

UNIVERSITY FOR DEVELOPMENT STUDIES

CHPS INITIATIVE: CHALLENGES AND OPPORTUNITIES TO IMPROVING RURAL ACCESS TO HEALTH SERVICE DELIVERY IN THE LAWRA DISTRICT.

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BY

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**THESIS SUBMITTED TO THE DEPARTMENT OF PLANNING AND
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OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF PHILOSOPHY
IN DEVELOPMENT MANAGEMENT**

JANUARY 2015

DECLARATION

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

Candidates Signature..... Date.....

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Supervisors Declaration

I declare that the preparation of the thesis was supervised in accordance with the guidelines on supervision of dissertation/thesis laid down by the University for Development Studies.

Principal Supervisor's Signature Date.....

Name: **DR ERNEST Y. KUNFAA**



ABSTRACT

Adequate coverage and efficiency of public health services are high priorities for sustainable growth and development. In many countries, public healthcare continues to fall short of demand, and remains unevenly distributed among the population. Some 70 per cent of the Ghanaian population resides in communities that are over five (5) kilometers from the nearest health facility, where childhood mortality is 40 per cent higher than in communities located within five (5) kilometers of health facilities. Also, there is a great disparity in health status between urban and rural areas. This disparity is caused by poor geographical access and service delivery barriers.

Results from an experiment of the Navrongo Health Research Centre demonstrated that childhood mortality and fertility can be reduced in impoverished rural communities through improved outreach and community mobilization. This finding, first disseminated as a preliminary finding in 1998, led to a Government of Ghana national program for developing primary health care on the Navrongo service model. Known as the Community-based Health Planning and Services (CHPS) initiative.

The Community-Based Health Planning and Services (CHPS) initiative, which is a participatory process of a sector-wide health system change and development, aims to provide accessible primary health care to all communities of Ghana, through the promotion of health interventions and actions designed to make people healthy and stay healthy; and to bridge the inequality gap between urban and rural communities.

Some opportunities for the successful implementation of the CHPS initiative depend largely on the support it enjoys from government through the introduction of the National Health Insurance Scheme (NHIS) as well as the participatory nature of the initiative. Some of the challenges that the initiative encounter include human resource constraints which are further complicated by the issue of brain drain and the concerns about clinical staffs not staying in the community, resource constrain as well as poor feeder road network. In order to improve upon access to quality health care services, the health sector will have to deepen efforts and emphasis on the three broad policy objectives of bridging the equity gap in access to quality health and nutritional services; ensuring sustainable financing arrangements that protect the poor; and enhancing efficiency and coverage in service delivery.

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While acknowledging the encouragement, support and assistance of the above, I wish to emphasize that any demerits and mistakes in my work remain my responsibility and mine alone.



DEDICATION

To my dear father, *NaaPuoweleKarbo III* and to the Blessed memory of my late wonderful mother, 'sister' and best friend, *Mrs Cecilia PuoweleKarbo*- you who are an embodiment of truth, genuine beauty and a sweet fragrance for all lives, REST PEACEFULLY IN THE LORD; for I am forever glad you are my mother.



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DEFINITION OF TERMS

Child Mortality: The probability of dying between exact ages one and five expressed per 1,000 live births of children surviving to 12 months of age.

Community –based Health Planning and Services (CHPS): As formerly defined, is the mobilization of community leadership, decision making systems and resources in a defined catchment area (zone), the placement of oriented frontline health staff known as Community Health Officers (CHO), with logistics support and community volunteer systems to provide services according to the principles of Primary Health Care (PHC).

Household: It is defined as persons or a group of persons, related or unrelated, who live together in the same house or compound, share the same housekeeping arrangements, and are catered for as one unit. The emphasis is on living in the same place and having common provision for food and necessities for living irrespective of size and relationship.

Household head: The head of a household is defined as the person in the household, recognized as such by other household members. This was generally the person responsible for the upkeep and maintenance of the household. In his/her absence, the person who took charge of the household was considered “temporary head”. All relationships are defined with reference to the head or temporary head.

Infant Mortality: The probability of dying between birth and exact age one expressed per 1,000 live births.

Inequality: Inequalities in health, formally defined, refer to a broad range of differences in both health experience and health status between countries, regions, and socioeconomic groups. Most inequalities are not biologically inevitable but reflect population differences in circumstances and behaviour that are in the broadest sense



socially determined. However, in industrialized term "inequalities in health" has tended to refer to differences in health status between regions and population subgroups that are regarded as inequitable.

Inequity: Health inequities, formally defined, are avoidable inequalities that are unfair and unjust. In reality, however, the term is mainly applied to unfair and unjust differences in access to health services between regions and population subgroups within a country. In developing countries, inequities in access have been the dominant preoccupation of those working on health inequalities and inequities.

Total Fertility (TFR): The total number of births a woman would have by the end of her childbearing period if she were to pass through those years bearing children at the currently observed rates of age-specific fertility. The TFR is obtained by summing the age specific fertility rates and multiplying by five.

Urban/Rural: the urban/rural classification of localities is population based, a population size of 5000 or more represents an urban area where as a population of less than 5000 is rural.

Under-Five Mortality: The probability of dying between birth and exact age five expressed per 1,000 live births.



ABBREVIATIONS

ACCORD	-	Austrian Center for Country of Origin and asylum Research and Documentation
APR	-	Annual Progress Report
CBAs	-	Community Birth Attendants
CHPS	-	Community-based Health Planning and Services
CHO	-	Community Health Officer
CHFP	-	Community Health and Family Planning
CHV	-	Community Health Volunteers
CWIQ	-	Core Welfare Indicator Questionnaire
DANIDA	-	Danish International Development Agency
DPCU	-	District Planning and Coordinating Unit
GDHS	-	Ghana Demographic Health Survey
GHS	-	Ghana Health Service
GHDR	-	Ghana Human Development Report
GPRS	-	Growth and Poverty Reduction Strategy
GPRTU	-	Ghana Private Road Transport Union
HIRD	-	High Impact Rapid Delivery
JICA	-	Japan International Cooperation Agency
MOH	-	Ministry of Health
MDG	-	Millennium Development Goals
NHPU	-	National Health Planning Unit
NHRC	-	Navrongo Health Research Center
PHC	-	Population and Housing Census
TBAs	-	Traditional Birth Attendants



UNICEF - United nations Children Education Fund

WHO - World Health Organization

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CHAPTER ONE

GENERAL BACKGROUND OF STUDY

1.1 Introduction

Enhancing the health indicators in developing countries has been a major priority of international development communities over the years, as a result considerable amount of resources in the form of financial, human and infrastructure have been invested in an attempt to reduce infant and child mortality rates. However, despite the fact that the health status of Ghanaians has improved considerably over the years, the rate of change has been slow and current indicators in the areas of child and infant mortality are unacceptably high (GSS and Macro International Inc 1999: cited in Debpuur et. al 2005).

Current indicators prove that maternal mortality rates have not improved significantly in the past five years, ranging between 204/100,000 in 2002 to 187/100,000 live births in 2006. In the same regard, infant mortality rates have equally remained high with very little improvement. For instance infant mortality dropped from 133 deaths per 1000 live births in 1957 to 77 deaths per 1000 live births in 1988, it further dropped to 66 deaths per 1000 live births in 1998 but later increased to 71 deaths per 1000 live births in 1999 while under-five mortality increased to 111 in 2003 and has remained the same in 2006 (GHDR, 2007).

Improving upon health service delivery and making basic and primary health care accessible to all Ghanaians has been a priority issue for governments over the years; under the Ghana Poverty Reduction Strategy II, the primary goal of the health sector is to promote a healthy and productive society capable of contributing to socio-economic development and wealth creation in the country. To achieve this goal the policy objectives of the health sector is continuously focused on the following:



- “ Bridging the equity gap in access to quality health care and nutrition services;
- Ensuring sustainable financial arrangements that protect the poor; and
- Strengthening efficiency in health service delivery” (APR: 2009).

Among the varieties of socio-economic priorities of the government issues concerning health is at the fore front of the Millennium Development Goals (MDG) which Ghana hopes to achieve by the year 2015. Health issues within the MDGs have been prioritized into three, so as to create a clear policy direction for government, “The fourth of the goals of the MDGs is to reduce under-five mortality rate to two-thirds by 2015; the fifth goal is to reduce the maternal mortality ratio by three-quarters by 2015, and the sixth is to try to reduce infection rates of HIV/AIDS, malaria, and other communicable diseases associated with hygiene and environment by 2015. All of these have been made primary health goals, which the government has sought to, integrate into community level health care” (ACCORD: 2009)

Thus, in developing health policies the government is guided by three essential goals in health service delivery to ensure that all individuals irrespective of their geographical location enjoys a good and healthy life, as outlined in the goals below:

- “ to maximize the total number of healthy lives of Ghanaians and all persons resident in Ghana regardless of age, sex, origins, ethnic group, religion, political beliefs or socio-economic standing (to increase the span of healthy life for Ghanaians and persons resident in Ghana);
- To achieve universal access to promotive and preventive services and emergency curative services to all Ghanaians resident in Ghana; and



- To reduce the disparities in health status among rural, peri-urban and urban communities. Special attention is needed to close the gap between rural and urban dwellers; between the well-off and people with low income, between children and adults” (Kunfaa, 1996: 58).

Over the years attempts have been made to bridge the gap in access to health care, as a result various interventions were initiated such as the Danfa Comprehensive Rural Health and Family planning project and the WHO-sponsored BrongAhafo Rural Integrated Development Project, (BARIDEP).

Based on the considerable success achieved from the implementation of the Danfa Comprehensive Rural Health and Family planning and the WHO-sponsored BARIDEP projects, the MoH initiated the Village Health Workers (VHW) system as part of the Primary Health Care strategy; unfortunately during the scaling up of the system it encountered organizational, training, resource and supervision setbacks. However in 1980, the system was abandoned (Cole-King et.al 1979: cited Nyonator et.al 2005).

The failure of the Volunteer Health Workers system resulted in controversies and criticisms about the volunteer approach to health care delivery (Walt 1988; Knippenburg et al .1990: cited in Nyonator et.al 2005).

In order to address the criticisms and controversies that arose as a result of the volunteer approach, a new type of paid worker system was adopted in the 1980s, referred to as the Community Health Nurses to provide a more professional, acceptable and effective health care delivery as compared to the Village Health Workers (NHRC: 1999 cited in Nyonator et.al 2005).



However, instead of placing community health workers in communities, they worked from the sub-district health centers. Despite the fact that outreach clinics formed part of the community health nurse's duties, community outreach remained static, however timing of outreach was not stable as a result of logistics constrains (Nyonator et.al 2005).

It is against this backdrop that the Ministry of Health (MoH) in 1997 introduced a Health Sector Reform (HSR) process basically aimed at improving both geographical and financial access to basic and quality health care as well as ensuring efficiency in the services provided. In 1998, the Community based Health Planning and Services (CHPS) initiative was developed by the MoH purposely to improve geographical "access, equity, quality and efficiency of basic and primary health care" (Nyonator et.al 2002).

"The Community-based Planning and Services (CHPS) initiative is a programme designed to translate innovations from an experimental study of the Navrongo Health Research Center (NHRC) into a national programme for improving accessibility, efficiency and quality of health and family planning services" (Binka et al.1995; Pence et al. 2001; Debpuur et al .2002: cited Nyonator et.al 2003:2).



The CHPS initiative has become a national health strategy initiated to provide community-based health service, and to deal with the issue of inequality in access to primary health care thereby reducing health inequalities and promote equity of health outcomes.

However, the question which needs an in depth study is whether the CHPS initiative has succeeded in improving access to quality health care in the Lawra District? If not, then what are the challenges that confront the initiative as well as the opportunities available that can be exploited to make health care more accessible in the Lawra District?.

The initiative is expected to have a three tier level system of service provision within a district, the District (Hospital) level, the Sub-District (Health Centre) level and community-based. As captured above, geographical access is a major barrier to health care and as such, the initiative is set out to improve geographic access to services. In line with this health service delivery strategy, the number of health facilities increased during the first and second five-year programme of work at the Sub-district and the District levels. However, coupled with the issue of 'brain drain', these investments did not remove the barriers to health care (GHS, 2005).

The National Health Care system primarily aims at improving equity and access to primary health care and also making sure that the sector plays its role in the national poverty reduction. The objectives of the health care system are built around improving geographic, financial and socio-cultural access to quality health care (GHDR, 2007).

1.2 Problem Statement

Over the years, it has been estimated that about 10 million children die of preventable disease-30,000 a day; more than 500,000 women die yearly during pregnancy as well as at child birth. However, majority of these deaths are more likely to have occurred in sub-Saharan Africa than in the developed countries. These statistics are quite shameful, the reason being that such deaths can be avoided if quality health care is brought closer to the people (HDR, 2003).

Though the health status of Ghanaians has improved considerably over the years, however, there exist considerable differences in some health indicators among different geographical regions and socio-economic groupings. In spite of the attempts by governments over the years to bridge the gap in access to quality health care, a great number of the population lack access to quality health service (GPRS and APR, 2006).

In Ghana, the lack of access to quality health care is one of the major barriers to quality health care and strongly tied to this is an excess of childhood mortality, which could largely be attributed to service inaccessibility. It is further stated that about 70 per cent of the Ghanaian population resides in communities that are over 5 kilometers from the nearest health facility. Childhood mortality in such communities is 40 per cent higher than in communities located within 5 kilometers of health facilities. Also, there is a great disparity in health status between urban and rural areas (GHS, 2002).

According to the GHDR (2007) “About 57.7% of Ghanaians have access to a health facility within 30 minutes of their places of residence. It is further stated that urban localities generally enjoy good access to health compared to rural areas as urban areas tend to have a relatively better concentration of health facilities and better road network as well as other factors that enhance access. Access to health facilities in the rural areas, therefore becomes a challenge for rural inhabitants as they have to travel for considerable distances for health care. In the Upper West, 30.4% of the total households in the Region have a health facility within 30 minutes of reach”.



In the Upper West Region, the lack of access to quality health care is one of the major contributors to the unacceptably slow rate at which infant mortality, child mortality and under-five mortality rates have reduced over the years. For instance as at 1997 infant mortality rate was 82 deaths per 1000 live births, in 2002 it fell to 74 deaths per 1000 live births and dropped to 62 deaths per 1000 live births in 2007, during the same period childhood mortality rate was 95 ,66 and 55 deaths per 1000 live births respectively. In the same regard, the under-five mortality rate in 1997 was 170 deaths per 1000 live births, it dropped to 135 deaths per 1000 live births in 2002 and it further dropped to 113 deaths per 1000 live births in 2007 (HIRD,2008).

However, there exist considerable differences in access to health care delivery between urban and rural areas; this to a very large extent has contributed to the wide variations in health indicators between rural and urban areas. In the Upper West Region for instance childhood mortality rates in urban areas are consistently lower than those in rural areas, for example, the infant mortality rate is 49 deaths per 1000 live births in urban areas compared to 70 deaths per 1000 live births in rural areas. The differences that exist between urban and rural health indicators are more obvious in the situation of under-five mortality rates where there is an 18% difference between rural and urban areas i.e. 127 and 103 deaths per 1000 live births (HIRD, 2008).

The health situation in Lawra is not different, for the period 2006-2007 maternal mortality increased from 215/1000 live births to 548/1000 live births (DHA: 2008). As at 2009 infant mortality in Lawra stood at 120/1000 live births which is very high compared to the national and regional figures which are 71/1000 live births and 90/1000 births respectively. Again the District also recorded a high rate of babies delivered with low body weight from 73 in 2007 to 193 in 2008; this was largely due to low maternal nutrition and ill health (DMTDP: 2006-2009).



Based on the above, one tends to wonder whether the CHPS initiative is actually bridging the gap in access to quality health service delivery in the Lawra District.

The purpose of this research is to identify the contribution CHPS has made in improving access to health service delivery in the Lawra District, the challenges that face the initiative as well as the opportunities that exist for the initiative to succeed.

1.3 Research Questions

1.3.1 Main Research Question

1. Has the CHPS initiative improved access to health services delivery, health status and health seeking behaviour in the Lawra District?

1.3.2 Sub Research Questions

- Has the CHPS initiative bridged the gap in access to basic health care in the Lawra District?
- Has the CHPS initiative achieved improved efficiency and responsiveness to clients' needs?
- How can the development of inter-sectoral collaborations enhanced the CHPS initiative?
- What are the challenges and the prospects of CHPS in improving access to basic health care?
- What can be done to overcome the challenges and take advantage of the prospects to improve access to basic health care?



1.4 Research Objectives

1.4.1 Main Research Objective

To assess the CHPS Initiative and its contribution in improving access to health care, the health status and health seeking behaviour of people in the Lawra District.

1.4.2 Sub Research Objectives

- To assess the accessibility to basic health care in rural communities in the Lawra District?

- To determine the efficiency and responsiveness of the CHPS initiative to clients' needs.
- To identify the challenges and opportunities of the CHPS initiative in the Lawra District.
- To suggest recommendations that would improve access and enhance health service delivery in the Lawra District.

1.5 Significance of the Study

There is a growing awareness on the need to increase access to quality health care irrespective of one's geographical location. It has therefore become imperative to encourage household and community involvement in health service delivery. The CHPS initiative is a national strategy developed to help bridge the gap in access to health care.

This strategy seeks to help reduce health inequalities and promote equity of health outcomes by removing the geographic barriers to health care. The CHPS initiative has been perceived as an appropriate way to deliver health care to communities in deprived and distant areas (usually rural areas) from health facilities and relocating primary health care from sub-District health centers to convenient community locations. "With about 70% of the Ghanaian population living in rural areas with very little access to quality health care" (GPRS II: 2006-2009), the introduction of CHPS initiative is not only timely but very appropriate.

As an initiative that has still not gained firm grounds in the Region it is however likely to be faced with a myriad of challenges which could cripple its efforts at making health service accessible to all as well as some opportunities if exploited can help strengthen the initiative, thereby making health more accessible to all. This therefore forms the basis of this study to identify the challenges and opportunities of the CHPS initiative.



1.6 Scope of the Study

The focus of this study is on rural access to Health Service delivery in CHPS zones in the Lawra District from the perspectives of the Sub-District Health Team (SDHT), Community Health Officer (CHO) and community members who are key pillars in the implementation of the CHPS initiative.

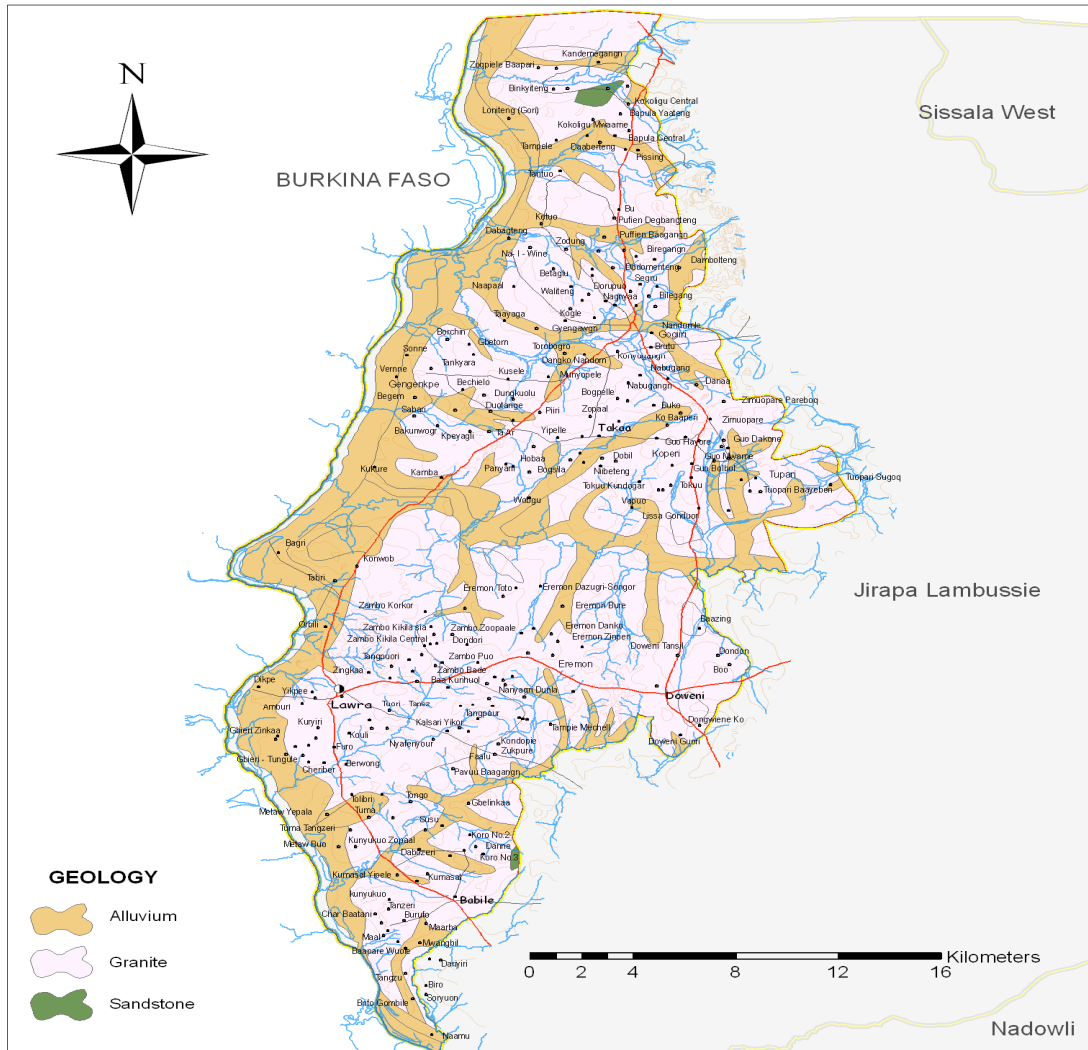
1.7 The Study Area

1.7.1. Location and Size

The District is one of the eight Districts that make up the Upper West Region. It lies in the north western corner of the Upper West Region of Ghana between Long. 2°25 W and 2°45W and Lat. 10°20 and 11°00. It is bounded to East and south by the Jirapa and Lambussie District and to the North and West by the Republic of BurkinaFaso. The total area of the District is put at 1051.2 square km. This constitutes about 5.7% of the Region's total land area, which is estimated at 18,476 square km (figure 1 shows the District in the Regional context).



Map 1 Showing the District in Regional Context



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DPCU, 2009.

1.7.2. Population Size and Density

The 2000 National Population and Housing census results put the District's population at 87,525. This is about 15.2% of the Region's total population of 576,583. This comprises 40,804 males and 46,723 females representing 47% and 53% respectively and the sex ratio is 87.3 males to 100 females (GSS, March 2002). There is intense pressure on natural resources particularly land for agricultural production as well as socio-economic facilities. The growth rate of the District is 1.7%. This is however below the national

growth rate of 2.7%. The current estimated population of the district as at December 2009 stands at 101, 600. This comprises 53,616 women and 47,546 men (DPCU, 2009).

The population in the District is distributed in rural and urban i.e. 86,999 (86%) and 14,163 (14%) respectively. The population is distributed among Two Hundred and twenty (220) settlements and only eight (8) localities in the district have population above one thousand (1000). However Nandom is the largest locality with a population of 7,596 followed by Lawra, the District capital with a population of 6,707 (DPCU, 2009).

1.7.3. Topography and Drainage

The District is gently rolling with a few hills ranging between 180 and 300M above sea level. It is drained by the main river – the Black Volta, to the west making a boundary between the District and the Republic of Burkina Faso. The Black Volta has several tributaries in the District; notable amongst them are the Kamba/Dangbang, Nawer, Duodaa and Kokoligu-baa. These if utilized, could offer an agro-based employment for the youth who migrate to the south in search of non-existing jobs during the dry season.

1.7.4. Vegetation and Climate



The District lies within the Guinea Savannah Zone which is characterized by short grasses and few woody plants. Common trees in the District consist of drought and fire resistant trees such as baobab, dawadawa, shea trees and acacia. The vegetation is very congenial for livestock production, which contributes significantly to household incomes in the District.

The greatest influence on the vegetation is the prolonged dry season. During this period, the grass becomes dry and the subsequent bush burning leaves the area patched and mostly bare of vegetation. Consequently, the torrential early rains cause soil erosion.

Bush burning reduces the vegetative cover and Transpiration and this affects average annual rainfall totals.

The climate of the District is tropical continental type with the mean annual temperature ranging between 27°C to 36°C. The period between February and April is the hottest. Climatic changes of late, however affects the weather pattern. Between April and October, the Tropical Maritime air mass blows over the area which gives the only wet season in the year. The rainfall pattern leads to the migration of the youth, a factor associated with the underdevelopment of the human resource base of the District.

1.7.5. Road Network

The main mode of transport in the District is road, which is an important determinant of the accessibility of people to services and facilities. The roads consist of a network of trunk and feeder roads, provided to promote effective inter and intra transportation as well as to facilitate socio-economic activities in the District.

However, the condition of trunk roads in the District has been of mixed improvement.

The District has two (2) major trunk roads, namely; Babile-Lawra-Hamile road, Lawra-Boo and Domwini-Nandom road. Babile-Lawra-Hamile road continues to receive attention, than the Lawra-Boo and Domwini-Nandom road which makes it become increasingly unmotorable due to the many pot holes and heavy corrugations on the road.

The only tarred portion of the District roads happened to be the township roads; i.e. both Nandom and Lawra townships. However, the District is not linked by any tarred road. It is hoped that the speedy investment on the road linking the District and beyond in the area of tarring could go a long way to increase the potentials of the District.



Over three quarters of the 218km road length of feeder roads in the District have now been reshaped or worked upon. Some of the roads that have seen improvement are:

- Koro-Kalsagri feeder road
- Kikila -Kamba, feeder road
- Suke-Sinaa feeder road
- Baazing-Eremon feeder road
- Kokoligu-Bikyinteng. Feeder road
- Vapourijn. - Vapouri, feeder road
- Nandomle jun.-Nandomle, feeder road
- Tolibre-Dapila, feeder road
- Kasari-Babile, feeder road

1.7.6.Economic Activities

It is estimated that 83% of the population are engaged in subsistence agriculture. Food production is low due to the poor nature of the soil and unfavorable weather condition. Most of the youth have to migrate to the southern part of the country every year either immediately after harvesting the poor yields of crops from their small size farms or after writing their Junior High School or Senior High School Certificate examinations.

The aim of the migration is to marshal resources for the upkeep of their families during the lean season and cater for their education if lucky to progress on the educational ladder. Animal farming, especially poultry rearing is a lucrative venture in the District. Fishing also goes on along the Black Volta and its tributaries to supplement the meagre income of the families of fishing communities. Most of the women engage in pito brewing, petty trading and shea butter extraction.

1.7.7. Transport and Communication

The main means of transport are bicycles, motorcycles, Urvans, Metro Mass Transport and Mummy trucks. The local GPRTU ply the major roads in the District to and from Kumasi and Techiman. Sub district health staffs were tasked to liaise with community members to meet and arrange with local GPRTUs and Vehicle owners to make their vehicles available for the transportation of emergency cases if the need arises at any point in time to save lives.

Dowine, Babile, Ko, Nandom and Lawra health facilities that were linked to the DANIDA financed TP-Radio Network have since 2004 broken down and never been repaired. JICA assisted some of the facilities with radio communication limited within only health facilities with similar gadgets.

However, the Lawra District Hospital, Nandom Hospital and the District Health Administration have fixed Telephone lines at their BMCs, which do not function to expectation due to the frequent breakdowns. In the absence of the TP radio services, the District has been lucky to have One-Touch Cellular Phone, Tigo, and MTN network services in about 90% of the total land area at vantage points. Most often, personal phones of staff within coverage areas are been explored in times of emergencies. All sub-districts centres can be reached through the Cellular Phone networks.

1.7.8. Health resource

There are ten (10) sub-districts, which offer comprehensive package of public health services. Eight (8) of the sub districts are being served by health centres and the remaining two are RCH centres attached to the hospitals in the District. The District has two hospitals (a district hospital at Lawra and one Agency hospital at Nandom). In an



effort to reach all settlers in the District, the District has implemented the CHPS programme with 10 CHPS compounds in operations as at December 2008.

There are 200 trained Traditional Birth Attendants (TBAs), 150 community based surveillance volunteers and 329 Community Based Attendants (CBAs). There are 15 chemical sellers in the District but most of these chemical sellers are located in Lawra, Nandom and Babile townships. The shops serve as sources for first aid drugs for the mass populace in the District. It is rather unfortunate that customers abused most of the drugs sold to them.

Health services are made accessible in the District through 12 static health facilities and 109 outreach points. Generally, accessibility to health service is adequate taking into consideration the compact nature of the District and its number of health facilities. Apart from the above mentioned, there are 10 functional CHPS compounds that make health services easily accessible with their catchment's areas.

Table 1.1 Trends of Infant Admissions and Mortality

YEAR	ADMISSIONS	MORTALITY
2003	1681	58
2004	2033	67
2005	1805	41
2006	965	32
2007	1042	18
2008	1243	34

Source: DHA, 2008 Annual Health Report

There was an increase in both infant admission and infant deaths in 2008 over 2007. The increase could be as a result of the floods in 2008 which prolonged the peak of the breeding period of malaria vector.



1.8 Limitations

In terms of scope the study looked at rural access to Health Service Delivery from the view point of the Sub-District Health Team (SDHT), Community Health Officer (CHO) and community members without taking into consideration the opinions of the Regional Health Management Team (RHMT), District Health Management Team (DHMT).

In addition to the above, the study is limited in terms of coverage, this is because the study is concentrated on Lawra District, and as such findings of the study might not be applicable to other districts. However, this report comes after the Lawra District has been split by government into Lawra District and Nandom District. Thus, any research on the same topic or similar health topic for Lawra District will not reflect similar results with what this research is reporting on.

1.9 Organization of Report

The report consists of six main chapters. Chapter one forms the introductory aspect of the report and comprises: background/introduction to the study, problem statement, research questions and objectives, as well as the significance of the study, choice of study area, limitations and organization of report

Chapter Two focuses on the review of relevant related literature and also looks at the historical and conceptual frameworks of the study. Chapter Three addresses methodological and analytical frameworks of the study, with much emphasis on sampling techniques, data collection and analytical methods. Chapter four is centered on presentation of findings and discussions of the study (CHPS), Chapter Five entails summary and discussion of major findings and conclusions of the study. Chapter Six comprises recommendations from the study and areas for further research.



CHAPTER TWO

2.0 LITERATURE REVIEW

Literature was reviewed on past and present documentation on health care particularly primary health care, inequality in health, participation, the CHPS initiative, Integration of Health Services, both published and unpublished literature was reviewed as well as official reports.

Literature was reviewed under the following concepts:

2.1 Community-based Health Planning and Services (CHPS).

2.1.1 Definition of CHPS

The community-based Health Planning and Services is defined as “the mobilization of community leadership, decision making systems and resources in a defined catchment area (zone), the placement of reoriented frontline health staff known as Community Health Officers with logistics support and community volunteer systems to provide services according to the principles of primary health care (PHC-Plus)” (GHS-PD,2005:6).

The community-based Health Planning and Services initiative (CHPS) is also referred to as a sector-wide health system of change and development with the primary aim of making Primary Health Care (PHC) accessible to every community in Ghana. However, in an attempt to achieve this aim the initiative makes it possible for District Health Management Teams (DHMTs) throughout Ghana to change and develop new strategies to community health care that are in line with local traditions, sustainable with available resources and compatible with prevailing needs (GHS,2002).



Before CHPS is introduced into communities extensive planning and community dialogue is done on the part of the Health Service and the community. An important principle for the introduction of CHPS is that traditional leaders of the community must accept the CHPS concept and commit themselves to supporting it. CHPS relies on participation and mobilization of the traditional community structure for service delivery. District Health Management Teams must augment the skills of Community Health Nurses (CHNs) to prepare them for the delivery of preventive and curative care while residing in the community.

This health staffs, known as Community Health Officers (CHOs), provide mobile doorstep services to community residents. By travelling from compound to compound on motorcycle, CHOs cover a catchment area of approximately 3000 individuals. The services of the CHOs include immunizations, family planning, supervising delivery, antenatal/postnatal care, treatment of minor ailments and health education. CHOs are supported by communityvolunteers who assist with community mobilization, the maintenance of community registers and other essential activities(Nyonator et al., 2005).

2.1.2 Rationale for CHPS



It is quite evident that the primary producers of health care are the individual households, where mothers usually take important decisions to seek health care for children when they are sick.

However the ability for individual households to make such decisions depends largely on the information available to them, communities intend provide the social setting in which families operate; in addition, increased household patronage of health care necessitates the need to make available the necessary health information and education to households in a manner that is acceptable and convenient for them.

In an effort to provide the Community-based level or ‘close-to-client’ doorstep health delivery with household and community involvement, the Ministry of Health through the Ghana Health Service pioneered the implementation of a national programme to replicate the results of Navrongo Community Health and Family Planning Project (CHFP) known as the Community-based Health Planning and Services (CHPS) initiative in key pilot Districts of Nkwanta, Birim North and Asebu-Abura-Kwamankese. The CHPS Initiative is therefore the national strategy for implementing the community based service delivery by reorienting and relocating primary health care from sub-District health centers to convenient community locations (GHS-PD, 2005).

“Studies of the diffusion of organizational change have demonstrated that changes perceived as being brought from outside are more difficult to introduce than are changes perceived to be owned by host institution” (Melgaard et al. 1998; Simmons et al. 2002).

Emphasis must therefore be placed on the fact that the key component of the CHPS initiative is community-based health service delivery that focuses on improved partnership with households and community leaders as well as social groups, addressing the demand side of service provision and recognizing the fact that households are the primary producers of health (GHS, 2005).

The Vision of the Ghana Health Service is to ensure that all Ghanaians are covered by community based service delivery using CHPS Initiative by 2015. By operationalizing CHPS the health sector is in a better position to fulfill its health system reform process of creating a ‘District Health System’ comprising three service delivery levels namely the Community level, Sub-District (Health Centre) Level and District (Hospital) level with strong referral components between levels. The overall goal of CHPS is to improve the

health status of people living in Ghana, by facilitating actions and empowerment at household and community levels (GHS, 2005).

“Within the context of the Ghana Poverty Reduction Strategy (GPRS II), community-based health service delivery using the CHPS approach, provides a unique opportunity for achieving critical intermediate performance measures of the health sector. Also, to be able to achieve the goal and reach the vision for 2015, the objectives of the CHPS initiative must be met. There are three important objectives and these are:

- Improve access to services;
- Improve efficiency and responsiveness to client needs; and
- Develop effective inter-sectoral collaboration” (GHS, 2005).

2.1.3 The Components of CHPS

The components of the CHPS initiative as identified by Nyongator et al (2005) are presented in Figure 2.1. This initiative involves a process of evidence-based organizational change for extending the logic of the sector-wide approach to the community level. In order to foster the transition from facility and component focused health care to integrated community- based health services; the CHPS initiative has three arms as indicated in the figure below;

- a research arm that provides evidence for guiding the process;
- an arm that provides policies, resources, and mechanisms for communicating the process and priorities for operational change; and
- an arm comprising informal mechanisms for spreading innovation and change between and within districts.



The figure clearly shows how to achieve the desired change in health services delivery through organizational change, which requires continuous research and the diffusion of innovations to enrich the process towards planned organizational change.

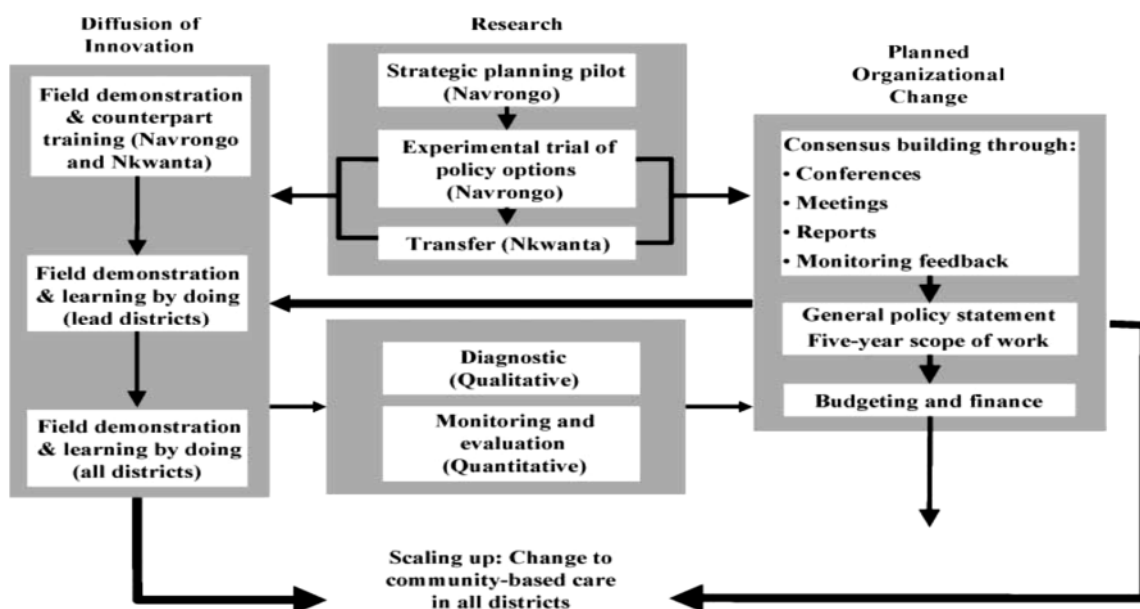


Figure 1.1 Components of the CHPS Process

Source: Nyonator et al., 2005

2.1.4 Key Elements of CHPS



The basic element of the CHPS initiative is the creation of a service delivery point that is community-based and aims at improving households, community leaders and social group’s partnerships, thereby addressing the demand side of service provision and recognizing the importance of households as the primary producers of health care. These elements are derived from the Navrongo research results demonstrating that *placing a nurse in the community substantially reduces childhood mortality, and combining nurse outreach with traditional leader volunteer involvement builds male participation in family planning and improves health service system accountability.*

Below are the key elements of CHPS;

- Community (as social capital)
- Households and individuals (as targets)
- Planning with the community (community participation)
- Service delivery with the community (client focused) (GHS-PD, 2005:6).

2.1.5 Basic CHPS Package of Intervention

The CHPS intervention package to be delivered by the CHO is in line with the Primary Health Care concept i.e. “essential *health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford*”(GHS, 2005).

The package also includes the following elements:

- Health education related to prevailing health problems and the methods of preventing and controlling them.
- Promotion of food supply and proper nutrition
- Provision of adequate supply of safe water and basic sanitation
- Maternal and child health care, including family planning
- Immunization Programmes against the major infectious diseases
- Prevention and control of locally endemic diseases
- Appropriate treatment of common ailments and injuries
- Provision of essential drugs

(WHO.1978)

The delivery of this package however is to be done in conjunction with the community members but not by the Community Health Officer (CHO) alone.



2.1.6 Recommended Basic Packages of Services to Be Provided By CHOs

The CHPS initiative has three basic recommended basic packages of service to be provided by the Community Health Officers; these services include promotion and prevention, Curative and Rehabilitative - Management of minor ailments and Referrals and Case Detection, Mobilization and Referrals (CDMR).

- I. *Promotion and Prevention:* this involves putting in place programmes and activities that promote healthy living and prevents outbreak of diseases and ailments, such programmes include Advocacy on Community Sanitation, Community Directed Treatments, Distribution of insecticide treated nets (ITNs), Distribution of Condoms and Non-injectable FP, Counseling on STIs/Family Planning services, counseling and advice, Counseling on Ante-natal and post-natal care , House to house visits coverage, Provision of Expanded Programme in Immunization (EPI) services, Provide and support Community based DOTS.
- II. *Curative and Rehabilitative - Management of minor ailments and Referrals:* under this package Community Health Officers can offer treatments for minor ailments and also undertake referral, these services include the treatment of uncomplicated malaria and fevers, treatment of simple cough and URTIs, treatment of simple diarrhea, First Aid for Burns, Cuts, toxic inhalations and consumptions (Home Accidents), Blood pressure monitoring, First Aid for spontaneous delivery.
- III. *Case Detection, Mobilization and Referrals (CDMR):* The Community Health Officers undertake case detection, mobilization and referrals, under this package Health Officers are expected to report unusual conditions, Referral of all conditions beyond the scope of authority, mobilization of communities for health

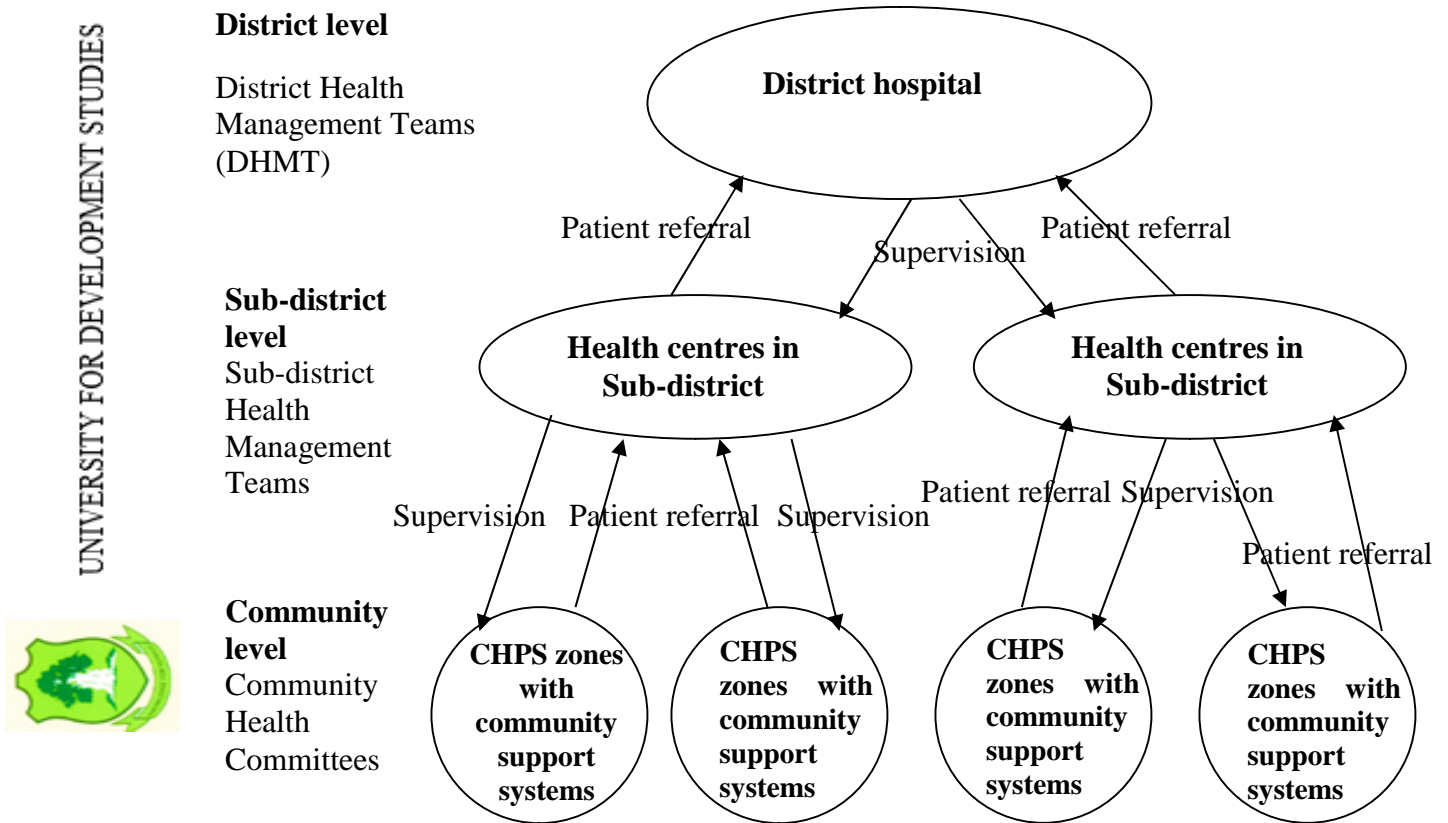


talks – Creating Community awareness, mobilization of communities for outreach services, Providing Support Community Decision Making Systems, Availability and completeness of community register

Source: GHS Policy Document No 20, May 2005

2.1.7 Organizational Structure for Rural Health

Figure 2.1 Organizational Structures for Rural Health Care



Source: GHS-PD, 2005

The District serves as the most important unit for Primary Health Care organization and management for service delivery in Ghana. The Health service system within the district is organized in a three-tiered hierarchy with the district level (level C) at the top, the Sub-District level (level B) next and the Community level (level A) at the bottom.

2.1.7.1 District Health Management Team (DHMT)

The DHMT is the decision making body, programme development Coordinator for the CHPS. The team serves as the central part of the health management, processing decisions and programmes from the Regional Health Management Team as well as giving directives for the provision of community level health care through the Sub District Health Team. The specific roles played by the DHMT are to develop, organize and implement community level health care programmes.

2.1.7.2 Sub District Health Team (SDHT)

Each District is zoned into about four (4) or more sub-Districts depending on its size. A sub-District has a population of about 20,000 – 30,000. Sub-Districts in the health sector administrative classification generally correspond to area councils in the local government classification; the difference being that sometimes the health sector may put two or three area councils together into one sub-District.

This team plays a supervisory role over the Community Health Officers (CHOs) and the Community Health Volunteers (CHVs) and serves as a link to the District levels. They also plan and budget programmes in their zones. The SDHTs manage the flow of essential medicines and family planning supplies between the DHMT and the Community Health Committees who distribute them to the volunteers to complete the actual delivery.

2.1.7.3 The Community Level

Several communities fall within a sub-district; in rural areas a community can be similar to a village or a cluster of hamlets, but it is not easy to define a community in terms of population. However, for the purpose of health service delivery, in defining a community, geographic location and population must be taken into consideration. A



community can have a population of 100 or less but are so far away from each other such that it would be so difficult to group them with another community. On the other hand, a large town with a 1000 or more population may not be easy to deliver service to as a single community even though the people are fairly closely clustered in the same geographic location.

It is recommended that CHPS zones should be created in synchrony with existing local government structures. The District Assemblies and Unit Committees use population of 1500. The recommended Population of a CHPS Zone is 3000 to 4500 people – i.e. covering two to three Unit Committees of the District Assembly. The CHPS zone should have a maximum of two trained CHOs to provide services to households within the communities. These services should focus more on outreach and house-to-house services, establishing community decision making systems and using community register to trace defaulters and people with special conditions like pregnant women and children at risk. The CHO in a CHPS zone is a member of the sub-District health staff, advocating for health in the communities.



Source: GHS Policy Document No 20, May 2005

2.1.8 Milestones in establishing community-based services by type of operational change required in the scaling-up process

The identified contrasts between the existing clinic based health delivery system and the community based system is presented in Table 2.1. The table clearly distinguishes between the existing clinic based system and the CHPS system, as well as the necessary tasks that will make the CHPS system operational.

Table 2.2 Milestones in establishing community-based services by type of operational change required in the scaling-up process

Milestone	Type of operation in the.....		Implementation task
 existing clinic-based Systemcommunity-based services	
Planning	District Health Management Team; office-based planning	Defined community service areas termed “zones;” traditional leaders; community nurses	Community mapping and enumeration; outreach to traditional leaders
Community Entry	None	Community leadership support for health Services; Community health Committees for Governing operations	Community awareness building liaison with leaders; community Health committee Selection; training of Community nurse for community entry; Community leadership training
Community Health Compound	None (sub-district health centre and hospital Services)	Community constructed or refurbished nurse service and dwelling units; community ownership of primary service point	Community mobilization for Facility development; Community support for maintenance
Essential Equipment	Four-wheel vehicle for bi-Weekly outreach clinics (rarely available); sub-district and district hospital equipment	Bicycles or motorbikes for continuous outreach by nurse; basic clinical equipment for community health Compounds.	Procurement of bicycles, motorbikes, and basic community clinical equipment.
Nurse Posting	Nurses resident at the sub-District or district level; Sub-district health centre Based services; passive (facility-focused); Bi-weekly/monthly outreach clinics at fixed Locations	Community resident Nurses providing static Services based on community health Compound augmented By active (client-Seeking) outreach to Families in their Homes.	Supervisory provision of fuel for household visitation activities and supplies for clinical work; supervisory community backstopping of nursing operations; community support for operations; in-service training for nurses; motorbikerider training and maintenance capacity building
Volunteer Deployment	None	Selection by traditional Leaders and Community Health committees; training by District Health Management Team	Train community Leaders in volunteer Recruitment and Management; train Community Health Committees to select And supervise Volunteers; train volunteers

Source: GHS Policy Document No 20, May 2005



2.1.9. Stages in the Implementation of CHPS

Implementing CHPS requires new operational mechanisms for establishing community health service accountability, service quality, and administrative control that are integrated into traditional institutions of village governance. However, establishing these mechanisms involves six stages of organizational change:

- *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 delineating zone boundaries, assessing manpower requirements and capacities, assessing equipment and training requirements, and scheduling the onset and frequency of nurses’ visits to each household in every zone. CHPS implementation is enhanced if planning begins with a few of the most committed community health officers who serve as counterpart trainers for other workers in the district, drawing on their local experience to guide the within district scaling-up process.
- *Community entry:* Community entry involves developing leadership and initial participation in the program through dialogue with community leaders and residents. Durbars, traditional gatherings that typically include drumming, dancing, speechmaking, public debate, and open discussion, are convened to foster open discussion of CHPS activities.
- *Creating community health compounds:* Community health services require a simple facility that provides a room for the community health officer’s living area and another for a clinic. Developing such facilities contributes to community ownership of the CHPS initiative by involving leaders in planning and resource mobilization and volunteers for construction work.



- *Procuring essential equipment:* Launching services requires clinical equipment for primary-health-care service delivery and transportation equipment such as bicycles or motorbikes.
- *Posting community health officers to the compounds:* The most critical stage of the CHPS process is the launching of the community health officer component, which takes place at a durbar celebrating the onset of care. The officers' services involve provision of clinical sessions at the compound; making household visits to provide family planning services, health education, and ambulatory care; and implementing outreach clinics for childhood immunization.
- *Deploying volunteers:* Depending upon the district health-management team's decisions and upon local needs, volunteer health aides may be recruited by community health committees and provided with a six-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.

Source: Adapted from Knippenberg in Nyongator et al (2003)



2.1.10 Conceptual Framework

The primary producers of health are the individual households with mothers often taking the first key decision to seek health care for their sick children. The decision to seek health care and which health care is sought depends on information available to the household. Communities provide the social cohesions for families to function in. In an attempt to increase the uptake of health services by households, it is necessary to provide health information and education to the households in a way and manner that is acceptable and convenient to them. To address the fundamental impediments in both access to and quality of healthcare as well as household or community side in

participation in service provision, Ghana's health care reforms is centered primarily on the mobilization of resources for health care and bringing the traditional society on board so as to achieve the goals of increased health status and decrease mortality rates.

In this regard the need for communities to be reoriented to enable them take up the challenge and ensure that they have access to quality health care services close to them is now, more than ever a priority.



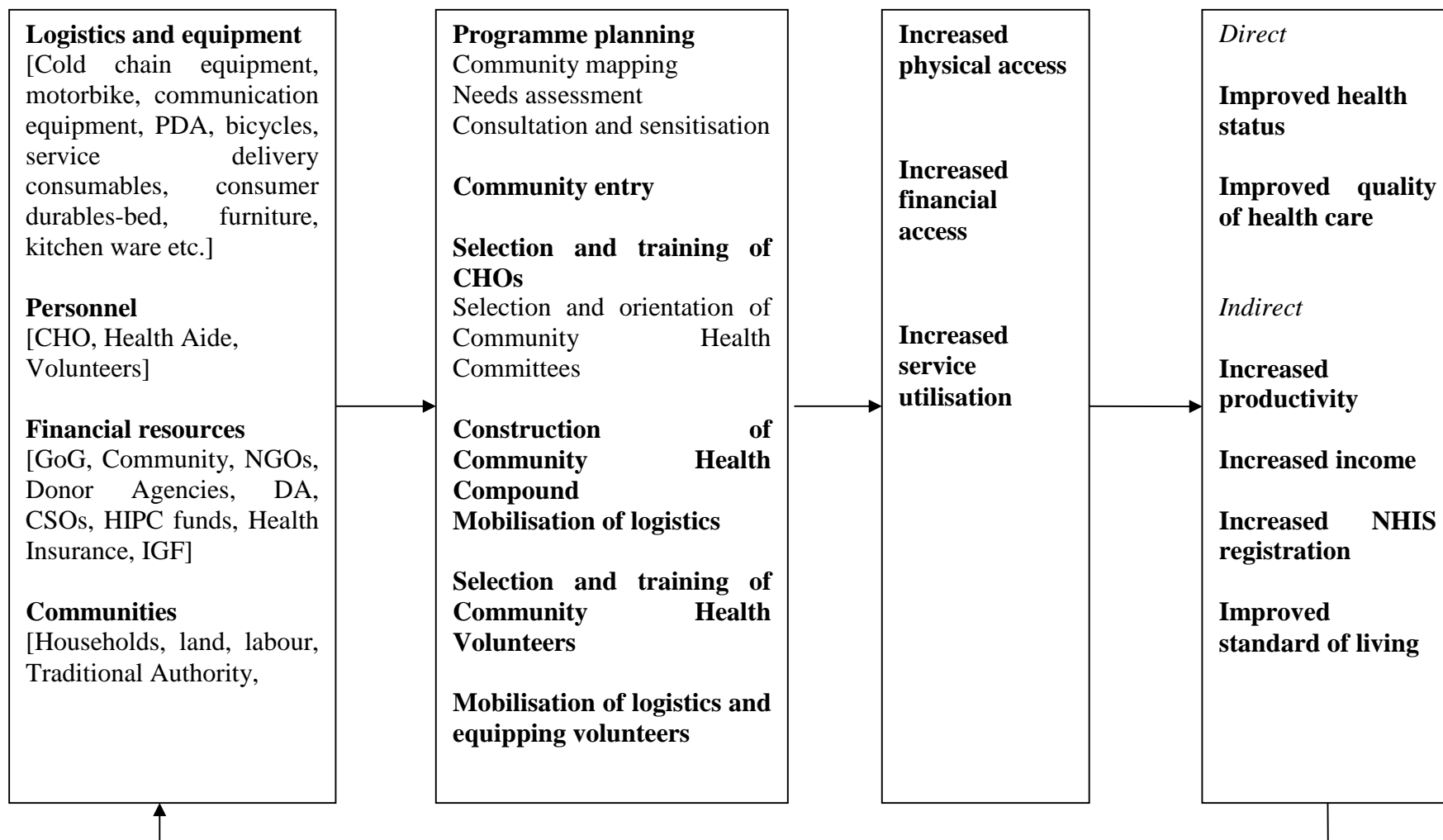


Figure 2.2: Conceptual Framework

Source: Emelyne, 2007

2.2 Health Inequalities and Inequities

Development of science has led to drastic improvements in health systems worldwide. Despite these changes all seem not well and there still exist wide disparities and inequalities in health particularly in developing countries (WHO, 2004).

WHO (2004) further argues that Global health is currently characterized by persistent inequalities, health systems are under severe pressure in parts of developing countries, and the growing realization that effective interventions are often not reaching people who need them most.

Inequalities and inequities in health care have over the years been central to the concerns raised about public health. In this regard governments in countries all over the world (including the United Kingdom) have shown renewed interest in dealing with these concerns. Attempts have however been made to push these concerns “up the global health policy agenda” (Acheson, 1998).

Despite the fact that equal opportunities for health are a desirable goal in all societies, it is however expected that everyone should have a fair chance to attain their full health potential and that no one should be excluded from achieving this. Although the health situation in most countries of the world has significantly improved over the past few decades, substantial inequalities in health outcomes among nations, socio-economic groups and individuals have remained (Leon and Walt, 2001).

However, recently issues concerning health inequalities and inequities have long been central to the concerns of public health officials; as a result Governments in several countries have shown renewed interesting dealing with these issues (Acheson, 1998).



Concerns about inequality and inequity in health care are viewed differently among countries the world over. For instance, in countries like the United Kingdom, Sweden and the Netherlands, majority of the studies on inequality in health are primarily based on the factors that promote “socio economic gradients in health and mortality”.

Based on the above, the policies that arise are usually targeted at the primary prevention of the disease. Unlike the less developed countries where the problem of inequalities is more on putting in place policies to ensure that health care is distributed equitably. There exist different views to this perception, in the United States for instance problems about equity in access to health care are more related to the causes of inequalities in the occurrence of disease. None the less in developed countries such as Western Europe, access to health care is quite universal and is less reliable on socio economic conditions.

However, in less developed countries attention is paid more on organizing and sourcing funds for the health sector than issues of inequalities. In addition international financial institutions are partly to be blamed since undue pressure is being put on governments in developing countries to reduce their expenditure on health and rather reorganize the health sector, a situation that has however been interpreted by most people as a hindrance to equity (Stott, 1999).

Gadikou et al (2000) further explain that instead of placing much emphasis on the manner in which health rates vary among socio-economic groups, rather the distribution of health across all individuals within the population should be measured. This approach however is quite similar to recording income inequality in relation to “spread of health (at an individual or household level) across the population”.



Braveman et al (2001) as cited in Galliford (2003), argues that equity in health has an ethical value that is broadly defined as striving to bridge the gap in health disparities among the advantaged and disadvantaged within and between countries.

Populations in rural communities are often assumed to be fairly homogenous; this perception coupled with the lack of relevant data have led to the absence of studies assessing socio-economic inequalities in rural Africa. Although socio-economic inequality may not be obvious in rural Africa, the capacity of individual households to deal with the challenges of life is not really uniform. Variations in individual and household socio-economic conditions that shape behaviour often result in variations in peoples' ability to protect and promote health (Debpuur et al 2005).

Health inequities result from differences in health status outcomes between groups that are avoidable and unnecessary, hence unacceptable and unjust (Whitehead, 1992).

To promote the health of rural communities, it is essential that sub groupings that are disadvantaged are identified so that health Programmes and interventions can be targeted at them thereby making a more focused use of available resources for health care delivery (Debpuur et al 2005).

The widening health gaps among groups or nations calls for global, national and sub national responses that involve the public health workers and development communities. They also call for careful monitoring and evaluation of interventions, not just for their impact on health outcomes but also their impact with respect to these "equity gaps" (Lanata, 2001; Vitorial et al 2001).

Though focusing on the 'poor' is significant, issues about health inequalities is not primarily about the most deprived in the society. For instance in developing countries,



more than half the population may be poor but those who are not would still be living in conditions that promote poor health. On the other hand in the developed countries where there is little or no poverty, “there are fine and graduated inequalities in health status that span the full economic spectrum” (Smith, 1996).

In spite of the fact that it is not generally perceived by governments all over the world that issues of inequalities in wealth and health is something that the public sector should address, rather governments are more interested in accelerating economic growth. Currently it is argued strongly by WHO that health is the key to reducing poverty thereby enhancing development; based on the above it can be said that if improved health can affect economic positively then issues of health should be an important priority for all governments: “Because ill-health traps people in poverty, sustained investment in the health of the poor could provide a policy lever for alleviating persistent poverty” (WHO, 1999).

2.3 Access to Health Care

Accessibility to health care plays an important role in improving the health status of people. However, in developing countries concerns about accessibility are related to the presence of basic health care i.e. the ease with which people have access to health practitioners in times of illness. In other words, in the advanced countries where health care is accessible concerns about accessibility is related to how comprehensive the health care system is, the degree of equity as well as the effectiveness of the care provided (Gulliford et al, 2003).

In economic terms, the World Bank (1993) explains accessibility in terms of the benefits it provides by improving the health status of people thereby providing and enhancing conditions that propel economic growth.



Worldwide accessibility to health care has been recognized as a basic human right, in that all individuals irrespective of ones geographic location or social status is entitled to basic health care (Dworkin, 1997).

This conviction is further emphasized by the United Nations in its covenant on Economic, Social and Cultural rights which recognizes ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health care’ and implores governments all over the world to create ‘conditions which would ensure all medical services and medical attention in the event of sickness’ (human rights, 1996: article 12).

In addition access to health care is generally assumed to be every citizen’s right and should not be influenced by income and wealth (William, 1993).

Access to health services means the timely use of personal health services to achieve the best health outcomes. In other to achieve this requires three distinct steps:

- Gaining entry into the health care system.
- Accessing a health care location where needed services are provided.
- Finding a health care provider with whom the patient can communicate and trust

Source: Bierman A. et al (1998).

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. When people have access to quality health care it leads to prevention of disease and disability, early detection and treatment of health conditions, quality of life and the overall physical, social and mental health status of the people.



Disparities in access to health services affect individuals and society, limited access to health care impacts people's ability to reach their full potential thereby negatively affecting their quality of life. Some of these barriers to health care services include: Lack of the availability of health care facilities, High cost involved, as well as the lack of insurance coverage. These barriers to accessing health services results in Unmet health needs, Delays in receiving appropriate care, inability to get preventive services as well as hospitalizations that could have been prevented (AHRQ, 2008).

There are several dimensions to access in health care as shown in the table below. Each of these dimensions has the ability to prevent the user particularly the most vulnerable in society-particularly the poor, most especially women and children from benefiting from health care. This research takes into consideration these dimensions of access in health care to identify the contribution CHPS has made in improving access to health service delivery in the Lawra District, the challenges that face the initiative as well as the opportunities that exist for the initiative to succeed.

Table 2.3 Dimensions of Access in Health Care



Dimensions	Details
Physical	<ul style="list-style-type: none"> • Distance to health facility from home. • Travel time. • User friendly layout of health facility. • Use of local languages where possible.
Financial/Economic	<ul style="list-style-type: none"> • Ability of users to pay for services such as Transport, diagnosis and drugs.
Linguistic and Cultural	<ul style="list-style-type: none"> • Language-effective communication. • Mutual respect for cultural differences.

Source: Yeboah, 2003 as cited in Gumah 2010

However in Ghana physical and financial access to health serves as the primary deterrent to quality health care and survival. Until quite recently, the primary mode of accessing health care in Ghana was the “cash and carry” system whereby patients had to

pay for medical services. To replace the “cash and carry” system the Government of Ghana introduced the National Health Insurance Scheme (NHIS) which makes it possible for the poor, children under 18 years of age as well as those over 70 years of age to be excluded from contributing (GHDR, 2007).

2.4 Primary Health Care (PHC)

“There is today a recognition that populations are left behind and a sense of lost opportunities that are reminiscent of what gave rise, thirty years ago, to Alma-Ata’s paradigm shift in thinking about health. The Alma-Ata Conference mobilized a “Primary Health Care movement” of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the “*politically, socially and economically unacceptable*” health inequalities in all countries. The Declaration of Alma-Ata was clear about the values pursued: social justice and the right to better health for all, participation and solidarity. There was a sense that progress towards these values required fundamental changes in the way health-care systems operated and harnessed the potential of other sectors. ” (WHO, 2008:11).

The process of changing these values into visible reforms has not been uniform. In spite of these setbacks issues of health inequity has taken center stage in discussions among political leaders and ministers of health including the local government and civil society organizations (WHO: 2008).

However the term Primary Health Care has been referred to the most peripheral level of the health care system i.e. the level to be contacted first by the public when seeking health care services. These include health institutions such as clinics, health centers, dispensaries, polyclinics, general practitioners among others. The PHC approach also



stresses that the first level of health care should not stretch beyond the conventional system described above but should start with community activities (Fowkes et.al:1988).

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

Kunfaa (1996) defines Primary Health Care as a common sense, practical and participatory approach to improving human health, thereby placing much emphasis on the relevance of nutrition, water and sanitation, health education, and the efficient and equitable distribution of health resources.

“Generally, the term Primary Health Care has been used to refer to the most peripheral level of health system-the first to be contacted by the public when seeking treatment. This includes such institutions as health (sub) centers, clinics, general practitioner’s offices, polyclinics, etc. The PHC approach, however, stresses that the first level of care not only goes beyond the conventional system described above, but actually begins with community activities. These may include activities by the community as a whole, by families for their own benefit and by individuals through health care” (Kunfaa: 1996).



UNICEF, 1990, suggests that the initial point of defense of health is the individual, the family as well as the community. However, communities that are well armed with knowledge, and which are organized to demand for and to participate actively in the services they need, are the principal agents in ensuring that quality health care is made accessible to all.

The PHC's value to ensure health for all requires a health system that "*Puts people at the centre of health care*". What people regard as better ways of living as individuals or as a community, what they expect for their societies, and what people value constitute important parameters for governing the health sector (WHO:2008).

As far back as 1978, Ghana became a signatory to the 1978 Alma Ata Declaration and therefore adopted the Primary Health Care concept as a health strategy. However, irrespective of the efforts put in place by government by way of policies, infrastructure among others very little success has been achieved. Even though some progress has been made in the area of preventable childhood disease such as polio, measles etc. three decades down the line, the country is still confronted with high maternal mortality, infant mortality and under- five mortality.

Primary care services also extend health care to communities and vulnerable groups. Outreach services may focus on prevention, such as providing immunizations or community-wide health promotion of child nutrition and other topics. Increasingly, the services are also tapped to provide home-based care for such chronic conditions as tuberculosis and HIV/AIDS. Through referrals, primary care facilities also give people access to higher levels of care, particularly at the district level. Because primary health care acts as a link between community health care and more specialized care at other levels, it requires management teams that can plan and implement the most effective



combinations of services that address local health conditions and risk factors (DCPP, 2007).

Primary Health Care “ involves, in addition to the health sector all related sectors and aspects of the national and community development, in particular agricultural husbandry, food, industry, education, housing, public works communication and other sectors; and demands coordinated efforts of all those sectors” (WHO, 1978:3).

Inter-sectoral collaboration is one of the key strategies of the Primary Health Care system; it implies intra and inter-sectoral collaboration. Intra-collaboration seeks to integrate vertical programmes that cuts across health care management and delivery as a result district and sub-district initiatives were undertaken realign vertical programmes and promote integrated services delivery whiles inter-sectoral collaboration on the other hand seeks to foster collaboration between health care providers i.e. traditional as well as modern and the public health system on the one hand and those other sectors whose activities have a direct impact on health (Galaa,2012).

2.4.1 The Alma Ata Declaration on Primary Health Care

The International Conference on Primary Health Care that was held in Alma-Ata 20th September, 1978 stressed the importance of the need for drastic action to be taken by the international community, governments as well as health and development workers, to promote and protect the health of all the people of the world. During the conference it stressed that during the planning and implementation of Primary Health Care the following should be taken into consideration.

Primary health care should:

1. reflect and evolve from the economic conditions and sociocultural and political characteristics of the country and its communities and is based



on the application of the relevant results of social, biomedical and health services research and public health experience;

2. address the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. include at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involve, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. require and promote maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need; and



7. Rely, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Source: Alma-Ata Declaration, September 1978.

2.4.2 Principles of Primary Health Care

After the Alma-Ata declaration in 1978, the World Health Organization adopted the Primary Health Care approach to health care as a strategy for effective health care delivery. The approach is also considered as a philosophy and a model for the provision of quality health care. The World Health Organization in its 2008 report on Primary Health Care identified five basic principles of PHC, below are the principles;

- *Accessibility:* This implies that quality health care is made available to all, irrespective of one's geographical location. The key principle of accessibility is that health professionals would be distributed in rural, remote and urban communities.
- *Public Participation:* This means that the beneficiaries are given the opportunity to contribute to decision making concerning their health i.e. they take part in identifying their health needs and assessing the advantages of alternative strategies to addressing these needs. In addition, the "design and delivery" of health care is made "flexible and responsive". Public participation therefore ensures "effective and strategic planning" as well as the evaluation of health care services.
- *Health Promotion:* This principle encourages programmes on "health education, nutrition, sanitation, maternal and child care, immunization,



prevention and control of endemic”. It is however believed that if this is done it would go a long way to reduce continuous demand for “curative and rehabilitative” care. Health promotion programmes would enable communities and families to better understand the causes of health and acquire the appropriate skills to develop and maintain their health and wellbeing.

- *Appropriate Technology*: this principle recognises how important it is to be able to adjust to “new and evolving realities”, thereby placing much emphasis on developing and testing new and innovative health care models and also spread research results that are related to health care. The principle of appropriate technology stresses the importance of conducting capacity building and professional development workshops to ensure that appropriate health care is given to individuals by professional health care providers at the appropriate time.
- *Inter-sectorial Cooperation*: this recognises that there is a link between “health and wellbeing and economic and social policy”. Inter-sectoral implies that there should be collaboration between health experts and experts in education, housing, employment among others. It also means that health professional and different disciplines should work interdependently so as to meet the health needs of all.

Source: Calnan et.al: 2002.



2.4.3 The Elements of PHC

The essential elements of PHC are:

1. Education to promote recognition, prevention and control of prevalent local health problems
2. Promotion of food supply and proper nutrition
3. Adequate supply of safe drinking water and basic sanitation
4. Maternal and child health care including family planning
5. Immunization against the major infectious diseases
6. Prevention and control of locally endemic diseases
7. Appropriate treatment of common diseases and injuries
8. Supply of essential drugs

Source: Adapted from Kunfaa (1996)

The primary goal of primary health care is “better health for all”, in this regard; the World Health Organization (WHO) has identified five key elements to achieve this goal:

- reducing exclusion and social disparities in health (universal coverage reforms);
- organizing health services around people's needs and expectations (service delivery reforms);
- integrating health into all sectors (public policy reforms);
- pursuing collaborative models of policy dialogue (leadership reforms); and
- Increasing stakeholder participation.



2.4.4. Scope of Primary Health Care

Primary Health Care renders first hand and continuous health care for families; it is usually their first encounter with the formal health care system. However in most third world countries, public health centres usually provide health care using nurses and mid-level health workers. Preferably doctors are available to provide the necessary support, training and referrals.

Primary Health Care performs a number of unique and important functions these include the following;

- Primary Health Care is the first point of contact for health care by many individuals; this is because the service points are often located in the communities.
- Again the services provided can cater for a broad range of basic health conditions.
- There is a follow up component in the primary health care system, where patients are followed over time by the same health care providers.
- In addition the health service is linked with a higher level of the health care system that can provide particular health services when the need arises.
- Finally, these services are extended to cater for the marginalised and underserved individuals that might not otherwise seek or receive health care (DCPP: 2007).

2.4.5 Components of Primary Health Care (PHC)

In 1978, the World Health Organization (WHO) adopted the Declaration of Alma-Ata. The declaration outlined the organization's stance towards health care made available for all people in the world. The declaration also defined eight essential components of



primary health care, which helped outline a means of providing health care globally.

Below are the components of Primary Health Care;

- **Public Education:** Public education is the first, and one of the most essential components of primary health care. By educating the public on the prevention and control of health problems, and encouraging participation.
- **Proper Nutrition:** Nutrition is another essential component of health care. Efforts have been made by the World Health Organization to prevent malnutrition, starvation and to prevent many diseases and afflictions.
- **Clean Water and Sanitation:** A supply of clean, safe drinking water and putting in place basic sanitation measures regarding trash, sewage and water cleanliness can significantly improve the health of a population, reducing and even eliminating many preventable diseases.
- **Maternal and Child Health Care:** Ensuring comprehensive and adequate health care to children and to mothers, both expecting and otherwise, is another essential element of primary health care. By caring for those who are at the greatest risk of health problems future generations have a chance to thrive. Sometimes, care for these individuals takes the form of counselling them on family planning and safe sex.
- **Immunization:** By administering global immunizations, measures are being put in place to wipe out major infectious diseases, thereby greatly improving overall health globally.
- **Local Disease Control:** Prevention and control of local diseases is critical to promoting primary health care in a population. Many diseases vary based on location, taking these diseases into account and initiating measures to prevent them are key factors in efforts to reduce infection rates.



- Accessible Treatment: Another important component of primary health care is access to appropriate medical care for the treatment of diseases and injuries. By treating disease and injury right away, caregivers can help avoid complications and the expense of later more extensive medical treatment.
- Drug Provision: By providing essential drugs to those who need them, such as antibiotics to those with infections, primary health care providers can help prevent disease from escalating. This makes the community safer, as there is less chance for diseases to be passed along.

2.4.6 Primary Health Care Strategy

The philosophy of the Primary Health Care approach involves certain fundamental values that are in line with the overall process of development but places much emphasis on the field of health. It states that health is related to the availability and distribution of resources, not only health resources such as nurses, clinics, doctors, medicines among others but also socio-economic resources such as education, water and food supply. Thereby implying that PHC is concerned with equity ensuring that both health and social resources are evenly distributed particularly to those who need them most.

It also states that health is an important component in the development process, implying that factors that affect health are cultural, social and economic as well as environmental and biological. In addition, to be able to achieve better health requires active involvement by individuals, families and communities by adopting healthy behaviour and ensuring a healthy environment.

The Primary Health Care strategy incorporates the values expressed in the Primary Health Care philosophy, below is the PHC strategy;





- *The need for change in the health care systems:* PHC is basically concerned with the creation of a system that would ensure that the essential health needs of vast majority of people are met. The approach also aims at achieving full coverage with essential health care by distributing health resources in a manner that would obtain maximum benefit for the people at a lower cost. This therefore implies that the allocation of resources would be done in line with health needs.
- *Intersectoral action for health:* the aim of this strategy is to ensure that matters concerning health are a priority in the entire development process, this is to be done through awareness creation on the factors contributing to health and disease and the need for non-health sectors to play an active role to better health conditions.
- *Individual and collective responsibility for health:* primary health care basically is concerned with ensuring that the responsibility of individuals and communities in health care delivery remains a priority in the health system. To achieve this initiatives need to be done; “*the first is for government to facilitate more community involvement in decision making. The second is to inform people of their potential for acquiring better health through their own efforts*”. To achieve this does not only require the adoption of particular behaviour patterns and living styles but the creation of an organizational and decision making system at the local level to help identify and deal with local level health concerns (WHO; 1988).

2.4.7 Primary Health Care Improvements

In most of the developing world, particularly in the poorest countries, only limited versions of the minimum package of care are available because of a lack of government commitment to primary care, inadequate financing, and shortages of skilled health

personnel and other resources, including drugs and medical supplies. The HIV/AIDS epidemic and the rise of cardiovascular diseases have also increased demands for these services. Scaling up and improving the quality of primary care, therefore, is needed in most low and middle-income countries. The success of these efforts will depend on several factors:

- **Developing a district health system:** If decentralized health care is to be successful, management teams at the district level will need to play a greater role in health planning and tackle inefficiencies such as low worker skills and productivity and faulty equipment. The district hospital is a focal point for such coordination and management.
- **More financial resources:** Recent estimates of the per capita annual cost of providing the minimum package of primary care are higher than estimates made in the 1990s because they take into account necessary management costs and improvements in quality of care. In poor countries, the additional funding will need to come from re-prioritized government budgets and donors. User fees should be applied with caution because they tend to suppress the use of services among the poorest groups.
- **Better training and support of health workers:** The skills and competencies of primary care workers need to be improved, and problems of understaffing, low motivation, and lack of incentives and support need to be addressed.
- **Harnessing the private sector:** Private-sector providers could provide services for a fee to some populations. Public private partnerships (through government contracting, for example) can be instrumental in bringing services to poor communities.



- Setting health priorities: The skills of local health managers need to be developed for decentralized health planning in particular, setting priorities for community oriented care based on the local disease burden. Greater political commitment is crucial for scaling up and strengthening primary health care, making it central in the battle against devastating diseases and their causes. Efficient primary care can pave the way for major gains in health and development and provide good value for the investment (DCPP, 2007).

2.5 Participation

One of the most crucial activity in the history of global public health that gave community participation an important position in public health discourse was the WHO and UNICEF sponsored conference on Primary Health Care at the Alma Ata in 1978. However this importance on community participation brought about a change in health planning and health care delivery, calling for active involvement of the community and other stakeholders in both the decision making process and health care delivery. The *health for all by the year 2000* campaign by the WHO, placing community participation at the center of its activities thus encouraging many countries to adopt this concept as a way of attending to pertinent health concerns. Further national efforts emerged to establish and strengthen mechanisms for community participation in health through social policy legislation and other public means (Oakley, 1989).

The term community participation has become so confusing that it can be referred to anything from consultation with a few selected power-holders to empowering citizens through the development of responsibilities and decision making alternatives for community members (Smith, 1991).



Several studies have proven that people tend to understand the concept of community participation differently and even development planners in the same field have defined community participation in diverse ways (Rifkin, 1986).

However a more suitable approach is to look at community and participation differently and using that understanding to define the concept, in this regard WHO 2002,p10, defines community participation as *“a process by which people are enabled to become actively and genuinely involved in the defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change”*.

Somnath and Sharma (1986) defines Community participation as an educational and empowering process in which the people, in partnership with those who are able to assist them, identify the problems and the needs and increasingly assumes responsibilities themselves to plan, manage, control and assess the collective actions that are proved necessary.

Ghai (1988) perceives community participation as a way of transferring central government power and some responsibilities to the local level. Under this approach the power to make decisions as well as the allocation of resources are transferred to local officials and elected bodies in villages, communities and districts.

Arnstein in Aryeetey (1992) defines “participation as a process of action by local people to reflect their own interests or to contribute their energies and resources to the systems which govern their lives. Participation is the process through which stakeholders’ influence and share control over priority setting, policy-making, resource allocations and access to public goods and services. Stakeholder participation in



projects and programmes can be a key for ensuring their long-term sustainability. Promoting participation helps build ownership and enhances transparency and accountability, and in doing so enhances effectiveness of development projects and policies”.

The health sector appears to be one area in which active involvement of rural communities seems to have achieved much result (Kunfaa, 1996). This is manifested in various illustrative statements by World Health Organization;

Oakley and Marsden (1987) define “community participation as a process by which individuals, families or communities assume responsibility for their own health and welfare and develop the capacity to contribute their own and the community’s development”

“However, the diverse nature of participation has been well articulated by Oakley and Marsden (1990) and Oakley et.al (1991). Several obstacles to participation were identified and elucidated by these writers. This notwithstanding, they assert that increased community participation would enhance project efficiency, effectiveness, self-reliance, coverage and sustainability” (Kunfaa, 1996).

The term 'community participation' refers to the collective involvement of local people in evaluating their needs and putting together strategies to meet their needs (Zakus and Lysack, 1998). The relevance of community participation in the development of rural health service is undisputed. The rural health policy framework recognizes that the principle of *participation by individuals, communities and special groups in determining their health priorities should be pursued as a basis for successful programs and services to maintain and improve their health*. The document also states that *'social capability and the physical capacity to plan and implement local programs are*



required for communities to improve and maintain their health' (National Rural Health Alliance 2000, p. 7).

The concept of community participation in rural health originates from its application by international organizations, such as the World Health Organization (1991) in developing countries with the aim of improving health, social and economic conditions.

In principle, true participation implies that the people should be knowledgeable about their own health problems and be able to identify the needs for their reduction, draw out action plans according to their priority and the resources available to them; organize and implement the programmes, as well as monitor and control their progress; periodically evaluate for the purpose of getting feedback, and do the reprogramming.

However, under poor social and economic conditions, it may be hard to expect spontaneous participation from the people. People have to be mobilized and encouraged to take greater interest and responsibilities for the maintenance of their own health. Initially, the involvement may be passive, and this has to be gradually and progressively made more active participation.

2.5.1. Stages in Community Participation

Community participation can take place during any of the following activities:

- Needs assessment – expressing opinions about desirable improvements, prioritizing goals and negotiating with agencies;
- Planning – formulating objectives, setting goals, criticizing plans;
- Mobilizing – raising awareness in a community about needs, establishing or supporting organizational structures within the community;



- Training – participation in formal or informal training activities to enhance communication, construction, maintenance and financial management skills;
- Implementing – engaging in management activities; contributing directly to construction, operation and maintenance with labour and materials; contributing cash towards costs, paying of services or membership fees of community organizations; and
- Monitoring and evaluation – participating in the appraisal of work done, recognizing improvements that can be made and redefining needs.

Source: Gajanayake and Gajanayake (1993)

2.5.2. Factors Promoting Participation

- Motivation – extent of people’s participation is improved by the level of motivation to their development. This implies expansion of general education, informal programmes and public awareness with respect to community self-help Projects.
- Organizational factor – in which a proper utilization of people’s enthusiasm and energy through effective participation could be realized through a proper mode of organization at the community level. This requires community leadership.
- Leadership – an important factor in promoting and sustaining community participation is the firm commitment of the leadership at all levels of national decision-making.
- Inducement by government - in which central government provides material and financial assistance to communities to augment their efforts. There could be voluntary participation, arising from people’s own initiatives, but this does not



often attract urgency, especially when it is highly correlated with people's level of education and training and is preferable.

- Re-organization and reorientation of local government – a consistent drive in the transformation and reorientation of the structures of, and development support for, local government is essential for the introduction of profound change at the community level.

Source: *Diaw in Aryeety, (1992).*

2.5.3. Conceptual Approaches to Community Participation

- *The Contributions Approach*

The contributions approach considers participation primarily as voluntary contributions, to a project, such as time, resources, or community-based knowledge. Professional developers, usually external to the community, lead participation and make the decisions about how the contributions will be used.

- *The Instrumental Approach*

The instrumental approach defines health and wellbeing as an end result, rather than as a process, with community participation as an intervention supporting other public health or primary health care interventions, health planning, or service development. Participation is usually led by professionals and the important components of the interventions or programs are predetermined according to local and national priorities.

- *The Community Empowerment Approach*

The community empowerment approach seeks to empower and support communities, individuals, and groups to take greater control over issues that



affect their health and wellbeing. It includes the notions of personal development, consciousness-raising, and social action.

- *The Developmental Approach*

The developmental approach conceptualises health and social care development as an interactive, evolutionary process, embedded in a community of place or interest. Local people, in partnership with professionals, have a role in decision-making and in achieving the outcomes they consider are important. The developmental approach is underpinned by the principle of social justice.

Source: Taylor J et.al 2008 cited in Preston et.al.

2.5.4. Benefits of Community Participation

As noted by Zakus and Lysack, one of the most essential aspects of community participation is its health and social benefits. According to them despite the fact that health literature in empirical studies that demonstrate these benefits are lacking it is generally accepted based on theoretical grounds and personal experience (Zakus and Lysack 1988).

In addition Zakus and Lysack also reports that the organization and delivery of health service benefits enormously from community participation. According to them through community participation health services are provided at a lower cost, and added resources can be brought into the system. The better determination of the need for health facilities, their location and size, the type and the nature of personnel's required are all expected benefits.

Greater local involvement is thought to decrease feelings of alienation on the part of the community and health officials. All these benefits are believed, ultimately, to have a positive impact on health (Galaa, 2012).



Somnath and Sharma (1986), identifies the following as benefits of community participation;

- A group of people belonging to the same entity and having a common perception of collective needs and priorities, and the ability to assume responsibilities for decisions made within the community can play an important role in community participation.
- Experience from within the country as well as from different parts of the world has clearly demonstrated that community participation can make significant contributions to bringing about general developments and to health development in particular.
- It increases understanding of the user-perspective in the management of health. The members of the community, who are chosen by the community and are appropriately trained, act as frontline workers being in direct contact with the beneficiaries. It also renders the services more accessible and acceptable to the people.
- It promotes and strengthens self-reliance in matters of delivery of health services. The community may be able to mobilize human, financial and material resources to supplement the extra-community resources being provided by the governmental or non-governmental agencies. This minimizes the sole dependence of the community on professional and bureaucratic structures. Participation also develops a sense of responsibility for the health care programme.
- Since the indigenous knowledge and local resources are utilized, it can bring down the cost of health care.



- For the organization of the preventive and promotive aspects of primary health care, the people in the community are the main actors.
- Various non-health sectors contribute significantly to health development. The integration and coordination of different sectoral activities necessary for making an adequate and sustained impact on health can be brought about only at the community level through community actions and organization. Community participation in health serves as a catalyst for further developmental efforts.

2.6. Integration of Health Services

The health system of every country came under severe pressure in the 1980s from various quarters including governments about the high cost of health care and the need for improved efficiency in health care delivery. Despite the rise in health care cost as a percentage of Gross Domestic Product (GDP) has been reduced in a few countries, the pressure to increase expenditure in relation to new technology, ageing population as well as increasing consumer expectation has continued to grow over the years (WHO;1996).

The World Health Organization (WHO) in its eight report on the world health situation, published in 1993 as well as the World Bank's development report 1993 with the theme "investing in health", identified major improvements in the health status of individuals measured by increasing life expectancy and infant and child mortality rates in both developed and developing countries. Nevertheless there has been an increase in health status disparities both within and between countries.

As noted by the Grone and Garcia-Barbero integrated health care is a concept that involves bringing together inputs, delivery, management and organization of services



related to diagnosis, treatment, care, rehabilitation and health promotion, integration is considered as a means to improve services in relation to access, quality, user satisfaction and efficiency (Grone and Garcia-Barbero ,2002).

However the above reports identify the emphasis placed on the privatization of the financing and provision of health care services; it is important to note that with privatization it can have an unequal impact on those in need, particularly children, the poor, the disabled and the elderly. Before a community can affect the process of change, it must be managed in a manner that ensures that however urgent, the process of change would be evolutionary instead of revolutionary and that impossible demands are not made on the staffs who implement these changes particularly those at the periphery.

The continues call for effective and efficient use of limited resources has intensified over the years through the use of integrated service delivery models as a result of the shortage in staff, cost inflation and service demand (Fleury 2006; Powell Davies 1996).in spite of the increasing call for integration of health service there seem to be little information related to implementing and evaluating integration-related interventions, as a result planners and decision makers have little guidance on how to plan and implement an integrated health care system. “With evidence-informed decision- making as an expectation in health care management and policy” (Cookson 2005), it is important to tease out and make use of recent knowledge on the integration of health system so as to ensure effective health care delivery.

Esther Suter et al. 2009 in their systematic review on recent literature on the integration of health system drew the conclusion that there was no commonly agreed upon conceptual model for health system integration. But despite the different approaches



and strategies for health system integration different authors related number of principles that would ensure a fruitful health system integration process. From the vast number of principles identified ten (10) were frequent and consistent, below are these principles;

A. Comprehensive services across the care continuum

- Cooperation between health and social care organizations
- Access to care continuum with multiple points of access
- Emphasis on wellness, health promotion and primary care

B. Patient focus

- Patient-centered philosophy; focusing on patients' needs
- Patient engagement and participation
- Population-based needs assessment; focus on defined population

C. Geographic coverage and rostering

- Maximize patient accessibility and minimize duplication of services
- Roster: responsibility for identified population; right of patient to choose and exit.

D. Standardized care delivery through interprofessional teams

- Interprofessional teams across the continuum of care
- Provider-developed, evidence-based care guidelines and protocols to enforce one standard of care, regardless of where patients are treated





E. Performance management

- Committed to quality of services, evaluation and continuous care improvement
- Diagnosis, treatment and care interventions linked to clinical outcomes

F. Information systems

- State of the art information systems to collect, track and report activities
- Efficient information systems that enhance communication and information flow across the continuum of care.

G. Organizational culture and leadership

- Organizational support with demonstration of commitment
- Leaders with vision who are able to instill a strong, cohesive culture

H. Physician integration

- Physicians are the gateway to integrated healthcare delivery systems
- Pivotal in the creation and maintenance of the single-point-of-entry or universal electronic patient record
- Engage physicians in leading role, participation on Board to promote buy-in

I. Governance structure

- Strong, focused, diverse governance represented by a comprehensive membership from all stakeholder groups
- Organizational structure that promotes coordination across settings and levels of care.

J. **Financial management**

- Aligning service funding to ensure equitable funding distribution for different services or levels of services
- Funding mechanisms must promote interprofessional teamwork and health promotion
- Sufficient funding to ensure adequate resources for sustainable change.



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the methods used in carrying out the research from sampling of the study communities through to the collection, presentation of data and findings.

3.2 Research Design

“The planning, organization and execution of social investigation take time , careful planning of each stage is essential in order to avoid waste of time, money and other resources”(Kumekpor,2002:39).

A research design describes the structure, strategy and the plan of action that if adopted would enable the researcher to obtain answers to research questions. It involves an outline of what the investigator will do right from the formulation of hypothesis and their implication to the final analysis of data (Kerlinger, 1986: cited in Kumar, 1996).

As indicated by Wagenaar(1992:44), a research design involves developing strategies for executing scientific inquiry. It involves specifying precisely what you want to find out and determining the most efficient and effective strategies for doing so. Appropriate research designs enable the social scientist to make observations and interpret the results.

In addition, a research design gives the researcher the opportunity to illustrate how, where, when as well as the circumstances under which data would be collected and analyzed. It further shows the methodology to be used, the object under study, the place and time of the research as well as the methods of data collection and analysis to be employed (Sarantakos, 1993).



The design for this research was a combination of both qualitative and quantitative assessment of selected CHPS zones. Qualitative and quantitative information are gathered through the administration of personal household questionnaires and conducting semi structured interviews with Community Health Officers (CHO) in charge of the CHPS zones as well as Sub District Health Team (SDHT).

In addition, the study objectives were developed first, so as to give the researcher a broad picture concerning the nature of the data to gather from the field so as to answer the research questions. This approach served as a guide to the researcher in the review of relevant data.

The next step was the selection of sampling procedures, data collection techniques and tools which the researcher would go to the field to gather relevant data. The reason why relevant literature was reviewed before going to the field is to enable the researcher identify indicators that would help address the issue as to whether the CHPS initiative is actually bridging the gap in access to quality health care.

The case study approach was used in this study, since it is best used in the study of contemporary issues. The choice of this approach is based on the fact that the study required multiple sources of evidence and the issue being investigated, is a contemporary phenomenon which is on-going and over which the researcher had little control.

A case study is a research method which allows for an in-depth examination of events, phenomena or other observation within real life context for purpose of investigating, theory development and testing. Case studies often employ the use of documents, interviews and observations during the course of the research.



Researcher Robert K. Yin defines the case study research method as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (Yin, 1984, p.23).

Also, the approach is mostly used for an intensive study of an individual unit, stressing factors in relation to the unit's own environment. By using this approach, a single entity or phenomenon was explored bounded by time and activity. Detailed information was obtained using a variety of data collection procedures (questionnaires for household surveys and interview guides for interactions with opinion leaders). The entity under investigation was primarily the household (heads and members).

3.3 Sampling Design

“Sampling is the use of definite procedures in the selection of a part for the express purpose of obtaining from its description or estimates certain properties and characteristics of the whole” (Kumekpor, 2002:132).

In deciding on a sampling design the population size must be determined by the researcher, the population size must also be outlined.

Kish (1967) as cited by Twumasi (2005) states that the first step in the selection of a sample is to consider a sampling design; the sampling design denotes the procedure, stages and processes involved in reaching the respondents. The following questions were asked when choosing the sampling design;

- a) “What are the units under consideration?”
- b) Who are the people in the system?



- c) Are they homogenous or heterogeneous group of individuals?
- d) Are they predominantly males or females?
- e) What are some of the background characteristics of the population?

These questions will enable the research scientist to have an idea about the existing social situation” (Twumasi, 2005:2).

3.4 Sampling Methods

Since a comprehensive survey could not be undertaken, samples from selected rural communities in the Lawra District were surveyed. Both probability and non-probability sampling techniques were adopted to make the research scientific and reliable. The probability sampling technique that was used was the cluster and simple random sampling techniques while the purposive sampling technique and convenience sampling were the non-probability techniques used.

The research was one based on purposive sample; as such the focus was on rural areas within the Lawra District in which the CHPS Initiative has been undertaken in the last four years, including communities which had attained the implementation milestone. From the above the purpose of the study was clearly known and that informed the choice of the population to be sampled, which were communities that fell within the various CHPS zones.

The CHPS initiative does not operate on the basis of individual communities, but on the local government structures, using the unit committees (with population of 1500). The recommended population of a CHPS zone is between 3000 and 4500 people, that is, covering up to three unit committees of the District Assembly, based on this the cluster sampling method was adopted. Twumasi (2001) defines cluster sampling as a technique



by which the researcher selects a group of units from groups of similar units as a first stage in sampling, even though it can also be used after the first line of sampling has been done. In this study, it was used as the second line of sampling. This approach is inexpensive in terms of time but also has the disadvantage of possible errors occurring.

As a result of this, the sample size was determined using the mathematical approach (Appendix 1). The sample size was then distributed among the various communities, on the basis of their population sizes. Five (5) out of the ten (10) communities that fell under the various CHPS zones, were sampled. This approach rectified the disadvantage of unrepresentative data as about 75 per cent of the said communities got to be sampled. In all, 277 households were captured for the study.

3.5 Data Collection

Both primary and secondary data were gathered for the purposes of this study. Primary data was gathered through the administration of questionnaires for personal household interviews, interview guides for discussions was held with key informants in rural communities in the Lawra District. The household questionnaires were used to collect information on those present at the time of the interview.

Secondary data was gathered from sources such as health reports and policy documents, journals, unpublished Bachelors and Masters Thesis, District Medium-Term Development Plan, Annual District Health Reports, as well as other publications sourced from libraries, institutions and the Internet.

3.6 Data Analysis Technique

Data analysis was done at the individual, household and institutional levels. The variables used for the individual level of analysis were sex, age, educational level,



ethnicity, religion, marital status, employment status. Variables considered at the household level were housing characteristics and facilities, source of fuel for lighting and cooking, sources of drinking water, types of toilet facilities, income levels, expenditure on health services, waiting time, level of satisfaction, health seeking behavior, types of health facilities available, services provided and the problems the households encountered in accessing health care.

However, both qualitative and quantitative techniques of data processing were employed in the analysis of data collected. Quantitative data was analyzed using statistical tools such as tables and averages and the Statistical Package for Social Sciences (SPSS) for data processing, since its application enhances the manipulation and easy use of the data to achieve the stated objectives of the study. Before using the SPSS, the data collected were edited and coded to detect and eliminate possible sources of error so as to make the data reliable. The qualitative data serves as a complement to the quantitative data.



CHAPTER FOUR

RESULTS AND DISCUSSIONS

This chapter provides a descriptive summary of the findings of the social, economic, and demographic characteristics of households sampled in the survey with a focus on some basic background characteristics such as age, sex, education and the socio-economic conditions of the households sampled. This information is crucial for drawing meaningful inferences so as to make appropriate recommendations.

The GPRS II (2006-2009), although the health status of Ghanaians has improved over the years, marked differences still exist in some health indicators among the different geographical regions and socio-economic groupings. These variations in health status are in part due to differential access to quality health care. Despite the considerable investments in the provision of health care facilities, a significant proportion of the people lack access to quality health services. The GPRS II document identified certain factors affecting access to health care, this include geographical and financial barriers, which this study sought to validate or refute.



4.1 Demographic Characteristics of Respondents

4.1.1 Age-Sex Structure

The welfare of every household depends largely on the size and composition of the households as well as the sex of the household heads. For the purpose of this study heads of household representing 6.7% of the total households within the CHPS zones. Approximately 81% of the households are headed by males while 19% are headed by females reflecting the rural situation in Ghana.

Table 4.1 Age/Sex Distribution of the study population

Age Cohorts	Male	Female	Total	Percentage (%)
0-4	15	21	36	5.6
5-9	17	20	37	5.8
10-14	20	16	36	5.6
15-19	25	18	43	6.7
20-24	57	19	76	11.9
25-29	50	29	79	12.3
30-34	49	38	87	13.6
35-39	38	14	52	8.1
40-44	26	20	46	7.2
45-49	22	25	47	7.3
50-54	16	14	30	4.7
55-59	13	14	27	4.2
60-64	17	10	27	4.2
65+	13	5	18	2.8
Total	378	263	641	100

Source: Author's Field Survey, June 2010

4.1.2 Religion and Ethnicity

The study population is largely represented by different religious and ethnic groupings. There are two dominant ethnic groups in the District the Dagaabas (55.4%), and Birifos (32.8%), the Hausa (7.0%) and Waala (4.8%). This result is quite similar to what was captured in the 2000 Population and Housing Census (PHC). Christianity however dominates the religion practiced followed by Traditional and Islamic Religions.



Table 4.2 Ethnicity/Religion

Ethnicity	Religion			Total	Percentage (%)
	Christian	Moslem	Traditional		
Dagaaba	255	35	65	355	55.4
Birifo	105	45	60	210	32.8
Hausa	10	25	10	45	7.0
Waala	9	19	3	31	4.8
Total	379	124	138	641	100

Source: Author's Field Survey, June 2010

4.1.3 Educational Levels

There is a well-known and persistent relationship between education and health seeking behavior. This is because the level of education of individuals helps them to make informed decisions concerning their health and wellbeing. From the data captured the percentage of females with some level of education is encouraging.

This situation can be attributed to the improvement in education over the years and also the measures put in place by governments over the years such as the Free Compulsory Universal Basic Education (FCUBE) programme introduced in 1996, the capitation grant, School feeding programme, providing school uniforms and exercise books. Since mothers often take the first key decision to seek health care for their sick children, their level of education tends to inform this decision.

Based on the survey conducted, the educational qualification of the study population is not encouraging, 56.5% of the study population has had no form of formal education as against 43.5% who has attained some level of formal education.

Table 4.3 Educational Levels Achieved

Educational Level/Sex	Male	Female	Total	Percentage %
Primary	51	35	86	13.4
JSS/Middle School	21	14	35	5.5
Secondary	45	41	86	13.4
Post-Secondary	35	23	58	9.0
Tertiary	9	5	14	2.2
None	237	125	362	56.5
Total	398	243	641	100

Source: Author's Field Survey, June 2010

It is widely known that there is a positive relation between level of education and the utilization of health services. Education tends to influence the type of services used; for instance Green (1992) stated that the educational levels of mothers and particularly



female are strongly related to infant mortality, effective feeding and good use of health services. That is to say that higher education means higher and more effective utilization of health services.

The influence of education is crucial in accessing and utilizing health services and is more significant in rural areas. A majority of people in the rural areas are not highly exposed to mass media; this affects their level of knowledge on the relevance of health care facilities. People tend to show little or no interest in their health or how to preserve it, until their own health is damaged or threatened. This can be related to ignorance about determinants of health and what to do or where to go when sick. The fact that the poor typically have lower levels of schooling explains why they have lower levels of utilization and access to health services.

4.2 Housing Characteristics

4.2.1 Building Materials

The cost and availability of building materials as well as the ability of individuals to be able to purchase them determines the type of building materials that would be used. In Ghana the two main building materials used for the construction of outer walls are mud/earth (50.0%) and cement blocks/concrete (39.2%) of the materials for dwelling places, in the Lawra District 89.6% of the population use mud/earth while 7.3% use cement blocks/ concrete (PHC,2000).

From the survey conducted 71.8% of the houses captured use mud/earth while 21.7% use cement block/concrete. The use of mud/earth as the main building material for the construction of outer walls depicts the acclimatization of the people to the hot environmental condition and also the availability and cost of these local materials. In



addition the fact that very few people within the surveyed population use cement blocks / concrete for the construction of outer walls may be largely due to its high cost.

The type of material used for the flooring of houses depends on the socio-economic standing of the household. According to the 2000 Population and Housing Census 72.2% of households use cement/concrete as a flooring material with 23.5% households using natural flooring materials like mud/earth/mud bricks. However, in the Lawra District 74.8% of the population use earth/mud as flooring material while 22.6% use cement block/ concrete.

Approximately 64.6% of the houses captured in the study use mud/ earth as flooring material while 28.2% use cement as a flooring material. This does not deviate from the situation in the District; this may be due to the fact that household heads find mud/earth to be a safe and cheap material since it does not contain chemicals.

The 2000 Population and Housing Census identified that 60.5% of Ghanaians prefer corrugated metal sheets as a roofing material as compared to 18.5% which prefer to use thatch/palm leaves/raffia. In the Upper West Region however, 45.9% use corrugated metal sheets while 16.4% use thatch from grass. In the Lawra District for instance 39.3% of the population use corrugated metal sheets while 23.2% use thatch from grass. The study further revealed that 54.2% of household heads prefer thatch from grass as roofing material with 45.8% using corrugated metal sheets, this is the situation primarily because it is cheaper to use thatch from grass than corrugated metal sheets.



Table 4.4 Main Construction Materials for Houses

	Number of Houses	Percentage
Outer Wall Materials		
Wood	18	6.5
Cement block/concrete	60	21.7
Mud/mud bricks/ earth	199	71.8
All outer wall	277	100.0
Flooring Materials		
Mud/earth	179	64.6
Wood	11	4.0
Cement /concrete	78	28.2
Other	9	3.2
All flooring	277	100.0
Roofing Materials		
Thatch/raffia	150	54.2
Bamboo	0	0
Corrugated metal/ aluminium sheet	127	45.8
All roofing	277	100.0

Source: Author's Field Survey, June 2010

4.2.2 Source of Lighting

According to the 2000 Population and Housing Census (PHC) report, kerosene lamp was the main source (83.1%) of light for households in the District. While 0.6% depend on other sources of light. In the areas captured in the study, electricity was predominantly used for lighting (66.4%), 13.7% has no light, 19.8% use kerosene lamp.

Table 4.5 Sources of Light

Main Source of Lighting		
Source of Lighting	Number of households	Percentage
No light	38	13.7
Kerosene lamp	55	19.9
Electricity	184	66.4
Total	277	100.0

Source: Author's Field Survey, June 2010

4.2.3 Source of Cooking Fuel

According to the 2000 Population and Housing Census report the two main sources of fuel for cooking in Ghana were firewood (59%) and charcoal (30%) respectively. Again about 87% of households in rural Ghana depend on firewood as fuel for cooking; in the Upper West Region 79.8% of the households depend on firewood as cooking fuel while 16.5% use charcoal.

Table 4.6 Source of Cooking Fuel

Source of Cooking Fuel	Frequency	Percentage
Fuel Wood	163	58.8
Charcoal	101	36.5
Kerosene	6	2.2
Gas	7	2.5
Total	277	100

Source: Author's Field Survey, June 2010

In the Lawra District 84% depend on firewood while 12.2% depend on charcoal, from the survey conducted about 58.8% of the households use firewood while 36.5%, 2.2% and 2.5% depend on charcoal, kerosene and Gas. This situation has devastating consequence as the use of firewood and charcoal is cumbersome and can affect the health of both women and children through the inhaling of smoke when burning the wood, more importantly is the depletion of the forest.

4.2.4 Source of Drinking Water

For members of a household to be able to attain good quality healthy lives, there is the need for adequate supply of accessible potable water. The 2000 PHC report indicates that 58.5% of households in the country have access to potable water, pipe-borne water (42.4%) and 16.4% boreholes. In the Upper West region 63.9% have access to portable water i.e. 16.1% pipe borne and 47.8% bore hole, the remaining households rely on wells and other surface natural water sources such as the river, spring or rain water. In



the Lawra District, 14.7% have access to pipe borne water while 51.2% have access to borehole water.

The availability of and accessibility to potable water may also to a large extent, reduce the incidence of water-related diseases among household members, particularly children. The source of drinking water was important because potentially fatal and devastating water borne diseases, such as diarrhea diseases, guinea worm, bilharzia, typhoid, cholera, and dysentery, are common in the country. The main sources of drinking water are well, borehole, and rivers or streams.

Table 4.7 Source of Drinking Water/Treatment of Water

Source of Water	Treatment Of Water Before Drinking			Total
	Nothing	By Boiling	By Filtering	
Stream/Lake/River	8	2	1	11
Rain Water	15	0	0	15
Well Water	9	0	0	9
Bore Hole	240	0	0	240
Other	2	0	0	2
Total	274	2	1	277

Source: Author's Field Survey, June 2010



Of the households captured, almost 99 per cent did not treat their water in anyway before consumption. Rain water which serves as a supplement to other sources of water needs to be treated, as well as water from the non-mechanized wells. These wells were not household wells, but communal wells, used by all community members and each household brought its own bucket to the well. If these buckets are not kept well, they become good sources of pollution.

The environment of the wells could also become sources of contamination. Transporting the water from the various sources could also pose problems. Thus water

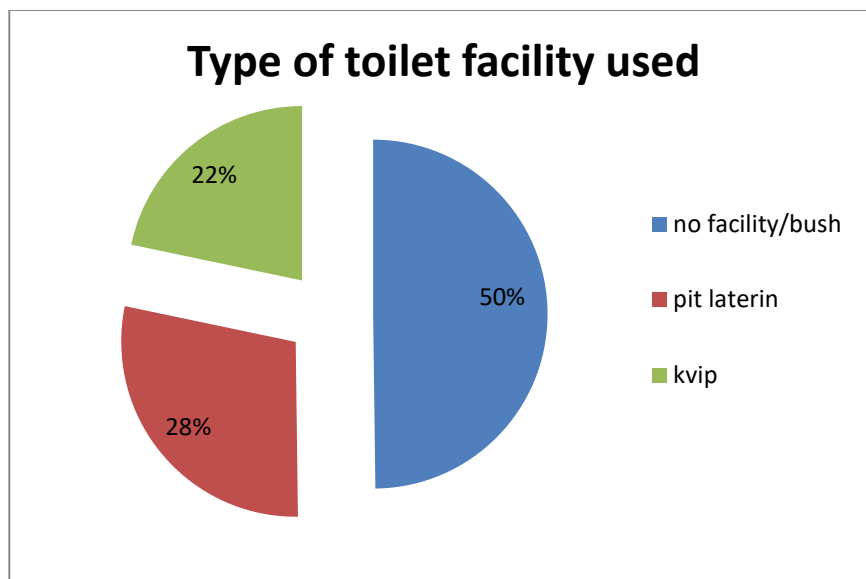
from the various sources need to be treated before consumption. These could take the form of sieving or boiling before consumption.

4.2.5 Types of Toilet Facilities

To ensure a more efficient and hygienic method of human waste disposal there is the need for households to have toilet facilities. According to the 2000 PHC majority of the households in Ghana (42%) have traditional pit latrines, 26% have improved ventilated pit latrines (KVIP), and 11% have flush toilets. The lack of a toilet facility is widespread in rural areas with about 31% of rural folks not having toilet facilities. Some 14% of rural households had KVIP toilets and traditional pit toilets were common in rural areas 54%.

The situation in the District was far from satisfactory; in that only 14.4 % of households had facilities provided in or around the house and in most cases were shared with other households in another house. For the rest of the households, 10.3% used public facilities, while the remaining 75.3% of households had access to no specified facility.

Figure 4.2 Type of toilet facility used



Higher proportions (31%) of the rural population do not have access to any toilet facility according to the GSS (2005) report. In the District 50% of the households surveyed do not have access to any toilet facility, this situation tends to have a negative health impact that can lead to the outbreak of diseases such as cholera, it is therefore not surprising that diarrhea which is a distinctive symptom of cholera is part of the top ten causes of in-patient admissions and Out-patient attendance in the District.

4.3 Economic Situation

4.3.1 Employment Status

The economic circumstance of the respondents captured during the study is quite similar to that of the District. Of those within the working class (15-64 year group) employed; a large proportion of 74.6% of the total employed engage in agriculture. The farming practices used are subsistent in nature and is dominated by small scale farmers who use traditional and labour intensive farming methods. The farmers cultivated rice, maize, millet, guinea corn, yam, tomatoes, pepper, and okro.

Table 4.8 Occupational Status/Employment Status

Occupational Status	Employment Status		Total
	Employed	Unemployed	
Agriculture	320	0	320
Commerce	65	0	65
Service	31	0	31
Industry	13	0	13
Student	0	57	57
None	0	155	155
Total	429	212	641

Source: Author's Field Survey, June 2010



4.3.2 Ownership of Durable Goods

Ownership of selected assets gives an indication of the level of wellbeing of the people, the possession of television and radio sets depicts the economic standing of the population. Respondents were questioned on the ownership of certain household assets such as radio and television (access to information), refrigerator (food storage), telephone (means of communication), and means of transportation (motorbike, bicycle and car). According to the 2000 Population and Housing Census 67% of rural households have a radio and about 30% own bicycle; very few owned items such as television, telephone, refrigerators cars which are mostly restricted probably due to the lack of electricity in rural areas and its affordability.

Based on the survey conducted, 51.6% of the households captured owned a functioning radio set, though none of the communities had a radio station but the District has one thereby making access to information easy. Approximately 29.9% of the households have access to a bicycle, while 6.9%, 10.5% and 6.1% have television set, cell phones and motorbikes respectively. With most of the communities not connected to the national grid the radio and television sets are powered using dry cells and car batteries.

4.4. Health Seeking Behaviour

The decision to employ the services of a particular medical channel is determined by a number of socio-economic variables such as sex, age, type of illness, access to the services and the perceived quality of the services (Tipping and Segall, 1995).

The health facilities accessible to members of the various communities apart from the Community-Based Health Planning and Services (CHPS) are the Ko Health Center, Puffien Health Center, Babile Health Center, Lawra Hospital and Nandom Hospital.



However, the respondents' decision to choose one health facility over the other is based on factors such as proximity, only type available to them, better alternative.

Table 4.9 Reasons for Choice of Health Facility

Indicator	Frequency	Percentage
Have all the needed facility	54	19.5
Proximity	156	56.3
Only type available	28	10.1
Better alternative	33	11.9
Don't know	6	2.2
Total	277	100.0

Source: Author's Field Survey, June 2010

About 56.3% of the surveyed population made a choice of which health facility to attend based on proximity to a health facility. About 19.5% of the households captured would select their preferred health facilities, based on the fact that the facility has the full complement of health services.

4.5 Client Satisfaction

A research conducted by Aragon et.al (2003) in the emergency department of hospitals proposed the "primary- provided theory" as a means to measure client satisfaction taking into consideration three underlying variables i.e. physician satisfaction, waiting time and nursing care. These three underlying variables determine the characteristics of quality healthcare proving that overall client satisfaction depends largely on physician satisfaction, waiting time and nursing care as well as the fact that it is positively related to two indicators i.e. the likelihood of patients approval of health care unit and the extent to which the service is useful in terms of money to be paid.

For the purpose of this study the level of client satisfaction was measured using the waiting times at the various CHPS facilities, the quality of healthcare services. The



Likert scale of between -1 to 2 (where -1 was not satisfied, 0 was fairly satisfied, 1 was satisfied and 2 was very satisfied) was used to assess the level of client satisfaction.

About 31% of the populations surveyed were satisfied with services and treatments offered by the CHOs but would still want to access other health facilities. This was attributed to the fact that the CHPS compounds did not have the full complement of health services. The remaining 43.3% of the surveyed population were satisfied with the services they received from the CHOs/Health Aides on the CHPS compound.

However 25.3% of the populations captured were not satisfied with the services they receive from the CHOs, the non-satisfaction of clients stemmed from the fact that clients felt the health personnel did not have enough time for them during consultation and diagnosis. Though this was attributed to the number of clients the health personnel had to attend to at a time.

4.6 Services Provided by CHOs

About 96% of the respondents captured for the study had received some level of information related to health care as well as health care services from the Community Health Officer (CHO). The frequent services that are usually provided by the CHO include health education related to the prevailing health concerns as well as the ways and means of reducing them, maternal and child care, immunization services against infectious diseases, ante natal and post natal care.



Table 4.10 Type of Services Provided By CHO/Regularity of Attendance by CHO

Type Of Services Or Information Provided By CHO	Regularity Of Attendance By CHO					Total
	Every Week	Every Other Week	Every Month	Every Few Months	Never	
Curative Health Services	2	1	5	7	0	15
Antenatal Services	2	4	10	2	2	20
Delivery Services	0	2	15	0	0	17
Post Natal Services	2	6	16	12	0	36
Immunization Services	1	3	15	17	0	36
Child Growth Monitoring	0	5	13	9	0	27
Family Planning Services	1	3	15	6	0	25
Health Education	3	4	14	0	0	21
Referral Services	0	0	9	0	0	9
Home Visits	3	8	15	11	0	37
Disease surveillance	1	4	8	12	0	25
Not Applicable	0	0	0	0	9	9
Total	15	40	135	76	11	277

Source: Author's Field Survey, June 2010

The services provided by the CHO to respondents all fell within the recommended basic packages. Thus, the CHOs were not over stepping their bounds in carrying out activities and providing services that they are not supposed to provide. Where cases are beyond management at the CHPS level, such cases are referred to higher level health facilities such as health centres or district hospitals as the case may be.



4.7 Problems Clients Encounter

In accessing health care services and facilities, the surveyed population outlined a number of problems they encountered. These include the following:

- narrow roads which make it impossible for one vehicle to move on the side of another;
- the roads are in bad conditions thereby limiting accessibility to referral centres when the need arises;

- limited number of vehicles ply the various community thus causing fares to be relatively higher than would have been the case; and
- The departure times of the few vehicles that ply the communities are unfavorable (dawn).

4.8 Health Facilities

Seven (7) health facilities were captured in the study; these include five (5) functional CHPS compounds, the Nandom Hospital and the District hospital in the capital in Lawra. Because of the referral cases that the higher order facilities handled from the CHPS compounds which are down the health facility hierarchy they were considered for the study. The analysis done was based on the data collected from the various CHPS zones.

4.8.1 Infrastructural Facilities and Services

The availability of functioning health and unexpired facilities, supplies and equipment as well as services provided, signify the beginning of the provision of quality health services. Accessibility to the health facility to the public is equally important to the public. Three indicators of accessibility are discussed in this section i.e. visible sign board indicating the existence of the health facility, the services available and the operational hours.

Visibly displayed sign boards displayed in all the health facilities visited and surveyed, aside from the District Hospital, all the other health facilities did not display the kind of health services available and their working hours. Though not a problem, if the above had been done it would serve as an advantage to health officials, because about 43.5% of the sampled population have some level of education so that they could be aware of the services available even before they come into contact with health care providers.



However, prior to the establishment of CHPS in the various communities some education on the services to be provided was carried out; and CHOs while on their routine rounds provided ready information, as to the kind of services available to clients in their facilities.

Asidestating the working hours on the sign board, the availability of health care becomes a reality if the health care services are provided at the stipulated time. Since the working hours were not stated, it would be difficult to hold service providers to task on when they actually start work. It is however worth noting that though the operational hours had not been stated, the CHPS compounds were accessible 24 hours a day, and 7 days a week, since the health officials are right on hand in the compounds. Services are also available in the District hospital any time of the day and throughout the week (24/7).

4.8.2 Availability of Functional Infrastructural Facilities

Essential components such as constant running water, functioning toilet as well as constant electricity supply are important to ensure an effective health system which would lead to efficient health service delivery. The recent energy crisis has had heavy toll on the District hospital with constant power outages and 'fluctuations. However the five (5) CHPS compounds visited during the survey had gas fridges which were used to store vaccines, this has sometimes proven to be unreliable in situations of gas shortages the fridges had to be put off.

Despite the fact that the CHPS compounds lacked running water, the communities where they were located had functioning boreholes. Three (3) out of the five (5) CHPS compounds had a functioning Motorola communication system, this enabled the CHO



to communicate with the higher order facilities about referral cases to ensure smooth continuity of medical care.

4.8.3 Medical Examination Facilities

To ensure that a patient's health condition is diagnosed appropriately and the right recommendation done, it is imperative that a patient is well scrutinized for any physical problems. The client must not be inconvenienced during such examination as such acceptable aural and visible privacy in an illuminated serene environment is important, this would enable the client express his/her health concern knowing that his/her privacy is assured. In conducting the survey it was realized that all the CHPS compounds visited met the above requirements except that at night due to the lack of electricity in these communities clients cannot be examined and attended to except at the District Hospital and the Nandom Hospital. It is also necessary to ensure that all the basic equipment required for medical examination such as the sphygmomanometer (BP apparatus) and the Thermometer are available and functioning, this which all the facilities visited have.



4.8.4. Problems in Health Delivery

- Inadequate supply of transportation to referral centres (road surface, lack of ambulance, irregular movement of vehicles)
- Inadequate and unreliable power supply
- Inadequate motivation
- Long delays of reported cases which result in complications
- Lack of water at the CHPS compounds.

CHAPTER FIVE

OPPORTUNITIES AND CHALLENGES, RECOMMENDATIONS AND CONCLUSION

5.1 Opportunities and Challenges

The successes gained in health care delivery through the implementation of CHPS in rural areas are centered primarily on both internal and external factors that support the initiative. However these opportunities as well as challenges that have the potential of promoting and or impeding the success of the initiative are discussed below;

- I. Trust –because of the exclusive relationship that is developed between Community Health Officers and members of the various communities surveyed in the Lawra District, a high level of mutual trust is natured that contributes significantly to health seeking behavior of community members. When this happen payments for drugs can be postponed, CHPS is therefore seen as a form of Health Insurance since health care services can be paid on a credit basis while previously the demand for immediate payment was a constraint (the cash and carry system of old).
- II. Accessibility- the fact that community members can easily access health care service without having to travel long distances to obtain medical services and also because emergency services are available 24hours a day and 7 days a week is a great opportunity for the continuous development of CHPS. Again due to the closeness of the health facility to the community, members are able to develop a close relationship with the community health nurses and feel safe when receiving health care services.





- III. The principle underlying the implementation of the CHPS initiative is that beneficiary communities should have a sense of ownership. This is demonstrated through involving of community members' right from the planning stage through to the implementation stages i.e. the selection of sites, carrying water, and sand, wood as well as molding blocks. The needed structures are also provided with the help and support of the community so that they feel a sense of ownership and pride in the programmes of the initiative.
- IV. The members that constitute the health committees and the volunteers hail from the community are selected by the traditional rulers and are under the direct supervision of the health committees. They deliberate and determine the basic health needs related to their communities, this situation promotes the acceptability and sense of ownership thereby enabling members of the community to access the needed health care services.
- V. The existence of government institutions such as the chieftaincy institution, traditional healers, religious leaders, teachers as well as the health institution is a very important opportunity for the CHPS initiative. These institutions serve as a medium through which community members can actively take part in the implementation of the CHPS initiative; this can be done through health education.
- VI. Another opportunity is smaller numbers of rural population as compared to that of urban areas, as a result the stress and the drain that health facilities and workers experience is nonexistent in rural areas. This makes it easier for health workers to interact well with their clients and a more personal basis thereby making it easy for them to tackle their health needs exclusively.



- VII. Shared Language- the population in rural areas is not homogeneous but there is a common language that is generally spoken and understood by all. This enhances smooth communication and makes the dissemination of information easy thereby helping people to appreciate outstanding issues, obtain the required information and make informed decisions.
- VIII. Considering the fact that CHPS is regarded as the most important approach for reaching the unreached, the initiative represents one of the health sector components of the national poverty reduction strategy. By travelling from compound to compound on motorcycle, Community Health Officers (CHOs) cover a catchment area of approximately 2000 individuals.
- IX. The services of Community Health Officers include family planning, immunizations, antenatal/postnatal care, supervising delivery, treatment of minor ailments and health education. CHOs perform these functions with the help and support of community volunteers who assist with community mobilization, the maintenance of community registers and other essential activities. This approach overcomes important barriers militating against community access to health care, notably geographical, social, financial, gender barriers, among others.
- X. The National Health Insurance Scheme (NHIS) - The introduction and acceptance of the National Health Insurance Scheme in the rural areas will impact positively on the health seeking behaviour of the rural folk. More people are now willing to access health services since by registering and paying their premiums, their health needs are readily met and they do not have to pay out of pocket when they visit the CHPS compound for care.



- XI. Government acceptance and support of CHPS - CHPS has been identified by the government as a strategy for reducing health inequalities and increasing access to health services. CHPS therefore enjoys government support for its successful implementation.
- XII. Support by the of Government of Ghana and community resources - Political leaders at all levels are committed to health sector reform. In 1996 an act of Parliament Act 525 created the Ghana Health Service (GHS) as an extra-ministerial agency that is outside the civil service, freeing the health sector to change, innovate, and reform health care operations in Ghana. This flexibility enables the GHS to utilize research for guiding innovation with research activities.
- XIII. Decentralization is a key element of health care reform in Ghana. The CHPS programme has demonstrated feasible ways of developing community health care in this new era of flexibility and dynamism. decentralization permits adaptation of service approaches to local needs and cultural circumstances, a critical component of effective community health care in a multi-ethnic African society.
- XIV. Research is guiding policy and programme development. Experimental research in Navrongo provides rigorous scientific appraisal of what works and what fails; The CHPS M&E System monitors the pace, content, and geographic spread of scaling up; CHPS survey research assesses the impact of CHPS; qualitative research diagnoses problems and clarifies the nature of innovation. Dissemination systems have been developed to communicate research findings to all District Health Management Teams (DHMT) and all senior GHS officials through newsletters, conferences, and site visits.

5.1.1 Challenges

- I. Bad road network- despite the fact that the roads that link the various communities in the CHPS compounds are in poor conditions, hardly do vehicles ply these roads.
- II. Majority of the CHOs are females who may be unwilling to accept postings very remote areas. This can be attributed to the conditions of the remote areas as well as the fear of not meeting marriage partners of their choice. However those who are married might be reluctant to move to remote communities because they are deeply concerned about their survival, their family and the welfare and education of their children.
- III. In communities where the health volunteers are very active, there is the tendency for community members to consider them as doctors and this could result in a situation where the volunteers start performing task that are outside their duties.
- IV. Another challenge is the irregular supply of energy and sometimes the unavailability of energy to power the refrigerators for vaccines to be stored. The problem is compounded with the erratic supply of LP gas,when this happens the fridges have to be turned off and vaccines destroyed since they are not to be stored in fridges that are not powered.
- V. Brain drain and staff attrition: the major challenge facing the sustainability of Ghana's health sector is brain drain and the CHPS initiative is also affected by this canker. The attrition rate of CHOs is high in some communities with most of them having the desire to further their education.
- VI. Cumbersome and time consuming report writing. Recognizing the fact that the CHO is a clinician, a public health officer, more of the health officer's time is spent compiling and writing a report at the end of every month. This means hours



lost to service delivery and attention client needs. Also, some incidences and activities on the compound or within the zone are overlooked and not recorded.

- VII. There is the tendency for the lack of continuous education and supervision of health programmes in the communities by the programme managers. These lead to a reverse to old negative ways in health care systems.
- VIII. The high expectations that communities have when new and innovative programmes are introduced tend to make them lose interest especially if their felt needs are not addressed by these programmes.

5.2 Recommendations

Water and Sanitation

- Water from sources such as rivers/streams, wells and rain water must be treated either by boiling or sieving before consumption.
- There is the need for community water and sanitation to intensify education on the need to wash their hands before eating and after visiting the toilet. This would go a long way to reduce the incidence of diseases such as diarrhea and cholera.
- In addition the District Assembly in collaboration with the District community water and sanitation agency must put measures in place to ensure that owners of houses to build toilets in their houses.
- Sanitary inspectors must be resourced adequately to continue the weekly inspection of houses to ensure they are clean and those found culpable be punished. This would help ensure that the various households are clean, thereby resulting in the decline of diseases such as malaria, diarrhea, and cholera among others.



Utilities and Fuel

- Majority of rural households depend on firewood and charcoal as the main source of fuel for household activities. The use of LPG if extended to rural communities has immense potential to reduce deforestation and the harmful impact to the health of the poor and the environment from the burning of wood for fuel. The challenge however is the cost of LPG compared to the wood for fuel it is to replace. The other challenge to the use of LPG is the extension of LPG distribution network. This can be overcome if subsidies are provided by government for the establishment and propagation of LPG refilling station in rural areas and also subsidies to make it cheap and affordable.

CHPS Compounds

- Advocacy for increased budgetary allocation to the Health Sector as well as more and better aid for the health sector the CHPS initiative must be brought into the budgetary frame of both MOH and GHS, just like the NHIS. The budgets should be for supportive activities like the provision of equipment and other minor essential items.
- Measures should be put in place to ensure effective community monitoring of staff performance, the quality of care from the client and provider's perspectives, as well as client satisfaction.
- Revamping and strengthening Community Health Committees; developing local civic coalitions as organs of ordinary people to reinforce community participation in decision-making, resource allocation and civic oversight of the health sector.
- The human resource base of the CHPS programme must be re-examined to take into consideration the skill mix of the CHOs which emphasizes on all components



(i.e. Curative, preventive and promotive health care). This can be done if the leadership of the CHPS programme at the Regional and District level are made to understand the concept and be proactive and innovative about the initiative. CHOs can also be paired with complementary skills.

- CHOs need to be motivated to develop their career progression in the GHS, this needs urgent attention to ensure clearly defined career pathway for CHOs. Distance learning programmes should be organized for the CHOs to enable them further their education. If this is done the challenges associated with brain drain and attrition as well as deployment would be reduced.
- Community members should be involved during the planning stage of the implementation of the CHPS initiative; this would enable them to understand fully the aim of the concept thereby improving their commitment and utilization. CHOs must plan with the communities and assist them in decision making without imposing decisions on them; community members must also be involved in monitoring the progress or otherwise of the initiative.
- The job description of Community Health Volunteers should be spelt out clearly for them and their activities well monitored and supervised by the CHOs, Community Health Committee members so that they do not perform functions / activities that are beyond their expertise.
- Home visits should be intensified to reduce the burden of transportation cost on the community members to the CHPS compounds; this would also promote early detection of ailments. This can be achieved by providing and insuring motorbikes for CHOs.



- Since the CHPS initiative is not only a health problem but also a developmental issue, other sectors such as local government authorities, Agriculture and Food and education sectors should be engaged in the planning and implementation of CHPS.
- There is the need for changes in institutional culture and processes. This recommendation is drawn from the observation that possibilities to respond to community priorities outside conventional preventative, curative and public health services are limited and community-level workers did not feel confident about their ability to influence departmental decisions. They often did not communicate the insights they gained in the community to departmental level.

Physical Access

- The District Assembly in collaboration with Feeder roads should hasten attempts at improving the road network in the district, so as to make the CHPS facilities more accessible to patients as well as encourage public transport owners to ply the road frequently.
- The District engineer in consultation with other stakeholders should develop a feeder road maintenance plan and strategy for the District prioritizing all the feeder roads within the district for both routine and periodic maintenance. Again where possible community labour should be used during the road maintenance, this would go a long way to reduce the cost of road maintenance.
- Responding to the priorities expressed by the community requires inter-sectoral collaboration. For example, health, agriculture and cooperatives departments could link improvements in livelihood opportunities with improvements in health.



5.3 Conclusion

The CHPS strategy is a community-based approach to health service delivery which seeks to provide health services through partnerships between the health programme, community leaders and social groups. The CHPS programme was launched against the realization that more than 70% of all Ghanaians lived over 8 kilometers from the nearest health care provider, a problem made worse by inadequate road and transport facilities. However there still exist marked differences in health indicators particularly between rural and urban areas.

Infant mortality rates in rural areas are 60% higher than the rates prevailing in urban areas and these deaths are mainly due to communicable diseases such as malaria and diarrheal diseases. The CHPS initiative was designed to take care of the health needs of the people especially the rural population, the major diseases that lead to high morbidity and mortality among Ghanaians are preventable or curable if diagnosed early and promptly treated. Therefore the main aim of CHPS is to extend coverage of basic primary health service to people who cannot easily access health care.



Factors contributing to poor geographical access include low capital investment in health facilities, poor feeder road systems in the country, poor location of facilities and lack of communication facilities. Service delivery barriers that have constrained access to quality health care include organizational and management constraints; weak support systems such as transportation and equipment for service delivery; and human resource constraints. Thus accessibility to basic health care services was the key factor that influenced the initiation of the CHPS concept.

The mal-distribution and problems associated with geographical and financial access coupled with staff attrition of highly qualified staff mean that new ways of working are

required to deal with the basic ailments that plague the poor. In response to this the CHPS initiative views that working with households and communities to ensure the availability of appropriate community-based services, and addressing all barriers to access at the local level are some of the most important areas that require new and innovative approaches. If this can be achieved, key barriers would be removed.


In addition the syllabus in training schools should include programmes on maternal health; afterwards the CHOs should be officially licensed by the Nurses and Midwives council to carry out simple deliveries.

Again the mode of family training concept should be integrated in to the activities of the CHO, this if done would go a long way to assist community members to educate each other on their health needs.

If CHPS succeeds, it will do so because it is fundamentally and intrinsically a Ghanaian initiative that blends health care reform with mobilizing support from social institutions and traditions. As such, CHPS is a bold departure from bureaucratic models for changing the way that health organizations operate. It represents a new and fundamentally African approach to organizational change by building consensus, marshaling local resources, and respecting indigenous institutions. Owing to these circumstances, Ghana is positioned to be a regional leader in evidence-based health sector reform.



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APPENDICES

Appendix 1

The actual sample size was determined using the mathematical approach;

$$n = \frac{N}{1 + N(\alpha^2)}$$

Where n is the sample size

N is the total population (households) and (α) is the error margin (5%), (Statistical service)

Table 3.1 Characteristics Study Communities

S/N	Communities	Popn. (2000)	No. Of Hholds	Av Hhold c Size
1	Gbengbee	826	119	
2	Ambur	385	55	
3	Gbelingkaa	185	26	
4	Boo Naayir	643	97	
5	Kunyukuo	563	70	
6	MethohBuo	234	72	
7	Gengenkpe	604	172	
8	Bikyilteng	435	79	
9	Kokoligu	620	105	
10	Tankyara	577	107	
	Total	5,072	902	

Source: 2000 PHCReport

Thus the sample used will be computed using



N=902 households

$\alpha=0.05$

$n=902/[1+(902 \times 0.05^2)]$

n= 277 households

Appendix 2:

Types of Participation

- Passive participation – people participate by being told what is going to happen or has already happened. It is a unilateral announcement by an administration or project management without listening to people’s responses. The information being shared belongs only to external professionals.
- Participation in information giving – people participate by answering questions posed by extractive researchers using questionnaire surveys or similar approaches. People do not have the opportunity to influence proceedings, as the findings of the research are neither shared nor checked for accuracy.
- Participation by consultation – people participate by being consulted and external people listen to views. These external professionals define both problems and solution, and may modify these in the light of people’s responses. Such a consultative process does not concede any share in decision-making, and professionals are under no obligation to take on board people’s views.
- Participation for material incentives – people participate by providing resources, for example labour in turn for food, cash or other material incentives. Much on-farm research falls in this category, as farmers provide the fields, but are not involved in the experimentation or the process of learning. It is very common to see this called participation, yet people have no stake in prolonging activities when the incentives end.
- Functional participation – people participate by forming groups to meet predetermined objectives related to the project, which can involve the development of externally initiated social organisation. Such involvement does not tend to be at early stages of project cycles or planning, but rather after major



decisions have been made. These institutions tend to be dependent on external initiators and facilitators, but may become self-dependent.

- Interactive participation - people participate in joint analysis which leads to action plans and the formation of new local institutions or the strengthening of existing ones. It tends to involve interdisciplinary methodologies that seek multiple perspectives and make use of systematic and structured learning processes. These groups take control over local decisions, and so people have a stake in maintaining structures or practices.
- Self-mobilization - people participate by taking initiatives independent of external institutions to change systems. They develop contacts with external institutions for resources and technical advice they need, but retain control over how resources are used. Self-initiated mobilization and collective action may or may not challenge existing inequitable distributions of wealth and power.

Source: Mikkelsen, 2005



Appendix 3 CHPS Milestones

- Participatory planning - Communities are mapped, problems are assessed, and a process of “community entry” is launched which involves dialogue between health care providers and community leaders. Early in the CHPS process, building political support for health is pursued to establish a strong collaboration between District Assemblies and DHMT in marshaling District development funds for CHC construction.
- Participatory programme development - Once leadership responsibilities are clarified, communities are encouraged to raise revenue and convene teams of volunteers to construct or locate simple accommodation that the Health Officer will reside known as “Community Health Compounds (CHC)”.
- Reorienting and posting nurses to communities - Successful completion of a CHC is followed by posting a nurse to the community. Existing Community Health Nurses are provided with refresher training in family planning, new procedures for community family planning services (such as injectables), and comprehensive training in community health service delivery and referral. Upon completion of training, these nurses are re-designated “Community Health Officers” (CHO), then become community-based front-line health workers who visit households, organize community health services, and conduct CHC clinics.
- Procuring essential equipment - CHPS requires additional equipment that is not part of a clinic-focused service provision. These health workers require motorbikes, clinical equipment, basic household equipment, and supplies that are required for their expanded role.
- Mobilizing traditions of volunteerism - CHPS depends on the support of volunteers to be successful. Community structures such as Community Health



Committees select and with the assistance of the DHMT and CHOs train them to support their work. CHPS demonstrates ways to develop CHO supervision and referral services that improve the quality of volunteer services and community participation in managing volunteerism. In the CHPS approach, volunteer effort is focused on mobilizing labour for clinic construction and male participation.

Source: Nyonatoret. al, 2002.



Appendix 4: Organisation of Community-based Service Delivery

A4.1 The District Level

The District is the major unit of primary health care organisation and management for service delivery in Ghana. Within the District, health services are organised in a three tiered hierarchy with the District level (level C) at the top, the sub-District level (level B) next and the community level (level A) at the bottom. Each District has a District Health Management Team (DHMT) with the District Director of Health Services (DDHS) as the head. Where such a person is available, this is usually a physician with training in public health. In the absence of a physician (as is the case in many Districts), one of the other members of the DHMT is nominated to take on this role.

The rest of the DHMT is made up of (depending on availability), a public health nurse, a nutrition officer, a communicable diseases control officer, an accountant / accounts officer, a pharmacist, a representative of clinical service delivery e.g. the Senior Medical Officer in charge of the District hospital, and a health education and promotion officer.

The members of the DHMT have dual responsibilities to the DDHS as well as to the Director of the functional unit they represent at the regional level. Thus, the DDHS must have team coordination as well as team leadership functions.

The functions of the DHMT are predominantly managerial as well as provision of technical support to the health teams providing service delivery at the sub-District and community level and at the District hospital (where there is one in the District). Managerial functions performed by the DHMT include planning, monitoring and supervision of strategies for achieving District health objectives drawn up in the light of national policy goals. The DHMT also has a “political” role in that it provides the link at the District level between the local government body (the District assembly) and the



health sector as well as other decentralized sectors or departments such as education and agriculture.

A4.2 the Sub-District Level

Each District is zoned into about four (4) or more sub-Districts depending on its size. A sub-District has a population of about 20,000 – 30,000. Sub-Districts in the health sector administrative classification generally correspond to area councils in the local government classification; the difference being that sometimes the health sector may put two or three area councils together into one sub-District.

Sub-District management and the concept of the Sub-District Health Team (SDHT) are much more poorly developed than the DHMTs; and there are many problems at this level. Depending on staff availability, the SDHT has a leader who is usually a Medical Assistant (a professional nurse with 2 years extra training in curative care delivery and some administration). Other members of the core team are a senior Community Health Nurse/Midwife, a communicable diseases control officer, a nutrition officer and an environmental health officer. They are assisted by several auxiliary grades of nurses and public health personnel as well as support staff such as cleaners. The sub-District based health workers operate from the health post or rural health centre and their functions are predominantly service delivery.

A4.3 The Community Level

There are numerous communities within a sub-District. In rural areas a community usually corresponds to a village or cluster of hamlets but it is not always easy to concisely define a community in terms of population alone. The definition of a community for purposes of service delivery has to take into account geographic location as well as



population. Some rural communities may have as few as 100 or less people, but are so far from everybody else it is difficult to group them with another community. On the other hand, a large town with several thousand or more population may not be easy to classify or deliver service to it as a single community even though the people are fairly closely clustered in the same geographic location.

It is recommended that CHPS zones should be created in synchrony with existing local government structures. The District Assemblies and Unit Committees use population of 1500. The recommended Population of a CHPS Zone is 3000 to 4500 people – i.e. covering two to three Unit Committees of the District Assembly. The CHPS zone should have a maximum of two trained CHOs to provide services to households within the communities. These services should focus more on outreach and house-to-house services, establishing community decision making systems and using community register to trace defaulters and people with special conditions like pregnant women and children at risk. The CHO in a CHPS zone is a member of the sub-District health staff, advocating for health in the communities.



Volunteer systems are to be set up in a way that the community health committees are in direct control of the volunteers. Their selection and incentive systems should be under the direct control of the community health committee. The District Health Administration (DHA) can also provide additional incentives, like bicycles, through the SDHT.

Finally, at the community level, health workers of the GHS must ensure that the service delivery package is adhered to and includes treatment of minor ailments, family planning, antenatal care, delivery and postnatal care, child welfare clinics, immunizations, counselling, school health, home visits, supervision of Traditional Birth Attendants and

volunteers. The community levels also provide support for CHOs and community volunteers.

Source: GHS Policy Document No 20, May 2005



Appendix 5: Job Description of the Community Based CHN (CHO)

- Household and Community level education on primary health care
- Provision of education on prevention and management of STD, HIV/AIDS and other diseases of public health importance as relevant
- Immunization and providing pre and post natal care
- Pre (Ante) and Post natal care
- Delivery and Intra-partum care
- Supervising and monitoring sanitation efforts
- Provision of nutrition education and care
- Primary care for simple uncomplicated cases of common endemic diseases
- Appropriate referral for more serious ailments
- Provision of family planning services and referrals
- Supervision and monitoring of community volunteers and TBA
- Disease surveillance
- Collection, compilation and analysis of routine HMIS data to monitor service delivery and provide input for planning



Appendix 6: Creating the CHPS Zones

The regional and district levels hold the key to achieving the target of providing access to CHPS services for all households. The first essential key step in implementing CHPS is for all Districts to conduct a situation analysis for their service delivery and coverage this analysis should define minimum indicators to warrant start-up in CHPS for a district, including physical distances, coverage for basic services and existing disease patterns. In line with this policy direction, the community level (level A) of the District Health system should be implemented such that all people living in Ghana are covered by its services by the year 2015. To accomplish this, all sub-districts within every district should be demarcated in to service delivery “zones” following the guidelines provided in the National Implementation Plan.

Once the decision is taken by the DHMT and the communities, the transformation of community health systems from clinic focused care to community-based care zones then involves the achievement of “milestones” that are documented in a monitoring system.

The following largely sequential “milestone” are essential to the establishment of a fully functional CHPS zone within a Sub-district;

- Preliminary Planning it involves grouping communities into service zones, specifying where each nurse is assigned to provide care, identifying community leaders and planning optimal location of the facilities to be used as service points for community-based health care (health compounds);
- Community Entry includes conducting meetings and diplomacy with village leaders, convening public gatherings known as durbars for communicating plans and activities to communities, and constituting health liaison committees for providing daily support to the programme;



- Health compound construction utilizes volunteer labour and community resources to develop the dwellings where nurses live and work;
- Procurement of essential equipment such as motorbikes, bicycles and client equipment.
- Posting nurses and providing them with technical refresher training and orientation to communities where they are assigned; and
- Volunteer recruitment involves engaging health committees in designating health volunteers to assist with community activities in child health, family planning and other reproductive health services.

Source: GHS Policy Document No 20, May 2005



Appendix 7

Faculty of Planning and Land Management

University for Development Studies

COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)

INITIATIVE: CHALLENGES AND OPPORTUNITIES TO IMPROVING RURAL

ACCESS TO HEALTH SERVICE DELIVERY IN THE LAWRA DISTRICT

LAWRA DISTRICT

(HOUSEHOLD SURVEY)

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HOUSEHOLD IDENTIFICATION



Name of Locality:.....

Name of community:.....

Name of Head of Household :.....

Interview Date:

SECTION 1: HOUSEHOLD COMPOSITION

101. Name of household member	102. Relationship to head of household*	103. Sex*	104. Age*	105. Ethnicity*	106. Religion*	107. Marital status	108. Educational level attained*	109. Employment status*

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***PLEASE FIND BELOW, CODED RESPONSES TO QUESTIONS**

SECTION 2: HOUSING CONDITIONS AND FACILITIES

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QUESTION NO.	QUESTION	REPOSES																								
201.	What is the major source of drinking water for the members of your household?	STREAM/RIVER.....1 RAINWATER.....2 WELL WATER.....3 BORE HOLE.....4 OTHER (SPECIFY).....5																								
202.	What do you do to your water before drinking?	NOTHING.....1 ADD ALUM.....2 BOIL.....3 SEIVE.....4 FILTER.....5 OTHER (SPECIFY).....6																								
203.	What kind of toilet facility do the members of your household use? If response is 'LATRINE', PROBE: <i>Is this a regular pit latrine or a Kumasi Ventilated Improved Pit Latrine (KVIP)?</i>	NO FACILITY/BUSH/RIVER/ FIELD/STREAM.....1 BUCKET/PAN.....2 PIT LATRINE.....3 KVIP.....4 WATER CLOSET.....5 OTHER (SPECIFY).....6																								
204.	What is the main source of lighting for this household?	NO LIGHT.....1 KEROSENE LAMP.....2 GAS LAMP.....3 OTHER (SPECIFY).....4																								
205.	What is the main source of cooking fuel for this household?	FUEL WOOD.....1 CHARCOAL.....2 KEROSENE.....3 GAS.....4 OTHER(SPECIFY).....5																								
206.	How many rooms does this household occupy? PROBE: <i>This includes living rooms, dining rooms and sleeping rooms, but not bathrooms and kitchen.</i>	TOTAL NUMBER OF ROOMS.....																								
207.	How many of these rooms are used for sleeping?	NUMBER OF SLEEPING ROOMS.....																								
208.	Does any member of your household own a functioning? <i>(Read aloud, filling in the blank with each of the items listed)</i>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>RADIO</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>TELEVISION</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>CELL PHONE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>BICYCLE.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>MOTORBIKE.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>CAR/TRUCK.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>TRACTOR.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		YES	NO	RADIO	1	2	TELEVISION	1	2	CELL PHONE	1	2	BICYCLE.....	1	2	MOTORBIKE.....	1	2	CAR/TRUCK.....	1	2	TRACTOR.....	1	2
	YES	NO																								
RADIO	1	2																								
TELEVISION	1	2																								
CELL PHONE	1	2																								
BICYCLE.....	1	2																								
MOTORBIKE.....	1	2																								
CAR/TRUCK.....	1	2																								
TRACTOR.....	1	2																								
209.	If a member of your household has a health emergency and requires care at	MYSELF.....1 HELP OF COMMUNITY.....2																								

	the district level, how would you arrange for transportation for this individual?	VILLAGE HEALTH COMMITTEE.....3 OTHER(SPECIFY).....4
--	---	--

SECTION 3: HOUSEHOLD INCOME AND EXPENDITURE

301. What are the sources and amounts of income available to this household?

Source	Amount/month	Amount/annum
Agriculture (1)		
Commerce (2)		
Service (3)		
Industry (4)		
Contributions from other household members (5)		
Remittances (6)		
Others, please specify (7)		

302. On what do you spend the household income and how much?

Item	Amount/week	Amount/month	Amount/annum
Food (1)			
Clothing (2)			
Toiletries (3)			
Rent (4)			
Utilities (5)			
Fuel (6)			
Health care (7)			
Transportation (8)			
Education (9)			
Communication (10)			
Farm inputs (11)			
Farm machinery (12)			
Raw materials (13)			
Household durables (14)			
Donations, gifts and remittances (15)			
Savings (16)			
Levies (17)			
Credit repayment (18)			
Others, specify (19)			



SECTION 4: National Health Insurance Scheme

- 401. Have you heard about the NHIS and its benefits? Yes...1 No...2
- 402. Are you insured? Yes...1 No...2
- 403. Do you know the minimum premium being charged? Yes...1 No...2
- 404. Will you be able to pay the said amount? Yes...1 No...2

SECTION 5: COMMUNITY CHARACTERISTICS

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501. Do you have any means of transport from your community to nearest town?

- (A) Yes [] (B) No []

If yes name them.....
.....
.....
.....

502. How often does this means of transport move?

- (A) Once A Day [] (B) twice A Day [] (C) Other []



503. If someone in this community is sick or injured and requires immediate health care, what means of transportation would most likely be used to reach the nearest health facility?

- (A) Bicycle []
- (B) Motorbike []
- (C) Public Transport/Bus []
- (D) On Foot/Walking []
- (E) Other []

504. Approximately how long would it take to reach the nearest health facility by this means of transportation?

(A) 0-60min [] (B) 1-2hrs [] (C) 3-4hrs [] (D) Other []

505. Can this community be reached by 4-wheel motor transport (such as a car, bus, truck, etc.)? (A) Yes [] (B) No []

506. Are there times during the year during which the community cannot be reached by motor transport (even a 4-wheel)? A Yes [] B No []

507. Does this community have access to an established *local* FM radio station?

(A) Yes [] (B) No []

SECTION 6: HEALTH FACILITIES AND SERVICES

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601. What are the health facilities available in your community?

CHPS Compound.....1 None.....2

602. Which health facilities do you visit when the need arises and why?

CHPS Compound.....1 Health centre.....2 District Hospital.....3

.....

603. How satisfied are you with the services of the facility in terms of the following?

Indicator	Very Satisfied (1)	Satisfied (2)	Not Satisfied(3)
Receiving desired information and services			
Having enough time during consultation			
Having enough privacy during consultation and examination			
Understanding the service provider			
Reasonable waiting time			

SECTION 7: CHPS/COMMUNITY HEALTH OFFICERS

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QUESTION NO.	QUESTION	REPOSSES
701.	Approximately how often does the CHO come to visit your household?	EVERY WEEK.....1 EVERY TWO WEEKS.....2 EVERY MONTH.....3 EVERY FEW MONTHS.....4 NEVER.....5
702.	What type(s) of services or information has the CHO ever provided you and/or the members of your household? <i>*Do not read choices aloud; spontaneous responses should be sought.</i> PROBE to be sure that all known CHO services have been mentioned.	CURATIVE HEALTH SERVICES....1 ANTENATAL SERVICES.....2 DELIVERY SERVICES.....3 POSTNATAL SERVICES.....4 IMMUNISATION SERVICES..... 5 CHILD GROWTH MONITORING....6 FAMILY PLANNING SERVICES.....7 HEALTH EDUCATION.....8 REFERRAL SERVICES.....9 OTHER (SPECIFY).....10
703.	<i>The CHPS programme involves a number of Community Health Volunteers. These Volunteers often visit the households in a village.</i> Have you or any member of your household ever received information or services from a Volunteer working in your community	YES.....1 NO.....2 DON'T KNOW.....3
704.	What type(s) of services or information has the Volunteer ever provided you and/or the members of your household? <i>*Do not read choices aloud; spontaneous responses should be sought.</i>	FIRST AID.....1 FAMILY PLANNING SERVICES.....2 IMMUNISATIONS.....3 HEALTH EDUCATION.....4 PARACETAMOL.....5

	<p>PROBE to be sure that all known Volunteer services have been mentioned. <i>*Health education may cover immunisation, nutrition, STIs, HIV/AIDS, antenatal care, sanitation, etc.</i></p>	<p>ORAL REHYDRATION (ORS).....6 REFERRAL SERVICES.....7</p>
705.	<p>Approximately how often does a Volunteer visit your household?</p>	<p>EVERY WEEK.....1 EVERY TWO WEEKS.....2 EVERY MONTH.....3 EVERY FEW MONTHS.....4 NEVER.....5</p>
706.	<p>How would you compare the quality of health service delivery in your community before vs. after the CHPS programme was introduced? (after the nurse came to live in your community?)</p>	<p>BETTER NOW.....1 WORSE NOW.....2 SAME/NO CHANGE.....3 CAN'T TELL/DON'T KNOW.....4</p>
707.	<p>Would you prefer going to a health facility than have a CHO or Health Aide attend to you?</p>	<p>YES.....1 NO.....2</p>

708. If yes, why?

.....

.....



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COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)
INITIATIVE: CHALLENGES AND OPPORTUNITIES TO IMPROVING RURAL
ACCESS TO HEALTH SERVICE DELIVERY IN THE LAWRA DISTRICT
(District Health Directorate)

1. Name of interviewer:
2. Name of respondent:
3. Position of respondent:
4. Date of interview:
- I. Number of health facilities as per category/level.
District Hospital [], Health Centre [], Community Clinic [], CHPS Zones [],
Others, Specify.....
.....
- II. What are the Top ten OPD diseases
- III. Top ten in-patient admissions
- IV. Sources of funding for health projects and services
- V. What are the Problems you encounter during health services delivery
- VI. Potentials that exist for health services delivery in the district
- VII. Support for CHPS in the district
- VIII. Health situation before CHPS and after CHPS
- IX. Process for CHPS implementation
- X. Community participation and role in CHPS services provision
- XI. District health indicators: IMR....., MMR....., U5MR.....



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COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)
INITIATIVE: CHALLENGES AND OPPORTUNITIES TO IMPROVING RURAL
ACCESS TO HEALTH SERVICE DELIVERY IN THE LAWRA DISTRICT

DISTRICT CHPS CO-ORDINATOR'S INTERVIEW GUIDE

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1. Name of interviewer:
2. Name of respondent:
3. Position of respondent:
5. Date of interview:

- I. What are the processes involved in the implementation of CHPS
- II. Elements and components of CHPS
- III. What is the Criteria for setting up CHPS
- IV. What is the role and contribution of the community in CHPS services provision.
- V. What are the categories and types of health facilities that relate to CHPS
- VI. CHPS communities under each zone
- VII. personnel required to man CHPS facilities
- VIII. Personnel needs and currently available
- IX. Contribution of other organisations/institutions to CHPS programmes in the district
- X. Prospects for the success of CHPS in the District
- XI. Mitigating factors of CHPS in the District
- XII. Problems



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COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)
INITIATIVE: CHALLENGES AND OPPORTUNITIES TO IMPROVING RURAL
ACCESS TO HEALTH SERVICE DELIVERY IN THE LAWRA DISTRICT

HEALTH FACILITY SCHEDULE

UNIVERSITY FOR DEVELOPMENT STUDIES



- 1) Name of locality:
- 2) Name of interviewer:
- 3) Name of respondent:
- 4) Position of respondent:
- 5) Date of interview:
- 1) Name of health facility:
- 2) Type of health facility: Community Clinic [], Health Post [], Health Centre [], Private Clinic (GP) [], Private Clinic (Specialist) []
- 3) What are your personnel needs? Need [] Currently employed []
- 4) How many of those employed are professionals?
-
- 5) Do you offer any community services such as immunisations and education programmes for community members? Yes [] No []
- 6) If yes, please specify.....
-
- 7) How many patients are attended to/treated in a day/week?
-
- 8) Which services are provided by your facility?
-
- 9) What is the catchment area for this health facility?
-
-



-
- 10) What is the sphere of influence of this facility?
-
- 11) What are the common diseases that are reported at this facility?
-
- 12) What relationship exists between this facility and other facilities?
-
-
- 13) Do you have the facilities that ensure auditory and visual privacy? Yes[] No[]
(*Interviewee can observe as well)
- 14) Do you have the medical equipment and instruments necessary for services to be delivered at this level by your facility? Yes [] No []
- 15) If yes, what are they?
- 16) If no, why?
-
- 17) How are the services you provide funded?
-
- 18) Is your facility enlisted on the National Health Insurance Scheme? Yes [] No []
- 19) If yes, what benefits do you derive from the scheme?
-
- 20) If no, why are you not?
-
- 21) Do you have any problems in services delivery? Yes [] No []
- 22) If yes, please specify.....
-
-
- 23) What are the major challenges that this facility faces?
-
- 24) Are there any prospects for this facility? Yes [], No []
- 25) If yes, what are they?
-
-

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COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)
INITIATIVE: CHALLENGES AND OPPORTUNITIES TO IMPROVING RURAL
ACCESS TO HEALTH SERVICE DELIVERY IN THE LAWRA DISTRICT

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MUTUAL HEALTH INSURANCE (DISTRICT OFFICE) INTERVIEW GUIDE

1. Name of interviewer:
2. Name of respondent:
3. Position of respondent:
6. Date of interview:

- I. How many facilities are enlisted on the scheme?
- II. What services do they offer? (with reference to various levels of health facilities)
- III. What are the criteria for a facility's selection?
- IV. Components (what you do)
- V. What don't you do and why?
- VI. What happens to a referred case?
- VII. How are referred cases treated?
- VIII. What are the premium levels?
- IX. Who pays the premiums?
- X. Who benefits from the premiums paid?
- XI. How long is the gestation period?
- XII. What is the current coverage (registered persons/population)



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COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS)
INITIATIVE: CHALLENGES AND OPPORTUNITIES TO IMPROVING RURAL
ACCESS TO HEALTH SERVICE DELIVERY IN THE LAWRA DISTRICT

OPINION LEADERS'/KEY INFORMANTS' INTERVIEW GUIDE

1. Name of interviewer:
2. Name of respondent:
3. Position of respondent:
7. Date of interview:

- I. What do you know about CHPS?
- II. When were you introduced to it?
- III. What were the activities undertaken to implement CHPS in your zone?
- IV. What role did the community play in the above activities?
- V. What are the benefits the community derive from CHPS programme?
- VI. What are the problems the community encounter with the CHPS programme?
- VII. Are there any things about CHPS that you would wish changed (added or deducted)?
- VIII. Would you recommend the CHPS idea to other communities in the district?
- IX. What are/is your recommendation for the CHPS programme
 - A. Your Community.....
 - B. Your District.....



Table 1.1 Top Ten Causes of Deaths

No.	2005 Deaths						2006 Deaths					
	Disease Condition	M	F	Tot	PMR	CFR	Disease Condition	M	F	Total	PMR	CFR
1	Malaria	47	33	80	30%	2%	Malaria	21	21	42	22%	2%
2	Pneumonia	14	6	20	7%	3%	Pneumonia	7	10	17	9%	3%
3	Hepatitis	14	4	18	7%	13%	Anaemia	11	4	15	8%	2%
4	Anaemia	11	6	17	6%	2%	Heart Failure	5	6	11	6%	28%
5	Heart Failure	4	3	7	3%	23%	Hepatitis	6	2	8	4%	15%
6	Cerebro Vascular	3	2	5	2%	71%	Meningitis	2	4	6	3%	35%
7	AIDS	4	1	5	2%	7%	AIDS	4	1	5	3%	9%
8	Accidents	5	0	5	2%	3%	Cirrhosis / liver Failure	3	2	5	3%	21%
9	Asthma / Bronchitis / URT1	3	2	5	2%	2%	Asthma / Bronchitis / URT1	2	1	3	2%	1%
	Meningitis	3	1	4	1%	33%	Tuberculosis	3	0	3	2%	11%
	All other Deaths	63	38	101	38%	2%	All other Conditions	47	26	73	39%	2%
	TOTAL	171	96	267	100%	2%	TOTAL	111	77	188	100%	2%

Top 10 Diseases continues

No.	2007 Deaths						2008 Deaths					
	Disease Condition	M	F	Total	PMR	CFR	Disease Condition	M	F	Total	PMR	CFR
1	Malaria	31	18	49	23%	1%	Malaria	30	22	52	19%	1%
2	Anemia	6	9	15	7%	4%	AIDS	17	10	27	10%	34%
3	AIDS	5	9	14	7%	19%	Septicaemia	13	6	19	7%	17%
4	Pneumonia	8	5	13	6%	3%	Pneumonia	14	4	18	7%	3%
5	Hepatitis	8	3	11	5%	14%	Anaemia	9	7	16	6%	3%
6	Septicaemia	6	2	8	4%	20%	Cerebro Vascular	6	5	11	4%	34%
7	Tuberculosis	3	4	7	3%	15%	Meningitis	8	2	10	4%	7%
8	Enteric Fever/Typhoid	5	1	6	3%	3%	Cirrhosis / liver Failure	6	2	8	3%	24%
9	Hypertension	3	3	6	3%	4%	Hypertension	4	2	6	2%	5%
10	Heart Failure	3	3	6	3%	21%	Enteric Fever/Typhoid	4	1	5	2%	1%
	All other Conditions	44	30	74	35%		All Other Disease	67	37	104	38%	2%
	TOTAL	122	87	209	100%		TOTAL	178	98	276	100%	2%

Source: DHA, 2008 Annual Health Report

The number one cause of death has been malaria followed by AIDS, septicaemia, pneumonia, anaemia, in 2008. While the case fatality of malaria remained 1% that of anaemia reduced to 3% in 2008.

2005						2006				
S/n	DISEASED CONDITION	M	F	Total	PMR	DISEASED CONDITION	M	F	Total	PMR
1	Malaria	597	443	1040	58%	Malaria	263	212	475	49%
2	Anaemia	148	130	278	15%	Anaemia	88	72	160	17%
3	Pneumonia	53	46	99	5%	Pneumonia	39	36	75	8%
4	Asthma / Bronchitis / URT1	29	39	68	4%	Asthma / Bronchitis / URT1	21	18	39	4%
5	Urinary Tract Infection	10	19	29	2%	Other Diarrhoea	8	12	20	2%
6	Malnutrition	9	8	17	1%	Malnutrition	7	6	13	1%
7	Other Diarrhoea	11	4	15	1%	Urinary Tract Infection	12	0	12	1%
8	Cellullitis / Abscess	6	9	15	1%	Enteric Fever/Typhoid	1	5	6	1%
9	Convulsion	6	5	11	1%	Hepatitis	4	1	5	1%
10	Enteric Fever	6	0	6	0%	Cellullitis / Abscess	1	4	5	1%
	All Other Conditions	123	104	227	13%	All other Conditions	80	75	155	16%
	TOTAL	998	807	1805	100%	TOTAL	524	441	965	100%

Top 10 infant admissions continue

2007						2008				
S/n	DISEASED CONDITION	M	F	Total	PMR	DISEASED CONDITION	M	F	Total	PMR
1	Malaria	420	278	698	67%	Malaria	263	212	475	49%
2	Anaemia	43	30	73	7%	Anaemia	88	72	160	17%
3	Pneumonia	34	26	60	6%	Pneumonia	39	36	75	8%
4	Asthma / Bronchitis / URT1	18	20	38	4%	Asthma / Bronchitis / URT1	21	18	39	4%
5	Gastro Enteritis	8	10	18	2%	Other Diarrhoea	8	12	20	2%
6	Urinary Tract Infection	8	10	18	2%	Malnutrition	7	6	13	1%
7	Cellullitis / Abscess	9	6	15	1%	Urinary Tract Infection	12	0	12	1%
8	Septicaemia	7	3	10	1%	Enteric Fever/Typhoid	1	5	6	1%
9	Other Diarrhoea	4	4	8	1%	Hepatitis	4	1	5	1%
10	Enteric Fever/Typhoid	5	1	6	1%	Cellullitis / Abscess	1	4	5	1%
	All Other Conditions	60	35	95	9%	All other Conditions	80	75	155	16%
	TOTAL	616	423	1039	100%	TOTAL	524	441	965	100%

Source: DHA, 2008 Annual Health Report

Malaria admissions among infants dropped from 67% in 2007 to 49% in 2008. Malaria accounted for the top cause of infant admissions (49%) followed by anaemia and pneumonia.

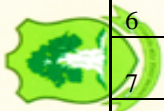


Table 1.3 Top Ten Infant Deaths

s/n	2005						2006					
	DISEASED CONDITION	M	F	Total	PMR	CFR	DISEASED CONDITION	M	F	Total	PMR	CFR
1	Malaria	9	7	16	39%	2%	Malaria	6	4	10	31%	2%
2	Anaemia	4	3	7	17%	3%	Pneumonia	3	3	6	19%	8%
3	Pneumonia	3	1	4	10%	4%	Anaemia	4	1	5	16%	3%
4	Hepatitis	1	1	2	5%	100%	Hepatitis	2	0	2	6%	40%
5	Other Diarrhoeal	1	1	2	5%	13%	Septicaemia	0	1	1	3%	100%
6	Convulsion	1	0	1	2%	9%	Tetanus	1	0	1	3%	50%
7	Malnutrition	1	0	1	2%	6%	Neo-Natal Tetanus	0	0	0	0%	0%
8	Asthma / Bronchitis / URTI	0	1	1	2%	1%	Enteric Fever/Typhoid	0	0	0	0%	0%
9	Neo-Natal Tetanus	0	0	0	0%	0%	Cholera	0	0	0	0%	0%
10	Tetanus	0	0	0	0%	0%	Other Diarrhoeal	0	0	0	0%	0%
	Other Conditions	7	0	7	17%	3%	Other Conditions	6	1	7	22%	3%
	TOTAL	27	14	41	100%	2%	TOTAL	22	10	32	100%	3%

Top Ten Infant Deaths continues

s/n	2007						2008					
	DISEASED CONDITION	M	F	Total	PMR	CFR	DISEASED CONDITION	M	F	Total	PMR	CFR
1	Pneumonia	2	2	4	22%	7%	Malaria	6	4	10	31%	2%
2	Malaria	3	1	4	22%	1%	Pneumonia	3	3	6	19%	8%
3	Anaemia	1	1	2	11%	3%	Anaemia	4	1	5	16%	3%
4	Septicaemia	2	0	2	11%	20%	Hepatitis	2	0	2	6%	40%
5	Enteric Fever/Typhoid	1	0	1	6%	17%	Septicaemia	0	1	1	3%	100%
6	Hepatitis	1	0	1	6%	17%	Tetanus	1	0	1	3%	50%
7	AIDS	0	1	1	6%	100%	Neo-Natal Tetanus	0	0	0	0%	0%
8	Neo-Natal Tetanus	0	0	0	0%	0%	Enteric Fever/Typhoid	0	0	0	0%	0%
9	Tetanus	0	0	0	0%	0%	Cholera	0	0	0	0%	#DIV/0!
10	Cholera	0	0	0	0%	0%	Other Diarrhoeal	0	0	0	0%	0%
	All Other Conditions	2	1	4	22%	2%	All Other Conditions	6	1	7	22%	3%
	TOTAL	12	6	18	100%	2%	TOTAL	22	10	32	100%	3%

Source: DHA, 2008 Annual Health Report

Malaria leads the top ten causes of infant deaths in 2008 followed by Pneumonia and anaemia. Septicaemia, Hepatitis and AIDS recorded the highest case fatality.

Table 2.1 CHPS Logistics Requirement and Funding Source

Logistics	Details	Funding Source
Accommodation	Home: two bedrooms, kitchen, toilet, bath, store, hall (Community Health Compound)	DA, Communities
Furniture	Living room set, dining hall set	DHA
TV	Black and white	DHA
Radio		DHA
Kitchen Ware	Set of plates & cup, set of cooking ware, set of cutlery	DHA
Refrigerator	Gas and Electricity	DHA, RHA
Drugs	Basic Drugs	DHA
Working Gear	Boot, rain coat and heavy duty gloves	DHA, RHA
Repackage Delkit		DHA, RHA
Stethoscope		DHA
Consumables	Basic consumables	DHA, RHA
Thermometres		DHA
Angiopoid lamps		DHA
Weighing scale	Bathroom scale	DHA
Training manuals and dissemination		RHA, HQ
IE and C materials		RHA, HQ
Cold boxes		HQ
Transport	Motorcycle, bicycle, boat	HQ
Boat logistics	Flash light, camp bed, student mattress, life jacket, kerosene stove, megaphone, Wellington boot	HQ
Delivery kit		DHA
Solar Electrification		DHA
Sterilizer (simple)		DHA
Vaccine carriers		DHA
Communication		DHA

Source: GHS-PD, 2005.

