UNIVERSITY FOR DEVELOPMENT STUDIES

AN EVALUATION OF THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) IN THE BINDURI DISTRICT OF THE UPPER EAST REGION

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FEBRUARY, 2017

DECLARATION

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere:

..... 25/03/17

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I hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies

..... 28th Feb. 2017

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ABSTRACT

The Community-based Health Planning and Services (CHPS) programme was adopted in 1999 as a national health policy to increase rural access to health care service while empowering local communities to take greater control over their health through the promotion of community-driven health care services with technical support from the central government. The objective of this study was to evaluate the CHPS programme in the Binduri district. The study used qualitative and quantitative methods. The primary respondents were mothers and caregivers of children between 0-59 months. District Assembly members, Community Health Officers and some opinion leaders of the communities were also interviewed. The study found out that 71.7% of mothers/caregivers often used the services of the CHPS. Involvement of health committees of the communities encouraged the use of the services (OR= 4.915, CI: 2.408-10.03, p<0.001). Visitation of community members especially women by the CHOs encourages them to use health services (OR= 0.735, CI: 0.573-0.941, p<0.015). The challenges to the provision of health care services in the CHPS compounds are lack of means of transport for both clients and service providers (OR=1.2, CI: 0.6-2.1, P< 0.001), and inadequate supply of drugs (OR= 0.3, CI: 0.1-0.6, p<0.02). The communities contributed in cash and kind to the construction of the CHPS compounds and are also involved in the planning of health services. The Binduri District Assembly supported in the construction of the CHPS compounds through funding however; they do not monitor the activities of the CHPS compounds. The CHPS programme has positively impacted the health of community members and through increased access of health services in the Binduri District. It is recommended that more CHPS compounds should be built in Binduri District by the Ghana Health Service and the District Assembly because some of the communities are far away from the health facilities making them to walk over 8Km as prescribed before accessing health care.

DEDICATION

To my family

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LIST OF ABBREVIATIONS

CHPS.....Community-based Health Planning and Services.

CHFPP.....Community Health and Family Planning Programme.

CHO..... Community Health Officer.

CHN.....Community Health Nurse

CHC.....Community Health Compound

CHV.....Community Health Volunteer

DDHS..... District Director of Health Services

DHMT.....District Health Management Team

FGD.....Focus Group Discussion

GHS.....Ghana Health Service

IMCI .....Integrated Management of Childhood Illnesses

MOH.....Ministry of Health

NHRC..... Navrongo Health Research Centre

PH C .....Primary Health Care

SDHT..... Sub-District Health Team

WATSAN..... …Water and Sanitation Committee

WHO .....World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The provision of accessible but affordable health care for the citizens of the country has been the aim of governments since the attainment of independence in 1957. Deliberations on health sector reforms, with the aim of achieving accessibility for all citizens started in the 1980s but were given impetus in the 1990s by a continuous and growing role of research which sought to bridge the gap between research and policy formulation and program implementation (Nyonator *et al.*, 2002).

It took Ghana over 20 years after the Alma Ata Declaration on Primary Health Care in 1979 to take bold departure from bureaucratic models of health service delivery to implement the Community-based Health Planning and Services (CHPS) as a national health policy initiative that was adopted in 1999. The initiative, as a strategy to increase rural access to health care service while empowering local communities to take greater control over their health, sought to promote community-driven health care services, with technical support from the central Ghana Health Service. The CHPS initiative was piloted in Navrongo through the Navrongo Health Research Centre. Initiated in 1994, it advanced the idea that the mobilization of traditional systems of leadership, resources, communication and governance had the potential of increasing health-care services accessibility, reducing child and maternal mortality whilst improving rural-population's overall health (Ministry of Health, 2000).

The strategy of the CHPS programme advocates the systematic planning and implementation of primary health care facilities and activities with active participation of community leaders and members. In practice, this is achieved through the mobilization of community leadership, decision making systems and resources in within defined catchment areas (zones) (Awoonor, 2002). Evidence from the piloted projects in by the Navrongo Health Research Centre showed that, there was the need to shift resources from curative institutional-based care to community-based preventive public health services (Nyonator *et al.*, 2002). It was in the light of this that CHPS program was adopted as an evidence-based organizational change, which placed emphasis on community-based approach rather than clinical facility-focused approach as a mechanism for integrating activities of the formal health sector into traditional institutions.

With the CHPS Initiative the communities have to be involved in the development of policies and plans and in monitoring and evaluation of the health programs. The community needs to be informed and educated about health, health policies and their implications, and their opinions sought in plan formulation.

The purpose of the initiative is to improve the accessibility, efficiency and quality of Healthcare and Family Planning Services based on community-based approach and the principles indicated above. Accessibility here is defined as living within one hour travel time (by any available means) from a health facility; efficiency is using minimal input (resources) to achieve the greatest output (health outcome) possible under a particular situation; quality means conforming to standards acceptable by the Ministry of Health (Ministry of Health, 2002).

After the inception and adoption of CHPS as a national programme for delivery Primary Health Care activities in Ghana, a good number of assessments of the programme have taken place in other to improve the programme performance, to provide modification and as a means for guiding programme implementation. However, what is not clear to front line health care providers is the range of health services to be rendered at the CHPS compounds; Also, the challenges facing front line care providers at the CHPS compounds in the Binduri District is not researched into and documented; the level of utilization or patronage of health services by the community members as well as the administrative and management challenges facing the CHPS implementation and sustenance in the Binduri District are not readily documented.

1.2 Problem Statement

Improving the health status of the population of the rural areas is crucial for poverty reduction in any country, given that ill health is a consequence and cause of poverty. As research reports have indicated (Ghana Macroeconomics and Health Initiative, October, 2005), the communities have to be involved in the development of policies and plans and in monitoring and evaluation of the health programs. They need to know their health rights and responsibilities and appreciate the interdependence of everyone in the society and also the ethical and moral values that are necessary for the development of health. To ensure that community members are involved in the planning, development of policies and the implementation of health programs, the CHPS concept was designed to meet the above thereby improving the health status of the population through the improvement of accessible, efficient and quality Healthcare and Family Planning Services.

The (CHPS strategy is a community-based approach, which seeks to provide health services through partnerships between the health system (District Health Directorates and Sub - district health management teams), District/Municipal Assemblies, community leaders and social groups. The CHPS programme was launched against the realization that more than 70% of all Ghanaians lived over 8 kilometers from the nearest health care provider (Phillips, 2002).Whereas long distance is considered a hindrance to health care, the issues of good road network and availability of transport facilities for referral are worth noting . Thus accessibility to basic health care services was the key factor that influenced the initiation of the CHPS concept. But CHPS as a strategic process of implementing the primary care concept have not achieved and sustained the expected health outcomes in the Binduri District because some of the service indicators of the CHPS concept are very low in the District. For example home visiting and referral to high level of care by CHOs is as low as 2.1% and 5.1% respectively (LQAS Survey, 2012) in the Binduri District, while there is increasing malnutrition such as stunting (22.7%), wasting (15.9%) and underweight (29.5%) in the District (Nutritional Surveillance Survey, November, 2013).This results places the district as having the worst forms of malnutrition in the region. Whereas these few indicators seems not good enough, it is also important to evaluate the health services provided by these CHPS compounds as well as examine the range of health services provided by these CHPS compounds. The fact is that the evaluation of CHPS services is either very low or completely absent in the district. It is against this background that a research in this regard would help provide and define and put the CHPS services in perspectives.

1.3 Objectives of the Study

1.3.1 Main objective

The main objective of the study is to assess the performance and utilization of the community based health planning and services concept in the Binduri District of the Upper East Region.

1.3.2 Specific Objectives

The study specifically sought;

1. To determine the factors that contribute to the utilization of health services provided by CHPS compounds in the Binduri District
2. To do a geospatial analyses of distance travelled by community members to access health services in CHPS compounds of the Binduri District
3. To identify the challenges faced by health services providers in the CHPS compounds of the Binduri District
4. To assess the role of the Binduri District Assembly to CHPS implementation in the District
5. To assess the level of community participation in the CHPS implementation.

1.4 Relevance of the Study/Justification

Although the health care system has evolved over time to ensure health is accessible to every conceivable part of this country, missionary and private sector have involved in health services provision, the government sector still remained the largest provider of

health care. This is justifiable since it is the responsibility of the government to ensure that people have access to good quality health services in the country. Generally, the public healthcare facilities can be distinguished in four layers depending on the services offered at the facility- the CHPS level, clinic, health center and the District hospital levels. The community health posts predominantly provide preventive and primary health care services; however, their curative treatment is limited due to the fact that they are mostly not staffed by doctors or highly skilled health personnel.

The successful implementation of the CHPS programme depends on the systematic application of the CHPS process in any district and therefore required the understanding of the processes and efforts of all health workers of the district health system. Binduri is almost a rural district and at the same time very young and it is only CHPS that can serve the health needs of the people. Since the inception of CHPS concept in 1999 and the scale up to the Binduri District, there has not been any known assessment of the performance and utilization of CHPS in the Binduri District of upper East Region. Besides, CHPS is the most dominant (70%) of health care system in the District.

Empirical investigation and assessment of the CHPS program in the district would enable policy makers to know the gaps and find alternatives to achieve maximum results. Thus the findings of this research would provide information that would guide policy formulation and reform.

1.5 Scope of the Study

This study was conducted in all the CHPS zones of the Binduri District. Communities that have CHPS compounds were used as study units with caregivers who came to seek health care in these CHPS compounds being the primary respondents. Community stakeholders such as traditional leaders and unit committee members were also interviewed.

The District Chief executive and the District Coordinating Director of Binduri District Assembly which provides funding for the construction of CHPS compounds were interviewed.

1.6 Conceptual Framework of the Study

The CHPS concept was introduced to make health services accessible to people living in rural areas. The concept requires that there should be collaboration between health services providers and community members. The figure below shows the conceptual framework that was guided the conduct of this study. The framework considered the implementation of CHPS by assessing the contribution of District Assemblies and community members in supporting the Ghana Health Service to implement the programme. The types of services provided in the CHPS compounds, the utilization of the services, accessibility of the health services and the determinants or factors that influence the utilization of these services.

Role of District Assembly: The study assessed the role played by the District Assembly in the implementation of the CHPS programme as well as the contribution of the District

Assembly in the construction of the CHPS compounds and the provision of furniture to the facility. The involvement of the District Assembly in the provision of means of transport such as motorbikes to staff of the CHPS compounds was also assessed.

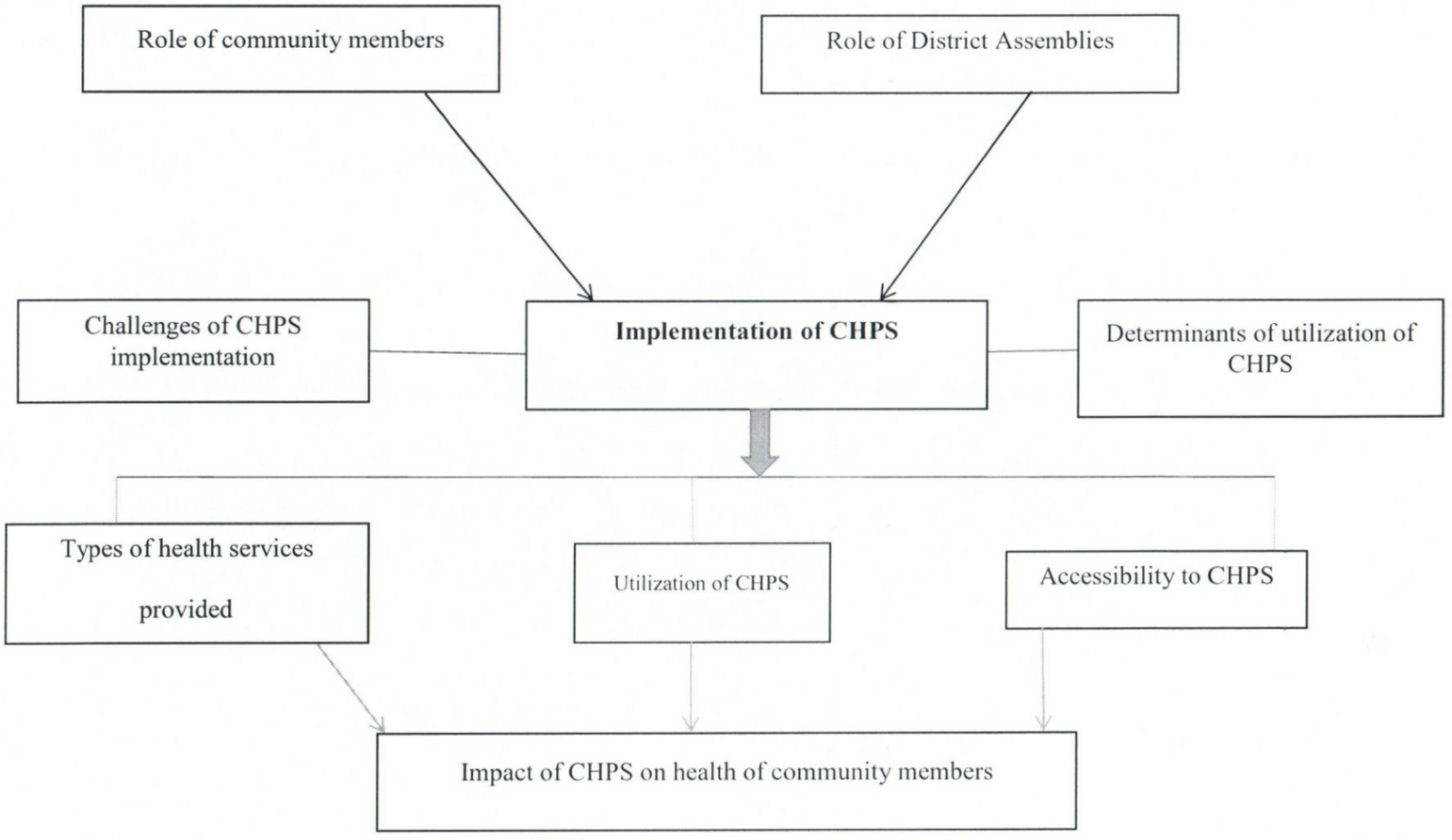
Role of Community members: Community members are to be involved in the planning of health services through the CHPS programme. This study therefore assessed the extent to which this mandate of the CHPS concept has been fulfilled. The contribution of the community members in the construction of the CHPS compounds and their involvement in the planning of health services was assessed.

Types of Services and utilization of services: The types of health services offered in the CHPS compounds were assessed. The study also assessed the utilization of these health services. The determinants or factors that influence the use of these health services were also assessed.

Challenges to health services provision: Provision of health care services is faced with several challenges. This study assessed the challenges that are peculiar to CHPS compounds in the Binduri District.

Impact of CHPS programme on communities: CHPS programme was designed to involve community members in the planning of health services. This study therefore assessed the impact of the CHPS programme on the health of community members.

Figure 1.1 Conceptual framework of the implementation of CHPS and its impact



1.7 Organization of the Study

This dissertation is organized into six chapters Chapter one includes the introduction to the study, background to the study, the problem statement, the study objectives, the significance of the study and the operational definition of terms of the study. Chapter two of this study reviews relevant literature in relation to the study. Literature was reviewed on universal health coverage, Primary Health Care concept, evolution of accessible and efficient health-care policy options in Ghana, the CHPS process and key players of the CHPS concept.

Chapter three is made of the methodology, which comprises the study design, study type, study variables (independent and dependent variables), data collection instruments, sampling procedure and sample size, study population, data collection methods, quality control measures, ethical considerations as well as plan for dissemination of results. The fourth chapter contains the results and findings of the study whilst the discussion of the results and findings of the study is done in chapter five. The conclusion and recommendations of the study are also presented in chapter six. A sample of the study questionnaire is presented as an appendix together with some relevant tables from the analyses.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter deals with work in the areas of CHPS done by policy makers and researchers. It is divided into the following sections; universal health coverage, Primary Health Care, evolution of accessible health policy options in Ghana, organizational of CHPS at the District level, policy on CHPS, implementation of CHPS, benefits to some communities, and other effects observed on some communities.

2.1 Universal Health Coverage

The United Nations passed a resolution unanimously on 12 December 2012, which endorsed universal health coverage as a pillar of sustainable development and global security. Despite progress in combatting global killer diseases such as HIV/AIDS and vaccine-preventable diseases such as measles, tetanus and diphtheria, the global gap between those who can access needed health services without fear of financial hardship and those who cannot is widening. Each year, 100 million people fall into poverty because they or a family member becomes seriously ill and they have to pay for care out of their own pockets. Around one billion people worldwide can't even access the health care they need, paving the way for disease outbreaks to become catastrophic epidemics (UN, 2013)

Universal Health coverage (UHC), is defined as making sure that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these health services does

not put the user to financial hardships or risks (WHO, 2010) Universal coverage brings the hope of better health and protection from poverty for hundreds of millions of people - especially those in the most vulnerable situations. The UN (2012) noted that UHC is not easy to be achieved in all nations at a time, but that all the nation in the World can work gradually and with good planning without deviation, take the necessary steps and actions to move more rapidly towards it, or to maintain and sustain the gains they have already made in certain health indicators. Again, it is noted that, in countries where health services and health indicators have traditionally been good and health care accessible, affordable and responsive, the governments of these countries in recent times are not getting it easy to maintain and sustain and moreover to even respond to the ever-growing diverse health needs of the populations and the increasing costs of health services.

A new global coalition of more than 500 leading health and development organizations worldwide is urging governments to accelerate reforms that ensure everyone, everywhere, can access quality health services without being forced into poverty. The coalition was launched to stress the importance of universal access to health services for saving lives, ending extreme poverty, building resilience against the health effects of climate change and ending deadly epidemics such as Ebola (WHO, 2012). The need for equitable access to quality health care has never been greater, and there is unprecedented demand for universal health coverage around the world. An equitable health system is one that provides its population with access to services according to needs and independent of the capacity to pay, thus safeguarding the right to health. Improving access to health services ranks among the strategic health policy goals across the globe. However, like equity, access is neither precisely definable nor measurable in a definite manner (Malcoci, 2011).

According to Tim (2010) for much of the 20th century, universal health coverage was limited to a few high-income countries, but in the past two decades, a number of lower- and middle-income countries have successfully embraced reforms to make quality health care universally available. Countries as diverse as Brazil, Ghana, Mexico, Rwanda, Turkey and Thailand have made tremendous progress toward universal health coverage in recent years. Marie-Paule (2013) reported that the two most populous countries; India and China, are pursuing universal health coverage, and more than 80 countries have asked the World Health Organization for implementation assistance. Putting people's health needs ahead of their ability to pay stems poverty and stimulates growth.

"Health care is not a commodity or privilege, but a human right."(Frenk, 2007, p 2) Universal Health Coverage (UHC) and investments in health systems can accelerate global efforts to ensure access to healthcare to anyone who needs it, leaving no one behind. UHC can help us galvanize progress towards achieving all the health-related Millennium Development Goals and ending preventable deaths, particularly among the most vulnerable populations – women, children and adolescents – as well as communities beyond 2015. With universal coverage, we can foster greater equity, empower countless individuals, and contribute to a life of dignity for all." (Ban Ki-Moon, 2013).

According to Binagwaho, (2009) If we invest in our health systems now—which we know yields an impressive return for the investment—we can build an Africa where individuals, families, and entire nations reach their full potential. Strong health systems that reach everyone, everywhere are crucial to fight HIV, TB and malaria.

Nyaradzayi (2010) *stated that* UHC secures health and well-being for women and girls everywhere. To be effective, universal health coverage requires a holistic approach to women's health – including universal access to their reproductive health and rights According to Babatunde (2011),the right to sexual and reproductive health is central to health for all and vital to the future we want. UHC is key to fighting poverty, reducing inequity and nurturing economic growth. Sustainable development with decent jobs for all requires investment in health protection – these linkages cannot be ignored in policy development.

2.3 The Primary Health Concept (PHC)

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process — Alma Ata Declaration, 1978 (TO, 2003).

In the last decades of the Cold War (the late 1960s and early 1970s) the United States of America (USA) was involved in a crisis of its own world dominion and it was in this political era that the context or the term called primary health care emerged. But before then, there was a vertical

health approach used in malaria control or eradication by US agencies and the World Health Organization since the late 1950s were being criticized. New proposals for health and development appeared, such as John Bryant's book *Health and the Developing World* (also published in Mexico in 1971), in which he questioned the centralized focus of the hospital-based health care system to developing countries and the lack of emphasis on prevention (Stensland, 1971). According to Bryant, "Large numbers of the world's people, perhaps more than half, have no access to health care at all, and for many of the rest, the care they receive does not answer the problems they have . . . the most serious health needs cannot be met by teams with spray guns and vaccinating syringes".

According to Cueto, (2004), Other studies, under taken from outside the public health domain, have also had a big influence in challenging the assumption that health resulted from the transference of technology or more doctors and more services. The British historian Thomas Mc-Keown argued that the overall health of the population was less related to medical advances than to standards of living and nutrition (Harris, 2004). More aggressively, Ivan Illich's *Medical Nemesis* contended that medicine was not only irrelevant but even detrimental, because medical doctors expropriated or seized health from the public. "Another important influence for primary health care came from the experience of missionaries. The Christian Medical Commission, a specialized organization of the World Council of Churches and the Lutheran World Federation, was created in the late 1960s by medical missionaries working in developing countries. The new organization emphasized the training of village health workers (VHWs) at the grassroots level or community level, equipped with essential drugs and simple methods. In 1970, it created the

journal *Contact*, which used the term primary health care, probably for the first time"(Cueto, 2004).

Mahler (1973-1988), a former Director General of the World Health Organization used the story of the sorcerer's apprentice to illustrate how health technology was out of "social" control. In contrast, "appropriate" medical technology was very appropriate to the needs of the people particular at the remote areas, scientifically sound, and financially feasible. In addition, the construction of health posts in rural areas and shantytowns, instead of complex hospitals construction with sophisticated medical personnel and equipment, was emphasized or proposed.

The declaration's second key idea, criticism of elitism, meant a disapproval of the overspecialization of health personnel in developing countries and of top-down health campaigns. Instead, training of lay health personnel or health staffs and community participation were stressed. In addition, the need for working with traditional healers such as "*shamans" or herbalist* and midwives was emphasized. Finally, the declaration linked health and development. Health work was perceived not as an isolated and short-lived intervention but as part of a process of improving living conditions(Cueto, 2004). Primary health care was designed as the new center of the public health system. This required an intersectorial approach (Sin et al, 2003)—several public and private institutions working together on health issues (e.g., on health education, adequate housing, safe water, and basic sanitation). Moreover, the link between health and development had political implications. According to Mahler, health should be an instrument for development and not merely a byproduct of economic progress: "we could . . . become the *avant garde* of an international conscience for social development."

The 32nd World Health Assembly that took place in Geneva in 1979 endorsed the conference's declaration. The assembly approved a resolution stating that primary health care was "the key to attaining an acceptable level of health for all." In the following years, Mahler himself became an advocate of primary health care, writing papers and giving speeches with strong titles such as "Health and Justice" (1978), "The Political Struggle for Health" (1978), "The Meaning of Health for All by the Year 2000" (1981), and "Eighteen Years to Go to Health for All" (1982). However, despite the initial enthusiasm, it was difficult to implement primary health care after Alma-Ata. About a year after the conference took place, a different interpretation of primary health care appeared.

2.4 Evolution of accessible and efficient health-care policy options in Ghana

In the foreword to a document of the Ministry of Health (November 1999) on the Community-based Health Planning and Services entitled "A Process for Effective Implementation of Primary Health Care Programs" the then Deputy Minister for Health Dr Moses Adibo made the following statement:" The provision of adequate, efficient and equitable Primary Health Care services to all Ghanaians is a crucial policy of the Government of Ghana. The major objective of the Ministry of Health in this regard is the extension of health services to most people through the use of front-line staff i.e. community Health Nurses and Community sponsored service support Volunteer outreach activities. The achievement of this objective involves:

(1) The engagement of the cooperation and authorization of the people themselves at the community level and

(2) The reorientation and deployment of some health workers from hospital and clinical activities to community based activities."

These words amply captured the purpose and essence of the CHPS Initiative which is the current policy option of the Government of Ghana in its attempt to make health care services accessible, efficient and of quality. The CHPS Initiative was preceded by other attempts at improving the quality of health of the population of the country for the purposes of national development and rural poverty reduction as discussed below.

According to Kodjo Senah, in his contribution to a book entitled "The State, Development and Politics in Ghana" by the Council for the Development of Economics and Social Research in Africa (1989), Ghana,,s experience with the western model of health care (the conventional model of health care) started since 1471 when the white man landed on the shores of the country and has undergone three phases.

The first phase spanned the period from 1471 to 1844; a period that coincided with the growth of the "germ theory" after Louis Pasteur"s discovery of germ as the causative factor of infectious diseases.

This period also coincided with the rise of capitalism with its focus on the individual. The result of this was that health and health care come to be interpreted in terms of the individual as against the community in the western model of health care services. During this period western health care services were the exclusive reserves for the white man and involved the use of medicine and medical technology without promotive, preventive or rehabilitative health-care practices.

The second phase started from 1844, when the British entered into a peace treaty with some coastal chiefs and brought much of the country under their dominion, till the down of independence. During this period, the first hospital of the country was built in 1868 at Cape

Coast after the colonial surgeon Thomas Jones submitted his reports to the colonial governor in 1867. The Gold Cost Medical Department was founded at this time.

During this period, health-care services continued to be based on curative practices but were expanded to include the local population especially those in the urban areas and those in the public services. Alongside this expansion in healthcare services was the attempt to liquidate traditional medicine and in 1879 a legalisation was passed to abolish traditional medicine.

Preventive medicine got recognition of the colonial government as a result of pressure from the then Sanitary Movement in Britain and the bubonic plaque in 1908. Consequent on these, the Sanitary Branch of the Medical department of Gold Cost was set up. The jurisdiction of this branch was stated in vague terms as removing sources of growth and multiplication of microbes and consisted in jobs like draining gutters, cleaning toilets and the likes. Severe budget cut in 1931 and 1932 forced the Sanitary Branch to restrict its activities to the urban areas and later became defunct-obviously the colonialist was not interested in preventive health. The features of the colonial health care system included the following:

1. A strong curative and urban bias

2. A centralized medical administration with the least concern for the rural areas

3. The central government was the largest provider of health services

4. The subordination of traditional healing system to bio-medicine.

5. A north-south disparity in the provision of health-care services and facilities with the southern half of the country as the greater beneficiary.

The Ministry of health came into being when the Gold Coast attained self-rule after internal arrangement in 1951.

At independence, the national leadership had made a commitment to better the health for the people. Consequently, early development in the health infrastructure took place along two main paths viz: along conventional lines-the growth of hospitals was associated with improvement in the quality of care and the development of centers of excellence and the

building of health centers and their satellite centers including health posts.(Ebrahim and Ranken ,1995).

Disparity between expenditure of the government on health care services and the need of the people become an issue in the post-independence era of the nation. Two central issues with immerse social, political and economic implications for the development of the health industry were health financing and coverage. Public health services became an intolerable burden on the exchequer, while it was at the same time, limited to a few Ghanaians (Senah, 1989).

In most developing countries, more than three quarters of the health budget was spent on hospitals which were mainly in the urban areas and cantered on the treatment of diseases whereas the need was for prevention, improved nutrition, personal hygiene and environmental sanitation. Preventive services like the Under Five"s and Antenatal care did not receive much emphasis in the national health plan (Ebrahim and Ranken, 1995).

Also, there was the disparity between resource allocation and population distribution. Most of the personnel and capital resources remain sequestered in urban areas catering for the elite even

though the population was largely rural or lived in urban squatter areas. A large share of the recurrent expenditure went into servicing the capital resources. (Ebrahim and Ranken, 1995).

Ofori –Amaah as reported by Kodjo Senah, reported that in 1974/75 financial year over one third of the health budget went to Korle-Bu Teaching Hospital and the Greater Region alone (CODESRIA,1989).

The policy at independence to adopt and literally apotheosize western models in our desire to be counted among the comity of "civilized" nations accounted for these inequalities. Also, the determination of health policies seemed to have been affected by prevailing elite and ruling class interests (CODESRIA, 1989).

Also, it seemed politically expedient for governments to build more clinics and hospitals thereby emphasizing the curative aspect of health at the cost of the preventive, promotive and rehabilitative, Community intervention by way of mobilizing community resources to effect a sanitatory environment received very little support from the communities.In conventional health care the regular focus of concern is the individual pathology. This kind of health care based on the western model has been described as the "engineering model" The analogy of the body as a machine and the doctor the medical scientist/ engineer has proved useful to the development of certain aspect of medical care especially in crises intervention and in the treatment of acute clinical disorders.

However, the attempt to manage ill health along the lines dictated by this framework has produced some distortions, for example the tendency to focus most efforts and resources on the curative dimensions of health care (Macdonald, 1996) as is shown in the preceding paragraphs.

Progress in medical technology has done little to remove many of the colossal mountains of suffering and ill health which exist in the societies of the third world with their patterns of communicable diseases often rooted in poverty (Macdonald, 1996).According to Macdonald (1996) the engineering model of health can be fairly described as reactive rather than proactive; to reduce ill health to an area susceptible to technical fixes is to ensure that health services will fail poorer countries. In the 1970s, it became clear to health policy makers in the country that something radical had to be done. The thinking was that since the rural areas especially experienced the highest mortality, morbidity and fertility rates, an integrated approach to rural health problems would be appropriate. The Easmon committee as cited by Senah (1989) in the CODESRIA series noted that rural areas had been neglected and that the preventive emphasis of health has not been taken seriously. Also Sai as reported by Senah (1989) in a similar vein observed that the number and distribution of hospitals and clinics were such that they could not offer any kind of service to more than at most 20 % of the population.

That, the basic health problem of many countries had not been addressed by considerable investment in institutions of tertiary care and the concomitant neglect of community level initiatives of care and prevention have been two of the major factors which have contributed to the emergence of the alternative approach to health care which is called Primary Health Care (Macdonald, 1996).

In 1975 a joint WHO – UNICEF study estimated that only 1/5 of the rural population in the developing countries received basic health care on a regular basis. This was followed in 1976 by a study from the International Labour Organization (ILO) which estimated that almost 2/3 of the

population of the developing countries were living in serious poverty and 700 million of them were destitute (Ebrahim and Ranken, 1995).

Based on the study, the ILO advocated a "Basic Needs" approach to national development from which the Primary health Care approaches emerged at Alma Ata in 1978 when the Global Health Conference was held.

The Declaration of that conference urges member states:

1. To take appropriate steps for consultation to raise awareness of the general public, political leaders, ministries and other partners concerned with social and economic development policy to the need to place health high on the political agenda in order to address the serious health challenges of the coming decades and to ensure that the foundation is laid for implementation of the global health policy in countries.
2. To adapt the global health policy after its adoption, into national or sub-national context for implementation- selecting approaches specific to their social and economic situation and culture.

Primary Health Care emerged as a strategy when these failures were becoming increasingly obvious. Frustration with existing approaches led to criticisms and innovative practices were tried.

In Ghana, the Danfa Comprehensive Rural Health and Family Planning Project took off with the important aim of developing an effective high quality and affordable Primary Health Care in the rural areas in 1970. In 1974, the Centre for scientific Research into Plant Medicine was founded.

In 1976, the first most significant step towards PHC with assistance from WHO was established in the Brong Ahafo region -the Rural Integrated Development Project at Kintampo for the training of meddle-level personnel for the proposed PHC program. The project was also mandated to determine, in a practical way, the social process that would help to institutionalize the participation of traditional healers in a health care program.In1977, the government adopted the PHC program. The goal was to extend health care coverage to 80% of the population (CODESRIA, 1989).

PHC is essentially, health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford in the spirit of self-reliance and determination. It forms an integral part of the country's health system of which it is the central foundation and main focus and the overall social and economic development of the country. It is the first level of the community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health-care process (Declaration of Alma Ata) (WHO, 2000)

Alma Ata takes a wider view which incorporates a concern for the treatment of individual symptoms but acknowledges that problem of ill-health can have structural causes; causes that lie outside the control of the individual and even sometimes outside the control of a whole community or country (Macdonald, 1996). It addresses the main problem in the community providing preventive, promotive and rehabilitative services (Alma Ata Declaration).

According to Macdonald (1996) three principles guides the philosophy of PHC and these are:

(1) Commitment to equity

(2) Adherence to the principle of the right of people to be involved in significant decision concerning their health services and

(3) Acceptance of the need for the medical profession to collaborate with other sectors which make significant contributions to the health of the population (intersectional collaboration).

The perspective of PHC builds on WHO"s definition of health as "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The position of Alma Ata is that health is a "social goal" whose realization requires the action of many other social and economic sectors in addition to the health sector. PHC is a reaction to a narrow medical approach to health care. (Macdonald, 1996).

The activities of the Primary Health Care program are as follows:

(1) Promotion of nutrition.

(2) Provision of adequate supply of safe water.

(3) Provision of basic sanitation.

(4) Maternal and child care including Family Planning.

(5) Immunization against the major infectious diseases.

(6) Prevention and control of locally endemic diseases.

(7) Education concerning the prevalent health problems and the methods of their prevention and control and (8) Appropriate treatment for common diseases and injuries.

Secondary and tertiary health care cannot be said to be part of "Primary Health Care" but they must be part of a health care system which is turned towards the needs of the community in the spirit of PHC. All must be integrated into a rational entity (Macdonald 1996).

The PHC program operated at three levels; A,B and C. level A was at the community level and had the Traditional Birth Attendant, Village Development Worker and Village Family Worker as its personnel. The function at this level was preventive and promotive health services, simple curative measures, pregnancy management, environmental protection and community mobilization for health-related community projects.

Level B was at the institution level of health center and had the following as its personnel: a Medical Assistant, Community Health Nurse /Midwife, a Health Inspection Assistant and a Senior Field Technician for communicable disease control. The function at this level was immunization and a referral point for level A.

Level C was the district which had the District Health Management Team (DHMT). This team consisted of a District Medical Officer, a District Public Health Officer, the District Technical Officer for Communicable disease control, a Senior Medical Officer for the hospital and a District Health inspector. The function at this level included planning, implementation and evaluation of health services for the entire district.

In 1984 the government set up the National Primary Health Care Committee made up of 17 governmental and non-governmental organizations to steer the PHC program. They selected the following functions for the PHC program

(1) Expanded program on immunization.

(2) Control of diarrheal diseases.

(3) Health education.

(4) Environmental sanitation and

(5) Growth monitoring.

Since the International Conference on PHC, held at Alma Ata in 1978, the call for health- for -all by the year 2000 through PHC provided motivational and unifying concept in international health development and made an important contribution to the achievement of better health which has occurred around the world: increased life expectancy, declining infant mortality and improved access to basic health care services (Macdonald, 1996).

However, as the target date approached, it could be seen as limited, may be, misunderstood and above all proposed time frame which was not universally attainable. To cite some few examples, in 53 countries representing 13% of the world's population average life expectancy at birth was less than 60 years, there was wide variation of infant mortality rates between countries and maternal mortality in sub-Saharan Africa was three times greater than in less developed countries as a whole (Macdonald, 1996).

In Ghana the PHC program was fraught with all kinds of problems resulting in the main from its organizational structure (CODESRIA, 1989). The structural problem of the PHC program in Ghana included the following:

(1) Limited support from the regional and national levels.

(2) The National Primary Health Care committee formed to steer affairs of the PHC was inactive.

(3) There was inadequate technical support.

(4) None of the positions in the DHMT was an established one.

(5) The DHMTs had a lot of responsibilities without authority.

(6) Inadequate logistics.

(7) Financially, the district lacked autonomy and since no direct budgetary allocations were made to the PHC program, health personnel allegiance to their original division persisted, a situation that further weakened the basis of commitment to the program.

The PHC program also had challenges in its implementation as follows:

1. Training for the health personnel was limited because of high cost. The result was that teams were left without any program to follow; and since they had not been trained to develop programs to meet health needs, they were left to continue operating as before.
2. There was lack of transportation for supervision.
3. Refusal of communities to pay remuneration to the Traditional Birth Attendants, Village Health Workers, and Village Development Workers as expected.

In the light of the above a new policy based on equity and solidarity, and buttressed by appropriate technical, political, social and economic strategies had to be universally adopted to serve as the objective and guidance for the updating of global, regional and national health for all strategies and for development of means and mechanisms to enable all contributing partners to fulfill their role.

The policy had to be based on a consensus for concepts and action. A framework for the policy had been developed to cover general and individual health situations in the world, to cover a

wide variety of political, economic, social and cultural situations to serve as the new concepts and ideas in health development and to serve as a basis for the development of new national policies (Macdonald, 1996).

There were a number of challenges which were underestimated in the initial enthusiasm of health-for all by the year 2000; for example, the importance of community participation and local determination of priorities and programs had been underestimated. The immerse diversity of problems with a bearing on health and the way in which solutions must vary from community to community across the full range of developed and developing countries made decentralization and local determination essential (Macdonald, 1996).

In Ghana, although health policy intended to address primary health care needs had been in place for decades, demonstrations of how to achieve health for all were rare. Rarer still were examples of how research-based demonstration could guide national health sector reforms. In response to the need for improved PHC: a phased program of research was launched to guide the process of changing the system from clinic facility- focused approach to community-based approach.

The CHPS initiative is a program designed to translate innovations from an experimental study at the Navrongo Health Research Centre into a national program for improving the accessibility, efficiency and quality of health care and Family Planning services (Banka et al, 1995).The Initiative employs strategies to guide national health reforms that mobilize volunteers, resources, and cultural institutions to support community-based Primary Health Care.

2.5 Definition of CHPS

According to the Ministry of Health (November, 1999), CHPS is a process of health care provision in which health workers and community members are actively engaged as partners in the delivery of primary health Care and Family Planning services and it involves:

(1) Community participation in primary health care and family planning services through community Health Committees and Community Volunteers.

(2) Locating Community Health Officers in a community Health compound and

(3) Mobilizing and re-orienting the Ministry of Health and District Assemblies to support the Initiative at the district level.

Adopted in 1999, CHPS is a national health policy initiative that aims to reduce barriers to geographical access to health care. With an initial focus on deprived and remote areas of rural districts, CHPS endeavours to transform the primary health care system by shifting to a programme of mobile community-based care provided by a resident nurse, as opposed to conventional facility-based and 'outreach' services.

The CHPS initiative represents the scaling-up of the Navrongo model into a national movement for health care reform. Regarded as the primary strategy for reaching the unreached, CHPS has, thus, become an integral part of the current Ghana Health Service Five Year Programme of Work and represents one of the health sector components of the national poverty reduction strategy.

The introduction of CHPS into districts occurs through extensive planning and community dialogue on the part of the Health Service and the community. A key principle of CHPS introduction is that traditional leaders of the community must accept the CHPS concept and

commit themselves to supporting it. CHPS relies on participation and mobilization of the traditional community structure for service delivery. District Health Management Teams must augment the skills of CHNs (or other cadre of staff) to prepare them for the delivery of preventive and curative care while residing in the community. These health staff, known as CHOs, provides mobile doorstep services to community residents. By travelling from compound to compound on motorcycle, CHOs cover a catchment area of approximately 3000 individuals. CHO services include immunizations, family planning, supervising delivery, antenatal/postnatal care, treatment of minor ailments and health education. CHOs are supported by community volunteers who assist with community mobilization, the maintenance of community registers and other essential activities.

2.6 Key players of the CHPS process

According to the Ministry of Health (1999) the key players of the CHPS process are as Follows;

(a) The Community

(1) The Community Members and Leadership including the opinion Leaders.

(2) The Community Health Committee.

(3) The Community Health Volunteers.

(b) ***The Ministry of health***

(1) District Director of Health Services

(2) The District Health Management Team (including the health workers-Medical Officers and other health personnel in the hospital the clinics.)

(3) The sub District Health Team.

(4) The community Health Officers.

(b) The District Assembly

(1) The District Chief Executive

(2) The Social services Sub Committee of the District Assembly.

2.7 Roles and Responsibility of the Key Institutions and Officials

(a) The community Health committee

The following are the roles and responsibilities of the key institutions and officials of the CHPS program;

- Settling of disputes concerning work of the Community Health Volunteers.
- Organizing communal activities in support of the programme.
- Advocating community health and family planning activities.
- Financial management of medical account.
- Managing Community Health Volunteers stock of drug and family planning materials; and
- Supervising bicycle maintenance for Community Health Volunteers.

(b) The community Health Volunteers

- ❖ Provide Preventive and curative services for malaria and diarrhoea;
- ❖ Provide family planning counseling;
- ❖ Refer serious cases to CHO and clinics;
- ❖ Provide Health education;

- Identify children for immunization;
- Notify disease appearance to CHO.

(c) The District Health Management Team (DHMT)

While the District Director of Health Services (DDHS) is responsible for overall program Management, providing guidance and technical assistance, planning and budgeting, the DHMT members:

- Assist in overall program management;
- Provide guidance and technical assistance to sub District Health Team;
- Plan and budget program activities;
- Serve as liaison and organize meetings between DHMT and SDHT;
- Supply essential medical supply to SDHT; and
- Supervise SDHT activities.

(d) The Sub district Health Team (SDHT)

- Holding management meetings with Community Health Committees and CHOs;
- Collecting data on CHO and Volunteer programs for the DHMT;
- Managing supply and monitoring usage of drugs and family planning materials by CHOs and volunteers; and
- Writing progress report to the DHMT.

(e) The community Health Officers (CHOs)

(1) Community and Compound level education on primary health care and family planning, Immunizing and providing pre and post-natal care

(2) Supervising and monitoring sanitation efforts;

(3) Provision of nutrition education and care;

(4) Primary care for simple cases like diarrhoea, malaria, acute respiratory diseases, wound and skin diseases;

(5) Providing referrals for more serious affliction;

(6) Provision of education on prevention and management of STDs and HIV/AIDS ;

(7) Provision of family planning counseling services and referrals;

(8) Submission of written report to the SDHT.

(f) ***The District Chief Executive and the District Assembly the*** District Chief Executive as the head of government machinery at the district level serves as the link between the CHPS process and other social services development program in the district. The District Chief Executive and the District Assembly through the Social Services Sub Committee is responsible for:

- Working with the DHMT in the selection and prioritization of communities for participation in the CHIPS process;
- Provision of funding and other material support operating the CHPS process particularly for the construction of Community Health Compounds and motivation of CHOs, Community Health Volunteers and the Community Health Committees;
- Informing and encouraging Members of Parliament in the district, as well as

NGOs to advocate for the CHPS process and provide material support for its implementation.

- Empowering District Assembly, Area Council and Unit Committee members to provide active organizational and material support to the development of CHPS program in their communities; and
- Receiving quarterly progress report on implementation of the CHPS process in the district from the DHMT and recommending or initiating necessary action.

2.7 Organizational Structure for Implementing the CHPS Process by the DHMTs

There are three inter-related components of this structure:

- The community with its operational units, the chiefs and elders, the community
- Health Committees, the Community Health Volunteers and the community members
- The Ministry of Health; comprising the District Health Management Team the
- Sub-District Health Team and the Community Health Officer and
- The District Political Authority made up of the District Chef Executive,
- Administrative Staff and the District Assembly at large

2.8 Policy on CHPS

In 1978, at Alma Ata in the United States of America, the Global Health Conference called for "Health for All" by the year 2000. This meant the provision of quality but affordable healthcare for the citizens of member countries by the year 2000.

In Ghana, despite the fact that, "Health for All" policies had been in existence for many years, the Ministry of Health reported in 1998 that, in 1990, more than 70 percent of all Ghanaians still

lived more than eight (8) kilometers from the nearest health services provider and rural infant mortality rates were 50 percent higher than corresponding urban rates (Ministry of Health, 1998).

National policies for healthcare reform during this period were guided by the "sector-wide approach" mandated by the World Bank for integrating healthcare planning, services and budgets (Nyonator *et al*, 2002).

Also, clinic-based health services were the mainstay of primary healthcare in Africa despite several convincing demonstrations that community-based operations can enhance the accessibility, efficiency and sustainability of essential health services (Amonoo-Larsen *et al*, 1984). Discussions and deliberations on health sector reform actually began in the 1980s but were given impetus in the 1990s by a continuous and growing role of research (Akosa *et al*, 2003). The growing influence of evidence-guided approaches was motivated by research showing that several large-scale national schemes for addressing the need for accessible primary healthcare had been fraught with serious organizational problems and resource constraints (Amonoo-Larsen *et al*, 1984).

Two general goals have guided the primary healthcare policy in Ghana. First, the need to expand public sector health facilities, under the assumption that convenient facilities providing low cost care will benefit the poor segment of the population. Second, the need to shift resources from curative institution-based care to community-based preventive public health services. But, the impact of strategic change among the poorest segment of the population had been disappointing (Ministry of Health, 1998).

The health sector reform in Ghana was launched in 1993 with the aim of increasing access to health services, improve health services quality and efficiency, decentralize planning and management, foster partnerships between providers and communities and expand healthcare resources (Ministry of Health, 1998)

Two resources for implementing and governing accessible and affordable community health and family planning care came under consideration. First, the UNICEF sponsored "Bamako Initiative" involving potential contribution of volunteer health providers and supporting cultural resources like chieftaincy, lineage and social network, (Knippenberg *et al*, 1990) and second the potential impact of relocating under-utilized community nurses to village locations (Amonoo-Larsen *et al*, 1984).

The Navrongo Community Health and Family Planning Project was used to test the relative impact of the two general sets of existing under used resources for primary healthcare. By 1997, evidence suggested that the Navrongo experiment was having an impact; a single nurse equipped with a motorbike outdid an entire sub-district health center, health service encounters increased eight fold, immunization and family planning improved, and fertility and mortality declined (Akosa *et al*, 2003)

Changes in the Navrongo approach to community mobilization were introduced in response to ethnic diversity, and the approach was replicated at Nkwanta District in the Volta Region to test its efficacy outside a research setting in 1999. In that year, baseline survey family planning usage in Nkwanta District was estimated to be less than 4% (Awoonor-Williams *et al*, 2009). By 2002, prevalence of family planning usage was 14% in communities exposed to the programme, representing three times the prevailing rate in the rest of the district.

Nkwanta had not only validated Navrongo efforts but exceeded Navrongo levels of impact on several health indicators (Awoonor-Williams *et al*, 2004). In response to this success, the Ghana Health Service utilized Nkwanta as a demonstration district for building Community Health Planning and Services (CHPS) implementation capacity. CHPS was launched in 2000 after consensus building.

In national policy documents, CHPS is viewed as a mechanism for integrating activities of the formal health sector into traditional institutions that define community leadership, foster consensus building and sustain collective action.

Research reports provided highly credible evidence supporting policy commitment to this model and such evidence has been a determinant of successful scaling-up elsewhere (Simmons and Shiftman, 2006). It is a program of evidence-based organizational change that changes the system from clinical facility-focused approach to a community-based approach and bridges the gap between research and programme implementation.

The purpose of the CHPS initiative is to improve the accessibility, efficiency and quality of health and Family Planning Services (Binka *et al*, 1995; Debpuur *et al*, 2002). With the advent of CHPS Initiative, the Navrongo experiment became the operational model for healthcare development in Ghana. It guides national health reforms that mobilize volunteers, resources and cultural institutions to support community-based primary healthcare.

At its core, the CHPS Initiative brought to an end various vertical programmes and established mechanisms for the decentralized administration of healthcare.

include drumming, dancing, speech making, debates and open discussions are convened to foster open discussions of CHPS (Nyonator *et al*, 2002).

Community Health Services require a simple facility that provides a room for the Community Health Officers' living area and another for a clinic. Developing such facilities contributes to community ownership of CHPS initiative by involving leaders in planning and resource mobilization and volunteers for construction work (Nyonator et al, 2002).

The next step is the procurement of essential equipment such as clinical equipment and means of transportation; for example motorbikes.

Posting Community Health Officers to the compounds is the most critical stage. It is the stage in which most communities are enthusiastic about. The responsibility of the Community Health Officer include the following: provision of clinical sessions at the compounds, making household visits to provide Family Planning Services, Health Education and ambulatory care and implementing outreach clinics for childhood immunization (Nyonator *et al*., 2002).

Deploying volunteers is the next step. In doing this a six weeks" course in community mobilization with particular emphasis on promoting Family Planning and Reproductive Health among men is organized. In some districts volunteers deliver Health and Family Planning Services. Implementing the program involves a durbar for celebrating the creation of volunteer services, educating communities about referral services, and linking volunteer-based services with the activities of the local health officer and the clinical services of sub-district health centers and district hospitals (Nyonator *et al*, 2003).

Ideas and innovations are spread through social network through mechanisms collectively called diffusion. For decades social theorists have argued that diffusion theory is relevant to health and population policy because official action can be taken to accelerate the onset and pace of social change or expand the scope of informal processes (Rogers, 1995). Diffusion theorists have also noted that exchange and interaction can lead to organizational change (Glaser *et al*, 1983).

Social diffusion refers to the process of ideational or behavioral change fostered by social interaction. Organizational diffusion is an analogous process in which change can occur through the communication of ideas or the demonstration of new methods (GMHI,2005).

The component activities of the CHPS as stated above have been designed to foster the diffusion of operational innovations as derived from the Navrongo experiment and Nkwanta project.

The CHPS activities are designed to maximize the likelihood that the process of diffusion will begin, be sustained and be amplified by program activities and resources.

2.10 Other effects observed in some communities

A report of the CHPS Monitoring and Evaluation Secretariat to the Ghana Health Service on February 8, 2002 made the following findings.

(1) In the communities where there is moderate development of CHPS there was confusion about the nature of the program. Conventional outreach clinic activities that have been in operation well before the CHPS programmes are sometimes labeled as "CHPS". In communities where the CHPS program is well developed, there was adequate knowledge of its nature.

(2) Reports from Hohoe and Keta indicated that, while the community leaders knew about CHPS the male participants of the focal group used in the qualitative assessment did not. This suggested that efforts to inform community members through leaders were insufficient and not wholly effective. While outreach to leaders is essential to getting started, the introductory programme must extend beyond community entry to include the provision of general community information and educational activities.

A report of qualitative assessment in the Volta Region on the perceptions, attitudes and reactions also submitted by the CHPS Monitoring and Evaluation Secretariat to the Ghana Health Service in February, 2002 noted the following.

(1) The CHPS programme was widely lauded but there was desire for a resident nurse on 24-hour call. Even where there is little tangible implementation of CHPS activities, and only vague awareness of its elements, community members are universally enthusiastic about the idea of CHPS and strongly support the commitment of voluntary assistance to making the community Health Officer productive and comfortable.

(2) The component of CHPS of most interest is the relocation of nurses from clinics to the community and the perception that this will make curative health services more accessible and affordable by reducing travel costs for first-aid or minor medical treatment. This was reported from Nkwanta.

During the Focal Group discussions the participants raised the following concerns which may shed light on the perceptions of community members of the nature of CHPS.

(1) They wanted diverse drugs of lower cost and also the administration of intravenous fluids by nurse. That indicated that the concept of CHPS was not well understood.

(2) In general, the concept of referral was not well understood.

(3) They wanted two community Health Officers to be at post.

(4) They were less enthusiastic about voluntary work.

(5) They entertained concerns about the character of a newly posted nurse and also about high rate of turnover.

According to progress report submitted to the Ghana Health Service Monitoring and Evaluation Division on December 31, 2000 and on December, 2002, twenty-two out of the then 110 districts have implemented the CHPS Programme in the year 2000.

A report on a multi–level qualitative assessment in the Volta Region by the CHPS Monitoring and Evaluation Secretariat of the GHS, February 8, 2002 noted the following:

Implementation of the CHPS initiative had had a dramatic effect on the lives of the Community Health Officers. The remote placement results in the CHO"s inability to visit family members. It has also brought about changes in family life because some CHOs have their husbands working elsewhere and children who attend school elsewhere.

Despite these hardships, CHOs discussed with pride the remarkable health benefits that the CHPS programme provided for the community. They described CHPS as an initiative which provided coverage, increased antenatal care and reduction in child and maternal deaths. Furthermore, the community's relationship with the CHO was such that the community members were able to talk freely to the CHO about their health problems. In addition CHPS programme

provided the community nurse the opportunity to develop new skills from the varied experiences of her work. CHOs have been taught to assist with childbirth and have had additional training in curative treatments.

The CHOs interviewed had numerous expectations when their districts began initiating the CHPS process. Initially, some CHOs expressed fears about forfeiting their chances to further their education. On the other hand, many CHOs were expecting to become more autonomous in their new professional role and this conveyed a sense of pride and status that was lacking in their role.

Although CHOs were not looking forward initially to being placed in communities, and have experienced many hardships, they have come to appreciate deeply the professional satisfaction they received from the work.

The range of services that the CHOs provided to the community was varied and exhausting. The CHOs that were resident in the community were kept busy virtually all day and many nights.

While CHOs were initially concerned about the many personal and familial problems that they experienced, these subsided if communities were enthusiastic for the

programme and supervisory support helped them overcome these initial concerns and focused more on the professional satisfaction they achieve from their work.

The Community Health Officers, as reported from Hohoe and Nkwanta in the Volta Region usually had accommodation and utility services problems initially. Many of the initial challenges were resolved through the contributions of the community, the DHMT and the World Vision International.

The Nurses in both Nkwanta and Hohoe had long list of requirements they felt were important in order to have a reasonably comfortable life and successful work. That list included financial incentives for long hours of work and rural living and hard work allowance. They needed motor bikes, rain coats and boots. They required portable water supplied to their CHC water storage, proper toilets for themselves and a separate facility for their clients. They require electricity - either mains or solar generated to run a refrigerator to store vaccines as well as for the comforts of lights, radio and TV.

The district manager of Nkwanta had provided poly or cement tanks for water storage, motor bikes and drugs. At the request of CHOs, the District Director had helped build an additional separate structure to provide health services for clients. With this history, the Nkwanta CHOs seemed optimistic about the handling of their requests. The CHOs at Hohoe, however, who had been given little of the support they had requested, seemed less optimistic about their needs been satisfied in the future.

Developing a capacity to respond to ad hoc living arrangement problems is crucial to sustaining morale among others.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter deals with the methodology. It begins with a description of the study area, study design, study population, sample size determination, study area/research setting, sampling procedure, ethical consideration and limitation to the study. It also describes the research instruments used in data collection, the administration of instruments, data processing and analysis and quality control measures.

3.1 Study Area

The study was conducted in the Binduri District of the Upper East Region of Ghana. The district is one of the new districts that were created following districts demarcation in 2012. Thus the district was previously in the Bawku Municipality. The district is located approximately between latitudes 11° 11' and 10° 40 ' N and longitude 0° 18 ' W and 0° 6 ' E in the north-eastern corner of the region. It shares boundaries with Burkina Faso, Bawku Municipality, Bawku West district and Garu-Tempane district to the north, east, west and south respectively. The district capital is Binduri. The population of the district can be projected to be sixty thousand two hundred and ninety three (60,293) and this population is predominantly rural with health implications. Predominantly, the people of the district are the Kusasi, Bissas, Mumprusis and Moshie tribes. Despite the spatial nature of the settlement, the district enjoys good number of health facilities across the entire district. There are currently Eight CHPS Compounds in the district. These include Aniisi CHPS, kukparigu, Nafkolga, Bansi, Zawse, Bansi, Manga and Azumsapeliga

CHPS. Also, the District is divided into seven subdistricts for easy health delivery. The major economic activity of the people is agriculture. This is done on subsistence basis of which dry season gardening is done along the White Volta tributary and in other dug outs. As a result of this dry season farming the District is noted for its seasonal boom of water melon and onions.

Three of the CHPS zones (Table 3.1) namely Bansi, Nafkolga and Zawsi CHPS have populations more than what is expected of a CHPS zone to handle. Zawsi population for instance is twice what a demarcated CHPS Zones is supposed to cover as per the revised CHPS policy which states that a CHPS zone should have a population of 4500-5000.

Table 3.1: CHPS Zones and the Population they serve

Name of CHPS Zone	Population 2015
Manga CHPS	4301
Aniisi CHPS	2472
Kukparigu CHPS	2865
Azumsapeliga CHPS	4452
Nafkoga CHPS	5624
Tetauko CHPS	1370
Bansi CHPS	8615
Zawsi CHPS	10498
Total	40196

3.2 Study Design

The study is cross sectional descriptive study and employed both quantitative and qualitative designs. Cross sectional studies measure certain phenomena (events, behaviour, attitudes) in the population of interest. Data is collected at one point in time and no follow-ups are made. These types of surveys are called descriptive surveys because the information is collected from a sample of the population of interest and descriptive measures or statistics are calculated. The respondents are generally asked to answer questions on events, feelings and behaviour

retrospectively therefore the surveys are called retrospective studies. Since the study is evaluating the CHPS concept, respondents are going to give their responses retrospectively.

3.3 Study population and sample size

The study population covered the Community Health Officers (CHOs) and the community members (mothers and caregivers of children 0-59 months in selected households) in the sub districts where the CHPS compounds are located, members of health directorate and the members of the District assembly also formed part of the sample. Thus the research considered four major groups of respondents. A total sample of 152 community members (mothers or caregivers of children 0-59 months) and CHOs were considered for the study. Four focus group discussions were held with opinion leaders in four randomly selected CHPS zones .

3.4 Sampling Frame

The sampling frame for this work were all communities being served by each of the CHPS compounds specifically on completed CHPS zones and not functional CHPS Zones. This is because each CHPS compound is zoned such that it can render health services to a number of communities.

3.5 Sampling procedure

The study used the Lot Quality Assurance Survey (LQAS) methodology of sampling. In the first place, all the CHPS zones were considered as clusters (that is 8 clusters) and the communities within each zone had their population enter into the LQAS calculation worksheet v1.0 June, 2012. This automatically calculated and located the clusters where the interviews were to be conducted. In each cluster, 19 interviews were conducted using a simple random sampling

to select households in which there are children 0-59 months and their mothers or caregivers were the respondents. Also, all the CHOS that were available during the day of the interview were interviewed using a structured questionnaire. In all 19 staffs of the CHPS facilities were selected for the interview. However, in certain zones the entire staff population of the CHPS health facilities was used when it was realized that the health officers were not many and would necessitate sampling. Also, the planning officer and his or her team from the district assembly as well as the District health management team formed another group of respondents. Four CHPS zones were also selected using simple random sampling for focus discussion for community opinion leaders.

3.6 Variables

The variables measured in this study included utilization of the CHPS services by the community members; this variable was measured in frequencies, which were; the number of visits if any to the CHPS compound to access health care by the household members of the community in the past six months, reason(s) of visit and reasons of no visit, distance to CHPS compounds, health insurance, presents of staff for 24 hour services, home visits by CHOs, durbars organized by CHOs, the usual variables such age, sex, education, employment and religion were considered. The variables in the second objective was based on the available health services rendered by the CHPS compounds and the evidence of such services been rendered, this was measured based on the number of available reports (documented evidence) of services rendered. The third objective measured variables such as the number of concrete challenges faced by both the frontline health staffs (CHOs) and the District health directorate in implementing CHPS services to the core. Here qualitative information was collected and put into perspectives. The forth objective measured variables such as the existence of community health committee members, community

health volunteers and the kind of contribution or support they have been given to the CHPS compounds or the CHOs. The measurement of the contribution of the District Assembly in the implementation of the CHPS programme and the geospatial analysis of the CHPS compounds in the district was done in the fifth and sixth objectives.

3.7 Data Sources

The data for the study was collected from at least four main sources (community, District assembly, District health directorate and the CHPS compounds); secondary data was collected from the health department of the district while primary data was collected from the CHO and the community members. The aim was to obtain comprehensive information on the research objectives. The primary data from the respondents included for instance the perceptions of the community members on the CHPS facilities and services.

3.8 Data Collection Instruments

A semi - structured questionnaire will be used to collect primary data from respondents.

Data gathered from the field was cleaned and entered into computer data base using the SPSS software version 20.0 for Windows. A 95% confidence interval was set for test of significance. Chi-square values and P-values were used to compare or establish the impact of CHPS on health care delivery.

Logistic regression analyses were conducted to determine the factors that contribute to the use of CHPS compounds and also the challenges that affect the provision of health care services in the CHPS compounds. The confidence intervals, P-values and Odd Ratios of these factors were used to establish their statistical significance and their relative contribution to the use health of

services in CHPS compounds and also the challenges health care providers face in the provision of health services.

The questionnaire allowed the respondents to express their opinion on the CHPS program, as well as the way forward for the package. On the other hand, a Focus Group Discussion guide was developed for Focus Groups Discussion session. A checklist or template was also developed to collect information on health services rendered at the CHPS level. Also, proximity or Spatial data was collected to measure the distance of the selected communities which have been served by each CHPS compound by the use of Geographical Positioning System (GIS).

3.9 Data Analysis and Presentation

The quantitative data was analyzed using the Statistical Package for Social Sciences (SPSS) software, invivo was used for analyzing the qualitative data and ArcGIS was used for Spatial analysis and other GIS works.

The major technique that was used for the data analysis is the quantitative method. Thus the analysis was centered on frequencies and percentages as well and description. The data after analysis was presented using tables, charts, graphs and community or CHPS zone maps relative to respective communities that have been served by the respective CHPS compounds.

Statistical difference was considered significant if the P-value was less than 0.05 and 95 % Confidence Intervals (CI) was calculated for all main outcome measures that met the normality and homogeneity criteria.

Multiple logistic regression analysis was used because the main outcome variable was binary and it also allows for testing for confounding and independent contribution of potential factors that

influence birth preparedness. This type of regression also gave the P-values together with the confidence intervals of the individual factors that were identified. This was helpful in determining factors that were statistically significant.

The focus group discussions were recorded with a voice recorder after which the recorded tapes were transcribed. A thematic analysis was then carried out for this qualitative data.

3.10 Geospatial Analyses of health facilities and CHPS Compounds

The study used a georeferenced database and digital topographic data on road networks of CHPS compounds providing health care as input to a network analysis algorithm to measure the distance from each community in the CHPS zone to the nearest CHPS compound.

The list of health facilities was compiled from the District health Directorate and a geo-referenced list of health facilities compiled by the Upper East Regional Town and Country Planning Office. The lists were cross-checked and reconciled.

Facilities without latitude and longitude values were georeferenced manually by matching with facility and community names on Google Earth. The Binduri District Health Directorate was also contacted to confirm the locations of all the communities under the CHPS zone.

Where there was more than one facility at a single location (either because they shared the same building or because they were georeferenced using a village location) the highest order facility was retained for subsequent analysis, thus, avoiding duplications. In all there were 8 geo-referenced CHPS compounds throughout the Binduri district.

The health service delivery audit was used to classify the status of the facilities based on the signal- functions they offer. Facilities offering skilled delivery services, antenatal care services,

postnatal care services, family planning services and treatment of mild illness and have met all the six milestones CHPS strategy were classified as functional CHPS compounds.

3.11 Plans for Dissemination of Results

The final results of this study will be significant enough for decision making and policy change at the District Health Directorate and District Assembly levels, even at the community level. So the results of this study will be disseminated to the people of the Binduri District assembly during any session of the assemblies meeting and copy of the report will also be given to the assembly. Also, the results will be shared with the District health Directorate during their half year or annual review meetings.

3.12 Data Quality Assurance

Pre testing: Pre – testing of the research questionnaire was done to eliminate possible challenges before the actual administering of questionnaire is done. Twenty (20) questionnaires were administered in each of the CHPS communities in the Binduri district.

Training of Data collectors: There was a training session held for the research assistants who assisted in the data collection to ensure that valid and reliable data were collected. The training gave the data collectors much insight into the questionnaires and what it sought to achieve.

Double entry: Double entry of data was done after which the two data sets were compared at the analysis stage. This helped in identifying some omissions during the data entry.

3.13 Ethical Considerations

In order not to infringe on the rights of the study participants, some ethical issues were considered. Firstly, permission was sought from the District Director of Health Services of the Binduri District before conducting the study. The questionnaires were also approved by the District Director before they were administered.

Secondly, the consent of the respondents was sought through by writing and a verbal or informed manner. The rationale of the study was clearly explained to the study participants.

Again, participation in the study was voluntary. None of the participants was coerced or deceived to take part in the study. They were also at liberty to withdraw from the study when they felt like doing so.

Furthermore, anonymity and confidentiality of the actual source(s) of information obtained from the study was ensured by not indicating the names of facilities and individuals who took part in the study. Names were not provided on the data collection tools and therefore no clues were provided for someone to trace the source of information

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the data analysis and findings of the study. Results of the quantitative arm of the study are presented in tables whilst extracts of the key informant interviews from the various respondents are presented as the results of the qualitative study. The respondents were selected from 8 communities where the CHPS compounds are situated.

4.1 Socio Demographic Characteristics of Caregivers

The results show that majority of the caregivers representing 92.8% (141) were married whilst 3.9% (6) were single. Majority of the respondents that is 60.5% (92) were illiterates whilst 1.3% (2) were educated to the tertiary level. About 24% (37) were educated to the primary school level whilst 11.8% (18) of them were educated to the JHS level as shown in table 4.1 below.

An assessment of the occupational status of the caregivers showed that majority of them thus 75.0% (114) were farmers whilst 10.5% (16) of them were traders. Only 1 person was unemployed with 1.3% (2) being civil or public servants. Table 4.1 below shows the socio demographic characteristics of the respondents.

Table 4.1: Socio -Demographic information of Respondents

Variable	Frequency (n)	Percentage (%)
Marital Status		
Single	6	3.9
Married	141	92.8
Widowed	5	3.3
Educational Level		
Illiterate	92	60.5
Primary	37	24.3
Basic	18	11.8
Secondary	3	2.0
Tertiary	2	1.3
Occupation (women)		
Unemployed	1	0.7
Trader	16	10.5
Farmers	114	75.0
Civil/ Public service	2	1.3
Student	5	3.3
Craftsmanship	14	9.2

Source: Field Survey, June 2015

4.2 Utilization of Health Services from the CHPS Compounds

Descriptive statistics of the category of staffs at the CHPS compounds were used in order to assess the quality of services provided at the CHPS centers. Respondents were asked to rate some items namely, the adequacy of human resource, emergency services, Drug availability, Staff Customer relationship, Staff availability, Facility availability and availability of Equipment and Logistics (weighing scale, BP apparatus, thermometer etc) on a five points scale with five being very high quality and one being poor quality.

Table 4.2 below shows the summary statistics of the ratings of these items. It was found that Equipment and Logistics (weighing scale, BP apparatus, thermometer etc) had the highest ratings (446) with mean rating of 2.93, followed by drug availability (418) and mean rating of 2.75. the

least ratings was found with availability of facilities(256), with a mean rating of 1.68, followed by staff – customer relationship(351), with a mean rating of 2.31. An ANOVA (Analysis Of Variance) was performed to test for significant differences in ratings of the service items between the CHPS compounds. As shown in Table 4.3 there were statistically significant differences in ratings for all the items with P-values less than 0.05. In other words, for each of the items, the ratings by the respondents varied significantly.

Table 4.2 : Resources of CHPS compounds

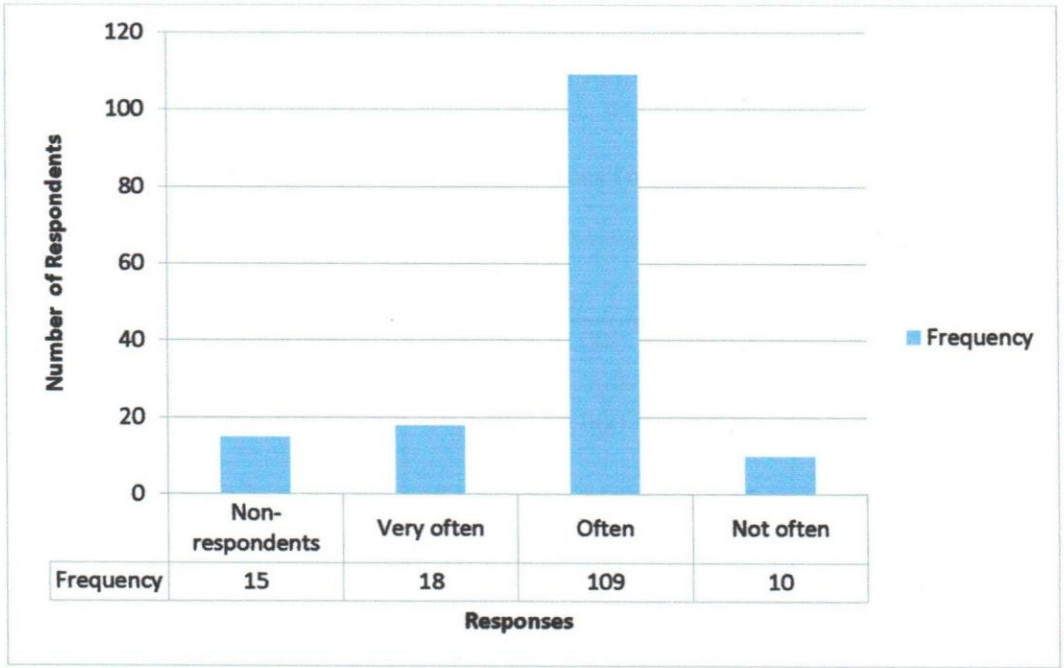
Community		Human resource(staff)	Emergency service	Drug availability	Staff Customer relationship	Staff availability	Facility availability	Equipment and Logistics(weighing scale, BP apparatus, thermometer etc)
Boko 2	Sum	49	56	57	44	58	57	58
	Mean	2.58	2.95	3.00	2.32	3.05	3.00	3.05
Yarigungu 1	Sum	44	48	47	45	53	19	59
	Mean	2.32	2.53	2.47	2.37	2.79	1.00	3.11
Kpalugu2	Sum	38	38	39	37	41	19	57
	Mean	2.00	2.00	2.05	1.95	2.16	1.00	3.00
Bansi-Bulugu	Sum	43	39	41	29	40	19	53
	Mean	2.26	2.05	2.16	1.53	2.11	1.00	2.79
Tambiigu	Sum	54	60	64	52	52	52	48
	Mean	2.84	3.16	3.37	2.74	2.74	2.74	2.53
Gumyoko 1	Sum	59	64	63	59	71	23	67
	Mean	3.11	3.37	3.32	3.11	3.74	1.21	3.53
Kpatarigu	Sum	58	56	62	42	52	46	48
	Mean	3.05	2.95	3.26	2.21	2.74	2.42	2.53
Ziako	Sum	38	43	45	43	47	21	56
	Mean	2.00	2.26	2.37	2.26	2.47	1.11	2.95
Total	Sum	383	404	418	351	414	256	446
	Mean	2.52	2.66	2.75	2.31	2.72	1.68	2.93

Table 4.3: Comparing mean ratings between service items

Indicator	Sum of Squares	df	Mean Square	F	P-value
Human resource(staff) * Community	26.257	7	3.751	7.330	0.000
Emergency service * Community	36.000	7	5.143	8.395	0.000
Drug availability * Community	39.658	7	5.665	7.781	0.000
Staff Customer relationship * Community	29.941	7	4.277	5.573	0.000
Staff availability * Community	36.184	7	5.169	8.438	0.000
Facility availability * Community	101.579	7	14.511	36.492	0.000
Equipment and Logistics(weighing scale, BP apparatus, thermometer etc) * Community	14.289	7	2.041	4.662	0.000

4.3 Frequency of Use of CHPS Services

An assessment of the frequency of utilization of health services in the CHPS compounds shows that 71.7% (109) of the respondents said that they often used CHPS services whilst 11.8% (18) of the respondents said that they used health services from CHPS very often. Figure 4.1 shows the frequency of use of health services in CHPS compounds.



Source: Field Survey, June 2015

4.4 Factors that Contribute to the Use of Health Services from CHPS

In multivariate analyses, the study assessed the contribution of individual factors to the use of health services provided in the CHPS compounds. The results show that proximity of the CHPS compounds to respondents was a strong predictor of the use of services of CHPS compounds. This is due to the reduced walking time (OR = 0.013, CI 0.003 - 0.053), p< 0.001. The study also found that the availability of health personnel in the CHPS compounds to provide health care services is a contributing factor to the use of health services. (OR= 7.735, CI: 3.652-4.940) p< 0.001. Other factors that contribute to the use of health services from the CHPS compounds include involvement of community health committee members (OR= 4.915, CI: 2.408-10.03) p<0.001, ability to handle emergency cases (OR= 0.002, CI: 2.97-6.87and visitations by CHOs to women in their houses (OR= 0.735, CI: 0.573-0.941) p<0.015. The table below shows the determinants of the use of health services offered in CHPS compounds.

Table 4.3: Determinants of use of health services from CHPS

	Wald	Sig.	Exp (B)	95% C.I.for EXP(B)	
				Lower	Upper
Proximity to CHPS compound	36.244	0.000	0.013	0.003	0.053
Availability of a nurse/midwife	79.338	0.000	7.735	3.651	4.940
Involvement of community health committee members	19.139	0.000	4.915	2.408	10.030
Households visitation by CHOs	5.947	0.015	0.735	0.573	0.941
Ability to handle emergency cases	0.926	0.002	0.005	2.97	6.87
Affordable treatment cost	0.142	28.014	0.004	1.15	0.438
Constant	33.232	0.000	0.001		

4.5 Perception of the Community Members on the Health Services Provided by CHPS

The study assessed the extent to which health services provided by CHPS meet the health needs of community members. The results show that 53.9% (82) said that the health services are easily accessible to them during emergencies. The study also found that 40.8% (62) said that CHPS compounds are able to treat mild illness or ailments. Table 4. 4 shows the perception of community members on the health services provided by CHPS compounds.

Table 4.4 : Perception of community members on services provided at the CHPS compound

Response	Frequency	Percent
Easily accessible emergency health services	82	53.9
Treatment of mild illness	62	40.8
For Immunization	5	3.3
Not good; the health personnel are not always available	3	2.0
Total	152	100.0

Source: Field Survey, June 2015

4.6 Satisfaction with Health Care Services Provided in the CHPS compounds

To illicit the satisfaction of respondents with regards the drugs administered to them ,respondents were asked to indicate their degree of agreement or disagreement with a statement regarding health care by choosing one of these responses: always, usually, and sometimes. The instrument developed for this study included 3 Likert-type items that sought to get the reaction of respondents with respect to drugs/medicine received:

i. How often did staff explain about medicines before giving them to you?

ii. Before giving you any new medicine how often did hospital staff tell you what the medicine was for?

iii. How often did hospital staff describe possible side effects in a way you could understand?

Responses were then coded as follows: "Sometimes/never = 1," "usually = 2," and "always = 3." Individual overall satisfaction scores were computed for each respondent by summing scores on each of the three items.

The relationship between patients and nurses has an effect on the healing process of patients. Patients have the right to know the types of drugs they are given and the possible side effects of these drugs. It was found that majority of the respondents forming 74.3% (113) said that nurses always explained the use of drugs given to them. About 54% also reported that nurses talked to them about new medicines given to them for their treatment. About 50% (76) of the respondents reported that nurses described to them the possible side effects of the drugs given to them. Table 4.5 shows the satisfaction of respondents with services rendered at the CHPS compounds.

Table 4.5: Description/Explanation of drugs to patients at the CHPS compounds

Variable	Frequency	Percentage
Nurse explained about medicines		
Always	113	74.3
Usually	27	17.7
Sometimes/never	12	8.0
Nurse talked about new medicines		
Always	83	54.6
Usually	46	30.3
Sometimes/never	23	15.1
Described possible side effects		
Always	76	50.0
Usually	43	28.3
Sometimes/never	33	21.7
Satisfaction with medicines		
Yes	120	78.9
No	32	21.1

Source: Field survey, 2015

4.7 Distance between Survey Communities and Respective CHPS Compounds

A geospatial analyses was done to assess the distance of communities in all the CHPS zones to the CHPS compounds. An audit was done based on the geospatial analyses to compare the services rendered in the CHPS compounds and the distance patients have to travel before accessing these services as shown in Figure 4.3 and table 4.8 below. The study found that respondents who stayed close to a CHPS compound used ANC, skilled delivery services and sought health care frequently.

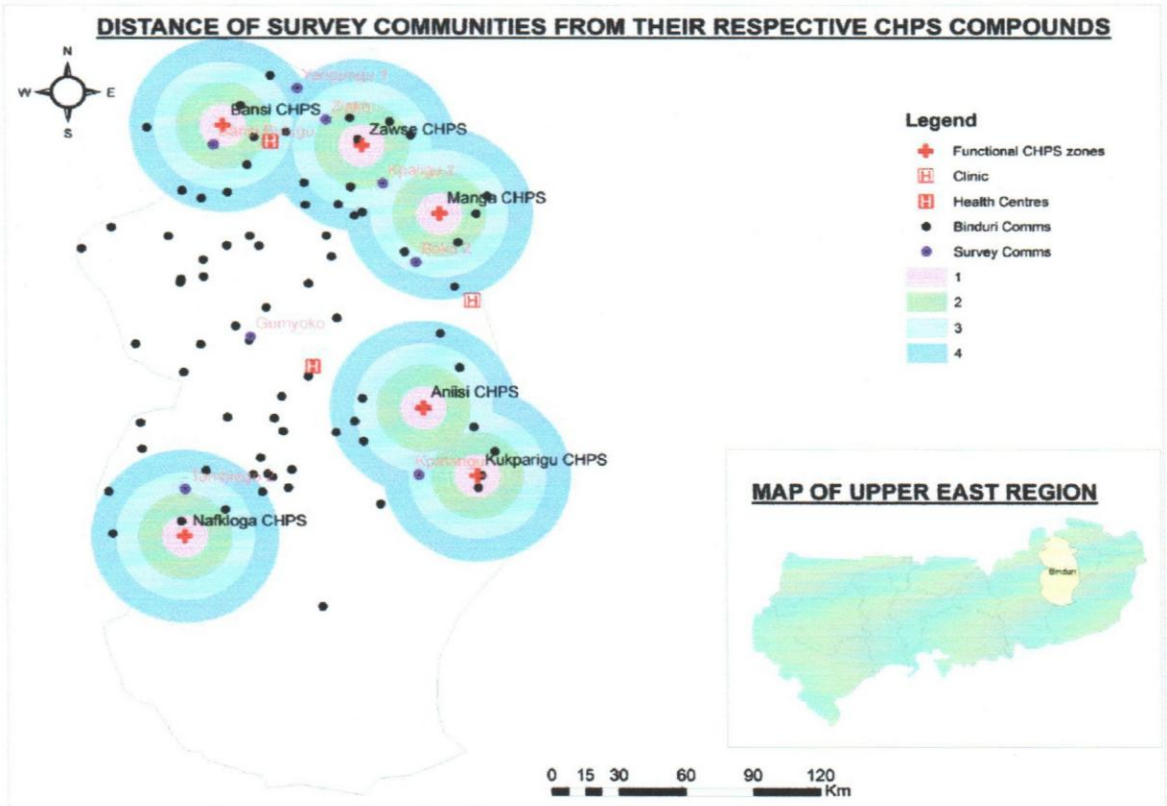


Table 4.6: Contribution of CHPS to Key Health Indicators, 2014

				BCG	OPV3	Penta 3	Measles	Emergency Delivery	Referrals	UNDER 5 ATT
Name of CHPS	**OPD Per Capita**	**EXP. PREG**	**ANC**	**CONTRIBUTION TO IMMUNIZATION (%)**						
Aniisi	1	131	0	2.8	5.4	5.4	6.1	0	39	960
Kukparigu	0.4	128	15	3.5	6.2	6.2	5.5	0	3	422
Nafkolga	0.4	212	50	8	8.9	8.9	8.8	0	7	746
Manga	0.4	178	0	5.4	7.2	7.2	6.8	0	8	662
Bansi	0.1	335	37	9.9	9.1	9.1	10.1	0	6	515
Azum-sapeli	0.05	173	0	0.2	1	1	0.6	0	0	90
Zawse	0.2	367	95	19.7	17.8	17.8	17.7	29	4	807
Total	2.55	1524	197	49.5	55.6	55.6	55.6	29	67	4202

4.8 Health Services Provided by CHPS compounds

The range of health services community members access at the various CHPS compounds are shown in the table below, most of the these health services are immunization (71.1%) and treatment of clinic symptoms (77.6%) either the caregiver of the child or the child itself. Family planning (21%), Nutrition rehabilitation (7.2%) and emergency are among the least of the health care services patronized.

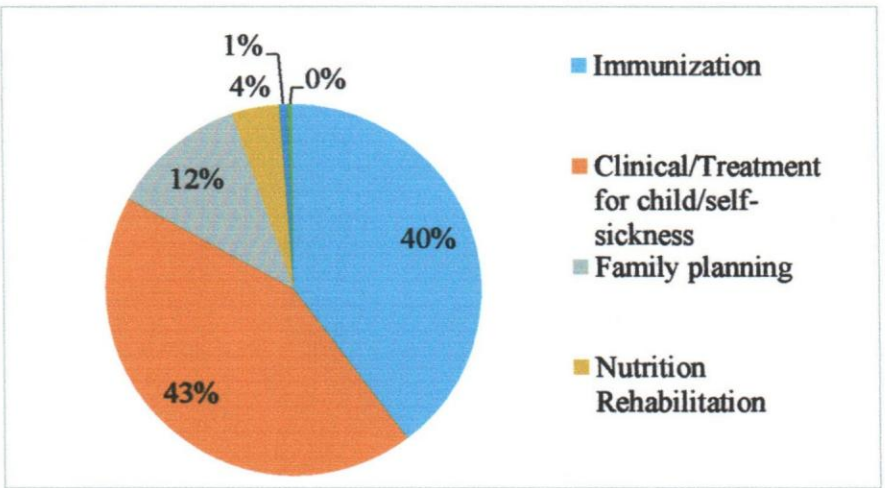


Figure 4.3: Kind of services sought by respondents
Source: Researcher's Field Survey, June 2015

Table shows the range of health services provided by CHPS Compounds, at least with the exception of Disease Surveillance (94.7%), Antenatal (47.4%), and emergency delivery and (36.8%) all the other rest of the health services are 100% provided. The areas that are not 100% are not usually the core area of the Community health officers as stated in the revised CHPS policy. Services such as antenatal, delivery are a preserve of midwives.

Table 4.7: Range of health services available at the CHPS compounds

Type health Services	Yes	%	No	%
Immunization	19	100.0	0	0.0
Family Planning	19	100.0	0	0.0
Treatment of minor ailment	19	100.0	0	0.0
Nutrition rehabilitation	19	100.0	0	0.0
Treatment of minor ailment	19	100.0	0	0.0
Health Education/Promotion/Community durbar	19	100.0	0	0.0
Disease surveillance	18	94.7	1	5.3
Antenatal services	9	47.4	10	52.6
Postnatal/CWC	19	100.0	0	0.0
Emergency delivery	7	36.8	12	63.2
Referrals to high level of care	19	100.0	0	0.0

Source: Researcher's Field Survey, June 2015

4.9 Challenges to Health Care Delivery at the CHPS Compounds

Barriers to health care provision could be classified under geographical, financial and social barriers. In this study, an assessment of the challenges to the provision of health care services in the CHPS compounds showed that lack of means of transport is a barrier to both clients and service providers (OR=1.2, CI: 0.6-2.1)P< 0.001. Health service providers find it difficult to travel to the health directorate and health centres for their drugs.

Inadequate water supply to the CHPS compounds was also cited as one of the challenges facing health care delivery in CHPS compounds (OR=2.4, CI:1.0.91 -5.4) P<0.002. Water is

needed especially during delivery of pregnant women by midwives to bathe the baby and also wash the equipment used during delivery.

Inadequate supply of drugs to CHPS compounds is also a challenge to the provision of health care (OR= 0.3, CI: 0.1-0.6) p<0.02. The study found that lack of essential drugs in the CHPS compounds is a challenge to health care delivery. Table 4. 8 shows the barriers to health care delivery in CHPS compounds.

Table 4.8 Barriers to the provision of health care services in CHPS compounds

Predictor	Wald	Sig.	Exp(B)	95% C.I.for EXP(B)	
				Lower	Upper
Lack of means of transportation	0.3	0.001	1.2	0.6	2.1
Inadequate water supply	5.2	0.002	2.4	1.0	5.4
Clients come with invalid cards	64.9	<0.001	0.1	0.1	0.2
Difficulty in organizing weighing sessions during raining se	31.7	0.005	1.6	1.4	5.8
Inadequate supply of drugs	11.8	0.02	0.3	0.1	0.6
Constant	3.530	0.016	0.244		

Source: Field Survey, 2015

Table 4.9: Table Availability of equipment

Essential Health Equipment	Yes	%	No	%
*Motorbike	8	100	0	0.0
Vaccine fridge available	1	12.5	7	87.5
Rack sack bag	7	87.5	1	12.5
Registers	8	100	0	0.0
Raincoat	0	0	8	100.0
Torchlight	0	0	8	100.0
Weighing scales	8	100	0	0.0
First aid medicines	8	100	0	0.0
Bed provided by the GHS/Community	7	87.5	1	12.5
Cooking utensils provided GHS/Community	1	12.5	7	87.5
TV/radio	1	12.5	7	87.5
Bicycles	1	12.5	7	87.5
Availability of water for CHPS compound	2	25	6	75.0
Do you have means for referring cases?	0	0	8	100.0

Source: Researcher's Field Survey, June 2015

4.10 Results from the Focus Group Discussions

Focus group discussions (FGDs) were organized to assess the community members' perceived ownership of the CHPS compounds, their involvement and level of consultation in the planning of health services and how the CHPS compounds are able to address the health needs of the community members.

4.10.1 Community Members perception on the ownership of CHPS compounds

Resource mobilization

The participants discussed the community members' involvement in the establishment and ownership of the CHPS compounds.

Findings from the interviews revealed that the communities had made significant 'in kind' and 'cash' contributions to support the program. Contributions in kind took the form of water, sand, purchase of stones, among others for the construction and maintenance of CHPS, as well as the labour to build and sustain the buildings. Contributions were also made in cash to support the building and maintenance of the CHPS program. There are committees that assist in the delivery of health care services. The community members have a sense of ownership of the CHPS compounds. These are some of the statements from the participants;

..."The Community made an appeal to the former Member of Parliament during one of his campaigns.. The community kept on reminding him until the contractor came and built it. It was a community imitative"... (A respondent from Manga)

..."we were told that officials from the Bawku Municipal Assembly came to identify a place here to build a facility for us because people were complaining that the hospital was far and also in the Mamprusi area so people were always afraid to go to the hospital. The chief and elders of this community gave them a plot of land to build the CHPS compound".. (A ....(Zawse Community)

The findings suggested that contributions to labour and materials were made by a wide range of community members irrespective of their economic status or gender.

...we supported by fetching water from the dam for the construction. Some people also helped by fetching sand and gravel"...

...."a meeting was held in the chiefs palace to consider the location of the CHPs because they did not want to build it to the advantage of others, so they decided to locate just by the school because its central of the town. I was also at the chiefs palace during the meeting"...

...."We contributed by fetching sand and water for the construction because the church said that if we don't support the contractor he can't complete on time. People were tasked to use their donkey carts to fetch sand and water"...

The discussions also revealed that the community members have a high sense of ownership of the CHPS compounds. These are some extracts from the discussions;

...."we see it to be ours, because if even Government build the structure it is now for us so we have to take care of it and the workers there too"....

...."I was told that by my late father that, there was a meeting in Binduri market and the DCE by then was there and the Chief of Nafkolga complained that Binduri clinic was far from Nafkolga so the assembly should consider building a clinic in Nafkolga. Alem Nicholas what I know is that the assembly man and the chief wrote a letter to Bawku council for the building to be constructed. It was a community imitative"...

..."my father use to tell me that he was a watchman at the facility when it was been put up, so am sure he was taking care of the contractors items. I remember the late chief also made the contractor to fetch stones free around Yarigugu"..

...."I remember when they were building the CHPs I was a bit young and me and my friends carried concrete and some men were also carrying water with donkeys for the construction. We also helped by taking care of the place especially in the night so that thieves don't steal the contractor's items. His workers were even sleeping in people's houses for free. For these reasons I think we legitimately own these facility"....

...."I think that all of us here belief that if the CHPs compound should succeed then all of us need to give the nurses all they support we can give. We have to as community members help them solve any problem they may be encountering in the community. Because if we do not support them they may not want to work here"....

The committees that exist in the communities were formed by the Ghana Health Service in collaboration with the community stakeholders. These communities support in the delivery of health care services in the CHPS compounds. These are some statements of the participants;

...we as volunteers support the nurses by organizing women for their weighing. The women group in the community is active, they organize meetings sometimes with the nurses at the facility for antenatal care services and postnatal care services"...

...we support the nurses in the facility by making sure we solve the problem we can solve. The volunteers also help them by organizing women for weighing. The Women group in the community is active, they organize meetings sometimes, organise the women group to weed around the health facility when it is bushy...

..."we contribute by organizing women for weighing or if there is polio we go round to immunize children. Women group in the community is very active"...

...."there is a committee and am a member, we have contributed by meeting the Director to get the CHPs with a midwife which he did. We also lobbied with the assembly for the renovation of the nurses accommodation when rain destroyed it sometime ago"....

4.10.2 Community stakeholder consultation and Involvement in Health Planning

The discussions also focused on the level of consultation by the Ghana Health Service and the community leadership. These are some extracts from the discussions;

.."a meeting was held at the primary school to decide where the building will be sited. It was at the meeting that the then assembly man told us to support the contractor and also watch over his things in the night"....

..."we have been supporting the nurses and making sure that they are comfortable when working in the community"...

..."I am a volunteer, we help the nurses anytime there is polio, we also inform the nurses whenever there is a new born the community and also organize women for weighing, but we don't dispense family planning commodities. We report on the CBS register monthly"...

...."apart from the nurses involving us as volunteers to set dates for weighing days I can't remember planning anything with the nurses. Sometimes when the nurses are to organize polio exercise, they always go to the chief to inform him"....

....."The chief together with the midwife went to lobby the DCE for the construction of a pavilion for weighing of children. This was done so the women have a place to sit anytime they come for weighing"....

4.10.3 CHPS compounds contribution to address the health needs of the community members

The study assessed the contribution of CHPS compounds to address the health care needs of community members. The participants discussed the changes that have occurred in their ability to access health care before the introduction of the CHPS and also after its introduction. The participants revealed that they have benefited from the CHPS concept. These are some of their statements;

...."a lot of women died in these communities during labour or child bearing because there was no health facility in this community. But since we had the health facility, we don't record maternal deaths again because there is a midwife who attends to women in labour"....

...."we found it difficult to go to hospital because it was too far from us. Most of the sicknesses were treated by herbalists because we could not go to hospital. However, we now go to the CHPS compound which is right here in this community"...

..."diseases which were considered as minor ailments are now reported at the CHPS compounds for treatment. Initially, because we did not have access to hospital some diseases were considered as minor ailments and were treated at home. This led to unnecessary deaths but now people seek health care for every ailment".....

The discussions also revealed that the CHPS concept has improved the use of antenatal and postnatal care services. These are some of the statements from the women;

.."we are able to make a lot of ANC visits because of the proximity of the health facility and the presence of nurses"...

..."Before in the building of this health facility in this community; pregnant women used to make few ANC and PNC visits because of the far distance they had to travel before accessing a health facility. However, we now have a health facility in this community so women are able to get health care very easily"....

4.11 Role of Binduri District Assembly in the CHPS Programme

Key formant interviews were conducted to assess the role of the District Assembly in the implementation of the CHPS programme. The District Chief Executive (DCE) is the head of government machinery at the district level serves as the link between the CHPS process and other social services development program in the district. The DCE and the District Assembly through the Social Services Sub Committee is responsible for working with the District Health Management Team (DHMT) in the selection and prioritization of communities for participation in the CHPS process. An interview conducted with the DCE of the Binduri District showed that he is involved in the CHPS process and the District Assembly supports the Ghana Health Service with funding. These are some statements from the interview;

..."since I took over as the DCE of this district, we have been able to build two CHPS compounds in some rural communities. The communities were selected in collaboration with the Ghana Health Service. This was done to ensure that the communities have access to health care."..

..*"the building of CHPS compounds is one of the priority areas of this current government. This District Assembly is committed to building CHPS compounds in all the communities that are in the remote areas with no means of transport"...*

The District Finance officer (DFO) also that the district is supporting the Ghana Health Service through its District Health Directorate with funds to provide logistics to the CHPS compounds. This is a statement from him;

..."The District Assembly has provided funding and other material support operating the CHPS process particularly for the construction of Community Health Compounds and motivation of CHOs, Community Health Volunteers and the Community Health Committees".....

The study however found that the District assembly is not involve in the day-to-day running of the CHPS compounds. Officials of the District Assembly do not attend meetings with the staff of the CHPS compounds to know the challenges and progress made by the programme in the communities. This is a statement from the District Coordinating Director;

..."the District Assembly is not able to monitor or supervise the activities of the CHPS compounds because we feel that it is the role of the District Health Directorate to perform that activity"..

CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

This study aimed primarily to evaluate the health care services provided by CHPS. The use of health services and accessibility of health facilities to community members was assessed. The main features of the results are discussed in this chapter. The discussion is done by comparing the findings with similar studies conducted by other researchers elsewhere.

5.1 Utilization of Health Services from the CHPS Compounds

Use of health care services is necessary for the prevention of mortalities, especially maternal and newborn deaths. According to Amoako et al (2015) CHPS compounds are set up in rural communities to improved access to care, demonstrating the facilitatory role of CHPS in stimulating access to better care at birth, in areas where health facilities are accessible. The provision of health services is significantly influenced by the numbers and quality of health personnel in the health facilities.

In this study, it was found that equipment and Logistics (weighing scale, BP apparatus, thermometer etc) had the highest ratings (446) with mean rating of 2.93. The results therefore showed that weighing scales, BP apparatus and thermometer were in all the CHPS compounds. These equipment had a high mean score which means that every CHPS compound. This assertion supports the findings of Turkson (2009) who reported that health facilities in Ghana have the less equipment and that simple equipment such as weighing scales for the conduction of ANC services.

The study also found that some of the CHPS compounds had essential drugs while others did not have. The study found that majority of the CHPS compounds had drugs which translated into higher mean rating of 2.75. This finding does not support the finding of Gething et al (2012) who found that none of the CHPS compounds in the Western region of Ghana had drugs for the treatment of minor ailments. The availability of drugs in the CHPS compounds could be attributed to the review of drugs list by the National Health Insurance Authority (NHIA) to include more drugs that are essential for the treatment of most common ailments in Ghana.

This study also found that the CHPS compounds are sparsely distributed in the Binduri District; therefore availability of health facilities had the lowest mean rating. This could limit access to health care services because of the lack of health facilities. This is against the declaration made by the UN on universal health coverage for every person in all parts of the world. It confirms the assertion by the UN (2013) that around one billion people worldwide can't even access the health care they need due to poverty, geographical location and social exclusion. This paves the way for disease outbreaks to become catastrophic epidemics.

The study also found that over 70% of the respondents often used CHPS services. This corroborates the findings of Amoako *et al.*, (2015) who conducted a study to assess the impact of CHPS on the uptake of maternal health services and found that the use of health services in CHPS compounds was high. This was attributed to the proximity of the CHPS compounds to people living in rural areas. This made it possible for them to access these health services easily and at a cheaper cost. This study can therefore affirm that CHPS concept has been beneficial to the Binduri residents since frequent use of health services helps to improve lives and reduce mortalities and morbidities.

5.2 Factors that Contribute to Use of Health Services from CHPS

According to Rhonda et al (2009), several factors influence the use of health care services. These include socio demographic factors, geographic factors and economic status. Oyedokun (2007) in recounting the contribution of economic status to the use of health care services reported that people with high economic status tend to use health services more than those with low economic status. Benefo (2006) in a study in Ghana found that a woman's socio-economic status as well as her life cycle stage affects her use of health care services.

In this study, multivariate analyses were done to determine the individual factors that significantly influence the use of health care services provided in the CHPS compounds. The results show that proximity of the CHPS compounds to respondents was a strong predictor of the use of services of CHPS compounds. This finding confirms earlier finding by Stephenson et al (2007) in their study on contextual influences on the use of heal care services. They found that proximity to a health facility strongly influences the use of health care services. This was due to the reduced walking time and the exemption of transportation cost from the cost of seeking health care. Similar finding was established by National Research Council, (2005) that people living closed to health facilities have the tendency of using health care services more than those who live far away from these health facilities. Other authors who established a similar finding are Mallucio and Thomas, (2003) in Ethiopia and Guilkey and Jayne, (2000) in Nepal.

The study also found that the availability of health personnel in the CHPS compounds to provide health care services is a contributing factor to the use of health services. This finding agrees with that of Lee et al (2011) who reported that building of health facilities without a

corresponding training of health personnel or staff to provide health care in these facilities is not useful. The GHS (2011) also reported that the number of OPD attendants was high in areas where there were enough midwives and nurses to attend to patients. The UN declaration on Universal Health coverage also postulates that health services of all countries should train enough health care providers to make sure that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these health services does not put the user to financial hardships or risks (WHO, 2010).

The study again found that the use of health services from CHPS compounds is influenced by the participation or involvement of community members or their representatives in the planning of health care services. The study found that communities have formed health committees and women group that collaborate with the staff of the CHPS compounds to plan health services. This finding corroborates that of Nyanator et al (2002) who reported that when community members are involved in the planning of health services, it increases and improves the utilization of health services. This could be attributed to the ability of community leaders or stakeholders to convince their people to use these health services due to relationship they have built with their community members. It was found that the committees and women groups helped in the organization of ANC and PNC services through house-to-house visitation assemble the women for these exercises. Involvement of community health committees increased the use of health services.

According to Benefo (2006) on his study on factors that influence the use of health care services among women found that visitation of women by nurses and other health care

service providers influenced the use of maternal health services. This reminded the women of the need to seek health care for themselves and their children. The finding f this study agrees with that of Benefo (2006) because the use of health services provided in the CHPS compounds was significantly influenced by the house-to-house visitation done by CHOs. This means that, the presence and visitation of health care providers especially those in CHPS compounds has the potential of increasing the use of health services.

5.3 Health Services and Satisfaction of Community Members with the Health Services Provided by CHPS

The CHPS concept was inspired by the Alma Ata commitment to primary health care to depart from bureaucratic models of health service delivery. The study assessed the extent to which health services provided by CHPS meet the health needs of community members. According to Debpuur et al (2002), the CHPS initiative is a strategy adopted by the Ghana Health Service in collaboration with District Assemblies to increase rural access to health care service while empowering local communities to take greater control over their health. The results of this study showed that more than 50% of the respondents said that the health services are easily accessible to all community members in the CHPS zones. This implies that the purpose of the CHPS initiative is fulfilling the purpose of making health services more accessible. A study by Koku- Awoonor et al (2007) reported that the CHPS concept sought to promote community-driven health care services, with technical support from the central Ghana Health Service. They further found that, access to health care was improved by more than 40% with the introduction of CHPS. The findings of this study is inconsistent with that of Koku-Awoonor et al (2007) because this study found that more than 50% of

respondents said that they have access to health care services because of the CHPS compounds.

Again, the study found that 40.8% of the respondents said that CHPS compounds are only able to treat mild illnesses or ailments. This is consistent with the report by the Ghana Health Service (2008) that CHPS compounds provide treatment for mild ailments and also maternal and child health services such as family planning, antenatal care, postnatal care and skilled delivery services. The report further stated that complicated health conditions are referred from the CHPS compounds to health centres and hospitals. Due to fact that CHPS compounds treat mild ailments and also provide maternal and child health services; the results of this study showed that CHPS compounds in the Binduri district do immunization, nutrition rehabilitation, family planning and emergency delivery. The study also found that antenatal care and postnatal care services are also provided in the CHPS compounds. These findings are consistent with the findings of other studies conducted by Amoako et al (2015), Baatiema et al (2013) and Simmons and Shiffman (2006) who established that maternal health services such as antenatal care, postnatal care family planning are provided in CHPS compounds. Their studies also found that immunization and other child health services are provided in these CHPS compounds to prevent infant morbidities and mortalities in rural areas.

To illicit the satisfaction of community members with regards to the drugs administered to them in the CHPS compounds, respondents were asked to indicate their degree of agreement or disagreement with a statement regarding health care by choosing one of these responses: always, usually, and sometimes. The main attributes of respondents satisfaction with respect

to drugs dispensed were the frequency of drugs received, the explanation given on the use/function of the drugs and the explanation of the side effects of the drugs. These predictors are similar to that of Anderson (2000) who measured satisfaction of patients with healthcare services using proxies such as communication of health care providers with patients by thoroughly explaining the functions and possible side effects of drugs given to the patients and also the availability of the drugs needed by patients. The same proxies were used by Aldana et al., (2001) to determine client satisfaction with health care services in rural Bangladesh. However, they found that majority (86%) of the patients in rural Bangladesh said that doctors and nurses did not explain to them the drugs that were given to them. There was also insufficient drugs to patients. Clients and patients have the right to know the types of drugs that are given and the possible side effects of these drugs. The study results showed that about 50% of the respondents stated that nurses/midwives always described the functions of the drugs that were given whilst some stated that they were sometimes/never given any explanation of the drugs. These findings are consistent with that of Aldana et al. (2001), who found that more than 86% of patients were not given an explanation of the functions of the drugs dispensed to them.

New drugs that are given to patients should be described to them and they should be taught on the possible side effects of the drugs. The results of this study showed that 41.2% of the patients reported that nurses usually informed them about new drugs given to them whereas, 44.2% said that the possible effects of drugs that were given to them were not explained. They were just given the drugs without any explanation of the possible side effects. The findings corroborate well with that of Balthussen et al.,(2002) in Burkina Faso who reported that nurses and doctors did not explain the side effects of drugs to patients. This is an

infringement on the rights of patients because the Patients Charter requires that patients have the right to know the drugs and medication they receive and decide whether to continue it or not. A study by Turckson (2009) also had similar findings in the Volta region of Ghana where drugs were just been imposed on patients without any explanation of the side effects of the drugs.

5.4 Distance between Survey Communities and Respective CHPS Compounds

A geospatial analyses was done to assess the distance of communities in all the CHPS zones to the CHPS compounds. An audit was done based on the geospatial analyses to compare the services rendered in the CHPS compounds and the distance patients have to travel before accessing these services. It was established that distance to health facility is a key geographical barrier to the uptake of health services focusing on a government initiative that places Community Health Officers in rural communities. The results showed that a substantial proportion of births continue to occur in communities with no access to both health facilities and CHPS, confirming poor access to healthcare in rural communities. It was also found that, respondents who were closer to CHPS compounds used health services such as antenatal care more frequently. This confirms the findings of Gethinget al (2012) and Stephenson et al (2007) who reported that geographic accessibility to health facilities is a barrier to the use of health care services.

Although there are a number of CHPS compounds and facilities in the Binduri District, the results show that access to CHPS facilities for women in labour is very low because they have to travel some distance before getting access to a health facility. This assertion

corroborates the report by Presbyterian Health Services (2014) which found that some women deliver at home in the Upper East region due to the lack of health facilities in their communities.

It was also found that antenatal care attendance and the uptake of skilled birth care is significantly higher in communities with access to conventional health facilities compared to communities where there is no facility whatsoever within 8 km radius. It is also worthnoting that respondents who frequently used health care services had CHPS compounds in their communities.

With regards to communities where CHPS has become functional, irrespective of whether there is a health facility in close proximity or not, the results show that the number of antenatal visits, has a significant positive effect on skilled birth care use, suggesting that contact with health services during pregnancy, whether because of complications or for routine checks, leads to a higher likelihood of giving birth with a skilled health worker.

5.5 Challenges to Health Care Delivery at the CHPS Compounds

The World Bank (2013) reported that Ghana's health system is getting better because of its positive structural attributes. Ghana has a well-established national, regional and district system of hospitals, clinics and health delivery centers, Ghana is producing more doctors; the training of nurses is on the upswing. The World Bank report again indicated that the public health infrastructure of Ghana has achieved full immunization coverage. The public structure is supported by a robust nongovernment health service delivery sector (e.g. Christian Health Association) that provides preventive and curative services and a private health care sector

that provides some emergency services. Despite these positive accolades cited by the World Bank report, the results of this study identified some challenges of health care delivery in the CHPS compounds. Lack of means of transport for the CHOs was found to a barrier to the health care delivery in the CHPS zones of the Binduri District. The CHOs are expected to be reporting to the health centres and also to take their drugs and other equipment for their operation. This finding is consistent with that of Turckson (2009) who assessed the challenges of health care delivery in the Volta and Central regions and found that lack of means of transport is a barrier to successful delivery of health services. According to the study by Turkson (2009) the Ghana Health Service and District Assemblies have not been able to provide motorbikes to CHOs for to enable them move freely into communities to provide antenatal and postnatal care services. In this study, it was found that Binduri district has very bad roads to all the communities where the CHPS compounds are located. Public transport services are also limited making it difficult for health care providers to travel. Health service providers find it difficult to travel to the health directorate and health centres for their drugs. Patients/clients who live within the CHPS zone but not in the communities where the CHPS compounds are located also find it difficult to access travel.

A study by Asirifi (2009) indicated that running water and electricity were not always available in majority of health facilities in Ghana which is adversely affecting the delivery of health care. According to the Ghana Water Company's report of 2013, water used in hospitals and other health care facilities comprises 7% of the total water use in commercial and institutional facilities in the in Ghana. The largest uses of water in hospitals are cooling equipment, plumbing fixtures, landscaping, and medical process rinses. In the CHPS compounds, none of them had any water supply system and therefore depend on the community boreholes or streams which has to be

fetched the CHOs themselves or hired persons. Lack of water supply was said to be a major problem especially during emergency delivery.

The study again found that inadequate supply of drugs to CHPS compounds is a challenge to the provision of health care. There are sometimes reported shortages of essential drugs in the CHPS compounds for the clients and patients. The communities do not have licensed chemical shops therefore the lack of drugs in the CHPS compounds may greatly affect the health of the community members. The shortage of drugs in CHPS compounds was reported by Naylor et al (2002) and Quarshie et al (2009) in their studies in the Central and Volta regions.

5.6 Community Members perception on the ownership of CHPS compounds

Nyanator et al (2002) reported that with the CHPS initiative, communities have to be involved in the development of policies and plans and in monitoring and evaluation of the health programs. The community needs to be informed and educated about health, health policies and their implications, and their opinions sought in plan formulation. In this current study, it was found that the communities had made significant 'in kind' and 'cash' contributions to support the program. Contributions in kind took the form of water, sand, purchase of stones, among others for the construction and maintenance of CHPS, as well as the labour to build and sustain the buildings. The community members have a sense of ownership of the CHPS compounds due to their contribution. Some statements made by during focus group discussions are indicated below;

...we supported by fetching water from the dam for the constructions. Some people also helped by fetching sand and gravel"...

...."We contributed by fetching sand and water for the construction because the church said that if we don't support the contractor he can't complete on time. People were tasked to use their donkey carts to fetch sand and water"...

The findings of the focus group discussions are consistent with that of Baatiema et al (2013) who conducted to assess the participation of community members in the CHPS programme. Their study found that community members supported in kind and in cash. They fetched water to support the contractor during the building of facilities and also provided gravels. Even though the establishment or building of health facilities was initiated by the government, the community members got involved by helping in labour.

Due to the involvement of community members in the construction of the health post, it gave the community members some sense of ownership of the health post. The statement below buttresses this assertion.

...."we see it to be ours, because if even Government build the structure it is now for us so we have to take care of it and the workers there too"....

The statement above affirms the assertion by Miller et al (2003) that when community stakeholders are involved in the planning and implementation of developmental projects, it it imputes a sense of ownership of the project on the community members which makes these projects to be successful. The finding is also consistent with the proposition by Smith et al (2000) that development projects and programmes should not be imposed on communities but rather, community members should be involved in planning these projects and programmes to make them more sustainable.

5.7 Role of Binduri District Assembly in the CHPS Programme

The concept of the CHPS programme requires that District Assemblies should be involved the programme. The involvement of the District Assembly is required at all levels of the programme implementation. According to the Ghana Ministry of Health (1998), The DCE of the District Assembly should work with the DHMT in the selection and prioritization of communities for participation in the CHPS process. The Assemblies should also provide funding and other material support operating the CHPS process particularly for the construction of Community Health Compounds and motivation of CHOs, Community Health Volunteers and the Community Health Committees. The policy again requires the DCE and the District Assembly to inform and encourage Members of Parliament in the district, as well as NGOs to advocate for the CHPS process and provide material support for its implementation. The results of this study showed that the Binduri District Assembly is involved in the construction of the CHPS compounds. The results also showed that the selection of the communities for the siting of CHPS compounds was done in collaboration with the Ghana Health Service as required by the policy.

The study found that the District Assembly has limited financial resources to build more CHPS compounds. The only source of funding is the District Assembly Common Fund. Also, all the DHMT and the DA members are not trained in the CHPS concept or strategy. Again, the DHMT have no source of funding for CHPS activities. These findings are consistent with that of Nyanator et al (2004) who reported that the capacities of District Assemblies has not been built in terms of training and financial allocations for the support of CHPS programmes.

However, the results showed that the Binduri District Assembly was not involved in the monitoring of the activities of the CHPS compounds after their construction or establishment. The CHPS policy requires all District Assemblies to empower District Assembly, Area Council and Unit Committee members to provide active organizational and material support to the development of CHPS program in their communities. Since the Binduri District Assembly was not monitoring the activities of the CHPS compounds it implies that they have not been playing their role to empower the District Area Council and Committees to get involved in the CHPS programme.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

The study evaluated the CHPS programme in the Binduri District of the Upper East region of Ghana. The summary of findings and conclusions drawn from the findings are presented in this chapter. Recommendations are also presented in this chapter.

6.1 Conclusions

The use of CHPS in the Binduri district is high. The study found that 71.7% often used CHPS.

Respondents who stayed close to CHPS compounds used the health services frequently thus proximity to the CHPS compounds (OR = 0.013, CI 0.003 - 0.053), $p< 0.001$. The availability of health personnel in the CHPS compounds to provide health care services is a contributing factor to the use of health services (OR= 7.735, CI: 3.652-4.940) $p< 0.001$.

When the health committee of the communities are involved in the planning of health services it encourages them to use the services (OR= 4.915, CI: 2.408-10.03) $p<0.001$. The ability of CHOs in the CHPS compounds to handle emergency cases influences the use of CHPS (OR= 0.002, CI: 2.97-6.87). Visitation of community members especially women by the CHOs encourages them to use health services (OR= 0.735, CI: 0.573-0.941) $p<0.015$.

CHPS compounds are easily accessible during emergencies as reported by 53.9% (82) of the respondents. The main services provided in the CHPS compounds are immunization, antenatal care, postnatal care, skilled delivery and health education.

The challenges to the provision of health care services in the CHPS are lack of means of transport is a barrier to both clients and service providers (OR=1.2, CI: 0.6-2.1) P< 0.001, inadequate water supply (OR=2.4, CI:1.0-5.4) P<0.002, and inadequate supply of drugs (OR= 0.3, CI: 0.1-0.6) p<0.02.

The communities contributed to the construction of the CHPS compounds and are also involved in the planning of health services. They contributed in "cash" and in "kind".

6.2 Recommendations

The following recommendations are made based on the findings of this study;

1. More CHPS compounds should be built in Binduri district by the Ghana Health Service and the District Assembly because some of the communities are far away from the health facilities making them to walk over 8Km before accessing health care.
2. There should be a closer collaboration between the District Assembly and the Ghana Health Service to promote the effectiveness of the CHPS concept.
3. The health committees in the communities should be strengthened and be involved in the planning of health services to increase the uptake of the services by the community members.

4. The Ministry of Finance and the Ministry of Local Government and Rural Development should set aside a special budgetary allocation to all District Assemblies for the support of health programmes in the districts.

6.4 Suggestion for Further Research

The study found that health committees in the communities were involved the planning of health services through the CHPS programme. However, the study could not establish the extent to which their involvement has contributed to the use of health services. It is therefore recommended that further research should be conducted into the extent to which community participation in health planning increase the uptake of health services.

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APPENDIX

An Evaluation of The CHPS Implementation In The Binduri District of the Upper East Region

QUESTIONNAIRE

Section A:

Demographic Characteristics of respondents

1. Community Name.....
2. Name of respondent.....

3. Gender

a. Male [ ] b. Female [ ]

4. Age .....

5. Occupation

a. Farmer [ ] b. Trader [ ] c. Fisherman [ ] d. Hairdresser/ Seamstress [ ]

e. Others (specify).....

6. Education

a. Primary [ ] b. Middle/JHS [ ] c. SHS [ ] d. Tertiary [ ] e. Others (specify).....

7. Marital Status

a. Single [ ] b. Married [ ] c. Separated [ ] d. Divorced [ ] e. Widow/Widower [ ]

F. Other (specify).....

8. Age of child (in months).....

Section B:

The usage of CHPS services

9. Are you aware of a CHPS compound in your community or one that serves you?

a. yes [ ] b. no [ ] if no skip to Q16

10. How relevant is the CHPS centre to you and the community?

a. Provides accessible health care services to the community [ ]

b. Provides immediate and timely health care services to the community [ ]

c .Don't Know [ ]

d. Other specify.....

11. Have you ever visited the CHPS compound when you or any of your household members is sick?

a. Yes [ ] b. No [ ]

12a. If no, why? .....

13b. Where do you go then.....

14. And if yes, how often do you access this facility?

A.Very Often [ ] b. Often [ ] c. Not Often [ ]

15. Give reason(s) if your answer to Q 14 is 'Not Often'

.....

16. What kind of health services do you usually visit the CHPS compound for?

a. Immunizations [ ]
a. Clinical/treatment for child/self-sickness [ ]
b. Family planning[ ]
c. Counseling/health education session [ ]
d. Nutrition Rehabilitation [ ]
e. Labour [ ]
b. Others (Specify).....

17.In your opinion, is the facility located at the place of your choice?

a. Yes [ ] b. No [ ]

18. If NO, state the place (local area) of your choice in your locality where the facility should have been located.

.....

19. Where do you often go for your health service delivery?

a.Hospital [ ] b. Health Centre [ ] c. Clinic [ ] d. CHPS Centre [ ]

e. Other specify.....

20. Do you have valid health insurance?

a. Yes [ ] b. No [ ] c. Yes, but invalid [ ]

20. Does the CHPS compound accept valid health insurance cards?

a. Yes [ ] b. No [ ]

22. If NO why? .....

23. Is your child 0-59 months having a valid health insurance?

a. Yes [ ] b. No [ ]

24. If a sick child visits your CHPS compound without health insurance, what do you do?

a. Provide treatment

b. b. refused treatment

c. c. refer.

d. d. others (Specify)……..

Section C:

Perception of Community members on CHPS Services

25. What is your perception of services provided at the CHPS compound?

.....

.....

.....

26. How do you rate the following items relative to service provision at the CHPS centre? (Rate appropriate item by circling a number to it e.g. "1 for very high")

a. Human Resource (Staff) :1. Very High 2. High 3. Moderate 4. Poor 5. Not Applicable

b. Emergency service: 1. Very High 2. High 3. Moderate 4. Poor 5. Not Applicable

c. Drug availability: 1. Very High 2. High 3. Moderate 4. Poor 5. Not Applicable

d. Staff- Customer relationship: 1. Very High 2. High 3. Moderate 4. Poor 5. Not Applicable

e. Staff availability: 1. Very High 2. High 3. Moderate 4. Poor 5. Not Applicable

f. Facility availability (for service provision): 1. Very High 2. High 3. Moderate 4. Poor 5. Not Applicable

g. Equipment & logistics (Weighing Scale, BP Apparatus, Thermometer etc.): 1. Very High 2. High 3. Moderate 4. Poor 5. Not Applicable

27. Do you know the number of health working in the CHPS compound?

1. Yes [ ] 2. No [ ]

28. How many are there at the CHPS compound? 1. One [ ] 2. Two[ ] 3. Three[ ] 4. Four[ ] 29. Five[ ] 6 Don't know[ ]

30. Have you attended the facility in an emergency situation in the last 6 months?

a. Yes [ ] b. No [ ]

If the response is 'No' to Q23 Skip Q24

31. If yes, were you attended to promptly?

a. Yes [ ] b. No [ ]

32. If No, give reasons why you were not attended to promptly

.....

33. Are you satisfy at this level with the services rendered at the facility?

a. Yes [ ] b. No [ ]

34. Whenever you attend the facility do you receive all prescribed drugs?

a. Yes [ ] b. No [ ]

35. If No, what was the reason?

.....

36. How would you describe the attitude of health staff at the CHPS compound?

a. Very good [ ] b. Good [ ] c. Poor [ ]

37. If poor give reasons.....

38. Is there a visible sign post/ sign board mounted with detailed information of the facility?

a. Yes [ ] b. No [ ] c. don't Know/ not aware [ ]

Section D:

Factors Associated With Utilization of CHPS Services

39. Are you aware of the opening and closing time of the facility?

a. Yes [ ] b. No [ ]

40. For the last three months have the CHO(s) visited your compound?

a. Yes [ ] b. No [ ]

41. In your estimation, what suggestions do have for improvement on the utilization of services at the CHPS compound? (this question is asked when the person have ever use or received Health services from CHOs)

.....

.....

.....

42. What is the estimated distance from the CHPS compound to the household in which the interview is conducted?..... (KM)

Section E:

Health services rendered by CHPS Officers

Name of CHPS Compound.....

1. How many health staffs are there in this CHPS compounds?.....
2. What are the categories of health staffs?.....

	Category	Number of staffs
1	Medical Assistant/Physician Assistant	
2	General nurse	
3	Midwife	
4	Community health Nurse/Officer	
5	Health Assistance/hats	
6	Field technician	
7	Orderly	
8	Others (Specify).....	

3. How many of the CHOS/CHNS have been trained or oriented on the CHPS concept.....
4. How many of the CHNs/CHOs stay at this compound?.....
5. Have you referred any client/patient to high level of care in the last 3 months?
   1. Yes [ ] 2. No [ ]
6. What are the ranges of health services rendered by this CHPS Compound?

S/N	Type of health services (List as mention by respondent)	Evidence of services rendered? (enter 1yes, 2 for No)		Remarks
		1.Yes	2. No.	
1	Immunization			
2	Family planning			
3	Nutrition rehabilitation			
4	Treatment of minor ailment			
5	Health education/promotion/ Community durbar			
6	Disease surveillance			
7	Antenatal services			
8	Postnatal			
9	Emergency delivery			
10	Referrals to high level of care			
11				
12				
13				
14				

Section F.

Challenges facing CHOs in delivery health services. (Cycle as appropriate)

1. Do you have challenges in rendering health services to the communities?
   a. Yes [ ]
   b. No [ ]
2. If yes, what are they?
   List as many as possible.....
   .....
   .....
   .....
3. Do your CHPS compound have the following
   a. Existence of CHPS structure? 1. Yes [ ] 2.No [ ]
   b. If yes, renovated before? 1. Yes [ ] 2. No [ ]
   c. Have electricity? 1. Yes [ ] 2. No [ ]
   d. What is the sources of Power .....

4. Do you have the following Essential health equipment?
   e. Motorbike 1. Yes [ ] 2. No [ ]
   f. Vaccine fridge available 1. Yes [ ] 2. No [ ]
   g. Rack sack bag 1. Yes [ ] 2. No [ ]
   h. Registers 1. Yes [ ] 2. No [ ]
   i. Wellington boot 1. Yes [ ] 2. No [ ]
   j. Raincoat 1. Yes [ ] 2. No [ ]
   k. Torchlight 1. Yes [ ] 2. No [ ]
   l. Weighing scales 1. Yes [ ] 2. No [ ]
   m. First aid medicines1. Yes [ ] 2. No [ ]
   n. Bed provided by the GHS/Community 1. Yes [ ] 2. No [ ]
   o. Cooking utensils provided GHS/Community 1. Yes [ ] 2. No [ ]

p. TV/radio 1. Yes [ ] 2. No [ ]
q. Bicycles 1. Yes [ ] 2. No [ ]
r. Availability of water for CHPS compound 1. Yes [ ] 2. No [ ]
s. Do you have means for referring cases? 1. Yes [ ] 2. No [ ]

4. What evidence are there of health programmes personnel changing their plans as a result of critiquing from the community member.....

Section G.

Checklist for community participation-opinion leaders

5. Is there an active community health committee in this community? 1. Yes [ ] 2. No [ ]
6. Is the community involved in planning the management and control of the health programmes at the community level? 1. Yes [ ] 2. No [ ]
7. Were the felt needs of the community explored in planning the programmes and notice taken of them in the programme objectives? 1. Yes [ ] 2. No [ ]
8. To what extent have social organizations and community representatives been involved in the decision making process (IF ANY)?.....
9. Is there a mechanism for community dialogue between health workers, community leadership and the community members? 1. Yes [ ] 2. No [ ]
10. Are marginalized groups such as the poor, unemployed, women and the youth adequately represented in the decision making process? 1. Yes [ ] 2. No [ ]
11. Have the community leadership been involved in monitoring, assessing and evaluating the CHPS programme? 1. Yes [ ] 2. No [ ]
12. Are there volunteers in the community to help in carrying out health education and also dispensing family planning commodities such as condoms? 1. Yes [ ] 2. No [ ]

13. Have the Community received feedback from CHOs about the health status of the community on regular bases? 1. Yes [ ] 2. No [ ]
14. Have the community provided security for the up keep of CHOs and CHPS equipment in the community. 1. Yes [ ] 2. No [ ]

Section H continued: (Community Opinion leaders such as assembly member, unit committee, women groups leader, youth leader, village school teacher, Catechist, pastor etc)

Focus Group Discussion

1. How was this CHPS Compound built?

   .....

   .....

   .....

2. Have you considered the CHPS compound as yours or government?

   .....

   .....

   .....

   .....

   ...

3. What local contributions or resources did the community make to build the CHPS Compound?.....

   .....

   .....

   .....

   .....

   .....

4. What other contribution have you made to ensure the sustenance of the CHPS process in your community?

.....

.....

5. What was the level of community stakeholder consultation before this compound was built?.....

.....

6. What do you think are your responsibilities to the success of the CHPS compound in your community?.....

.....

.....

7. If there is Community health committee, what contribution have they made for the CHPS process in their community? .....

SECTION I: DISTRICT ASSEMBLY QUESTIONAIRE.

1. Have you heard of Community Based Health Planning Services Concept?
   1. Yes [ ] 2. No [ ]
2. Have you as an assembly taken any decision on CHPS rollout in your District?
   1. Yes [ ] 2. No [ ]
3. Any evidence of the decision? 1. Yes [ ] 2. No [ ]
4. How many are orientated/trained on the CHPS concept? .....
5. Have the DHMT share the Roll out plan to these Organizations? 1. Yes [ ] 2. No [ ]
6. If yes, does this roll out plan conform with what is at the DHMT? 1. Yes [ ] 2. No [ ] **if no, skip to Q8**
7. Do you have a prototype design of a CHPS compound for the District 1. Yes [ ] 2. No[ ]
8. Which organizations support CHPS development in the District?.....

9. What are the challenges facing CHPS in the District

.....

...

10. Is the District Assembly having a CHPS roll out Plan? 1. Yes [ ] 2. No [ ]
11. Have the district Assembly undertaken any works on CHPS in the last three years? 1. Yes [ ] 2. No [ ]
12. If yes list the kind of works

a.....

b.....

c.....

d.....

e.....

13. Which aspect of the CHPS roll out plan do you support?

a.....

b.....

c.....

d.....

e.....

14. Do you have funding for rolling out of CHPS in the District? 1. Yes [ ] 2. No [ ]
15. If yes, what are the possible sources of funding?

.....

.....

.....

16. What are the roles of the assembly members or unit committee members in the roll out of CHPS at the electoral areas?

.....

.....

SECTION J: DHMT QUESTIONNAIR.

1. How many staffs are there at the DHMT? .....
2. How many are orientated/trained on the CHPS concept? .....
3. Is there CHPS roll out plan in the DHMT? (Evidence) 1. Yes [ ] 2. No [ ]
4. Which organizations support CHPS development in the District?

   .....
5. Have the DHMT share the Roll out plan to these Organizations?

   1. Yes [ ] 2. No [ ]
6. What are the challenges facing CHPS in the District?

   .....
7. Is the District Assembly having a CHPS roll out Plan? 1. Yes [ ] 2. No [ ]
8. What are the sources of funding for CHPS roll out in the District?

   a.....

   b.....

   c.....

   d.....

   e.....
9. Which aspect of the CHPS roll out plan do you support?

   a.....

   b.....,....

   c.....

   d.....

   e.....
10. Do you have funding for rolling out CHPS in the District? 1. Yes [ ] 2. No [ ]
11. If yes, what are the possible sources of funding?

    .....

    .....

    .....

    .....

12. Do you have partners in your District to help in any aspect the CHPS roll out plan? 1. Yes [ ] 2. No [ ]

13. If any, please list them.....