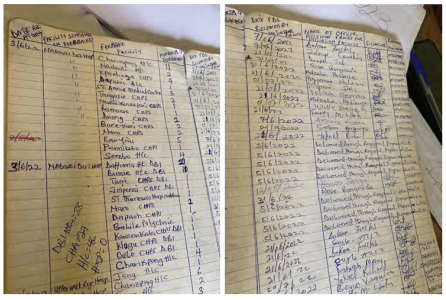
Referral feedback plays an important role in a client's continuum of care. At the CHPS level, referral feedback serves as a learning opportunity for CHOs in the clinical management of clients. To improve referral feedback, DHMTs and hospitals developed their own referral tracking register referred to as referral feedback trackers. The content of the referral tracking register consists of referrals made from various levels every month, feedback received, the name of the person receiving the feedback as well as the time and signature of the recipient for easy reference. It significantly boosted the referral feedback rate in the district.

"The feedback tracking system has helped put my team on our toes to giving prompt feedbacks to initiating facilities. This again has aided in addressing some basic clinical challenges the lower facilities are faced with."

Dr. Benjamin Yitah,

Medical Superintendent, Talensi District Hospital, UER


MONTHLY REFERRAL RETURNS FORM (PILOT)



Monthly Referral Returns (Top)

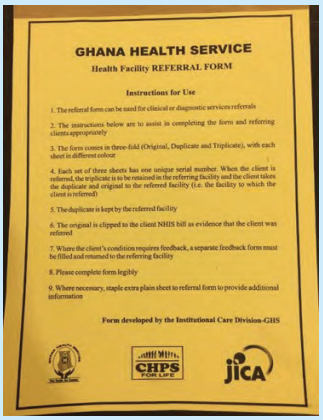
Referral Tracking Register (Left)

District Referral Coordinator sorting out the referral feedbacks received from the hospital (Nadowli-Kaleo, UWR)

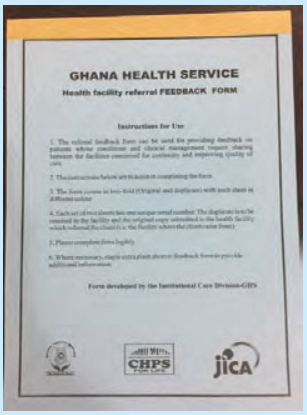
Box 7 Family Clinical Meeting- Nadowli-Kaleo District, UWR

Nadowli-Kaleo district of UWR has instituted quarterly family clinical meetings, which brings together staff from all levels of the district, including core management from both the hospital and the District Health Management Team (DHMT) and service providers from lower tier facilities such as health centers and the CHPS zones including private facilities. Also, representatives from the Upper West Regional Hospital and Wa Municipal Hospital are usually invited since they manage cases referred out of the districts. At these meetings, the DHA and the district hospital make presentations on the district's referral situation, including feedback rate. The meeting provides a good forum for open and objective discussions amongst staff of the various levels of care on their challenges with referral, documentation, and feedback, among others.

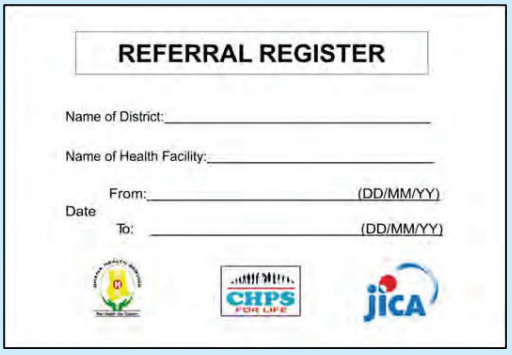
Misunderstandings among staff, outstanding feedback, and referral telephone directory are usually addressed to foster teamwork. Subsequently, staff from all levels learn to appreciate the roles, responsibilities and challenges their colleagues face at the various levels, devoid of blame game. Based on the challenges, solutions are agreed upon by all levels. A simple action plan is developed for each level to take away for the next quarter for implementation. The previous meeting action plan is reviewed every quarter to ascertain the status of performance before the presentations from the DHA and hospital in the next quarter.


GHANA HEALTH SERVICE
Health Facility REFERRAL FORM
Instructions for Use
Form developed by the Institutional Care Division-GHS

Referral Form


GHANA HEALTH SERVICE
Health facility referral FEEDBACK FORM
Instructions for Use
Form developed by the Institutional Care Division-GHS

Referral Feedback Form


REFERRAL REGISTER
Name of District:
Name of Health Facility:
Date From: (DD/MM/YY)
To: (DD/MM/YY)

These documents were adopted in the New National Health Referral Policy and Implementation Guideline 2022-2030.

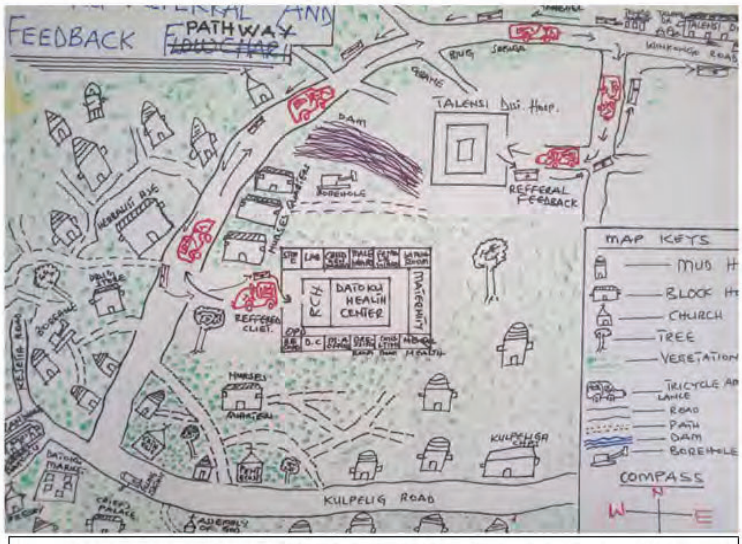
CHO reading referral feedback from the hospital.

Box 8 Development of Referral IEC posters - Talensi District, UER

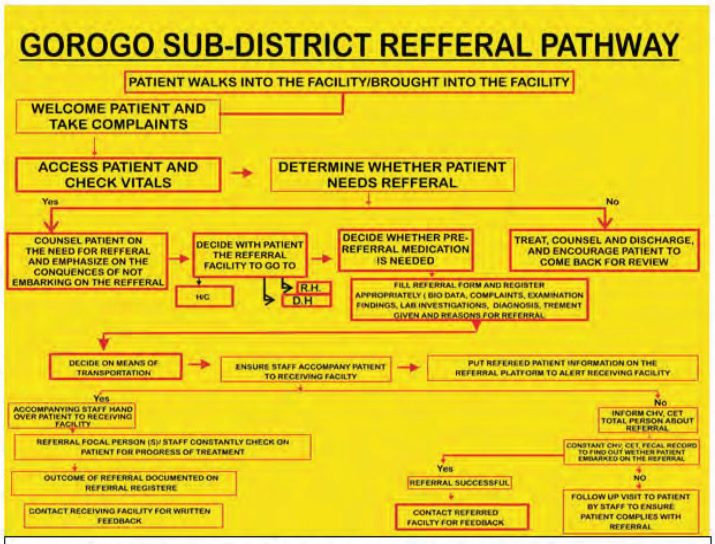
Sensitization on referral starts from the health facility as the compliance of referral depends on both the health facility and the client. The UER Regional Health Directorate has taken it upon itself to strengthen ownership and community participation in referral services in the quest to improve the referral system in the region. Two types of referral IEC posters were developed on a competitive basis in Talensi District; flow charts and pathways. The flow chart aims to enhance staffs' adherence to standard referral procedures whilst the community-based referral pathway seeks to sensitize the community on the referral system for improved compliance. All sub-districts in the Talensi participated in the IEC poster development, which helped deepen their understanding of the referral system. The sub-district with the best poster was awarded after an evaluation by the RHMT, with the practice subsequently scaled-up to other districts in the region.

"I am happy for the various strategies put in to address referral issues which has strengthened the referral system in Talensi District."

Mr. Francis Ayamga
CHO, Tenzug CHPS , Talensi District, UER



Referral Pathway (MAP) for community sensitization (developed by H/C)



Referral Flow Chart for health staff Developed by H/C in UER

SDHT staff explaining the Poster to the judges during a referral stakeholder meeting in UER. (Right)

Talensi DHMT and Hospital team in a pose with winners of the referral IEC material development competition (Left)

3. IMPROVING HEALTH CARE FOR ALL AGE COHORTS

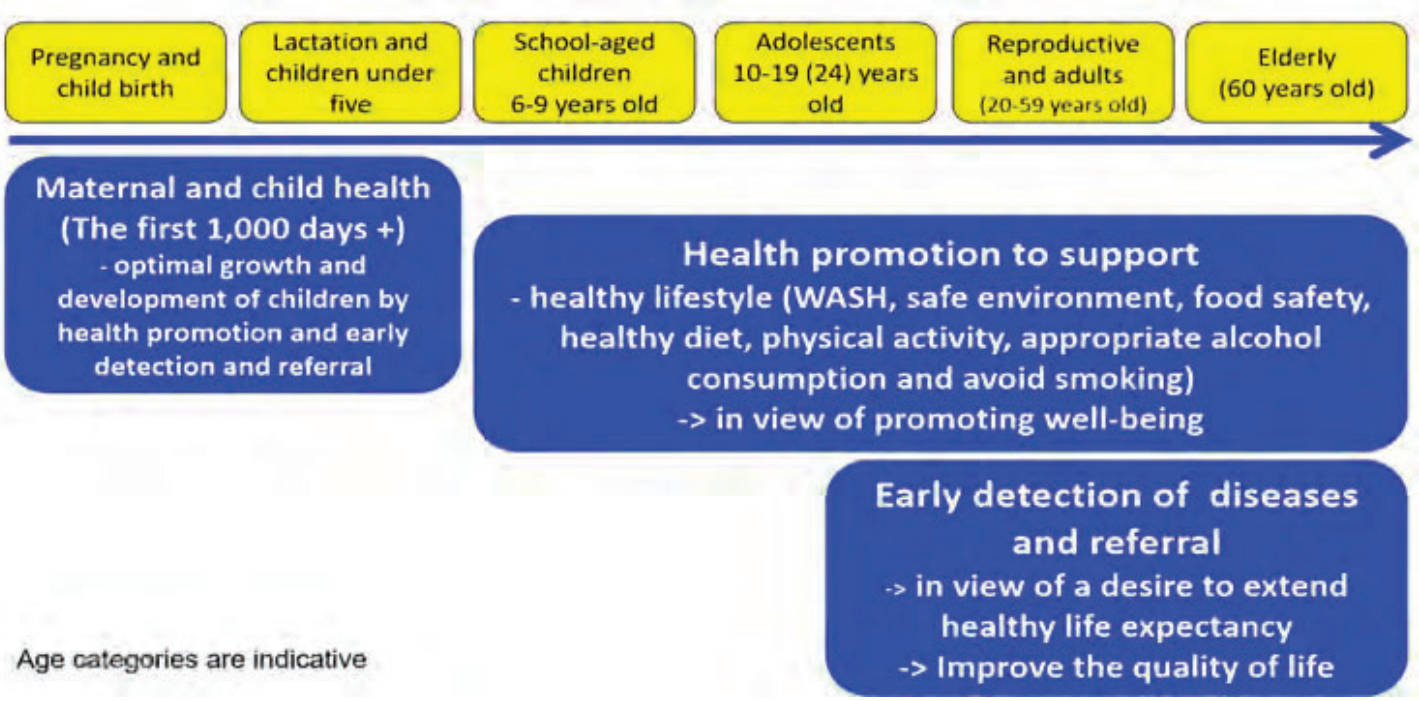
Summary of the Approach	The project worked closely with GHS to develop a definition of the concept of Life-Course Approach (LCA) within the context of Ghana. Through several trainings, the project identified the minimum services to be provided at CHPS zones and developed training materials. The project also ensured quality of LCA services through capacity building of CHOs
Key results Achieved	• 650 CHOs and 39 Sub-District Health Teams were trained on LCA-related services • LCA training package and tools were developed and submitted to GHS • LCA training materials integrated into Pre-service training and district CHO orientation (DCHOO) for sustainable training. • Provision of basic equipment • Health screening data collection and analysis
Lessons learned and replication	• LCA activities unite staff of different units (MCH, Nutrition, Public Health etc.) in the provision of cohort-sensitive services • Monitoring of CHOs is key to ensure quality services and continuous capacity building for CHOs. • Documentation of health screening results is crucial for data availability and also helps to evaluate the performance of CHOs

Definition of LCA in Ghana

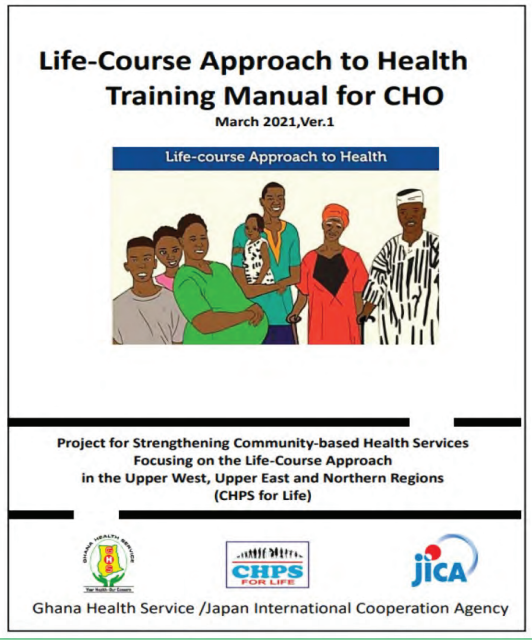
"A life-course approach to health emphasizes the importance of all ages and stages of life, and sets goals of investment in health capital through health promotion and prevention"

(GHS/JICA, 2018).

Focus of the Life-course Approach at CHPS level in Ghana



LCA manual developed by the Project and contents



No	Contents
1	Introduction to LCA
2	Maternal and Child Health
3	Care for School-age Children
4	Adolescent Health and Development
5	Adults and Aged Health
6	Tools for LCA Services
7	Response to COVID-19 at CHPS level

Box 9 **Life Course Approach in UWR : RHMT**

"In fact LCA leaves no age group behind with the package of services. LCA services are organized for all age cohorts and well recorded in the health screening register".

Mr. Anthony Kullah
Regional Nutrition Officer, RHD, UWR

Hitherto the introduction of LCA, we didn't have any system of capturing Non-Communicable Diseases (NCD) prevalence in the region. Health staff were not orientated to prepare for screening services and the population was equally not orientated to willingly visit health facilities for free health screening services.

With the introduction of LCA, the capacity of health staff has been built to provide LCA interventions and logistics including registers provided to capture data on services rendered. Massive health education on NCDs is on-going through various channels including community health volunteers, CHMCs, community durbars, outreach services and radio.

The health screening has been very revealing and timely as a lot of seemingly healthy people were picked up early with NCDs and referred. LCA has selected health services for every age cohort .

LCA is very instrumental in community mobilization. Anytime we call for community meetings or durbar, we usually include LCA services and this attracts a lot of community members to the meeting ground. At least they know they will be screened for free. Through LCA, we were able to detect pre-hypertensive and diabetic patients early, counselled and managed these cases and they are now doing very well.

We are beginning to change the orientation of community members about visiting the CHPS compound. Prior to LCA, only sick people used to visit the facility, but now people who are not sick also visit the facility for screening after our sensitization exercise.

Box 10 **Life Course Approach in UWR : DHMT**

"LCA fits well into the National NCD policy. NCDs have become a great challenge and to tackle this challenge, LCA is the way to go. With LCA, policymakers can develop specific strategies targeting specific age cohorts in an attempt to reduce the prevalence of NCDs in the country"

Madam Phoebe Bala
DDHS, Nadowli District, UWR

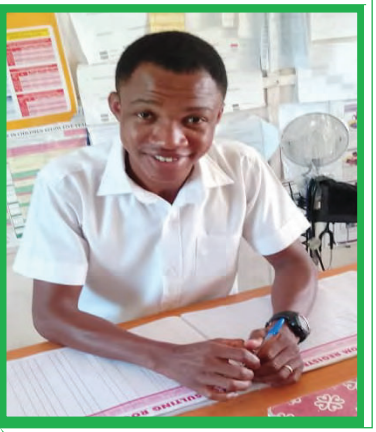
The implementation of LCA has had positive effects on both health staff and community members. Health staff have seen improvements in their skills, particularly in providing screening services, as identified capacity challenges were addressed through LCA monitoring visits. The program has also increased health staff awareness of NCDs and improved their ability to care for individuals of different age groups. Additionally, the regular reporting by staff on logistics for LCA services has enabled the DHMT to procure necessary supplies.

Community members have experienced a significant increase in awareness regarding NCD risks, resulting in a higher demand for LCA services. Many community members visit health facilities for screening and counseling, and they receive personal health cards containing details such as weight, height, blood pressure, and waist circumference. This empowers community members and allows them to track improvements in their health status.

However, challenges remain, particularly regarding logistics such as blood pressure apparatus and glucometer strips. Large-scale screening often prevents health staff from using the Healthy Life Assessment Questionnaire (HLAQ) due to time constraints. Additionally, the cost of glucometer strips limits community members' ability to monitor their blood sugar levels, despite its importance

Box 11 **Life Course Approach in UWR : CHO**

"My capacity as CHO has been built on BMI calculation and classification, wait circumference measurement and classification, blood sugar among others through LCA trainings and monitoring visits. I am also able to do focused counseling for my clients based on the outcome of their indicators assessed. I am now an ambassador of LCA"



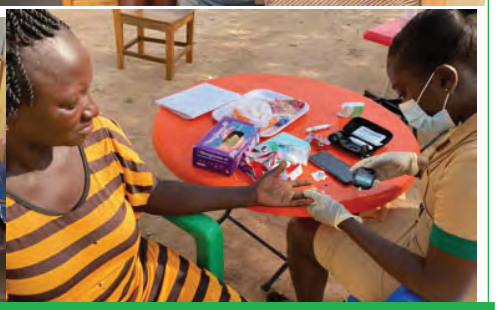
Mr. Dampson K Jude
CHO, Kpagadigah CHPS, Nadowli, UWR

Improving health care for all age cohorts

Health screening and counselling for Adults





Care for children under five



Care for Adolescents



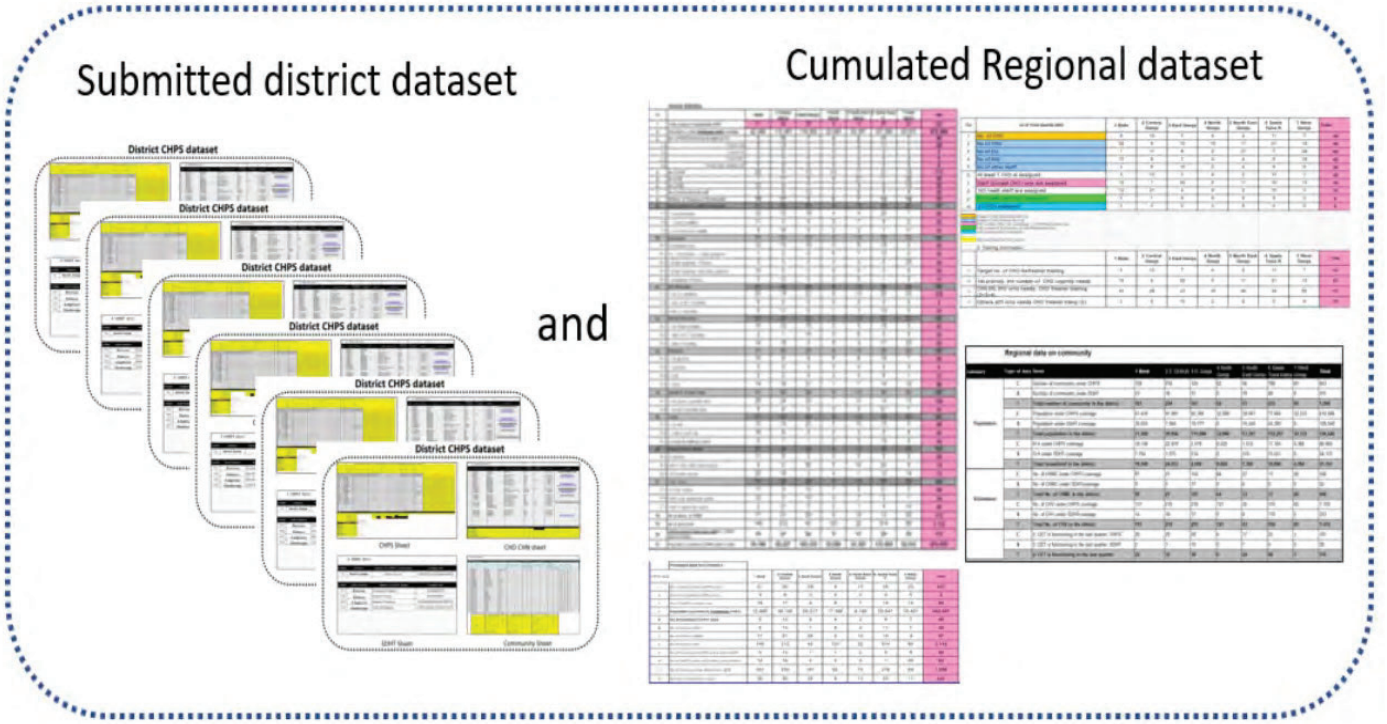
Care for the Aged



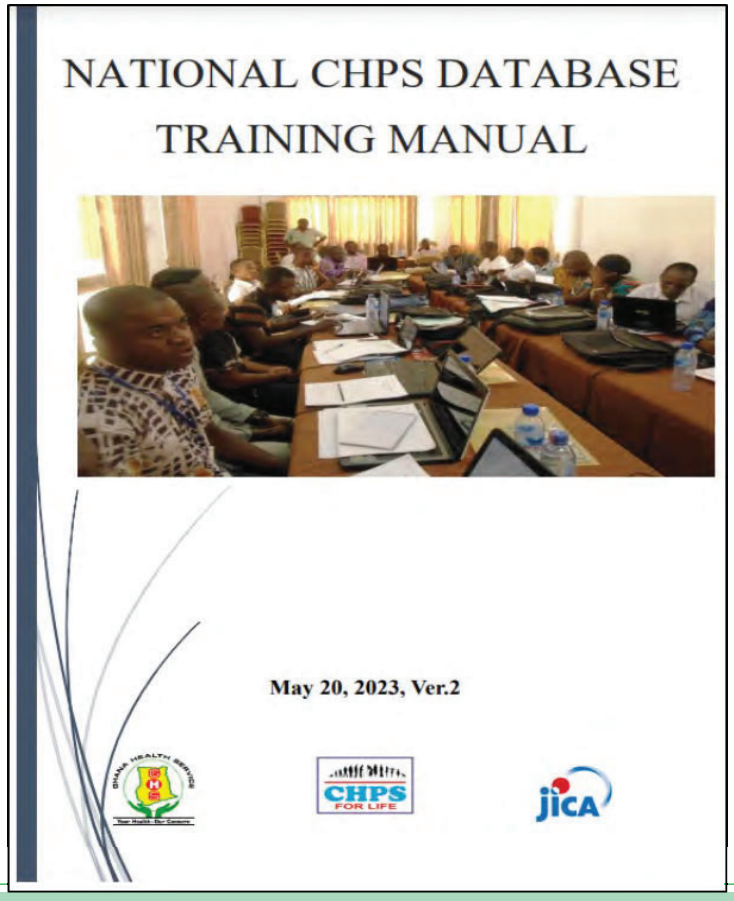
4. CHPS DATABASE:
A TOOL FOR EFFECTIVE CHPS IMPLEMENTATION

Summary of the Approach	The CHPS database is a system to support data collection of CHPS zones as part of the strategy to improve CHPS implementation and the accuracy of CHPS-related data. CHPS database is an excel-based tool that captures information on CHPS human resource status, equipment and amenity status as well as community mobilization/engagement status. When populated, the CHPS database allows for districts /regions to ascertain their overall CHPS implementation situation and also identify the gaps in CHPS implementation.
Key results Achieved	• CHPS database has been successfully rolled out in all regions of Ghana. • The status of CHPS implementation in the five northern regions has drastically improved. • Districts/Regions are able to mobilize resources from DA, development partners by using CHPS database as evidence. • Districts/Regions are able to use the CHPS database for resource allocation
Lessons learned and replication	• Strong leadership and commitment at the regional/district levels are key • To sustain the tool, periodic follow-up has to be made to the district teams to collect the data for collation . • Due to attrition, district and regional teams need periodic refresher training on the database.

CHPS database (Excel sheet)



CHPS Database Manual



Box 12 **CHPS database in the UWR: RD**

"It is worth recollecting that in 2021, I met with the Upper West Region caucus of the Members of Parliament and highlighted the key health challenges for all the 11 constituencies of the region. The CHPS database served as the main source of information for that engagement. It was very easy to share detailed and accurate information with the MPs".

Dr. Damien Punguyire
RDHS, UWR

As a region, before the introduction of the CHPS database, we didn't have any comprehensive tool that collects CHPS data. As such, there was no standard system of collecting CHPS data. Data quality basically was not the best and there was the need to introduce a system to improve CHPS data for quality decision making.

The CHPS database was introduced to enhance CHPS data collection for decision making. The CHPS database is an advocacy tool that is used to solicit support for health care delivery at the CHPS level.

The presentation generated a lot of interest from the Members of Parliaments (MPs). This has since engineered the provision of motorbikes, equipment and electricity in most of the CHPS zones by the MPs and District Assemblies. We distributed some five motorbikes in 2022 easily using the CHPS database. The CHPS database is our main data source for our HIAP formulation.

Box 13 CHPS database in UWR: RHMT

The CHPS database has proven to be an invaluable tool enabling us to efficiently manage and monitor the implementation of CHPS in the respective districts. .

One of the key advantages of the CHPS database is its ability to provide real-time information on the status of CHPS zones in terms of resource availability. This allows coordinators to have a comprehensive understanding of the situation in each zone, enabling them to make informed decisions and allocate resources effectively. For instance, they can quickly determine the number of CHPS zones with compounds, assess the availability of essential resources such as water, toilet facilities, and network connectivity. This information helps to identify gaps and prioritize interventions where necessary.

Additionally, the CHPS database has streamlined communication and coordination between CHPS coordinators and district directors. With access to up-to-date data on staff and logistics distribution at the CHPS level, coordinators can provide accurate reports to their district directors.

In order to maximize the benefits of the CHPS database, CHPS Coordinators adhere to certain best practices. They ensure that data entry into the database is accurate, timely, and consistent across all CHPS zones. Regular data updates are conducted to maintain the database's reliability and relevance. Coordinators also undergo training to enhance their proficiency in utilizing the database effectively, including data analysis and interpretation.

Furthermore, CHPS coordinators actively engage with the CHPS database by regularly reviewing and analyzing the data. They use the database as a powerful decision-making tool to identify trends, patterns, and areas requiring attention. By leveraging this information, coordinators can proactively address challenges, monitor progress, and implement targeted interventions to improve the overall functioning of CHPS zones.

"Overall, the CHPS database has revolutionized the work of CHPS coordinators in the Upper West Region by providing them with a comprehensive and accessible platform to manage and monitor CHPS implementation. By adhering to best practices and harnessing the full potential of the database, these coordinators can effectively ensure the availability of resources, facilitate coordination, and promote the delivery of quality healthcare services in CHPS zones throughout the region."

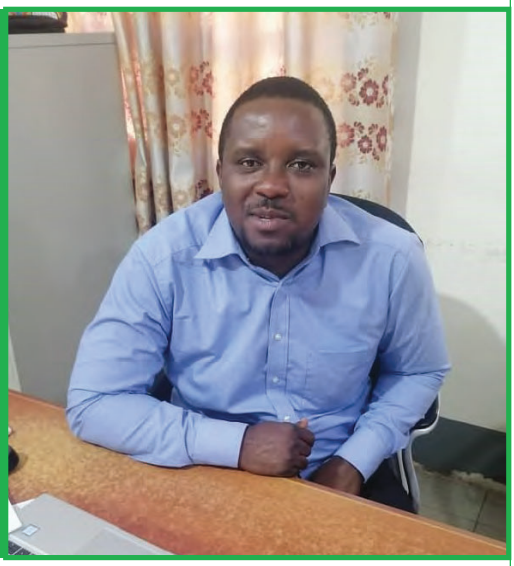
Mr. Ambrose Naawa
CHPS Coordinator , RHMT, UWR

Box 14 **CHPS database in the NR: RHMT**

"I was appointed Regional CHPS Coordinator in 2022. As a newly appointed person, I needed to quickly understand the key definitions in CHPS and also understand the issues of CHPS implementation in the Region. Going through the CHPS database, I not only got to know the level of CHPS implementation in the region, but also got to understand some basic CHPS terminologies better.

I feel more empowered in this role due to my understanding of the CHPS database"

Mr. Benedict Ofori - Appiah
Regional CHPS Coordinator, RHMT, NR



The introduction of the CHPS database system to the Northern Region of Ghana in 2017 has been a game-changer in generating accurate and real-time data on CHPS for planning, decision-making, and training purposes. Prior to the implementation of this system, the region faced challenges in generating accurate and reliable data on CHPS zones and their activities, which adversely affected the region's ability to plan and allocate resources for health services effectively. Any time the region -needed data on CHPS, district teams were contacted, leading to inconsistent data from time to time.

One case in point is the Tamale Metropolis, where the CHPS database system was used to identify that CHPS demarcation had not been completed. This incomplete demarcation meant that there were fewer CHPS zones to serve the entire population of the metropolis, making it difficult to provide health services to the entire metropolis. Through the database system, health authorities were able to track the progress of CHPS demarcation and identify areas where additional resources were needed to complete the process.

As a result of this, the health authorities were able to allocate additional resources to the Tamale Metro area to complete the CHPS demarcation process, which has led to improved CHPS service delivery in the area. With the demarcation completed, health workers are now able to serve the entire Tamale Metro area more effectively, resulting in improved health outcomes for the community.

Moreover, the CHPS database system has been instrumental in improving the overall management and administration of CHPS activities across the Northern Region. Health authorities can now use real-time data to make informed decisions on resource allocation, training needs, and other critical aspects of CHPS implementation.

Box 14 **CHPS database in NR : RHMT Cont.**

In conclusion, the introduction of the CHPS database system in the Northern Region of Ghana has been a significant success story, enabling health authorities to generate accurate and reliable data on CHPS activities for planning and decision-making purposes.

The case of the Tamale Metro area illustrates how this system has led to improved CHPS service delivery by identifying critical gaps and enabling health authorities to allocate resources more effectively.

The CHPS database system is a valuable tool for improving health outcomes and should be adopted in other regions to enhance health service delivery.

Box 15 **CHPS database in NR: DHMT**

" CHPS functionality depends on a number of parameters including availability of a CHO, service delivery, active CHMC and CHAP development. Through the use of the CHPS database, I am able to identify the functional CHPS zones in my district and also identify the reasons why others are not functional. Based on this information, I support the CHPS staff to address the causes of non-functionality. "

Hajia Haruna Hadjara
DDHS, Yendi , DHMT, NR

NOTES

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