UNIVERSITY FOR DEVELOPMENT STUDIES

COMMUNITY BASED HEALTH PLANNING AND SERVICES: IMPLEMENTATION CHALLENGES IN THE SABOBA DISTRICT OF THE NORTHERN REGION

BY

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DECLARATION

Candidate's Declaration

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

CHARLES APOOZAN YAKUBU 23rd March, 2016 .....

DATE SIGNATURE

Supervisor's Declaration

I hereby declare that the preparation and presentation of this thesis were supervised in accordance with the guidelines laid down by the University for Development studies.

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DEDICATION

I dedicate this work to my family, for their love, support, and encouragement during the entire period of my studies. May the Almighty God continue to bless and keep you all well.

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ABSTRACT

Community-based Health Services and Planning (CHPS) initiative has become one of the strategies to enhance and improve accessibility to healthcare in rural communities. However, the implementation of this facility comes with a myriad of challenges. This study therefore investigated the implementation challenges of CHPS initiative in the Saboba District of Ghana. Results of this assessment could guide the District and other districts as well as policy makers in the design and implementation for CHPS and other similar Community-based Primary Health Care initiatives. This is a qualitative study. Five Focus Group Discussions and thirteen Key Informant Interviews with Community Health Committee members, district level health staff, were conducted to capture their perceptions of CHPS as well the implementation challenges of the initiative in the District. Results of the study show that Community Health Committee members were unanimous in the appreciation of CHPS as a strategy for cheap and more people-centered health care strategy. The health staff agreed that CHPS is a strategy to ensure equity in health care, but also indicated implementation challenges of the initiative in the District. The study concluded that whereas there is a positive perception among stakeholders of CHPS, factors of human resource, logistics and finance present huge implementation challenges. The study recommends that dedicated funding from central government and development partners be made available to districts for CHPS implementation. The introduction of the CHPS concept into the syllabus of the health training institutions will help to adequately prepare trainees before they go out onto the field and assume new roles and responsibilities.

KEY Words: Community based Health Planning and Services, Perceptions, Logistic, human resource, Finance.

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LIST OF ABREVIATIONS /ACRONYMS

CBS—Community based Surveillance

CHAG—Christian Health Association of Ghana

CHC—Community Health Compound

CHFP Community –based Health and Family Planning

CHN Community Health Nurse (s)

CHO—Community Health Officer

CHPS Community –based Health Planning and Services

D.A—District Assembly

DDCO—District Disease Control Officer

DDHS—District Director of Health Services

DHA—District Health Directorate

DHC—District Health Committee

DHMT—District Health Management Team

DHIMS---District Health Information and Management Systems

DPHN—District Public Health Nurse

FGD—Focus Group Discussion

GDHS—Ghana Demographic and Health Survey

GHPC—Ghana Population and Housing Census

GSS—Ghana Statistical Service

GHS—Ghana Health Service

HIRD—High Impact Rapid Delivery

CoHK--College of Health and Wellbeing (formerly KRHTS—Kintampo Rural Health Training School)

MDG—Millennium Development Goal

MOH—Ministry of Health

MP-Member of Parliament

NGO—Non Governmental Organization

NHRC—Navrongo Health Research Centre

PHC—Primary Health Care

PMTCT Prevention of Mother to Child Transmission

PNDC—Provisional National Defense Council

POW—Programme of Work

PPMED—Policy Planning, Monitoring and Evaluation Division

SD Sub-district

SPSS---Statistical Package for Social Services

UNICEF—United Nations Children Fund

WHO—World Health Organization

OPERATIONAL DEFINITIONS

Implementation: putting a programme into action, doing the work.

Health services: A system of institutions, people, technologies and resources designed to improve the health status of a population. Also, service provided to the population (e.g. preventive, promotional curative etc.)

Health status: Degree to which the health of a specified population meets accepted norms (of mortality morbidity, impairment, etc.).

Health system: set of factors (economic, social, cultural, political) including the health services, that determine the health status of a population at any time.

Input: what goes into implementing an activity; information, resources, and time.

Objective: The planned or intended result of a programme or activity. Anticipated outcomes of a venture.

Resources: the means, (personnel, materials, financial) requested for the implementation of a programme or activity.

Progress: Actual implementation compared with scheduled implementation.

Programme: A set of interrelated activities, in time sequence, and a statement of personnel and other resources required, directed towards achieving a stated goal or objective.

Strategy: A broad approach to achieving goals, within which a programme may be formulated.

Target: A statement of a measurable output related to certain population and a certain time.

Community: Individuals and groups living and interacting within certain boundaries (e.g. physical, cultural), sharing common beliefs, identity, aspirations, sense of oness and with common practices.

Efficiency: about reaching ends by only the necessary means or by least wasteful means. Has implication for the use of resources

Expendable equipment is that is used within a short time e.g. cotton wool, fuel, disposable syringe and needles)

Non-expendable equipment: Equipment that last for several years and needs care and maintenance e.g. motorbike, fridge's furniture, weighing scales, vehicles.

Perceptions: The experiences, views, understanding and beliefs etc. that people have from their encounters with the CHPS programme in their communities.

Logistics: Those materials and equipment that are required to aid in health care delivery and the comfort of the CHO

Human Resource: People with the appropriate training that are required to provide health care in the CHCs.

Finance: The monetary resources, cash in the various forms. E.g. Financial encumbrances (FEs), budget, Internal Generated Funds (IGF).

CHAPTER ONE

Introduction

1.0 Background to the study

This section generally introduces the study. It is composed of the goals of health systems, the Alma Ata declaration, Principles of Primary Health Care and Community based Health Programmes. Experiences of implementing community based health programmes and the health care system of Ghana are also contained in this chapter. The definition of CHPS and its brief historical perspective, as well as its objectives and including, the problem statement, objectives of the study, including the research questions, are stated in this chapter

1.1 Goal of Health Systems

The goal of health systems in all countries is to provide universal access to quality healthcare services in a culturally appropriate, low-cost, and in an efficient manner so as to improve and promote the health status of their populations. (WHO, 2006).At the end of World War II, many developing countries strived to provide healthcare and sustain medical health systems established by developed countries and the colonial masters. However, most of the developing countries found it extremely difficult to develop the target level of resources and personnel, primarily due to poverty and inadequately developed political and social structures. (Yeboah, 2003). Healthcare delivery and services tended to be limited to the urban areas, and accessible only to the well-off minority and white settlers.

The health care needs (medical care and preventive services) of a majority of rural populations were over looked. This segment of countries' populations was abandoned and the people continued to wallop in poor health.

1.2 Adoptation of Alma Ata Declaration

At the historic conference of Alma Ata in 1978, member states of the World Health Organization (WHO) adopted the goal of health for all by the year 2000 by means of primary health care. Since then, the healthcare systems of many countries and nations have taken new directions, as countries began to implement their strategies to attain this goal.

1.3 Principles of Primary Health Care

Primary health care is a complex concept, requiring the most efficient use of resources, which are almost always scarce, and implying choices and the setting of priorities. It involves communities making decisions about their own healthcare and accepting responsibility for protecting their own health. The general principles of Primary Health Care (PHC) were given as fairness and equality, participation of community cooperatives and individuals, appropriate technology and a multi-sector collaboration and diversified approach.

These principles have since been expanded into a new field, "community-based health" which is concentrated on providing preventive health and medical care within the community. This new initiative takes full advantage of human and other resources already present within the community, and represents a public

approach characteristically led by local residents, or what is now called "community-based health approach".(WHO, 2014).

1.4 Community based Health Programmes

Community-based health programmes have become an important strategy to enhance and improve accessibility to healthcare since the Alma Ata declaration of 1978. Since then, the belief that the community-based approach is beneficial has become a deeply held conviction in public health. According to Cheadle and Colleagues, (2012) "it is almost an article of faith that locating programmes in the community and involving community members in planning, implementation and evaluation can be an effective strategy for improving population health".

However, this is not without challenges. Some implementation challenges of community-based health programmes are limited availability of resources, propensity for high levels of staff turnover, etc. Others include wrong perceptions by beneficiaries, inadequate financial and logistical support. Implementing community-based health initiatives are strongly influenced by the characteristics and main challenges of the day, the way government and local health authorities and managers address those challenges and the way the local society functions. (Keleher, 2001).

Since the Alma-Ata declaration, some countries, e.g. Brazil and Cuba, have successfully implemented the Primary Health Care approach to deliver health services, whilst others, mostly in Africa, continue to battle with challenges that impede progress in this regard. Globally today, most governments and nations

have policies and strategies at the community level as a way of working towards providing healthcare for all by strengthening Primary Health Care and providing healthcare at a low cost.

In about the late 1980s, most countries still had wide disparities in access to healthcare (rural-urban).e.g. Ghana, Kenya, Somalia, Liberia and Rwanda (World Bank,2008). Notwithstanding, some countries have continued to initiate and implement health reforms within the frame work of Primary Health Care to increase and provide quality healthcare to their populations. (Rufaro & Tumisine, 2006).

Though many countries have been implementing many community-based health programmes for more than a decade today, the progress towards achieving the desired goals is rather very slow. Despite the wide adaptation and application of community-based health programmes during the past three decades, there is a paucity of evaluations from which to obtain evidence regarding the challenges of implementing community based health programmes.

Ghana like many Sub-Saharan African and developing countries is bedeviled with endemic and emerging diseases, poor health indicators like high infant and maternal deaths, high childhood diseases like diarrhea, malnutrition, malaria and HIV/AIDS (Adebola et. al, (2012). Others include low antigen coverage, prevalence of communicable diseases and health infrastructure. Barriers to solving these problems include poor health infrastructure, inadequate health workforce, and inequitable health financing (Wood & Esena, 2013). It is estimated that about

49.1% of Ghana's population is impoverished and live in poor and remote communities where it is difficult to access proper and timely health care (GPHC, 2010).

As part of the strategies of the Ghana Health Sector Reforms, the country adopted the Community-based Health Planning and Service (CHPS) programme to increase access to health care services to underserved and remote communities (GHS, 2009). The CHPS programme relies on communities and local structure support and relocates health staff and health services from the health centre into the communities. This system offers opportunity for door step, high quality and acceptable health care to rural and remote communities in the country (Nyonator, et al. (2003).

The Saboba district was chosen as the study setting because it is the first district in the Northern Region to initiate the CHPS programme and even served as an innovation district for other districts of the Region. However, since the inception of the programme in 2002, only six (6) CHPS zones have been launched. The District has not been able to roll out the programme to cover the eighteen (18) demarcated zones for the CHPS programme as a result of implementation challenges. Due to the limited access to health care and service delivery, between 2000 and 2002, the District has a poor record for health service indicators as shown in Table 1.1 below.

Table 1:1 Health Services indicators - Saboba 2000-2002: Before CHPS

INDICATOR YEAR	MATERNAL DEATHS	INFANT DEATHS	EPI COVERAGE (DPT3 as proxy)	GUINEA WORM DISEASE
2000	58	297	47	198
2001	37	101	56	210
2002	51	119	45	206

Source: DHMT Saboba, 2002.

Concerned with the poor service indicators, as a result of inadequate access to health service delivery and coverage, the Saboba district, since the year 2002, has been implementing the CHPS initiative within the context of PHC to reduce the health inequalities, improve service indicators and promote equity of health outcomes by removing geographical barriers to healthcare.

1.5 Experience of implementing community-based health programmes from other countries

In a summary of countries' experiences on Primary Health Care and community based health care services like CHPS, African countries enumerated some of their challenges for implementation of community-based health care to include, low motivation of community representatives to participate in health services, inadequate supervision of health personnel as well as in their training and retraining in community health, lack of financial resources and inadequate budget lines for health, lack of human resources, diverse understanding (misconceptions and perceptions) of health managers and some stakeholders of what community-

based health care is, limited community involvement is also a significant factor that inhibits implementation of community-based health programmes and also the concern that peripheral health staff are unprepared to assume new administrative functions resulting from decentralization (WHO, 2008).

In Nigeria, documented evidences has shown the widespread misunderstanding about the essential concepts of community-based health programmes, not only amongst lay public, but also health professionals and decision makers and this has presented a huge challenge to the implementation of community-based health programmes in that country (WHO,2014). In Chad, it was also shown that some health workers, especially physicians working in hospitals were not involved in Primary Health Care and community-based health programmes and are not familiar with such concepts (WHO, 2014).

The diverse understanding among stakeholders of what Primary Health Care is, coupled with misconceptions that community-based health service is a cheaper way of delivering health services are noted as implementation challenges of community-based health care in Uganda.

In Brazil, Primary Health Care is not achieving its full capacity because of conservatism and politics. The lack of political will to implement health programmes to help people in rural areas causes problems for the health system (WHO, 2008). Another challenge is to gain people's confidence. Sometimes people travel to urban areas to receive health care that they could have received from health units in their communities.

Human resource for health has been identified as one of the most critical and core area for every health system (WHO, 2008). The global shortage of about 4.3 million health professionals poses a major bottleneck to the implementation of community-based health programmes. Also, there are staggering inequities, among health workers, of skill levels and geographic distribution. Whereas Sub-Saharan Africa bears about 24% of the global disease burden, it is served by 4% of the global health workforce (Binang waho et al, (2013).

The inadequacy in human resource both in terms of numbers and quality, low motivation of health workers as a result of poor working conditions and poor remuneration were noted as challenges in the Cameroon (WHO, 2014). In Burkina Faso, an outstanding challenge to implementation of Primary Health Care is noted to be the urgent need to strengthen the implementation of the national human resource plan for health development (WHO, 2014).

The training of health personnel and the need to create an attractive career development scheme and to increase the capacity of the national health system at the local level were prominent challenges in the Cape Verde. Inadequate capacities of health workers to implement community-based health care programmes were observed in the Gabon where as in the Senegal, the lack of policy on community health workers, and their motivation are serious challenges (WHO-AFRO, 2008). In Uganda, implementation of community-based health services are hindered by inadequate human resource and their inequitable distribution; the lack of skills of health workers. In the Republic of Togo, implementation challenges of community-based health programmes are noted to

be lack of human resources in the health sector as well as limited knowledge and experiences and skills in Primary Health Care. Successful implementation of Primary health care in Zimbabwe was prefaced on the assumption that health workers would be available to lead the process; but unfortunately, the country is not spared by the human resource crisis currently faced by other countries.

Inadequate resource allocation by governments to the health sector is noted as a challenge to implementation of community-based health care interventions at the community level in the Central African Republic (WHO-AFRO, 2008). In other instances, the redirection or diverting of resources for community health programmes poses a huge challenge to implementation of such initiatives as was a case in the Cote D'Ivoire. An implementation challenge for community-based health programmes noted in Gabon, and Mali has been the need to mobilize more resources to support such plans whilst in Rwanda and Senegal, the insufficient supply of materials and equipment and insufficient decentralization of resources to health facilities is noted respectively to be implementation challenges of community-based health programmes and hence their failure (WHO-AFRO, 2008).

1.6 Health care system in Ghana

The government is responsible for healthcare delivery in Ghana. This is stipulated in article 36 clause 10 of the 1992 constitution of Ghana thus, "the state shall safeguard the health, safety and welfare of all persons in Ghana... and shall establish the basis for the full deployment of the creative potential of all

Ghanaians" (Republican of Ghana, 1992). By this constitutional mandate, healthcare delivery in the country is led by the government. A centralized system of government is what prevails in Ghana with a limited degree of some decentralization to lower levels. The Ghana Health Service which is established by Act 525 in 1996, under the 1992 constitution is the main agent charged with the responsibility of providing health services to the people of Ghana. Other agencies and bodies that complement health care delivery in Ghana are Faith based Organizations as in the Christian Health Association of Ghana (CHAG), Private Practioners, and Traditional medicine.

At the apex, is the Ministry of Health which is the general overseer of health care delivery in the country, The Ministry of Health, Ghana, has the responsibility for policy issues, resource mobilization, human resource development, as well as financial and infrastructural development for health service delivery in the country (MOH, 2008).

The Ghana Health Service system is structured at Administrative and Functional or service delivery levels. Administratively, the health system is organized at three (3) levels-thus National, Regional, and District; whilst functionally or for service delivery, it is organized at five (5) levels-thus, National, Regional, District, sub district, and Community. It is at the community level that the CHPS initiative operates.

Level of health care varies throughout the country. The big urban centers are well served with health facilities, whereas the rural areas have little access to health

care. (Yeboah.2003). People in rural areas tend to rely on traditional medicine and herbalists, or have to travel long distances for health care. Health care in Ghana is funded by the government, and also through internally generated funds and other financial credits. Package of services under the health system include, clinical, preventive, promotive, and rehabilitative.

1.7 Health Care delivery in the Northern Region

Health care delivery in the Northern Region is designed in line with the National Health Service structure: thus community level, District level and Regional level. Health care is provided mainly by Government Health institutions. These are CHPS CHCs, clinics health Centres, Poly clinics and Hospitals. The Tamale Teaching Hospital is a Tertiary Institution in the Region. Health care delivery in the Region is complemented by Faith based health institutions, Private health care institutions and Maternity Homes. Traditional and Herbal medicine is also practiced in the Region.

The Region has a land area of 70,384 sq.km which makes it cover about 27 % the land mass of Ghana. Population density of the Region is 35 persons sq.km with a growth rate of about 4% %.There are 26 districts in the Region with a total of 112 health facilities.

Health care delivery in the Region is faced with numerous challenges. These include the vastness of the Region with scattered settlements, inadequate health facilities, and poor road network. There is also inadequate human resource for health, inadequate and obsolete equipment, inadequate and overaged transport.

Others include dwindling and irregular release of funds which affect health care delivery as well as poor leadership and staff to deliver health care at the periphery, which all have a bearing on the quality of health care in the Region. The Region is highly disadvantaged in health care delivery and it is important that pragmatic measures are put in place to improve access and quality of health care in the Region. In view of this, the CHPS initiative by all standards presents a good opportunity for vigorous implementation in the Region to address the health gaps and challenges in the Region.

1.8 Health Care Delivery in the Saboba District

The Ghana Health Services is the over seer of Health Services in the District. There is a District Health Management Team (DHMT) which serves as the Administrative and Technical that that supervises and coordinates health activates in the District. There are three (3) sub districts and a total of eleven (11) health facilities (DHMT, 2014). Access to health care in the District is low and uneven and inadequate. This is characterized by factors such as inadequate health infrastructure, poor geographical access. Quality of health care is low; causing high infant and under one (1) deaths. Malnutrition is prevalent as well as communicable diseases like Tuberculosis. There is poor There is huge gap in health care delivery in the District. Health staff/patient ratio, and also inadequate fund for health care delivery.

1.9 Definition and brief history of CHPS

Community based Health Planning and Services (CHPS) is defined as "the mobilization of community leadership, decision making systems and resources in a defined catchment area (zone), the placement of reoriented frontline health staff known as Community Health Officers (CHOs) with logistics support and community volunteer systems to provide services according to the principles of primary health care (PHC-Plus). It is a "close –to –client "service delivery system (GHS, 2005).

CHPS is a process of healthcare provision in which health workers and community members are actively engaged as partners in the delivery of Primary Health Care and Family Planning Services: It involves:

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

(2) Locating of Community Health Officers in a Community Health Compound (CHC) and

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

The Community based Health Planning and Services (CHPS), is an off shot of what was known as the Navrongo experiment. The Navrongo experiment began as a Community Health and Family Planning (CHFP) project, based on lessons learnt from Bangladesh. (Phillips et al (2006). The Navrongo experiment involved the

re-engineering and re-certifying of Community Health Nurses (CHN) as Community Health Officers to serve as community resident health care providers.

The table below demonstrates the model of the Navrongo experiment which was an operational research conducted in Navrongo between 1994-1999 and piloted in sub districts (called cells), which involved three (3) different methods of health care delivery.

Table1.2 Model of the Navrongo Community Health and Family Planning (CHFP) project.1994-1999

Mobilizing MOH /GHS Outreach Services		Mobilizing Traditional and Community Health Organizations	
		NO	YES
	NO	CELL 4 Health Service Delivery (Comparison)	CELL 1 HC Service delivery Health Committees and Volunteers System
	YES	CELL 2 HC Service Delivery Nurse Outreach	CELL 3 HC service delivery Nurse in Community Health Committee and volunteer system

Source: PPMED. GHS. 2015

From the table above, each "cell" is a sub district with a functioning health Centre that provides planned routine health care including outreaches to outlying and satellite communities within its catchment area.

Cell 4, as demonstrated, is a control, which is the traditional health Centre, where static planned routine services are provided with no additional supporting agent. In cell one, in addition to the planned routine health care delivery at the health

Centre, volunteer system and Health Committee have been out in place to support the planning and delivery of health services. In cell 3 however, a resident Nurse is in the community. In addition, the volunteer system and Health Committee are put in place who mobilise and are involved in the planning and delivery of health services.

Lessons learned from the experiment showed that cell 3 worked best In. this cell, health care is planned to address the community needs. The Health workers adopt their service delivery strategies and approaches to solving the community health problems and the community is involved at all stages of planning health care activities and above all, the Nurse is resident in the community.

The Navrongo experiment demonstrated that orienting health workers and locating them to communities had the potential to contribute significantly to health service delivery and actually increase volume of service output by 89 %.(PPMED, 2015). The success of the Navrongo experiment prompted the replication of the cell strategy in the Nkwanta district; where using available resources within the district, it also proved to work (PPMED. GH, 2015).

The success story of the initiative was widely disseminated and at a conference on the new strategy in Kumasi in 1999, the name Community based Health Planning and Services (CHPS) was adopted. Thereafter, the initial implementation of the initiative was through the 'Lead District" concept at two (2) district per region, where regions and districts implemented the strategy with support from District

Assemblies, communities and other development partners. The graph below demonstrate the roll out of the CHPS initiative nationwide from 2002-2014.

Trend of CHPS Implementation in Ghana.2002-2014

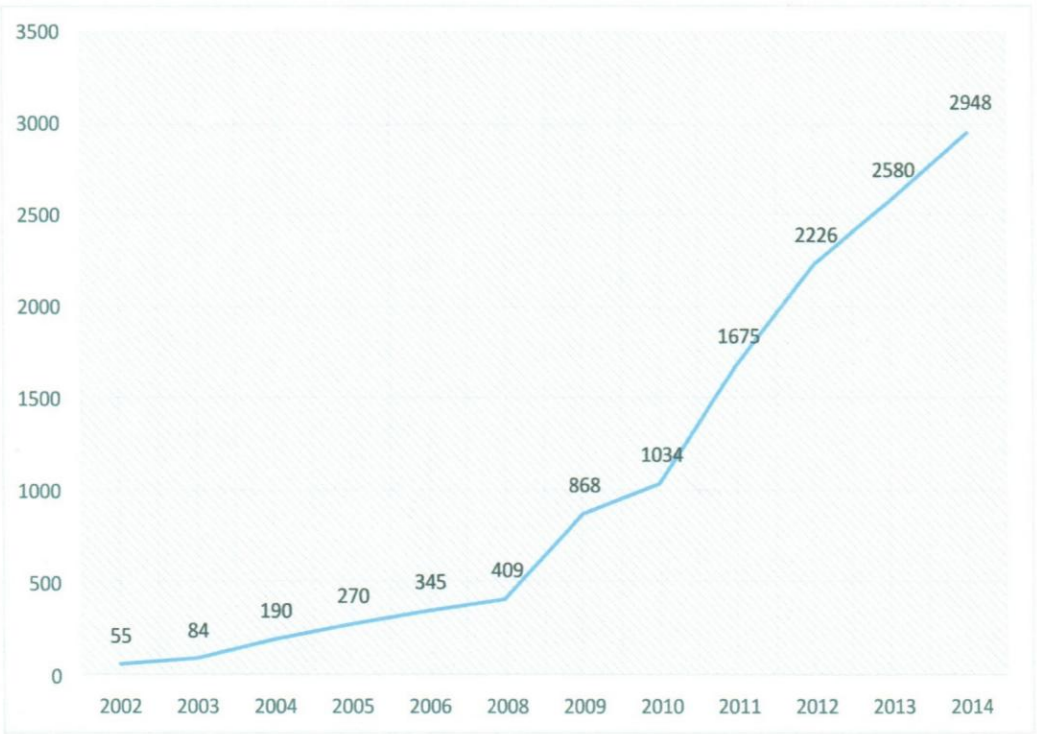

Figure 1.1 Trend of CHPS implementation in Ghana 2002-2014

Source: .PPMED.GHS 2015.

From the graph above, it is observed that over the years, there is a gradual rollout of the CHPS initiative; however the roll out is marginal, especially between 2002-2008, and picking up gradually from 2003 to 2014.This slow rollout is due to implementation challenges

In the Northern region, the roll out of the CHPS initiative shows a similar trend as the national data. There is an observed roll out of the initiative in the districts of

the Northern region. The number of CHPS compounds does not match show any appreciable match with the number of demarcated zones for CHPS, hence creating a huge implementation gap. The inability of districts to roll out the initiative to correspond with the number of demarcated zones is obviously due some militating factors which can be attributable to finance for the procurement of the needed logistics for service provision and also human resource constraints in terms of skilled staff to man the Community Health Compounds. This scenario is depicted in figure 1.2 below.

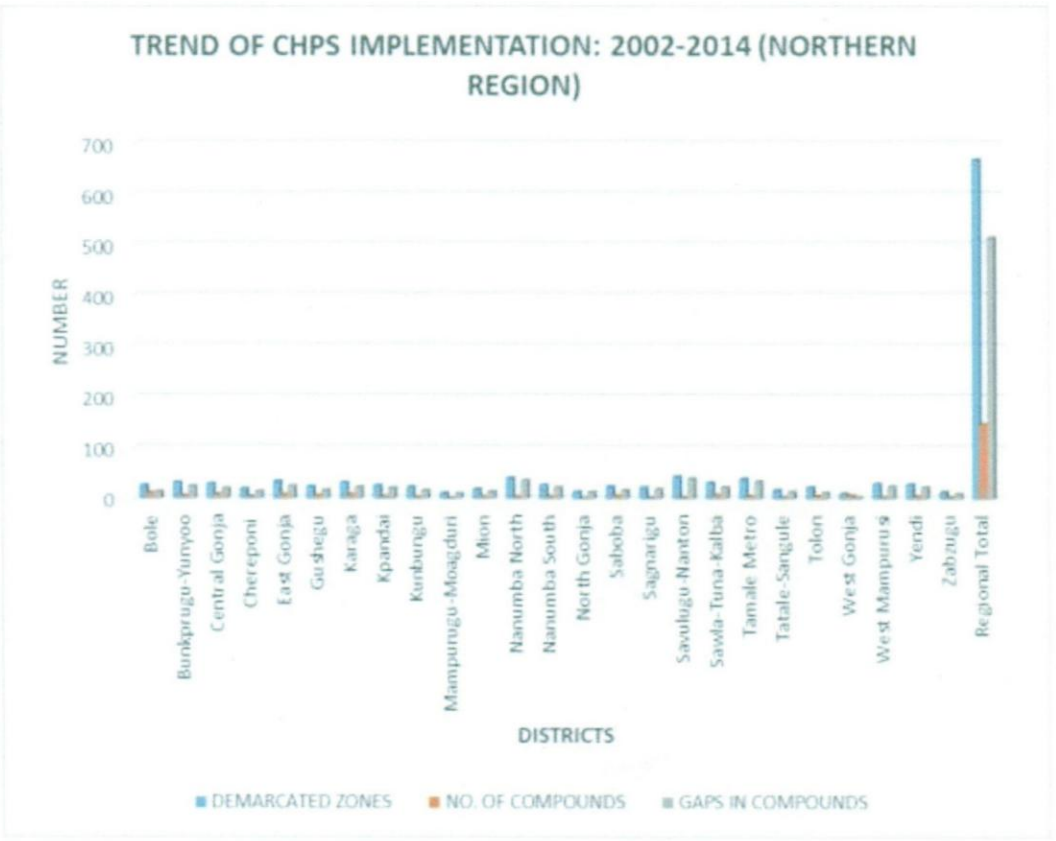

Figure 1.2 Trend of CHPS implementation Northern Region 2002-2014

1.10 Contribution CHPS to Health Service delivery

There is documented evidence that show CHPS contributes to the improvement of national health indicators; and even in some instance, performs better than established health institutions. Table 1.3 below demonstrates the contribution of CHPS to overall health service delivery in Ghana for the period 2014.

Table1.3: Contribution of the CHPS initiative to National Health Indicators

LEVEL OF SERVICE DELIVERY	FAMILY PLANING %	POLIO.IMM UNIZATION %	OPD ATTENDANCE %	SKILLED DELIVERY %
CHPS Zones	30.4	36.1	10.2	3.8
Health Centres	43.0	53.2	27.1	24.8
Hospitals	22	9.2	58.7	65.6
Maternity Homes	4.3	1.5	4.0	6.6
Total	100	100	100	100

Source; PPMED. GHS.2015

1.11 Resources for CHPS Implementation

The traditional budgetary allocation for financing the health sector is expected to be the main source of financing CHPS. This is expected to be complemented by internally generated funds from health insurance schemes. Also, the availability of skilled human resource for the successful implementation of the CHPS strategy cannot be over emphasized. Delivery of the appropriate package of services to

communities is provided by frontline health workers who are appropriately trained and deployed as CHOs.

To ensure efficiency of the CHPS strategy for health service delivery, the availability of appropriate logistics is an important factor; logistics is required for service delivery, such as drugs and other consumables, cold chain equipment Bp apparatus, weighing scales, delivery beds, water holding receptacles, working gear and communication gadgets; and also mobility logistics that include motorbikes and bicycles for outreaches and home visiting. Comfort items to furnish the Community Health Compounds (CHCs) and staff accommodation are also very important, such as beds and mattresses, television (TV), radio, kitchen ware etc.

1.12 Objectives of CHPS

The focus of the CHPS approach is to achieve three important objectives;

1. Improve access to basic health services
2. Improve efficiency and responsiveness to client needs
3. Develop effective inter sectorial collaboration

Overall, CHPS is the decentralization of the Ghana Health Service system.

1.13 Problem Statement

The CHPS strategy was introduced in 1999 by the Ministry of Health as a national policy to improve access to and provide quality health care to rural communities.

In districts where CHPS is function well, it has proven very useful as a model for providing access to health care. (MOH, 2009).

In 2002, the Saboba District adopted the CHPS strategy to increase access to health care to remote and underserved communities in the district. Available evidence, as shown in the table below, show that since the inception of the initiative, there is observed improvement in some health indicators.

Table 1.4: CHPS Contribution to Health Service indicators, Saboba 2003-2005

INDICATOR YEAR	MATERNAL DEATHS	INFANT DEATHS	EPI (%) PENTA 3 is used as a proxy	GUINEA WORM CASES
2002	51	119	45	206
2003	2	37	97	51
2004	0	24	118	41
2005	2	12	120	22

Source: DHMT, Saboba, 2005.

In the year 2001, the Saboba sub district (as known at that time) had demarcated eighteen (18) zones for the implementation of CHPS. Plans were that, commencing the year 2002, and by the close of 2013, a total of eighteen functional CHPS zones would have been launched and operational in the District. (DHMT, 2003). The Saboba district become a separate district in 2008, following the elevation of Cheriponi to full District status. Since 2002, and at the close of

2013, of the eighteen demarcated CHPS zones, only six (6) CHPS zones have been launched and are functional in the Saboba District. The District has not been able to achieve the target of progressively rolling out the initiative to 18 functional CHPS zones (DHMT, 2014). Using a qualitative approach, this study sought to answer the question; what are the challenges that exist for the implementation or roll out of the CHPS strategy that the District has not been able to reach its target of achieving 18 functioning CHPS zones by the year 2013.

1.14 Research Questions

1. What are the perceptions of community health committee members' and health staff of the CHPS initiative and its implementation in the Saboba District?

2. What are the logistics, human resource and financial challenges for CHPS programme implementation in the Saboba District?

1.15 General Objective of study

The study is to identify the implementation challenges of the CHPS programme in the Saboba district, and the need to take cognizance of these in implementing similar Community-based Primary Health Care Programmes.

1.16 Specific objectives

1. To determine the perceptions of community members and Health staff of CHPS and its implementation in the Saboba District.

2. To determine the logistical, human resource and financial challenges for CHPS implementation in the Saboba District.

1.17 Significance of the study

Even though there is anecdotal evidence of the success of the functional CHPS zones, the Saboba District has not been able to add on to the functional CHPS zones in the District since 2002. No study has been done to determine any challenges or obstacles that may exit to impede the roll out of more CHPS zones in the district. This study is therefore to identify and assess the implementation challenges of the CHPS initiative in the District. This assessment would guide the District and other Districts and policy makers in the design and implementation strategies for CHPS and other similar Community-based Primary Health Care initiatives.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews relevant literature on Primary Health Care, with emphasis on community based health programs like the Ghana Community-based Health Planning and Services (CHPS). From the review of literature, not very much published works exist on the implementation challenges of CHPS which makes the work in some cases to rely much on the already existing scanty empirical studies. The chapter looks at the term 'Primary Health Care" and Primary Health Care in Ghana; a brief history of health care and reforms in Ghana, concept of CHPS and CHPS coverage as well as the benefits of CHPS and achievements as well as challenges associated with CHPS. This chapter concludes with the topic, why programmes fail and the conceptual model of the study.

2.1 Primary Health Care

The term 'Primary Health Care' (PHC) gained widespread currency following the 1978 International Conference on Primary Health Care held by the World Health Organization (WHO, 1978) and United Nations International Children's Fund (UNICEF) at Alma-Ata. Since that time, PHC has meant many different things to many different groups and countries. In this section I briefly summarize the key characteristics of PHC and draw attention to those elements of PHC which are most relevant to this study.

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 that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO,1978).

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 (WHO, 1978).

2.2 Primary Health Care in Ghana

Before Alma Ata, Ghana was practicing PHC in different forms. Health care delivery was designed and delivered at three (3) levels;

1. Community level
2. Health Centre level
3. District (Hospital level)

Other initiatives included training of Village Volunteers, and Training of Traditional Birth Attendants.

The MDGs goals 4, 5 and 6 put PHC on the international agenda for health care. In Ghana, it is the MOH and the GHS that define the health systems and its organization. Health care delivery is in four (4) categories, thus public, private-for-profit, private-not-for-profit, and the traditional sector (ACCORD, 2009).

Primary health care in Ghana is structured to serve the rural and urban populations according to priority. The rural areas which are mostly deprived of permanent health infrastructures have been prioritized with programmes such as the Community Health Planning Service (CHPS), which aims to transform clinic-based primary health care and reproductive health services to community-based health services. Within the context of Primary Health Care, Ghana has adopted and used many initiatives to provide health to communities. These include Community Health Volunteers, National Traditional births Attendants (TBAs) etc. Ghana also embarked on training health workers, especially for the need of rural areas. The Kintampo Rural Health Training School (KRHTS), situated in the middle of the rainforest region of Brong Ahafo, the Navrongo Health Research Centre (NHRC) situated farther in the north-east of the country, and others of their kind in other regions of the country train community health workers, nurses for deployment into rural areas (GH, 2005).

2.3 Brief history of Health care in Ghana

Since the colonial days, Ghana has pursued vigorous and extensive health sector reforms. The goals of all such reforms were to improve access, increase efficiency and reduce health inequalities. The country has attempted to achieve these through

significant initiatives and strategies, including state control and interventions through a public national health system and even in some periods, adopted a market competition under "cash and carry" system. Health delivery in Ghana is noted to have passed through three (3) eras (Yeboa, 2003).

2.3.1 Pre-Colonial Era Health care

During the Pre-colonial Era, there was no organized national health system. Modern medical care was non-existent. Key players in the health care provision were traditional health practitioners. People relied almost entirely on their own indigenous expertise for health care.

2.3.2 Colonial Era Health care

The colonial era of 1844-1957 saw the introduction of modern health care on a limited scale. Health care was not organized on a national scale to benefit all people. Mostly the Europeans and their house helps benefited from the system (Kunfa, 1996). During this era, health care was restricted to the cities and more so to the sections that the Europeans resided-European towns.

2.3.3 Post Independence Era Health care

The post-independence era saw various governments (military and civilian) come up with various policies and strategies all aimed at modernizing the health care system to make it more responsive to the health care needs of the people. There was the seven (7) years development plan 1963-70 that had the understated as its key health policy objectives (Yeboa, 2003).

This plan was abandoned with the inception of a new government in 1966.In this year, a 2-year Development Plan 1968-70 was drawn and this was the first plan that aimed at reversing the urban biased national health system with equity as the overriding principle (Yeboa, 2003).

Among the strategies adopted to overhaul the colonial inherited health system included, rural biased national health resource allocation: construction of more health posts in deprived regions and districts, aimed at improving physical infrastructure, emphasis on preventive and promotive health, the package of which included health education, school health, water and sanitation, maternal and child health; the training of more community and public health nurses so as to increase cadre of health staff for service delivery.

This plan yet again did not see its full life span and with yet another change of government, a 5-year plan was introduced in 1975-80 (Yeboa, 2003). This 5 year plan had equity as its priority, which was aimed at reversing the ever increasing trend of urban biased curative care at the expense of urban and rural poor. Also, emphasis was placed on Primary Health Care, the functions of which were to be so arranged to ensure local participation and the use of community or village health workers.

In 1983, another government introduced a health plan which did not differ from previous ones, but also had emphasis on Primary Health Care e.g. the use of community or Village Health Workers, construction of more health centers as well as the decentralization of health service administration that aimed to strengthen

healthcare delivery at district level (PNDC Law 2007, 1988). All these plans, have achieved results. For instance, infant mortality rate, a good indicator of the health of every nation has been dropping (Yeboa, 2003).

At independence, it was 133 per 1000 live births and by 1988 it had reduced to 75 per 1000 live births. Mortality rate of children under five (5) years was also 154 per 1000 live births and this also reduced to 110 by 198 (GDHS, 1999).

However, the rate of change was slow, and there were still wide disparities within the country, and this was a major concern for health managers, planners and policy makers (Yeboa.2003).

2.4 Health Sector Reforms in Ghana

As a result to changes in economic philosophy, Ghana embarked on a health sector reform based on market forces, aimed at improving access to basic health care and ensuring efficiency, whilst improving links with other sectors.

In 1996, Ghana developed a long term vision for growth and development to move from low income to a middle income country by the year 2020 known as "Vision 2020". In response to this national philosophy, the Ministry of Health in 1996 developed and published a Medium Term Health strategy and a 5-year Programme of Work, 1997-2001 to guide health development in Ghana.

There was vigorous construction of health centers in the rural areas so as to increase geographical access to basic healthcare services; an introduction of quality assurance systems to guarantee better quality of care to users in all

facilities. In addition, all the 110 administrative districts were divided into between four (4) to (9) nine sub-districts for effective and efficient planning and implementation of health programmes.

A second health sector programme of work (POW) was developed for the period 2002 – 2006. This contained the strategic direction of Ministry of Health, with a vision "improved overall health status and reduced inequalities in health outcomes of people living in Ghana".

The strategic pillars of this POW were to:

1. Improve quality of health service delivery
2. Increase access to health services
3. Improve the efficiency of health service delivery.

In all the policies, objectives, and strategies, the focus has been on access to health care within the context of Primary Health Care. The Health sector reforms and the follow-up five year programme (1997 – 2001) no doubt achieved some results. However, the challenges of inequitable access to health care delivery still existed.

Health care in Ghana has thus passed through three (3) phases, and even chequered in some stages, culminating in the health sector reforms aimed at improving access and ensuing quality health care to the people.

2.5. The concept of CHPS

In Ghana, Community-based Health Planning and Services (CHPS) initiative is a Programme designed to translate innovations through an experimental research study at the Navrongo Health Research Centre (NHRC) into a national programme for improving the accessibility, efficiency and quality of health and family planning services (Binka et al.,(1995); Pence et al.(2001): Debpuur et al., (2002). Despite the existence for two decades of "health for all" policies, in 1990 more than 70 percent of Ghanaians still cannot get access to quality health care services as they stay about eight kilometers away from the nearest service provider, leading to rural infant mortality rates being 50 percent higher than corresponding urban rates (GHS, 2008). Improving access to healthcare, therefore, remained a primary goal of health-sector reform since the 1990s. When the Navrongo Health Research Centre (NHRC) experiment demonstrated that community-based health services could reduce child mortality and fertility in impoverished communities, the Government of Ghana launched the Community-based Health Planning and Services (CHPS) initiative to scale up results. Navrongo presented an approach to evidence-based policy development, which aimed to bridge the gap between research and programme implementation (Nyonator et al., (2005a).

The CHPS Initiative scaled up innovations from NHRC's experimental study into a programme of national community health care reform that sought to improve the accessibility, efficiency and quality of health and family planning care. Regarded as the primary strategy for reaching the unreached, CHPS became an integral part

of the Ghana Health Service Five Year Programme of Work and represented one of the health sector components of the national poverty reduction strategy (Nyonator et al, 2005a). Over a two year period, 104 out of the 110 districts in Ghana started CHPS (Nyonator et al, 2005b).

2.5.1 CHPS as a change process

The Community-Based Health Planning and Services (CHPS) initiative is a national programme for reorienting and relocating primary health care from sub-district health centers to convenient community locations. The CHPS organizational change process relies upon community resources for construction, labour, service delivery, and programme oversight. As such, it is a national mobilization of grass-roots action and leadership in health and family planning. The CHPS initiative enables the Ghana Health Service (GHS) to reduce health inequalities and promote equity of health outcomes by removing geographic barriers to health care. CHPS is a component of other government policy agendas, such as the Ghana Poverty Reduction Strategy (GPRS), which identifies CHPS as a key element in pro-poor health services; as well as the New Patriotic Party Manifesto which identifies CHPS as a priority health activity. In addition, various sector performance reviews in 2002 commended CHPS as an appropriate way to deliver health care to communities in undeveloped and deprived areas distant from health facilities (MOH, 2001).

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 endeavors 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. Like other community-based health programmes, 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 structures for service delivery. District Health Management Teams augment the skills of Community Health Nurses (CHN) or other cadre of staff to prepare them for the delivery of preventive and curative care while residing in the community

2.5.2 Components and Objectives of CHPS

The main components of CHPS are, the zones, the compound, the CHO, the community Health village volunteers and Community Health Committee.

Objectives of CHPS are:

1. Improve quality in access to basic health services to underserved communities.
2. Improve efficiency and responsiveness to community health needs
3. Develop effective inter sectoral collaboration

Community Health Officers (CHOs), are health staff who have been orientated and located in a zone to provide 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, and community health committees who assist with community mobilization, the maintenance of community registers and other essential activities (Nyonator et a, 2005b).

2.5.3 Elements of CHPS

The specific elements of the CHPS service delivery model are based on Navrongo research results demonstrating that placing a nurse in the community substantially reduces childhood mortality, and combining nurse outreach with traditional leader and volunteer involvement builds male participation in family planning and improves health service system accountability. Recent results, based on rigorous experimental research, show that the Navrongo experiment reduced total fertility by one birth, and childhood mortality by 38 percent in the first three years of project operation (Debpuur, et al, 2002).

According to Nyonator, et al, 2002) in 1998, the Navrongo programme was launched to disseminate the experiment by training District Health Management Teams (DHMT) in procedures for establishing community-based care. When a participating team from Nkwanta District in the Volta Region demonstrated that

this community-based service model could be replicated with limited Ghana Health Service (GHS) funding, consensus emerged about the feasibility of replicating this model on a large scale. In the 1999 National Health Forum, a policy statement leading to the launching of the CHPS initiative was adopted based on the Nkwanta experience: With modest DHMT support, communities would build clinics and support health and family experiment planning services.

Once the programme was started in two demonstration communities, the remaining Nkwanta communities soon learned about the initiative and constructed health facilities with volunteer and community labour. This suggested that pilot trials in a district would lead to rapid diffusion of organizational change elsewhere in the district.

District teams visiting Nkwanta gained insight from the experience, and replication efforts spread to other districts. Initially, ten districts were designated where innovation could be disseminated to neighboring districts, on the Nkwanta model. Subsequently, ten additional "lead districts" were designated where CHPS progress is used for the dissemination of innovation (Nyonator, et al, 2002).

As of June 30, 2002, 95 out of 110 districts had launched the planning stage of the CHPS programme. Of these, 20 had launched nearly all elements of the CHPS approach in one or more service implementation areas; seven districts had completed the CHPS programme in one or more implementation zones. National coordination and policy leadership has been directed to ensuring service quality

standards and launching technical training for all participating workers (PPMED, GHS, 2002).

2.6 CHPS coverage

The average population covered by CHPS, as at 2009, was about 6.4%, with a range of 1.4% in the Brong Ahafo Region to 12.5% in the Upper East Region (GHS, 2007). The CHPS implementation moved from 24% in 2005 to 35% in 2008. The level of roll out of the CHPS initiative varies by district. The former Kassena – Nankana District is the most successful with about 67percent roll out rate (MOH, 2009).

Information available indicates that the assessment of performance of the CHPS programme has over the years been limited to the number of CHPS compounds built annually (MOH, 2009).

Over an eight (8) year period, the number of functional CHPS compounds has grown from 19 in 2000 to 401 in 2008. The implementation of the CHPS programme nationwide has been below average. The planned roll out of demarcated CHPS Zones at the end of 2008 was 1,314 (i.e. only 31% of the planned number (MOH, 2009).

Between 2000 and 2003, 85 percent of districts in Ghana began CHPS implementation and only completed the planning process. Relatively few districts had moved beyond the planning and actually launched community services. Progress with CHPS implementation declined following the planning stage.

(Nyonator et al, 2005). In general, there are implementation challenges of CHPS relating to issues of manpower numbers, training, service capacity, and deployment (Awonoor et al, 2008).

2.7. Benefits of CHPS

With CHPS as a primary health care provider, there are fewer and less hospital admissions. There is also the spirit of working for the community, absorbing of community support and assistance as well as community empowerment. The mobilization of necessary local resources and use of local structures lead to reduction of costs. In addition, there is also consumer or beneficiary engagement. In a report by the Ghana Health Service Monitoring and Evaluation Division (PPMED, GH, 2002) some benefits of the CHPS initiative to the communities include health education on malaria, HIV/AIDS and Family Planning; Immunization services and growth monitoring of children; decrease in maternal and infant mortality, and increase in family planning use, as well as improved disease surveillance.

In all, there is no doubt that the initiative is capable of improving access to health care, lowering health care cost and improving health status if given the appropriate support. Considering the future, CHPS is the "donkey " on which Ghana can ride to achieve MDGs 4,5 and & 6.Services like ante natal and post-natal care, health promotion and education, child hood and other vaccinations, and the prompt management of minor ailments will be provided at the community

level. Prompt referrals also go a long way to reduce maternal complications and deaths.

2.8 Achievements of CHPS

There is evidence to demonstrate that CHPS roll out has made some achievements. (PPMED.GHS, 2002). The CHPS programme has led to an increase in the resource allocation to the MOH/GHS .Also, the introduction of the initiative has contributed to an increase in the establishment of more health training institutions across the country and consequently the training of more community health nurses. In addition, the CHPS programme has contributed to effective engagement with partners, e.g. USAID Systems for Health, the World Bank, etc.

It is also documented that CHPS has contributed to improvement of health indicators, nationwide (PPMED, GHS, 2015). The programme has also earned international recognition, such that countries like Kenya, Ethiopia, Rwanda, and Uganda have come to under study the programme and replicated the programme in these countries with varying degrees of successes

2.9. Challenges associated with CHPS

Community based health care programme like CHPS provide a unique way of health delivery. However, this initiative has its own set of considerations and challenges.

The District and sub-district levels are responsible for implementation of MOH policies, baseline data collection, in-service training, and providing care at the community level. At the community level, great strides have been made in recent years, with the government committing itself, to moving health care from established facilities of which there are woefully few, directly to communities as by the CHPS programme (MOH, 2006). This concerted effort was outlined in the country's Programme of Work (POW) for 2002-2006, which has been the backbone of MOH and GHS activities for more than the past ten years and will continue to be influential in its plan of work. According to the Annual Health Sector Reviews (2009), information gathered from the field indicates that although the CHPS programme is considered by policy makers, development partners and public health providers as a good pro-poor health service delivery strategy, particularly in rural areas, its implementation has been thwarted with obstacles and/or problems that have not permitted the full realization of its benefit. The implementation obstacles and challenges over the period include :(MOH, 2006).

2.9.1 Different Understanding of CHPS

There is different understanding of CHPS among the Health Sector Leadership: The different understanding of CHPS among MOH and GHS leadership at the various levels has led to skewed implementation toward curative services to the detriment of promotive and preventive services.

In the Upper East Region, some of the directors consider CHPS to be implemented and functional even without a compound as long as a Community Health Officer (CHO) provides services. In contrast, directors based elsewhere tend to disagree with this perspective (Awonoor, et.al, 2013).

2.9.2 Inadequate resources

The MOH and GHS have no specific budgets to support the CHPS programme. This has resulted in incoherent partnership and overemphasis on CHPS compounds to the detriment of other components. CHPS is considered a key health delivery strategy at the National level, however, the Ministry of Health/ Ghana Health Service lacks or does not demonstrate the required political will and clout with the requisite resources to enhance implementation or scale up. Inadequate provision of basic equipment is another implementation challenge. There is a lack of the Community Health Officer (CHO) Tools kit, made up of basic clinical tools such as BP apparatus, weighing scales and thermometer. Also, other equipment like solar fridges and basic equipment to motivate the staff are lacking. Means of transport (motorbikes) for the CHO to do visitation is also another challenge. Even maintenance of broken down motorbikes is generally

poor. The purchase of poor quality motorbikes that often lead to frequent breakdown is also a problem. The issue of irregular and erratic supply of fuel and lubricants cannot be over emphasized (Binka et al, 2009).

2.9.3 Insufficient CHPS Compounds

Even where the zones are demarcated, they are not functional because there are no Community Health Compounds (CHCs).

2.9.4 Inadequate means of transports

There are inadequate motorbikes for the CHOs for their visitations. Maintenance of broken down motorbikes is generally poor and supply of fuel is a problem.

2.9.5 Inadequate Human Resource

Field investigations have also shown that CHO and manpower shortages and financial resource constraints explain much of the implementation gap (CHPS GHS, 2002). Human resource problems exacerbate constraints to CHPS implementation. Even if all available community nurses were trained and deployed, serious shortages would exist in many districts. The problem of turnover further complicates posting and availability of Community Health Officers (Nyonator, et.al, 2003).

Williams (2003), in Lessons learned from scaling up a community-based health programme in the Upper East region of Northern Ghana, also noted challenges to CHPS implementation and scale up to include issues related to manpower

numbers, training, service capacity and deployment. For instance, CHOs in the early phases were unprepared to deliver essential health service, such as addressing maternal and neonatal complications.

2.9.6 Inadequate skill mix of CHOs

CHOs are limited in skills for the provision of some services such as suturing, management of asphyxia, conducting delivery etc CHOs need improved skill mix to improve their functionality.

2.9.7 Limited Community Mobilization Skills of CHOs

Another recognized challenge is the limited community mobilization or engagement skills for CHOs. Community participation and mobilization component of the CHPS program which forms the backbone of preventive activities and home visitation is a challenge in the program, leading to more static and curative services. (Binka et al, (2009).

2.9.8 Finance

Although launching CHPS is not expensive, its incremental costs are difficult to sustain. The estimated total expenditure for fully functional CHPS zone covering a population of about 3,000 is US$ 33,245 (about US $9.50/capital including a solar panel but excluding CHO salaries, fuel for vehicles for monitoring activities and training costs). The most costly components are facility construction ($20,240) and motorbike procurement ($5,300). However, if community members conduct construction, using traditional material for building, the cost is reduced

substantially (to about $3 per capital). These modest costs are nonetheless a major challenge to district health managers, who often lack adequate resources for implementing even the most basic health service agenda (Awonoor et al, 2013).

The Ministry of Health and Ghana Health Service do not have a specific budget to support the CHPS program. This has contributed to incoherent partnership and over emphasis on CHPS compounds to the detriment of other components. (Binka et al, 2009).

2.9.9 Issues related to new health initiatives

Issues related to new health initiatives are another implementation challenge for CHPS. There appears to be conflict between CHPS and High Impact Rapid Delivery (HIRD) The HIRD was supposed to be built on the CHPS program and not to replace it. (Health Report, 2009).

There is evidence (anecdotal) to demonstrate or show that support for CHPS was reduced when the Ministry of Health decided to fund High Impact Rapid Delivery (HIRD) instead of CHPS; all because the Ministry was unhappy with the progress CHPS was making to rapidly achieve Millennium Development Goals 4 and 5 (Binka et al, 2009).

2.9.10 Leadership and Management

It has also been demonstrated that resource constraints and leadership problems often prevent the spread of CHPS. (Nyonator, et.al, 2003). In many districts, the lack of leadership and political engagement, coupled with the absence of a budget

line for CHPS, resulted in inadequate resources for implementation of the initiative. Another key challenge related to implementation of community-based health programmes is the quality of supervision (Oliver et al, 2012).

From 2.1 table below, all regions are implementing CHPS, however, there is a huge gap between the demarcated zones and those with compounds. This gaps between demarcated and those with compounds can be attributed to various implementation challenges, which include human resource, funds and equipment.

Table 2.1 Trend of regional CHPS implementation, Ghana

Region	Demarcated	Demarcated with compound	Gap
Ashanti	1015	92	923
Brong Ahafo	724	206	518
Central	365	124	241
Eastern	768	236	532
Greater Accra	912	35	877
Northern	428	150	278
Upper East	259	146	113
Upper West	241	114	127
Volta	474	79	395
Western	363	100	263
National	5487	1189	4298

Source.PPMED.GHS.2015

2.9.11 Lack of political will to scale up

At the national level, CHPS is not considered as a key health delivery concept to enhance scale up. At the implementation level (i.e. district and community), there seems to be misunderstanding of the concept of CHPS and lack of district and community participation.

Anecdotal evidence suggests that the support for CHPS was reduced when the MOH decided to fund High Impact Rapid Delivery (HIRD) instead of CHPS, because they were unhappy with the progress CHPS was making to rapidly achieve MDGs 4 and 5.

2.10 Why programmes fail

Various key factors that affect health programmes and strategies implementation emerge. This makes the delivery of effective Health Programmes to people in need to be compromised, particularly in remote rural areas. Some of such factors that pose as challenges to health programme implementation include perceptions of the people, insufficient resource allocation, Health Workforce, and financing.

2.10.1 Perceptions of the People

There are many writers who tell the story of why programmes and projects fail. For instance, in a study "Factors that affect the success and failure of insecticide Treated Net Programme for Malaria in South East Asia and the Western Pacific"; Tony.2005) noted that community perceptions and needs play a significant role for the success of or failure of programmes. In the study, it was revealed that

making mosquito nets available to villages does not necessarily make them a desirable commodity. The nets may not be used as intended for a variety of reasons. For example, people may not share the beliefs of the causation of the disease, and the relationships between mosquitoes and Malaria. For instance, where disease incidence, and biting nuisance appear not to be clearly related. Also, where malaria is not perceived as a priority problem in a community, the availability and acceptance of nets may not automatically lead to a consistent and effective use of the nets (Tony, 2005). Another study in Ratchaburi Province, Thailand (Tony, 2005) showed that the use of impregnated bed nets was significantly related to factors such as knowledge of malaria prevention and perception of benefits of the use of the nets.

Studies in rural communities in central Malaita, Solomon Islands showed that reasons why people used bed nets differed within communities, and this affected pattern of usage. Children from households where nets were used for malaria protection were more likely to sleep under bed nets than children from households where nets were used as protection from mosquitoes only (Tony & Rom, 2005).

Also, in a study entitled "Why international medical aid programmes to prevent HIV/AIDS often fail at the local level", Atik (2009) concluded that the most important thing in a successful intervention programme is to change people's behaviour, where local beliefs, attitudes and perceptions about HIV and the perception about condom use is taken into account and local influential people are included in the intervention programme.

2.10.2 Logistic Constraints

Logistics play strategic importance, and good logistics availability is critical for programme success. Attention to reliable and adequate logistics is crucial for programmes to meet their objectives.

Where there is no creation for and sustaining an enabling environment for logistics supply, most community-based health programmes run the risk of withering on the geographical, and organizational periphery (WHO, 2007).Numerous programmes have failed in the past because of unrealistic expectations, poor planning and underestimation of the effort and inputs required to make them work (WHO, 2007).

YokuSha-Tylor in a report in the Daily Graphic of 17th February, 2014, writing on the topic "Failures and Challenges of Ghana's Health Care System" noted among other things that challenges in Health Services in Ghana remain as not enough providers (physicians, nurses and other trained care givers), but mal-distribution of providers, and lack of required equipment, among others.

An effective logistics and equipment availability and supply system is essential for programme implementation success. For programmes like the CHPS initiative, a reliable and good supply of appropriate transport, fuel, refrigerators, scales, Bp apparatus, communication gadgets, water storage vessels, lightening equipment as well as comfort items work together to make sure that programmes meet the desired objectives.

2.10.3 Inadequate Human Resource and Training

According to the WHO, extreme shortage of Health workers exists in 57 countries for which 36 are in Africa (WHO, 2006). This crisis (situation) has been exacerbated by inequities in workforce distribution and brain drain. More than 18 million people die each year worldwide from communicable diseases, maternal and prenatal conditions and nutritional deficiencies. The vast imparity of these deaths occurs in developing countries (WHO, 2005).

The international community has set ambitious goals, i.e. Millennium Development Goals (MDGS) to improve health in developing countries by 2015: two–thirds reduction in child mortality, three quarter reduction in maternal mortality and half mortality and reversal of incidence due to HIV/AIDs, tuberculosis and Malaria Epidemics (UN, 2003). Effective and often cheap interventions and programmes exist to achieve these goals. However, a number of factors impede or cause the failure of such Health Programmes and interventions to achieve health improvement similar to the Millennium Development Goals (MDGS).

Relevant to all health programmes is the human resource factor. On the supply side, the availability of adequately qualified and motivated human resource for health prove to be one of the most challenging obstacles to the successful implementation of health programmes and to achieving the MDGS in poor countries

The community Health Officer and lay health worker programmes have been promoted in many countries since the 1970s and 1980s. However, many of such Health programmes have failed or have been abandoned as they failed to realize the potential demonstrated in several initiatives. An example is the China "barefoot doctors" (Lehman & Sanders, 2007).

According to Lewin et al, 2005), and also recounted by Haines et al, 2007) and reinforced by Morrow (2005), search of key databases and interrogation of published reviews of lay health worker programmes, find that unavailability and high turnover of health staff, is widely recognized as a factor for failure of Health programmes. Success and sustainability of such programmes are threatened by high rates of attrition of health work force.

In the 1980s, it is reported that health worker attrition rates were between 3.2 percent and 77 percent (Parlata et al, 1982). The challenge of human resource for health programmes persist. In a programme in the Plurinational state of Bolivia, a lay health worker attrition rate of 43% percent was noted (Tenerio et al, 2009).

In South Africa, a tuberculosis intervention programme failed because the programme suffered a loss of 11 to 12 health workers in less than a year (Atikins et.al, 2009).

In Bangladesh, implementation of an intervention aimed at improving new born care lost 32 out of 43 heath workers over a four year period (Rahma et al, 2010).

Relative to other sub-African countries, Tanzania is well endowed with human resource (WHO, 2002). Yet on the whole; the human resource challenge of expanding priority health interventions in mainland Tanzania is daunting. Though doing well in comparison with other sub-Saharan African countries, in 2004, the government of Tanzania declared human resource for Health, a crisis (Dominick & Kurowski, 2004).The scaling up of the HIV/AIDs related cluster, in particular, the treatment and care of people living with HIV/AIDs was highly affected by the over imbalance in human resource for health (Christopher et al, 2007).

Inadequate human resource capacity has also been identified as a constraint to effective Prevention of Mother to Child Transmission (PMTCT) services in study areas in Arba Minch, Ethiopia (Adebola et al, 2012).

In Algeria, human resource challenges come from deteriorating professional qualifications, and this has very serious consequences on the implementation and failure of Health programmes. The scaling up of priority interventions to achieve health improvements require human resources far in excess of the number likely to be available in 2015.Access to skilled health care providers is a major challenge facing developing countries. The fulfillment of the MDGS call for improved access to skilled attendance at birth, but the number of nursing and midwifery staff in Africa is only 11 per 10,000populations compared with 79 per 10,000 in Europe. The World Health Organization estimates that countries with fewer than 23 skilled health care providers (that is physicians, nurses and midwives) per 10,000 population will not be able to bring essential interventions for the MDGs up to a nationwide scale (Anand et al, 2004); WHO, 2009).

Even if sufficient investments in training new health care providers are made, poor countries are challenged by difficulty of retaining nurses and midwives of high need. In many low income countries, the unavailability or lack of skilled human resources is a key constraint to implementing and scaling up priority community-based health interventions. Another study in Ratchaburi Province, Thailand (Tony, 2005) showed that the use of impregnated bed nets was significantly related to factors such as knowledge of malaria prevention and perception of benefits of the use of the nets.

In the journal *"Health challenges in Africa and the way forward"* (Joses & Saidou, 2008) have also indicated that health programme failure is characterized by low investment.

2.10.4 Inadequate Funds

Alanna Shaikn (2010) writing on the topic "*Set back in public health: - When a program doesn't work*" indicated that there are a lot of kinds of reasons for programme failures. Among reasons for failures were, badly designed programmes that are not tailored to the community it works for, and also the unavailability of the required finances or money to actually achieve their objectives.

Insufficient finance has been documented to be the barriers why some countries in sub-Saharan Africa fail to adopt new vaccines for immunization programmes despite the recognition of high disease burden.

Vaccine infrastructure is sub-optimal in Africa and operational factors are the problem barriers that require substantial and continuous investment in human capital, equipment and financing (Mark & John, 2006).

Commenting on the Ghana free delivery care policy, Ofori-Adjei (2007) states that generally while the policy was considered favorable by both service providers and users, there were significant problems with its implementation. This is so because the implementation of the policy did not have adequate financial backing and a system of standard charging was not applied. Failure of prompt and adequate reimbursement to the clinical facilities led to near failure of the programme (Ofori-Adjei, 2007).

2.11 Conceptual model

Programme implementation is an interactive process involving a number of factors that at all times require due consideration during the implementation. This requires translation of the broad conceptual understanding of the factors so that adequate preparations can be made to ensure smooth implementation and sustainability. The process of CHPS implementation requires due consideration of the perceptions of programme beneficiaries, including logistics human and finance.

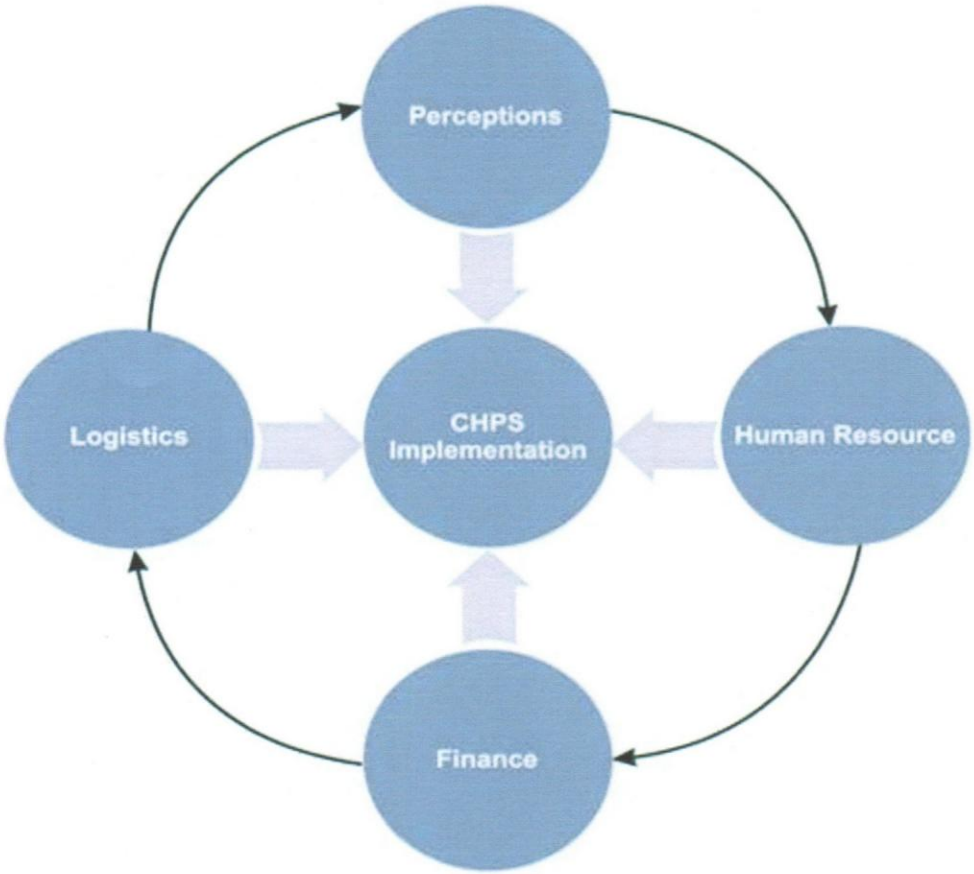

Figure2.1 Conceptual Model

Source: Author's Construct 2014

Perceptions are important aspect of human behaviours. Depending on how people see, appreciate or conceptualize things, what their beliefs are, and their experiences, all influence the individual positively or negatively, and determine how the individual is able to cope and keep with such. In the CHPS programme how the various stakeholders tend to appreciate things about the programme will influence what support and knowledge they will bring on board to support the implementation of the programme and ensure its sustainability. Programme

implementation involves creating linkages with other people and this requires the common understanding of all so as to avoid conflicts and bring interdependence to address issues for effective programme implementation. As the end beneficiaries of the CHPS strategy, it is important that the perceptions of community members are considered in the process of its implementation. If the perceptions of the people are taken into consideration, it enables clarification of misconceptions and this leads to a greater acceptance and the participation of community members.

Logistics: are those material things in their peculiar forms that are essential and required to enable health services to be provided to people. Logistic support and availability is crucial for the successful implementation and sustainability of a programme like the CHPS initiative. A good and reliable logistics support is fundamental for a continuous and efficient provision of quality health care. Consideration for logistics support should include the present and the future, appreciating the changing environment and circumstances of the health care delivery system and local circumstances. In addition, logistics support should be sustainable and flexible to meet program needs and beneficiary expectations. A good financial base is crucial to ensure the procurement and continuous flow of inputs for programmes to be successfully implemented. For logistic to be of any use to any programme, the human resource factor should be considered; since it is the people who will manipulate and use the resources to the benefit of the people.

Human Resource According to the WHO, (2006), Human Resources for Health is "...all people engaged in actions whose primary intent is to enhance health". It is important to ensure the availability of the appropriate human element that can

fulfill and enhance programme implementation. Without the required human resource, the logistic for any programme will not inure to the benefit of programme recipients. Identifying and addressing the staff challenges of such community-based health programmes will ensure smooth implementation. The people or human management component is essential to effective programme implementation as it also ensures trust and confidence. The way people perceive things and with adequate availability of the required resources for people to work with will enhance project success and sustainability.

Finance. Finance is the money or umbrella term used for resource mobilization for all programme implementation. A strong financial base has the capacity to mobilize adequate resources for CHPS programme implementation. The financial mechanism available play a significant role in all health programme implementation. Financial availability and assurance is crucial for effective CHPS implementation. Above all, human resource (Staff) and logistical challenges require financial investment.

CHAPTER THREE

STUDY AREA AND METHODOLOGY

3.0 Introduction

The methodologies used to collect and analyze the data in this study are presented in this section. A description of the study area as well as an overview of health services delivery, sampling size determination, and sampling procedure are also stated in this chapter.

3.1 Study setting

The study setting is the Saboba district of the Northern Region. The Saboba district, with Saboba as district capital, used to be a twin district (Saboba–Chereponi district), but became separate district when Chereponi was elevated to full district status in 2008 The Saboba district lies in the North Eastern corridor of the Northern Region. It is located about 196 km from Tamale, the regional capital. The district population is estimated to be about 65,706 (projected from the Ghana Population and Housing Census (GPHC, 2010), (GSS, 2011). The district has an annual growth rate of 4.9%. Female to male ratio is 52.2 to 48.8. (GPH, 2010). The age distribution of the population mimics that of the national level, thus indicating a high dependency ratio .According to the 2010 GPHC, GSS, 2011 by geographic delineation, 80% of the district is predominantly rural and 20% urban. The district covers a land area of about 1100 sq.km, with over 290 settlements or communities

The district is bounded to the north by the Chereponi district and to the west by the Gushegu district. On parts of the eastern border, it is bounded by the river Oti and Zabzugu district. In fact the river Oti serves as an international boundary between Ghana and the Republic of Togo. To the south, the district is bounded by the Yendi district. It is typically Savannah grassland and experiences one rainy season and a long spell of dry season.

Sketch map of the Saboba district

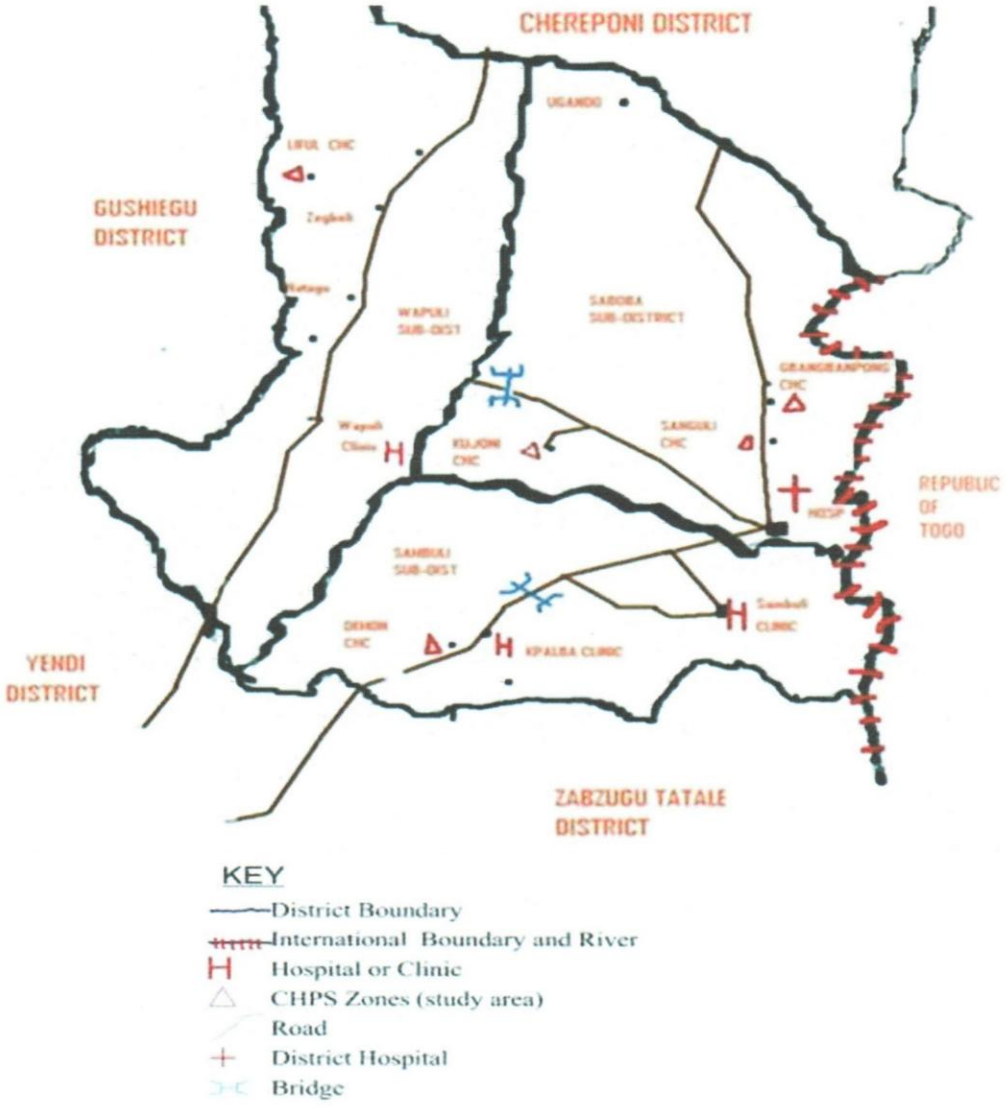

Figure 3.1 Sketch Map of Saboba, the study District.

The district has three (3) traditional areas of which each is a paramountcy, namely Nambiri, Sangule and Saboba. It is relatively a homogenous society, with the main ethnic group being the Konkombas, made up of various clans. A small proportion of other groups like Moshi's, Ewes, Battors and Chakosis exist. The

main language spoken is Likpankpan. The principal religions are African traditional region, Christianity and a small proportion of the inhabitants practice Islam. Peasant and subsistence farming is the main occupation of the inhabitants.

Politically, there is a District Assembly, composed of 25 elected members and 12 Government Appointees. The District Assembly is the main coordinating body of the various departments and their activities. It plans, formulates and implements plans and development programmes in the district. It also interprets and disseminates government policies. The District Chief Executive (DCE) is the political head of the District Assembly whilst the District Coordinating Director is the secretary to the Assembly and Head of all the decentralized departments and agencies.

For the study, the Liful, Demon, Kujoni, Saguli and Ggbangbanpon CHPS zones were chosen. This zones were chosen because they are functional and providing health services.and zones also have functional Community Health Committees

3.2 Health care delivery in the Saboba district

The Ghana Health Service is the overseer of health care delivery in the district. There is a District Health Management Team (DHMT), which serves as both the technical and administrative unit that supervises and coordinates all health activities in the district. Non-Governmental Organizations (NGOs) complementing health care delivery in the district include Action Aid and World Vision International. Other structures such as the district health committee (DHC), community health committees (CHCs), Community Based Surveillance (CBS)

Volunteers and some prominent individuals also support to provide healthcare services in the district. For health service delivery, the district is divided into three (3) sub-districts. There are few traditional and herbalists practitioners scattered across the district that provide additional and alternative health care to persons who patronize them. There are also traditional birth attendants (TBAs).

3.3. Health facilities profile

There are twelve (12) health facilities, one of these is a hospital and serves as the district hospital, whilst the rest are Health Centers and CHPS compounds and public health units. Apart from the Ministry of Health and Ghana Health Service (MOH/GHS), healthcare delivery is complemented by the Christian Health Service Association of Ghana (CHAG), traditional healers and practioners.

3.4 Disease burden/Profile

There is a prevalence of communicable diseases like malaria diarrheal diseases, typhoid fever respiratory tract infections, and sometimes outbreaks of cerebrospinal meningitis, cholera. Malaria is the leading cause of morbidity.

3.5. Study design

The study was based on an exploratory qualitative research, designed to obtain data through Focus Group Discussions (FGDs), Key Informant Interviews (KII)), and record review. This was a multi-level qualitative descriptive study design, and adopted to assess perceptions of Community Health Committee members, and the

logistics, human resource, and financial challenges of the CHPS programme implementation in the Saboba District.

Interviews and FGD were conducted with Community Health Committee members in five zones with functioning CHPS compounds whilst the KII interviews involved the DHMT members at the District health Directorate Offices, five sub-district leaders (direct Supervisors of the CHPS zones) Community Health Officers in five functioning CHPS compounds.

This type of study is practical as it assesses and reports the real scenarios of things as they are. It focuses as well on vital facts about the people's perceptions, outlooks, intentions and way of life or behaviour, and describes and provides appreciation of a phenomenon (Wood, & Esena, 2013). In addition, this study design can be used with a certain degree of confidence with particular questions of special interest to the person conducting the study. (Wiersma & Stephen, 2008). Also, such descriptive studies provide information and outcomes on which to base sound decisions. This design was chosen because the intention is to generalize from the study sample to the population so that deductions can be made about attributes and perception of the population (Gay & Airasian, 2009). Above all, this design was used because of its economic advantage, coupled with rapid data collection and the ability to identify attributes of a general group or population from a sample or from a small group of individuals (Gall, Gall, & Berg, 2003).

3.6 Data collection

The study employed focus group discussions and Key Informant Interviews to collect the data. Interview schedule and focus group discussion guides were designed in English and translated into the local language (Likpankpan) by linguistic experts using a back-to-back translation strategy. Research assistants who are proficient in the local language were recruited and trained by the researcher. The training included mock interview exercises after which they were deployed to the communities for the data collection.

Five (5) focus group discussions were conducted with 19 homogenous community health committee members seated in a semi-circle. Each member of the group was given the opportunity to make their contribution on any question posed before proceeding to another question. Both KIIs and FGDs were completed within 30–60 minutes.

Information gathered under each of the data collection methods included the following:

1. At the Administrative level (DHMT and Sub district) Key Informant/ In-Depth Interviews- focused on CHPS implementation issues: challenges of the initiative in the district (logistics, financial and human resource).

2. At the community level: Focus Group Discussions - This collected normative views from both men and women who are members of Community Health Committees living in communities with functioning

CHPS zones. Interviews were focused on committee's members' perceptions of the CHPS programme in their communities and the general challenges of the initiative. The FGDs were conducted with same discussion guide in all five communities. Each focus group consisted of nineteen (19) respondents and the only consideration in selecting the FGD participants was that members should be Community Health Committee member and were active members of the Community Health Committee and should have been resident the CHPS zone for not less than five (5) years.

3. At the CHC level, interviews of the CHOs focused on the perceptions as well as the challenges of implementation and service delivery.

3.7. Secondary Data

Data for the period 2011-2013 on health indicators was assessed from annual reports and the District Health Management Information System (DHIMS).

3.8 Study population

The study population was community health committee members, district health managers, sub- district team Leaders and community health officers (CHOs).

3.9 Study unit

The study unit comprised ninety-five members of community health committees from five CHPS zones, one District Director of Health Services, one District

Public Health Nurse, one District CHPS coordinator), one District Disease Control Officer, one district health information Officer, three sub-district Leaders, five Community Health Officers residing and providing health services in five functional CHPS zones.

3.10 Sampling size

According to Glass and Hopkins (1984); Anastasia (1982), Franklin and Wallen (1984), descriptive studies require a sample size with minimum number of hundred (100) which is essential if the population under study is homogeneous. Sampling for this study involved five (5) District Health Managers, three (3) sub-district Leaders, Five (5) Community Health Officer's, ninety-five community members. The sample size was 108. The five (5) CHPS zones were selected because; they are existing and functional, providing service to community members. The Health Committees were identified and selected because they are community members in functional CHPS zones. This ensured that more accurate and reliable information was collected from the true and main players of the CHPS programme.

Table 3.1 Variables and data sources

VARIABLES	DATA SOURCE
Perceptions	CHOs and Community Health committee Members, Health staff.
Financial	Health Staff and Financial Encumbrances (FEs)
Logistics	Health Staff (Managers Sub district Leaders, and CHOs).
Human Resource	District Health Managers and Sub-district Leaders, and CHOs

Source: Author's Construct. 2012

3.11 Study instruments

Semi-structured questionnaires were designed in English for the Focus Group Discussions and Key Informant Interviews. Also, discussion guides were used to facilitate the FGDs.

3.12 Data processing and analysis

Nvivo version 9 was used for qualitative data analysis, which followed a thematic framework.

FGDs data was audiotaped using digital audio/voice recorders. The tapes were first transcribed and translated from Likpankpan to English before they were double checked for consistency and accuracy by the researcher and other independent native speakers of Likpankpan. In selected cases, the original words or phrases in the Likpankpan language were left in the transcripts. Responses to the semi-structured questionnaires were recorded on the questions sheets and field

notes written on paper and transcribed into the research records. Responses and transcripts were reviewed for obvious errors by both field staff and the main investigator. Errors were corrected in the transcripts only after discussing the transcriptions with the interviewer/transcriber to ensure appropriate meaning. Data from the structured questionnaires for the Health Managers were cleaned and entered in MS Excel and transferred to Statistical Package for Social Sciences (SPSS) version 17.0 where it was analyzed.

3.13 Quality control measures

There was a two-day training session held for the three research assistants that 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.

There was a pilot survey to pre-test the questionnaires in order to refine and restructure the questions where necessary. The pre-testing was done in three communities in Chereponi District which shares boarder with the Saboba district. The pre-testing helped to compare the responses with the objectives of the study.

Double entry of data was done in MS Excel. This helped in identifying some omissions during the data entry.

3.14 Ethical considerations

Ethical clearance was granted by the University for Development Studies Ethics Committee for this study and permission was sought from the Ghana Health

Service Regional Health Directorate, Tamale before carrying out the study. All the respondents in this study provided written or oral informed consent before taking part in this study, which was part of the protocol for the study. For those who gave oral consent, the consent form was translated into the local language by the interviewers. The consenting process was then recorded digitally on a separate digital recorder before the beginning of the interviews and discussions. The digital recorder containing the verbal consents given by respondents was kept separately from the ones used to record the interviews. Personal identifiers and location information was not collected, and any identifying information accidentally mentioned was removed from the text prior to analysis.

Permission was also sought from the District Director of Health Services of the Saboba district before embarking on the study. An informed consent of the respondents was also sought and in the consent form, the objectives and significance of the study were clearly stated and explained to the prospective respondents. Respondents were given the free will to decide whether to partake in the study or not.

Anonymity and confidentiality of the actual source(s) of information obtained from the study was ensured by not indicating the names of communities 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. The recorded tapes of the focus group discussions were destroyed after transcription so that the voice recordings of those who took part in it are not recognized.

CHAPTER FOUR

PRESENTATION OF RESULTS

4.0 Introduction

In this section, the demographic and other characteristics of the respondents, study findings, results and analysis are presented. In all the analysis, everything emanates from the responses of the Health Managers, CHOs, Sub-district Leaders as well as the focus group discussions and review of documents.

4.1 Presentation of Findings

Some characteristics of the study respondents as well as the study main findings in relation to the perceptions of community health committee members of the CHPS initiative and the logistic, human resource and financial challenges to CHPS implementation in the Saboba District are presented in this section.

The table below illustrates the age profile of the respondents in the study. It was important to consider the age of the respondents on order to elicit the views of matured individuals.

Table 4.1 Age profile of the respondents in the study

Age in Years	Number of Participants	Percentages
20-30	15	13
31-40	39	36
41-50	31	29
51-60	19	18
60 +	4	4
Total	108	100

Source: Field Data, 2015.

The age profile of the respondents show that they are all adults. This is important for the survey as their expressed opinions can be assured of being independent. Where an individual is matured, the opinions and expressed can be assured of a fair degree of maturity and not influenced by the opinions and views of others. As the table above shows, all the respondents were adults and matured individuals whose views and opinions expressed can be relied upon.

The sex distribution of the respondents in the study is showed in figure 4.1 below.

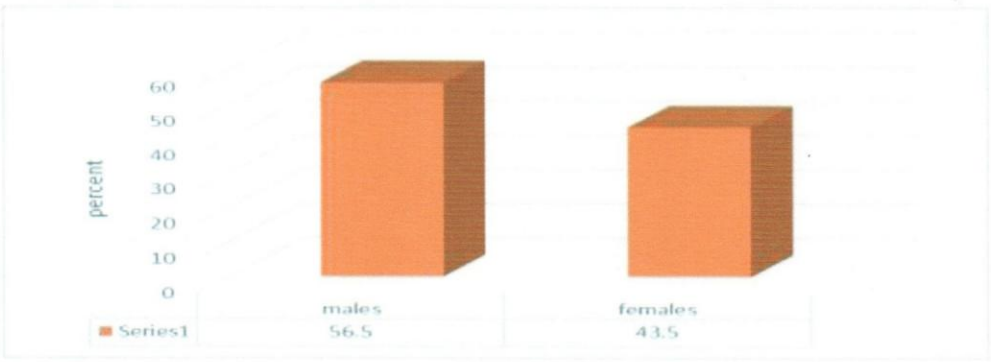

Figure 4.1 Sex distribution of respondents
Source: Field Data, 2015

The respondents were mostly males who made up of 56.5 percent of the respondents while 43.5 percent were females. Gender is an important variable in the local Ghanaian context, which is variably affected by economic or social phenomenon.

4.2 Educational Background of Respondents

In table 4.2 the Educational levels of the respondents in the study is showed. This characteristic is important as it affects and influences one's beliefs, opinions and views as well as experiences about any particular health programme or intervention. Somehow, the response of the respondents is likely to be determined by educational status and therefore it was important to know the educational background of the respondents in this study

Table 4.2 Educational background of respondents

Educational Background	Primary	Middle/ Junior High	Senior High	Tertiary/ Others	No Education	Total
No. of Respondents	25	17	18	8	40	108
Percentage	21	18	11	8	42	100

Source, Field Data, 2015.

The educational background of the respondents spans all the levels of education, with 40 (42%) having no education at all. While 20 or 21% have primary education, 8 % of the respondents have had tertiary education. Primary and Senior High school levels 21% and 11%% respectively. More than half of the community

health committee members have a certain level of education and thus functional; therefore their opinions and views can be considered to reliable.

4.3 Occupation of Respondents

The type of occupation engaged in by the respondents is shown in the chart, Figure 4.2 below. It was important to consider the occupation of respondents of the study as this can influence the circumstances under which people get into contact with a programme.

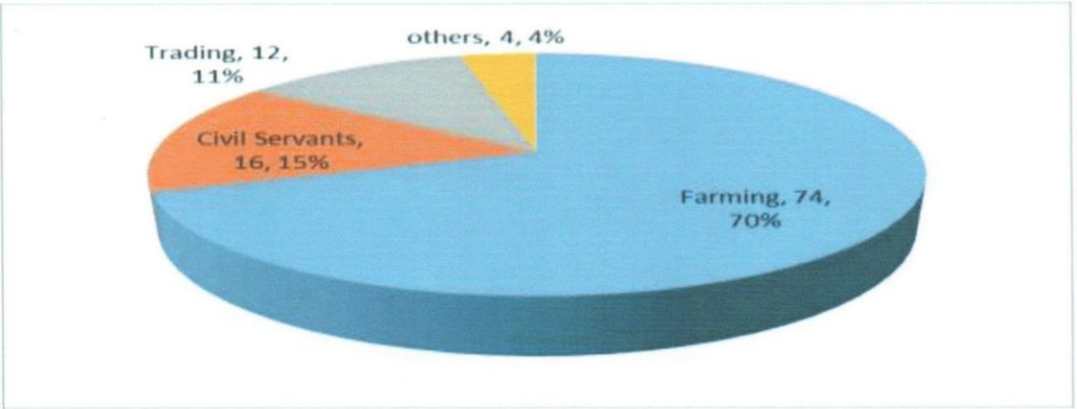

Figure 4.2 Occupational distribution of Respondents.

Source: Field Data, 2015

Typical of rural settings, farming is the main source of livelihood of most of the respondents,74 representing 68.5%; government employees or salaried workers totaled 16 (14.8%),twelve (12) of the respondents or 11.1% are engaged in some form of trading, mainly buying and selling and four (4) are engaged in other forms of work, e.g. bicycle or motor fitting.

4.4 CHO Profile

The five CHOs were in the age bracket of 20-30 year, and by ethnicity, all were from outside the District, in fact from outside the Northern region, and by sex distribution, there are four females and one male.

Table 4. 3 CHC Respondents length of stay in the CHPS zones

Length of stay in CHPS zone	Frequency	Percentage
>5	2	2
>10	6	3
>15	15	15
>20	21	24
>25	20	26
Since Birth	31	34
TOTAL	95	

Source Field Data: 2015.

The length of time or periods that an individual has encountered or interacted with a programme can shape and have overbearing influence on the individual's experiences and beliefs of such a programme. Over 80% of the community health committee members have been staying in the CHPS zones for over ten years. By this, they have had a long period of encounters and engaged in one form or another with the CHPS initiative in their communities. They therefore have reliable, independent and objective opinions of the initiative. Based on this attribute, persons who were deemed to have the most experience with the CHPS were selected for this study.

Table 4.4 below show the location and representations of the respondents. There were a total of thirteen (13) from the health sector. This representation made 12% %of the total respondents. There were a total of 95 community respondents, of equal representation of nineteen (19) per each of the five CHPS zones in the study. Total community member representation was therefore 88%.

Table: 4.4 Location and representation of Study Respondents

Location/Level	Number of Respondents	Percentage
DHMT	5	5
Sub district Leaders	3	3
Sangule CHPS Zone	19	18
Gbanganpon CHPS Zone	19	18
Kujoni	19	18
Demon	19	18
Liful	19	18
Total	108	100

Source: Field Survey, 2015

Community health Committee members representation in the study was 88% and this is important because these are the persons who are actively engaged in the programme implementation as well as being the direct beneficiaries. Equal representation was also ensured so as to get balanced expressed views.

4.5 Trend of CHPS implementation, Saboba District

Over a fourteen (14) year period, the Saboba district was able to implement only six (6) CHPS zones, out of a total of eighteen (18) demarcated zones. This has implications for overall service indicators, as there is no corresponding initiative existing to complement service delivery.

Table 4.5 Trend of CHPS implementation, Saboba district, 2002-2014

Year	No.	Sub District Location	Community Location of CHC
2002	1	Saboba	Gbangbanpon
2003	1	Saboba	Kujoni
2004	1	Demon	Sambule
2005	1	Sambule	Kucha
2006	0	0	Nil
2007	1	Saboba	Sangule
2008	1	Wapule	Liful
2009	0	0	NIL
2010	0	0	Nil
2011	0	0	Nil
2012	0	0	Nil
2013	0	0	Nil
2014	0	0	Nil
Total	6	3	

Source: Field Data, 2015

4.6 Perceptions of Respondents of CHPS and its implementation in the Saboba district

The perceptions or views of people or individuals or communities of a health programmes are influenced and shaped by the individual and community encounters with such interventions. A total of 95 Community Health Committee members and thirteen (13) health staff took part in the study. The study revealed some crucial knowledge and perceptions of the CHPS programme among community health committee members and health staff the district.

The community health committee members (93 or 86%) were unanimous in their views that, the CHPS initiative is people centered, and also responsive to their health needs. Proximity of the service delivery point (CHC) was also one they highly acknowledged and that it reduces their travel time to access health care."—here you can go to farm, and come to go the Nurse for care if you are sick, but before, you will have stay with your sickness till next day before going to Saboba with it" (FG Discussant, Gbagbanpon)."—and you know Saboba too is far, no means of transport to get to Saboba fast, and the road too, you saw it when you were coming ---, added another discussant. "When I returned from Saboba after my operation, it was the nurse who was coming to dress my sore daily. If not because of her, I would have stayed in Saboba for the 3 month sand pay plenty hospital fees", one discussant from Demon CHPS zone noted.

They also indicated that that CHPS provides cheap and affordable health services. As another added to buttress this point "here you don't pay much, even if you

don't have health insurance, but at Wapule, (meaning Wapule Health Centre), you will pay plenty".

For the health staff, they indicated that of all health programmes, it is CHPS that put the GHS on the "ground"." If not because of CHPS, it only out reaches we can organize to go areas which may not be regular, but with CHPS the nurse stays there to serve them. That is good" (KII).

In the view of a Key Informant, CHPS is an initiative that it brings to reality collaboration between community members and the health sector and ensures joint decisions between communities and the health sector about community's health needs. For the Saboba sub district leader, CHPS provides opportunity for community members to be responsible, and to take ownership and control of their health. "They were involved in the construction of the CHC, so they are the owners and will not let anything happen to it "he said.

According to the Key Informant, where the initiative is implemented, it makes it easy and cheap to implement other health service programmes. "In the CHPS zones, our NIDs are always smoothly implemented and the coverages are high. Even drug distribution for filariasis is also high in the CHPS zones. The supervision is done by the health committee members, so we don't hire any supervisors to go there", He also added that surveillance is good, as suspected health events and occurrences are reports promptly for follow up investigations.

4.7 Logistic challenges for CHPS implementation in the Saboba district

CHPS is the flagship of the current government, but unfortunately, the programme is woefully under resourced.

The logistics challenges for CHPS implementation as revealed in the study is defined or categorized in three areas; Service delivery logistics, mobility logistics and household or comfort logistics.

Service delivery logistics like Bp apparatus, and scales, were lacking in three of the CHPS zones, two zones had no thermometers, only the Demon zone had solar lighting system, the other four had no source of power. Water supply was grossly inadequate, as all the zones rely on the few bore holes in the community for water to deliver services .It is only the Demon zone that has a solar refrigerator to store vaccine for EPI. The other four zones have to travel to the sub district capitals for vaccines for immunizations.

All the zones run essential services like ANC, however, the five nurses said they have running these clinics for over half a year without SP for prevention of malaria in pregnancy. Supply of protective clothing like gloves, was also poor. In addition, none of the nurses is able to do estimation of hemoglobin estimation in pregnant women, due to unavailability of testing equipment.

The Sangule, Liful, and Kujoni zones had motor bikes whose ages ranged from 9-11 years. Gbangbanpon and Demon zones had no means of transport for home and community visitations. All five nurses in the five zones indicated the frequent

unavailability of fuel supply for them to go round for community visitation for service delivery.

The nurses at the Kujoni and Liful zones said they have not been able to go out for out reaches for over a month due to lack of fuel to run their motor bikes.For comfort or household items, each of the zones had a single bed and mattress. All other items were owned by the Nurses. Without the required logistical support, the initiative cannot be expected to meet its objectives.

4.8 Human resource challenges for CHPS implementation in the Saboba district

In this study, the human resources challenges identified of the CHPS programme were varied. According to the DDHS, the district like other rural district, suffers from rural bias, whereby health staff refuse to accept postings to the district. This has led to serious staff inadequacy in the district. "Last year eight CHN were posted to the district, but only three reported. As at today, two of those three have left. The staffing situation in this district is just serious" (KI).

The issue of health staff refusing or reluctance to accept postings to CHPS zones was also echoed by the DPHN when she stated among other things…,"the staff are not there. They don't want to come here let alone to say that you want to create CHPS zone and send them there".

The staff unavailability is further aggravated by staff reluctance to accept posting to CHPS zones "… the moment you mention that you want to send a staff to a

CHPS zone, they will come with all sorts of reasons and excuses not go to a CHPS zone, some even leave the district unofficially because of that"(KI).

"One problem we see here is that, the nurses they bring here don't stay for long. The nurses don't want to stay here, they stay for a short period and then go away, and it takes a long time before they bring another nurse" (FGD).

A FG discussant at Demon CHPS zone said, "For three months, this place was not working. We met the district health people and they told us that the nurses don't want to come here. We thank God that this one (referring to Nurse at CHC) has accepted to come".

High staff mobility and turnover, is another staffing challenge that adversely affects the CHPS initiative roll out in the Saboba District. The District is not able to hold that critical staff required to post to the CHPS zones. A Key Informant stated," This year, I have lost five staff, all Community Health Nurses. They have left for various reasons, but mostly for school .Every year staff go out, but we don't get commiserating number coming into the district"In fact, during the course of this study, two of the Nurses at CHCs stated their intentions of leaving in the course of the year." As for this year, me too I want go to school" (KI).Another finding of the study was that, all the five CHOs in the CHPS zones are not familiar with the CHPS concept. Not even in training at school. A Key Informant stated, "See, I was not trained in CHPS in school. Even at the district level, I was not trained in CHPS. I was just posted here to be a CHO for this zone. I am just managing". Stated another Key Informant.

The need for the nurses to be trained was reinforced, "In my view, I think if they are trained in the concept, it will help them accept postings to the zones and also make them more efficient". (KI). Another challenge revealed in the study is the inadequate skills of the Nurses in the CHPS zone All the five nurses in the CHPS zones lack knowledge and skills in some service areas, like conducting delivery and some emergencies. A Focus Group discussant revealed this and said, "any time we send a woman in labour to the Nurse, she will let us go to Saboba, we don't understand why, but what can we say' Another Key Informant stated this," You see, the nurses at the CHPS zones cannot provide some services, like delivery, suturing, and this is a challenge. So normally the Villagers bring such cases here, and sometimes bad ones"

Uncertainty about changing roles and new responsibilities was another staffing related challenge that was recorded in the study. All the five nurses in the five CHPS zones have no training or orientation in the CHPS concept to give them an insight into the concept, and its operation, as well as their responsibilities at CHCs, including their relationships with communities and other structures like Community Health Committee, Community based Surveillance Volunteers; before posting to man the CHPS zones. In addition, none of the five nurses in the five zones has had the formal two week training to equip them as CHOs. "Me I heard of CHPS when I reported in the district, and they (referring to DHMT) said they were sending to a CHPS zone, so I came here". (KI). Another Key Informant confessed "We have not been able to train any of the nurses as CHOs".

4.9 Financial challenges for CHPS implementation in the Saboba district

The financial challenges for CHPS implementation identified in the study included unavailability of funds for district health service delivery. This was confirmed by the DDHS when he stated that for four (2010-2013) years running, the district has not received any funds by way of financial encumbrances (FE) for service delivery. Even where any funding is made to the district, there is observed reduced or dwindling funding, as happened in the second quarter of 2014 when the district received GHC 200.00 as FE for service delivery, the DDHS disclosed. The Wapule sub district Leader also stated the inadequate and often delayed re-reimbursement by the NHIA of services provided by the health facilities. "The district has no money, and the Health Insurance people are not paying our little money, so we cannot buy fuel for the nurses in the CHPS zones". Evidence based practices like CHPS require financial support right from the start.

CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

This chapter discusses the main findings that have been established in the study.

Overall, whilst the study shows that Community Health Committee members and Health Staff had positive and good impressions of the CHPS program in the district, it also revealed obvious implementation challenges of the initiative in the district in terms of logistics, human resource and finances.

The results of this study show that although the required administrative and institutional structures are in place, i.e. there is a DHMT, there sub district health Teams, the district has been appropriately demarcated into CHPS zones, there are Community based volunteers responsible for disease surveillance, these do not necessarily provide or create the needed factors for effective CHPS implementation in the district. This confirms results of other studies that have noted that, all systems and categories are faced with challenges of implementing new practices at one time or another (Shannon et al.(2012).

5.1 Demography

Of the 108 respondents, 19 (18 %) each were from the CHPS zones of Gbangbanpon, Liful, Kujoni, Sangule, and Demon whilst health staff constituted 13 (12%).The views and responses of respondents in this study cuts across two

important categories of stakeholders in the CHPS programme; community level and the health sector. These are the critical stakeholders and players of the initiative.

5.2 Occupation of community health committee members

A person's occupation has an influence on his or her personality and consequently his or her outlook, attitude, experiences and the way they look at or view issues before them. Occupation also determines the quality of life and also socializes him or her in a particular way, which in turn reflects his or her level of understanding particular issues. An individual's response to an issue can be determined by the type of occupation he is engaged in. In the study, occupation is considered crucial as it influences how the individual encounters with the CHPS programme. As rural communities with farming as main occupation, when people are able to access health care close to them, it frees up enough time for them to engage in their farming activities, instead of travelling long distances to seek health care. As a discussant indicated, closeness of the services enables them to access health care even when they close from farm work; this increases time for farm work and consequently productivity and the overall benefit of improvement social status.

5.3 Perceptions of Respondents about CHPS

Perceptions as used in this study refers to the experiences and encounters that community health committee members and health staff have had with the CHPS programme as a health care delivery strategy in the district and their communities.

The respondents in the study gave their perceptions of CHPS to be people centered, responsive to their health needs, cheap services.

"...In CHPS, the community is first in its design and the concerns and the needs of the community members are considered first" (KI).

This fits into the Ghana health service new strategy of people centeredness and integrated Health services, aimed at empowering people, and strengthening community engagement for implementing health system priorities and initiatives.

Within this context of people centeredness, the CHPS initiative is considered a useful way of ensuring the inclusion of communities and community members towards the development of universal health coverage, and ultimately to achieving the Millennium Development Goals (MDG).The understated illustrates:

""In CHPS, the community members are followed with health services and information, you don't wait for them. That is what makes it unique"(KI).

Where the concerns and needs of people are considered upfront in the design of a health programme, they are motivated and prepared to provide worthwhile support to such community based health programs to make them work, and by such, it can contribute to enable people increase control over and improve their health as they feel such programs are not imposed on them and they tend to appreciate the uniqueness of these programs and the resources and benefits it may bring.

The United States National Academies of Sciences has identified people centered health care as an important global issue and as one of six attributes of health care

quality.(WHO.2007).By its design and concept, CHPS, addresses the issue of being people centred and empower people in promoting and protecting their own lives.

Responsiveness to their health needs is a perception translated to mean that services are within reasonable physical reach. The CHC is the first level of contact of individuals, the family and community members 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. People do not need to travel long distance to access health care. This is in line with PHC concept that persons should not travel more than eight kilometers to access health care. This is affirmed by Nyonator (2003) that the CHPS system is designed to improve access to health care delivery at the peripheral levels by reducing walking distance to access health care.

"People in this area no longer travel the long distance to Saboba, and some times where you will not meet any nurse, for health services"(FGD).

."……here you can go to farm, and come to go the Nurse for care if are sick, but before, you will have stay with your sickness till next day before going to Saboba with it" (FGD).

Responsiveness of health care is an important issue that has been identified as one of three keys that measure performance of health systems. (WHO.2007) Responsiveness of care is an important global issue and among other things, addresses prompt attention, and CHPS addresses this issue

That CHPS provides cheap and affordable health care was an expressed perception of respondents "here you don't pay much, even if you don't have health insurance, but at Wapule, (meaning Wapule Health Centre), you will pay plenty"

Cheap medical care is a right. Social protection laws stipulate that medical care should at all times and everywhere be made cheap and affordable for all. The Affordable Care Act of America emphasis this. (Act HR3590.2014).When health care is cheap and affordable, people get and prompt quality care and this reduces periods of sickness, thereby increasing time for productive work. In addition, affordable and cheap health care is security for families, as they can assess health care at least cost.

When health is cheap and affordable, people will not be motivated to self-medicate or patronize quacks and other unqualified persons who will aggravate and complicate simple medical conditions. Most countries in Africa overall health performance continue to lag on health indicators. The traditional health sector appears inadequate to provide the required coverage of health care

The district health staff all viewed the traditional health sector as incomplete in covering geographical areas for health services and perceived CHPS to be filling that gap.

"To me, CHPS translates everything about the Ghana Health Service. It is an important interface that puts the Ghana Health Service on the ground. The community is first, and that is important" (KI).

.The CHPS initiative is seen as an appropriate platform which the health sector can use to reach a wider segment of a district population, which otherwise would not have been possible relying on the traditional sector alone.

".. With CHPS, to me, it gives us opportunity for us the health workers to easily reach out to much more communities and community members with our services. It is good programme in that line, but the challenges are there...." (KI).

These perceptions, experiences and views of the respondents in the study, illustrates and confirms the importance of CHPS as an appropriate health care delivery strategy. (Nyonator 2003). Also, evidence and responses from the respondents showed that, in spite of the challenges of the CHPS implementation in the district, the CHPS program cannot be forgotten or ignored as the initiative proceeds over time.

5.4 Logistic challenges to CHPS Implementation in the Saboba District

The unavailability of logistics for service delivery was pervasive across the five CHPS zones much like any organizational investment, successful implementation of any evidence-based practice like CHPS, requires a variety of logistics to be available if success is to be expected. Without the required logistical support, the initiative cannot be expected to meet its objectives. Evidence based practices like CHPS, require commitment of logistic provision and support right from the start.

Results from other studies show that logistics availability is a key component of any successful health program implementation (Bossert et al., 2003).

All the five zones in this study reported about the difficulty of logistics in its entire context for CHPS implementation in the district. In this study, the logistics challenges for CHPS implementation in the Saboba district were identified to be in three (3) categories. These are:

1. Service delivery logistics, Bp apparatus, weighing scales, source of light, to including cold chain equipment, service delivery consumable like gauze and cotton wool, medicines, working gear, e.g. gloves and communication equipment to enhance referrals etc.

2. Mobility logistics and these comprise motorbikes, fuel for the CHO, bicycles for volunteers, maintenance of motorbikes etc.

3. Comfort logistics, which comprise accommodation, and consumer durables e.g. bed, furniture, TV, Radio, Kitchen ware, etc.

Where there is poor logistics availability for service delivery this can lead to loss of confidence and compromise quality of care and ultimately program failure. (Huicho et al., 2010). This affirms results from other studies that have acknowledged that where basic equipment and lifesaving drugs are a problem; this seriously undermines program implementations.

The strive to provide quality health cannot be achieved without the adequate availability of appropriate logistics. Due to various reasons, the district is not able to provide the needed logistic infrastructure for the smooth implementation of the CHPS initiative in the district. Appropriate logistics availability is the driving

force for program implementation success cannot be over stated. As noted that in other studies, whilst the health sector reforms have conferred authority on district health teams for the designing and implementation of district health care services, it has not provided the needed resource regime(logistics ,etc.) for implementing CHPS (Nyonator et al.,2007).

The implications are that, when health staffs do not have the required logistics for service delivery.it leads to demotivation, frustration and general sub optimal performance. A nurse in the Demon zone had this to say: "..."Sometimes I feel guilty when I conduct Antenatal clinics ... I am not able to dispense SP for Malaria prevention in pregnancy, or five folic acid, I am not able to do EPI for lack of vaccine. "I am like a hunter without weapon" (KI).

Adequate logistics availability is an essential requirement to ensure people centered health interventions and strategies as well as to maintain the confidence and trust of clients. There is an increasing focus on better and quality of care in health service delivery and the logistics base for health is therefore crucial.

When health staff do not have appropriate logistics to work with, they are exposed to unnecessary risks of the job, provide substandard services and are also not effective and efficient. Appropriate availability and use of the required logistics reduce preventable harm and the associated infection rates from both clients and service providers.

According to the WHO, numerous programs have failed in part basically due, to poor planning and the underestimation of the effort and inputs required to make such program work (WHO, 2007).

Reliable transport form and integral part of all community based health programmes. Non-availability and poor means of transport creates a barrier between the Nurse and the communities they serve; and these barriers act to limit the delivery of health services to individuals and communities. Only two of CHOs in the study have a means of transport. "See, the means of transport is bad. No motorbike for the nurses to go round. Sometimes, it is the Assemblyman that helps her to go round". (FGD).

This lack of transport for the nurses in the CHPS zones to reach out to communities to provide services, are non-financial based barriers that prevents community members from receiving health services in their circumstances, and this defeats the philosophy of the CHPS concept. There is no maintenance of the motorbikes and this led to three CHPS having weak non-functional motor bikes. Transport is very important and has a bearing on the efficiency and effectiveness of health delivery systems.

Transportation has been identified as a general barrier to health care, especially to underserved populations. Reliable means of transport is crucial to enable the nurses respond to health issues in their zones.

Comfort or household items are essential components CHPS logistic profile. These serve to motivate the nurses and ensure that at least these basic household

equipment will make life bearable in their current circumstances. In all of the five CHPS zones, the nurses had no room furniture for their comfort. Communication gadgets are their own and they recharged the units at their own expenses. All of them had just two pieces of cooking utensils that they procured on their own. There is practically no support for the nurses in the CHPS zones, and there is the felling amongst the nurses in the CHPS zones that they are unlucky "unlucky", and therefore not motivated to work as expected. Considering their circumstances, it is important to create good conditions for nurses in the CHPS zones to work. When health staff in such rural settings is not supported to make life a little bearable for them, they feel abandoned and neglected, and will consequently use all means possible to run away from such locations. Providing health services in such remote locations is a challenge, but it is these areas that there is the most need for health care. Providing support for the nurse in such locations will contribute to enhance her work and make her comfortable to be able to stay longer in such locations.

Whilst the operational logistic for implementing the CHPS initiative may tend to be straight forward; the findings of this study show that it still does require proper attention for successful programme implementation. The degree of attention, and appropriateness to the acquiring and managing equipment and logistics have the potential for successful implementation CHPS.

5.5 Human Resource Challenges to implementing CHPS in the Saboba District

The human resource challenges to CHPS implementation in the Saboba district is huge and dire. This challenge is in six dimensions: staff inadequacy, skill mix, refusal to accept postings to the district, reluctance to accept posting to CHPS zones, uncertainty about new roles and changing responsibilities, and high staff turnover. Adequate availability of human resource is a core building block for a successful implementation of health initiatives.

The desired category of staff preferred for the CHPS Zones is the community Health Nurse (CHN). However, other category like Enrolled Nurses, (EN), Midwives (MW) or Technical Officers (Disease Control),or any qualified health staff and appropriately trained and orientated can be posted as CHO.

The Saboba district, like all rural districts is suffering from "rural bias" which keeps health professionals from accepting posting to the district. "Staffing is a big challenge here. The few staff that are posted here most often refuse to come. For those who even come, when you mention of relocating them into a CHPS zone, that is the end. They will seek permission to go and prepare to come, and they don't turn up (KI).This phenomenon has contributed hugely to the staff inadequacy in the district, Implication for this is that, the district is not able to access the critical staff, by way of numbers to train and send to the CHPS zones

Reluctance of staff to accept posting to the CHPS zones is another phenomenon observed in the study. Staff posted to the CHPS zones feel they are unlucky, or as

a form of punishment. This does not make for effective planning and leads to gaps in health service delivery. It can also weaken community engagement and loss of confidence. In addition, a feeling of waste of resources amongst community members will be high since the CHCs will not be utilized.

Similar studies have revealed human resource problems as a challenge to CHPS implementation (Nyonator, et al., 2003).Another aspect of the human resource challenge in the district is high staff turnover or attrition. Health staff posted to the district are very unstable and do not stay long. The average length of stay of the community health or Enrolled Nurses is one year.

A Key Informant remarked "…where are the staff? They don't stay. The few that come, at most one year, and they are gone. Either going to school, or to marry and join the husband or something else". Where staff attrition is so pervasive, it leads to ineffective planning as well as ineffective community engagement. There is also policy failure if staff is unstable and unavailable for health programme implementation.

In similar studies, the challenges of human resources for health systems have been emphasized. For instance, Dr. Y Shaw-Taylor, in a report in the Daily graphic of 17th February, 2014, writing on the topic 'failures and challenges of the Ghana Health Care system' noted the challenges in the health system of Ghana among other things were not enough providers in terms of physicians , nurses and other trained care givers.

The uncertainty of changing roles is another big challenge to CHPS implementation. The pre-service trainings CHNs do not prepare them to assume leadership positions and roles. The leadership and responsibility role of the CHPS concept turns to be uncharted grounds for them. "…. I have not been trained in this CHPS programme in school. Even at the district level, I was not trained. I was just posted here to be a CHO for this zone. I am just managing" (KI).The lack of training/orientation in the CHPs concept has the potential for demotivation of the CHO. Where staff are not trained and orientated for new roles and responsibilities, it leads to fear and anxiety, and can also affect confidence and self-esteem of the individual, and hence the overall output and the programme as a whole.

It is important to adequately prepare such staff about the programme and its concept so that they can appreciate its value and identify with its objectives and they will have the confidence and feel comfortable to work with it.

There is skills limitations in all the nurses in the five CHPS zones. They have no skills in delivery, emergency obstetrics care, lifesaving skills such as management of asphyxiation and hemorrhaging, insertion of Intra Uterine Devices (IUDs). All this mainly due to objection by regulatory bodies. It is important to note that community and individuals determine quality of care by the package and range of services that the health workers can provide. The skills limitations of the CHOs put them in awkward circumstances in the area of some services and care. This can lead to loss of confidence by community members, as one discussant put it,

A Key Informant summed this up, "look I am not a midwife, I am not to conduct delivery, but the women come and I cannot help. How can I be a CHO and cannot provide some services here". (KI). "….. we don't understand, anytime we send a woman in labour to the nurse, she will tell us to take the woman to Saboba and that she cannot do delivery, for that we don't understand".(FGD).

Training of staff is the backbone for the successful implementation of health programmes like CHPS, it is therefore important that the main players in the programme are given the appropriate training. Of the five (5) CHPS Zones in the study, none of the nurses in the zones has received the formal training as a CHO, therefore by implication, none of the five nurses in the five zones is CHO.

Health workers in the communities are an essential link in service delivery between primary health care facilities and the communities (Greenspan et. al., 2013), it is therefore very crucial that health workers of such community based health programmes like CHPS are adequately imbued with the required skills for their work Such training and orientation is essential to enable the staff appreciate the concept and be motivated to work in such designations. Also, such appropriate and initial as well continuous professional training is critical to ensure and reinforce knowledge and skills and this will eventually impact on quality of care. In addition, training is necessary to maintain the moral and self sufficiency of the staff, as it helps programme staff feel confident, trusted, valued and skilled enough to provide services.

"You see, I have not been trained in CHPS. Since my basic training nobody has trained me in anything about CHPS. I need training, I am young you know (laugher). (KI).

Skills mix is an important ingredient in the health workforce and is essential for efficient health service delivery (James & Mario. 2002). In this survey, it was found out that most of the CHOs have not got the skills to perform some essential services. Most of the CHOs have no midwifery skills, so cannot conduct delivery.

The training of health workers in the CHPS concept and its operations is paramount to sustaining the activities of CHPS compounds. It has been observed that the concept of CHPS as a primary healthcare delivery model is not on the curricula of the training schools, where students will have prior knowledge of the concept and the rudiments of its operations. This poses a big challenge as the newly qualified health staff sees their first postings to a CHPS zone as a punishment and hence they do everything to resist such postings. Aside the fact that much training is not received in schools for the operations of CHPS, it was also noted that those posted to CHPS compounds are not given orientation at the district level so as to adequately prepare the new staff as they take up their jobs. The need for orientation cannot be under estimated since the trained nurse would be offered the chance to have face-to-face instructions on the practical expectations of being at a CHPS compound. It was also observed that because of remote locations of the CHPS compounds, coupled with the lack of facilities like electricity, telecommunication, unreliable and difficult transport systems, most health professionals refuse postings to the CHPS zones. Ethnicity, as considered

in this study does not intend to connote any negativity, similarity of background ensures trust worthiness and respect, and this leads to a sense of empathy for kinsman and strong desire to help.

Over all, human resource or Staffing is a significant factor in programme implementation and it is crucial that, this is well considered so as ensure effective programme implementation. Successful implementation of the CHPs programme depends on the availability of human resources to be deployed in the communities are CHOs.

5.6 Financial challenges to CHPS implementation in the Saboba district

In the study, a pivotal challenge identified to the CHPS programme implementation in the Saboba district is finance. According to the District Health Management Team members, this is the biggest challenge around which others factors like logistic, training of staff whirl.

In the routine fund allocation to the district in the form of financial encumbrances (FE), there is no budget line for CHPs and this has resulted in erratic and incoherent CHPS implementation in the district. The District Director of Health Services Saboba, noted "I have no budget for CHPs, it is just tight. The district largely depends on programme funds to operate" Whilst it is anticipated that the CHPS initiative is to be expanded to cover all communities in the country by the year 2015, and with financial provision largely from government sources, yet there is no health sector budget to cater for CHPS implementation (Awonoor et al., 2013).

The lack or unavailability of a budget line or dedicated funding for CHPS, is an overarching challenge for CHPs implementation that was identified in the study. In the absence of funding for CHPs, it results in adequate resources and logistics mobilization for CHPs implementation and its operations.

".....I cannot go out as expected, because the sub district leader and the DHMT say they have no money for fuel. I am always here (CHC). I just do what I can. Sounding frustrated. (KI).

The Community Health Officers are considered a bridge between the community and the health system, but they take the blame from the community members for the failures of the health system. When health services are not optimal in the CHPS zones, as a result of inability to provide basic logistics, community members suspect the CHOs might have taken advantage of the resources supplied them.

Where CHPS is not implemented properly, it is not able to operate and function properly and this has the potential for the initiative or strategy to loss focus and program clarity.

In the study, it was shown that implementing the CHPs initiative may not be expensive, but in the absence of first line funding for basic resources and logistics to work, the programme can fail.

"The initiative is not backed by any type or source of funding of its own. For the existing ones, it is when we are running other programmes that we "cut" to get

one or two things going for CHPS." It is difficult to implement CHPS without direct funding" (KI).

Other studies have also shown that, while policies may be considered favorable by service providers and users (consumers), significant problems can exist with implementation. This can happen where implementation of a policy has no financial backing (David. 2007).

Record review at the DHMT offices also showed that the routine quarterly fund for districts, Financial Encumbrances (FEs) for district level health activities have been progressively reducing since the year 2006 to 2012.It is only in 2014, that only one trunk of subvention has been allocated to the district. The DDHS lamented, "Only two hundred Ghana cedis has been allocated to me as FEs, for this year, 2013, imagine that, this is ridiculously low for service delivery that is our situation".

From the KII, it was noted that financially, the District Health Administration did not have adequate financial resources to take care of their needs. Generally it was identified that there were no dedicated funds at the district level for the implementation and operations of the CHPS compounds.

"Over the years there have not been a very clear budgetary allocation for the implementation of CHPS at all levels of the health administrative system. Policies for its implementation abound, but there is no financial support for the initiative" (KI).

It is envisaged that funds for implementation and development of CHPS will come from traditional sources as well as internally generated funds. However, where these sources are not able to provide the needed funding, it can stifle and limit the diffusion and rollout of well researched and evidence based health initiatives like the CHPS strategy.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECCOMMENDATIONS

6.0 Introduction

This study sought to assess the perceptions of community health committee members service providers, supervisors and health managers of the CHPS initiative as well as determine the implementation challenges of the CHPS programme in the Saboba district. This chapter looks at the key findings of the study, the overall conclusions and suggested recommendations that could enhance or facilitate the roll out of the initiative in the Saboba district and other districts.

6.1 Summary of Key Findings

This study was a qualitative assessment of the CHPS programme from the view point of its implementation in the Saboba district. The study concludes that, there are positive perceptions of CHPS as a health delivery strategy, however, there are challenges related to logistics, human resource and finance faced by the Saboba district in its efforts to implement the CHPS initiative to address health inequalities and improve on health outcomes in the district. The study revealed the CHPS initiative is a significant pro-poor policy for improving geographical and financial access to health care in rural communities.

The positive perceptions of respondents as shown in the study indicate that despite the challenges of implementing the CHPS programme in the district, the initiative cannot be ignored as the programme proceeds over time.

Where the views and perceptions held by stakeholders of a programme are known, it removes barriers of sustainability and enhances the replication of such programmes in other settings.

These perceptions can be used to make recommendations for future programmes and also serve as lessons to aid and guide future programme implementation.

The study showed the main challenges to the implementation of the CHPS initiative to include:

1. Unavailability of logistics: the logistics unavailability was in terms of a. service delivery logistics to include Bp apparatus, cold chain equipment, communication gadgets, medical consumables like drugs and medicines; b. mobility logistics defined in terms of means of transport like motor bikes, fuel, and c. comfort items: bed, cooking utensils, TV, and other household or furnishing items for the CHO.

2. The unavailability of these to enhance service delivery compromises on quality of health care, has a bearing on community members' trust for services at the CHCs, as well as impinges on the efficiency of the nurses at the CHCs, exposes nurses to job risks and can ultimately demotivate the nurses and make them abandon the CHCs and all combined can lead to programme failure or collapse.

3. Inadequate human resource: this is manifest in low numbers of staff; inadequate skills mix of the staff to provide some services as well as high

staff attrition. Also, staff refusal to accept posting to the district further compounds the dire staff situation of the district.

4. Implications of the above challenges include; poor and inadequate planning for community health programmes, inadequate community engagement, service delivery gaps and policy failures.

5. Financial constraints: There are no dedicated funds or budget lines at the district level for CHPS programme and in addition, there is no budget line in routine funds (Fes) to support CHPS programme. There is also a weak capacity for the generation of Internal Generated Fund to support CHPS implementation in the district.

6. Implications for the financial challenges include; inadequate or poor logistics supply, poor or lack of maintenance of motorbikes, lack of staff motivation, fear and insecurity of the nurses in the CHPS zones.

6.2 Conclusions

This study report is prepared with the acknowledgment that the CHPS initiative is the result of the Ghana Health Sector Reforms and that it is a watershed in terms of decentralization of the health service system, improving access to and providing quality health care to the people of Ghana especially to the rural, remote and underserved communities.

CHPS can be considered in 3 components:

1. Is a strategy, a home grown evidence based approach.
2. Is a process, fifteen (15) interactive dynamic steps and six (6) milestones.
3. Is a policy, accepted by government as a health delivery strategy

In view of all the above, CHPS as a strategy for health care delivery is not an option. The rural bias of the CHPS concept ensures that the underserved and rural communities are appropriately and adequately assured of improved and quality health care.

Various stakeholders as well as respondents in this study, have acknowledged the initiative as a pro poor health service delivery strategy, but bereft with challenges.

In line with policy directives, a number of districts across the country have adopted this initiative to improve access to and ensuring that quality of care is provided to local and rural inhabitants. Whereas some districts have implemented the CHPS strategy with varying degree of success, other Districts have not been that successful, as they are faced with varying degrees of challenges.

There are anecdotal and empirical evidence that where the programme is properly implemented it has contributed to a reduction in infant and maternal mortality rates, improved EPI antigen coverage, and contributed to disease surveillance, mobilization of communities and resources for the execution of health programmes. The findings of this study affirms the value of CHPS as it is

described as a culturally acceptable method for providing health care to rural and underserved populations. However, there are certain factors that militate against its implementation in the Saboba District. The study revealed issues of human resource, logistic and financial as the factors of challenge to CHPS implementation in the district.

Acknowledging this, it is important to give practical meaning of this programme by eliminating such implementation challenges. Addressing these factors require the review of policies for CHPS implementation as well as those regarding education and training of health staff, provision of dedicated and adequate financial support to districts for CHPS, rigorous logistic mobilization and commitment and development of innovative ideas and strategies for CHPS implementation and rollouts.

Where the programme is not supported by the required human resource, logistic requirement and financial backing, it has the potential to erode modest success achieved.

6.3 Recommendations

On the basis of the findings of this study, the following recommendations are made to address the implementation challenges identified.

6.3.1 Perceptions of Respondents

There is a strong and positive community health committee member, service provider, supervisors and health managers' perceptions of the CHPS initiative in

the Saboba District. There is therefore the need for the Ghana Health Service to build on this and do well to marshal the appropriate human and national resource to provide the needed assistance to districts to effectively roll out the initiative in their districts .For instance, stakeholder consultation meetings can be held to build on the current positive perceptions and explore ways for support and commitment for addressing the challenges to CHPS implementation in the Saboba District.

The knowledge gap of CHOs could be expanded and service package at the CHCs also be expanded to make the CHCs more effective and responsive to the health needs of the communities .e.g. CHOs should be trained to conduct deliveries, insertion and removal of family planning devices and minor surgeries.

6.3.2 Logistic Challenges

Logistics are essential for ensuring quality health care. Conscious and deliberate efforts should be made by the MOH/GHS for the mobilization of the required logistics for the CHPS programme. The District Assembly, Saboba should consider to a percentage of the district Assembly Common Fund to be set aside for the mobilization of logistics for CHPS. Also, a certain percentage of the MP for Saboba fund for health should be earmarked for logistics and equipment.

The commitment of the 10% levy of salaries of the Executive should not be limited to constructions of CHCs alone. Procurement of service delivery, mobility and comfort items for the CHCs should be considered.

6.3.3 Human resource challenges

The District Assembly, Saboba, should also consider scouting for local qualified candidates to sponsor such in health training institutions and bond them to serve in the Saboba District for a certain period of time. This can go a long way to address staff inadequacies.

The Ministry of Health, Ghana, should consider the revision of the training curriculum/syllabus of the Health training institutions to include essential skills that will adequately equip health staff to function as CHOS .e.g. .midwifery skills to improve skilled deliveries, community mobilization skills, etc. This will also equip the CHOs with the necessary skills to provide those essential services.

Also, the Ministry of Health, Ghana should consider to make it mandatory for the CHN or other appropriate staff to be trained as a CHO to serve in a CHPS zone after qualification before he/she can be eligible for promotion or consideration for professional promotion and academic development.

There is the observation of Nurses reluctance or aversion to working in rural areas. The District Assembly, Saboba, should consider the introduction and operationalizing of incentives for health staff working in the district. This will make staff stay for longer periods in the district and may even attract health staff to the district.

It is also recommended that, potential CHOs be adequately orientated at the district level before deployment in the CHPS zones. When one understands a concept, there is acceptance and commitment to support and work with it, as this will remove any biases.

Sometimes locations of the CHCs can be solitary. This makes the CHOs, who are mostly females, insecure, unstable and mobile, a cause of the high staff attrition. Consideration should be given for rigorous recruitment and training of males as CHOs to address this challenge.

A special career progression should be considered for CHOs so as to entice health workers into CHCs.

It is also important to avoid placing CHOs in a CHPS zone and" forget of them, a sort of "Siberia." Consideration should be given for a definite period to serve as a CHO and then move such staff or sponsor for professional skills development.

Consideration should be given to training of all qualified Community Health Nurses as CHOs. This will create a ready available pool of CHOs from which can be drawn to replace CHOs who will move on.

6.3.4 Financial Challenges

The need for dedicated funds for CHPS activities is crucial. Consideration should be given to the designing of a separate budget line at the national level, and this devolves to the district to support for the CHPS initiative.

The Ministry of Health/Ghana Health Service should consider increasing the Financial Encumbrances (FEs) to districts and make the release of these two districts regular. This will enable districts to provide the additional support required for community level health programmes like CHPS. It is also important to ensure that budgeted funds for district level health care activities are promptly disbursed to districts, and not their allocation.

Also, District Assemblies, Members of Parliament should consider human capital development, logistics and equipment and financial support for the CHPS initiative other than mere infrastructure development.

In 2001, the Government of Ghana signed the Abuja Declaration committing itself to spending at least 15% of total budget on health (15% bench mark).Recent data (2012) however show that Government fell short of meeting this bench mark, as only 12.5% of total budget was spent on health. (Health News, 12 July, 2013).Honoring this Abuja Declaration pledge is important for the MDG goals as well as ensuring universal basic health care, as CHPS seeks to achieve.

To improve and ensure reliable funding for CHPS, HealthCare, with emphasis in CHPS should be included in the four medium sectors selected for funding from the petroleum fund.

In addition, the CHCs should be designated automatic services points for the Health Insurance provision. The CHCs can also be considered for capitation also under the National Health Insurance Scheme. These considerations will ensure reliable financial provision for the CHCs.

6.3.5 Policy Revision for CHPS implementation

There is perceived honesty of policy makers about the CHPS as a pro-poor health initiative. This honesty reflects in acknowledging the implementation and rollout challenges of CHPS. (PPMED.GHS, 2015). It will be useful for the CHPS initiative if consideration is given to a policy review of the concept, grounded on the recognition of the challenges of implementation and slow rollout of the initiative, and seeking to address the key challenges of human, financial and logistics.

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Appendices: Data collection tools

Appendix 1: QUESTIONAIRE FOR THE DISTRICT HEALTH MANAGEMENT TEAM (DHMT) AND SUB DISTRICT LEADERS

Location:

Urban/Rural:

Date:

INTRODUCTION

Thank you for agreeing to do this interview. My name is Yakubu Charles Apoozan, a student from the University for Development studies and I'll be talking with you today.

PURPOSE OF INTERVIEW: The MOH/Ghana Health service in 1999, adopted the CHPS initiative, aimed at addressing the fundamental challenges of access and quality of Health care to remote and underserved rural communities.

Your district in 2002 initiated this programme to increase access to and use of health service in remote communities.

Since 2002, your district demarcated 26 CHPS zones, hoping to operate these 26 by the year 2013; however, as at the close of 2013, only 6 CHPS zones have been launched and are providing services. The purpose of this interview today is to learn more about your views, experiences and perceptions of the initiative as well as the implementation challenges of the programme in your district.

Before we start, I want to let you know that I will be taking notes and recording this interview and it will be transcribed to ensure that all of the information that we document is accurate. Results from this interview will not specifically identify individuals interviewed. Rather, the results will be reported in aggregate and by the number of persons that have been engaged. Do you have any questions? Is it ok to begin the interview?

The interview will last about 1 hour.

Did you read the consent form that was sent to you? Do you have any questions?

Ground rules

Everything you tell me will be confidential. To protect your privacy, I won't connect your name with anything that you say.

At any time during our conversation, please feel free to let me know if you have any questions or if you would rather not answer any specific question. You can also stop the interview at any time for any reason.

Please remember that I want to know what you think and feel about the CHPS programme and its implementation challenges and that there is no right or wrong answers.

Is it OK if I audiotape this interview?

[Turn on recording equipment.]

Section B: Demographic Characteristics of Respondents

- Gender

a. Male [ ] b. Female [ ]

- Age----------

- Professional Grade----------

- Education,

a. Post Basic [ ] b. Tertiary [ ] c. Others (State)

- Marital Status

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

Section B; General Professional Background of Respondent

I'd like to begin by asking you some questions about your current job.

What is your position in this organization? What are your major responsibilities in your current position?

How long have you been in this position?

Can you tell me a bit about your work and experience as it relates to community based health intervention programmes

How long have you been working in this district

Section C; Inception of CHPS

1. This district is credited with being the first district in the Northern Region to initiate the CHPS Strategy for health care delivery. When was the CHPS initiative started in this district?
2. What was the motivation or circumstances for initiating the CHPS programme in this district?
3. How many demarcated CHPS zones have been designed in the district?
4. How many of these are operational or functional and providing Health care delivery
5. How have the service of these functional zones contributed or impacted on the overall health service or indicators in this district
6. Can you elaborate on the factors you have enumerated above?
7. How many CHOs are currently working in the Community Health Compounds?
8. How many of these are trained as CHOs
9. What career progression system is in place for someone working as a CHO?

1. Section C: Perceptions of CHPS

10. In your view, do you consider or see this strategy as relevant for health care delivery

Section D: Challenges of CHPS Implementation

11. Since a total of 26 have been demarcated to be rolled out as functional CHPS as at the close of 2013 you still have only 6 zones operating. What are the main challenges of implementation of the initiative?

12. Can you elaborate on these?

13 What suggestions will give to improve the implementation of this initiative?

CONCLUSIONS

Thank you very much for your time and for sharing your experiences with me.

Do you have any additional comments on the issue we discussed?

Do you have any questions for me?

Again thank you very much.

Have a good day

APPENDIX: 2 INTERVIEW SCHEDULE FOR COMMUNITY HEALTH OFFICERS

Name of CHPS zone:

Urban/Rural

Date:

INTRODUCTION

Thank you for agreeing to do this interview. My name is Yakubu Charles Apoozan, a student forms the University for Development Studies, and I'll be talking with you today.

PURPOSE OF INTERVIEW: The MOH/Ghana Health service in 1999, adopted the CHPS aimed at addressing the fundamental challenges of access and quality of Health care to remote underserved rural communities.

Your district in 2002 initiated this programme to increase access to and use of health service in remote communities.

Since 2002, your district demarcated 26 CHPS zones, hoping to operate these 26 by the year 2013; however, as at the close of 2013, only 6 CHPS zones have been launched and are providing services. The purpose of this interview today is to learn more about your views, experiences and perceptions of the initiative as well as the implementation challenges of the programme in your district.

Before we start, I want to let you know that I will be taking notes and recording this interview and it will be transcribed to ensure that all of the information that we document is accurate. Results from this interview will not specifically identify individuals interviewed. Rather, the results will be reported in aggregate and by the number of persons that have been engaged. Do you have any questions? Is it ok to begin the interview?

The interview will last about 1 hour.

Did you read the consent form that was sent to you? Do you have any questions?

Ground rules

Everything you tell us will be confidential. To protect your privacy, we won't connect your name with anything that you say.

At any time during our conversation, please feel free to let me know if you have any questions or if you would rather not answer any specific question. You can also stop the interview at any time for any reason.

Please remember that we want to know what you think and feel and that there is no right or wrong answers.

Is it OK if I audiotape this interview?

[Turn on recording equipment.]

Section A: General Professional Background of Respondent

I'd like to begin by asking you some questions about your current job.

- What is your position in this organization? What are your major responsibilities in your current position?
- How long have you been with Health Service?
- Can you tell me a bit about your work and experience as it relates to community based health intervention programmes

Section B: Demographic Characteristics of Respondents

- Gender

a. Male [ ] b. Female [ ]

b. Age----------

c. Professional Grade----------

d. Education,

a. Post Basic [ ] b. Tertiary [ ] c. Others (State)

e. Marital Status

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

Section C: Working as a CHO

1. How long have you been working as a CHO
2. Have you been trained as a CHO?
3. If yes how long ago

Section D: Perceptions of CHPS

4. What is you understanding of the CHPS concept
5. What is your opinion, view or perception of CHPS as strategy for Health care delivery?
6. Can you elaborate?
7. In your view, do you consider the CHPS strategy as appropriate for health care delivery

Section E: Challenges of Implementation of CHPS

8. In your opinion or view what are the challenges of implementing this initiative. Give five (Indicate these on the back of the question or use additional paper)
9. Can you elaborate on these?
10. What suggestions will give to improve the implementation of this initiative?

CONCLUSIONS

Thank you very much for your time and for sharing your experiences with me.

Do you have any additional comments on the issue we discussed?

Do you have any questions for me?

Again thank you very much.

Have a good day.

APPENDIX 3: FOCUS GROUP GUIDE FOR COMMUNITY HEALTH COMMITTEE MEMBERS

Name of CHPS zone-

Urban/Rural:

Total Participants in Group:

Date:

Welcome and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. I realize you are busy and I appreciate your time.

Introduction: This focus group discussion is designed to assess your current thoughts and feelings, views and perceptions about the Community based Health Planning and Services which is operating and providing health care to the people and communities of this zone. The focus group discussion will take no more than two hours. May I tape the discussion to facilitate its recollection and also so that we do not lose any important point that you will mention? (If yes, switch on the recorder)

Anonymity: Despite being taped, I would like to assure you that the discussion will be anonymous. The tapes will be kept safely in a locked facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the focus group will contain no information that would allow individual subjects

to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. I and the other focus group participants would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however please try to answer and be as involved as possible.

Ground rules

- The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.
- There is no right or wrong answers
- You do not have to speak in any particular order
- When you do have something to say, please do so. There are many of you in the group and it is important that I obtain the views of each of you
- You do not have to agree with the views of other people in the group
- Does anyone have any questions?
- OK, let's begin
- Warm up

- First, I'd like everyone to introduce him or herself. Can you tell us your name?

Section A: Demographic Characteristics of Respondents.

1. Can each of us tell what work he or she does or profession
2. I want to believe we are all married.
3. How many of us have been to school and what stage did we reach.
4. How many of us are between the age brackets of-------

Section B: General Knowledge of CHPS

5. What is your understanding of this programme that is bringing you health services in this area (CHPS).
6. When was the programme started in this area

Section C: Perceptions

7. How relevant is the programme to this community
8. Do you consider it as a good programme of bringing health care to you and your communities?
9. In your opinion is this programme appropriate for Health Care delivery in this area/zone.

Section D: Challenges of Implementation of CHPS

10. Can you tell me some of the challenges you may know that were encountered in bringing the CHPS programme to this place

    - How will you rate the availability of following, at the CHC

➢ Staff availability: a. Excellent. b. Very Good. C. Good. d. Poor

➢ Equipment and logistics (weighing scales, BP apparatus, thermometers, etc.)

➢ Human resource; Excellent, very good, good, bad, poor.

Concluding question

11. Of all the things we've discussed today, what would you say are the most important issues you would like to express?

12. Has anyone anything to say about the programme that I have not asked.

Conclusion

- Thank you for participating. This has been a very successful discussion
- Your opinions will be a valuable asset to the study
- I hope you have found the discussion interesting
- If there is anything you are unhappy with or wish to complain about, please contact the CHO or speak to me later.

- I would like to remind you that any comments featuring in this report will be anonymous

I thank all of you very much for your cooperation and the discussions.

hp LaserJet 4350 printers

job storage status page 1

Error: Unable to store job at printer
Reason: Insufficient disk space for this job

Solution: Delete some files from the disk before resending this job.