

REVIEW REPORT

COMMUNITY-BASED SURVEILLANCE IN GHANA

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LIST OF ACRONYMS AND ABBREVIATIONS

AFP	Acute Flaccid Paralysis
AR	Ashanti Region
BU	Buruli Ulcer
CBS	Community Based Surveillance
CBSV	Community Based Surveillance Volunteer
CCA	Community Clinic Attendant
CHN	Community Health Nurse
CHO	Community Health Officer
CHPS	Community Based Health Planning and Services
CR	Community Register
CRVE	Community Register for Vital Events (CBS Booklet)
DA	District Assembly
DCO	Disease Control Officer
DCU	Disease Control Unit
DDHS	District Director of Health Services
DMS	Director of Medical Service
GWEP	Guinea Worm Eradication Programme
IDSR	Integrated Disease Surveillance and Response
MDG	Millennium Development Goals
NR	Northern Region
NSU	National Surveillance Unit
PH	Public Health
PPME	Programme Planning Monitoring and Evaluation
RDHS	Regional Director of Health Services
SMO/PH	Senior Medical Officer/Public Health
TO	Technical Officer
VV	Village Volunteer
WR	Western Region

EXECUTIVE SUMMARY

The Community Based Surveillance (CBS) system was piloted in the Northern Region as an expansion of the Village Volunteers' Surveillance system for the Guinea Worm Eradication Programme.

The Northern Region successfully expanded the disease under surveillance by the volunteers and wrote a proposal for support to introduce the system for a countrywide application. UNICEF recognised the potential of this village based surveillance system and offered to support a nation-wide introduction of the system.

Ten years after its introduction, CBS is not practised countrywide. What is the current situation and how can we move forward? The need to move forward is undeniable, given the health seeking behaviour of the general population, the paucity of health facilities and access to health services both physical and financial. We are not likely to detect all cases of targeted diseases occurring in our communities through facility-based surveillance system. The need to detect all cases and report is particularly necessary for certification of eradication of the targeted disease. It is also a very sensitive system for detecting epidemics very early and recording health events such as births and deaths which are necessary for monitoring impact of health interventions towards the MDGs. A vibrant CBS system is an indication of a good active surveillance system.

The desk review provided data on the level of implementation of the CBS by Regions. The field visits showed many variations between the three Regions in terms of actual coverage, quality of the Community Based Surveillance, supervision of CBSVs and the use of data collected by the volunteers.

The number of volunteers trained is not equivalent to volunteers actually functioning. Some volunteers were not known to the immediate supervisors from the sub-district level an indication that they were not functioning or not being supervised.

Some volunteers were made to carry their booklets/ registers to the Health Centre rather than the supervisors visit them in the communities. In the Northern region, many of the CBS supervisors are non health workers (Zonal Co-ordinators) this calls to question the purpose of the supervisory visit.

There have been varying use of the wealth of data collected by the CBSVs and not much of it analysed regularly. Even where this is done, credit is not given to the CBS programme as the source of the information. (Exception Northern and Ashanti Regions)

Some Regions and some Districts have managed to attract financial and material support for their CBS programmes through demonstrating the usefulness of CBS to partners, this information should be shared with others.

There is a clear need for a National Strategic plan for the implementation of this all important surveillance tool as part of the Integrated Disease Surveillance and Response

(IDSR) programme with specific resources earmarked for it. The strategic plan should be shared with our development partners.

INTRODUCTION

This report summarizes the findings of a review conducted to assess the current status of Community Based Surveillance (CBS) implementation in Ghana. The findings will input into a strategic plan to give national direction for accelerating CBS implementation in the country.

BACKGROUND

Ghana in the 1970s introduced the Village Volunteer(VV) and Community Clinic Attendant (CCA) system to bring health services closer to the population. This was in response to a review of the health services that showed that over 70% of the health services' resource were used in tertiary institutions in the big towns. The system served only a third of the population and also did not deal with the major causes of morbidity and mortality, which included malaria, diarrhoea and measles, diseases of rural Ghana. As more Rural Health Posts and Health Centres were being established, the CCAs and VVs were faced out. Where as the VVs were trained mainly in community mobilization for health promotion, the CCAs were trained in case management for minor health problems. In some parts of the country, the latter soon turned themselves into “quack doctors” and tried to treat disease conditions beyond their capacity. The programme was subsequently abandoned in favour of training more personnel to man rural health facilities.

In the Northern Region where both health facilities and staff were very few, the GWEP reactivated the VV concept with a new role to facilitate surveillance on the Guinea worm disease, Dracunculiasis. The concept was presented at the annual GWEP review in 1990 in Yamosoukro La Côte d'Ivoire.

The Community Based Surveillance (CBS) system was piloted in the Northern Region as an expansion of the Village Volunteers surveillance system for the Guinea Worm Eradication Programme. The system was very effective for detecting Guinea worm case which otherwise would not have come to any health facility since there was no effective treatment for the disease. The health seeking behaviour of the population in general in Ghana is poor, therefore facility based surveillance only detects a small proportion of cases. Could these VVs expand their services to cover other diseases that were easy to recognise and were of priority to the health services?

As a prelude to this extension of their role, the NR conducted a study on whether VVs would be prepared and capable of undertaking the expanded role.(Asigri V L & Bugri S Z). Our finding was that yes they were prepared for the workload increase with the understanding that:

- 1) they be trained in what ever they were going to do,
- 2) it does not involve their having to collect any moneys from their people or sell anything,
- 3) they are recognised by the community and respected as doing a national undertaking,

- 4) they be recognised by the health system as staff even though they were not salaried employees.

The Northern Region wrote a proposal for support to introduce the system for a countrywide application. UNICEF recognised the potential of this village based surveillance system and offered to support a nation-wide introduction of the system. All efforts to get the other regions to buy into the system failed. The then Director of Medical Service (DMS), Dr Moses Adibo gave the Northern Region the go ahead to introduce the system in the NR. In 1995 when I was the Head of Disease Control Unit, I started sensitising Regional directors on the efficacy of the system. When I became the Director of Public Health Division in 1996, I put through the proposal to introduce the CBS system countrywide. Some Regions recognised the potential of the system and were quick to introduce the strategy, others run into the problem of volunteerism.

Ten years after its introduction, CBS is not practised countrywide. What is the current situation and how can we move forward? The need to move forward is undeniable, given the health seeking behaviour of the general population, the paucity of health facilities and access to health services both physical and financial. We are not likely to detect all cases of targeted diseases occurring in our communities through facility-based surveillance system. The need to detect all cases and report is particularly necessary for certification of eradication of the targeted disease. It is also a very sensitive system for detecting epidemics very early and recording health events such as births and deaths which are necessary for monitoring impact of health interventions towards the MDGs.

METHODOLOGY

Pre-mission review

The review started with a briefing session with the Head of NSU and his staff on the task at hand. It was suggested that apart from the desk review, first hand information from a selected group of implementers from the regions would give a better picture on the current situation and how best to proceed. Disease control and surveillance officers from Northern, Eastern and Central Regions were invited to this meeting. They each explained what their experiences were in the regions in relation to CBS. They also gave ideas as what changes or additions that they wanted to see in CBS. Based on these discussions, review tools drafted by the consultant were discussed and amended to collect the necessary information needed to understand the current situation.

Early this year 2005, the NSU requested Regions to provide an update on the current situation of CBS implementation. The data submitted is summarised under findings chapter. Even though the quality of coverage could not be assessed from these reports, coverage in general was below expectations in most regions.

Field Visits

It was agreed that since the exercise was not an evaluation but rather a mission to get a feel of the current situation, a convenient sample would do. Three regions were visited;

- Northern Region because they have the most extensive coverage in CBS and we wanted to know how they managed to achieve that.
- Ashanti Region to represent the middle belt and to look at the variations that they had introduced to the CBS and were doing well until recently.
- Western Region to represent the southern sector and as an example of a poor performing Region in CBS.

In each Region visited, two districts, relatively one poor performing and one better performing were visited in each district. The Regional Director or the SMO/PH and the core PH or DCU staff were interviewed using a questionnaire guide. They also identified their best and worse performing districts, which were later visited. At the District level, the DDHS and or the DHMT core members were interviewed. A convenient sample of five CBSVs were interviewed individually or with their Village Health Committee Chairman or member.

FINDINGS

COMMUNITY-BASED SURVEILLANCE

DATA BASE ON COMMUNITIES AND VOLUNTEERS BY REGIONS

2005

NO.	REGION	DISTRICT	NO. OF COMMUNITIES	NO. OF COMMUNITIES WITH CBS	%TAGE COMMUNITIES WITH CBS	NO. OF CBSVs TRAINED	DATE OF SUBMISSION (MM/DD/YYYY)
		GRAND TOTAL	25,672	20,029	78	18,441	
	TOTAL	WESTERN REGION	2,550	1,501	59	1,609	8/2/2005
1	Western	<i>Juabeso</i>	418	418	100	602	8/2/2005
2	Western	<i>Bia</i>			#DIV/0!		
3	Western	Sefwi Wiaso	198	150	76	150	8/2/2005
4	Western	Biibiani A. Bekwai	125	50	40	50	8/2/2005
5	Western	Aowin Suaman	305	0	0	0	8/2/2005
6	Western	Wassa Amenfi East	162	150	93	150	8/2/2005
7	Western	Wassa Amenfi West	331	230	69	230	8/2/2005
8	Western	Wassa West	202	0	0	0	8/2/2005
9	Western	Mpohor Wassa East	260	200	77	95	8/2/2005
10	Western	Jomoro	113	42	37	42	8/2/2005
11	Western	Nzema East	194	94	48	100	8/2/2005
12	Western	Ahanta West	107	107	100	130	8/2/2005
13	Western	Shama Ahanta East	135	60	44	60	8/2/2005
	TOTAL	VOLTA REGION	4,287	1,927	45	1,927	8/3/2005
14	Volta	Krachi West	477	217	45	217	8/3/2005
15	Volta	Krachi East					
16	Volta	Nkwanta	346	<i>507</i>	147	507	8/3/2005
17	Volta	Kadjebi	98	<i>103</i>	105	103	8/3/2005
18	Volta	Jasikan	157	<i>163</i>	104	163	8/3/2005
19	Volta	Hohoe	173	126	73	126	8/3/2005
20	Volta	Kpando	131	39	30	39	8/3/2005
21	Volta	South Dayi					
22	Volta	Ho	600	130	22	130	8/3/2005
23	Volta	Adaklu-Anyigbe					
24	Volta	North Tongu	520	245	47	245	8/3/2005
25	Volta	South Tongu	287	89	31	89	8/3/2005

NO.	REGION	DISTRICT	NO. OF COMMUNITIES	NO. OF COMMUNITIES WITH CBS	%TAGE COMMUNITIES WITH CBS	NO. OF CBSVs TRAINED	DATE OF SUBMISSION
26	Volta	Akatsi	762	120	16	120	8/3/2005
27	Volta	Ketu	563	63	11	63	8/3/2005
28	Volta	Keta	173	125	72	125	8/3/2005
	TOTAL	EASTERN REGION	3,701	2,567	69	1,805	8/3/2005
29	Eastern	Afram Plains	564	254	45	320	11/16/2005
30	Eastern	Kwahu South	233	233	100	155	8/12/2005
31	Eastern	Kwahu West	134	101	75	0	8/5/2005
32	Eastern	Fanteakwa	174	48	28	48	8/5/2005
33	Eastern	Manya Krobo	371		0	190	8/5/2005
34	Eastern	Asuogyaman	102	102	100	41	8/5/2005
35	Eastern	Yilo Krobo	143	143	100	143	8/5/2005
36	Eastern	Akwapim North	214	107	50	107	8/22/2005
37	Eastern	Akwapim South	193	193	100	136	8/5/2005
38	Eastern	New Juaben	160	90	56	90	8/5/2005
39	Eastern	Suhum K.C.	330	330	100	13	8/5/2005
40	Eastern	West Akim	292	292	100	270	8/5/2005
41	Eastern	Birim South			#DIV/0!		
42	Eastern	Birim North	231	141	61	27	8/5/2005
43	Eastern	Kwaebibirim	322	322	100	105	8/12/2005
44	Eastern	East Akim	119	92	77	117	8/5/2005
45	Eastern	Atiwa	119	119	100	43	8/5/2005
	TOTAL	BRONG AHAFO REGION	2,528	2,215	88	1,363	8/10/2005
46	Brong Ahafo	Asutifi	121	121	100	62	8/10/2005
47	Brong Ahafo	Sunyani	246	161	65	90	8/10/2005
48	Brong Ahafo	Berekum	37	37	100	18	8/10/2005
49	Brong Ahafo	Tano North	77	74	96	68	8/10/2005
50	Brong Ahafo	Tano South	106	87	82	55	8/10/2005
51	Brong Ahafo	Jaman North	88	43	49	43	8/10/2005
52	Brong Ahafo	Jaman South	107	62	58	60	8/10/2005
53	Brong Ahafo	Atebubu/ Amanten	168	132	79	125	8/10/2005
54	Brong Ahafo	Pru	180	173	96	130	8/10/2005
	REGION	DISTRICT	NO. OF COMMUNITIES	NO. OF COMMUNITIES WITH CBS	%TAGE COMMUNITIES WITH CBS	NO. OF CBSVs TRAINED	DATE OF SUBMISSION

55	Brong Ahafo	Techiman	175	175	100	132	8/10/2005
56	Brong Ahafo	Wenchi	113	113	100	80	8/10/2005
57	Brong Ahafo	Tain	152	152	100	58	8/10/2005
58	Brong Ahafo	Sene	273	273	100	120	8/10/2005
59	Brong Ahafo	Asunafo North	222	222	100	87	8/10/2005
60	Brong Ahafo	Asunafo South	258	258	100	66	8/10/2005
61	Brong Ahafo	Dormaa			#DIV/0!		8/10/2005
62	Brong Ahafo	Kintampo North	118	77	65	96	8/10/2005
63	Brong Ahafo	Kintampo South	87	55	63	73	8/10/2005
64	Brong Ahafo	Nkoranza			#DIV/0!		8/10/2005
	TOTAL	UPPER WEST REGION	1,059	985	93	829	8/10/2005
65	Upper West	Jirapa	200	189	95	189	8/10/2005
66	Upper West	Lawra	154	134	87	134	8/10/2005
67	Upper West	Nadowli	159	159	100	83	8/10/2005
68	Upper West	Sissala East	82	77	94	74	8/10/2005
69	Upper West	Sissala West	55	49	89	69	8/10/2005
70	Upper West	Wa East	137	137	100	85	8/10/2005
71	Upper West	Wa Municipal	74	66	89	21	8/10/2005
72	Upper West	Wa West	198	174	88	174	8/10/2005
	TOTAL	UPPER EAST REGION	1,308	1,271	97	2,342	8/10/2005
73	Upper East	BMA	261	253	97	306	8/10/2005
74	Upper East	Bawku West	116	104	90	208	8/10/2005
75	Upper East	Bolga	110	110	100	220	8/10/2005
76	Upper East	Bongo	132	132	100	264	8/10/2005
77	Upper East	Builsa	140	140	100	280	8/10/2005
78	Upper East	Garu Tempane	207	202	98	404	8/10/2005
79	Upper East	KND	238	226	95	452	8/10/2005
80	Upper East	Talensi Nabdam	104	104	100	208	8/10/2005
	TOTAL	ASHANTI REGION	1,888	1,604	85	1,646	8/10/2005
81	Ashanti	Adansi North	118	118	100	118	5/22/2005
82	Ashanti	Adansi South	202	202	100	184	5/22/2005
83	REGION Ashanti	DISTRICT Afigya Sekyere	NO. OF COMMUNITIES 91	NO. OF COMMUNITIES WITH CBS 91	%TAGE COMMUNITIES WITH CBS 100	NO. OF CBSVs TRAINED 132	DATE OF SUBMISSION 8/10/2005
84	Ashanti	Ahafo Ano North	95	76	80	100	8/10/2005
85	Ashanti	Ahafo Ano South	173	160	92	160	8/10/2005

86	Ashanti	Amansie Central	206	52	25	86	5/22/2005
87	Ashanti	Amansie East			#DIV/0!		
88	Ashanti	Amansie West	160	160	100	180	8/10/2005
89	Ashanti	Asante Akim North			#DIV/0!		
90	Ashanti	Asante Akim South	103	103	100	103	8/10/2005
91	Ashanti	Atwima Mponua			#DIV/0!		
92	Ashanti	Atwima Nwabiagya	89	74	83	78	8/10/2005
93	Ashanti	BAK	120	120	100	120	8/22/2005
94	Ashanti	Ejisu Juaben	90	76	84	69	8/10/2005
95	Ashanti	Ejura Sekyedmase	90	76	84	69	8/22/2005
96	Ashanti	Kumasi			#DIV/0!		
97	Ashanti	Kwabre	88	88	100	87	8/22/2005
98	Ashanti	Obuasi Municipal	60	60	100	60	8/10/2005
99	Ashanti	Offinso			#DIV/0!		
100	Ashanti	Sekyere East			#DIV/0!		
101	Ashanti	Sekyere West	203	148	73	100	8/10/2005
	TOTAL	GREATER ACCRA REGION	1050	998	95	314	8/11/2005
102	Greater Accra	Accra Metro	420	420	100	0	8/12/2005
103	Greater Accra	Dangme East	120	120	100	120	8/11/2005
104	Greater Accra	Dangme West	160	160	100	98	8/11/2005
105	Greater Accra	Ga East	54	2	4	0	8/11/2005
106	Greater Accra	Ga West	250	250	100	50	8/11/2005
107	Greater Accra	Tema	46	46	100	46	8/11/2005
	TOTAL	NORTHERN REGION	5,056	5,056	100	5,056	
108	Northern	Bole	144	144	100	144	8/22/2005
109	Northern	Bunkurugu Yinyoo	238	238	100	238	8/22/2005
110	Northern	Central Gonja	256	256	100	256	8/22/2005
			NO. OF COMMUNITIES	NO. OF COMMUNITIES WITH CBS	%TAGE COMMUNITIES WITH CBS	NO. OF CBSVs TRAINED	DATE OF SUBMISSION
111	Northern	East Gonja	434	434	100	434	8/22/2005
112	Northern	East Mamprusi	243	243	100	243	8/22/2005
113	Northern	Gushiegu	397	397	100	397	8/22/2005
114	Northern	Karaga	190	190	100	190	8/22/2005
115	Northern	Nanumba North	260	260	100	260	8/22/2005
116	Northern	Nanumba South	114	114	100	114	8/22/2005
117	Northern	Saboba Chereponi	525	525	100	525	8/22/2005

118	Northern	Savelugu Nanton	174	174	100	174	8/22/2005
119	Northern	Sawla Tuna Kalba	266	266	100	266	8/22/2005
120	Northern	Tamale Metro	404	404	100	404	8/22/2005
121	Northern	Tolon Kumbugu	279	279	100	279	8/22/2005
122	Northern	West Gonja	110	110	100	110	8/22/2005
123	Northern	West Mamprusi	326	326	100	326	8/22/2005
124	Northern	Yendi	433	433	100	433	8/22/2005
125	Northern	Zabzugu Tatale	263	263	100	263	8/22/2005
	TOTAL	CENTRAL REGION	2,245	1,905	85	1,550	8/22/2005
126	Central	AAK	120	120	100	115	8/22/2005
127	Central	AEE	163	106	65	106	8/22/2005
128	Central	AES	219	214	98	170	8/22/2005
129	Central	Agona	385	100	26	100	8/22/2005
130	Central	AOB	183	147	80	147	8/22/2005
131	Central	Assin North	125	107	86	38	8/22/2005
132	Central	Assin South	85	84	99	42	8/22/2005
133	Central	Cape Coast	76	76	100	76	8/22/2005
134	Central	Gomoa	186	186	100	186	8/22/2005
135	Central	KEEA	100	87	87	87	8/22/2005
136	Central	Mfantseman	164	158	96	158	8/22/2005
137	Central	THLD	175	200	114	175	8/22/2005
138	Central	U/Denkyira	264	320	121	150	8/22/2005

The desk review provided the above data on the level of implementation of the CBS by Region. The field visits showed many variations between the three Regions in terms of actual coverage, quality of the Community Based Surveillance, supervision of CBSVs and the use of data collected by the volunteers.

The number of volunteers trained is not equivalent to volunteers actually functioning. Even in the NR where they have 100% coverage, it has not always been so. For example CBS activities in the East Mamprusi District had become dormant until June 2005 when it was reactivated with a series of training and retraining.

Some volunteers were made to carry their booklets to the Health Centre rather than the supervisors visit them in the communities. Some supervisors did not even know the villages of the volunteers. In the Northern region, many of the CBS supervisors are non-health workers (Zonal Co-ordinators). Both scenarios call to question the purpose of the supervisory visits as provided in the guidelines.

There have been some presentations made on previous occasions on the usefulness of the CBS data Ashanti, Northern etc. Some Regions and some Districts have managed to attract financial and material support for their CBS programmes through demonstrating the usefulness of CBS to partners, this information should be shared with others.

Details of Findings

National level

At the National level we were interested in policy issues. so we wanted to know;

Is there a written National Strategic Plan for CBS?

Yes as part of the Five-Year Strategic Plan for Surveillance 2001-2005. This current review is with the intention of developing a Strategic Plan specifically for the CBS programme. An initial outline of the plan was made by the N.S.U.

When was the last time that CBS was discussed at national level and were any decisions/recommendations made?

❖ A review of the NR CBS programme was made before the instructions to implement countrywide. The last review of CBS was in August 2005 during the Surveillance Review meeting and it was recommended that the CBS be reviewed and a strategic plan developed in collaboration with our Health Partners.

What is the relationship between CHPS and CBS? (How does CHPS fit into the public health system vis-à-vis the relationship with CBS)

CHPS was introduced to bridge the gap or introduce another step in the structure of service delivery below the sub-district level. Ideally the CHO of the CHPS zone should be the direct supervisor of the CBSVs within the zone but CHPS is not widespread.

Which partners/ stakeholders have you identified in CBS and their possible roles?

- ❖ The main partners at National level have been; WHO, UNICEF, Global 2000 GWEP and USAID. Some Regions and districts have had support from other sources.

Are CBS activities specifically budgeted for?

- ❖ Yes as an activity of the Surveillance Unit's budget

How do you assess the input of CBS in the overall surveillance system?

- ❖ CBS is a major and crucial component of the surveillance system. The Integrated Disease Surveillance and Response (IDSR) system can not function without CBS. Facility based surveillance detects only a proportion of cases and CBS helps us to get a more comprehensive picture

How often is CBS evaluated and which units were involved?

An evaluation of the Northern Region's CBS programme was carried out before it was scaled up nation-wide. Since then no Nation-wide evaluation has been done but limited evaluations have been done in some districts by the GWEP and USAID.

Regional level

1. POA for CBS

Northern Region Plans for CBS is integrated in the overall surveillance plan in accordance with the IDSR strategy

Ashanti Region; CBS usually part of the Public Health Units POA for surveillance

Western Region; *The Region has no specific plans for CBS but it was discussed during planning meetings. It is recognised as a priority but it is left to the Districts to schedule its implementation.*

2. Current Status of CBS in the Region

100% Districts and communities were covered. The quality of coverage is better in GW endemic communities. There is a lot of interest by communities for CBS and they have had persistent demand for CBS from communities considered too small in population for CBS.

Ashanti Region; Region had made tremendous progress in establishing the CBS programme and their report to PPME in 2000 showed how well CBS had been integrated with the CHPS strategy. PPME instructed them to stop the integration and that killed their initiative for expanding CBS in the region. (Ashanti will make a presentation at the stakeholders meeting)

Western Region; *All districts have some CBS in place but generally low coverage. Juabeso and Bia may be the only districts with appreciable coverage.*

3. Innovation introduced to better CBS

NR had proposed changes to the book but was stopped because National level had already printed large quantities of the book which had to be used. *Proposed changes submitted for review*

The contents and analysis of data from book has become the subject of *Community Durbars* infant mortality, maternal mortality, growth rates etc. *Saboba District* was given an award by UNICEF for their use of the CBS data. Records of the book is used for contacts and defaulter tracing in EPI

Zonal and Area Co-ordinators (ZC)

In the original plan CBSVs were to be supervised by sub-district staff, in view of the limited staff numbers and the spatial expanse of sub-districts this would have been impossible in the NR. The innovation was to introduce *Zonal and Area Co-ordinators* who supervised and collected surveillance data from the volunteers weekly. They are given a monthly allowance by the GWEP

Ashanti Region; Innovations made included the introduction of the community register which was very useful until PPME ordered them to stop. (AR to make a presentation on their experience and the usefulness of the Community Register)

Western Region; *The Region is still grappling with the original concept and have not had time to think of any innovations to the CBS.*

4. Support needed to establish CBS fully

The services of the ZCs will be needed long after the GWEP has ended. The CHPS programme will be the ideal support channel for the CBS supervision, therefore National and Partner support is needed to put CHPS in place in all the demarcated zones. NR has very limited health staff to establish CHPS and therefore some acceleration of training CHNs needs to be given priority.

Strengthen the capacity of the Sub-District to supervise CBS, augment staff numbers and provide transport.

Ashanti Region; The Region will like to see a National Strategic Framework incorporating CBS, CHPS and Community Registers. Printing of large numbers of Community Registers to cover the numerous communities that they have in the Region.

Western Region; *In view of the poor progress CBS may need to be introduced afresh. District staff will need to be briefed on the concept to understand the concept of volunteer system and the volunteer selection process. Technical and material support will be required for the training. If it comes out as a National strategy to merge CBS and CHPS, then human resource for CHPS will need to be provided.*

5. How soon can CBS be fully functional in the Region

In the NR CBS is in place but at a price. The CBSVs are supervised by non health workers, Zonal and Area Co-ordinators who are supported by external sources, ie the GWEP, and the Carter Center. ***How long will this support continue?*** A National strategic plan for placing CHOs in all zones will answer this question for NR.

Ashanti Region; For Ashanti region it will only be a question of reactivating the system which was already working so well with retraining and support to the CHPS zones for supervision.

Western Region; *Given the many sub-district facilities, the focus will be on the volunteer selection process and the training of their immediate supervisors and therefore one year could see CBS in place in the WR.*

6. Relationship between CHPS and CBS

The NR has only 20 functioning CHPS zones due to lack of staff to appoint as CHOs. The CHPS programme/Strategy as given did not take into consideration CBSVs in place but most CBSVs are also the CHPS volunteers in the communities. The NR hoped that this review will raise National attention to the issue for clarification and a National Strategic direction for CHPS. PPME to clarify. The CHO should become the direct supervisor of the CBSV but the prospects of having enough staff for CHPS in the NR within the next 5 years are very slim.

Ashanti Region; The Region used the CBS as the entry point for the CHPS programme and therefore the relationship was already established.

Western Region;*The Region has about 50 functioning CHPS zones out of 200 the limiting factor being staff, equipment, transport and the compound for establishing the CHPS stations. If CBS is linked to CHPS its implementation will be delayed. The introduction of the Zonal Co-ordinators may have to be considered.*

7. Partners Stakeholders

Currently the Carter Center of Global 2000 is the biggest stakeholder in the CBS in NR as indicated above.

The District Assembly could have been a major stakeholder and partner for the CBS but they have not taken control of the Health Service as one of the Decentralised Organizations of the District Assembly. The births and deaths registration done by the CBS would have given them the indicators for measuring growth/development.

Ashanti Region; A Nutrition Surveillance programme initiated by the Ashanteman Traditional Council uses the CBSV for social mobilization and keeping of the records of all the children registered in the programme.

Western Region; *Some districts have had support from World Vision International with bicycles*

8. Other Issues Raised

- The evaluation of the GWE Programme made some valid recommendation, which should be taken on board.
- The NR CBS programme started as a Region Driven programme so the districts are yet to assume ownership and use the data at that level. Saboba did and won an award from UNICEF.
- DHMT not taking ownership of the programme is one of the reasons for not signing the CBS book during visits to the villages.
- The Sub-Districts of the District Assembly and those of the Health Service are not coterminous

District Level/DHMT/DDHS

Question	Northern Region – District	Ashanti Region - District	Western Region	Remarks
What is CBS	<p>Tolon-Kumbungu (T-K); Community involvement in the Health System, they select a person to be trained to recognise health events and report</p> <p>East Mamprusi (E-M); A system that enables you to get firsthand info from the village. First AFP/WPV in the district was reported by CBSV. Dissemination of info to community</p>	<p>Ejisu-Juaben (E-J); CBS demonstrated that with training, a community member can detect and report vital events.</p> <p>Amansie West (AW); Community participation in surveillance of vital events</p>	<p>Juabeso District: System by which volunteer in the community report cases through the CHO to district level</p> <p>Mpohor Wasa East (MWE); A permanent and continuous surveillance post in the community</p>	
Do you have CBS in the District	<p>T-K; Yes since the inception of CBS in the “90s.</p> <p>EM; The duty of the CBSV is described to the community</p>	<p>E-J; Yes; Community Register programme preceded CBS, Village Health C’tee used same for CBS</p> <p>A W; Yes since 2001</p>	<p>Juabeso; Yes since 2000, but >60% of those trained are not active</p> <p>MWE; Yes 90 trained and functional.</p>	
Describe CBS in your District	<p>T-K; Concept explained to village and selected volunteers trained. 300CBSV supervised from 5 sub-districts, data analysis at district</p> <p>E-M; Describe duty of CBSV and guide community to select- literate, respected, resident. 450CBSV reactivated this year after 2year dormant.</p>	<p>E-J; Community opinion leaders were briefed on CBS and asked to select volunteer. CBS rewarded through training and in-kind gifts.</p> <p>AW; Sub-District staff were briefed on CBSV selection process and criteria.</p>	<p>Juabeso; Process of community entry, explain CBS concept and provide guidelines for selection of 2Volunteer. Literacy required.</p> <p>MWE; 3/5 Sub-districts are covered with trained 90 CBSV selected by communities. Sub-Dist. explain CBS to community, most selected already in other progs.</p>	
How Different is your CBS from NR CBS	NA	<p>E-J; CBSV also keep the community register and the Nutrition Surveillance Programme</p> <p>AW; CBSVs in the mining area were trained and supplied with</p>	<p>Juabeso; Similar except we insist the volunteer be literate.</p> <p>MWE; Not different will like to see change of mortality picture to a coffin</p>	

		drugs for treating minor ailments		
Funding source for CBS activities	<p>T-K; Monitoring and supervision of CBS is normal outreach service but for training and Volunteers Events Book are from Regional level</p> <p>E-M; District budget with allocation for DC. Training funds come Regional level plus District fund</p>	<p>E-J; CBS is funded from regular budget. The DA supported a special training of CBS for the Nutrition Surveillance programme.</p> <p>AW; Mainly from District regular budget. Global Malaria fund, NGO from Spain, Mining Co. Resolute Amansia Ltd</p>	<p>Juabeso; General vote from Reg for district + specific allocation for NIDs and similar activities with allowances for Volunteers</p> <p>MWE; Activities funded from regular budget based on POA which includes CBS</p>	
How are CBSV supervised	<p>T-K; Sub-district staff do supervision during outreach service</p> <p>E-M; ZC visit CBSV weekly for GW data and sub-district staff monthly during outreach service</p>	<p>E-J; Zonal Officers go round monthly to collect information</p> <p>AW; CBS are supervised by Zonal staff Sub-district staff and District staff on monthly monitoring visits Stop and check every pregnant woman project introduced.</p>	<p>Juabeso; CBSV supervised through CHOs monthly using special forms. Copy attached. Most CBSV have no CRVE book.</p> <p>MWE; Supervised from sub-district. District staff make ad-hoc monitoring visits</p>	
Training when, what, number	<p>T-K; Yearly training, last training July 500 participants including Red Cross women. Content – GW, Meningitis, the events book and forms to be filled.</p> <p>E-M; Retraining in March and Sept. 486 volunteers, 21 ZC, 12 Sub-district staff. Content- vital events, promptness of reporting, feedback.</p>	<p>E-J; Every year 76 CBSV are trained, this year 4/5 training on surveillance, EPI, CHO support, growth monitoring.</p> <p>AW; All volunteers trained every year. April – July 2005 training on leprosy, BU, AFP, NID</p>	<p>Juabeso; 107 participants June/July training specifically for Village Health C'tees of CHPS, CHOs, CBSV. On use of book but no books were available.</p> <p>MWE; First quarter 2005, trained 60 with support from World Vision International. Content; use of CBS book, diseases, case definition as in IDSR</p>	
Which other health events would you like to have in CBS	<p>T-K; Trachoma/eye infections, deformities at birth.</p> <p>E-M; Yaws and skin ulcers BU</p>	<p>E-J; As adapted in the Community Register</p> <p>AW; Epilepsy, BU, accidents, teenage pregnancy, CR</p>	<p>Juabeso; Any health event ,food poisoning</p> <p>MWE; BU Cholera/diarrhoea, snake bite, dog bite</p>	
Is CBS important or useful	<p>T-K; Their reports help prevent/contain epidemics</p>	<p>E-J; Very useful, surveillance + Case searches, growth monitoring</p>	<p>Juabeso; Very important & useful. CBSV is resident in the community</p>	

	E-M; Yes, cases may go undetected. CBSV assist in community mobilization for EPI, Filariasis, Trachoma etc	AW; All suspected epidemics have been detected by CBSV, BU, Community mobilization for CWC	and records real-time data MWE; Very useful. No hospitals in the area, all IMR and MMR is based on data from CBSV	
Do you write a report on CBS activities, frequency	T-K; Report as part of District quarterly report to Region E-M; Las year 2004 no report- CBS was dormant. As part of reactivation we send report monthly.	E-J; Yes as part of annual report. Significant number of AFP were detected by CBSV AW; As part of analysis of district surveillance data	Juabeso; There is always a chapter on CBS activities in Annual Report. Data is integrated into surveillance reports MWE; Quarterly report to Reg. Includes chapter on CBS +monthly reports and training reports	
Feedback	T-K; Feedback as part of response to our quarterly report. E-M; No written feedback but discussion during monitoring visits from Region.	E-J; Feedback on surveillance reports on timeliness, completeness comments on specific issues, errors AW; Feed back from Reg is for surveillance in general	Juabeso; Feedback on surveillance in general but no specific CBS MWE; No specific feedback on CBS but general report from Reg shows that this district is best performing on CBS.	
Relationship CHPS and CBS	T-K; Volunteer common to both programmes but only 3/22 CHPS zone functional E-M; The CHO supposed to supervise CBSV but complains of load of work. CHPS still far from being established.	E-J; All zones have CHOs but not all are resident in community. Monthly reports on CBS AW; CHOs supervise the CBSV but only 1 functioning CHPS. 3/6 established 2CHOs left for school.	Juabeso; CHOs supervise CBS. 21/35 zones functional MWE; CHPS not yet inplace but CBS will be the first volunteers	Juabeso; Only 2CBSV had books
Partners/stakeholders identified	T-K; District assembly shown interest. E-M; DA willing but not committed funds. CRS supported with motorcycles	E-J; District assembly AW; District Assembly, Mining companies, NDGO -ANESVAD Spain	Juabeso; Population Council support for CHPS with CBS added MWE; World Vision international, National Malaria Programme IPT as home based care agents.	
?specific budget for CBS activities	T-K; As part of District work plan. Resources from Reg for specific activities such as training	E-J; Budget for training, surveillance, monthly meetings, annual get-together.	Juabeso; No specific budget but part of surveillance & other vertical programmes	

	E-M; When we stopped activities no fund but now direct from Reg	AW; Yes budget line for CBS in estimate to Region	MWE; Yes for training. Proposal to WVI and to Malaria Progm	
How often is CBS reviewed	T-K; Internal review by DHMT monthly E-M; CBS was reviewed during training in March after leadership change	E-J; Review when their performance is queried and to replace dropouts AW; CBS reports are reviewed ¼. Buruli Ulcer was the driving force for CBS when Region relaxed.	Juabeso; Need for external evaluation of CHPS & CBS MWE; CBS was dormant, but reactivated with WVI support.	
How do you assess the input of CBS to surveillance	T-K; They are quick to report events, They are also our link for information to community E-M; All 5AFP cases in 2004 were detected by CBSVs and District was awarded 1.2million cedis for best AFP reporting	E-J; Highly valued AW; very important, CBSV reported 60% of measles, 80% of Buruli Ulcer cases	Juabeso; Excellent, instrumental in discovery of BU cases MWE; It looks very good. We are getting data/information which hither to we did not have. All our births and deaths information is from CBS	

Community Level (Respondent(s) – CBSV, VHCs),

In this sector the responses of the CBSVs are summarised, indicating variations in answers where substantial. A total of 30 volunteers were interviewed, and only 2 were females. Most of the volunteers were interviewed individually others in groups of three which gave them opportunity to share their views with each other.

How did you become a CBS volunteer?

- Selected by the Chief and elders and or the Chairman of the Development Committee
- Took over from father who was the volunteer and he used to help him in the work
- Converted from NID volunteer

Trained by health workers on how to keep records of events in the book. Training repeated every year (NR) but Ashanti and Western Regions there was a break and resumed last year

How are cases identified and recorded?

We do house to house visits but most often community members come to inform us. The health staff come to look at our book and ask about the cases we recorded. Other health problems are brought to our notice for action, such as women in labour, accidents etc.

Do you get feedback from the district/ sub-district?

Monthly when they come for Child Welfare Clinic/ outreach services in the village. They look at our books and tell us if we are doing the right thing. An AFP case was reported and a feedback received showed that it was not Polio (Adienbra, Juabeso Sub-District, WR)

How do you disseminate the feedback to the community?

- With permission of chief/assembly Man/Committee Chairman a gongong is beaten to summon residents to a durbar for the information to be disseminated. Major information is done jointly with health workers
- Simple information is made directly by the gongong beater/town crier
- The dissemination is also done during house to house visits
- The chief calls for a meeting of sectional leaders who will then carry the message to their hamlets or sections.
- Churches and Mosques are used for dissemination in some cases.
- Local FM station used. (Mary Hall- CBSV, Doboase, Mpohor Wasa East uses her own money to place announcement)

Health Staff response to urgent events

Response to reports were generally immediate and included AFP, Measles, Guinea worm The CBSV are also called upon for emergencies such as labour cases, accidents etc and they usually use their own resources to get the patient to the hospital

How often are you supervised?

Supervision varied from weekly to monthly as stated by the Volunteer but signatures in the books tell a different story.

- Northern Region; volunteers in Guinea worm endemic areas get weekly visits and non endemic communities get visits every 2 weeks. These visits are done by Zonal Co-ordinators mostly to collect surveillance data in general but particularly on GW cases. The District Disease Control Officer (DCO) conducts monitoring visits to some CBSV monthly. Evidence of visit as indicated by signature in the Community Register of Vital Events book was less than the number of visits stated by the volunteer but at least 3 entries a month.
- Ashanti Region; Volunteers are supervised by trained health workers, Community Health Nurses (CHN) during outreach services /CWC and District Disease Control Officers. Even though the Volunteers claim they were visited at least 2 times a week, there is no evidence in the book ie any signatures. Volunteers were proud of their Community Register which was updated monthly, some were also involved in a growth monitoring programme initiated by the Traditional Council. Ashanti Region will dilate on that.
- Western Region; Supervision was poorest in the Western Region. Most volunteers in Juabeso District did not have the CBS book so records of supervisory visits could not be verified. The CBSV said their contact with the Health staff was once a month when they come to conduct CWC. There were two outstanding volunteers in WR. CBSVs at Tikobo, Moya Sub-District, Juabeso District are supervised by CHO of the sub-district. The CHO has 20 hamlets for his village visits. There existed evidence of monthly visits by CHO in the register.

Are you pleased with supervision from higher levels?

CBSV are generally pleased with supervision, they are visited at least once a month and discuss recordings in their book. In districts with other programmes running, visits are more frequent, Malaria Intermittent Preventive Treatment Programme (IPT), Ashantiman Traditional Council Growth Monitoring Programme, Buruli Ulcer programme, Guinea worm Eradication Programme etc.

What support do you benefit from the community?

Most volunteers will first say they have no support from community because it is perceived that they are paid by the Health Service for their work. Probing further, however, reveals that there is some level of non-material support from the community.

- The eagerness with which they seek them out to report cases is a sign of support for the work they do
- Community elders always ready to authorise call to durbars and attend personally
- Community members always ready to give out their bicycle for me to run errands to report cases
- Exempted from communal labour and development levies

Community support for volunteers was least in the NR may be because of the support from the GWEP.

What are some of the problems with CBS at the community level?

- Some members of the community do not believe that we are not paid any salary.

- Through the training we get to know more about health and we see the underdevelopment such as lack of safe water, schools and clinics but these issues are not addressed.
- There is apathy in some community members towards the health of their children, they would rather take them to the farm than stay just that one day for immunization.
- Some times we are branded as witches and traitors because we report neonatal and maternal deaths, which are taboos, and the health authorities come to investigate.

What do you think can be done to sustain interest of volunteers (apart from a salary)

- Some form of remuneration was at the top of list but after explaining the meaning of Volunteer, they understood and raised other issues.
- Recognition of their contribution to the health service by issuing them with **ID cards** with accompanying preferential treatment at health facilities.
- Recognition by the political authorities ie District Assembly of their contribution to development and to mention it when they hold durbars or visit the chief of their village will boost their moral.
- Training usually comes with some allowances which they appreciate very much but as they get to know more about health, could it qualify them for a paying job with the health services? When I said the village would lose a valuable person, they said yes but a new one could be trained.
- Material incentives; The T-shirts are fine but they do not last. Would prefer more durable things such as **Raincoats, Boots, torchlight, waterproof bag for their documents,**
- Transport; Some of them cover more than the village they live in and bicycle would help them get around. Some NGO have provided bicycles for some CBSV in some districts.

Who should be a CBS volunteer?

This question was thrown in to end on a hearty note. Most volunteers agreed that a volunteer should be;

- ❖ A respected member of the community so that he could enter every house without problems.
- ❖ He/she must have the community at heart enough to make him/her want to help or make sacrifices.
- ❖ Should not be a lazy person because there will always be a big demand on his/her time
- ❖ Should not feel shy and should be able to communicate.
- ❖ Should respect people's privacy because of what they see or hear when they visit homes.

COMMENTS AND CONCLUSIONS

National level see CBS as a very important tool in surveillance but this does not seem to have been translated into action in all the Regions. This may stem from the fact that no specific Strategic Plan with targets and indicators set for its implementation. The Regions therefore implemented the programme at their own pace with varying degrees of importance or priority as well as success.

The Community-Based Health Planning and Services (CHPS) was introduced without any reference to CBS even though both programmes are community based. The Regions feel they could marry the two but a clear policy on the issue has to come from the National level. CHPS requires many trained health personnel to serve as CHOs and with the current shortage of staff, some Regions do not see how soon it can be functional but CBS could still be made functional.

Zonal Co-ordinators used in the NR to supervise CBSVs is peculiar only to the NR. These cadres of “staff” are paid from external resources. Is this sustainable? If it is a stopgap measure to ensure surveillance for the GWEP, then the Region has to start the process of fading them out and replacing them with CHOs if that is chosen as the alternative.

At Regional level there were variations in implementation of the CBS even though there were guidelines provided by the NR.

- The guidelines for volunteer selection were not adhered to strictly and this resulted in high attrition rates. Many “volunteered” with the hope of financial gain and others thought it would be a stepping stone to employment.
- Supervision of the CBSV was to be done by sub district staff but with the paucity of health staff NR introduced Zonal Co-ordinators because of the peculiar situation of large areas with long distances between villages and the frequency of reporting Guinea worm cases. Some districts are rich in staff and so CHOs take up the supervision of the CBS. In some districts CHOs have their own volunteers in the villages.
- In Ashanti Region the keeping of the Community Register is the responsibility of the CBSV. This enables effective defaulter tracing for immunization. They are now thinking of introducing Demographic Surveillance which would make analysis of CBS data more accurate.

The review covered 6 Districts each with varying degrees of implementation levels. Since it was not an evaluation, the sample was not representative and therefore only the qualitative information tabulated above is available. DDHS interviewed all agree that CBS is useful but they have not been provided with enough resources to implement it fully. Some of them were resourceful and were able to attract support from local NGOs to support CBS, Mpohor Wassa East-World Vision International, Juabeso-Population Council, Amansie West -ANESVAD Spain, East Mamprusi-CRS.

CBS Book

Some changes have been suggested to be made to the current Community Register for Vital Events book. The changes include;

Title page:- Prepared by RHMT, NR to change to Ghana Health Service

Page i:- BASELINE DATA

- Introduce year 20_ _
- (Prominent) *Major* Ethnic groups
- Chief's Name *Name of Traditional leader*
- No. Water Sources *Types of water source*
- Latrines *KVIP No, WC No, Pit Lat. No*

Page ii:

- Whenever there is an unusual event please report to the nearest health facility or to the Zonal Co-ordinator ?? **CHO**

Page 1: CBS TALLY SHEET FOR VITAL EVENTS

- Need for a column for the signature of the health worker confirming the case identified by CBSV
- AFP (POLIO) should be just AFP
- DEATHS: INFANT to be split into Infant (0 – 12 mths and Child 1 – 5 years
- DEATHS: Introduce coffins
- Events to be added: **Buruli Ulcer, TB, Cholera, Yaws**

Page 15: DEATH ANALYSIS SHEET

- Introduce column Place of death

Page 16: IMMUNIZATION REGISTER

- Substitute PENTA for DPT
- Introduce column for TT

Page 18: VISIT BY HEALTH STAFF

- Turn page to Landscape and introduce column **Purpose of Visit**
- Increase number of pages

Page 19: CBS REPORT FOR NORTHERN REGION

- Delete Northern region

RECOMMENDATIONS

National Level

Review the proposal made for changes to the Community Register for Vital Events tool and agree on the changes.

Review the relationship between CHPS and CBS for a National Consensus as to whether CBS should be linked and dependent on CHPS or CBS should develop ahead of CHPS.

Draft a Strategic Plan for full implementation of CBS throughout the country and share with partners.