UNIVERSITY FOR DEVELOPMENT STUDIES, TAMALE

ASSESSMENT OF COMMUNITY PARTICIPATION IN COMMUNITY – BASED HEALTH PLANNING AND SERVICES (CHPS) IN HEALTH CARE DELIVERY A CASE STUDY OF THE KASSENA – NANKANA DISTRICT OF GHANA

Mumuni Nadia Jeedah

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BY

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(BSC. REAL ESTATE MANAGEMENT)

A TERM PAPER SUBMITTED TO THE DEPARTMENT OF GOVERNANCE AND DEVELOPMENT MANAGEMENT, FACULTY OF PLANNING AND LAND MANAGEMENT, UNIVERSITY FOR DEVELOPMENT STUDIES, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN DEVELOPMENT MANAGEMENT

March, 2018

DECLARATION

I, Mumuni Nadia Jeedah declare that besides citing from authorities which we have duly acknowledged in this report, this output is my independent work under the supervision of the signed supervisor. I am herein responsible for any errors, omissions and oversight in this work.

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SUPERVISOR	Signature	Date

ABSTRACT

The world as a whole and Ghana in particular is faced with various kinds of health problems, such as poverty, inadequate health facilities, lack of good roads to convey patients, lack of logistics for effective and efficient health service delivery, and many more. These factors have negative repercussions on health status of Ghanaians such as high rate of maternal and infant mortality and poor service delivery at the health sector. Adopted in 1999, CHPS is a national health policy initiative that aims to reduce barriers to geographical access to health care. Hence the study set out to assess community participation in the CHPS programme using the Kassena- Nankana District as case study. Descriptive design was adopted for the study. Descriptive statistics such as tables and figures were also employed to present data analysed with the aid of the SPSS version 21.0. In all a sample of 146 respondents were drawn comprising people who are community members as well as staff of the healthcare centres. Interviews were conducted in assessing views on the issues of local knowledge as well as performance of the CHPS programme. The study revealed that, opinion leaders were inform of its establishment and aside, respondents expressed their knowledge on the fact that it has existed for over a year. Also most of the respondents reported that they have knowledge of the CHPS concept and understand the concept as well. However, it was revealed that community members do not participate fully in the decision – making of the CHPS programme. Some were of the view that they are completely neglected in the process. Additionally, the CHPS programme is fulfilling the initial intent of providing accessible health care to the people in the selected communities and by so doing the author can conclude that although the CHPS programme is bedeviled with some challenges, it has significantly impacted positively on the health of the people in the district. It is recommended that civil society organizations should support efforts by government in providing healthcare to those at the grassroot.

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This work would not have come to fruition without the invaluable contributions by a number of personalities. Especially, the work benefited greatly from the intellectual advice and guidance of Mr. Samuel Z. Bonye (my supervisor). I express my sincere and special appreciation to him for the immense contribution. I am also grateful to, Head of the Kasena- Nankana CHPS. I also wish to thank the Community members for assisting me with relevant data. I am also thankful to all who have contributed in one way or the other towards the success of this work.

DEDICATION

To God Almighty To my family----------

TABLE OF CONTENT

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

1.1 Introduction

There is no doubt that a healthy population is the most priceless asset of any nation. A country with a population of strong human resource base is a healthy nation which is a prerequisite for economic growth and development of the nation. With Ghana working towards sustainable development goals, it is therefore imperative that its human capital is strengthened and improved. Generally as a result of the millennium development Goals (MDG's) and the Sustainable Development Goals (SDG's) the health status of most countries in the global world as well as Africa of which Ghana is part has improved over the years. However, there are clearly some health indicators among the different geographical regions and socio-economic groupings showing areas in need of attention. People still lack access to quality health services in spite of the various interventions by governments (Prata *et al.* 2010).

1.2 Background to the Study

The world as a whole and Ghana in particular is faced with various kinds of health problems, such as poverty, inadequate health facilities, lack of good roads to convey patients, lack of logistics for effective and efficient health service delivery among others. These factors have negative repercussions on health status of Ghanaians such as high rate of maternal and infant mortality and poor service delivery at the health sector. However, it is the aim of every country to achieve the MDGs 4, 5 and 6 which are; to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases respectively and now sustainable development goals (SDGs). Moving from the MDGs to SDGs these initiatives should be sustained for the future generation. These are the main

concerns for both developed and developing nations as well as the Kassena Nankana district to have the needed facilities and logistics for efficient and effective service delivery to bridge the gaps between the rural and urban supply chain (WHO, 2013).

In most developing countries, contraceptive use and Reproductive Health (RH) status in rural areas lags far behind urban populations. In Ghana, for instance, urban–rural fertility differences range from two to three children (DHS 2008). Similarly the number of maternal deaths globally decreased from 523,000 in 2013 to 289,000 a decrease of 45 percent from 1990 (WHO. 2013). However, 56 percent of global maternal deaths occur in sub-Saharan Africa. Ghana is among the countries in sub-Saharan Africa with the highest overall maternal mortality ratios (MMR) at 380 deaths per 100,000 live births in 2013 (WHO, 2013). However, progress in achieving MDG 5 is still slow in sub-Saharan Africa, as is the move toward universal skilled birth attendance (United Nations, 2013).

In Ghana half of childbearing women give birth with a skilled attendant; and the rural–urban gap is 88% in urban areas and 54% in rural areas (Ghana Statistical Service (2012).

This is the reason why Ministry of Health (MOH) through collaboration with Ghana Health Service (GHS) pioneered the implementation of a national programme to replicate the results of the Navrongo Community Health and Family Planning Project (CHFP) known as the Community-based Health Planning and Services (CHPS) initiative in Ghana in some key pilot districts such as Nkwanta, Birim North and Abura-Asebu-Kwamankese, to provide health care to the door steps of the rural communities, CHPS is a health strategy adopted by the MoH as a national policy to bridge the gap in healthcare access. Hence, the Ghana Poverty Reduction Strategy (GPRS) identified CHPS as a key element in pro-poor health services. Thus, the community-based level service provision will enable the GHS to reduce health inequalities and promote equity of health outcomes by removing geographic barriers to health care. A key component of CHPS is a community-based service delivery point that focuses on improved

partnership with families, community leaders and other stakeholders to address the demand supply side of service delivery and recognising that families are the primary producers of health (Nyonator *et al*. 2005).

CHPS is a national health policy initiative adopted in 1999 to reduce barriers to geographical access to healthcare. It aims at transforming the primary health care system by a programme of mobile community-based care by a resident nurse in a community. It is currently an integral part of the Ghana Health Service Five Year Programme of Work and one of the health sector components, which aims at reducing national poverty. Traditional leaders and DHMT are expected to incorporate CHPS into their health service delivery (Nyonator *et al*. 2005).

CHPS involves six implementation components that change primary health care services from a curative facility based to a comprehensive community-based programme. The components comprise of community Planning, Community Entry, and Community Health Compound construction, Community Health Officer, Essential Equipment and Volunteers. The completion of these six CHPS components heralds in a functional CHPS, ready to provide comprehensive primary health care services with strong health system strengthening at the community level. Evidence suggests that the definition and understanding of CHPS is not consistent across board, and therefore most of the CHPS programmes were focusing on building compounds for curative services and little outreach services to the detriment of preventive and promotive programmes.

Community-based Health Planning and Services (CHPS) is a system designed to improve health care access; to bridge equity gaps in accessing quality health services and to remove non- financial constraints to health care delivery. CHPS is the operational outcome of the GHS' "Close-to-client" system of primary health care delivery. Unlike the typical facility-based health care delivery, CHPS is a community-based, community-involved care system that enables District Health Monitoring Team (DHMTs) to adopt and develop approaches to community health care that are consistent with local traditions, sustainable with available resources, and that is compatible with prevailing needs

(Sakeah et al, 2014).

A study by Sakeah (2014) showed that women of the Nankana ethnic group and those with uneducated husbands were less likely to access skilled attendants at birth in rural settings. The CHO-midwife programme in UER appeared to have contributed to expanded skilled delivery care access and utilization for rural women. However, women of the Nankana ethnic group and uneducated men must be targeted with health education to improve women utilizing skilled delivery services in rural communities of the region (Sakeah et al, 2014).

1.3 Research Problem

Generally the health status of Ghanaians has improved significantly over the years. However there still exist some differences in some health indicators among the different geographical regions and socio-economic groupings. Despite the considerable investments in the provision of health care facilities, a greater number of the population lack access to quality health delivery services.

Information gathered from the field indicates that although the CHPS programme is considered by policy makers, development partners and public health providers as a good pro-poor health service delivery strategy, particularly in rural areas, its implementation has been thwarted with obstacles and/or problems that have not permitted the fulfilling of the initial intent. However, there is an increase in the level of misunderstanding of the concept of CHPS and lack of community participation (Gala, 2012).

There is no budget by Ministry of Health MOH and GHS have no specific budgets to support the CHPS programme as a result of inadequate resources and basic equipment such as lack of basic clinical, transportation and communication equipment. This has resulted in incoherent partnership and overemphasis on it was observed that in all the regions visited, no CHPS zone had an action plan. These districts were, therefore, running the CHPS programme as what can be termed CHPS without a plan (Nyonator *et al*. 2005). This situation has arisen due

to inconsistent understanding of the CHPS concept and the weak partnership among stakeholders. This finding suggests that activities that are characteristic of the health sector bureaucracy are more readily scaled up than activities such as community mobilization. While community participation is not a new concept, concerns with involving community in government decision-making processes including lack of clarity about how to involve people in decision-making processes have existed (Government of Western Australia, 2006)

Despite the considerable investments of providing healthcare facilities, a significant number of people still lack access to quality health services. Information gathered from the field indicates that although the CHPS programme is considered by policy makers, development partners and public health providers as a good pro-poor health service delivery strategy, particularly in rural areas, its implementation has been thwarted with lack of full knowledge of the participation in the CHPS programme, problems have not permitted the full realization of its benefit and also lack of education of the existence of the CHPS programme by the community people. Moreover, the omission of community-entry activities by District Health Monitoring Team suggests that the concept of CHPS is not well understood, since community participation, mobilization and ownership is central to the system reform process (Nyonator *et al*. 2005).

These challenges are clear and need to be addressed in most community participation initiatives (Canadian Policy Research Networks and Ascentum, 2005). These challenges not only compromise poverty reduction efforts but also bring untold hardships, pain and sufferings to the families (Ardsygio, 2005). The Kassena – Nankana community and the CHPS programme is not an exception to these challenges since this is going on in Ghana and other parts of the world as discussed above. This study therefore seeks to unravel the reason for the gabs still hindering the progress of the CHPS programme in the Kassena – Nankana community of the Upper East Region.

1.4 Main Research Questions

What is the level of community participation in CHPS programme in health care delivery within the Kassena- Nankani district in the Upper East Region of Ghana?

1.4.1 Sub - Research Questions

1. What is the implementation process of the CHPS programme?
2. What is the level of knowledge and understanding of the CHPS concept by the community members?
3. What is the level of community participation and involvement in decision – making of the CHPS programme?
4. How is the performance of the CHPS programme in the District?
5. What are the obstacles hindering the progress of the CHPS programme?

1.5 General Objective

The main objective of the research is to seek to provide within the theoretical framework a critical assessment of the perspective of community participation in CHPS programme in health care delivery within the Kassena Nankani district in the Upper East Region of Ghana.

1.5.1 Specific Objectives

The specific objectives pertaining to this study will be:

1. Evaluate the implementation process of the CHPS programme.
2. Determine the level of knowledge and understanding of the CHPS concept by the community members.
3. Find out the level of community participation and involvement in decision – making of the CHPS programme.
4. Evaluate the performance of the CHPS programme
5. Unravel the obstacles hindering the progress of the CHPS programme

1.6 Purpose / Relevant of the Study

The purpose of this is to explore the extent and level of community participation and collaboration among health care and stakeholders, and to understand the impact of the participation and the efficiency and effectiveness of the healthcare delivery process in the community. The study explored the potential impact of participatory decision making and communication in improving collaboration among stakeholders in the community. Finally, to know whether, the knowledge and understanding of the CHPS concept and its potential effect on the effectiveness and efficiency of health program implementation will assist in the formulation of quality health programs. Social Surveys, interview guide and in-depth interviews were used to collect the data. The rationale is that the research seeks to develop or contribute to generalizable knowledge and specifically seeks to help solve a specific planning or policy problem.

1.7 Scope of the Study

The study was conducted in kasena-Nankana East Municipality. Generally, the study is finding out the level of community participation in CHPS programme in health care delivery within the Kassena- Nankani district in the Upper East Region of Ghana? Time period of the study was from July, 2016 to March, 2018.

1.8 Organization of the Study

This section tells how my study was organized. The Term Paper is organized into six (6) chapters. Chapter one(1) provides a general introduction to the research work and contains the background to the study, the problem analysis and statement, research questions and objectives, hypothesis, rationale and layout of chapters. Chapter two (2) will examines the methodologies employed in gathering data from the field. These include the research design, sources of data, sampling techniques and data collection tools. Chapter three (3) examines existing literature on small-scale mining and education. It looks at the effects of small-scale mining activities on education.

Chapter four (4) will include findings and discussions of findings. Chapter five (5) will contain summary, conclusion and recommendations and chapter six (6) comprises of references.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of empirically, theoretically and conceptually relevant literature on the predictors of community participation in health care delivery in the implementation of Community Health Planning and Services (CHPS) programme implementation process, level of involvement and participation, sense of ownership of community members, accessibility of health care by the rural community members, knowledge of the concept of CHPS by the local people.

There is no doubt that a healthy population is the most priceless asset of any nation. A healthy population provide a strong human resource base that is required to improve productivity and hence the development of a country. With Ghana working towards becoming a middle income country by 2015 it is therefore imperative that its human capital is strengthened and improved. Generally the health status of Ghanaians has improved over the years. However there exist marked differences in some health indicators among the different geographical regions and socio-economic groupings. Despite the considerable investments in the provision of health care facilities, a significant proportion of the people lack access to quality health services. High maternal mortality is a grave concern worldwide. The global burden of maternal death is enormous, especially in less developed countries (Prata *et al.* 2010).

According to WHO and the World Bank, the number of maternal deaths globally in 2013 was 289,000, a decrease of 45 percent from the 1990 levels (523,000) (WHO. 2013). However, 56 percent of global maternal deaths occur in sub-Saharan Africa. Ghana is among the countries in sub-Saharan Africa with the highest overall maternal mortality ratios at 380 deaths per 100,000 live births in 2013 (WHO. 2013). Different strategies are required to reduce MMRs in countries such as Ghana. Among these are, improved family planning, safe

abortion or adequate post-abortion care, improved coverage and quality of skilled attendance at birth, and access to emergency obstetric care to address maternal mortality (UNFPA, 2003: WHO, 2007). Experts have argued that access to skilled attendants at birth is a key indicator of a nations commitment to preventing maternal deaths; indeed, the proportion of births with skilled attendants is one of the key indicators for monitoring progress towards the achievement of Millennium Development Goal (MDG) 5 (UNFPA, 2003: WHO, 2007).

However, progress in achieving MDG 5 is still slow in sub-Saharan Africa, as is the move toward universal skilled birth attendance (United Nations, 2001). In Ghana overall, half of childbearing women give birth with a skilled attendant; and the rural–urban gap is wide (88% in urban areas and 54% in rural areas) (Ghana Statistical Service, 2012). Since the adoption of the Millennium Declaration by the General Assembly of the United Nations, where the eight Millennium Development Goals (MDGs) were borne and defined, the achievement of these goals remains to be a mirage in most developing countries. In view of this observation, most national governments of the developing countries have become preoccupied by the search for the financial resources to change the current situation. However, financial resources alone seem not to be the answer as new strategies are needed (World Bank, 2004). The approach in terms of human development as set out in the United Nations Development Programme (UNDP) since 1990 constitutes one of the major advances in the new concept of development (Bouquet, 2005).

The Global Human Development Reports (GHDR) which has appeared since then insists on the need to increase income and put the idea of opportunity‘, for all at the forefront. Opportunity here reflects distributive justice and fairness in resource distribution. Therefore, the concept of equity must be at the heart of development strategies. In its annual Development Report, World Bank (2006) gave the following explanation on the need for equity. When personal and property rights are enforced only selectively, when budgetary allocations benefit mainly the politically influential, and when the distribution of public services favors the wealthy, both middle and poorer groups end up with unexploited talent. Society,

as a whole, is then likely to be more inefficient and to miss out on opportunities for innovation and investment. Therefore, achieving equity in resource allocation and having an equitable development of a society provide a springboard for sustained economic growth (UNDP, 1997).

Equity in health, apart from ensuring achievement of its related MDGs, ensures that a country achieve its full potential as poor people and those populations suffering from poor health benefits from the deliberate actions of government of delivering equitable distribution of resources. This leads to increased employment, increased tax revenues, and a faster rate of growth as the economy moves towards achieving its full potential. It is for these reasons that there has been a growing global concern for health equity as it is explicit that there is a strong and direct linkage between health and economic growth. The Ghana Demographic and Health Survey (GDHS, 2008) showed a 30% reduction in the under-five mortality rate, as it declined from 111 per 1000 live births in 2003 to 80 per 1000 live births in 2008, while infant mortality rate as at 2008 stood at 50 per 1000 live births compared to 64 per 1000 live births in 2003. But a closer look at the regional figures shows that regional disparities persist and wide too. These disparities signify inequities in public service delivery. Public services are usually considered essential in modern life such that their universal provisions are guaranteed for moral reasons; and they form fundamental human rights. Universal Declaration of Human Rights Article 21 (2) gives everyone the right of equal access to public service in his country. In developing countries, public services are much less well developed and may only be available to the wealthy middle class. One of the functions of the Government of a functioning democracy is to provide these public services that cannot be left to the private sector to provide through market mechanisms. This ensures fairness to the less privileged in the society and guarantee basic human rights of better living. In order to better provide these services, the Government of Ghana, in 1988, provided for decentralized structures (Local) to improve the accessibility, efficiency and quality of health and family planning care (Binka et al. 1995).

Both the Navrongo experiment and the CHPS programme respond to longstanding policy originating with the 1978 Alma Ata Conference in the United States of America. Despite a decade of trials of various strategies for achieving 'Health for All' in the 1980s, research demonstrated that in 1990 more than 70% of all Ghanaians still lived over 8 km from the nearest health care provider (Ministry of Health, 1998).

The health care sector has been undergoing a major transformation over the past decades (Abernethy *et al*. 2007). Significant changes in demography, the impact of technology, limited health resources, increasing demand from stakeholders for quality and affordable health care, the complexity of providing health care (El Ansari *et al*. 2004), and the diversity of health care skills have together transformed the approach to delivering health care. Martin-Rodriguez, D'Amour, and Ferrada-Videla (2005) argue: By bringing together in real time the competencies, experiences and judgment of a variety of professionals, organizations are trying to respond to a reality that is becoming increasingly complex in terms of both the knowledge and the working methods that are being applied. (p. 132).

The burden of maternal mortality in sub-Saharan Africa is enormous. In Ghana the maternal mortality ratio was 350 per 100,000 live births in 2010. Skilled birth attendance has been shown to reduce maternal deaths and disabilities, yet in 2010 only 68% of mothers in Ghana gave birth with skilled birth attendants. In 2005, the Ghana Health Service piloted an enhancement of its Community-Based Health Planning and Services (CHPS) programme, training Community Health Officers (CHOs) as midwives, to address the gap in skilled attendance in rural Upper East Region (UER). The study determined the extent to which CHO-midwives skilled delivery program achieved its desired outcomes in UER among birthing women. Methods we conducted a cross-sectional household survey with women who had ever given birth in the three years prior to the survey. We employed a two stage sampling techniques: In the first stage we proportionally selected enumeration areas, and the second stage involved random selection of households. In each household, where there is more than one woman with a child within the age limit,

we interviewed the woman with the youngest child. We collected data on awareness of the program, use of the services and factors that are associated with skilled attendants at birth. (Sakeah et al, 2014)

2.2 Understanding of CHPS Concept

Adopted in 1999, CHPS is a national health policy initiative that aims to reduce barriers to geographical access to health care. With an initial focus on deprived and remote areas of rural districts, CHPS endeavors to transform the primary health care system by shifting to a programme of mobile community-based care provided by a resident nurse, as opposed to conventional facility-based and 'outreach' services (Nyonator *et al*. 2005).

The CHPS initiative represents the scaling-up of the Navrongo model into a national movement for health care reform. In response to preliminary evidence from Navrongo, the MoH convened a national managers' conference in 1998 to deliberate on the implications of the experiment's model for national action, and to review a draft policy statement declaring the Navrongo community health care system as the national model for community-based care (Nyonator *et al*., 2005).

Credible evidence emerged from research projects that, there was the need to shift resources from curative institutional-based care to community-based preventive public health service (Nyonator et al., 2005). It was in the light of this that CHPS, a programme of evidence based organizational change, which places emphasis on community-based approach rather than clinical facility-focused approach was adapted as a mechanism for integrating activities of the formal health sector into traditional institutions (Nyonator et al., 2005).

CHPS involves six general implementation activities that change primary health care services from a sub-district clinic-based operation to a comprehensive community-based programme. These "CHPS milestones" are Planning, Community Entry, and Community Health Compound construction, Community Health Officer, Essential Equipment and Volunteers. The completion of these six CHPS milestones heralds in a functional CHPS, ready to provide comprehensive

primary health care services with strong health system strengthening at the community level. Evidence suggests that the definition and understanding of CHPS is not consistent across board, and therefore most of the CHPS programmes were focusing on building compounds for curative services and little outreach services to the detriment of preventive and promotive programmes (Annual Health Sector Report, 2009).

The involvement of actual health programme stakeholders in the planning, prioritization, and the final implementation process can significantly influence the effectiveness of such programmes (Akukwe, 1999; Clare & Cox, 2003; Chopra & Ford, 2005). Chopra and Ford (2005) also argued that such an inclusion will help stakeholders "define who they are, what they want, and how they can get what they want" (p. 386). Stakeholders can help determine issues that are important to them especially to the community (Clare & Cox) through the negotiation of their unique health priorities (Chopra & Ford; Akukwe). They can also be an essential source of gaining information on factors that can either inhibit or improve the 10 implementation process, including information on non-health factors (Akukwe). According to Akukwe, non-health factors can play valuable roles in the success or failure of programmes. Finally, by their participation, stakeholders have collective responsibility for ensuring that programme implementation is effective (Chopra & Ford; Akukwe).

There is no doubt that a healthy population is the most priceless asset of any nation since it provide a strong human resource base required for productivity and enhance development. It is therefore imperative that its human capital is strengthened and improved. Ghana is traced with plethora of health problems such as inadequate of health facilities among others. These factors have negative influence such as high rate of maternal and infant mortality and poor service delivery at the health sector (World Bank, 2011). The six milestones are explained:

2.3 Preliminary planning

The fundamental operational unit of CHPS is the 'zone', a geographic area where all CHPS services are phased in over time. Starting the CHPS process involves conducting a district assessment of manpower needs and capacities, grouping communities into zones with delineated boundaries, assessing district equipment and training requirements, and scheduling the onset of nurse assignment to zones where the programme is launched.

2.4 Community entry

'Community entry' moves the planning process from the district to the zone level. This involves developing community health leadership and initial participation in the programme through dialogue with community leaders and residents. Community 'durbars' are traditional gatherings comprised of drumming, dancing, speechmaking and public debate. In the community entry process, this tradition is marshalled to foster open discussion of CHPS activities.

2.5 Creating Community Health Compounds

Community health services require a simple facility, known as a Community Health Compound, comprising a room for the CHO living area and a room for a community clinic. Building these facilities involves both community leaders in planning and resource mobilization, and volunteers in construction work. This collaborative activity contributes to community ownership of CHPS.

2.5.1 Posting CHOs to Community Health Compounds

The CHO component of the programme represents the most critical milestone in the CHPS process. CHO training workshops have been convened to upgrade clinical services, introduce techniques of community diplomacy, establish counselling methods and develop midwifery skills. Launched by a durbar celebrating the onset of care, the CHO is handed over to the community to assume her resident post. CHO services involve clinical sessions at Community Health

Compounds, household visits for family planning services, health education, ambulatory care and outreach clinics for childhood immunization.

2.5.2 Procuring essential equipment

Launching Community Health Compound services requires clinical equipment for basic primary health care service delivery and new logistics equipment such as bicycles or motorcycles.

2.5.3 Deploring volunteers

Depending upon the decisions of the District Health Management Team (DHMT) and local needs, volunteer Community Health Aides may be recruited by Community Health Committees, and provided with a 6-week course in community health mobilization, with particular emphasis on promoting family planning and reproductive health among men. In some districts, the volunteers deliver health and family planning services, which requires volunteer training, and Community Health Committee training in pharmaceutical procurement and volunteer programme management, in keeping with the UNICEF-sponsored 'Bamako Initiative' (Knippenberg *et al*. 1990). Implementing the programme involves a durbar for celebrating the creation of volunteer services, educating communities about referral services, and linking volunteer-based services with CHO activities and clinical services at sub-district health centres and district hospitals. (Nyonator *et al*. 2005).

2.6 Theoretical Framework

2.6.1 Structural Functionalism Theory

The social world consists of the behaviors, interactions, and patterns of social organization among human beings. Sociological theory tends to focus on interaction and organization more than behavior as such, but interactions are interpersonal behaviors, and patterns of social organization are ultimately built from interactions among individuals. Sociological theory is a set of assumptions, assertions, and propositions, organized in the form of an explanation or

interpretation, of the nature, form, or content of social action. Sociological theory is defined as a set of interrelated ideas that allow for the systematisation of knowledge of the social world. This knowledge is then used to explain the social world and make predictions about the future of the social world (V. SEMESTER, 2011). The sociological perspective describes community as a group of people united by at least one common characteristic i.e., location (geographic boundaries), connectors (shared interests, activities, values, experiences, motivating forces, or traditions), or people (socioeconomics and demographics, health status and risk profiles, cultural and ethnic characteristics) (Centers for Disease Control and Prevention, 1997).

Community participation can be located within the broader subject – matter of sociological theory or perspective. The community health care Preventive and services (CHPS) does not exist in isolation from other relevant health care giving system in the society. It is perceived as an integral part of a network of interrelated system with definite functions and roles towards maintaining the whole. Against this background that this study will utilize the structural functionalism theory developed by Radcliff – Brown (1952) to explicate primary health care in society. Schultz and Lavenda (1995: 396) argued that structural functionalist theory explores how a particular social forms function from day to day in order to reproduce the structure of the society so as to maintain the whole system. According to Durkheim (1893) in a society there are different structures which function interdependently in order to maintain solidarity, equilibrium and social stability which society strives to maintain.

Functionalism is a sociological paradigm that originally attempted to explain social institutions as collective means to fill individual needs especially social stability. There are institutions which are the major aspect of the social structure. Community participation as well as the CHPS concept in this case is viewed as a structure that interrelates and is interdependent on other structures in society such as political and economic structures to bring harmony, specifically within the context of the whole health care system. In this modern form, the concepts of

community participation took shape in the 1950s (Chowdhury, in Middlemiss, 2009).

It is therefore vital to pay closer attention to who is participating, in what and for whose benefit. The utilization of non-professionals through citizen involvement mechanisms to address social problems has become more a common place in community interventions (Kaufman and Poulin, in Middlemiss, 2009). The district Assembly fails to perform their function of providing the needed logistics and facilities. On the other hand if community members are not on the known on the decisions regarding the implementation process and as a result no durbar is organized for the community members to be aware of the existence of the CHPS programme.

Community participation in development dates back to the 1970s when it was seen as an important component of rural development and basic needs strategy. It was in 1973 under the leadership of Robert S. McNamara, that the World Bank adopted "new directions" in rural development policy with community participation as one of the key elements. In his policy speech, McNamara said, "No programme will help small farmers if it is designed by those who have no knowledge of their problems and operated by those who have no interest in their future" (McNamara, 1973:26 cited in Wombeogo, 2014)

2.7 Definition of Terms

For the purpose of this framework, a working definition of community participation by Home Office (2005) proposed that Community participation is a process of involving, at various levels of participation, empowerment and capacity, groups of citizens affiliated by geographic proximity and/or special interest and/or similar situations to address issues affecting the well-being of those citizens. Community members initiate and direct the works and efforts of the community regarding the CHPS programme.

Definition of roles: Community members, district health monitoring team and the other stakeholders define and solve problems together.

Bridging the gap: Community members' roles become institutionalized in the CHPS programme, creating a pathway for mutual information sharing and feedback.

Stakeholders' consultation and influence: There is comprehensive consultation and influence thus the Ghana health service monitoring team asks members for ongoing and more substantive inputs.

Periodic checks on inputs: district health monitoring team asks community members for periodic input on specific topics regarding the progress of the CHPS programme.

Education: Education is provided by the Ghana health service to the community members concerning the CHPS concept.

Financial Access: Even though maternal healthcare services are free in all parts of Ghana, low-income mothers still lack access to healthcare because they do not have money to transport themselves and their children to health facilities especially during referral (Kaiser Commission, 2000).

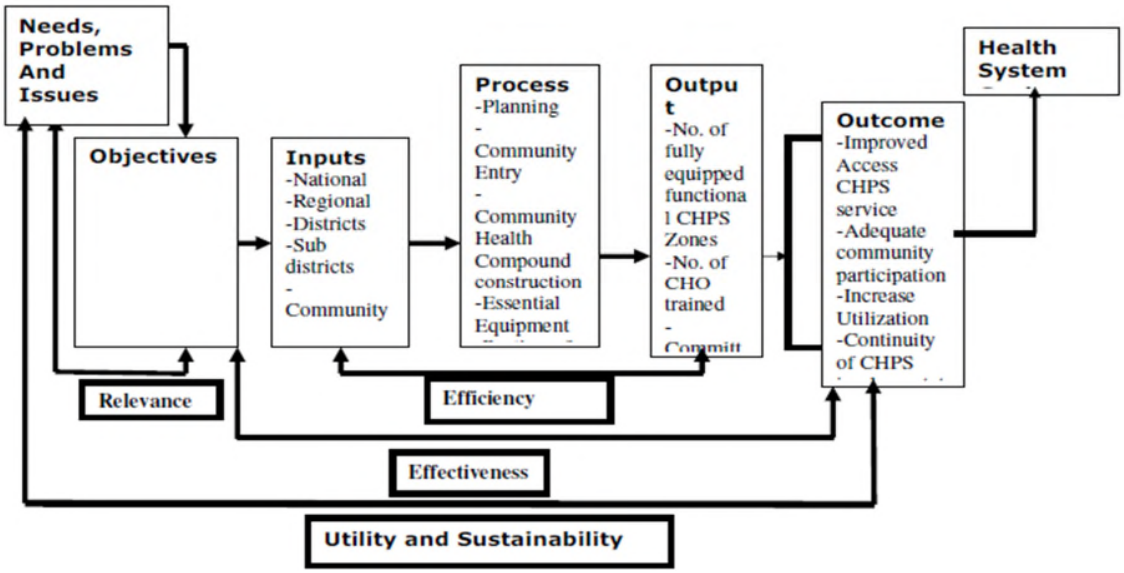
Limited Community Mobilization Skills for CHOs: Community participation and mobilization component of the CHPS programme is completely absent in the programme leading to more static and curative services. (Annual health Report, 2009)

Issues related to new health initiatives: Introduction of new initiatives such as High Impact Rapid Delivery (HIRD) need to clarify the role of CHPS so that it is not implemented in a way that contradicts CHPS (Annual health Report, 2009). According to Annual Health Report the linkages and supportive mechanism must also be identified and clarified.

2.8 Conceptual Framework

A conceptual framework is a model that allows the researcher to explore the relationship among variables in a logical and prescribed fashion (Anderson, 1990). A conceptual framework is a model that allows the researcher to explore

the relationship among variables in a logical and a prescribed fashion (Anderson, 1990). The framework looks at the needs, problems and issues that brought the vision of CHPS, the objectives, the inputs, process and the output. The analysis is done using the following; Relevance; Efficiency, Effectiveness, Utility and Sustainability.



Source: European Commission Evaluation Tool, 2005

Relevance

The health needs varies from context to context and the target population should be considered when addressing these needs. When addressing a health intervention the health needs, problems and issues are used to formulate appropriate objectives to address the needs. The relevance of a health programme is the extent to which an intervention's objectives are pertinent to address the health needs problems and issues (EC, 2005).

Effectiveness

The effectiveness of a programme is the extent to which objectives set are achieved

Efficiency

Efficiency is the extent to which the desired effects are achieved at a minimum cost, time and resources (EC, 2005). It is simply the use of minimum input to obtain maximum output

Utility

Utility is the extent to which effects correspond with the needs, problems and issues to be addressed (EU, 2005). The usefulness of a health system depends on how well the problem, issues and needs in relation to health are addressed.

Sustainability

Sustainability means maintenance or institutionalization. A development programme is sustainable when is able to deliver an appropriate level of benefits for an extended period of time after major financial, managerial and technical assistance from an external donor is terminated (US Agency for International Development, 1988).

CHARPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methods and tools used in obtaining and analyzing the data for the study. Topics discussed under this chapter are the research design, type of study, area of study, target population and sampling techniques, sample size or unit of analysis, data collection tools and the methods for the analysis of data and ethical consideration. The discussion was focused on the rationale for adopting a qualitative and quantitative approach to the study (mixed method).

3.2 Study Area

The Kassena-Nankana East district is one of the 12 districts in the Upper East Region of Ghana. It was created out of the then Kassena-Nankana district in 2008. The district capital is Navrongo, which is 18km from Bolgatanga, the Upper East Regional capital. The district shares boundaries with the Builsa North district in the south, Bolgatanga municipality in the east, Kassena-Nankana West in the west and parts of the Northern Region in the south-east. The district lies between latitudes 〖10〗^030‟ and 〖11〗^000‟ north of the equator and between longitudes 1^000‟ and 1^030‟ west of the zero meridian and covers an area of 851.5 square kilometers and has an altitude of 200m - 400m above sea level. The land is relatively flat and passing through it from Burkina Faso is the White Volta River, which feeds Lake Volta (the world's largest artificial lake) in the Volta region south of Ghana. It covers about 129.1inches per kilometer square of Sahelian savannah with an estimated population of 109,944 (Codjoe, 2010).

The district is largely rural, with only 9.5% living in urban quarters. The population consists of two distinct ethno-linguistic groups: the Kassena forms 49% of the district's population, while the Nankani constitutes about 46%. The Builsa and migrants belonging to other ethnic groups make up the remaining 5%. The main languages spoken are Kassim and Nankam, with Builli being spoken by

most of the minority tribe. Despite the linguistic distinction, the population is, in many respects, a homogenous group with a common culture. The district has about six traditional paramount chiefdoms and is characterized by traditional forms of village organization, leadership and governance. At both the village and family levels, there is a strong traditional social structure which influences economic and social behavior. Male dominance is strong, constraining the autonomy of women and limiting their health decisions. For example, curative and preventive health care may not be sought without the permission of the male spouse or, in his absence, the head of the compound (Binka et al., 1999).

Presently, about a third of the people are Christian, 5% are Muslim and the rest profess the traditional religion. However, the dominant animist faith guides daily life, economic decisions, health beliefs and practices. This reliance on traditional medicine hampers the utilization of health services (Nyarko et al., 2001; Oduro et al., 2012). A Dam (Tono dam) is in the middle of the district provides water throughout the year for irrigation. Subsistence agriculture is the mainstay of the district‟s economy, complemented to some extent by retail trading. About 90% of the people are farmers. The major agricultural products are groundnuts, millet, guinea corn, rice, sorghum, sweet potatoes, beans and tomatoes. Rearing of cattle, goats, sheep, pigs, fowls and guinea fowls also form part of the agricultural activities.

The district has 77 primary schools, 35 junior secondary schools, 5 senior secondary schools, 1 training college and 2 vocational institutions. The district also accommodates the third faculty of the University for Development Studies, which focuses on integrated science. The main sources of water supply in the Kassena-Nankana district are streams, wells and boreholes. In a few urban houses, however, pipelines have been installed to provide treated water. The district has a hospital, six pro-health Centers and four clinics located in selected communities. These static health delivery points are complemented by community-based service delivery in all the communities. There are also the Navrongo Health Research Centre and a Community Health Nurses Training College that belong to the Ministry of Health. There is also a high prevalence of cerebrospinal

meningitis, with the peak season occurring between March and April. Schistosomiasis, lymphatic filariasis and onchocerciasis are endemic in the district (Amankwa et al., 1994; Gyapong et al., 1994).

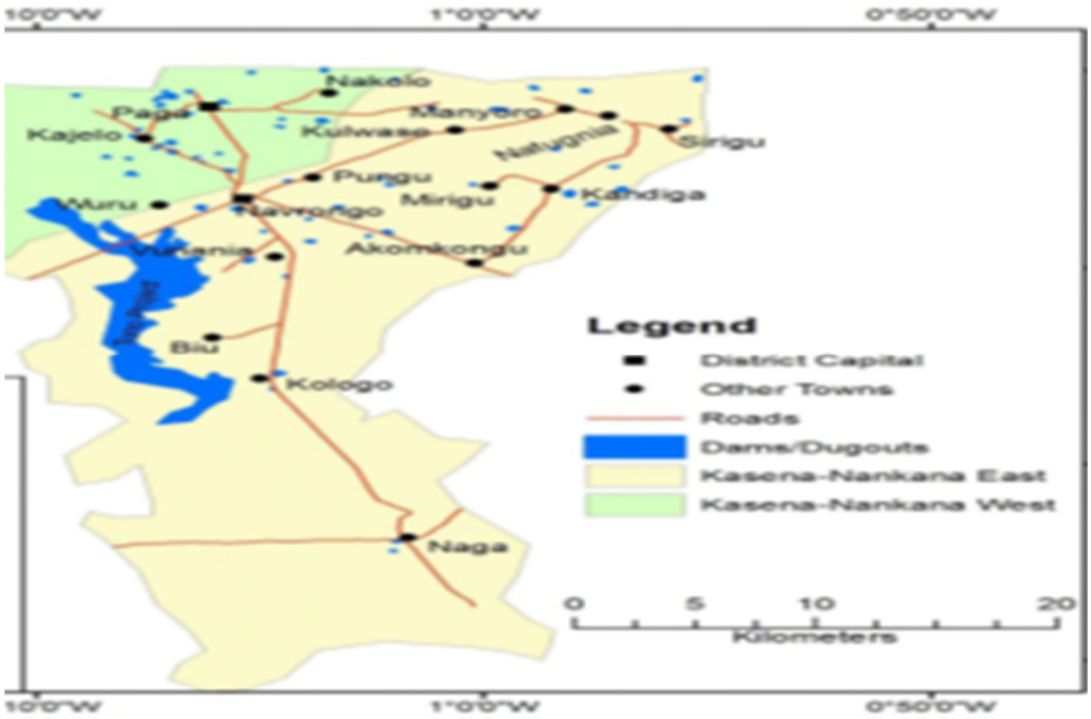


Figure 3.1: District map of Kassena Nankana East Municipality

3.3 Research design

Research design provides information about how the actual research is going to be carried out after the research method has been identified. According to Yin (2003), the research design is the action plan of the whole research process that guides how the research is going to be executed to answer outlined research questions. The study adopted a descriptive design and a mixed method in analyzing data. The researcher will adopt a descriptive design for the study. Descriptive designs are useful for examining "what is going on or what exists" (Trochim & Donnelly, 2007, p. 5) about a phenomenon.

The use of the descriptive approach will lead to a detailed examination of the obstacles that is hindering community participation in the implementation of the

CHPS programme. The core objective of the CHPS is that communities can be active participants in the provision of their own healthcare and that healthcare is provided at the doorstep of the rural people. CHPS programme encourages local community involvement, interaction, and participation in the delivery of their healthcare by determining the administration and direction of the healthcare delivery process based on their specific local circumstances, resources, and needs. Communities also provide voluntary services and resources for the establishment of community health facilities including the building of a Community Health Compound consisting of clinic and a place of residence for the CHO (Nyonator, Jones, Miller, Phillips, & Awoonor-Williams, 2005).

3.4 Target Population

The population of investigation may be considered as the total number of units of the phenomenon to be investigated that exist in the area of investigation. A population therefore is made up of sampling units (Kumekpor, 2002). On the other hand, a sample from a population or universe consists of that proportion of the number of units selected for investigation.

However, Kassena Nankana community has an estimated total population of about 109,944 (Codjoe, 2010). At both the village and family levels, there is a strong traditional social structure which influences economic and social behaviour. Male dominance is strong, constraining the autonomy of women and limiting their health decisions. For example, curative and preventive health care may not be sought without the permission of the male spouse or, in his absence, the head of the compound (Binka *et al*., 1999).

The District has quite a number of health facilities to meet the health needs of the people. The war memorial Hospital located in the Municipality (Navrongo) is the Municipal Hospital and a referral center to the other health facilities at the Zonal and community level (Ghana Statistical Service, 2014). The Municipality has 2 Health Centers, 17 functional CHPs compounds, 1 Health Research Centre, 1 Private Clinic and a Health post by the Catholic Mission (Ghana Statistical Service, 2014). Therefore the target population in this study will be opinion

leaders, community members' health workers or officers, community health volunteers, the Municipal Assembly, district health monitoring team and other stakeholders of the CHPS programme.

3.5 Sample size / unit of analysis

According to Kumekpor (2002) unit of analysis is the actual empirical unit, object or occurrences which must be observed or measured in order to study a particular phenomenon. The unit of analysis will be all the health officers and community members of the CHPS compound. For the purpose of this study, the researcher used a sample size of one hundred (140) respondents from the target population. Community members will be selected from four (5) communities with twenty (20) respondents to be selected from each community; twenty (40) respondents will be selected from the health professionals with eight (8) from each CHPS Zone in the Kassena -Nankana community.

3.6 Sampling Technique

For the purpose of this study, the researcher used both probability and non-probability sampling techniques, thus purposive sampling and simple random sampling were used. The simple random sampling method was used in selecting the community members and a purposive sampling was also used in selecting the health workers because they are professionals. The justification for the purposive sampling is that the health workers are professionals and as such have in-depth knowledge as far as this study is concerned. While simple random sampling method was used by stratifying or grouping the community members in groups of four (4) and thereafter samples of 20 members were randomly selected. This was undertaken to eliminate as much as possible biases and make the findings more representative.

3.7 Method of data collection

The methods that were used for obtaining primary data were self-administered questionnaire and in-depth interview. Self-administered questionnaire was used for quantitative data collection. This was adopted because the literates can express

themselves very well and to as much as possible save time. Secondly, respondent who have no formal education, the questionnaire will be explained to them in their local language thus Kassem and Nankana. In-depth interviews were conducted to supplement the quantitative survey to obtain additional information to buttress the responses that were gathered from the questionnaires.

3.7.1 Source of data

Data will be obtained from both primary and secondary sources. On the part of the primary data, information will be collected from the field through the respondents. The secondary source of data were obtained from both published and unpublished materials, articles, text books, periodicals as well as the internet.

3.7.2 Method of data Analysis

The quantitative data were entered into a computer and analyzed using SPSS version 20.0 and Microsoft Office Excel 2010. SPSS was used for the construction of tables, while Excel was used for the graphs because it is easy calculating the percentages and also the graphs are more presentable. During the process of analysis, frequencies and percentages of different variables were determined to determine the association of these selected variables. Qualitative data were transcribed and translated under themes based on the question guides and summarized manually, thus qualitatively, all responses from the interview guide were summed up and references were drawn to arrive at a generalized conclusion.

3.8 Ethical consideration

The researcher sought the consent of the opinion leaders, Chiefs and other stakeholders who were relevant to this study. The author also assured respondents of confidentiality and anonymity. The purpose of the research was also made very clear to the major actors in the research process and their consents and views taken on board. This was deemed necessarily due to the fact that the study is health related and respondents needed to be fully aware of its purpose, in order that doubts were not invoked in their minds that could affect the outcome of the research.

3.9 Study Limitations

A number of issue emerged at various stages of the research that proved daunting and threatened to limit a comprehensive and more efficient execution of the study. First and foremost were financial constraints which limited the researcher in trying to cover more grounds in terms of selecting a higher sample that would have been more representative. However, with a thorough sampling procedure, it was hoped that the issue of representativeness was addressed.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents the analysis of the empirical data obtained from the field. The first step was to transcribe the entire questionnaire and interviewing. This provides a completed and facilitates analysis of the data. Issues discussed include the participation of community members in decision making in healthcare delivery, knowledge of the concept of the CHPS by community members as well as the contribution and challenges in the implementation of the CHPS programme in the Municipal. A total of 175 questionnaires were administered and two interviews were conducted, mainly with the Municipal health director, and the Municipal CHPS coordinator. The responses have been analyzed below;

4.2 Demographic Characteristics

Table 4. 1 Demography of Respondents Gender, Marital Status, Education & Occupation

Name	Description	Frequency	Percent
Gender	Males	67	45.9
	Females	77	52.7
Marital Status	Married	53	36.3
	Separated	12	8.2
	Divorced	9	6.2
	Widowed	10	6.8
	Never Married	59	40.4
Educational Attainment	None	20	13.7

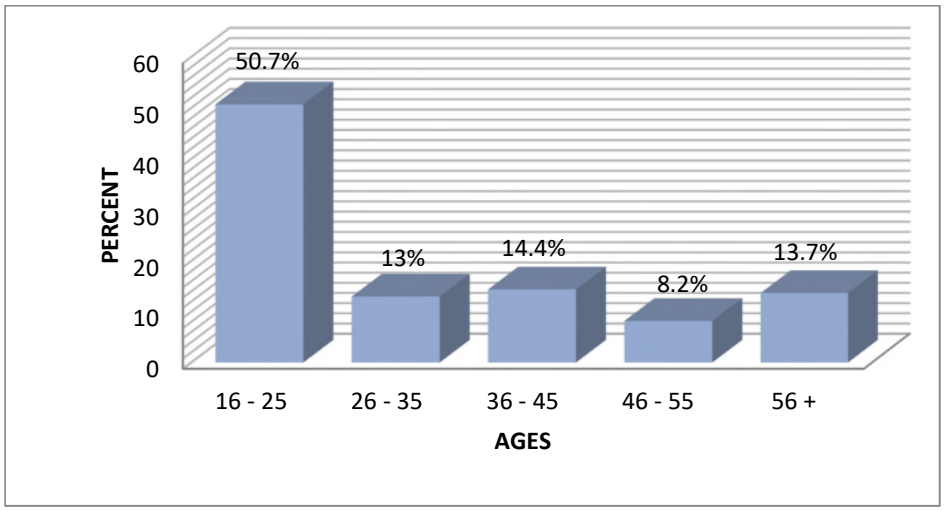
	Primary	23	15.8
	J.H.S	21	14.4
	S.H.S	59	40.4
	Tertiary	19	13.0
	Other (s)	10	1.4
Occupation	Gov't Emp.	10	6.8
	Private Emp.	17	11.6
	Trader	24	16.4
	Farmer	15	10.3
	Student	58	39.7
	Unemployed	18	12.3

Source: Field Survey, 2016

Issues related to health affect everyone irrespective of one's gender, marital status, education or occupation. This is the reason why as part of the questions, the researcher asked questions related to respondents' gender, marital status, education and occupation. From table 4.1, the findings revealed that majority of the respondents were females representing 52.7% whiles males constitute only 45.9%. On marital status, most of those interviewed confirmed they never married or are married representing 40.4% and 36.3% respectively. The least (6.2%) of respondents indicated they were previously married but now divorced. From the table 40.4% out of the total sampled respondents also reported they have attained Secondary Education, while 15.8% indicated that they have attained primary education. Those who have never gone to school constitute 13.7%. This may be attributed to the lack of social amenities in the selected communities. More so, the findings reveal that of the total respondents, 58 of them representing 39.7% are students whiles 16.4% are traders.

Age of Respondents

The age of respondents is very relevant to the subject under study as it shows the age groups who are active in community participation On respondents' age, out of a total of 146 respondents the findings reveal that most of them fall within the youthful bracket of 16 to 25 years representing 50.7% whiles 14.4% fall within the 36 to 45 years category. This implies that the most respondents to this study were at a youthful age. Figure 4.1 and Table 4.2 illustrate the age of respondents.



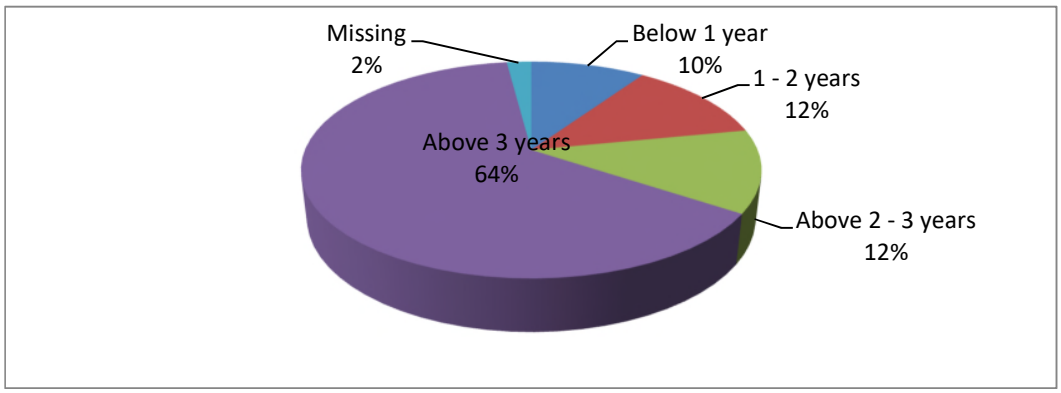
Source: Author's field Survey, 2017

Figure 4. 1 Age of respondents.

4.3 - The Implementation Process of the CHPS Programme

Programme existence

Majority of respondents (64%) indicated that the programme has been in existence for over three (3) years in the community. Also, 12% of respondents indicated it has being in existence between two (2) and three (3) years. Whiles other 12% indicated between one and two years, only 10% indicated that it has being in existence below one year. The disparity in responses may be linked to either a disconnect between implementors and community or poor education and sensitization.



Source: Field Survey, 2016

Figure 4. 2 Existence of CHPS Programme

4.4 Level of Knowledge on Existence of CHPS in the Community

For the programme to be successfully implemented and for it to achieve its initial intent, community knowledge is very relevant for collaboration and support. One major issue that arose was that in all the communities visited, no CHPS zone had an action plan. From table 4.3, most of the respondents (93.2%) indicated that they have knowledge on the existence of the CHPS programme. This finding is contrary to that of Nyonator *et al.* (2005) who found that there was inconsistent understanding of the CHPS concept and weak partnership among stakeholders. This finding suggests that activities that are characteristic of the health sector bureaucracy are more readily scaled up than activities such as community mobilization. Moreover, the omission of community-entry activities by District Health Monitoring Team suggests that the concept of CHPS is not well understood, since community participation, mobilization and ownership is central to the system reform process. While community participation is not a new concept, concerns with involving community in government decision-making processes including lack of clarity about how to involve people in decision-making processes have existed (Government of Western Australia, 2006). These

obstacles are real and need to be considered and addressed in most community engagement initiatives as opined by the Canadian Policy Research Networks and Ascentum (2005).

This is illustrated in table 4.3 below

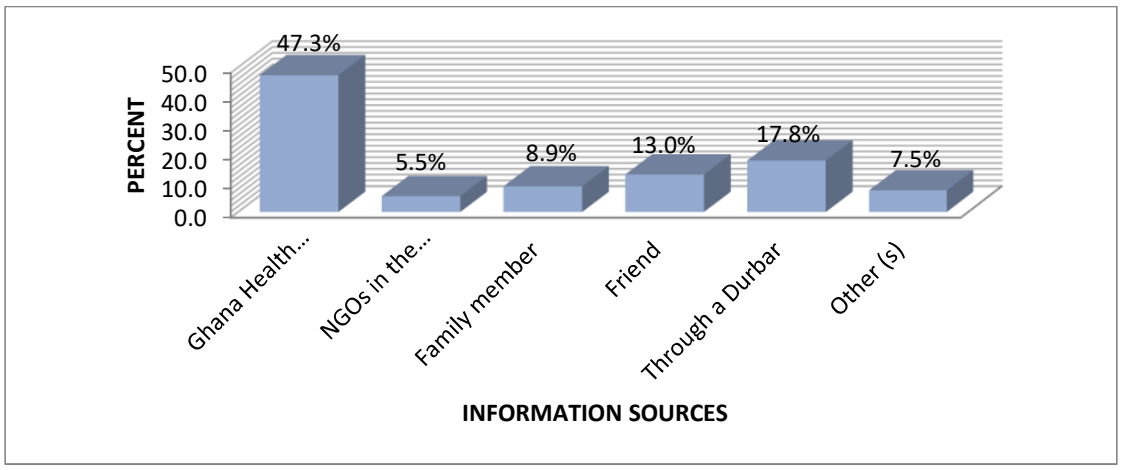
Table 4. 2 Existence of CHPS in Community

Description	Frequency	Percent
Yes	136	93.2
No	10	6.9
Total	146	100.0

Source: Author's Field Survey, (2016)

Sources of Information

With regards to the sources of information on the CHPS programme, 47.3% of respondents indicated that they receive the information through the Ghana Health Service. Also 17.8% and 13.0% reported that they receive information through Durbars and Friends respectively. Only 5.5% of the total respondents indicated that they receive information through the Non-Governmental Organizations in the Communities.

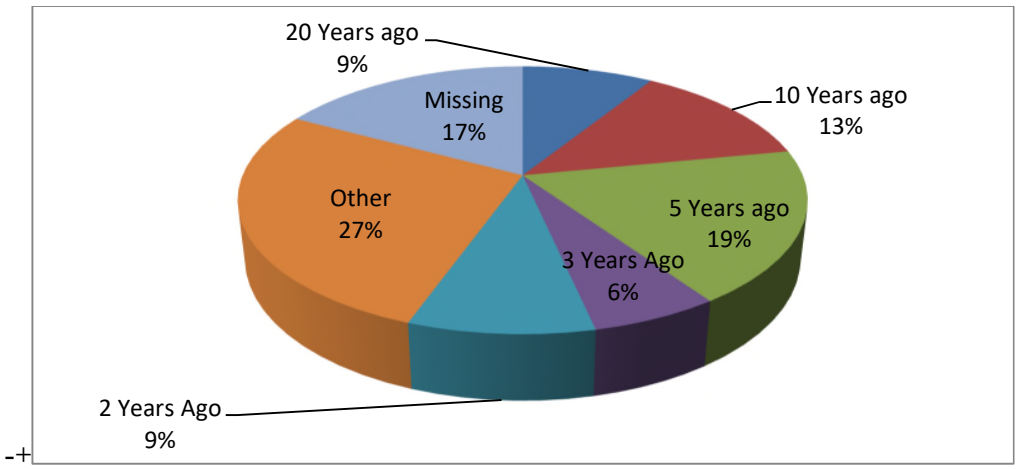


Source: Field Survey, 2016

Figure 4. 3 Sources of Information

Initial Knowledge of the CHPS Programme

On initial or previous knowledge of the CHPS before its existence in the communities, majority of the respondents (27%) reported that their initial knowledge of the programme is due to other time periods other than 20, 10 or two (2) year periods. Figure 4.4 illustrates this result;

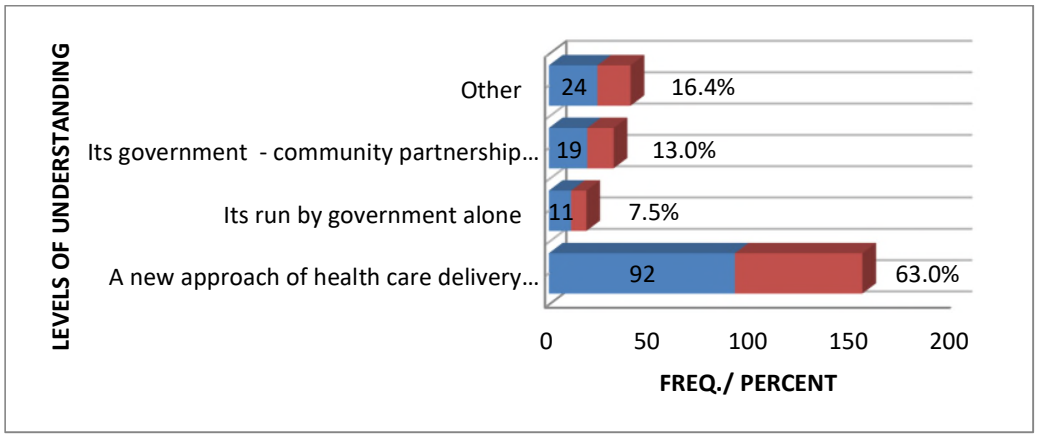


Source: Field Survey, 2017

Figure 4. 4 : Initial Knowledge of the Programme

Level of understanding of CHPS Concept

Also, respondents were asked on their level of understanding of the CHPS concept. This was necessary to know need for participation and knowledge. Most of the respondents (63%) reported that it is a new approach of healthcare delivery by government. Secondly, 16.4% indicated their level of understanding of the concept is attributed to other factors or issues whiles only 7.5% revealed that it is run by the government. The figure next illustrates this resuts;



Source: Field Survey, 2016

Figure 4. 5 Level of understanding of CHPS concept

Community Entry of the CHPS programme

Upon the commencement of the CHPS programme it is necessary for an appropriate community entry process to take place in every beneficiary community. When asked how this was undertaken, 56 (38.4%) respondents revealed that it was undertaken through the gathering of chiefs and Health officials. Secondly, whiles 37 (25.3%) of them indicated that it was through opinion leaders and health officials, 35 (24%) revealed it was carried out through a Durbar. Table 4.4 presents the results of this finding;

Table 4. 3 Community entry of CHPS programme

Description	Frequency	Percent
Gathering of Chiefs and Health Officials	56	38.4
Gathering of opinion leaders and Health Officials	37	25.3
Through a Durbar	35	24.0
No involvement of people	7	4.8
Other (s)	11	7.6
Total	146	100.0

Source: Field Survey, 2017

4.5 level of community participation and involvement in decision – making of the CHPS programme

Decision Makers of CHPS programme; District health directorate, Chiefs, Opinion leaders Members of the Municipal Assembly as well as Civil Society Organizations. Community involvement and participation are key elements of the community health officer(CHO) and the community health volunteer(CHV) working relationship, with communities developing and managing their local health governance system through a health committee overseeing and supporting CHVs (Tapsoba *et al*. 2012). The author further stipulated that in the CHPS implementation however, community entry and mobilization are often ignored, with CHOs posted to CHPS zones without community members' prior

knowledge. Findings from the field revealed that, majority of the respondents (74.6%) are not directly involved in decision making.

Table 4. 4 Involvement of Respondents in decision making

Description	Frequency	Percent
Yes	37	25.3
No	109	74.6
Total	146	100.0

Source: Field Survey, 2017

4.6 Whether the CHPS programme is really fulfilling the initial intent of providing accessible health care to the rural people

Opinions as to whether the CHPS programme is fulfilling its initial intent or objective indicate that, about 96.6% of respondent agree that the entire programme has indeed fulfilled its initial intent of providing accessible health care to the rural people. Only 3.4% of the respondent did not provide answers to this question. The results are presented in table 4.7;

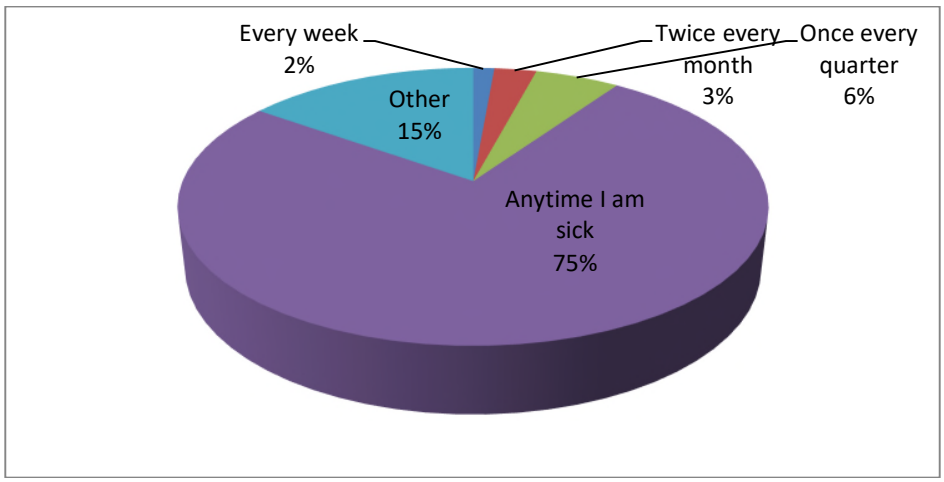
Table 4. 5 Opinions on whether Respondents have ever visited the CHPS compound

Description	Frequency	Percent
Yes	141	96.6
Missing	5	3.4
Total	146	100.0

Source: Field Survey, 2017

Additionally, respondents were also asked the number of visitations to the CHPS compound. In responds to this, majority of them (75%) indicated that they visit the compound anytime they are sick whiles 15% reported that they visit the

compound due to other reasons aside health grounds. The results are presented in the figure below;



Source: Field Survey, 2017

Figure 4. 6 4.5 Number of visitation to CHPS Compound

Preferences to CHPS

One hundred and twenty eight (128) respondents representing 87.7% indicated that they prefer CHPS to other health facilities. Their preference was due to the fact that they offer better services, services are affordable, and that's the only option and proximity to their homes. However, 12.4% indicated otherwise. The results are shown next;

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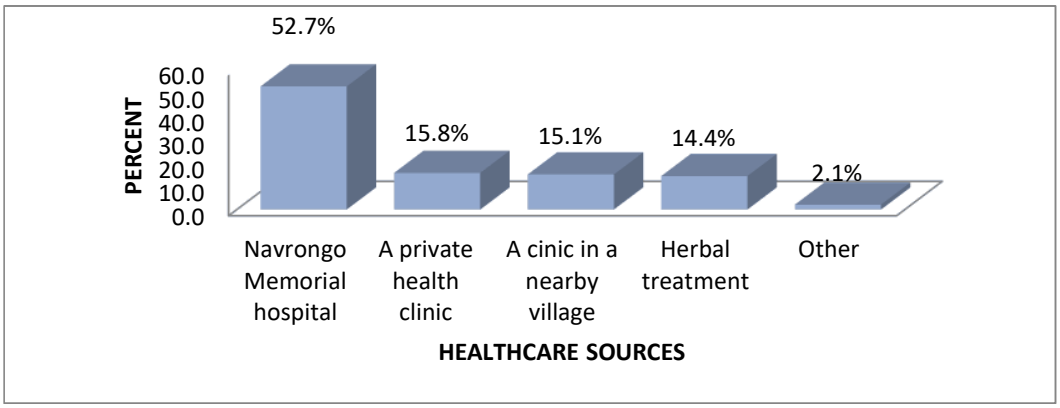
Table 4. 6 Preference of CHPS to other Health facilities

Description	Frequency	Percent
Yes	128	87.7
No	18	12.4
Total	146	100.0

Source: Field Survey, 2016

Source of healthcare before CHPS establishment

Like other communities, the selected communities within the Kassena-nankana district are expected to really on other sources for healthcare which may be traditional or non-traditional. However, most respondents (52.7%) indicated that they mainly relly on the Navorongo Memorial Hospital for healthcare before the establishment of the CHPS. Other respondents also indicated that they resort to private health clinics and herbal treatments representing 15.8% and 14.4% respectively. Figure 4.6 presents the results of this findings;



Source: Field Survey, 2016

Figure 4. 7 Source of healthcare before CHPS establishment

Ever being visited by community health Volunteer

During the interview, respondents indicated that they are aware of the presence of community health volunteers in the community. However*, 81.5% of them reported that they have ever been visited by them whiles 18.5% indicated that they have never visited them. The table below illustrates this finding;

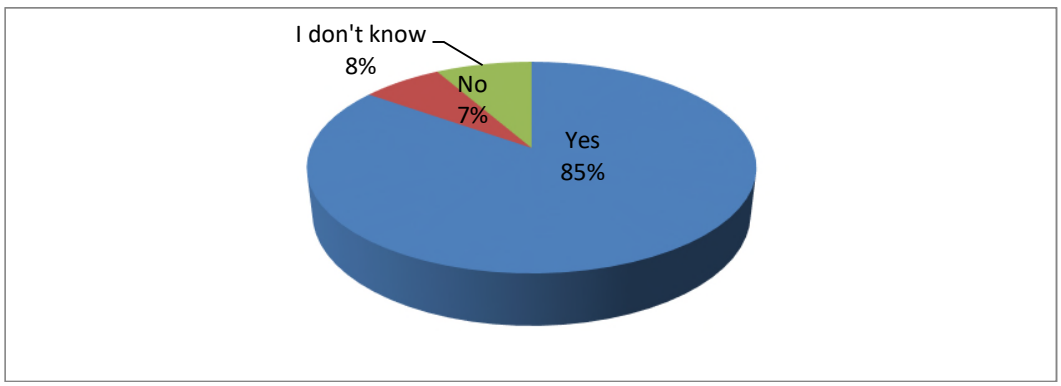
Table 4. 7 Ever being visited by community health Volunteer

Description	Frequency	Percent
Yes	119	81.5
No	27	18.5
Total	146	100.0

Source: Field Survey, 2016

Knowledge on Impact of Community Health Volunteerism

On knowledge on impact of community health volunteerism, 85% of the respondents asserted that they have indeed impacted positively on their health. Also, 8% indicated no knowledge on the impact whiles 7% reported that they have not impacted on the individual and or community. This they explained is the main course for patronizing other healthcare facilities other than CHPS. Figure 4.8 present findings on this;



Source: Field Survey, 2016

Figure 4.8 Figure 4. 8 Knowledge on Impact of Community Health Volunteerism

Relationship between Community Members and Volunteers

They author with the quest to unravel programme impact asked respondents their relationship with the community health volunteers. These volunteers are those who serve as link between the prgramme and the community by way of service provision. In response to this, about 78% of the respondents indicated that there is generally a good relationship with these volunteers. Further, 12% and 9% of responses also indicate reluctance or failure to state a reason and a very good relationship respectively. The figure below illustrates this finding:

Source: Field Survey, 2017

Figure 4. 9 Relationship between Community Members and Community

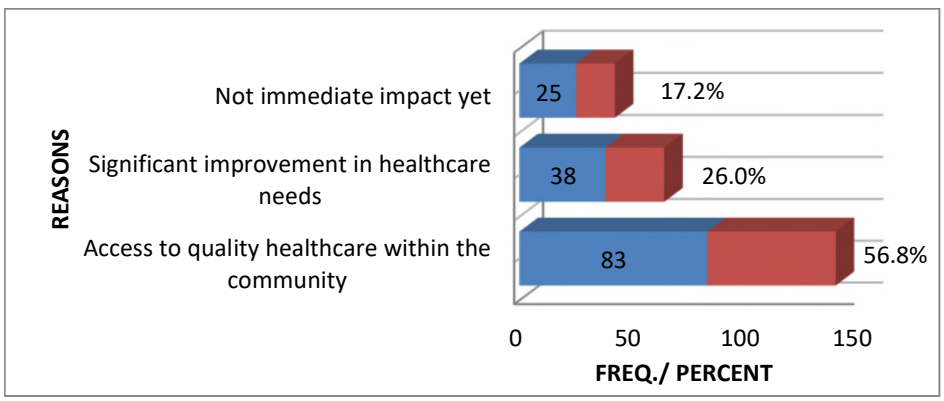
Table 4.12 indicates results of responses on the performance of the CHPS programme. From the table, 74% of the responses indicate that the CHPS programme have had positive effects on the individual within the community. Whiles some (14.4%) reported that contrary to the above they have not experienced any improvement yet others (11.7%) also indicates that they are not sure of the effects of the programme.

Table 4. 8 Positive effect of CHPS on the individual

Description	Frequency	Percent
Yes	108	74.0
No	21	14.4
Not sure	17	11.7
Total	146	100.0

Source: Field Survey, 2017

From the finding on programme performance, there was the need to find out the reasons for the effectiveness of the CHPS programme. The essence of this was to establish whether or not the claims made by respondents on programme effectiveness were entirely true. Owing to this, Figure 4.10 shows that 56.8% of the respondents linked their earlier assertion to improved access to quality healthcare within the communities' whiles only 25 respondents representing 17.2% reported that there is no immediate impact yet. The implication of this is that perhaps not all community members utilize the facility.



Source: Field Survey, 2017
Figure 4. 10 Reasons for the Effects

Community Participation in the CHPS programme

Table 4.13 illustrates opinions of respondents on whether or not community members are involved in the CHPS programme. Majority of the respondents 90 (61.7%) indicated that community participation is low as far as the CHPS is concerned. When asked of the reasons why they indicated such, some linked this to lack of education on the overall concept whiles others resorted it to total neglect by programme officials.

Table 4. 9 Respondents Participation of CHPS programme in the community

Description	Frequency	Percent
Yes	56	38.4
No	90	61.7
Total	146	100.0

Source: Field Survey, 2016

Respondents' View on Whether CHPS has improved access to Healthcare

The opinions of respondents on this revealed that indeed the CHPS though not entirely effective has improved access to health. Table 4.10 indicate this view;

Table 4. 10 Opinions on whether CHPS has improved access to healthcare delivery in the community

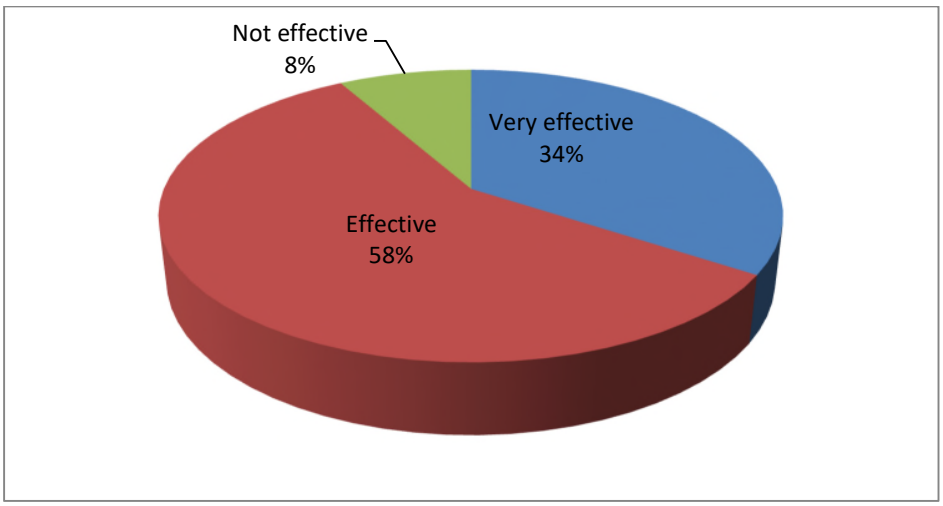
Description	Frequency	Percent
Yes	134	91.8
No	12	8.2
Total	146	100.0

Source: Field Survey, 2017

Access to health facilities in the rural areas by UNDP Report (2007) indicates is a major challenge for rural inhabitants. Among the regions in Ghana, the Upper

East and West Regions enjoy the least. While Ministry of health (2006) iterated that at the community level, great strides have been made in recent years, with the government committing itself, to moving health care from established facilities of which there are woefully few, directly to communities as CHPS.

For beneficiaries to receive services as intended by the programmes policy document there is the need for the CHPS to deliver effective (right) services to the community members. On this, the author asked respondents on how they view the effectiveness or otherwise of the programme. In response, about 58% of them assert that indeed the programme is effective. Also, 34% and 8% of respondents indicated that the CHPS programme is very effective and not effective respectively. When asked why they rated the programme as not effective, some respondents linked this to poor service delivery due to non-availability of health professionals, absence of supervisors, no government support among others. The figure below illustrates this result;



Source: Field Survey, 2016

Figure 4. 11 Effectiveness of CHPS programme in improving health delivery in the community

4.3 Challenges Facing the CHPS Programme

Information gathered from the field indicates that although the CHPS programme is considered by policy makers, development partners and public health providers as a good pro-poor health service delivery strategy, particularly in rural areas it is faced with some form of challenge(s). Evidently, healthcare providers' specifically maternal healthcare professionals are not available everywhere and for everyone. Another barrier to healthcare in the communities is the primary care provider availability and distribution. Another barrier to healthcare is primary care provider availability and distribution a phenomenon referred to as health professional shortage areas or medically underserved areas (Issah, 2008). With regards to challenges respondents face in interacting with community health officers, majority of the respondents indicated that they do not face any challenge (s) representing 79.5% whiles the rest 20.6% reported that they encounter challenges when interacting with community health officers. The implication of this is that challenging that people face may in a way result in the abandoning of the CHPS services and focusing on other areas for healthcare.

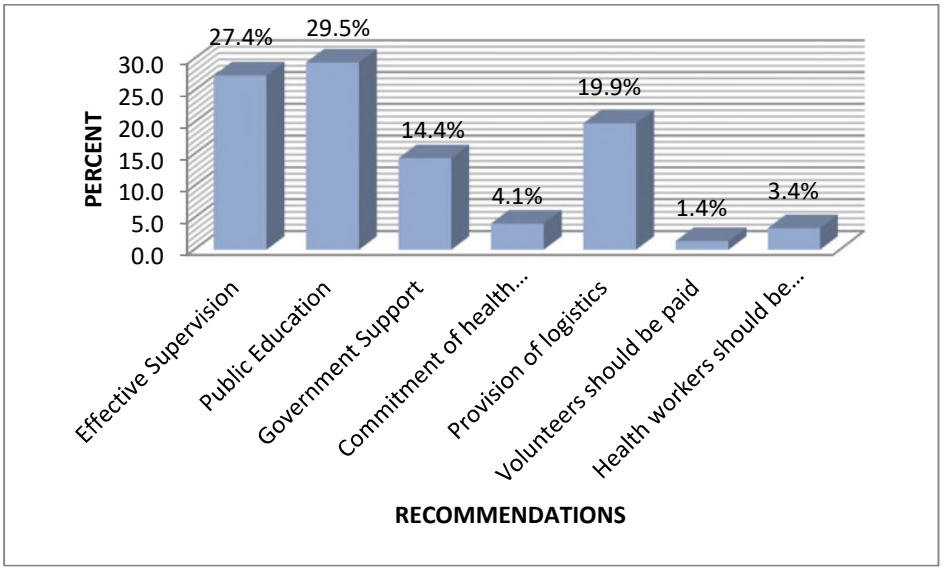
Table 4. 11 Challenges in interacting with Volunteers

Description	Frequency	Percent
Yes	30	20.6
No	116	79.5
Total	146	100.0

Source: Field Survey, 2017

4.8.1 Recommendations for Improving the CHPS Programmeme

On recommendation for improving the CHPS programme, majority of the respondents representing 29.5% indicated that public education of the programme is very necessary and hence deserve attention. Also, 27.4% indicated that effective supervision is needed for the programme to deliver its services as expected. Only 1.4% of respondents revealed that volunteers should be paid in order to improve their service delivery. Figure 4.13 illustrate this finding;



Source: Field Survey, 2016

Figure 4. 12 Recommendations for the improvement of CHPS programme

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents summary, conclusion and recommendations of the study. Attention is given to the major findings and conclusions. Appropriate recommendations from the study are highlighted to show the extent of community participation in in the CHPS programme.

5.1 Summary of Major findings

This study has assessed the extent of community participation in CHPS programme in health care delivery within the Kassena Nankana district in the Upper East Region of Ghana. It uncovered the implementation process of the CHPS programme. It also examined the knowledge and understanding on the CHPS as well as community participation in relation to decision making processes. The study also assessed whether or not the original intent of the programme is being achieved as well as its overall performance. The CHPS programme has largely impacted positively on the health of community members. However, during the course of this research work, the study was divided into five chapters for the purpose of clarity.

On the implementation process of the CHPS programme it was revealed that opinion leaders were inform of its establishment and aside, respondents expressed their knowledge on the fact that it has existed for over a year. Also most of the respondents reported that they have knowledge of the CHPS concept and understand the concept as well. However, it was revealed that community members do not participate fully in the decision – making of the CHPS programme. Some were of the view that they are completely neglected in the process. Additionally, the CHPS programme is fulfilling the initial intent of providing accessible health care to the people in the selected communities and by so doing the author can conclude that although the CHPS programme is bedeviled

with some challenges, it has significantly impacted positively on the health of the people in the district.

5.3 Conclusion

The study is conclusive in its findings that roll out of the programme has been rather erratic with no conscious efforts at educating the beneficiaries to let them understand the significance of the programme. Findings also suggested that although majority of the respondents are aware of community volunteers, their services was not felt by all. On knowledge and understanding, it can also be concluded that even though individuals have considerable knowledge of the programme, they really don't understand the various services that the CHPS render. The implication is that it may be the reason community members may resort to other facilities for healthcare. Hence, sources of information such as the electronic media (television and the radio) could prove very crucial in educating people.

It could further be concluded that the CHPS have largely contributed significantly to the health of the people of the Kassena Nankana District. However, with high poverty levels outbreak of diseases as well as maternal mortality could retard efforts of the programme if not well supported by government.

5.4 Recommendations

On the basis of the findings of the research, the study would like to make recommendations, which could be considered by stakeholders and the communities at large;

On the knowledge and perception of the programme, it is recommended that programme implementers should undertake more education on the benefits and how to access the programme be intensified using such outlets like the radio and community durbars, since traditional thinking and superstition still rule the minds of a section of the population regarding modern health facilities (Non-traditional).

In the same vein, high risks zones should be targeted by health officials in citing CHPS. Additionally, high risk demographic categories should be located with

particular focus on the youth and pregnancy cases. When done, this will prevent patients from seeking healthcare from nearby and far communities.

Adult education should be organized periodically and encouraged by opinion leaders and health officials within these communities. This must focus on first aid and use of drugs recommended by the facility so that community members will be abreast with these issues and not put burden on the facility.

It is further recommended that, for occupational and group-based categorizations, particular attention be paid to farmers, traders and students who based on the sample selection seem to be the most vulnerable in terms of accessibility. Particularly on students, schools within the district should be encouraged to organize orientations based on pressing health issues like HIV and AIDS.

There is the need for civil society organizations to collaborate or support efforts by government to extend healthcare to those in rural communities. This when done, will eradicate the challenge of relying solely on government to certain emergency cases.

5.5 Suggestion for further Research

However, since time and resource constraints did not allow for a bigger sample, the study recommends that further studies be done on other communities within the district to see whether reporting rates on implementation, knowledge, performance of the CHPS programme among the selected communities in comparison with other communities could result in similar patterns.

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APPENDICES

APPENDIX A:

This is a questionnaire from an MSc Final year student of the above-named Department of the University for Development Studies, Wa Campus to seek your candid views *"Assessment of Community Participation in Community –Based Health Planning and Services (CHPS) In Health Care Delivery:A Case Study of the Kassena – Nankana District Of Ghana"*

All responses will be treated with all confidentiality and will be used only for academic purposes. Your participation is appreciated.

Please, tick where appropriate

PART A

PERSONAL DATA

1. Name of community……

2. Age of respondent……

3. Gender (1) Male [ ] (2) Female [ ]

4. Marital status: (1) Married [ ] (2) Single [ ] (3) Divorced [ ] (4) Widow [ ]

(5) Widower [ ]

5. Educational Background: (1) No Education [ ] (2) JHS/Middle School [ ]

(3) SHS/Voc/Tec [ ] (4) Tertiary [ ]

6. Number of years in this community……

7. Ethnicity……

8. Number of people in household……

9. Main economic activity…….....

PART B

The Implementation Process of the CHPS Programme

10. Is there CHPS in the Community?

a. Yes b. No

12. If yes, for how long has the programme existed in the community?

a.below 1 year b.1-2years c. above 2-3years

13.Where do you receive information about CHPS programme?

a. Ghana Health Service b. NGOs c. Family Members d. Friend

e. Durbar f. Others

Initial Knowledge of the CHPS Programme

14. Since when did you hear about the CHPS Programme?

Please indicate.....

15. What is your understanding to the CHPS programme in your community?

Explain in your opinion.....

.....

.....

16. How was the projects Community entry done?

Please state.....

.....

Level of Community Participation and Involvement in Decision – Making Of the Chps Programme

17. Were you involved in the decision making process?

a. Yes b. No

18. Have you ever visited the CHPS Compound?

a. Yes b. No

20. If yes, how many times have you visited the CHPS?

a. Twice every month b. Every week c.Once every quarter d. anytime am sick

21.Do you prefer the CHPS to other Health facility?

a. Yes b. No

22. If yes what are the reasons.....

.....

23. What was your source of healthcare before CHPS establishment?

a. Navrongo hospital b.A private clinic c. Herbal treatment d. other.....

24. Have been visited by any health Volunteer?

a. Yes b. No

25. Does their visitation have any form of impact?

a.Yes b.No

26.Kindly rate the relationship between the community and the volunteers

a.Very good b.Good c.Bad d.Can't tell

27.The CHPS has a significate positive effect on the individuals?

a.Yes b.No c. Not Sure

28. The CHPS service delivery is.....

a. Very effective b. Effective c. Not effective

29. Kindly provide reasons for your response @28 .....

.....

.....

Effects and Challenges of CHPS

30. What have been the effects of CHPS on healthcare delivery in the Community?

.....

..

31. What are the benefits/importance of CHPS to healthcare delivery?

.....

32. What factors impede the activities and operations of CHPS?

.....

33. What efforts are being made by the Community to improve CHPS?

.....

34.Kindly state some of the challenges encountered in interacting with the volunteers.....

.....

31What recommendations can be made to improve the CHPS programme?

.....

.....

Thank you..