# Internal Ex-Post Evaluation for Technical Cooperation Project

conducted by Ghana Office :（March, 2014）

| Country Name | Scaling up of Community Based Health Planning and Services (CHPS) Implementation in the Upper West Region |
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| Republic of Ghana | |

## I. Project Outline

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| Background | In Ghana, a national policy "Community Based Health Planning and Services (CHPS)" started in 1999 for better access to health services. CHPS was implemented mainly by District Health Management Teams (DHMTs) in the following way: a district was divided into CHPS zones between 3,000-5,000 populations; Community Health Committee (CHC) was set up at each CHPS zone; CHPS compounds are constructed and CHOs are trained and deployed to these zones. However, the scaling up of CHPS was slow for reasons such as lack of district-level administrative capacity, insufficient number and capacity of CHOs, and low level of community participation. In the Upper West Region (UWR), the performance of health indicators such as infant mortality rate was particularly worse than other regions, showing the poverty level of the people with limited access to basic health services. |
| Objectives of the Project | 1. Overall Goal: To increase coverage of functional CHPS[1].<br>2. Project Purpose : Institutional capacity of the Ghana Health Service (GHS) on CHPS implementation in UWR is strengthened.<br>3. Assumed steps for achieving the project goals[2]: in the two pilot districts (stage I districts), (1) the administrative capacity for CHPS implementation is developed (i.e. equipment are provided and CHOs are trained) and Community Health Action Plans (CHAPs) for promoting community participation are implemented, (2) capacity development for health personnel at each level of UWR is carried out through the Facilitative Supervision (FSV), and (3) the referral system among hospitals is improved. Through these improvements, the services, which follow the CHPS policy, are able to be provided throughout the health system. Further, such good practices of health services in stage I districts are disseminated to other districts (stage II districts). |
| Activities of the project | 1. Project site: Upper West Region (UWR)<br>2. Main activities: (1) standardized training in health administration management; (2) training for CHOs and Community Health Nurses (CHNs); (3) conducting situation analyses on CHPS activities and developing a supervision guideline; (4) conducting situation analyses and developing a guideline on the referral system; (5) conducting situation analyses on community participation and developing training materials; and (6) disseminating good practices to other districts through training and sharing the guidelines.<br>3. Inputs<br>Japanese Side<br>(1) Experts: 12 for Short term<br>(2) Trainees (short course) received: 9 persons<br>(3) Equipment: motorcycles, bicycles, medical equipment, radio communication system<br>Ghanaian Side<br>(1) Core Staff:19 persons (RHMT and DHMT)<br>(2) Land and facilities: project office, utilities |
| Project Period | March 2006 – February 2010 / Project Cost: Approx. 500 million yen |
| Implementing Agency | Ministry of Health (MOH), Ghana Health Service (GHS) and Policy Planning Monitoring and Evaluation Department (PPMED), Regional Health Management Team (RHMT) of UWR; and District Health Management Team (DHMT) of each pilot district. |
| Cooperation Agency in Japan | IC Net Limited |
| Related Projects (If any) | Japan's cooperation:<br>This project was the central part of the Programme for the Improvement of the Health Status of People Living in UWR, the first model JICA programme. Together with this project, activities were carried out through: (1) dispatch of Japan Overseas Cooperation Volunteers (JOCVs) (JFY2005-JFY2009), (2) procurement of equipment through the Grant Aid project (May 2006 – December 2007), and (3) cooperation with the Aid Coordination Advisor (November 2008 – November 2009). After the completion of this project, (4) the Improvement of Maternal and Neonatal Health Services Utilizing CHPS system in the Upper West Region (Technical Cooperation, 2011-2016) and (5) the Project for the Development of CHPS Infrastructure in the Upper West Region (Grant Aid for Community Empowerment, JFY2012) were implemented. In addition, (6) the Policy Advisor for Promoting Community Health (individual expert at GHS and PPMED, 2011-) is supporting PPMED HQ.<br>Other donors' cooperation:<br>USAID : training and provision of equipment to support the CHPS implementation in 28 districts in the seven regions excluding the three regions in the north (5 years from 2004).<br>UNICEF: training of CHOs, construction of CHPS compounds, support for CHOs' living environment, etc. |

[1] Regarding the definition of functional CHPS, this survey followed the definition of CHPS with i. assignment of CHO and ii. home visit paid by CHO. (This definition was redefined after the project completion and the original definition was CHPS with fulfillment of : 1.completion of community awareness 2. acceptance of community 3.CHO assigned 4.CHO with basic necessary equipment 5. CHV assigned.)

[2] Reviewed at the time of the ex-post evaluation.

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| | Multiple donors: Sector Budget Support (Health) |

**II. Result of the Evaluation**

1 Relevance

This project has been highly relevant with Ghana's development policy such as the second Health Sector Five Year Programme of Work (2002-2006), the third Health Sector Five Year Programme of Work (2007-2011) and the Health Sector Medium-Term Development Plan (2010-2013) that all prioritize the implementation of CHPS, development needs for provision of basic health services and better access to such services in UWR, where under-five mortality rate is still high at 108 per 1,000 births (2011), as well as Japan's ODA policy the Country Assistance Program for Ghana (2006), at the time of both ex-ante evaluation and project completion.

Therefore, relevance of this project is high.

2 Effectiveness/Impact

This project aimed to strengthen administrative capacity of GHS in implementation of CHPS in UWR. The degree of achievement of the project purpose was verified based on the performance of the five indicators listed in the table below[3]. On Indicator 1, while FSV implementation rate varied by level of local administration, the rate at the district level, i.e. FSV implemented by DHMT for the Sub District Health Teams (SDHTs), increased from 56.7% (2009) to 69.8% (2012). Managerial and supervisory officers at district or higher levels consider that FSV has contributed to more timely and direct services such as supervision and guidance for health personnel and provision of supplies. Although sufficient data were not available on FSV implementation by SDHTs and CHOs, the rate is estimated to have decreased due to factors such as unavailability of the FSV tools, and high staff attrition. It is considered that the data collection was insufficient after project completion because the FSV tools were not directly applicable for operations at the district level, and therefore data were not properly managed. The subsequent project is revising the tools to improve such situation. Indicator 2 showed a decrease from the time of terminal evaluation presumably due to the difficulties in ensuring transportation means and fuel and conflicting programmes. However, CHPS Implementation Guideline (Final Draft) recommends that estimated number of home visit by CHO is about 50 times per month. Therefore, the number of home visit at the time of ex-post evaluation is still above recommendation. On Indicator 3, the procured equipment was well utilized until the time of project completion but not sufficiently enough at the time of ex-post evaluation (see the table below). As for Indicator 4, appropriately-referred cases in the target area accounted for around 80%. Since 2009, the referral operation monitoring has been incorporated into FSV. Also, the current project is engaged in the revision of the tools and training for further strengthening the referral system. Indicator 5 showed an increase from 48% at the time of terminal evaluation to 54% at the time of ex-post evaluation. In addition, all of the surveyed CHOs said that the contents of the CHO training, especially how to enter the community (community entry), formation of CHCs, how to promote community participation, problem identification and finding solutions, were very useful, and they often referred to the learning guides that they had received in the training.

With respect to the overall goal, "to increase coverage of functional CHPS", the number of functional CHPS zones increased from 81 at the time of terminal evaluation to 166 at the time of ex-post evaluation, achieving 84% of the target of 197 CHPS zones for 2015. It is likely that GHS will achieve this target by 2015 through implementation of its plan to construct CHPS compounds that are funded by the Project for the Development of CHPS Infrastructure in the Upper West Region (JFY2012), and others to be constructed by District Assemblies (DAs)/Member of Parliaments (MP) etc. It was also observed that the dissemination of the activities developed and initiated under this project (CHAP, the Community Emergency Transport System (CETS), FSV, etc.) have been promoted and disseminated to other regions and nationwide by study tours for district directors and other means. Furthermore, FSV is expected to be reflected in the national CHPS implementation guideline that is currently being revised. Besides, a number of good practices were observed including the followings: institutionalized delivery (recommended) has increased thanks to CHOs' facilitation of community participation, and the enhanced communication among CHPS, districts and sub districts through FSV; and the community members contributed for the construction of rooms in CHPS compound for mothers' privacy and emergency delivery. As for the relation to other projects, it was observed that collaboration with the grant aid project and other activities, including those by JOCVs and other donors such as UNICEF, contributed to the increase in CHPS zones.

In summary, the project purpose was achieved to a certain degree at the time of project completion, however, the decreased in the use of the tools, which had to be revised by the subsequent project. The overall goal has been achieved based on the increase in functional CHPS zones.

Therefore, effectiveness/impact of the project is fair.

Achievement of Project Purpose and Overall Goal

<table>
<tr><th>Aim</th><th>Indicators</th><th>Results</th></tr>
<tr><td>(Project Purpose)<br>Institutional capacity of GHS on CHPS implementation in UWR is strengthened.</td><td>1. Job performance of health personnel is improved according to performance standard (PS) for RHMT, DHMTs, SDHTs and CHOs (verified through FSV implementation rate and performance</td><td>FSV implementation rate
<table>
<tr><th>Target FSV</th><th>At the time of Terminal Evaluation (2009)</th><th>At the time of Ex-post Evaluation (March 2012)</th></tr>
<tr><td>RHMT to DHMT</td><td>na</td><td>97.2%</td></tr>
<tr><td>DHMT to SDHT</td><td>10.9%(2008) -> 56.7% (2009)</td><td>69.8%</td></tr>
<tr><td>SDHT to CHO</td><td>7.5%(2008) -> 23.7% (2009)</td><td>8%</td></tr>
<tr><td>CHO to Community Health Volunteer (CHV)</td><td>52.5%</td><td>na</td></tr>
</table></td></tr>
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[3] The analysis took into consideration the Improvement of Maternal and Neonatal Health Services Utilising CHPS system in the Upper West Region (2011-2016), the subsequent (Phase 2) project that is currently being implemented.

<table>
<tr><td></td><td>assessment)</td><td>Source: JICA internal documents<br><br>Performance assessment: improvement was confirmed in most of the performance items in all districts.</td></tr>
<tr><td></td><td>2. Number of households covered by CHO home visit increases</td><td>
<table>
<tr><td>No. of home visits per month per CHPS zone</td><td>2006</td><td>Terminal Evaluation (2009)</td><td>Ex-post Evaluation (Sept. 2013)</td></tr>
<tr><td>Visits/month</td><td>57.8</td><td>90.1</td><td>53.6</td></tr>
</table>
Source: extracted from the District Health Information Management System (DHIMS2)</td></tr>
<tr><td></td><td>3. All of the motorbikes/ medical equipment/ radio sets procured by the project are fully utilized until the end of the project period.</td><td><Project completion> Fully utilized until the end of the project period.<br><Ex-post evaluation> They have been properly maintained but not fully utilized. Uses of motorbikes have been restricted to save fuel and for other reasons (home visits are carried out on foot as much as possible). The radio sets have not been used since 2010 due to limitations in connectivity settings. CHOs use mobile phones for communication. When a blood pressure cuff is broken, it is repaired by the region or a new set is purchased by the district.</td></tr>
<tr><td></td><td>4. Promotion of cases appropriately referred by CHO increases (in three districts)</td><td><Terminal evaluation> 98% (March-May 2009), 93% (June-August 2009)<br><Ex-post evaluation> around 80% in most districts according to the district-wide data collected by the region (2011).</td></tr>
<tr><td></td><td>5. Proportion of CHPS zones implementing CHAP increases</td><td><Terminal evaluation> 52.6% of CHPS zones implemented CHAP activities at least once. Approx. 30% of them implemented the activities without support from NGOs.<br><Ex-post evaluation> The number of CHPS zones implementing CHAP has increased.<br>s
<table>
<tr><td>Item</td><td>2009</td><td>2013</td></tr>
<tr><td>No. of CHPS zones where CHO/CHN was assigned</td><td>138</td><td>166</td></tr>
<tr><td>No. of CHPS zones where CHO/CHN carries out community participation activities</td><td>77</td><td>127</td></tr>
<tr><td>No. of CHPS zones where CHAP is implemented.</td><td>37</td><td>69</td></tr>
<tr><td>% of CHPS zones where CHAP is implemented</td><td>48%</td><td>54%</td></tr>
</table>
Source: JICA internal documents</td></tr>
<tr><td>(Overall Goal)<br>To increase coverage of functional CHPS.</td><td>Increase in the number of functional CHPS zones</td><td>
<table>
<tr><td>Item</td><td>Project commence-ment (2006)</td><td>Terminal evaluation (2009)</td><td>Ex-post evaluation (Nov. 2013)</td><td>Target for 2015</td></tr>
<tr><td>No. of functional CHPS zones</td><td>24</td><td>81</td><td>166</td><td>197</td></tr>
<tr><td>Target achievement rate (%)</td><td>12%</td><td>41%</td><td>84%</td><td>100%</td></tr>
</table>
Sources: JICA internal documents and interviews</td></tr>
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Note: For some indicators, information as of project completion was not available, and information as of terminal evaluation was used.

## 3 Efficiency

While the inputs were appropriate for producing the outputs of the project and the project period was within the plan (ratio against the plan: 100%), the project cost was higher than the plan (ratio against the plan: 131%) because of the expansion of the project sites during the second half of the project period from the planned two pilot districts to all of the nine districts, and the increase in the project activities following such expansion.

Therefore, efficiency of the project is fair.

## 4 Sustainability

In the policy aspect, the Health Sector Medium-Term Development Plan (2010-2013), and the objective 1 “Bridge the equity gaps in geographical access to health services” of the Health Sector Medium-Term Development Plan (2014-2017) that is currently being drafted attaches importance on strengthening of the district-level primary health care system and acceleration of implementation of the revised CHPS policy. Also, the Annual Programme of Work (APOW) 2014 that is being developed based on the above-mentioned draft Medium-Term Development Plan promotes the increase of CHPS coverage, increase of outreach and home visits and improvement of quality of basic medical services. Therefore, strengthening the administrative capacity of GHS in implementing CHPS is still important. In the institutional aspect, considering that the extension of CHPS requires multi-sector involvement and the local administration systems and community participation are essential particularly in the district or lower levels, GHS plays a central role in the technical aspect of CHPS and facilitates stakeholders’ participation to promote CHPS. Currently, community participation is being extended and established by CHOs without depending on external resources (such as support from NGOs). With the 14 facilitators developed under this project, there are sufficient human resources for UWR to independently conduct training for CHOs. The subsequent project also continues training for CHOs and the sufficient number of human resources is ensured. In the technical aspect, while there are rotations of CHOs in every two to three years mainly due to their return to school and personnel transfer, the quality of services

have been maintained through supervision and coaching as part of FSV that was introduced under this project. Also, the manuals and guidelines that were revised based on the ones developed under this project are used, and there is a mechanism to disseminate those outputs to district health directors in other regions through study tours, etc. In the financial aspect, expenses for providing services (such as vaccination) are covered by the budget for CHPS that is allocated as part of the health programme budget. Purchase and provision of medical supplies and equipment for implementing CHPS is funded by the Internally Generated Fund (IGF) that is reimbursed from the National Health Insurance Scheme. Staff costs are funded from the central government, and some budget is allocated from the district level to cover a certain extent of cost for fuel and maintenance of motorcycles for CHOs' activities. Cost for CHPS compound construction is funded from the Project for the Development of CHPS Infrastructure in the Upper West Region (Grant Aid for Community Empowerment) and the development budget of DAs/MPs, and others. To ensure sustainability, the local government structures must be fully engaged in all levels of CHPS implementation. Through this, the institutional, technical and financial aspects will be sustained, partly due to the sustainability component of the current project. Therefore, sustainability of the effects of this project is high.

5 Summary of the Evaluation

This project achieved its project purpose, "institutional capacity of GHS on CHPS implementation in UWR is strengthened" to a certain extent at the time of project completion. Although part of the outcomes has not been maintained at the time of ex-post evaluation, a number of positive changes have been observed through interviews. As for the overall goal, "to increase coverage of functional CHPS", the number of functional CHPS zones has steadily increased and achieved 84% of the target for 2015 at the time of ex-post evaluation. It was also observed that the activities developed and started under this project have been extended to other regions and the country at large through study tours, etc. and that FSV would be reflected in the national guidelines. In terms of sustainability, the institutional, technical and financial aspects of the implementing agency are considered to have been continuously improved with support from the current project. For efficiency, the project cost exceeded the plan. In light of the above, this project is evaluated to be satisfactory.

**III. Recommendations & Lessons Learned**

Recommendations for Implementing agency：

1) FSV is a good tool for monitoring units in the region, districts, sub districts and community. It is recognized by districts and other higher levels but not so by the service providers. Therefore, efforts are required to disseminate the system to all stakeholders for the sake of expanded community activities and services. Data management and reporting are particularly important for the system, hence it is recommended to consider how to ensure relevant inputs (human resources, budget, equipment, etc.) are available in a sustained manner.

2) CHOs are critical staff in facilitating community level activities. Therefore, efforts are needed to manage the high attrition of CHOs, strengthening the instruction and support system through the training and supervision of CHOs, and promoting active community health activities (prevention and health promotion) through smooth communication.

Lessons learned for JICA：

1) In this project that was to promote strengthening of administrative capacity in local health services, FSV was found to be effective in increasing communication between different administrative levels, promoting community participation (expanding the CHAP/CETS area) and enhancing regional activities. Therefore, in similar projects where different levels of stakeholders are involved, it is important to place emphasis on linkage between one level and another and to support strengthening of management and supervision between those levels.

2) While the manuals and guidelines developed for training and other activities are still kept and utilized, the FSV tools and the database are not much used anymore in some districts. Based on this finding, it is considered important to thoroughly check the acceptability of tools in the tool development stage.