UNIVERSITY FOR DEVELOPMENT STUDIES, TAMALE

SCHOOL OF GRADUATE STUDIES

ASSESSING THE CONTRIBUTION OF COMMUNITY HEALTH COMMITTEES IN MATERNAL HEALTH CARE DELIVERY IN THE BOLGATANGA MUNICIPALITY

BY

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(UDS/CHD/0051/19)

A THESIS SUBMITTED TO THE DEPARTMENT OF SOCIAL AND BEHAVIOURAL CHANGE, SCHOOL OF PUBLIC HEALTH, IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL DEGREE IN COMMUNITY HEALTH AND DEVELOPMENT.

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DECLARATION

Candidate's Declaration

I hereby declare that, this result is my own research work carried out in the department of Social and Behavioural Change, and to the best of my knowledge contains no material previously presented for the award of any other degree in this University or elsewhere except where due acknowledgement has been made in the text.

Candidate's Name: SAMUEL NGUMAH

Candidate's ID: UDS/CHD/0051/19

Signature: ……..…… Date: ……1/3/2024……..……

Supervisor's Declaration

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

Supervisor's Name: DR. HARUNA UMAR

Signature: …….. Date: 1/3/2024 ……

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DEDICATION

I dedicate this work to Almighty God, who has been my source of strength and wisdom. To my parents and other family members for their love and support.

ABSTRACT

Since professionals and community (grassroots) members collaborate, it is commonly considered that Community Health Committees (CHCs) have a major impact on community health and well-being. They basically use a common socio-ecological lens to address many factors that affect community health and well-being in order to address issues that have been discovered. Despite all these enumerated contributions of CHCs to health care delivery in general, little has been explored about their specific roles towards the delivery of maternal and child health services and improvement of same, especially within Ghana's much touted CHPS framework. The study aimed to assess the contribution of CHCs in the delivery of maternal and child health care within the CHPS system using the Bolgatanga Municipality as the study area.

A descriptive cross-sectional qualitative study design, targeting multiple respondents was employed. Key Informant Interviews and Focus Group Discussions (FGDs) were used in collecting data. In all, nineteen (19) in-depth interviews were conducted to augment the 22 Focus Group Discussions (FGDs). The thematic analysis method was used to analyze the data.

The study reveals that CHC's roles include a) making the community understand the health systems and why they should take control of their health; b) providing support to the healthcare staff, c) educating community members and creating an enabling environment for the provision of healthcare. The overall effect of this was that, these contributed to improving maternal health delivery within the catchment area. Additionally, the study found that, members of the CHCs had a very cordial relationship with the healthcare staff. The study unearthed that, some CHPS facilities lacked the essential amenities, which hindered the work of both the health committees and community health workers.

The study finds that Community Health Committees (CHCs) can play a vital role in promoting community empowerment and increasing participation in health initiatives, leading to better program ownership and sustainability. However, it is crucial to provide regular training to CHC members on skills such as maternal and child health care delivery, community mobilization, dialogue, and facilitation. This training is necessary to ensure the successful functioning of CHCs, especially due to the poor incentive system that may cause members to serve shorter periods and leave. Building the capacity of new members is essential to maintaining the quality, service coverage, and influence of CHCs.

ABBREVIATION

ANC	Antenatal Services
CDC	Center for Disease Control
CHAG	Community Health Action Group
CHCs	Community health committee
CHF	Community Health Fund
CHMCs	Community Health Management Committees
CHN	Community Health Nurse
CHOs	Community Health Officers
CHPS	Community-Based Health Planning and Services
CHVs	Community Health Volunteer
CHWs	Community Health Workers
DDHS	District Director of Health Services
DHMTs	District Health Management Teams
FP	Family Planning
GHS	Ghana Health Service
HCACs	Health Centre Advisory Committees
HCC	Health Community Committees
HDAs	Health Development Armies
HFGC	Health Facility Governing Committees
HUMC	Health Unit Management Committees
MARL	Multi-Agent Reinforcement Learning

MDGs	Millennium Development Goal
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NGOs	Non-Governmental Organisation
PHC	Primary Health Care
SDHT	Sub District Health Team
SSA	Sub-Saharan Africa
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
VHCs	Village Health Committees
WB	World Bank
WHO	World Health Organisation
ZDHS	Zambia Demographic Health Survey

TABLE OF CONTENT

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Access to equitable, community-based health care has long been a cornerstone of global health strategies, particularly in developing countries. The 1978 Alma Ata Declaration marked a pivotal moment in the evolution of primary health care (PHC), emphasizing the need for universal access to essential health services through community participation, equity, intersectoral collaboration, and appropriate technology (WHO, 1978). This declaration influenced several low- and middle-income countries, including Ghana, to rethink their health systems and adopt community-oriented models of care to reduce health disparities and promote inclusive development.

As a crucial component of health promotion and the building of health systems, the Ottawa Charter for Health Promotion of 1986 was also advocated for the improvement of community actions through the empowering of communities to better own and govern their health actions. As a result, numerous governments have started forming community organizations that collaborate to accomplish particular health objectives and encourage community involvement in health, advocacy, and awareness-raising (Gilmore et al., 2016). In 1999, the Ministry of Health of the Government of Ghana initiated a Community-based Health Planning and Services (CHPS) pilot program to enhance the accessibility of health care services in Navrongo, Upper East Region. The model which led to improvement in healthcare access and utilization became a national health policy in 1999 (Braimah, 2017).

A defining feature of the CHPS strategy is its emphasis on community engagement through Community Health Committees (CHCs). These committees serve as the social infrastructure supporting the physical presence of CHPS compounds and healthcare staff. CHCs are established in every CHPS zone and are expected to mobilize community resources, facilitate health education, oversee facility management, and mediate between health providers and residents (GHS Policy Guidelines, 2016). Their roles are particularly crucial in promoting maternal and child health by advocating for skilled birth attendance, antenatal care, immunizations, and culturally acceptable care practices.

A Community Health Committee (CHC) is a group of individuals who agree to work together to achieve a common goal and who represent different organizations, factions, or constituencies within the community, according to Gilmore et al. (2016). Rather than being housed in medical institutions, CHCs are found in local communities. Community health committees are commonly believed to have a longer-lasting impact on health and well-being because they address the various determinants of community health and well-being by responding to identified challenges via a shared socio-ecological lens. This belief is partly due to professional and community (grassroots) member collaboration (Okuga, Kemigisa, Namutamba, Namazzi, & Waiswa, 2015). In order to boost program ownership and sustainability, the Community Health Committee can also improve the coordination of health efforts, raise the possibility of community empowerment, and make it easier for community members to participate in health initiatives (CDC, 2015).

CHCs serve as vital links between health workers and the community, acting as advocates, facilitators, and monitors of health service delivery at the grassroots level. Their roles include supporting pregnant women to attend antenatal clinics, organizing emergency transport systems,

participating in health education campaigns, and ensuring community ownership of health facilities (Karuga, 2024). By engaging local leadership and promoting volunteerism, CHCs are expected to enhance the responsiveness and sustainability of primary health care interventions, particularly in the area of maternal and child health.

Through the Community Health Committees (CHCs) and Community Health Volunteers (CHVs), the CHPS approach offers a framework for implementing health services in rural regions and involving the community in the delivery of health (Dougherty et al., 2018). Because CHPS requires careful planning and negotiation with all relevant parties, including the local government, the political establishment, and community members through effective participation and community mobilization, its local implementation requires cooperation between the formal health sector and communities (Adongo et al., 2013).

However, while the establishment of CHCs under the CHPS framework was envisioned to enhance community participation and improve maternal health indicators, questions remain about their actual contribution and effectiveness (Elsey et al., 2023). In many rural and peri-urban communities, challenges such as limited capacity, inadequate resources, poor coordination with professional health staff, and weak institutional support hinder the ability of CHCs to function optimally. Moreover, the specific roles, functionality, and collaborative dynamics between CHCs and other actors in the health delivery system are not always clearly defined or consistently implemented

Community health nurses are trained in preventative health care services (such as vaccines, Family Planning (FP), prenatal and postnatal care, treating minor illnesses, and health education) by the health sector within this health care delivery system. After that, the nurses are dispatched to the

neighborhood to deliver services door-to-door (Adongo et al., 2013). In order to help Community Health Officers (CHOs) with their work of community involvement and mobilization, key community data recording, and other crucial responsibilities, communities also select community volunteers in partnership with the health sector (Adongo et al., 2013).

Maternal mortality is still high in Ghana despite the country's 20 years of progress in improving maternal health, and the country did not fulfill the targets set forth in the 2015 Millennium Development Goals. Maternal fatalities per 100,000 live births decreased from 634 in 1990 to 319 in 2015, but this decrease was not enough to meet the 185-millennium development goal for 2015 (WHO, 2015). Thus, community engagement should be a part of maternal health improvement strategies in addition to any facility-based components (Akinyi, Nzanzu, & Kaseje, 2015). Additionally, in high-mortality circumstances, developing nations' progress towards MDGs 4 and 5 remained poor (Akinyi et al., 2015).

1.2 Problem Statement

Community Health Committees (CHCs) play a critical role in the implementation of Ghana's Community-Based Health Planning and Services (CHPS) strategy, which was introduced as part of efforts to operationalize the Alma Ata Declaration's vision of accessible, equitable, and community-driven primary health care. Within this framework, CHCs serve as essential links between health professionals and community members, promoting local ownership of health initiatives and supporting health-seeking behaviors, particularly in maternal and child health care.

Several studies in Ghana have examined the broader impact of CHPS and the contributions of community health volunteers (CHVs) and committees to primary health care delivery (Adongo et al., 2013; Akinyi et al., 2015; Braimah, 2017). However, while the importance of CHCs is often

acknowledged, there remains a limited and fragmented understanding of their specific contributions to maternal health service delivery, especially within the context of rural and resource-constrained districts. Most existing literature focuses on the CHPS model as a whole, with minimal attention to the functional dynamics, operational capacities, and intersectoral relationships that define the work of CHCs.

In regions such as the Upper East Region, where maternal mortality remains high despite the presence of CHPS infrastructure, the performance and functionality of CHCs become even more critical. Statistics from the Ghana Health Service show a troubling trend: maternal deaths in the Upper East Region rose from 31 in 2019 to 43 in 2021. In the Bolgatanga Municipality, skilled birth attendance remains low, with only 34% of women delivering at health facilities, and CHPS compounds contributing less than 10% to total deliveries (Achana, 2024). These figures raise important questions about the effectiveness of CHCs in mobilizing communities for maternal health care and ensuring timely referrals and facility-based deliveries.

Although the CHPS policy mandates the establishment of functional CHCs in every CHPS zone, there is insufficient empirical evidence on how these committees operate, the challenges they face, how they interact with community health officers (CHOs), and what institutional or systemic constraints hinder their effectiveness. This lack of detailed, localized data limits policy and programmatic efforts aimed at strengthening CHCs to improve maternal health outcomes.

Therefore, this study seeks to assess the contribution of Community Health Committees to maternal health care delivery in the Bolgatanga Municipality, with a focus on their composition, roles, collaboration with health staff, and the constraints they encounter. By addressing this

specific gap in the literature, the study aims to inform strategies for enhancing CHC performance within Ghana's decentralized health system.

1.3 Research Objectives

The main objective of the study was to assess the contributions of Community Health Committee in the delivery of maternal health care within the CHPS system in the Bolgatanga Municipality.

1.3.1 Specific Objectives

1. To examine the composition, capacity and functions of CHCs in the Municipality.
2. To ascertain the specific contributions of CHCs to maternal and child health care delivery in the Bolgatanga Municipality.
3. To describe the nature of relations between CHCs and other health workers within the CHPS framework in the Bolgatanga Municipality.
4. To examine challenges confronting CHCs in contributing to maternal health care delivery within the CHPS framework in the Bolgatanga Municipality

1.4 Research Questions

What is the role of the community health committee in maternal health care delivery under the Community-Based Health Planning Service concept?

1.4.1 Specific research questions

1. What is the composition, capacity and functions of CHCs in the Bolgatanga Municipality?
2. What are the specific contributions of CHCs to maternal and child health care delivery in the Bolgatanga Municipality?

3. What is the nature of relationship between CHCs and other health workers within the CHPS framework in the Bolgatanga Municipality?
4. What are the challenges confronting CHCs in contributing to maternal and health care delivery in the Bolgatanga Municipality?

1.5 Significance of the study

The CHPS concept as a national health reform program employs community mobilization, volunteerism and traditional institutions to support community-based primary healthcare. While the CHCs is an integral part of the CHPS concept, their role in maternal and child health care delivery is not well documented and largely unknown by many. The objective of this research is to ascertain the fundamental contextual elements and underlying mechanisms that facilitate the operations of community health committees (CHCs), foster community capacity in the area of mother and child health, and enhance the uptake of ANC/PNC health care.

Thus, the findings of this study sheds more light on the important role of CHCs in maternal and child health care delivery, bridge the knowledge gap on CHCs performance and become a foundation for future studies on improve ways of delivering maternal and child health care services in Ghana and in rural environs in particular.

The documentation of the role, performance and challenges of CHCs is useful information in policy reviews, formulation and implementation of the CHPS model fused with CHCs as part of the Ghana health system for better health care access, uptake and ownership as envisaged by the policy through participation.

1.6 Scope of the study

The Upper East Region has an estimated 224 CHPS facilities with 11 of them located in the Bolgatanga Municipality to augment maternal and child health care service delivery. In 2015, Bolgatanga Municipality with 11 CHPS facilities together with other health facilities recorded a skilled birth rate of only 34%. This study specifically selected 11 CHPS in the Bolgatanga municipality for this research. The study targeted staff of CHPS, CHC members with qualitative tools on their role, performance, challenges and ways to better their service delivery and collaboration.

1.7 Organization of the study

The study is structured into six chapters. Chapter one provides a general introduction which includes the background of the study, statement of the problem, objective of study, research questions, significance of the study, scope, and organization of the study. Chapter two is a literature review that evaluates the works of other researchers related to the research questions and the theoretical frameworks, approaches, and criticisms. Chapter three is the research methodology that explains the study design, sampling strategy, and data collection methods, tools, and data analysis techniques. Chapter four presents the findings of the study, which includes analyzed results, verbatim quotes, tables, graphs, and charts that illustrate the collected data. Chapter five is the discussion, which interprets the results into user-friendly information, giving meaning to data and tables. Chapter six is the conclusion, which summarizes the key findings and provides recommendations for further research or review of practices, methods, and strategies of implementation. Additionally, chapter six presents the references and appendices, which include additional materials such as questionnaires, survey forms, or consent forms used in the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section of the study covers the review of relevant literature on the topic. The review comprised of theoretical review, conceptual review, empirical reviews and summary of literature. The empirical review covered the contribution of Community Health Committee in the CHPS system, challenges of the CHCs in maternal healthcare in the CHPS system.

2.2 Theoretical Review

There are several theories that can be used to underpin the contribution of CHCs on improving maternal health care in the CHPS system. However, two of these relevant theories were reviewed for the purpose of the study. They are; the Diffusion of Innovation theory and the Social Capital framework.

2.2.1 The Diffusion of Innovation theory (DOI)

The pattern and speed at which novel concepts, behaviors, or goods proliferate throughout a populace are explained by the diffusion of innovations theory. Innovators, early adopters, early majority, late majority, and laggards are the key participants in the notion, according to Rogers in his book Diffusion of Innovations (Boora, 2022). Through "diffusion," creativity and novel concepts proliferate throughout social networks. Social diffusion is the process by which social interaction can support and foster changes in beliefs or behavior. According to Khan et al. (2020), organizational diffusion is the process by which new ideas are shared or innovative techniques are demonstrated, leading to change. Ghana Health Service CHPS model is an attempt to spread

(diffusion) a new strategy (innovation) of reaching rural population with improved health service by establishment of CHPS compounds, changing people's health care seeking behavior through participation with the introduction of CHC. The system further provides information and link communities and other health agencies for well-being of all.

The important role of innovative diffusion theory is seen in the design of Ghana Health Service (GHS) programs and activities which are planned to include beneficiary populations and communities. Research on the diffusion hypothesis showed that when changes are introduced and accepted, they are more readily accepted when they are seen as belonging to the host rather than coming from the outside (Dako-Gyeke et al., 2022). It is evident why community ownership is considered a crucial component of the GHS and CHPS program. This is pertinent to research on the role that CHCs play in the CHPS system nationwide and in local areas through diffusion.

In relation to the first objective which seeks to examine the composition, capacity, and functions of CHCs, the DOI theory helps to explain how CHCs act as early adopters or change agents who interpret and implement maternal health innovations (e.g., skilled birth delivery, ANC attendance) in ways that are compatible with local culture and beliefs. Their position within the community allows them to demonstrate relative advantage and enhance observability of the new practices, thereby encouraging broader adoption.

For the second objective, which seeks to assess the specific contributions of CHCs to maternal and child health delivery, the theory illustrates how innovations are more likely to be diffused when promoted by trusted opinion leaders. CHC members, including religious leaders, women leaders, and chiefs, serve as influential nodes in the social network, using interpersonal communication to disseminate health information and promote behavioral change.

The third objective, concerning the relationship between CHCs and other health workers, ties into the DOI concept of communication channels. Effective diffusion requires strong formal and informal communication between stakeholders. By serving as mediators and facilitators, CHCs ensure the bidirectional flow of information between communities and health providers, which enhances compatibility and encourages broader acceptance of services.

Finally, the fourth objective, which examines the challenges facing CHCs, can be linked to the barriers that affect the speed and extent of innovation adoption, such as limited incentives, inadequate logistical support, and perceived complexity of roles. These challenges may hinder CHCs' capacity to act as effective diffusion agents, delaying or obstructing the uptake of maternal health innovations at the community level.

Thus, the Diffusion of Innovation Theory provides a useful lens through which to assess not only the role and influence of CHCs in health promotion but also the factors that enable or hinder their effectiveness in facilitating maternal health outcomes in rural settings like Bolgatanga.

2.2.2 Social Capital framework

Social connections are a resource that can assist individuals in developing and accumulating human capital, claims social capital theory. Examining social capital in community systems, Linde and Egede (2023) observes that social capital is essential to supporting the health system in communities. According to this paradigm, people inside a social network are learning agents who develop interpersonal connections repeatedly in order to acquire social capital. The system is driven by an algorithm called Multi-Agent Reinforcement Learning (MARL), which trains agents to make better decisions by having them play games repeatedly.

Every intervention, according to WHO (2009), has an impact on the community system as a whole. These consequences may be expected or unexpected, beneficial or bad. According to the WHO, social capital, decision-making ability, trust amongst community members, and social support are significant factors that influence the use and results of health services. People's lives eventually come into contact with health systems in their local communities. According to Linde and Egede (2023), community settings are miniature worlds of intricate social, political, associational, economic, power, and cultural dynamics. As such, they provide a different environment than a hospital for the delivery of healthcare services and the promotion of behavior change. Health status is influenced by these linkages and dynamics both within and between communities and their surroundings.

In applying this theory to the first objective which seeks to examine the composition, capacity, and functions of CHCs, social capital manifests in the bonding and bridging relationships that CHC members share within their communities. These social linkages strengthen their legitimacy as local leaders and enhance their ability to mobilize community members for maternal health initiatives such as antenatal care attendance, skilled birth delivery, and immunization campaigns.

The second objective, which focuses on the contributions of CHCs to maternal and child health, is directly supported by the trust and collective action mechanisms embedded in social capital. CHC members often leverage their roles as religious leaders, traditional authorities, or respected elders to influence health-seeking behaviors, correct misconceptions, and promote the uptake of facility-based maternal care services. The ability of CHCs to coordinate community health activities reflects the shared norms and reciprocity that define strong social capital.

Regarding the third objective which seeks to describe the relationship between CHCs and health workers within the CHPS framework, the concept of linking social capital becomes relevant. Linking social capital refers to relationships between community members and institutions or authorities. A strong, trust-based relationship between CHCs and community health officers enhances cooperation, improves referral mechanisms, and facilitates accountability in service delivery. This ensures that community health concerns are communicated effectively and responded to within the formal health system.

For the fourth objective, which examines the challenges confronting CHCs, Social Capital Theory highlights the risks of weak or eroding community cohesion. Where community trust is low or perceptions of inequity or exclusion exist, the effectiveness of CHCs may be compromised. Additionally, when CHC members are under-resourced or underappreciated, the motivational basis for voluntary community action may deteriorate, leading to disengagement and decreased maternal health outcomes.

Overall, the Social Capital framework enables a nuanced understanding of how community engagement, trust, and cooperation underpin the work of CHCs and influence the success or failure of maternal health interventions in decentralized settings. It also underscores the importance of supportive social environments, intersectoral collaboration, and community empowerment in strengthening health systems at the grassroots level.

2.3 Overview of the CHPS Concept

2.3.1 Historical Overview of CHPS

Ghana's Community-based Health Planning and Services (CHPS) system is a primary health care strategy designed to enhance the provision of healthcare in underserved and rural areas (CHPS

policy, 2002). It entails establishing community health compounds staffed by qualified community health officers who offer primary healthcare, health education, and community health promotion initiatives. The CHPS initiative seeks to eliminate geographical barriers to health care access in remote and challenging-to-reach areas through community resource mobilization (Dako-Gyeke et al., 2022). By reducing the significant gap in access to healthcare between urban and rural areas, the CHPS system is anticipated to assist Ghana in achieving UHC (Akweongo et al., 2017). The principles of PHC, which were endorsed by the Alma-Ata statement in 1978 and promote community involvement in the provision and administration of health care services, form the foundation of the CHPS model (Baatiema, Skovdal, Rifkin, & Campbell, 2013; WHO, 2008).

In order to address the healthcare needs of rural and underserved populations by bringing necessary health services closer to the communities, the Ministry of Health launched the Community-based Health Planning and Services (CHPS) system in Navrongo, Upper East Region, as a pilot project in 1994. (MOH 2008, Akweongo et al., 2017). Since then, the CHPS program has grown and changed, becoming an important part of Ghana's primary healthcare system (GHS 2006).

The idea shifts the focus of health care service delivery from an institutional setting to a mobile, community-based system managed by a resident Community Health officer (CHO) or nurse, according to Atuoye et al. (2015) and Woods (2016). A CHPS is a complex that provides health services and is situated inside a designated area known as a "CHPS zone" (Atuoye et al., 2015). The CHPS facility, which is often constructed through community resource mobilization, also houses the CHO and nurse. The zoning system was put in place to ensure equity and efficiency in the delivery of healthcare services. In essence, a "CHPS zone" is a defined area where a compound, a CHO/nurse, and health services are assigned. Currently, CHPS zoning is based on electoral area

matriculation, which deviates from the conventional population size approach (Kyei-Nimakoh et al., 2016).

2.3.2 Structure of the CHPS system

The CHPS system is the lowest unit of health care delivery in the Ghana under the public health policy and it is the primary responsibility of the GoG through the Ministry of Health, and Ghana Health Service to set them up and operate CHPS (CHPS Policy 2002).

The structure for implementing the CHPS process has three inter-related components:

- The community and its operational components, including the people and chiefs, the community health committees, and the community health volunteers
- The ministry of health; comprising the Ghana Health Service, District Health Management Teams, the Sub-District Health Team and the Community Health Officers and
- The local government authority- the assemblies led by Chief Executive officers, and administrative staff.

Under the CHPS system, the government of Ghana develop polices, allocate resources and oversee the implementation of the CHPS program to ensure health care services are accessible and effective especially in rural areas. In setting up CHPS, local community leaders, health professionals and stakeholders often collaborate with local government establishments to ensure successful operation (CHPS implementation guidelines 2004). The process of setting up CHPS involved several steps;

1. Planning and allocation of resources by the government on the number of facilities to be established in the year. Once the plan is in place the MoH through GHS in the various local

government areas are encouraged to scout and select possible sites in consultation with community leaders and people for consideration. Once the decision is made, the DHMT engages with the community leaders and members to ensure their full participation and sustenance of the operations.

2. The next step in the process is the development of appropriate infrastructure to house the staff, material and equipment for the proper functioning of the CHPS. During construction, community labor and resources are utilized as part of ownership drive under the CHPS policy.
3. Once constructed, Ghana Health service post community health nurses and officers to provide a range of services, including health education and promoting preventive measures. Each CHPS serves as homes for nurses and place for delivering primary health care. During CHPS construction, community labor and resources are utilized. Once built, CHPS compounds function as locations for primary healthcare delivery as well as residences for nurses.
4. Every town must establish a health committee and seek out community health volunteers who will receive training, supplies, and recommendations for basic medical treatment as part of CHPS's development. These elements come together to form the set of actions or procedures involved in implementing the CHPS system in each location. In addition to providing family planning information and identifying cases, community health volunteers also carry out illness surveillance, send patients to community health officers for treatment, and provide additional family planning services. Community health volunteers have a variety of roles in the delivery of healthcare, although they are typically divided into two

categories: a. helping community health officers with their duties and b. doing home visits. Among other things, they support language translation, case tracing, condom delivery to defaulters, identification of defaulters, and the spread of health information through meetings and routine immunizations (MOH/GHS 2009).

2.3.3 Stakeholders in the CHPS system

The involvement of key stakeholders in the planning, prioritization, and the final implementation process of any health program can have significant impact on the effectiveness of the intervention (Atwal et al., 2023). The stakeholders in CHPS program in Ghana include a diverse range of individuals, organizations, communities, agencies (Sakeah et al., 2021). The first is the Government line agencies-ministries, departments, and institutions of which Ministry of Health, Ghana Health Service, Health professionals including community health nurses, midwives, and community health workers.

Local communities and their leaders are the second important stakeholder group. According to Haldane et al. (2019), community participation is a methodical procedure that involves obtaining beneficiary community opinions and incorporating them into the health care strategy. Both the community and the health service providers had to actively participate. There is a wealth of information regarding the function that local health committees play in developing nations' health management (Haldane et al., 2019). The chief, elders and local leaders as well as groups play a crucial role in mobilizing community support to facilitate the implementation of the health programs for their respective communities.

The integration of community volunteers/representatives, opinion leaders, women groups, the poor or marginalized to participate is essential in health care delivery because it produces understanding

and acceptance for smooth implementation of interventions. It is established that, the rapid expansion and inclusion of communities have contributed to increasing rural people's access to health care and helping people take absolute control over their health due to empowerment (GHS, 2011; Sakeah et al. 2021). The participation of beneficiary communities leads to generation of the needed resources and support for the establishment of health facilities across communities particularly through the CHPS system. The resident's participation, utilization, and feedback on the CHP services are central to the success of the program and hence they form a major part of the stakeholders.

Non-governmental organizations and private actors are often in the business of collaborating with government to provide support, resources as well as technical expertise to enhance the program effectiveness. CHPS program success remains an important part of NGOs in the process to bring health care services closer to the people in rural places.

Other important stakeholders are the development partners- international organizations donor partners, provide funding, technical support to help expand and make the CHPS program effective (Haldane et al., 2019). In every development endeavor, stakeholders play key role in the success of initiatives and interventions and the CHPS program in Ghana is no exception. Other stakeholders such as civil society organization and the media play important roles in continuous advocacy for improve health care services delivery (Dako-Gyeke et al., 2022). The collaborative role of stakeholders in ensuring the successful implementation and sustainability of the CHPS program cannot be understated. Below is an account of some key stakeholders in the CHPS program;

2.3.3.1 The Community Health Committee (CHC)

The CHC is an essential component of the CHPS program in Ghana (CHPS Policy 2002). The CHC is local committee formed within the community to actively engage community members in the planning, implementation and management of health-related activities and services provided under the CHPS compound (CHPS implementation guideline 2002). The CHC primary role of the CHC is to ensure active involvement of community members in health care decision-making, foster a sense of ownership and responsibility among the people for the well-being of the community.

In particular, the roles include; community engagement, advocacy, supporting the staff and serving as liaison between staff and community, mobilizing resources, monitoring the CHPS activities and providing feedback. (CHPS Policy, 2002, CHPS implementation Guide 2004, CHPS Training manual 2012).

2.3.3.2 The Community Health Volunteers

A community health Volunteer is an individual who provides basic health related services, education, and support to their local community often on voluntary basis (Health Research Policy and Systems, 2015). They are crucial in CHPS system because of their role in extending services to communities with the knowledge of the community health officers.

CHVs assist in identifying children for immunization, notifying community health officers of disease appearance, providing family planning services (distribution of condoms) and counseling, providing preventive and curative services for malaria and diarrhea, and referring serious cases to clinics and community health officers (Dako-Gyeke et al., 2022).

2.3.3.3 The District Health Management Team (DHMT)

The District Health Management Team (DHMT), under the direction of the director of health, is in charge of the entire health management system. The DHMT assists the Sub District Health Teams (SDHT) in putting health plans into action and offers direction and technical support for planning and budgeting. It is responsible for the supply of essential medical supplies and supervision of SDHT activities for compliance and quality service delivery.

2.3.3.4 The Sub District Health Team (SDHT)

As a component of the healthcare system, the SDHT plays a liaison and managerial role. In order to support the District Health Management Team, the SDHTs oversee community facilities, conduct management meetings with committees and officers dedicated to community health, and gather information on volunteer programs and community health officers. The SDHT oversees the distribution of medication and family planning supplies, keeps an eye on how community health workers and volunteers use them, and reports any updates to the District Health Management Team.

2.3.3.5 The Community Health Officers (CHO)

The Community Health Officer (CHO) plays a vital role in providing primary health care services within communities (CHPS Implementation Guidelines 2004). They are trained medical professionals who work to improve the health and well-being of people in rural and underserved areas. Their responsibility often includes preventive care, health education, maternal and child health care, immunization disease management, offer basic medical treatment and referrals of more serious conditions

CHOs help bridge the gap between communities and the formal health systems, promoting better health outcomes and raising awareness about healthy practices.

2.3.3.6 The District Assembly

The local government agencies play a critical role in Community Health Planning and Services system (CHPS) program. Often headed by political appointee called Chief Executive, they typically serve as the link between the CHPS program and other social development services programs in the district to ensure synergy and holistic approach to community development.

The District Assembly, via its social services subcommittee, is in charge of working with the DHMTs to identify and rank communities for the CHPS program, build community health compounds, coordinate the efforts of various stakeholders, including NGOs and members of parliament, and promote support for the program's implementation.

The District Assemblies also receives quarterly progress report on implementation of the CHPS program and uses that information to initiate necessary action for efficient operation of the program.

2.4 The Role of Community Health Committees in Health Delivery:

Improved health outcomes are a result of community involvement in the provision of health care services. According to research conducted in Zimbabwe by Loewenson et al. (2021), medical facilities with health committees had: 1) More staff and financial resources; 2) Fewer drug stock outs; and 3) Greater coverage of basic health care services. Once more, a study conducted in Kenya by Otieno et al. (2020) showed that health facilities with active health committees used healthcare services more effectively. This is related to the function and duties of health committees, which

include organizing individuals and resources to assist in the administration of the medical facility, delivering healthcare education, establishing outreach programs for the far-flung villages, and overseeing the interactions between medical professionals and the public (Otieno et al., 2020).

The majority of developing nations, particularly those in Sub-Saharan Africa, aim to provide all of their residents with universal access to primary healthcare. Participation of communities through health committees is a key tactic to achieve this goal (Marston et al., 2016). On the other hand, nothing is known about how health committees' participation in the provision of primary healthcare services benefits the general health of the community. In order to standardize the assessment of community participation levels and processes in health programs, Gathege and Yusuf (2019) established a conceptual framework that makes use of five process indicators: women's involvement, leadership, planning and management, mobilization of external resources, monitoring, and evaluation. This framework's definition of various community participation processes makes it possible to perform a more thorough investigation of the extent to which health committees improve the general health of the community.

The engagement framework designates "mobilization" as the lowest degree of engagement on the community participation continuum, which consists of three levels (Gathege and Yusuf, 2019). At this point in the continuum, health workers merely organize community members to take action and to obediently support decisions while managing primary health programs. The second level of involvement is called "collaboration," in which medical experts identify the community's primary healthcare needs and ask them to lend their time and personal resources to the event's promotion. According to the paradigm, the continuum's "empowerment" level, where community members

may exercise their right to make decisions that impact their health, represents the highest degree of community participation.

It is advantageous, difficult, and demands more understanding of how health committees influence community involvement and how participation affects community health program results to operationalize and expand community involvement in health, including through health committees (Gathege and Yusuf, 2019).

This custom is used in the community admission process to encourage candid conversation about CHPS initiatives (Haldane et al., 2019). As a result, the working relationship between volunteers and community health officers is improved. A community health committee that is in charge of and provides support for the network of community health volunteers helps communities create and administer a local health governance system operating under a sub district. In addition to maintaining CHPS facilities, health committees arrange community gatherings, or durbars, for the purpose of health education, arrange for emergency service transportation, and resolve disputes between community health officials and volunteers. In addition to overseeing and monitoring community health volunteers, community health committees assist community health officers by holding regular monthly meetings that include matters pertaining to health and involve both parties. The goal of CHPS would be lost if community members and health committees did not actively participate in its operations due to a lack of strong coordination mechanisms (Haldane et al., 2019).

Health-seeking behavior is encouraged by the mutual trust that nurses and families have thanks to the special relationship that CHPS fosters with the community (Zeng et al 2020). According to Okoh-Owusu (2022), people are more likely to seek care from a community practitioner than from

the sub-district's culturally distant clinical staff. Furthermore, informal payment agreements increase the influence of well-founded trust on health seeking. While CHPS clients usually postpone payment, clinic patients are required to pay at the time services are rendered. This arrangement is made possible because nurses have faith that CHPS clients' extended families will fulfill their financial commitments (Grant et al 2017).

Community people who are involved in the CHPS implementation process come to appreciate this new relationship with the healthcare system and view CHPS as a form of health insurance because it allows patients to request emergency funding from their extended family. Kakama et al. (2024) explain how, in contrast to the past, when health seeking behavior was limited by the immediate expense of care, CHPS uses an informal mutual trust framework to mobilize the social resources of traditional health insurance for Western medical treatment. The GHS hierarchy's duties are greatly influenced by the ways in which community ownership is achieved through community mobilization and engagement.

The atmosphere of commitments arising from community involvement in communal labor for CHC construction is unquestionably more significant for CHPS than the construction of a CHC; it is the basis of community ownership of CHPS in the advanced program area. Participation in CHC construction projects by the community can result in long-lasting organizational structures and teamwork, as well as attitudes of community ownership and leadership, all of which are important for maintaining CHPS in ways that go beyond the physical facilities that communities build. It is logical to draw the conclusion that using outside contractors to build these compounds will reduce community participation in CHPS and circumvent community interaction throughout development.

The volunteer method instills ownership and transforms public sector institutions, such as the health authority structure. The primary focus of worker accountability and oversight shifts to grassroots political influence and community cohesion. In turn, supervisors are supposed to assist district authorities in implementing the project by removing obstacles and providing resources (Okoh-Owusu, 2022). Therefore, encouraging participation and persuading community health committees creates an environment of accountability for service quality, which is something that respondents felt was absent from clinical care in the past. Concerns regarding resident community nursing services were apparent in areas where CHPS has not yet begun.

In order for communities to adopt CHPS, the community's opinion leaders, chiefs, and elders must be actively involved at the grassroots level to make sure that roles are assigned to the many clans that make up the community. Initiating the CHPS Program in a community would require a great deal of community problem solving, particularly when building a CHC. Although the traditional community structure offers problem-solving mechanisms, external catalytic support from NGOs and the assembly is necessary to attain the advanced stage of the CHPS program implementation (Kakama et al. 2024).

The district director is intended to report to the district chief executive and assembly as the technical lead in the district. As a result, overseeing service delivery in the CHPS zones is the responsibility of the district director of health services (CHPS Policy, 2016). Direct supervision of CHOs in the CHPS zone is the responsibility of the officer in charge of the sub-district health center, who serves as the head of the sub-district. The CHPS policy guideline states that the district director shall choose a suitable person to assume responsibility in the event that a public health facility is unavailable. Another condition placed on the "district hospital" is the assignment of

medical officers to several sub-districts for which they will be responsible for technical supervision and mentorship, and they will visit a CHPS zone in their assigned sub-district at least once each quarter (CHPS Policy, 2016).

2.5 The challenges of the CHPS system

Due to administrative and logistical errors, the CHPS program has not been implemented consistently (MoH, 2016). Along with these implementation hurdles, the initiative faces operational challenges as well, such as inconsistent and insufficient government funding, delays in receiving reimbursement from service providers like the National Health Insurance Authority (NHIA), a lack of qualified medical professionals, and weak community support (Baatiema et al., 2013; MoH, 2016).

One of the main obstacles to the successful operationalization of the CHPS program has been the lack of suitable human resources. This has led to insufficient public health initiatives at the sub-district and community levels, as well as low community participation in standard health care and CHPS operations that hinder the service's expansion.

Not only is there a shortage of healthcare workers, but the skill sets of those that are available are not uniform. This problem has been exacerbated by the unequal distribution of health workers, which has led to understaffing in some facilities and overstaffing in others. Although there has been a gradual rise in the number of skilled workers nationwide, there hasn't been much of an influence on the locations that need staff the most, which are remote and rural facilities.

Human Resources for Health (HRH) are concentrated most in Greater Accra, according to GHS statistics; nonetheless, many rural communities, as well as the Upper West and Upper East regions,

lack the minimal minimum of skilled professionals needed to improve service delivery and care quality (GHS, 2015). The five regions in Northern Ghana experienced some growth in HRH in 2014, despite the many efforts to ensure equitable distribution of health human resources; however, these numbers still fall short of expectations. The UWR, for example, has the second-lowest ratio of midwives to population and the lowest distribution of doctors in the region (11), per the GHS report (GHS, 2015).

According to an assessment report, certain CHPS compounds in the Central and Western areas were only partially furnished and had no accommodations, while the compounds themselves were in bad repair. Additionally, community health officers voiced their displeasure with the lack of an operating budget (MoH, 2014). Furthermore, it has been noted that additional services are being introduced in some CHPS zones, which has led communities and supervisors to expect that CHOs will apply the CHPS concept to offer clinical services in the community (MoH, 2014). These experiences in CHPS zones most likely stem from improper or insufficient community engagement and communication, which causes misunderstandings among community members regarding the distinctions between services provided by higher level health facilities and community-based health services (Kakama et al. 2024).

Many CHNs do not live in CHPS zones due to ongoing logistical problems with the implementation of Community-Based Health Planning and Services (CHPS Policy, 2016). In light of these challenges, one may wonder if the current infrastructure and support services provided in CHPS zones are adequate for the effective delivery of continuing healthcare, particularly in the field of maternity and child nutrition initiatives. Other issues that affect service delivery in CHPS zones include CHOs' dissatisfaction with the location and duration of their current placement, the

lack of a policy governing the length of time a CHN can stay in a deprived community, and the absence of incentives to recognize and honor those who serve in deprived areas (CHPS Policy, 2016). Another aspect of the CHPS deployment architecture that is often disregarded but is crucial to the delivery of healthcare services is the recruitment, development, and retention of volunteers (MoH, 2014). An estimated 55% of CHPS zones do not have regularly trained active volunteers working with CHOs on a regular basis (MoH, 2014).

2.6 Maternal healthcare in the CHPS system

According to Akweongo et al. (2017), the CHPS system offers a variety of crucial maternal health care services, the majority of which are preventive, curative, and promotional. These services include antenatal care (ANC), postnatal care, emergency births, family planning, immunizations, education, and treatment for malaria, acute respiratory infections, diarrheal disorders, and infections. The Ghana Health Service 2014 Annual Report states that 3.8% (18,680) of skilled deliveries, 10.2% (2,407,966) of outpatient department visits, and 30.4% (143,727) of family planning services were provided by CHPS in the nation (GHS, 2015).

Kakama et al. (2024) observed that health education and promotion by CHPS contributes tremendously to MNCH service uptake. According to their findings, CHPS was successful in doing away with the conventional gatekeeper system, which gives household leaders the sole right to control how their members behave when seeking health care, including how they move.

According to the CHPS strategy, community involvement is essential to empowering marginalized groups to participate in and seek health care services on their own (MoH, 2016; Woods, 2016). Participation of community people in health-related decision-making processes promotes sustainability and local ownership.

Similarly, according to GSS et al. (2015), only 82% of pregnant mothers in rural areas have access to ANC services, while 93% of moms in urban areas have access to ANC facilities. The percentage of women who make the recommended 4+ ANC visits has increased from 78% in 2008 to 87% in 2014 as a result of the CHPS program's expansion (GSS et al., 2015). Between 2011 and 2014, Ghana's rate of skilled delivery increased gradually, from 49.4% to 56.7% (GHS, 2015).

Just as ANC access, skillful delivery by a birth attendant is far more common in urban (90%) than rural (59%) locations. The bias between rural and urban areas in the creation and distribution of health infrastructure is primarily responsible for these disparities (GSS et al., 2015). Despite attempts to outlaw them, this resulted in rural residents continuing to use and rely on the services of unskilled traditional birth attendants. A 2015 annual report from GHS states that data collected indicates that 16% of all births within the nation's healthcare system are still overseen by traditional birth attendants.

Again, a supply-side factor, availability refers to a person's capacity to obtain the appropriate kind of assistance when needed. The availability of health professionals and logistics, conducting outreach services contributes to access as well as the willingness to seek care because of nearness and resident CHOs (Kakama et al., 2024). Under-five mortality decreased from 108 per 1,000 live births to 80 in selected CHPS program regions between 1999 and 2008, and the total fertility rate (TFR) decreased from 4.6 to 4.0 children per woman (CHPS Project 2010;). The role of CHPS in MNCH services is vital to maternal and child health (GHS & PPME, 2002; MoH, 2016).

2.7 Empirical review

2.7.1 Community Health Committees in Perspective

Health Committees or coalitions are described as a collection of people from various community groups, factions, or constituencies who get together to cooperate toward a shared objective (Chen et al., 2024). In the view of McCoy, Hall & Ridge (2012), any public governance establishment with participation from the community and a clear connection to a primary healthcare institution is considered a community-level health committee.

Globally, CHCs are usually integrated into the community, with membership coming virtually entirely from within the community. They may or may not have a formal, strong connection to the health facility and the MoH as a whole (Gaudrault, et al. 2016). These committees' main goal is to make it possible for community members to participate in decision-making on issues connected to enhancing the delivery of health services and health outcomes (McCoy, Hall & Ridge, 2012).

Although they have a common goal and similar function, Health Committees assume different names or labels across countries. Below are some examples of the different names for this committee in the different locations:

Table 1: Terms used for health committees in ESA countries

Country	Terms used for Community Health Committees (CHCs)
Ghana	Community Health Committee
DRC	Health Centre Management Committees (HCMCs)
Kenya	Health Facility Committees (HFC)

	Community Health Committees (CHCs)
Lesotho	Health Centre Advisory Committees (HCACs)
Madagascar	Village Health Committees (VHCs)
Malawi	Health Centre Advisory Committees (HCACs); Health Centre Management Committees (HCMC)
Mauritius	Area Health Committees (AHCs)
Mozambique	Community Health Committees (CHCs)
Namibia	Clinic Health Committees/Councils (CHCs)
South Africa	Community Health Committees (CHCs)
Swaziland	Local Health Committees (LHCs)
Tanzania	Health Facility Governing Committees (HFGCs)
Uganda	Health Unit Management Committees (HUMCs)
Zambia	Neighbourhood Health Committees (NHCs)
Zimbabwe	Health Centre Committees (HCCs)

2.7.2. Selection and Composition of Community Health Committees

The composition and how community's health committees are formed vary from one place to the other. In exploratory research to evaluate the selection processes and responsibilities of Community Health Volunteers and Community Health Management Committees within the CHPS model in Ghana, Sakeah et al, (2021) discovered that the selection process includes choosing, appointment, or nomination, hiring via advertisements and or inheriting the post through apprenticeship. In Ghana, two male community opinion leaders and two female "magazias," or senior women leaders who represent the interests of other women, made up the community health committee. With consultation of the larger population, they are chosen by local chiefs and other opinion leaders to serve on the committee (Baatiema et al., 2013).

Similarly, in Namibia, health committee members may be elected or appointed though people are required to volunteer themselves through community structures, (Makwatikizo, 2023). Those deemed capable by the community structures are selected from the volunteer pool, interviewed, and appointed as necessary. Popular election procedures encourage civic engagement and enable voters to hold elected officials accountable for a healthcare system that is more focused on the needs of the local community (Biu et al., 2024). However, the CHC's composition may become less transparent through the appointment process, which might result in the selection of committee members who are unqualified and have a negative impact on the committees' operation.

Community Health Management Committees and Community Health Volunteers serve as the program's regular community representatives in its routine execution. They are involved in the development and implementation of health services and health measures, and they encourage public responsibility in health by allowing involvement in the operation of the health center and

PHC activities (Sakeah et al., 2021). Community ownership and ultimate sustainability of the CHPS approach result from the community's effective participation in community entrance, volunteer recruitment during compound construction, and CHC development (Atta – Nyarko, 2017).

The Health Community Committee (HCC) as it known in Malawi is composed through selection by residents of nearby communities and serve terms of five years. Various male to female ratios exists. Additionally, in Kenya, Women's groups or organizations make up at least one-third of the committee, along with local youth organizations, spiritual communities, and individuals with disabilities. There are no records of the election or appointment procedure of members of the Community Health Action Group (CHAG) (Loewenson R, Machingura F, K et al., 2014).

In terms of sex, a study fund that majority of the health committee members are always men, a negative effect that previous researchers have noticed (Attree, et. al., 2011, George, et. al., 2015). According to a survey conducted in Ghana's Eastern Region, men predominate in the health committees' makeup as well (Atta – Nyarko, 2017). Further research conducted by the Ifakara Health Institute (2011) found that there were few female representatives, despite the fact that each committee included at least one female community representative.

2.7.3 Functions and Roles of Community Health Committees

Committees at the primary healthcare and community levels provide social knowledge, experience, opinions on health-related matters, and solutions to health system plans and finances. (Mulumba, et al, 2018). With this position in governance, health committees are equipped with the knowledge, power, and drive to mobilize social action, promote communication with all stakeholders to guarantee that issues are addressed, develop effective partnerships, and execute

services and health initiatives. This increases their ability for monitoring as a result (Mulumba, et al 2018). Their work should be seen as comprehensive, including efforts to address social determinants of health, many of which are outside the purview of the healthcare system, in addition to efforts to enhance justice and the quality of healthcare (Mulumba et al., 2018).

In addition to managing the financial aspects of medical accounts, supervising the maintenance of Community Health Volunteers' bicycles, pushing for family planning and community health initiatives, and resolving conflicts involving the work of the Community Health Volunteers, the CHC also plans community events in support of the program (Clement, 2011).

Communities as a whole are involved in CHCs, which encourage a "culture of health" through changing social norms, building social capital, and adhering to cultural values (Ekane et al., 2019). In order to change social norms, build social capital, and adhere to cultural values, CHCs create "clubs" with the participation of entire communities.

In a study aimed at evaluating volunteer roles, sources of inspiration, and challenges in Ghana's CHPS project, Community Health Committees (CHCs) were found to provide operational support for the program by mobilizing resources, keeping an eye on logistics, assisting Community Health Officers (CHOs) in organizing CHPS events, and mediating conflicts between CHOs and community members (Kweku et al., 2020). As stated in The Population Council, Inc. and the Ministry of Health/Ghana Health Service (2009), the CHMC is in charge of managing conflicts between the CHO and volunteers and community members as well as overseeing health volunteers and promoting the welfare of the CHO. The community may elect members to the CHC based on their readiness, acceptability, and social status.

Community Health Volunteers direct and organize neighborhood initiatives, assist medical professionals with health promotion initiatives, treat minor diseases, and motivate expectant mothers to use maternal health services. Community Health Volunteers also transcribe health messages that healthcare professionals communicate to the public in their native tongues (Sakeah, Aborigo, Debpuur, et al., 2021).

In addition to providing leadership in constructing temporary shelters to accommodate midwives so they can continue to serve in the area and deliver babies, the Community Health Committees are in charge of organizing funding for the construction of CHPS compounds. The committee acts as a channel for complaints regarding community healthcare services to be directed toward the healthcare facility's personnel. In order to solve issues with the community health complex and enhance communication between the officers and their clients, they collaborate closely with the community health officers (Sakeah, Aborigo and Debpuur et al., 2021).

The purpose of the Community Health Management Committees (CHMCs) is to earn money for the building and maintenance of the CHPS complexes. They oversee the work of the CHVs and help the CHOs as well. CHVs and CHMCs have received training and are part of the CHPS program (Kweku et al., 2020). For example, CHMCs encourage community involvement and increase access to and use of primary healthcare services through community mobilization and education (Katigbak, Van Devanter, Islam and TrinhShevrin, 2015).

In another study by Karuga et al. (2020), Health committees have been shown to be successful in bringing up community issues regarding the quality of care provided by medical professionals, the continuous management of healthcare facilities, and the mobilization of financial and non-financial resources for health-related projects and activities (Karuga et al., 2022). By keeping an

eye on employee absences, the standard of care provided, and healthcare facility expenses, health committees keep healthcare professionals accountable.

Health committees can successfully assume a role in oversight and responsibility, according to Flores (2016). Kweku et al. (2020) argued that it is the duty of members of Health Facility Governing Committees (HFGC) to improve the quality of healthcare, ensure that exemptions are followed, and mobilize resources, such as money in the case of the Community Health Fund (CHF) and from partner contributions. The efficacy of accountability systems at the facility level is not well supported by data, but Tanzania's regional and district accountability structures have been shown to perform rather well

It has also been determined that health committees encourage community involvement by keeping primary health care providers responsible, expressing the concerns of their constituents, and securing funding for health-related activities and initiatives (Karuga et al., 2022). A study by Gitonga (2021) indicated facility committee's primary responsibility is to gather resources from the residents; both financial and non-financial, ensure participation of members in both health care provision and development services as well as decisions on service delivery.

Educating the community makes HCCs more effective at incorporating community needs and goals into decisions about how to operate health services. HCCs work with communities to collaboratively create and carry out the plans and budgets for the health system at the primary care and community levels (Loewenson, 2021). They bring social knowledge, experience, and perspectives on health issues and solutions to the table. The HCC now has the knowledge, power, and incentive to enable community debate and consultation on plans, mobilize social action,

develop positive alliances and dialogue with many players to ensure that issues are handled, and execute services and health initiatives (Loewenson, 2014).

2.7.4 The Capacity of Community Health Committees (CHCs)

As a requirement to perform duties and roles as committee members, CHCs individually and collectively must possess key competencies and capabilities in order to function effectively.

2.7.4.1 Collaborative Skills

Community capacity building, according to Ekane et al. (2019), enhancement of community groups' abilities to identify, evaluate, examine, and take action on health issues that are important to their constituents. Since they CHCs usually respond to recognized problems using a common socio-ecological perspective that tackles the numerous determinants of community health and well-being, community coalitions are frequently seen to have a stronger long-lasting impact on community health and well-being. This is in part because they collaborate with professionals and community (grassroots) people (Loewenson, 2021). In order to promote program ownership and sustainability, coalitions may also harmonize health activities more, boost the possibility for community empowerment, and make it easier for community people to participate in health projects (Karuga et al., 2022).

2.7.4.2 Resource Mobilization

The ability of communities to rally and contribute the necessary resources to implement effective community-based health interventions is referred to as resource mobilization (Rifkin, Muller, 1988 as cited in Agalga et al., 2022). In order to overcome the chains of inactivity and reliance, community involvement in resource mobilization is crucial for the ownership and sustainability of any initiative (Isham and Kahkone, 2009).

2.7.4.3 Advocacy, Communication, and Social Mobilization

Community Health Committees in Kenya offer direction and governance supervision for the execution of health and associated policies in local community health services as well as the management and administration of the medical institution. In order to participate in community dialogue and health action, they plan, coordinate, and mobilize the community. The community receives advice on how to best promote health services, and in local development forums, they speak for and represent the community's interests in health. In addition, they carry out community decisions pertaining to their personal health and offer input to the community on the management and operations of the medical facility. In terms of resources, they oversee community health by managing people and resources, mobilizing community resources for the expansion of health services in the area, and facilitating resource mobilization for the implementation of the community work plan while maintaining accountability and transparency. CHCs take the lead in advocacy, communication, and social mobilization; they promote negotiations and help resolve stakeholder misunderstanding at a level; they monitor, evaluate, and report on the community work plan (Kenya MoH, 2006; Kenya Ministry of Public Health and Sanitation, 2013).

2.7.4.4 Monitoring and Supervision

In South Africa, HCCs are tasked with well-defined monitoring duties. These include keeping track of and disclosing how well the medical facility is gathering and meeting the primary health care objectives and indicators, scheduling its opening and closing hours, and supervising the primary health care packages' compliance and delivery (Nelson Mandela Metropolitan University, 2010, Haricharan, 2011; South Africa Department of Health, 2013). Additionally, they keep an eye on how well communities are informed and how well the health institution handles and

resolves community issues. They are not involved in the hiring of employees at healthcare facilities, but they do make sure that management carries out committee decisions and works toward the facility's goals. To do this, they can make facility information more accessible, suggest studies be conducted on facility performance, and provide facility performance reports to the District Portfolio Council for Health. They play roles in advocacy, social mobilization, fundraising, and training in addition to these monitoring tasks (Nelson Mandela Metropolitan University, 2010; Haricharan, 2011; South Africa Department of Health, 2013).

2.7.4.5 Capacity to be trained

According to Loewenson et al. (2021), a capacity gap in one area might limit the ability to do other tasks successfully. For instance, the ability to provide service supervision or community involvement is limited by a capacity gap in monitoring services. In order to keep people up to date on new skills, expand on prior training, and ensure they are applying the abilities they have acquired, Creigler et al. (2011) suggest that people should undergo both initial training to prepare them for their position and ongoing training. Furthermore, as stated by Karuga (2024), the CHC approach program demonstrates effective, measurable action on the ground and builds community capacity through participatory training.

Study findings included knowledge changes, perceived competences, members' comprehension of their responsibilities, and the sustainability of health committees; additionally, training effects on the interactions between health committees and healthcare providers were examined. Health committee training improved members' abilities, consciousness, and understanding of community involvement and the right to health (Chikonde, 2017). After the training, it was observed that HC members seemed more cognizant of and accommodating of their responsibilities inside the

medical institution (Chikonde, 2017). It was also observed that the training improved the perspectives of health care providers (HCs) on duties and sustainability, improved their social skills, and raised their self-esteem. According to the study, training for health committees increased community involvement in areas including planning, advising, and consulting on the implementation of the right to health (Chikonde, 2017).

Despite some feeling that the training fell short of their expectations in terms of its extent, research findings revealed that CHC were taught on their expected responsibilities and functions. In contrast to the 42.9% who said they had acquired education, 50.6% of respondents said that CHC members did not receive any continuing education. 154 respondents, or 95.1%, had gone through training that was either funded by partners (77.8%) or the Ministry of Health (22.2%). 89.5% of respondents said their training only lasted a week, while 10.5% said it lasted two weeks (Patta, Oluoch and Onyango-Osuga, 2021).

2.8. Community Health Worker Relationships

Community Health Workers are often trained professionals who reside in the same community they serve. By the nature of their job, they are expected to build a cordial relationship with the community members for successful service delivery. This relationship must be characterized by trust, collaboration and empathy (CHPS implementation guidelines 2008).

2.8.1 Trust

According to Bhutta et al. (2010) and Glenton et al. (2013), CHWs are frequently seen as the cadre best suited to enhance equitable access to healthcare for patients as well as for members of the facility's medical staff, supervisors, and the greater community. But there could be disadvantages to this intermediary role for CHWs, such as when expectations from the community and the health

sector differ about what CHWs should be doing, which could lead to an excessive workload or demotivation (Kok et al. 2014). There is need to build trust, understanding and respect for the cultural beliefs, norms and values of the people. This cultural competence makes the CHW relatable, accessible and sensitive. Familiarity with the local customs such as language helps establish credibility, openness and acceptance for smooth health care delivery.

2.8.2 Collaboration

The CHPS program is a hired-on participation. This require the CHW to facilitate open communication, between the community and the health care facilities through such groups as CHCs and CHVs. It involves listening to community concerns and relay them to health management teams and also explain medical information to them. This is effectively done through through health education, promotion of self-care practices. In the Mberengwa District, Ward 19, a study discovered a stronger leadership, better community cohesiveness, and more people participating in self-initiated activities like community gardens is down to the relationship between the ministry of health officers (CHW) and community (Chingono, 2013).

2.8.3 Advocacy

CHWs hold a distinct intermediary position between patients and the wider community, sometimes known as the "community," and healthcare providers at the facility level, including their managers (also known as the "health sector"). In order to ensure that the residents of the community receive the care they require, the CHW is responsible for advocating for the health needs of their communities inside the official health care system. The CHW does this through the gathering of health-related data from community, which can inform health planning and resource allocation through reporting and review meetings. However, this intermediate function might have

drawbacks for CHWs, such as when community and health sector expectations regarding the role of CHWs diverge, resulting in a heavy workload or demotivation (Kok et al. 2014).

The relationship between CHW and communities is dynamic and reciprocal and involves a deeper understanding of the community dynamics, commitment to improving health outcomes and willingness to adapt approaches based on community feedback and needs.

2.9 Challenges of the CHC

A multitude of factors impact health committees. A lack of support from health services, scarce resources, capacity limitations, medical professionals' attitudes toward participation, staff perceptions and attitudes, resources, poor community connections, top-down decision-making processes, and unclear roles and functions are among the issues raised by studies from South Africa and Africa (Kilewo and Frumence, 2015). The lack of clarity about health committees' tasks and obligations, along with HCs' lack of authority and legislative mandate, may hinder their consistent functioning and efficient integration into the healthcare system (Haricharan, 2012).

A qualitative study that examined the effects of participation in health committees on policy and practice in the Western Cape Province of South Africa found that health committees were required to have countervailing authority by the Health Committee Act. The Act's requirements, however, ensure that the Health Department limited involvement through ministerial nominations and limited the authority of health committees by defining specific responsibilities. By asserting that it represented communities, the prevailing organizational paradigm established oppositional power. However, this assertion is called into question by the representation of primarily organized segments, the absence of accountability mechanisms, and the fragility of community bonds. The conclusion of the report argues that a model with elected community representatives would offer

a more potent opposition force since elections may allow the members of the health committee to assert their community-wide representation. The argument is based on a human rights perspective that sees the state as the duty bearer and committees as claimants, and it suggests that when requested participation is necessary, there may be adequate countervailing authority. Furthermore, it comes to the conclusion that effective substantive involvement requires both enabling and opposing power (Haricharan, 2019).

Another issue is that health panels lacked legitimacy as a result of occasionally opaque and non-participatory selection procedures. Because they felt committee members lacked the required training and education, health professionals do not include committee members in planning or budgeting. In addition, the male preponderance of most health committees typically limits the involvement of women. A South African study found that, the health committees largely used a kind of restricted participation and encountered issues with sustainability and functionality. Furthermore, their ability to make decisions was limited, and they mostly served as a volunteer workforce helping clinics with daily operations and health promotion speeches. The findings also revealed that, participation in health committees was affected by a number of variables, such as unclear tasks for health committees, the qualifications of committee members, the attitudes of facility managers and ward councilors, a lack of resources and assistance, and a lack of recognition (Haricharan, Stuttaford and London, 2021).

Respondents of a study highlighted the lack of clarity on the purpose and duties of the health committees during informal meetings and focus groups. In response to a survey question on what they needed to do their jobs effectively, several members of the health committee said they wanted clarity on their roles and responsibilities. Job and function of health committees was the most

chosen training option (81%), which further underscored the ambiguity surrounding their role (Haricharan et al., 2021).

In another study, where the community engagement method for health in Ghana's Birim North District was critically examined, it was argued that, CHCs were established to handle the CHPS compounds, but not the full CHPS program. Although the community members were aware of these committees, they were not fully informed of their functions. The existence of already-existing community structures was not taken into consideration when the CHCs were established (Atta – Nyarko, 2017).

Similar to this, Shrestha et al. (2020) pointed out that committee members seldom shared information with one another, which prevented them from coming to a consensus on what was appropriate to demand or expect from service providers. Members of the community and the committee were unable to adequately supervise the operations of the health center due to this information imbalance.

2.10 Summary of Literature Review

This chapter reviewed relevant theories, concepts and empirical literature relevant to the topic under discussion. One key finding from the literature review was that though there is many scholarly works on the contribution of the CHPS system on rural health coverage (MNCH) in Ghana, there is limited evidence on the contribution of Community Health Committees in MNCH services delivery.

The review revealed that the CHC is an integral part of the CHPS system has positively affected maternal healthcare in hard to serve areas. The literature is very clear that about improvement in

ANC attendance, decrease in maternal deaths, increased in skilled birth attendance and increase in health seeking behavior of people.

It is also established form the literature that, CHPS and CHCs still have challenges confronting them. These include logistic inadequacies, lack of incentives, and lack of staff to manage the CHPS among others.

Table 2 Summary of Key empirical issues relative to the study objectives

Objective	**Key highlights from the empirical review literature**
Composition, Capacity and Functions of CHCs	CHCs comprises, members of the community elected, nominated or selected to assist health workers to deliver health care In some areas, the nominees represent a section of the society, either, youth groups, women groups etc. It has traditionally been dominated by men, but this is changing For the purpose of delivering on their mandate effectively, members require skills and capacities such as; communication, advocacy, monitoring and supervision, trainability, social mobilization, fundraising, etc. Functions are diverse and vary from one context to the other. Typical functions include; mobilize social action,

	promote communication with all stakeholders to guarantee that issues are addressed, develop effective partnerships, execute services and health initiatives; resolving conflicts involving other health cadres, planning community events in support of the program, promoting community health and family planning initiatives, managing the financial aspects of medical accounts, advocating for community health and family planning initiatives
Contributions to MNCH	Advocate, supervise and assist in implementing activities to such as; antenatal care (ANC), postnatal care, emergency deliveries, family planning, reproductive health education, immunizations, prevention, care and management of childhood illnesses e.g. malaria, acute respiratory infections and diarrheal disease

Relationship between CHCs and other Health Workers	trust, collaboration and empathy are key imperatives for successful CHC relations
Challenges of CHCs	unclear roles and functions, staff perceptions and attitudes, poor community connections, top-down decision-making processes, dominance of medical professionals, scarce resources, capacity limitations, attitudes of health workers toward participation, and a lack of support from health services . opaque and non-participatory selection processes results in lack of legitimacy . male dominance

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter provides an overview of the systematic approach used for conducting the study. It explains the study's design, sampling strategy, data collection methods, and data analysis techniques, including the tools used for data validity and ethical considerations. A well-structured methodology is crucial to ensure that the research is conducted in a rigorous, transparent and reproducible manner. It provides a roadmap for future researchers to follow while collecting, analyzing and interpreting data to draw meaningful conclusions.

3.2 Study Design

This study adopted a qualitative case study design to explore the contribution of Community Health Committees (CHCs) to maternal health care delivery within the Community-Based Health Planning and Services (CHPS) framework in the Bolgatanga Municipality. A case study design was considered appropriate because it enables an in-depth, context-rich examination of complex social phenomena (Creswell & Poth, 2017). The case study approach allows the researcher to gather detailed insights from various stakeholders such as CHC members, health workers, community elders, and opinion leaders, across multiple CHPS zones.

The design aligns well with the study objectives, which aim to explore the roles, relationships, and challenges of CHCs in maternal healthcare delivery. It also allows for triangulation of data sources and perspectives to deepen understanding and enhance the credibility of findings (Yin, 2014). The term "study design" refers to the overall approach a researcher takes to ensure the research problem

is effectively addressed by integrating the various components of the study in a coherent and logical manner. It serves as the guide for data collection, measurement, and analysis (Creswell, 2017).

3.3 Study Setting

The Upper East Region's Bolgatanga Municipality served as the study's location. It is also the regional capital, situated roughly in the middle of the Upper East Region between latitudes 10°30' and 10°50' North and longitudes 0°30' and 1°00' West. With 131,550 residents, the Municipality makes up 12.6 percent of the Upper East Region's total population. The Municipality is bordered to the north by Bongo District, to the south by Talensi, to the east by Nabdam, and to the west by Kassena-Nankana Municipal. Despite the fact that urbanization is quickly catching up to the Bolgatanga Municipality, 50.2% of people live in rural areas. The Municipality's population is young, with 37.0% of those under 15 and 7.4% of those over 60.

3.3.1 Health Profile of the study region

The entire land area of the Bolgatanga Municipality is 729 square kilometers. Legislative Instrument (LI) 1797 (2004) established the first municipality in the Upper East Region. Twenty hospitals (7 government, 3 CHAG, and 10 private), 67 health centers, 38 clinics, and 3 private maternity homes make up the Upper East Region's total of 96 healthcare facilities. There are also 224 CHPS compounds, 395 Functional CHPS zones, 488 delineated CHPS zones, and 224 CHPS compounds in the region; the Bolgatanga Municipality is home to 224 of the CHPS compounds.

The ratio of doctors to population in the area is 1:24,124, whilst the ratio of nurses to population is 1:313. Maternal mortality in the area has been trending upward (Ghana News Agency, 2021). The region saw 31 maternal fatalities in 2019, 36 in 2020, and 43 in 2021. These figures show

continued upward trend. Abazesi (2015) reports that the municipality has a skilled birth attendance rate of 34%, with community health centers (CHPS) accounting for fewer than 10% of all deliveries.

3.4 Study population

According to Hurley et al. (2013), a study population is the entire collection of objects or entities that have or share common characteristics, such as age, sex, or health status, that the researcher is interested in. All 11 CHPS facilities in the municipality made up the study's target population. Community representatives, namely elders, chiefs and assembly members were eligible as respondents. Additionally, all members of the CHCs for each CHPS facility were considered as viable participants. Finally, healthcare staff operating the CHPS in communities were included in the study.

3.5 Study Sample

In a qualitative study, the sample size should be sufficiently large to address the research question and adequately explain the phenomenon of interest. Large sample sizes, however, run the danger of containing redundant data. Thus, reaching saturation should be the aim of qualitative research. When more participants are added to the study but no new insights or data are obtained, saturation sets in (Shetty, 2018). Being mindful of this, the researcher consciously sampled respondents until saturation was reached. This was achieved when at a point in the interview process the investigator observed there were repeated and similar responses by different respondents. At that point the researcher was convinced, there will be no new information generated in any other further interviews to be conducted.

3.6 Sampling technique

The researcher used the purposive sampling technique to carry out this investigation. According to Creswell and Poth (2017), purposive sampling involves the researcher choosing respondents and settings based on the assurance of information retrieval and comprehension of the topic under investigation. Polit and Beck (2010) also proposed that when using purposive sampling, the researcher deliberately selects participants who can most effectively meet the information needs of the study.

As a result, all 11 CHPS facilities within the municipality were purposively enumerated by census method. Purposive sampling techniques were used to sample respondents for the study in each CHPS zone. Twenty-two health workers (two from each facility) as well as 44 members of the community health committees connected to each CHPS compound (4 from each facility) were selected. The sample also included members from the 11 communities where CHPS facilities were located, these included chiefs, community elders, assemblypersons and opinion leaders.

However, a potential limitation of purposive sampling is the risk of selection bias, as the researcher's judgment in selecting participants may unintentionally exclude alternative perspectives, thereby affecting the representativeness and generalizability of the findings.

3.7 Demographic Profile of Respondents

For this study, the research respondents covered two categories of respondents, namely; key informants, and FGD respondents. The research covered Health workers at the CHPS facilities, members of CHC operating within the 11 CHPS facilities, and Chiefs, Elders, Opinion leaders as well as Assembly members representing various electoral areas that hosted the CHPS facilities.

In all, the research utilized - 36 respondents (17 males and 19 females) for the interviews and 44 (28 males, 16 females) participated in the 6 FGDs. The study included 7 Chiefs, 6 elected Assembly Members, 22 health workers and 12 elders/opinion leaders and 33 CHC members across the 11 CHPS compounds.

Table 3 Profile of Respondents

Designation	Number	Mode of participation	Gender
Chief/ Tindaana	7	Key Informant Interview	7 Male
CHOs/Nurse/Midwife	22	Key Informant Interview	18 Females, 4 Males
Assembly member	6	Key Informant Interview	6 Male
CHC	33	FGD	22 Males, 11 Females
Elders and Opinion Leaders	12	1 KII, 11 FGD	6 Males and 6 Females
Total	**80**		**45 male, 35 female**

3.8 Data Collection

For a qualitative study such as this, the main technique was interviews and community dialogues. This is because the study focus was on experiences and feelings of people about the functioning of CHCs within the CHPS program and how this contributes to improved maternal and child health

outcomes. Key Informant Interviews and Focus Group Discussions were employed to collect the relevant data for the study.

A carefully crafted interview guide was used in conducting in-depth interviews with selected respondents. The tool was developed using information obtained from a review of literature and other relevant resources in relation to the research objectives. The interview guide made provision for probing in the instances where participant's responses demanded follow-up questions to get a clearer understanding of the issues.

The in-depth interviews were conducted with health care workers, the Assembly members, and the various community leaders including chiefs, community elders and opinion leaders within the 11 communities in which the CHPS are located. Prior to each interview, participating members were contacted through phone calls to schedule the interviews. Chiefs and community elders were interviewed at their residence. Other respondents were interviewed at locations most convenient for them.

At the start of each interview, the researcher would explain the purpose of the study and obtain their permission to conduct the interviews and also to record the discussion for transcription. In all 36 interviews were conducted across the 11 CHPS centers under the study. Of the 36 interviews; 7 were Chiefs, 22 with health care workers, 6 assembly members and 1 women leader. Each interview lasted for a maximum of forty-five (45) minutes.

In order to complement the key informant interviews, FGDs were conducted among the members of the various community health committees and selected opinion leaders. The list of eligible participants for the FGDs were obtained from the various CHPS compounds managers called 'in-

Charge". The investigator called them one after the other, introduced him-self and explained to them the purpose of the study. A suitable date, time and location was then agreed between the investigator and respondents for the FGD for each CHPS.

A day prior to each discussion the investigator made follow-up calls to remind participating members of the pending group discussion. On the discussion day, the researcher began greetings and the purpose of the study was again explained to participants. The participants were given a consent form to fill. The participants' permission was sought to record each of the discussions.

On the average, each FGD consisted of 5 to 11 members and the researcher moderated each discussion. In total, 6 FGDs were conducted; four (4) of were with members of community health committees and two (2) were among opinion leaders. Three of the FGDs were male only groups, while the other 3 were female only groups. Each discussion lasted for a maximum of one and half hours.

Two trained research assistants assisted the researcher in the conduct of all the focus group discussions. In each discussion, the researcher moderated whiles the assistants took notes and kept control of the meeting. The discussions were all held in Gruni and tape recorded for transcription. This was intentional to allow the respondents the opportunity to express themselves very well in the local dialect. The researcher and assistants all had Gruni as their mother tongue making the conversation more interactive and seamless.

Table 4 Names of CHPS Zones

CHPS Zones	Electoral Area

Anateem CHPS	Anateem electoral area
Yebongo CHPS	Yebongo Electoral Area
Azorbisi CHPS	Azoribisi Electoral Areal
Kuakua CHPS	Asorobisi Electoral area
Kelbeo CHPS	Kelbeo Electoral Area
Yorogo CHPS	Yorogo Electoral area
Kulbia CHPS	Kulbia -kologo Electoral
Agusi CHPS	Agusi Electoral Area
Madina CHPS	Yorogo madina Electoral area
Punpugu CHPS	Sirigu central Electoral area
Dorogo CHPS	Dorogo Electoral Area

3.9 Data analysis

The data were analyzed using a thematic approach. Thematic analysis is the process of identifying themes or patterns in qualitative data. According to Braun & Clarke (2006), it is the first qualitative method that may be used for any kind of qualitative study. Finding themes—that is, noteworthy or fascinating patterns in the data—and using those themes to discuss the research or make a point where the goals of a thematic analysis. Strong theme analyses explain and give meaning to the data, going much beyond simple data summarization (Clarke & Braun, 2013).

Initial codes were generated from the data and from the codes, themes and sub-themes were generated to gather similar thoughts, views and responses of the respondents into categories based on the objectives of the study. These are to; examine the composition, capacity and functions of CHCs, ascertain the contributions of CHCs to maternal and child health, describe the nature of relations between CHCs and health workers within the CHPS framework, and examine challenges confronting CHCs in maternal health care delivery within the CHPS framework in the Bolgatanga Municipality

The researcher transcribed the recorded interviews and discussions manually into English language. The transcripts were read and re-read to ensure completeness and data accuracy based on the questions and recordings and rough notes or identified impressions jotted down. A written report highlighting the key findings of the study by quoting respondent responses verbatim.

3.10 Data Validity and Reliability

To ensure rigor, and data credibility of the data results, the study started with well-designed research plan that clearly defined the research objectives, variables and methodology for the conduct of the study. As a part of ensuring the credibility of the study findings, the researcher used purposive sampling technique to ensure the selected sample represented the targeted population accurately.

Another technique was with the use of standardized instruments with clear instruction. For a qualitative study, the researcher employed reliable data collection tools- In-Depth Interview guides and FGDs guides. These tools ensure consistency and minimize researchers forming his own opinions. The application of thematic data analysis technique ensured that, the results are accurate and represent the views of the respondents. Again, to ensure no information is lost during the

analysis and reporting, audio recordings, and field jotters were used to take data from the participants. The served as reference point of the data obtain from the participants. FGDs were transcribed and conclusions drawn directly from data to exhibit confirmability. Haven followed standard process, the researcher has ensured rigor, reliability of the research leading to more valid conclusions on the objectives of the study as presented in the report.

3.11 Ethical consideration

University for Development Studies ethical review board offer ethical clearance letters for studies of this nature. An introductory letter from the Department of Social and Behavioral Change, School of Public Health, seeking permission to conduct the study in the Bolgatanga Municipal was shared with the Municipal Health Directorate. In return, the Bolgatanga Municipal Health Directorate granted me permission to conduct the study across the 11 CHPS zones. Further permission was obtained from the various community Chiefs and leaders during community entry processes. The verbal appeal made at the chief palace in the presence of elders, assembly members, health committees and the heads or nurse's in-charge of the various CHPS facilities under the study forms part of the ethics of research- respecting the custom and traditions of the people.

Before any engagements, respondents were briefed on the purpose of the study and its significance prior to the process of the interviews and focus group discussion. The research team gave utmost confidentiality of data and anonymity assurance throughout the data collection period.

3.12 Research Paradigm and Epistemology

This study was situated within the interpretivist paradigm, which views reality as socially constructed and shaped by human experiences. The subjectivist epistemology underpinning this approach assumes that knowledge is co-created between the researcher and participants through

interaction and dialogue (Creswell & Poth, 2017). This epistemological stance was implemented through the use of in-depth interviews and focus group discussions, allowing participants such as CHC members, health workers, and opinion leaders to express their subjective experiences and perceptions of maternal health service delivery.

3.13 Data Quality and Rigor

To ensure credibility, interviews and FGDs were conducted using a semi-structured guide, and some participants were later consulted to verify the accuracy of interpreted findings (member checking). Transferability was ensured by providing a thick description of the Bolgatanga Municipality context, CHPS structure, and participant profiles. Dependability was enhanced by keeping an audit trail documenting methodological decisions, and confirmability was addressed through researcher reflexivity and regular peer debriefings.

CHAPTER FOUR

STUDY RESULTS

4.0 Introduction

This chapter presents the results of the study on themes and in line with the objectives of the study. Both written and recorded data were translated and transcribed word for word (verbatim). To facilitate the analysis and presentation of the results, research themes were developed and structured into four main themes. The themes are; the composition and capacity of CHCs in health care service delivery, the contribution of CHCs in the provision of Maternal Health Care, the nature of the relationship between CHCs and community health workers within the CHPS framework, and the challenges confronting CHCs in health care delivery. Table 4.1 presents an overview of the identified themes and sub-themes that guide the structure of this chapter.

Table 4.1: Emergent Themes and Sub-Themes from Data Analysis

No.	Main Theme	Sub-Themes
1	Composition and Capacity of CHCs	- Composition - Capacity and Functions of CHCs
2	Contributions of CHCs to Maternal Health Delivery	- Community Engagement and Cultural Transformation in Maternal Health - Individual Contributions of CHC Members to Maternal and Child Health

		- Community Health Outcomes Resulting from CHC Interventions
3	Relationship between CHCs and community health workers	- Collaboration and Role Clarity Between CHCs and Health Workers - Community Leadership Perspectives on CHC–Health Worker Collaboration
4	Challenges confronting CHCs in health care delivery	- Motivational and Logistical Challenges Facing CHCs and Health Workers - Recommendations for Enhancing CHC Performance and Commitment

4.1 The Composition and Capacity of CHCs

Community-Based Health Planning and Services (CHPS) is a program that aims to improve health and well-being of communities. The goal of CHPS is to provide essential health services, education and outreach to underserved or rural areas often focusing on preventive and care, maternal and child health sanitation, and diseases prevention. The ultimate objective is to empower communities to take control of their health and well-being through active participation and collaboration with health care providers. For effective participation and collaboration, the CHPS program requires the establishment of Community Health Committees (CHCs) to act as intermediaries in facilitating the implementation of the program.

4.1.1. Composition

The study first sought to ascertain if there were CHCs in the 11 CHPS in the municipality. All respondents indicated that they have CHCs in their various CHPS. The views of respondents were then solicited on the composition of the CHCs in the municipality. All responses indicated that the CHCs members are selected based on their roles and standing in the community. The respondents indicated that CHCs members are often people who stay in the community and can influence decision making processes in the community as some of them narrated:

> *"……the members of the CHCs includes opinion leaders, traditions rulers, and heads of religious bodies in the catchment area of the CHPS, leaders of women association, chiefs, and leaders of youth groups in the area and assembly members and the community health officer* **(Community Health Officer, CHPS 1).**

> *"……. The composition is made up various community stakeholders, such as heads of institutions, religious leaders, chiefs, people that wield influential in the community but are neither chiefs nor heads of institutions. Specifically, the CHC in the CHPS is made of chiefs, healthcare staff, assembly members, and women groups' leaders, youth groups leaders and powerful individuals who can make a change in the community* **(Tindaa-na, CHPS 4).**

On how the CHCs members were selected, majority of respondents indicated that most of the people were selected by virtue of the position and the role they play in the development of the community and the influence they have on others. They also mentioned that, the Community

Health Officer also identified some members and proposed to the community and they were added to the CHCs membership. The narrations below show how CHC members were selected as indicated by some of the respondents.

> *"……. some people are central in the decision-making processes in the community. Such people cannot be sidelined when it comes to healthcare decisions in the community and thus are automatic members of CHCs. Such people include the chiefs, assembly members, tindaa-na and leaders of various groups in the community* **(Women leader, CHPS 11).**

> *"……..some of the members were selected because of the influence they have in the community not because they are leaders. When the community health officer identifies an influential community member who can aid in the promotion of maternal healthcare delivery in the community, he recommends to the CHCs member to add that individual to the committee. However, the chiefs and religious leaders are automatic members of the committee* **(Chairperson of CHC, CHPS 5).**

> *"……..I think the CHCs members are selected by the community members. In our case, the various groups were made to present representatives to form the committee after which a community durbar was organized to introduce the members to the community* **(Opinion leader, CHPS 8).**

After identifying the composition of the CHCs and the selection processes, the study sought to understand the qualification of members of the committee. Respondents were asked to describe the typical qualification for a person to become a CHC member. It was revealed that the qualification is not based on only the educational level of the individual, but the influence the person has and the interest the person has on health issues and the ability of the person to mobilize others and non-partisan.

Below are narrations from respondents relating to the issue.

> *"…… i think the main thing that is considered in selecting someone to be part of the CHC is the person's ability to mobilize the community members. Therefore, the qualification in my opinion is good human relation, community influencer, well-mannered people loved by community members who can lead people to act (CHC member, CHPS 10).*

> *"……you see, we cannot elect people to lead the community based only on the person's educational background, the CHC members must be member of groups in the community or holds a position which they can use to influence people. There are some well educated people who cannot influence others in taking decision, thus, selecting such people to represent the community will be suicidal* **(Community Health Officer CHPS 3).**

> *"…… the major factors to consider in selecting CHC members are: must be member of the community, must have interest on health issues, must have influence in the community, ability to mobilize, must represent an interest*

group or a major stakeholder in the community and must be a non-partisan person **(Chairperson of CHC, CHPS 7).**

4.1.2 Capacity and Functions of Community Health Committees

In an attempt to ascertain the capacity and functionality of the CHCs, the study further requested respondents to outline the current duties performed by CHCs. Majority of the responses revolved around the belief that the CHCs serves as an intermediary or middle person between the health service and the community. The CHCs plays a significant role in making the community understand the health systems and why they should take control of their own health. Almost all respondents indicated that the core duty of the CHCs is to ensure they help the community to improve upon health seeking behavior as some of them narrated.

"……..it is the duty of the CHCs help create an enabling environment for the provision of healthcare such as the resolving conflict between healthcare staff and community members, helping in the provision of accommodation for healthcare staff, lead in community mobilization for health durbar, sensitizing the community-on-community ownership and participation in the management of the CHPS **(Opinion leader, CHPS 6).**

"……..the healthcare staff alone cannot provide quality and efficient healthcare without the support and participation of the community. That is why it is important to select people of influence in the community to augment the efforts of the healthcare staff. The CHCs therefore, help in organizing the community for healthcare activities, providing basic amenities for the facility

and sensitizing the people to have good health seeking behaviors **(Chief, CHPS 11).**

The results of the study indicates that, CHCs committee members individually and collectively must possess key competencies and capabilities in order to function effectively. This is so because CHCs are known to have a stronger long-lasting impact on community health and well-being because they collaborate with professionals and community (grassroots) people. Since the CHCs usually respond to recognized problems using a common socio-ecological perspective that tackles the numerous determinants of community health and well-being, the ability of the members of the CHCs needs to be higher.

4.2 The Contribution of CHCs in the provision of Maternal Health Care

After establishing that all the CHPS in the municipality has CHCs, the study went further to ascertain whether the CHCs just exist by name or they are functional and have contributed to the provision of maternal healthcare in the municipality.

4.2.1 Community Engagement and Cultural Transformation in Maternal Health

Respondents were asked "do you think the CHC has contributed to the improvement of maternal health care? Most respondents were of the view that maternal healthcare provision in the area will not be effective without the support of the CHC as some narrated.

"……..in the past we had several cultural practices that impeded the practice of exclusive breastfeeding and even skilled birth delivery. But the role played by the chiefs and the traditional rulers, some of these practices

are no more in existence. This wouldn't have been possible without the CHCs. A health worker cannot tell how to study our cultural practices and values without an order from the rulers. But when we ourselves are involved in deciding what to do and what not to do, it is accepted by all because we are the custodians of the tradition **(Tindaa-na CHPS 9).**

"……the participation of women leaders in healthcare delivery in the community has significantly impacted many. The women leaders are automatic members of the CHCs, as such we bring onboard TBAs who still influence women to practice outmoded practices that are not helpful. At our women meetings, we are able to sensitize and encourage our follow women to improve on their health seeking behavior ***(Women leader, CHPS 1*****).**

Although respondents cited a number of roles played by the CHCs in the provision of healthcare in general, they also specifically mentioned other contributions of the CHCs in relation to maternal healthcare provision. Among other things, they cited contributions such as demanding for midwives to be posted to their CHPS, support in the sensitization and encouraging women to attend ANC, facilitate the transportation of women to health centre during labor.

"……the contributions of the CHCs in the provision of maternal healthcare are so many that one may not be able to list all of them. We contribute in ensuring that midwives are posted to the CHPS, educating pregnant women to attend ANC, making sure the midwives posted are comfortable by helping them to get accommodation near the health facility

to enable them attend to women in labour at night and sensitizing pregnant women to patronize skill birth delivery **(Assembly member, CHPS 3).**

"……the CHCs leads in organizing community durbar for sensitize women in areas such as exclusive breastfeed, using skilled delivery, attending ANC regularly and reporting to the health facility when they experience dangers signs **(CHCs member, CHPS 10).**

"…….Before I became a member of the CHCs, I was taught how to practice exclusive breastfeeding at a community durbar organized by the CHC. Most of my colleague breastfeeding mothers at that time did not know it was possible to practice exclusive breastfeeding. You know, the few nurses and midwives will not be able to do all the education and sensitizing alone. Furthermore, when you are taught by your own people who you live with, you tend to belief them because you know they cannot deceive you. So to me, the CHCs contributes a lot to maternal healthcare provision **(Women leader, CHPS 8).**

"……as chief, I feel pain when women are in labour and have to be transported to the health facility on bicycle or even motor bicycle. Yet I don't have what it takes to provide a convenient transport system for my people. But through the CHC and the support other institutions we are able to acquire and maintain a tricycle which facilitate the transportation of women in labour to the health facility **(Chief, CHPS 6).**

4.2.2 Individual Contributions of CHC Members to Maternal and Child Health

Furthermore, respondents were asked to cite the contributions they have added as individual CHC members in the provision of maternal and child health care. The responses were all focused on the support the give to the healthcare staff, education of community members, and creation of enabling environment for the provision of healthcare. Some of their responses are cited below;

> "……. *Religious leaders have influence over diverse aspects of the life of their congregants, being a member of the CHC in this community, my congregants and other people who look up to me as role model will act on whatever I tell them regarding their health. I have also used my pulpit to encourage and sensitize my congregants based on the information I have from the CHCs meetings. Even anytime we are to have community durbar, we announce in the church and as I go there myself, my church members cannot refuse* **(CHC member, CHPS 9).**

> *"……..I can't mention all the things we have done to contribute to maternal healthcare provision in this zone. However let me cite few of them, we provided benches for the CHPS so that women will have comfortable places to seat anytime the go for ANC, we also occasional weed around the CHPS to ensure the place is neat, as youth, we ensure that no one unduly frustrate the healthcare staff or try to make things difficult for them. These are some of our contributions as youth* **(CHC member, CHPS 2).**

"……..As a woman leader, I used to attend to labour cases at home before I was elected to join the CHC. Since then, I have ensured that every woman deliver at the health facility. Anytime am I call to attend to a labour case at home, I quickly mobilize for the woman to be taken to the hospital. I think this is a significant contribution **(CHC member, CHPS 10).**

4.2.3 Community Health Outcomes Resulting from CHC Interventions

During the FGDs, participants were discussed activities of the CHC that had led to an improvement in maternal and child health delivery and outcomes. Some of the areas that have witnessed some improvement as a result of the activities of the CHCs is skilled birth deliveries, exclusive breastfeeding, and ANC attendance as cited by some of the community members in the narrations below.

"……..this program (community durbar) has helped us a lot, before they started organizing programs to educate us, some of us, I will say majority of us use to give water to our infants as early as two months. But now most of us try out best to practice exclusive breast feeding. Even those who are not able to practice exclusive breastfeeding do not introduce water within the first three months **(FGD Participant, CHPS 11).**

"……..to be honest with you, my wife delivered out previous two children at home. But since the chief threaten to summon the husband of any women who delivered at home, my wife delivered twice at the health facility. The nurses took care of her very well and I was happy. We didn't even pay any money. We thank them for educating us **(FGD participant, CHPS 3).**

"……i am one of the oldest woman in this community, I have seen many women die during delivery at home, I have witnessed many children die immediately after birth, and some were rushed to the hospital and later died. But since the community leaders (CHC) started educating women and even their husbands on the need to go to the hospital for delivery, I have not witnessed or heard of death at birth for so many years **(FGD participant, CHPS 1).**

Additionally, the FGDs generated some revelations regarding the contribution of CHCs on the improvement of maternal healthcare in the Bolgatanga Municipality. Some of the contributions mentioned included the improvement in the health seeking behavior of expectant mothers, reduction in the usage of over-the-counter drugs, ANC visitations and knowledge on the danger signs in pregnancy.

"…… Many pregnant women used to patronize over-the-counter drugs in the past, however, for some years now they only take the medicine given them during ANC. Also, the traditional birth attendance in the community is now jobless because they don't get patronage anymore. Every woman now wants to deliver in the health facility **(FGD Participant, CHPS 1).**

"You can see that we don't experience maternal death again as it used to be in the past. The CHCs have significantly influenced the health seeking behavior of many families. They have educated many pregnant women to embrace healthcare services and that have consequently improved on maternal healthcare in the community **(FGD Participant, CHPS 3).**

A husband had this to say regarding the contribution of CHCs in improving maternal healthcare in his community.

> *"……we the local people have our own belief, until 'you people'* (CHC members) *came to educate us to support our wives during pregnancy, we use to leave everything in the hands of the old women in the community. The old lady in the family determines where the woman should deliver and who should help her in the process. But now, we take them to the hospital and stay there till she put to birth* **(FGD Participant, CHPS 5).**

Health education in areas like diet and exclusive breastfeeding is another way that the CHC helps women and infants have better health. A healthy diet gives kids the nutrients they need to develop a stronger immune system and fend off illnesses. All of the FGDs included extensive mentions of the health advantages of exclusive breastfeeding for both the kid and the parents. It was also mentioned that the Lactational Amenorrhoea Method, or exclusive breastfeeding, is a form of contraception. Another element that has helped child health is the use of mosquito nets as a technique to lower the incidence of malaria in children.

> *"…….I believe the CHC has done well in this community because we are recommended not to provide food or drink to our newborns for the first six months after birth. This prevents the children from diarrhea, which in the past has been the cause of many child deaths"*- **(FGD Participant, CHPS 6).**

From the forgoing, it is safe to summarize that, CHCs have contributed to the improvement of maternal health care in the Bolgatanga municipality and maternal healthcare provision will be meaningless without the CHC. Some of the direct contributions to maternal healthcare include the CHCs advocating for postings of midwives to CHPS to assist with MNCH services, increased sensitization and women attendance to ANC.

4.3 The nature of relations between CHCs and health workers within the CHPS

Another objective of the study was to examine the nature of relations between CHCs and the health workers within the CHPS framework. The data gotten from this section are presented in the subthemes as follows.

4.3.1 Collaboration and Role Clarity Between CHCs and Health Workers

Respondents were asked if there was any friction between you and the health workers in line with your duties. The findings of the study revealed that the members of the CHCs have a very cordial relationship with the healthcare staff. The responses indicated that CHCs members had nothing or very little to do with clinical work or direct care provision in the CHPS compounds. To almost all respondents, they do not have any conflict with the healthcare staff as their role is just to support and mediate between the healthcare staff and the community.

> *"……..our role is to ensure that the community adheres to the directions and instructions of the healthcare staff, to ensure the community take ownership of the CHPS and to create a friendly environment for effective healthcare delivery. We are not directly involved in the provision of care; that is the duty of the healthcare staff. Hence, there is no conflict between us,*

on the contrary, we have a very cordial relation **(CHCs chairperson, CHPS 9).**

"……we really do not have any issue with the healthcare staff. We only support them to be efficient. For example, if a woman is in labour at home and our attention is brought to it, what we do is to facilitate the transportation of the woman to the health facility. What ever happen there is now in the hands of the care providers **(Assembly member, CHPS 4).**

"……honestly speaking, I have never witnessed a member of the CHC have argument with the nurses. Anytime they come to meet us during ANC visitations, they only ask if we have challenges. I think their main interest is to ensure that we are safe and receive the best of care **(FGD Participant, CHPS 7).**

"…….If you are sick and you attend the CHPS clinic, the nurses will treat you and allow you to go back home, but the CHC will monitor how you are taking your drugs and also ensure that your health is improving. If they CHC see that your condition is getting worse, they will force you to back to the hospital, sometimes you done even have money, yet you have to go" **(FGD participant, CHPS 7).**

These views were corroborated by some of the healthcare staff as the narrations indicates

"……..we actually do not have any issues with the CHC, what I can only say is that, they health us a lot. We are able to attend to clinical cases while they do the organizations and mobilization works for us. They organize durbar for us to give the input, they actually augment our work **(Health worker, CHPS 6).**

"…….I have worked in this CHPS for the past five years and have worked with the CHC throughout. We have never had any misunderstanding relating to conflicting roles in service delivery. They are very much aware of what they are supposed to do and what they should not do **(Health Worker, CHPS 1).**

4.3.2 Community Leadership Perspectives on CHC–Health Worker Collaboration

Also, chiefs and assembly members also provided their perspectives on the relationship between the CHCs and the healthcare providers. Chiefs and assembly members also indicated that there was cordial relationship between the CHCs and the healthcare staff.

"……myself I am a member of the CHC in this zone. The community development and the health of my people is paramount to me. How will is therefore seat down and watch the CHC have issues with the healthcare staff in my presence? It is not possible. We live as a family with a common goal of providing quality care to our people **(Chief CHPS 9).**

The statement of the chiefs was corroborated by the healthcare staff as indicated below:

"……As I previously mentioned, the community used to initially not trust the medical staff in situations that went against their cultural norms; however, these days, the community explains to those who are hesitant to use the CHPS service, the value of CHCs has increased, and parents of sick children now come to us for advice, which was not the case in the past" **(Community Health Officer, CHPS 3).**

Other opinion leaders and community elders also reported that the healthcare staff are duty conscious and have good working relationships with CHC members. They worked closely with them to facilitate clinical attendance of pregnant and newborn mothers and referrals of cases beyond their capability to the municipal hospital.

"……..For the two times I visited the CHPS compound, I realised that the health workers here are hardworking and friendly. They relate well with us the women especially when we come for clinical care. They normally go round to talk with CHC members to pregnant women specially to come for check-up … Yes, they respect people well" **(FGD, CHPS 9).**

It can be inferred from the above narratives that, generally, CHCs in Bolgatanga municipality do not have significant conflicts with the healthcare staff. As such they are able to support and mediate between the cadre of healthcare workers and the communities they serve and represent. The cordial relationship between health workers, CHCs and communities facilitate open communication, between the community and the health care facilities. The relationship is vibrant and reciprocal

and involves a deeper understanding of the community dynamics, commitment to improving health outcomes and willingness to adapt approaches based on community feedback and needs.

4.4 Challenges confronting CHCs in Health Care Delivery

A final objective of this study was geared towards exploring the challenges confronting CHCs in their roles in health care delivery within the CHPS framework. The main complain of CHCs in this study was lack of incentives and motivation. The respondents complained of leaving their farms and other responsibilities to attend meetings and organize community durbar which is not well appreciated by the Ghana Health Service and the Ministry of Health.

4.4.1 Motivational and Logistical Challenges Facing CHCs and Health Workers

The CHC members are men and women with families and responsibilities. While they leave their responsibilities to work for the betterment of the entire community, nothing is done to appreciate their efforts. This issue is further compounded by the attitude of some community members who think the CHCs are paid salaries and will often go to them for financial support anytime they have problems. The following narrations reflects the situation;

> *"……Though we volunteer our time, some mistakenly believe we are paid. We spend time performing this voluntary work after leaving our farms, yet we never even receive a simple thank you"* **(CHC member, CHPS 1).**

> *"……We use fuel for meetings, we move around the community to organize them for health talks and many others. Yet the government never appreciated our sacrifice. We know it for our own good but at least they should help us to be more effective* **(CHC chairperson, CHC 6).**

Other challenges mentioned by participants was lack of essential materials for quality service delivery. Respondents indicated that they get demoralized when they sacrifice to take pregnant women to the hospital only for them to be referred simply because the facility lacks some basic materials.

> *"……They promised us frequent meetings and programs when they set up this CHPS compound, but they never show up. Do they really think we should give up on our career and choose a lifestyle that they don't value?* **(Chief, CHPS 8).**

The assertion of the CHC members was confirmed by the community health officers who indicated that the CHPS lacks basic necessities for the full functioning of the various CHPS in the municipality.

> *"……most of the facilities lacks basic amenities. No accommodation for midwives to stay close to the facility to attend to night cases, no basic equipment and so on. "Sometimes those who don't use CHPS compounds are justified, but we always condemn them for it. Tell me, is this a bedroom or a medical facility?* **(Community Health Officer).**

> *"……I have spent the last three years working at this facility. Not only do we lack adequate accommodation here, but we also lack the supplies we need to conduct our jobs. The less said about water, the better"* **(Community Health Officer).**

> *"……Our lack of logistics and equipment is one of our problems. We occasionally run out of the essentials needed for a safe delivery. Mothers are urged to bring gloves, soap, and disinfectants"* **(Community Health Officer).**

Another challenge cited by respondents is the poor road network coupled with lack of ambulance in the area. The CHCs indicated that they often have it difficult with expectant mothers because they prefer to give birth at home than to be transported with a motor bike on unmotorable road to the health center.

> *"……..Despite owning a motorcycle, the condition of the road connecting this community with the medical facility prevents me from even using it to transport a pregnant woman during the rainy season. I might not be lucky enough to find a nurse who can help me with my issue. On occasion, when a patient's health issue is complex or there isn't a nurse nearby to provide care, we are asked to visit the municipal hospital* **(FGD participant, CHPS 9).**

For example, several isolated communities lack access roads and transportation to make it easier for residents to visit CHPS facilities. They stated that there are problems with the communication system and the ambulance service. The lack of transportation options was an issue for certain towns with access to good highways, and things got worse for women living in rural areas. There have been reports of few commercial cars operating in several regions of the study setting.

"……..You are able to observe for yourself. A pathway connects this settlement to the next community that has a CHPS facility. I was wheeled to the facility on a bicycle just before I gave birth to my last child. I decided to walk because the pain was too great, although it was a long way to the facility. We had to detour to a TBA's home while traveling in order to deliver" **(FGD, participant CHPS 11).**

4.4.2 Recommendations for Enhancing CHC Performance and Commitment

Regarding what should be done to improve on the performance of CHC, respondents made several suggestions but all their suggestions revolved around the provision of incentives and motivation for CHCs. Additional, participants in the FGDs suggested that the necessary materials and equipment should made available to ensure the healthcare provide quality services to client to the satisfaction of the CHCs. When quality care is provided, the CHCs will have the feeling that their efforts are not in vain and thus put in more efforts. On the other hand, if after all their sacrifices there is still no improvement on the provision of care, they will be discouraged and possibly give up.

"……..to improve on the performance of CHCs, there should be motivation. It may not be in cash, citations can be provided for CHCs members, their health insurance cards can be renewed free of charge. This will motivate them to do more **(CHC member, CHPS 11).**

"……..those days community volunteers were given items like bicycles, cutlasses and farm input. You remember those that were night school

> *teacher? But now volunteers are not motivated at all, sometime should be done about it. When they attend meetings are they not given allowances? They receive salary yet the still collect money for meetings. But CHC members are not given anything, that's bad* **(Tindaa-na, CHPS 9).**

According to the community members, you cannot expect efficiency when there are no resources for operation, thus the necessary resources should be provided to enable the CHCs work effectively.

> *"……undoubtedly, there cannot be improvement without materials for the healthcare staff to work. When the CHCs encourage pregnant women to go to the health facility and there are no materials for treatment it will be difficult convincing them to go the next time. So the best thing to do for improvement is availability of resources in good quantities* **(FGD participant, CHPS 3).**

The major challenges with CHCs can be summarized as scarcity of resources, lack of basic amenities and perception of community members about the role and benefits of members of the CHC. Lack of incentives and motivation for CHCs is a major challenge in CHPS program. Members of CHC stated how attending to community health duties without any material reward affecting is their family livelihoods and at times commitment to duty. It was further stated that, the greatest of challenge is that "some community members believe they are paid for their role as CHC members, whiles in actual fact, they are not". There were times some community members needed financial assistance from members with the perception that, they are paid as CHC members.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter presents discussions of analysis of the empirical study. The chapter discusses the composition and functions of Community Health Committees (CHCs) within the Community-Based Health Planning and Services (CHPS) program in the Bolgatanga municipality. The chapter explores how CHCs are formed, their roles and responsibilities, and their contributions to maternal healthcare delivery. It also examines the relationship between CHCs and healthcare workers within the CHPS framework and the challenges faced by CHCs.

5.2 The Composition of CHC

The study found that, there were CHCs in the entire CHPS compound in the Bolgatanga municipality. An individual becomes a member of a health committee by appointment due to his or her stature and influence in the community. Also, community health officers sometimes determine one's membership of the committee. Ones qualification to be selected as a member is strictly based on the influence the person wields and the interest the person has on health issues and the ability of the person to mobilize others and non-partisan. The appointment to a health committee is usually not based on educational credentials.

This finding is in line with what previous studies have alluded to. An exploratory research was carried out using qualitative methodologies to evaluate the selection processes and responsibilities of Community Health Volunteers and Community Health Management Committees, discovered that Community Health Management Committees and Community Health Volunteers serve as the

program's regular community representatives in its routine execution. Their communities choose, appoint, or nominate them. Others are hired through advertisements, while some are given or inherit the post through apprenticeship (Sakeah, Aborigo, Debpuur, et al., 2021).

Similarly, another study found that, Health Unit Management Committees (HUMC) in Uganda are composed of 9 members who are chosen by the local councils and proposed by the sub-county health committee. The district health committee proposes, and the district council appoints, the HUMC for a level four health center. The medical officer in charge (who also serves as secretary), the head of the nursing division, community representatives, staff representatives, and the assistant chief administrative or assistant town clerk in a municipality are all examples of public personalities "with great integrity." A reputable person, the doctor in charge of the Health Unit, two well-known individuals who can write and read, a staff member from the health unit, and a teacher from a local school are all members of the HUMC. When required, a parish chief for the area where the center is located and the head of the local council may be co-opted (Ministry of Health Uganda, 2003; Orkman and Svensson, 2009).

In Namibia, CHC members are both elected and appointed. Members of the committee are requested to volunteer themselves through community structures, according to information (Namibia's Ministry of Health, 2009). Those deemed capable by the community structures are selected from the volunteer pool and interviewed, chosen, and appointed as necessary. In this process, it is believed that popular election procedures encourage civic engagement and enable voters to hold elected officials accountable for a healthcare system that is more focused on the needs of the local community (Boulle, 2013).

Health Community Committee (HCC) in Malawi composed of ten members are chosen by residents of nearby communities and serve terms of five years. Various male to female ratios exists. Members who have the ability to carry on HCC activities include retirees and retired public officials. In Kenya, CHCs consist of Women's groups or organizations who make up at least one-third of the committee, along with local youth organizations, spiritual communities, and individuals with disabilities. There are no records of the election or appointment procedure (Loewenson, et al., 2021).

Similar to the Ghanaian context, Health facility committees in Zimbabwe typically included 11–15 people on them. These include community members chosen or elected by their institutions and associations, such as youth, women, civil society, faith-based organizations, and special interest groups that represent vulnerable communities. They also include representatives from the public and private health sectors, as well as other fields such as education, agriculture, labor, housing, women's issues, and law enforcement. Ex-official members of the committee include the council member and other political figures (Loewenson et al., 2021).

According to Ministry of Health/Ghana Health Service (2009), the CHMC has the responsibility to supervise health volunteers, promote the welfare of the CHO, provide security for the CHO, and handle disputes between the CHO and community members and volunteers. The community may elect members to the CHMC based on their readiness, acceptability, and social status.

Presently, the basic qualification for members of the CHC is not the educational level of the individual, but how ***much influence*** the person wields in terms of their power and skills in mobilizing the community to participate and contribute. The study found that; the main consideration in selecting someone to be part of the CHC is the person's ability to mobilize the

community members. Most of the communities mentioned good human relation, community influencers, good interpersonal skills and persons who can communicate well and loved by community members.

5.3 Capacity and functions of CHC

For instance, in South Africa, health committees have well-defined monitoring responsibilities. In addition to the capacity to monitor and report the extent to which the health facilities gather and achieve their health indicators and goals set for primary health care, they are responsible for dedicating the opening and closing times of all local health facilities within their jurisdiction. They also oversee compliance and provision of the primary health-care package, including the general norms and standards of the health facility. Additionally, they keep an eye on how well communities are informed and how well the administration of the health institution handles and resolves community issues. They play roles in advocacy, social mobilization, fundraising, and training in addition to these monitoring tasks (Nelson Mandela Metropolitan University, 2010; Haricharan, 2011; South Africa Department of Health, 2013).

Another study found that, Community Health Committees in Kenya offer direction and governance supervision for the execution of health and associated policies in local community health services as well as the management and administration of the medical institution. In order to participate in community dialogue and health action, they plan, coordinate, and mobilize the community. The community receives advice on how to best promote health services, and in local development forums, they speak for and represent the community's interests in health. In addition, they carry out community decisions pertaining to their personal health and offer input to the community on the management and operations of the medical facility. they oversee community health by

managing people and resources, mobilizing community resources for the expansion of health services in the area, and facilitating resource mobilization for the implementation of the community work plan while maintaining accountability and transparency. CHCs take the lead in advocacy, communication, and social mobilization; they promote negotiations and help resolve stakeholder misunderstanding at a level; they monitor, evaluate, and report on the community work plan (Kenya MoH, 2006; Katabarwa et al. 2005) in Kenya; Kenya Ministry of Public Health and Sanitation, 2013).

In the Bolgatanga context, the findings showed that local communities had contributed significantly in both "monetary" and "in kind" to support the initiative for the construction and upkeep of CHPS. Contributions in kind included labor to erect and maintain the structures as well as water, sand, and the purchase of stones, among other things. Cash contributions were also provided to help with the construction and upkeep of the CHPS program. Additionally, it was mentioned that a variety of community members, regardless of their gender or economic standing, contributed labor and supplies. Men and women received distinct cues, though, according on their gender. While the ladies hauled water, sand, and cleaned the CHPS area, the males contributed their labor, money, and other resources (Baatiema et al., 2013).

The committee acts as a channel for complaints regarding community healthcare services to be directed toward the healthcare facility's personnel. They work closely with the community health officers to address problems that the community health complex has and to improve communication between the officers and their clients (Sakeah, Aborigo and Debpuur et al., 2021). Through community mobilization and education, CHMCs promote community involvement and

boost access to and utilization of primary healthcare services (Katigbak, Van Devanter, Islam, TrinhShevrin, 2015).

This finding is in line with previous research studies. Research conducted in Kenya by Otieno et al. (2020) found that health facilities with active health committees used healthcare services more effectively. This is related to the function and duties of health committees, which include organizing individuals and resources to assist in the administration of the medical facility, delivering healthcare education, establishing outreach programs for the far-flung villages, and overseeing the interactions between medical professionals and the public (Otieno et al., 2020).

Additionally, Fisher (2013) asserts that the CHC strategy fosters a culture of health since participants routinely get together to talk and learn about strategies to enhance hygiene. Clubs are utilized to encourage community engagement, which promotes better health, as well as to create a place for participatory learning and action. Clubs are considered as a tool to foster community leadership and fit in with existing organizational structures in many areas (Jones et al., 2018).

Moreover, Community Health Volunteers direct neighborhood organizing initiatives, assist medical professionals with health promotion initiatives, treat minor diseases, and motivate expectant mothers to use maternal health services. Community health volunteers also transcribe health messages that healthcare professionals provide to the public in their native tongues. They act as a go-between between the community's residents and the medical staff at the medical facilities.

5.4 The Contribution of CHCs in the provision of Maternal Health Care

This study established that, CHCs in the municipality have contributed in diverse ways to the improvement of maternal and child health care. Some of the contributions were in the form of demanding for midwives to be posted to their CHPS facilities, supported in the sensitization and encouragement of women to attend ANC, and facilitate the transportation of women to health centres during labor. CHCs also give support to the healthcare staff, by facilitating the education of community members and creating enabling environment for the provision of healthcare. Some of the aspects of maternal care that have been impacted as a result of these activities of the CHCs were in skilled birth deliveries, reduction in the usage of over-the-counter drugs, knowledge on the danger signs in pregnancy and exclusive breastfeeding.

There findings are in sync with a recent study where it was revealed that Community Health Management Committees and Community Health Volunteers are essential to the delivery of basic healthcare (Sakeah, Aborigo, Debpuur et al., 2021). In addition to providing leadership in constructing temporary shelters to accommodate midwives so they can continue to serve in the area and deliver babies, the Community Health Committees are in charge of organizing funding for the construction of CHPS compounds.

The findings of the study are unsurprising since it has been established that, CHCs are typically positioned strategically to strengthen community organizations' capacity to identify, evaluate, analyze, and take action on health issues that are important to their members (Gilmore et al., 2016). CHCs typically support the nurses and volunteers at CHPS by helping them provide health promotion, referral, and referral services, such as family planning, community case management, and tuberculosis treatment. CHCs have made a substantial contribution to families' education

regarding safe birth practices, vaccinations, water and sanitation, hygiene, and nutrition over the years. This is in line with recent finding by Gupta and Khan (2024), who reported that up to fifteen national public health initiatives, such as those pertaining to nutrition, NCD screening, communicable disease prevention, reproductive health, family planning, and vector surveillance, are carried out by CHWs. Among other things, they offer family-focused services, reproductive services, basic health education, and diarrhea surveillance. In the Bolgatanga context, the nurses organize and conduct weekly home visits while promoting prenatal care, immunization, vaccination, breastfeeding, and maternal health with the assistance of CHCs.

5.5 The nature of relations between CHCs and health workers within the CHPS module

The findings of the study revealed that the members of the CHCs have a very cordial relationship with the healthcare staff. CHCs have very little conflict with the healthcare staff as their role is just to support and mediate between the healthcare staff and the community. Also, the healthcare staff are duty conscious and have good working relationships with CHC members.

These findings resonate with previous study which examined the effect of the Community Health Club strategy on neighborhood health. Members of CHCs and MoH employees both stated that CHCs had significantly improved community health outcomes. The study discovered indications of stronger leadership, better community cohesiveness, and more people participating in self-initiated activities like community gardens (Chingono, 2013).

Contrary to this, other studies have reported that, due to criticism or failure to meet community expectations, as a well having to deal with different responsibilities because of their vertical programs, CHWs in Kenya and Malawi, were occasionally confronted with misunderstanding at

the community level. This was often exacerbated by their inability to live up to some expectations from communities, resulting in strained relationships. Some CHCs in Ethiopia have also reported that conflicting programs and demands from higher cadres resulted in alterations to their planned operations, which inflicted distrust on the communities (Kok, 2015).

5.6 Challenges confronting CHCs in Health Care Delivery

The study found that, CHCs in the Bolgatanga municipality lack of incentives and motivation to carry out their duty. Some CHC members had to juggle their regular jobs with that of committee duties sometimes to the detriment of their wage-earning occupations. In the midst of this, some of the community members believed that CHC members were remunerated financially so they occasionally sought financial assistance from them.

Some CHPS facilities lacks social amenities which make the work of both the health committees and community health worker difficulty. This is in-line with the study which stated that, majority of the health committee members are men, which has negative effects that previous research has noticed (Attree, et. al., 2011, George, et. al., 2015). According to a survey conducted in Ghana's Eastern Region, men predominate in the health committees' makeup as well (Atta – Nyarko, 2017). Another research conducted by the Ifakara Health Institute (2011) corroborated this and found that there were few female representatives, despite the fact that each committee included at least one female community representative and that community members made up 70% of the committee's membership. According to Patta, Oluoch and Onyango-Osuga, (2021) women are significantly underrepresented in the CHC as compared to men.

Additionally, Serneels and Lievens (2018) found that Community Health Committees in Rwanda were ineffective at improving the quality of care through the monitoring of performance indicators

unless they had full authority to recognize and discipline high-performing health workers. In reality, there was no capability or planning for this kind of monitoring and evaluation. According to the argument of Kweku et al. (2020), it is the duty of members of Health Facility Governing Committees (HFGC) to improve the quality of healthcare, ensure that exemptions are followed, and mobilize resources, such as money in the case of the Community Health Fund (CHF) and from partner contributions.

Table 5 Summary of Discussions

Objectives	Summary of Discussions
The composition, capacity and functions of CHCs.	• CHCs in the municipality play a significant role in improving maternal and child health care. • Contributions include advocating for midwives to be stationed at CHPS facilities, encouraging women to attend antenatal care (ANC), facilitating transportation for women during labor, and supporting healthcare staff. • Impact areas of CHC activities include skilled birth deliveries, reduction in over-the-counter drug usage, increased knowledge of danger signs in pregnancy, and promotion of exclusive breastfeeding. • Similar findings were observed in a recent study emphasizing the essential role of Community Health

	Management Committees and Community Health Volunteers in basic healthcare delivery. • CHCs are strategically positioned to build community capacity in defining, assessing, analyzing, and addressing health concerns. • Within CHPS operations, CHCs assist nurses and volunteers in offering health promotion, referral, and management services, including family planning and TB treatment. • Over the years, CHCs have significantly contributed to educating families on various health topics such as nutrition, safe delivery, immunizations, hygiene, and water and sanitation. • Recent findings highlight the broad scope of services provided by Community Health Workers (CHWs), including reproductive health, family planning, and communicable disease prevention.
Contribution of CHCs in Maternal Health Care	• CHCs in the municipality play a significant role in improving maternal and child health care. • Contributions include advocating for midwives to be stationed at CHPS facilities, encouraging women to

attend antenatal care (ANC), facilitating transportation for women during labor, and supporting healthcare staff.

- Impact areas of CHC activities include skilled birth deliveries, reduction in over-the-counter drug usage, increased knowledge of danger signs in pregnancy, and promotion of exclusive breastfeeding.
- Similar findings were observed in a recent study emphasizing the essential role of Community Health Management Committees and Community Health Volunteers in basic healthcare delivery.
- CHCs are strategically positioned to build community capacity in defining, assessing, analyzing, and addressing health concerns.
- Within CHPS operations, CHCs assist nurses and volunteers in offering health promotion, referral, and management services, including family planning and TB treatment.
- Over the years, CHCs have significantly contributed to educating families on various health topics such as nutrition, safe delivery, immunizations, hygiene, and water and sanitation.

	• Recent findings highlight the broad scope of services provided by Community Health Workers (CHWs), including reproductive health, family planning, and communicable disease prevention.
Nature of Relations between CHCs and Health Workers	• CHCs within the CHPS module exhibit a very cordial relationship with healthcare staff, characterized by minimal conflict. • CHCs primarily serve to support and mediate between healthcare staff and the community. • Healthcare staff are described as dutiful and maintain good working relationships with CHC members. • Similar positive impacts of CHCs on community health outcomes were observed in a previous study, indicating improved leadership, community cohesiveness, and increased community participation in health-related activities.
Challenges Confronting CHCs in Health Care Delivery	• CHCs in the Bolgatanga municipality face challenges such as lack of incentives and motivation, leading some members to balance committee duties with wage-earning occupations.

- Community members may mistakenly believe that CHC members are financially remunerated, leading to occasional financial requests to CHC members.
- Some CHPS facilities lack social amenities, complicating the work of both CHCs and community health workers.
- Gender imbalance in CHC membership is observed, with men predominating, which can have negative effects on committee effectiveness.
- Studies in Ghana and Rwanda have found similar gender imbalances in CHCs, with women significantly underrepresented.
- CHCs may lack the authority or capability to effectively monitor and improve the quality of care, as observed in Rwanda.
- Health Facility Governing Committees (HFGCs) are expected to play a role in improving healthcare quality and mobilizing resources, but their effectiveness may be limited without proper planning and capabilities.

In conclusion, the discussions surrounding Community Health Committees (CHCs) within the context of health care delivery underscore both their potential and the challenges they face. Across

various objectives, it is evident that CHCs play a crucial role in promoting community health outcomes, facilitating collaboration between community members and healthcare providers, and enhancing access to essential health services, particularly in maternal and child health care.

However, several challenges impede the effectiveness of CHCs. These include a lack of incentives and motivation for CHC members, gender imbalances within committees, inadequate resources and support for CHPS facilities, and limitations in authority and capabilities for monitoring and improving healthcare quality.

Moving forward, addressing these challenges requires a multi-faceted approach. Research efforts should focus on identifying innovative strategies to incentivize and support CHC members, promote gender equity within committees, and enhance the authority and capabilities of CHCs to monitor and improve healthcare quality. In practice, it is imperative to prioritize capacity-building initiatives, policy reforms, and targeted interventions to strengthen the functioning of CHCs and maximize their potential contributions to community health.

By addressing these challenges and leveraging the strengths of CHCs, we can foster a more collaborative and effective approach to health care delivery, ultimately improving health outcomes and advancing the well-being of communities.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Introduction

This segment provides a synopsis of major findings of the study draws conclusions based on the analysis and findings and finally provides recommendations on the contribution of community health committees in maternal health care in the Bolgatanga municipality.

6.2 Summary of Findings

The study of 11 CHPS centers in the Bolgatanga Municipality established that, all 11 facilities have well-constructed CHPS centers with the requisite staff at post and serving the communities. All 11 CHPS compounds had properly constituted and functioning CHCs. The members of the Health Committee were appointment based on the CHPS implementation guideline and requirement. They involved persons who are resident in the communities, and wields a certain degree of influence to support the CHWs in the planning, mobilization and execution of the CHPS program for better health outcomes. Membership in CHC, the communities said is never base on educational qualification but influence and interest.

The study also found that, CHCs play a significant role in improvement of the rural health systems. They have led communities into accepting and taking control of their own health through changes in health seeking behaviors such as early treatment and preventive measures.

CHCs contributed to the improvement of maternal health care in the Bolgatanga municipal. Their modest contributions to maternal and child health were evidenced by improvements in ANC attendance, skilled delivery, improved child nutrition and increased utilization of appropriate

health services in the municipality. The support to the healthcare staff in educating community members created enabling environment for the provision of healthcare in the municipality.

A good working relationship is a critical ingredient for successful initiatives. The study found that, the CHCs in the municipality have a very good working relationship with the healthcare staff. This effective collaboration is resulting in the attainment of most health targets set and health outcomes in the municipality.

As a challenge, the CHCs in the Bolgatanga municipality like many others across the country still lack the needed resources and hence are unable to motivate members. This single challenge coupled with the perception of the community members that, members of the committee are paid to carry out their duty is affecting the morale and commitment of some committee members.

In addition, the lack of basic amenities in some facilities is affecting the delivery of some services. For instance, CHPS that are upgraded to conduct deliveries do not have well build and equipped maternity wards yet they are expected to conduct birth delivery. The lack of such amenities makes the work of both the health committees and community health workers difficult.

Table 6 Summary of the Main Findings

Objective	Key highlights from the empirical review literature
Composition, Capacity and Functions of CHCs	➢ There are CHCs in the entire CHPS compound in the Bolgatanga municipality. ➢ Individual become a member of a health committee by appointment due to his or her stature and influence in the community.

	➢ Community health officers sometimes determine one's membership of the committee. ➢ Ones qualification to be selected as a member is strictly based on the influence the person wields and the interest the person has on health issues and the ability of the person to mobilize others and non-partisan. ➢ The appointment to a health committee is usually not based on educational credentials. ➢ CHCs plays a significant role in making the members of the community understand the health systems and why they should take control of their own health. ➢ CHCs in this context were very conversant with their core duty ➢ Helped their communities to improve upon health seeking behavior.
Contributions to MNCH	➢ Demanding for midwives to be posted to their CHPS facilities ➢ Supported in the sensitization and encouragement of women to attend ANC.

	➢ Facilitate the transportation of women to health centres during labor. ➢ CHCs also give support to the healthcare staff, by facilitating the education of community members ➢ Creating enabling environment for the provision of healthcare. ➢ Some of the aspects of maternal care that have been impacted as a result of these activities of the CHCs were in skilled birth deliveries, reduction in the usage of over-the-counter drugs, knowledge on the danger signs in pregnancy and exclusive breastfeeding.
Relationship between CHCs and other Health Workers	➢ CHCs have a very cordial relationship with the healthcare staff. ➢ CHCs have very little conflict with the healthcare staff as their role is just to support and mediate between the healthcare staff and the community. ➢ Healthcare staff are duty conscious and have good working relationships with CHC members.
Challenges of CHCs	➢ the lack of basic amenities in some facilities is affecting the delivery of some services. For instance, CHPS that are upgraded to conduct

	deliveries do not have well build and equipped maternity wards yet they are expected to conduct birth delivery. The lack of such amenities makes the work of both the health committees and community health workers difficult.

6.3 Conclusion

Community Health Committees are a group of local community members who come together to actively participate in and support the management, planning and monitoring of health care services and programs within their communities. Often these committees are established as part of community health initiatives to ensure that health care services are tailored to the specific needs and preferences of the local people.

Community health committees play key roles in advocating for improved health services, planning and decision making about health care interventions that are most relevant to the community health needs, mobilizing community resources and social capital to support the execution of the health intervention plans, supporting the education and awareness creation on preventive health measures and early treatment.

Over the years CHCs contributions to improve health care delivery in general and maternal and child health in particularly has not been given the right acknowledgement. This study has therefore established that CHCs paly and remain a crucial mechanism/cog in the wheel of primary health care delivery within the famous CHPS framework. By involving the local

residents in decision-making, implementation process, CHCs contributes to more effective and sustainable health care interventions that are closely aligned with the needs and preferences of the local communities. They play a crucial role in ensuring social accountability and community mobilization efforts. They are ubiquitous and generally well constituted across the municipality. Their engagement with other members of the health systems is very cordial however, lack of incentives, other basic amenities are a threat to the gains CHCs have made and this has to be address.

6.4 Recommendations

To enhance the CHPS program effectiveness and continuous reviews of the implementation in order to identify gaps and design solutions is critical. Continuous funding, capacity building for community health workers and the integration of technology in daily management of the CHPS must be prioritized. It is also very necessary to develop a more effective and coordinated collaboration between government and NGOs and local communities in order to sustain the success.

6.4.1 Specific Recommendation

1. The Ghana Health Service (GHS), in collaboration with the Bolgatanga Municipal Health Directorate and the District Assembly, should develop and implement a structured incentive package for CHC members. This package could include non-financial rewards such as National Health Insurance Scheme (NHIS) renewal, certificates of recognition, and periodic stipends. This will help address CHC members' loss of income and time, reduce

absenteeism, and sustain their commitment to health programs, thereby strengthening CHPS performance and health outcomes.

2. The Ministry of Health and Ghana Health Service, supported by development partners such as UNICEF or WHO, should prioritize logistical and infrastructural support for CHPS compounds, especially those designated to conduct skilled birth deliveries. This includes constructing maternity blocks, equipping facilities with delivery tools, and ensuring functioning referral systems such as ambulance services. Without these, the presence of midwives alone will not translate into quality skilled birth attendance.
3. The Municipal Health Directorate and Ghana Health Service Training Division should conduct regular training sessions for CHC members on topics including primary health care, community mobilization, health promotion, and basic facilitation techniques. These trainings should be part of a standardized onboarding and refresher program to address high turnover and ensure continuity and effectiveness in CHC roles.
4. Academic institutions and public health research bodies, such as the University of Ghana School of Public Health or the Ghana Health Service Research Division, should consider conducting national-scale studies to assess the role and effectiveness of CHCs across different regions. Such comparative research will facilitate cross-learning, policy innovation, and standardized best practices for community-based health governance in Ghana.

REFERENCES

Achana, J. W. (2024). *Knowledge and Utilisation of the WHO Modified Partograph in Managing Labour: A Study Among Midwives in Bolgatanga Municipality* (Doctoral dissertation, University of Cape Coast).

Adongo, P. B., Tapsoba, P., Phillips, J. F., Tabong, P. T.-N., Stone, A., Kuffour, E., . . . Akweongo, P. (2013). The role of community-based health planning and services strategy in involving males in the provision of family planning services: a qualitative study in Southern Ghana. Reproductive Health Journal.

Akinyi, C., Nzanzu, J., & Kaseje, D. (2015). Effectiveness of Community Health Workers in Promotion of Maternal Health Services in Butere District, Rural Western Kenya. Universal Journal of Medical Science, vol 3(1). doi:10.13189/ujmsj.2015.030102

Akweongo, P., Adongo, P. B., Awoonor-Williams, J. K., Phillips, J. F., Tabong, P. T.-N., Stone, A. E., Kuffour, E., & Tapsoba, P. (2017). Scaling up experimental project success with the Community-based Health Planning and Services Initiative in Ghana.

Alatinga KA, Agalga, Abiiro GA(2022). Enablers and inhibitors of community participation in Ghana's Community-based Health Planning and Services programme: a qualitative study in the Builsa North Municipality. BMC Health Services Research (2022) 22:1468 doi:10.1186/s12913-022-08869-

Atuoye, K. N., Dixon, J., Rishworth, A., Galaa, S. Z., Boamah, S. A., & Luginaah, I. (2015). Can she make it? Transportation barriers to accessing maternal and child health care services in rural Ghana. *BMC health services research*, *15*, 1-10.

Atwal, S., Schmider, J., Buchberger, B., Boshnakova, A., Cook, R., White, A., & El Bcheraoui, C. (2023). Prioritisation processes for programme implementation and evaluation in public health: A scoping review. *Frontiers in public health*, *11*, 1106163.

Baatiema, L., Skovdal, M., Rifkin, S., & Campbell, C. (2013). Assessing participation in a community-based health planning and services programme in Ghana. BMC Health Services Research, 13, 233. doi:10.1186/1472-6963-13-233

Bassoumah, B., Adam, A. M., & Adokiya, M. N. (2021). Challenges to the utilization of Communitybased Health Planning and Services: the views of stakeholders in Yendi Municipality, Ghana. BMC Health Services Research, vol 21(1223). doi:10.1186/s12913-021-07249-8

Boora, S. (2022). Process of Diffusion and Adoption in Innovation. *Agricultural Extension*, *69*, 55.

Boulle, T. (2013). A Review of the Functioning of Health Committees in Nelson Mandela Bay Health District - With Particular Emphasis on Identifying Key Challenges. The Learning Network on Health and Human Rights.

Braimah, J. A. (2017). Community-based Health Planning and Services and Women's Access to Health Care in the Upper West Region of Ghana. Electronic Thesis and Dissertation Repository.

CDC. (2015). Utilizing Community Health Workers to Improve Access to Care for Maternal and Child Populations: Four State Approaches.

Chen, S., Walt, G., Aldrich, A., McAlearney, A. S., Linas, B., Amuchi, B., ... & Walker, D. M. (2024). A Qualitative Study of Health Equity's Role in Community Coalition Development. *Health Education & Behavior*, *51*(4), 613-624.

Clement T (2011). Impact assessment of the community-based health planning and services initiative in the Berekum Municipality.

Dako-Gyeke, P., Asampong, E., Opoku-Mensah, K., Tabong, P. T. N., Awor, P., & Tucker, J. D. (2022). Social innovations to increase health coverage: evidence from a crowdsourcing contest in Ghana. *BMJ open*, *12*(6), e063119.

Dougherty, L., Stammer, E., Derbile, E., Dery, M., Yahaya, W., Gle, D. B., . . . Fotso, J. C. (2018). A Mixed Methods Evaluation of a Community Based Behavior Change Program to Improve Maternal Health Outcomes in the Upper West Region of Ghana. Journal of Health Communication, vol 23. doi:10.1080/10810730.2017.1414901

Donkor, F. K. (2019). *The nexus of land-based livelihood adaptation and natural resource governance in a former homeland communal area of South Africa* (Doctoral dissertation, University of the Witwatersrand, Johannesburg (South Africa)).

Ekane, N., Dickin, S., Gabrielsson, S., Amans, N., & Rujeni, N. (2019). Implementation challenges for Community Health Clubs in Rwanda.

Elsey, H., Abboah-Offei, M., Vidyasagaran, A. L., Anaseba, D., Wallace, L., Nwameme, A., ... & Agyepong, I. (2023). Implementation of the Community-based Health Planning and Services (CHPS) in rural and urban Ghana: a history and systematic review of what works, for whom and why. *Frontiers in public health*, *11*, 1105495.

Flores, W. (2016) Public health for indigenous peoples in Guatemala: monitoring from the bottom up. In McDonald DA editor, Making public in a privatized world. London: Zed Books, 81–99

Gathege, N. W., & Yusuf, M. (2019). Influence of monitoring and evaluation on sustainability of women based agricultural projects. a case of Joywo Uasin Gishu County. *International Journal of Management and Commerce Innovations*, *7*(1), 250-259.

Gilmore, B., McAuliffe, E., Larkan, F., Conteh, M., Dunne, N., Gaudrault, M., . . . Vallières, F. (2016). How do community health committees contribute to capacity building for maternal and child health? A realist evaluation protocol. BMJ Open. doi:10.1136/bmjopen-2016-011885

Grant, M., Wilford, A., Haskins, L., Phakathi, S., Mntambo, N., & Horwood, C. M. (2017). Trust of community health workers influences the acceptance of community-based maternal and child health services. *African Journal of Primary Health Care and Family Medicine*, *9*(1), 1-8.

Haldane, V., Chuah, F. L., Srivastava, A., Singh, S. R., Koh, G. C., Seng, C. K., & Legido-Quigley, H. (2019). Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. *PloS one*, *14*(5), e0216112.

Haricharan, H.J. 2019. Health committees in South Africa: the Influence of power on invited participation in policy and practice. . ,Faculty of Health Sciences ,Department of Public Health and Family Medicine. http://hdl.handle.net/11427/30371

Isham J, Kahkone S. Institutional determinants of the impacts com - munity: a rapid assessment of Kenya's water, sanitation and sewerage framework. Nairobi: Institute of Economic Afairs; 2009.

Jones, G. J., Edwards, M. B., Bocarro, J. N., Bunds, K. S., & Smith, J. W. (2018). Leveraging community sport organizations to promote community capacity: Strategic outcomes, challenges, and theoretical considerations. *Sport Management Review*, *21*(3), 279-292.

Kakama, A. A., Atuheire, A., & Kahyana, D. (2024). Culture, tradition and healthcare: exploring the Kisiizi Community Health Insurance scheme. *International Journal of Anthropology and Ethnology*, *8*(1), 14.

Karuga, R. N. K. (2024). As long as you have engaged Community Health Promoters, no one cares if you have involved the CHCs or not": Factors influencing community health committees in performing their community participation roles in a devolved health system in Kenya.

Karuga R, Kok M, Luitjens M, Mbindyo P et al., (2022). Participation in primary health care through community-level health committees in Sub-Saharan Africa: a qualitative synthesis. BMC Public Health (2022) 22:359 https://doi.org/10.1186/s12889-022-12730-y

Khan, M. T., Khan, T. I., & Khan, S. (2020). Innovation & its diffusion in business: Concept, stages & procedural practices. *sjesr*, *3*(4), 174-186.

Kweku M, Manu E, Amu H, Aku FY, Adjuik M et al. (2020). Volunteer responsibilities, motivations and challenges in implementation of the communitybased health planning and services (CHPS) initiative in Ghana: qualitative evidence from two systems learning districts of the CHPS+ project.

Kyei-Nimakoh, M., Carolan-Olah, M., & McCann, T. V. (2016). Millennium development Goal 5: progress and challenges in reducing maternal deaths in Ghana. *BMC pregnancy and childbirth*, *16*, 1-9.

Linde, S., & Egede, L. E. (2023). Community social capital and population health outcomes. *JAMA Network Open*, *6*(8), e2331087-e2331087.

Loewenson, R., Colvin, C. J., Szabzon, F., Das, S., Khanna, R., Coelho, V. S. P., ... & Nolan, E. (2021). Beyond command and control: a rapid review of meaningful community-engaged responses to COVID-19. Global Public Health, 16(8-9), 1439-1453.

Loewenson R, Machingura F, Kaim B (2014) 'Supporting the role of health centre committees: A training manual – Pilot edition', TARSC, CWGH: Harare

Marston, C., Hinton, R., Kean, S., Baral, S., Ahuja, A., Costello, A., & Portela, A. (2016). Community participation for transformative action on women's, children's and adolescents' health. *Bulletin of the World Health Organization*, *94*(5), 376.

McCoy DC, Hall JA, Ridge M (2012) 'A systematic review of the literature for evidence on health facility committees in low- and middle-income countries', Health policy and planning 27:449–66

Mulumba M, London L, Nantaba J and Ngwena C (2018). Using Health Committees to Promote Community Participation as a Social Determinant of the Right to Health: Lessons from Uganda and South Africa.

Ngeh, I. (2017). Assessing The Factors Influencing Utilization Of Family Planning Services At The Community-Based Health. Planning Services (Chps) In The Bongo District Of The Upper East Region Of Ghana.

Okuga, M., Kemigisa, M., Namutamba, S., Namazzi, G., & Waiswa, P. (2015). Engaging community health workers in maternal and newborn care in eastern Uganda. Global Health Action. doi:10.3402/gha.v8.23968

Otieno, P. O., Wambiya, E. O., Mohamed, S. M., Mutua, M. K., Kibe, P. M., Mwangi, B., & Donfouet, H. P. P. (2020). Access to primary healthcare services and associated factors in urban slums in Nairobi-Kenya. *BMC Public Health*, *20*, 1-9.

Patta SO, Oluoch M and Onyango-Osuga B (2021). Determinants of functionality of community health committees: A case of Mombasa County, Kenya. International Journal of Professional Practice (IJPP) Vol . 9 Issue No. 3, 2021

Sakeah, E., Aborigo, R. A., Debpuur, C., Nonterah, E. A., Oduro, A. R., & Awoonor-Williams, J. K. (2021). Assessing selection procedures and roles of community health volunteers and community health management committees in Ghana's community-based health planning and services program. *PloS one*, *16*(5), e0249332.

Serneels, P., and Lievens, T. (2018). Institution for Health care delivery. A formal exploration of what matters to health workers. Evidence from Rwanda.

Shetty S, (2018). Sample Size in Qualitative Interview Studies https://pubmed.ncbi.nlm.nih.gov/26613970

Spector, P. E. (2019). Do not cross me: Optimizing the use of cross-sectional designs. *Journal of business and psychology*, *34*(2), 125-137.

TARSC, CWGH, Medico Int (2014) 'Strengthening health centre committees as a vehicle for social participation in health in east and southern Africa: Regional meeting report, Harare, Zimbabwe 30 January - 1 February 2014' EQUINET: Harare.

Waterkeyn, J. A. and Waterkeyn, A. J. (2013). Creating a culture of health: hygiene behaviour change in community health clubs through knowledge and positive peer pressure. Journal of Water, Sanitation and Hygiene for Development, 3(2), 144. DOI: 10.2166/washdev.2013.109

World Health Organization. (1978). Declaration of alma-ata. In *Declaration of Alma-Ata*.

APPENDICES:

Interview guide

Section A: Bio data of respondents

1. Age of respondents
2. Sex of respondent
3. Level of education
4. Occupation

Section B: Interview guide for health workers

1. Do you have CHCs in this Zone?
2. If yes, what is their current Composition?
3. How were they selected?
4. Can you describe the typical qualification for a person to become a CHC member?
5. Can you outline the current duties performed by CHCs?
6. Do you think it is importance to have CHCs in your facility?
7. What role do CHCs play towards improving maternal and child health in your Zone?
8. Do you think the CHCs role conflicts the role of the community health nurse?
9. What is the nature of relations between the CHCs and health workers within the CHPS system?
10. Kindly suggest ways that CHCs can improve the performance of their function

Section C: Interview guide for CHCs members

1. What is the composition of the CHC?
2. What are the general roles of CHCs in the provision of health care in general?
3. What role do you play in the provision of maternal and child health care?
4. Do you think the CHC has contributed to the improvement of maternal health care?
5. Is there any friction between you and the health workers in line with your duties?
6. How will you describe your relationship with the healthcare staff?
7. What are challenges you are confronted with when performing your role?

Interview guide for chiefs and assembly members

1. How will you describe the impact of the CHPS system on your community?
2. Do you think the CHC has contributed in the provision maternal health in your community?
3. Will you encourage the establishment of CHCs?
4. Don't you think the CHCs are performing the role of the health professional who are paid to this?
5. What do you think should be done to improve the performance of CHCs?

Interview guide for community members

1. Have you heard of CHCs before?
2. Do you have one in your community CHPS?
3. What have the CHC been doing in your community?
4. Do you think the activities of the CHC has led to an improvement in maternal health?

- If yes, explain how? Give examples?
- If no, why?

5. In your opinion, will you say the CHC is interfering in the duties of the health workers?

6. What do you think should be done to improve the performance of the CHC?

APPENDIX II – ETHICAL APPROVAL LETTER

UNIVERSITY FOR DEVELOPMENT STUDIES

Tel: 03720-93382/26634/22078
Email: registrar@uds.edu.gh
Website: www.uds.edu.gh

P. O. Box TL 1350
Tamale, Ghana

Our Ref: UDS/RB/104/22

Your Ref:.....

OFFICE OF THE REGISTRAR

Date: 10TH November, 2022.

DR. HARUNA UMAR,
UNIVERSITY FOR DEVELOPMENT STUDIES,
P. O. BOX TL 1350,
TAMALE, GHANA

ETHICAL APPROVAL NOTIFICATION

With reference to your request for ethical clearance on the research proposal titled ' **Assesing the contribution of Community Health Committtees in Maternal Health Care in the Bolgatanga Municipality,** ' I write to inform you that the University for Development Studies Institutional Review Board (UDSIRB) found your proposal including the consent forms to be satisfactory and have duly approved same. The mandatory period for the approval is six (6) months, starting from 10th June, 2024 to 10th November, 2024.

Subject to this approval, you are please required to observe the following conditions:

1. That the anonymity of the respondents shall be guaranteed as mentioned in the consent forms.
2. That you will acknowledge the source of the data collected in any publication related to this research.
3. That you will submit a field report and a copy of the research report to the UDSIRB.
4. That you may apply to the UDSIRB for any amendments relating to recruiting methods, informed consent procedures, study design and research personnel.
5. That you will strictly abide by the code of conduct of this University.

Please do not hesitate to refer any issue (s) that you may deem necessary for the attention of the Board.

Thank you.

Prof. Nafiu Amidu
Chairman, UDSIRB
Cc: file

APPENDIX III – INTRODUCTORY LETTER

UNIVERSITY FOR DEVELOPMENT STUDIES
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Office of the Dean

11/06/2024

To whom it may concern

LETTER OF INTRODUCTION
SAMUEL NGUMAH-UDS/CHD/0051/19

This is to introduce to you Mr. Samuel Ngumah a final year MPhil Community Health and Development student in the Department of Social and Behavioural Change, School of Public Health of University for Development Studies. Mr. Ngumah is currently working on his thesis titled: ***"ASSESSING THE CONTRIBUTION OF COMMUNITY HEALTH COMMETTEES IN MATERNAL HEALTH CARE IN THE BOLGATANGA MUNICIPALITY"***.

Mr. Ngumah wants to have access to carry out this important academic exercise in the Bolgatanga Municipality.

I would be grateful if you could provide him with this information and any other assistance he may need.

Thank you.

OFFICE OF THE DEAN
SCHOOL OF PUBLIC HEALTH
UNIVERSITY FOR DEV'T
STUDIES, TAMALE

Mrs Eleanor Araba Antwi
(Snr. Asst. Registrar)
for: Dean, SPH

APPENDIX IV – PERMISSION LETTER FROM BOLGATANGA MUNICIPAL HEALTH DIRECTORATE

OUR CORE VALUES
1. People-Centred
2. Professionalism
3. Team work
4. Innovation
5. Discipline
6.. Integrity
My Ref No. GHS/UER/BMHD/SG-34
Your Ref. No

GHANA HEALTH SERVICE
Your Health · Our Concern

Municipal Health Directorate
Ghana Health Services
P. O. Box 26
Bolgatanga, UER
GHANA.
GPS: UB-0014-1321
bolgatanga.mhduer@ghs.gov.gh
Date: 1st July, 2024

TO whom it may concern

RE: LETTER OF INTRODUCTION
SAMUEL NGUMAH -UDS/CHD/0051/19

We write to acknowledge a letter introducing a final year MPhil Community Health and Development Student in the Department of Social and Behavioural Change, School of Public Health of University for Development Studies who is currently working on his thesis titled **"ASSESSING THE CONTRIBUTION OF COMMUNITY HEALTH COMMITTEES IN MATERNAL HEALTH CARE IN THE BOLGATANGA MUNICIPALITY".**

We are grateful to inform you that Mr. Samuel Ngumah would be accorded the needed assistance.

Thank you.

MR. STEPHEN BORDOTSIAH
MUNICIPAL DIRECTOR OF HEALTH SERVICE
BOLGATANGA