

**UNIVERSITY FOR DEVELOPMENT STUDIES**

**ASSESSING THE EFFECTIVENESS OF THE COMMUNITY BASED  
HEALTH PLANNING AND SERVICES AS A CLOSE-TO-CLIENT  
STRATEGY IN HEALTH CARE DELIVERY IN WEST  
MAMPRUSI DISTRICT, GHANA**

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**FACULTY OF INTEGRATED DEVELOPMENT STUDIES**

**DEPARTMENT OF AFRICAN AND GENERAL STUDIES**

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**BY:**

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UNIVERSITY FOR DEVELOPMENT STUDIES



**THESIS SUBMITTED TO THE DEPARTMENT OF AFRICAN AND  
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**SEPTEMBER, 2019**

## DECLARATION

### Candidate's declaration

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

Candidate's Signature..... Date: .....

Name: Mr. Robert Kolbila

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### Supervisor's declaration

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

Supervisor's Signature: ..... Date: .....

Name: Dr. Africanus L. Diedong

## **DEDICATION**

I dedicate this research work to my Family

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## ACKNOWLEDGEMENT

Firstly, I express my gratitude to my supervisor, Dr. Africanus L. Diedong, for guiding me in writing this thesis. His critical revision of the drafts, constructive opinions, and his scholarly guidance made it possible for me to finish this thesis. I also thank Mr Konlan Ganiu and Joans Larney for their helpful comments and valuable ideas. I am also grateful to the staff of the Faculty of Integrated Development Studies who helped me in varied ways.

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## ABSTRACT

The study set out to examine the effectiveness of the Community Based Health Planning and Services (CHPS) as a close-to-client strategy in health care delivery within the West Mamprusi District. The study applied a mixed approach and used 195 community members and 24 key informants. The simple random, purposive and convenient sampling procedure was used as sample size for the study. The study found that community perception of the programme is that the compound is a hospital or clinic and hence do not fully understand its operations. It was evident that, CHPS has enhanced access to primary healthcare. The study revealed that, the level of stakeholder participation is generally low as community members are not included in the implementation process. On effectiveness of programme implementation processes, the study found that it was not effective. The CHPS compounds serve as the first point of call in the structure of the health system but the health personnel requirement at the CHPS compounds were inadequate in terms of numbers and technical expertise. The CHPS serves as the first point of call in health care delivery at the community level. Affordability of health care services by the local people is through the use of NHIS cards. The location of CHPS compounds using the zone systems do not effectively serve all communities under the catchment area. In conclusion, the researcher found the implementation of CHPS and the services provided compared to the CHPS national implementation guidance as less effective as a close to client health services in the west Mamprusi Municipality.



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## LIST OF ABBREVIATIONS

CHFP	Community Health and Family Planning
CHO	Community Health Officer
CHPS	Community-based Health Planning and Services
DHA	District Health Authority
DHMT	District Health Management Team
DMHIS	District Mutual Health Insurance Scheme
DMTDP	District Medium Term Development Plan
GHS	Ghana Health Service
GHSPD	Ghana Health Service Policy Document
GSS	Ghana Statistical Service
MMR	Maternal Mortality Ratios
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
NHRC	Navrongo Health Research Centre
OPD	Out Patient Department
PHC	Primary Health Care
PHC	Population and Housing Census
SDG	Sustainable Development Goals
SPSS	Statistical Package for Social Scientist
TBA	Traditional Birth Attendant
UNICEF	United Nations Children Fund
WHO	World Health Organization



## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background to the Study

Access to healthcare services is a major challenge facing developing countries. In sub-Saharan Africa, Ghana is among countries with the highest overall maternal mortality ratios (MMR) at 144 deaths per 100,000 live births in 2014 (UNDP, 2015). One of the panaceas to tackle this problem both in Ghana and globally is the Sustainable Development Goals (SDGs) implemented in 2015. Goal 3 of the SDGs is to ensure healthy lives and well-being for all at all ages by 2030 (UN, 2015). Notwithstanding this, in Ghana, half of childbearing women give birth with a skilled attendant; and the rural–urban gap is 88% in urban areas and 54% in rural areas (Ghana Statistical Service, 2014).

The Community Based Health Planning and Services (CHPS) initiative was introduced in 2000 by the Ministry of Health in partnership with the Ghana Health Service as a national policy for improving rural health care delivery. CHPS represents the contribution of the health sector to national poverty-alleviation policies. This initiative has its origin in an experimental research programme known as Community Health and Family Planning (CHFP) project, which was developed and tested at Navrongo Health Research Centre (Nyonator et.al. 2005a). With the advent of the CHPS initiative, the Navrongo experiment became the operational model for health-care development in Ghana. Improving access to health care is a critical aspect of poverty alleviation, especially in the severely under-developed areas of the country.



The programme is underpinned with five strategic pillars. These are; improved quality, access, efficiency, partnerships and financing, which is applied to the delivery of an essential package of health services and improved equity and access for the poor. Thus, the purpose of the initiative is to improve the accessibility, efficiency and quality of Healthcare and Family Planning Services based on community-based approach and the principles indicated above. Attention is also given to improving health worker performance and responsiveness to client needs, improving financial, geographical and socio-cultural access to care, and improving partnerships with households and communities, between private and public sector providers, and with other ministries, departments and agencies. (Nyonator *et al.*, 2005).

A key component of CHPS is a community-based service delivery point that focuses on improved partnership with families, community leaders and other stakeholders to address the demand-supply side of service delivery and recognising that families are the primary producers of health (Nyonator *et al.*, 2005). Specifically, CHPS involves six implementation components that are supposed to change primary health care services from a curative facility based to a comprehensive community-based programme. The components are; community Planning, Community Entry, and Community Health Compound construction, Community Health Officer, Essential Equipment and Volunteers. The completion of these six CHPS components leads to the provision of comprehensive primary health care services with strong health system strengthening at the community level.

With the CHPS initiative the communities have to be involved in the development of policies and plans and in monitoring and evaluation of the



health programmes. The community needs to be informed and educated about health, health policies and their implications, and their opinions sought in plan formulation. This community-based level service provision will enable the Ghana Health Service to reduce health inequalities and promote equity of health outcomes by removing geographic barriers to health care. The CHPS system brings trained health care workers directly into the communities and rallies community support behind them to ensure the system's acceptability and sustainability.

Regarded as the primary strategy for reaching the unreached, CHPS has become one of the health sector components of the national poverty reduction strategy (Nyonator et. al., 2005a). According to Nyonator, the CHPS system is designed to improve health care access; to bridge equity gaps in accessing quality health services and to remove non-financial constraints to health care delivery. It is also recognized as one of the most strategic measures for increasing geographical and financial access to health care and is promoted as the principal means of providing health care services to deprived rural communities.

Most importantly, CHPS is the operational outcome of the Ghana Health Service's "Close-to-client" system of primary health care delivery. Unlike the typical facility-based health care delivery, CHPS is a community-based, community-involved care system that enables District Health Management Teams (DHMTs) to adopt and develop approaches to community health care that are consistent with local traditions, sustainable with available resources, and that is compatible with prevailing needs (Sakeah et al., 2014).





In the West Mamprusi District, health care delivery in rural areas is heavily dependent on CHPS due to inadequate clinics and hospitals (Ghana Statistical Service, 2014). The highest level of health delivery systems in the district is the Walewale District Hospital which serves as a referral centre. Other health facilities within the district are the Janga Polyclinic, Kpasenkpe Health Centre, Kparigu PPAG clinic, Mandela and Our Lady of Roccio private clinics in Walewale. The rest are CHPS compounds at Tinguri , Gbeo, Nasia, Duu, Nabari, Arigu, Yama, Daboya, Bugya and Guabuliga Hence, it is worth investigating the effectiveness of CHPS as a Close-to Client strategy in healthcare delivery particularly in the West Mamprusi since it has become the district main approach to delivering health care to its inhabitants.

## **1.2 Problem Statement**

Despite the “health for all” policies launched over two decades ago in 1990, more than 50% of Ghanaians still cannot get access to quality health care services as they stay about eight kilometres away from the nearest service provider, leading to rural infant mortality rates being 43% higher than corresponding urban rates (GDHS/MoH, 2016). Deprived communities in Ghana including the West Mamprusi District have limited access to quality basic healthcare. This is especially so among the vulnerable population such as women and children who need such services most (GSS, 2014; MoH Policy Document, 2016).

The Community Based Health Planning and Services (CHPS) initiative was instituted to provide quality, community-based, or “close-to-client” doorstep



health delivery with household and community involvement and ensure efficiency in resource utilization. Although the CHPS programme is considered by policy makers, development partners and public health providers as a good pro-poor health service delivery strategy, particularly in rural areas; its implementation is challenged with lack of full knowledge of participation in the programme by stakeholders. There is also lack of education by the Ghana Health Service of the existence of the CHPS programme by the community people. Moreover, the omission of community-entry activities by District Health Monitoring Team suggests that the concept of CHPS is not well understood, since community participation, mobilization and ownership is central to the system reform process (Nyonator et al., 2005). There is an increase in the level of misunderstanding of the concept of CHPS and lack of community participation (Gala, 2012). Furthermore, despite the considerable investments in the provision of health care facilities, a greater number of the population lack access to quality health delivery services.

The community-based health planning and services is designed to improve the health status of the population through accessible, efficient and quality Healthcare and Family Planning Services. In this regard, it is essential that the people understand the CHPS programme well. As research reports (Ghana Macroeconomics and Health Initiative, 2005) have indicated, communities have to be involved in the development of policies and plans and in monitoring and evaluation of the health programmes. They need to know their health rights and responsibilities and appreciate the interdependence of everyone in the society that is necessary for the development of health. In areas where health services are available, lack of community involvement in

the planning and delivery of healthcare can prevent people from accessing such services.

The CHPS programme is also faced with limited planning and personnel (Nyonator *et al.*, 2005). This situation has arisen due to inconsistent understanding of the CHPS concept and the weak partnership among stakeholders. In the West Mamprusi District, even though the CHPS initiative have been implemented some ten years ago, there still exist among others high infant, child and maternal mortality rate as reported by the Ghana Statistical Service (2014). The West Mamprusi District is not only largely rural but also deprived of basic social amenities such as schools, markets and healthcare centres. With 10 CHPS compounds strategically positioned to serve the entire district with a household of 14,432, access to health care remains low even though the programme is presumed to utilize a Close-to-Client strategy. These challenges not only compromise poverty reduction efforts but also bring untold hardships to the families (GSS, 2014).

More so, as important as healthcare delivery, no research work has been carried out to investigate these challenges in relation to the West Mamprusi District. Existing literature predominantly focused on other districts in Ghana (for example, Krumholz *et al.*, (2014); Nyonator *et al.*, 2005; Yeleduor, 2012). Therefore, there is the need to focus on these challenges within the context of the West Mamprusi District. This study will examine the effectiveness of the CHPS programme as a close-to-client health delivery system vis-à-vis the Programme's intended objective as a close-to client strategy in healthcare delivery in the West Mamprusi District.



### **1.3 Research Questions**

#### **1.3.1 Main Research Question:**

How effective is the Community Based Health Planning and Services (CHPS) as a close-to-client strategy in health care delivery within the West Mamprusi District?

#### **1.3.2 Specific Research Questions:**

- i. What is the community perception on the responsiveness of CHPS to the primary health Care needs of communities?
- ii. How accessible is CHPS services to communities in the District?
- iii. What is the level of community stakeholders' participation in the implementation of the CHPS programme in the District?
- iv. How effective is the implementation process of the CHPS programme in the District?
- v. What challenges do communities face in accessing primary healthcare offered by the CHPS?



### **1.4 Research Objectives**

#### **1.4.1 Main Research Objective**

The main research objective is to examine the effectiveness of the Community Based Health Planning and Services (CHPS) as a close-to-client strategy in health care delivery within the West Mamprusi District.

#### **1.4.2 Specific Research Objectives**

The specific objectives of this study are:

- i. To assess community perception on the responsiveness of CHPS to the primary health care needs of communities.

- ii. To what extent is CHPS services accessible to communities in the District.
- iii. To explore the level of stakeholder participation in the implementation of the CHPS programme in the District.
- iv. To examine whether the implementation process of the CHPS programme is effective in the District.
- v. To explore challenges that communities' face in accessing primary healthcare offered by the CHPS?

### **1.5 Significance of the Study**

This study is significant in a number of ways. First, this study will expose how the CHPS programme is impacting on communities within the West Mamprusi District. Second, findings from this study will guide the Ministry of Health and its agencies in the decision making concerning the operationalization of the CHPS concept. Third, this study may be useful to students and organizations with specializations in similar research work. Finally, findings from this study will add to existing literature on the impact of the Community Based Health Planning and Services (CHPS) programme from the perspective of the West Mamprusi District.

### **1.6 Scope of the Study**

The study is restricted to the Mamprusi West District of the Northern Region of Ghana. The West Mamprusi District was created in 1988 under Legislative Instrument (LI) I 1448 which was later in 2012 replaced with LI 2061 following the creation of the Mamprugu Moagduri District. The District is one



of the 26 administrative assemblies in the Northern Region of Ghana with Walewale as its capital. Administratively, the district lies within the Northern Region, although it has strong economic and functional linkages with some major settlements in the Upper East Region like Bolgatanga and Fumbisi. The West Mamprusi District has a population of 121,117 (GSS, 2010 PHC). The District is predominantly rural, with a population of 76,503 living in rural settlements. Urbanization in the District is centered in Walewale, which is the dominant urban centre having many social amenities. This has implications on healthcare delivery since indigenes from rural areas will have to travel to Walewale to access better health care services.

According to the Ghana Statistical Service (2014) report, by age 20-24 years, more than 65 percent of females are married compared to about 29 percent of males. At age 65 and above, widowed females account for as high as 51% while widowed males account for only 6.6 percent. Among the married, 79% have no education while 29% of the never married population has never been to school. On Information Communication Technology (ICT), report of the GSS (2014) indicate that 21% of those who are 12 years and older own mobile phones. Also, less than one percent (0.9%) of this category use internet facility in the district. Although the report revealed that higher proportion of males (1.3%) than females (0.5%) use internet facility, less than two percent (1.4%) of the total households in the district own desktop/laptop computers. By implication, contacting a health facility for health services particularly emergency services was made easy due to the ownership of these gadgets. Alternatively, this must corroborate with the presence of health facilities (CHPS in this case) in every community within the District.



The GSS (2014) report further revealed that, of the population 11 years and older, 40% are literate while 60% are not literate. The proportion of literate males (46.4%) is higher than that of females (33.8%). The majority of the literate can read and write in English and a Ghanaian language (56.5%). Two-fifths (40.0%) of the literate population can read and write in English. In relation to the CHPS programme and overall concept, this may impact negatively on the programme since clients need to be educated and sensitized as part of the Close-to-Client strategy.

Furthermore, for those who are 3 years and older in the district, 49% has never attended school, 41% are currently attending and 9.9 percent have attended in the past. This gives indication of positive future prospects with regard to education in the district. The proportion of females who have never attended school (54%) is higher than their male counterparts (44%). Again, there is the need to focus on the gender disparities in terms of education of the sexes in the District. This will enable stakeholders to assess the category of gender that need more attention as far as the CHPS implementation is concerned. But for those who are currently attending school, 51% are in primary and 17% are in JHS (GSS, 2014).

On housing, the district has a household population of 119,595 with a total number of 14,432 households (GSS, 2014). The average household size in the district is 8.4 persons per household. Children constitute the largest proportion of the household structure accounting for 49.5 percent. Heads of households form 12%.





In the District, there are more dwelling units in rural (60.3%) than in urban (30.1%) areas. The GSS (2014) report also indicated that, the average number of persons per house is 11.8. The main type of dwelling unit in the district is compound house (79.5%). About one-third (32.6%) of the sleeping rooms are occupied by households with 10 or more members (GSS, 2014) and this have implications on their health. Less than one percent (0.9%) of households with 10 or more members occupy single rooms. The main source of fuel for cooking for most households in the district is wood (83.9%) and charcoal (12.7%). The three main sources of water in the district are Protected well (28.6%), Unprotected well (27.2%) and Bore-hole/Pump/Tube well (25.07%). This finding makes the presence of CHPS compound in every community of the District imperative. Critically, about 75% of the households in the district have no toilet facility. Pit latrine (9.1%) and Public toilet (8.6%) are the dominant toilet facilities used by households in the district.

The principal sources of water supply in the district are small town water supply systems in Walewale, Wulugu and Guabuliga. There are water point sources fitted with hand pumps and hand dug wells. The main agencies facilitating access to water and sanitation services in the West Mamprusi District are Community Water and Sanitation Agency (CWSA), NGOs including World Vision Ghana, NORST, New Energy, and European Union RWSP. Moreover, the most widely method of solid waste disposal is by public dump in the open space accounting for 45.5 percent (GSS, 2014). More than one-quarter (27.9%) of households dump their solid waste indiscriminately. About 11 percent of households also burn their solid waste which has serious implications on their health. For liquid waste disposal, throwing waste onto the

street/outside (71.6%) and onto the compound (14.2%) are the two most common methods used by households in the district.

The Total Fertility Rate for the district is 3.8 children per woman. The General Fertility Rate is 111.9 births per 1000 women aged 15-49 years which is among the least in the region. The Crude Birth Rate (CBR) is 25.4 per 1000 population. The crude death rate for the district is 7.9 per 1000 which is higher than the regional figure of 5.9 per 1000. Majority (51.8%) of the migrant population within the region is born elsewhere in the Northern Region while 48.2 percent of migrants living in the district were born in another region. For migrants born in another region, those born in Upper East constitute 36.6 percent followed by those born outside Ghana with 22.6 percent. This finding is likely to be affected by inadequate CHPS compounds in the District.

The study focused on 10 CHPS communities, namely, Nabari Gbeo, Duu, Yama, Bugya, Tinguri, Wulugu, Arigu, Nasia, and Guabuliga in the district. The Mamprusi District Hospital including four other CHPS compounds in the 10 communities were selected for the study. The district was chosen purposively because of the poor health care status and the growing number of CHPS as a preferred alternative means to delivering a close-to client service in the region and the district in particular, the Mamprusi District Hospital is the highest healthcare delivery system and a serve as a referral point for all health centers within the District (GSS, 2014). The study could cover health facilities in other districts of northern Ghana since they share similar problems of lack of access to health care but for the constraints in resources.



## 1.7 Conceptual Definitions

It is considered significant to make clear the meaning of the following concepts as was used in this study. Key concepts are:

**A CHPS Zone:** refers to a demarcated geographical area of up to 5000 persons or 750 households in densely populated areas and may be co-terminous with electoral areas where feasible. Each zone may be made up of a town, part of a town or a group of villages or settlements mapped for ease of planning of itinerant services and assignment of CHOs and CHVs.

**A CHPS Compound:** refers to an approved structure consisting of a service delivery point and accommodation complex both of which must be present (CHPS Policy, 2016).

**A Community Health Officer (CHO):** is a trained and oriented Community Health Nurse working in a CHPS zone and may be assigned to a Community within the zone (CHPS Policy, 2016).

**Community Health Volunteers (CHVs):** are non-salaried community members identified and trained persons supporting CHOs in a Community within the CHPS zone (CHPS Policy, 2016).

**Community Health Management Committees:** are community leaders drawn from the CHPS Community with different competencies and responsibilities who volunteer to provide community level guidance and mobilisation for the planning and delivery of health activities and see to the welfare of CHOs in their community (CHPS Policy, 2016).



**Ministry of Health (MOH):** Ghana's Ministry of Health responsible for health policy formulation, monitoring, and evaluation.

**Stakeholder:** any group or individual who can affect or is affected by, the achievement of the organization or programme's objectives (Freeman, 1984). In this study, stakeholders are organizations and individuals that have participated in the CHPS programme.

**Accessibility:** living within one hour travel time (by any available means) from a health facility (CHPS Policy, 2016). For the purpose of this study, access is categorized into three: thus, Physical (reachability), Economic (direct and indirect cost) and Socio-cultural (indigenous practices) access to health care.

**Efficiency:** is using minimal input (resources) to achieve the greatest output (health outcome) possible under a particular situation.

**Quality:** means conforming to standards acceptable by the Ministry of Health.

**Close-to-Client Strategy:** Delivering health service at the doorstep of client, beneficiaries or patients.



## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

This chapter presents a review of relevant literature on the study. Specific areas are; the concept of healthcare, dimensions and principles, Evolution of the Community-Based Health Planning and Services (CHPS) Concept, community and stakeholder participation as well as and barriers to the CHPS programme in Ghana. The chapter also presented a conceptual framework and reviews papers that are both theoretically and empirically related to healthcare delivery in Ghana.

#### 2.2 The Concept of Healthcare, Dimensions and Principles

The World Health Organization (1981) defines health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The concept of health in this study can be observed as the human state devoid of physical, mental, and emotional sickness/illness. Health is a fundamental human right and that the achievement of the highest possible level of health is a most important social goal whose realization requires the action of all sectors whether public, private or civil society groups.

It is in this vein that the United Nations established the Sustainable Development Goal to promote the well-being of all. Goal 3 of the SDGs is to ensure healthy lives and well-being for all at all ages (UN, 2015). Specifically, Target 3.8 requires to “achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and



access to safe, effective, quality, and affordable essential medicines and vaccines for all by the end of 2030". To achieve a comprehensive health care, a number of dimensions are necessary. There are four (4) main dimensions of healthcare namely effectiveness, affordability, relevance and accessibility. The dimensions of healthcare are discussed below;

**Effectiveness:** effectiveness is the degree of achieving desirable health outcomes, given the correct provision of evidence-based healthcare services to all who could benefit, but not to those who would not benefit (WHO, 2000). Juran sees effectiveness as the degree to which processes result in desired outcomes (Juran and Godfrey, 2000). It is the extent to which improvements in healthcare are attained (Donabedian, 2003)

**Affordability:** The ability and power of an individual or group of persons to pay for health care services at the point of receiving/delivery services without any financial difficulty no matter the cost of services.

**Relevance:** The degree of importance of health care services to an individual or community.

**Accessibility:** Access according to the Ghana Health Services (2011), implies either the ability to reach a health facility within one hour of travel time or location of facility within 8km distance. Access to healthcare is of fundamental importance to governments globally, since the health service was founded on the principle of equity of access for equal need. Furthermore, as society changes, the public increasingly expects to receive not just fairness in access to healthcare but prompt and convenient services (Rosen et al, 2001). Improving



access to health services ranks among the strategic health policy goals across the globe.

Access is a multi-dimensional concept. According to McIntyre and Thiede (2006), access is in three dimensions namely; availability, affordability, and acceptability. The availability of health care captures all factors that relate to the actual existence of a specific service within reach of the client as well as aspects of user-friendliness with distance as the main indicator. Affordability refers to the direct and indirect costs of care relative to the client's ability to pay. Lastly, acceptability covers many of the subjective, social, and cultural factors, such as the degree to which a particular service is culturally secure (Wilkes et al, 2002).

Yeledour (2012) categorized access into Physical, Economic and Socio-cultural. According to the author, Physical Access is the location of health facilities within reach of people; and freedom to use the facility within a well-defined geographical setting like a community. To the author, the location should take into consideration distance, road network and condition and availability of transportation. Economic Access refers to the direct and indirect costs of health care relative to the client's ability to pay. Therefore, availability of economic opportunities to people will earn them income to make health care services affordable. Whiles, socio-cultural factors influence health by affecting exposure and vulnerability to disease, risk-taking behaviours, the effectiveness of health promotion efforts, and access to, availability of, and quality of health care.



However, the World Health Organization (WHO) outlined seven basic principles to guide the successful implementation of Primary Health Care.

These principles are:

- i. Primary health care should be shaped around the life patterns of the population it is to serve and should meet the needs of the community.
- ii. Primary health care should be an integral part of the national health systems, and other echelons of service should be designed in support of the needs of the peripheral level, especially with regard to technical supply, supervisory and referral support.
- iii. Primary health care activities should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, housing etc).
- iv. The local population should be actively involved in the formation and implementation of health care activities, so that health care can be brought in line with local needs and priorities. Decisions as to the community's needs should be based on a continuing dialogue between the people and the service.
- v. Health care offered should place maximum reliance on available community resources, especially those that have hitherto remained untapped, and should remain within the strictest cost limitations.
- vi. Primary health care should use an integrated approach of preventive, curative and rehabilitative services for the individuals, family, and community. The balance between these services should vary according to community needs and may change in the course of time.



- vii. The majority of health interventions should be undertaken at the most peripheral level possible of the health services by those workers most suitably trained to perform these activities (WHO 1981).

Conversely, Macdonald (1996) identified three principles that guide primary healthcare and these are: Commitment to equity; Adherence to the principle of the right of people to be involved in significant decision concerning their health services and; Acceptance of the need for the medical profession to collaborate with other sectors which make significant contributions to the health of the population (intersectional collaboration). The position of Macdonald is that health is a “social goal” whose realization requires the action of many other social and economic sectors in addition to the health sector. Deducing from these views, the underlying principle is collaboration between communities (beneficiaries) and government (implementers). The fusion of this two can facilitate the smooth running of any health care programme. For instance, in the case of the CHPS, there is the need to ensure inter-sectoral collaboration in order to achieve the close-to client service that the programme seeks to achieve.



### **2.3 Evolution of Health Care Delivery in Ghana**

The Ministry of health came into being when the Gold Coast attained self-rule after internal arrangement in 1951. After independence, the national leadership had made a commitment to better the health for the people. Consequently, early development in the health infrastructure took place mainly along two main paths thus: along conventional lines (the growth of hospitals was associated with improvement in the quality of care) and the development of

centers of excellence and the building of health centers and their satellite centers including health posts (Ebrahim and Ranken, 1995). However, a major challenge that the health industry faced was financing and coverage. Public health services became an intolerable burden on the patient, while it was at the same time, limited to a few Ghanaians (Senah, 1989).

During this period, there was the disparity between resource allocation and population distribution. Most of the personnel and capital resources remain in urban areas catering for the elite even though the population was largely rural. A large share of the recurrent expenditure went into servicing the capital resources (Ebrahim and Ranken, 1995). For instance, Ofori-Amaah as reported by Kodjo Senah, reported that in 1974/75 financial year over one third of the health budget went to Korle-Bu Teaching Hospital and the Greater Region alone (CODESRIA,1989). Also the determination of health policies seemed to have been affected by prevailing elite and ruling class interests (CODESRIA, 1989). It seemed politically expedient for governments to build more clinics and hospitals thereby emphasizing the curative aspect of health at the cost of the preventive, promotive and rehabilitative community intervention by way of mobilizing community resources. At the time, conventional health care was based on the western model has been described as the “engineering model”. Hence, the desire to be likened to western nations who practice these form of healthcare created some form of inequality.

In the 1970s it became clear to health policy makers in the country that something radical had to be done. This was relevant since the rural areas especially experienced the highest mortality, morbidity and fertility rates, an integrated approach to rural health problems would be appropriate. The



Easmon committee as cited by Senah (1989) in the CODESRIA series noted that rural areas had been neglected and that the preventive emphasis of health has not been taken seriously. Also Sai as reported by Senah (1989) in a similar vein observed that the number and distribution of health facilities was limited in these areas. As a result of the neglect of communities, Primary Health Care (PHC) therefore emerged as a strategy when these failures were becoming increasingly obvious. Frustration with existing approaches led to criticisms and innovative practices were tried.

Against this backdrop, in Ghana, the Danfa Comprehensive Rural Health and Family Planning Project took off with the important aim of developing an effective high quality and affordable Primary Health Care in the rural areas in 1970. In 1974 the Centre for scientific Research into Plant Medicine was founded. In 1976, the first most significant step towards PHC with assistance from WHO was established in the Brong Ahafo region (the Rural Integrated Development Project at Kintampo) for the training of middle-level personnel for the proposed PHC programme. The project was also mandated to determine, in a practical way, the social process that would help to institutionalize the participation of traditional healers in a health care programme.

In 1977, the government adopted the PHC programme. The goal was to extend health care coverage to 80% of the population (CODESRIA, 1989). PHC is essentially, health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford in the spirit of self-reliance and



determination. It forms an integral part of the country's health system of which it is the central foundation and main focus and the overall social and economic development of the country. It is the first level of the community with the national health system bringing health care as close as possible to where people live and work.

Currently, service delivery in Ghana follows the three tier system of care; primary through secondary to the tertiary level service (Adokiya 2014). Two major government agencies control health care delivery in the country: the Ministry of Health (MOH) and the Ghana Health Service (GHS). The primary mandate of the MOH, which is headed by the Minister of Health, is "to improve the health status of all people living in Ghana through effective and efficient policy formulation, resource mobilization, monitoring and regulation of delivery of health care by different health agencies"(MOH, 2009). Among its functions are:

- i. Provision of overall policy direction for all stakeholders (players in health delivery); provision of a strong and effective advocacy role in inter-sectoral action in health delivery; mobilization and allocation of resources to all providers in health delivery services
- ii. Provision of relevant and adequate information for coordination and management of health services
- iii. Provision of regulatory framework for all providers of health services
- iv. Monitoring and evaluation of health services in Ghana
- v. Coordination of activities of the agencies, providers, and partners in the health sector (MOH, 2009). GHS implements the health programmes.



This agency derives its existence, authority, and operations from Act 525 of 1996 as required by the 1992 Constitution of Ghana.

However, implementation of national health policies is done by the Ghana Health Service which by itself is autonomous and headed by the Director General. To administer health care, the GHS follows a decentralized system based on five levels: national, regional, district, sub-district, and community. Hospitals, clinics, health posts, maternity homes, and other health administrators and health care professionals (GHS, 2009) constitute each of these levels.

Nonetheless, Ghana is burdened with countless health challenges. Communicable diseases are high and they contribute to the majority of morbidity and mortality in the country (Selah, 2013). Even though some decline has been observed, it is noted to account for 53% of Ghana's disease burden (Selah 2013). In addition, the doctor-patient population ratio for the year 2006-2007 was 1: 13,683 while that of the nurse-patient population ratio for the same period was 1:1,451(MOH, 2009). These ratios affect the country's ability to provide good quality and accessible health care services (UNDP-Ghana, 2007). According to UNDP (2007), 57.7 % of Ghanaians have access to a health care facility that is located 30 minutes away from their homes. Critics note that the level of access fails to recognize people's transportation and cost difficulties to get to such facilities (UNDP, 2007). Ghana has increased health services access to the majority of its population through the scaling up of the CHPS programme.



## 2.4 Overview of the CHPS Concept

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

The CHPS initiative represents the scaling-up of the Navrongo model into a national movement for health care reform. In response to preliminary evidence from Navrongo, the MoH convened a national managers’ conference in 1998 to deliberate on the implications of the experiment’s model for national action, and to review a draft policy statement declaring the Navrongo community health care system as the national model for community-based care (Nyonator *et al.*, 2005). Credible evidence emerged from research projects that, there was the need to shift resources from curative institutional-based care to community-based preventive public health service (Nyonator *et al.*, 2005). It was in the light of this that CHPS, a programme of evidence based organizational change, which places emphasis on community-based approach rather than clinical facility-focused approach was adapted as a mechanism for integrating activities of the formal health sector into traditional institutions (Nyonator *et al.*, 2005).

The core objective of the CHPS was to “promote the idea that communities can be active participants in the provision of their own healthcare” (CHPS Policy, 2016). The CHPS programme encourages local community



involvement, interaction, and participation in the delivery of their healthcare. Communities participate in the programme by determining the administration and direction of the healthcare delivery process based on their specific local circumstances, resources, and needs. Communities also provide voluntary services and resources for the establishment of community health facilities including the building of a Community Health Compound (CHC), consisting of clinic and a place of residence for the CHO (Nyanator, Jones, Miller, Phillips, & Awoonor-Williams, 2005).

A nurse or a community volunteer trained as a Community Health Officer (CHO) takes up residency, lives, and works within the community. These volunteers are sent to villages in order to provide basic preventive, curative and promotional health services in homes or community clinics. A trained community health nurse is assigned to a zone (with a catchment area of 3000-5000 people) as a Community Health Officer (CHO) who resides in a designated Community Health Compound (CHC) (Nyanator et al. 2015, 7) equipped with a clinic, and from where a close-to-client healthcare service is provided to those living within the zone. In principle the CHO conducts household visits to provide basic medical treatment, advice, and health guidance; but they may also refer patients to more specialised medical institutions in the sub-District Health Centre or District Hospital, affirming Ghana's three-tier health delivery service.

CHOs are supported by community organizational activities including the recruitment, training and deployment of volunteer workers. Critically important to CHPS is the effective provision of family planning information and services, which include doorstep provision of oral, injectable, and barrier



contraception; referral for IUDs and other long-acting methods; and promotional services targeted to the needs of men and organized by male volunteers (Debpuur et al., 2002; Frank et al., 2005). Hence, the inclusion of stakeholders is imperative in achieving the objectives of the programme.

The involvement of actual health programme stakeholders in the planning, prioritization, and the final implementation process can significantly influence the effectiveness of such programmes (Chopra & Ford, 2005). Chopra and Ford (2005: 386) also argued that such an inclusion will help stakeholders “define who they are, what they want, and how they can get what they want”. Stakeholders can be an essential source of gaining information on factors that can either inhibit or improve the 10-implementation process, including information on non-health factors (Akukwe, 1999). According to Akukwe, non-health factors can play valuable roles in the success or failure of programmes. More so, stakeholders have collective responsibility for ensuring that programme implementation is effective (Chopra & Ford, 2005).

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



The CHPS programme aims to accelerate responses to medical complications and maintain effective referral systems in order to minimize mortality (Binka et al., 1995). This is accomplished through improved community decision-making processes, including strengthened local partnerships between households, community leaders and social groups. This also includes the Community Health Officers (CHOs) or voluntary nurses who reside in these areas.

Pence et al. (2001) reported that, accessible nursing care reduced childhood mortality by a third. There is also evidence that with the introduction of this experiment, the fertility rate has declined by one birth per woman (CHPS Report, 2009). Aside, maternal and child health can be improved through community mobilization (Altman, et al., 2015). Therefore, one may assume that the efficacy of CHPS activities in the West Mamprusi District.

Practically, GHS is organised at five Levels: National, Regional, District, Sub-district and Community levels (GHS, 2005). At the regional level, curative services are delivered at the regional hospitals and public health services by the District Health Management Team (DHMT) as well as the Public Health Division of the regional hospital. At the district level, curative services are provided by district hospitals, many of which are mission or faith based. Public health services are provided by the DHMT and the Public Health Unit of the district hospitals. At the sub-district level, both preventive and curative services are provided by the health centers as well as outreach services to the communities within their catchment areas. Basic preventive and curative services for minor ailments are handled at the community and household level

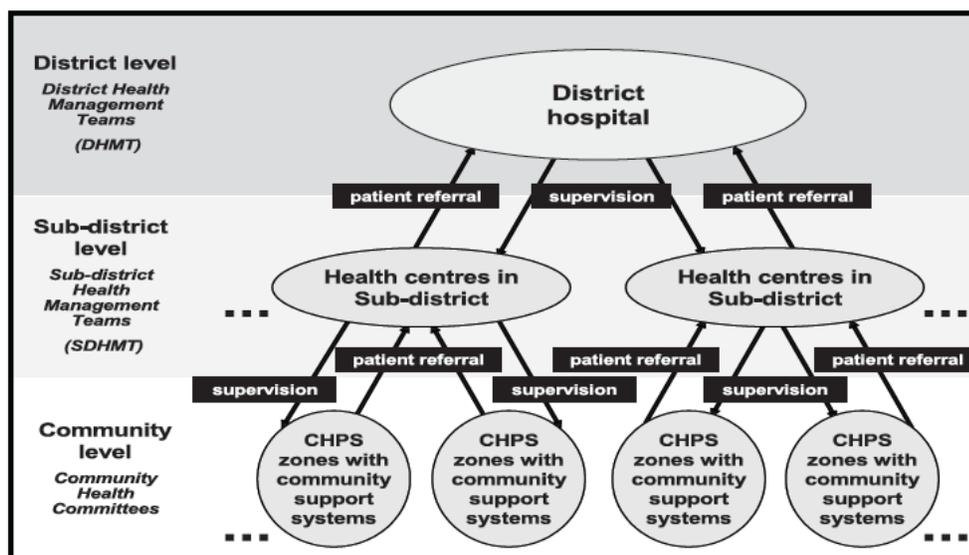


with the introduction of the Community-based Health Planning and Services (CHPS) (GHS, 2005).

Currently, the strategic policy adopted by the Ghana Health Service to bring health care to the door step of the people, especially those in the rural and deprived areas, is a three-tier level of service provision within the district: the District (hospital) level, the sub-district (health centre) level and community-based level (GHS, 2005). Community-Based Health and Planning Services (CHPS) compound serve as the first point of call for basic treatment of minor ailment, family planning, antenatal care, delivery and postnatal care, child welfare clinic, and immunization, among others. The CHPS compound is manned by a resident Community Health Officer (CHO) and assisted by volunteers and community members (GHS, 2005). The introduction of CHPS into districts occurs through extensive planning and community dialogue on the part of the Health Service and the community. Figure 2.1 illustrates the levels of Primary Health Care in Ghana



**Figure 2.1: Levels of Primary Health care**



Source: CHPS Policy, 2016

A key principle of CHPS introduction is that traditional leaders of the community must accept the CHPS concept and commit themselves to supporting it. This is because; the CHPS relies on participation and mobilization of the traditional community structure for service delivery. Due to this, the 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.

Moreover, the CHPS concept has attracted international attention as a useful way to combat these issues by bringing health to the doorstep of the least fortunate. Other countries in West Africa and beyond are realizing the gains to be made from mobilizing community momentum to drive health. A minority of the population also seek care from traditional healers such as spiritual healers, bone setters, and herbalists. Barriers to solving these problems include poverty, low education and literacy rates, lack of organization in the health system, poor infrastructure, inequitable health financing, and dearth of skilled health personnel.

Despite the fact that CHPS offers the best opportunity for more effective and efficient health care in rural communities by ensuring access to quality healthcare for all especially mothers and children who form the vulnerable part of many rural communities, the situation is different from the context of the West Mamprusi District. If indeed the concept and its related activities have improved the well-being of rural communities, the same cannot be said of rural communities within the District and the Northern region. According to Penchansky (1981) those who need health services most that is, women and children tend, to be the least able to gain the benefits and are frequently more



harmful or ignored by the actual operations of the CHPS services as they are delivered.

Nevertheless, a study by Awoonor (2012) shows that the CHPS is working, promoting access for maternal healthcare and mobilizing local resources for the provision of healthcare. Utilisation of health care services had increased under the CHPS initiative from 37% in 2004 to 70% in 2008 in Ghana (Ayizem, 2012). Similarly, the Ministry of Health (Ghana) in 2008 reported that the use of out-patient under the CHPS initiative almost doubled between 2005 and September 2007.

Also, a recent study in the Volta Region of Ghana, also found CHPS to have positively affected health seeking behaviour and the consumption of healthcare services (Gobah 2011). Elsewhere in Burkina Faso, Gnawali and others (2009) reported higher utilization rates (about 40% higher) for out-patient services under the Community-based Health Facility programme similar to the CHPS in Ghana. Contrary to this finding, Yeboah (2003), contend that out of 80% of the population who require healthcare at any given time, only 20% of them are able to access it. That is, about 80% of people living in Ghana, majority of who were women and children who need healthcare cannot afford to pay out-of-pocket at the point of service use. This has resulted in delays in seeking healthcare, non-compliance to treatment, and consequently divergence to the close-to client initiative by the CHPS programme.

The CHPS programme also aim to shorten the gap between health access for the increasingly urbanized south and the agrarian north. Even within districts, there is often a spectrum between urbanized areas and remote communities.



The CHPS system decentralizes Ghana's health system by involving communities in important health decisions. This empowers communities with choices about their health care and gives individuals the opportunity to receive quality and prompt treatment from the health system.

Conversely, like Yeboah (2003), access to healthcare varies across the country because of lack of healthcare providers and consumers (spatial factors); it also varies among population groups because of their different socio-economic and demographic characteristics (non-spatial factors). Accordingly, spatial access emphasizes the importance of geographic barriers (distance or time) between consumer and provider, whereas non-spatial access stresses non-geographic barriers or facilitators such as social class, income, ethnicity, age, sex, among others ((Phillips et al., 1984). Accessibility of health for the client means that the health care services are unrestricted by barriers such as geography, cost, language, and times when the facilities are open. Also, access refers to a client's perception of the physical healthcare facility, as well as supplies and equipment within the facility.

However, as a strategy the CHPS system is flawed on several levels, associated with weaknesses within its operations due to lack of resources, and, more acutely, due to weak administrative capacity (Republic of Ghana 2010, 9-30; Binka et al., 2009). For instance, from the national to the sub-district levels 'no administrator works full-time on CHPS, this connotes lack of commitment and support' for the project (Ntsua et al. 2012: 12). And while the CHPS concept revolves essentially around home visits by the CHO, who should 'conduct at least 10 home visits each day for preventive health education', instead they conducted 'on average, one home visit per week' (Ntsua et al., 2012: 5), which



defeats the essentially preventative purpose of the initiative and orients it more towards curative healthcare. In other words, the strategy seems inclined towards ‘static service provision’, with the CHO stationary at a delivery point where the patients have to go to receive the services they require, thus undermining the very essence of the initiative (Ntsua et al. 2012: 8). Particularly, such challenges may impact negatively on access, efficiency and quality of health care delivery. This underscores the need to investigate implementation process as well as efforts made by stakeholders in achieving the overall goal of the CHPS initiative.

CHPS was bound to emerge even after the implementation of the above mentioned PHC elements and principles because there was still problem of health care access (Simmons R.et al., 2007). As indicated in (Ackon, 2003; GHS 2006), in the 1990s, 70% of the Ghanaian lived in localities, 8km or more from the nearest health facility which resulted in 40% mortalities higher and Family Planning use considerably lower than those in vicinities close to service destinations. About 130,000 Ghanaians mostly women and children died every year from preventable disease conditions. Infant mortality rate in Ghana at the time was 131 per thousand live births while for instance in the United States of America and United Kingdom, it was 70 per thousand (Ackon, 2003). Maternal mortality rate also ranged from over 140 deaths per thousand deliveries whereas in the developed countries, it was two deaths per thousand. In Ghana then, prenatal deaths were about seventy times more than those in the developed countries. Infant mortality quoted was 66 per thousand live births and maternal mortality ranged from 5 to 14 per thousand (Ackon, 2003). These were clear evidence that PHC did not achieve the



desired results and therefore, it was imperative for the Ministry of Health to find means of getting health closer than what PHC in its three-tiered system was offering to people especially those in the rural areas.

#### 2.4.1 Implementation of Primary Health Care (PHC)

Health for All, 2000 was to be executed by the PHC concept, along five key principles under eight (8) essential elements. The principles were closely connected to what development experts like Rostow (1960), proposed as the philosophy of developmental benefits trickling down to the disadvantaged in Fried and Gydos (2002) namely universal access, Equity, Community participation, Inter-sectoral collaboration and Appropriate Technology. Table 2.1 below indicates the eight elements, their benefits and constraint within the African sub-region which was considered too broad to be effective and called for its re- evaluation, resulting in many countries restructuring it, whilst Ghana terming the PHC revitalization as the Community based health planning and Services (CHPS).



**Table 2.1: PHC Eight Elements**

<b>Essential Elements</b>	<b>Benefits</b>	<b>Challenges</b>
<b>Education on prevailing health problems and control and prevention method</b>	Education addressed the broad determinants of disease and ill- health in the Region	Since 1986, WHO five global health promotion conferences has not yielded much improved health.
<b>Promotion of food supply and proper nutrition</b>	Policies pursued during the 1970s and 1980s achieved food security (FAO 1992).	FAO, showings proportion of undernourished African rose from 38 to 43% between 1969 and 1992



<b>Adequate supply of safe water and basic sanitation</b>	Water and sanitation coverage increased from 32% in 1980 to 56% in 1999, 28% sanitation in 1980 to 55% in 1999. (AFR/WSH/00.3).	Water and sanitation sector development in Africa were constraint by limited funding; inadequate logistics;
<b>Maternal and child health care, including family planning</b>	Child health now includes immunization campaigns to eradicate childhood diseases. WHO/UNICEF approach for an integrated management of childhood illness (IMCI) achieved reduction in child-hood death and illnesses	The maternal mortality rate (MMR) in the Region is the highest in the world, averaging around 1000 deaths per 100.000 live births, with disparities among countries and between urban and rural areas (WHO, 1997).
<b>Immunization against the major infectious diseases</b>	Child immunization coverage increased in most countries, with immunization of almost two-thirds of all children under one year (UNICEF (2002; WHO, 2008 )	Immunization against tetanus in fertile women was low. E.g. Central African Republic coverage of pregnant women with 2 or more tetanus toxoid doses in 1991 to 2001 ranged between 14% and 32% below expectation. (WHO,19)
<b>Prevention and control of locally endemic diseases</b>	Roll Back Malaria (RBM) adopted in 2000. HIV/AIDS in 1996 to combat epidemic. For tuberculosis, the Directly Observed Treatment Short course (DOTS) was also implemented. Increasing patronage in 1980s to 41 out of 46 by 1998. 56% of the countries attained 100% population coverage. (WHO, 2008).	Communicable diseases, however, still accounted for a large proportion of the disease burden.(WHO, 2008)
<b>Appropriate treatment of common diseases and injuries</b>	Most countries developed their Standard Treatment Guidelines	The Region faced problems of multi-drug resistance in treatment of tuberculosis and anti-malarial.
<b>Provision of essential drugs</b>	38 Member States have used these guidelines, with WHO assistance, to start reviewing their national drug policies, and 33 have official national drug policies (WHO, 2001).	Despite these efforts, over 50% population in Africa do not have regular access to the most basic essential drugs (WHO 1999).

Source: Green (2007) and WHO (2008).

## 2.5 Participation in Decision-making and Collaboration of the CHPS

### Concept

Evidence exists pointing to the formation of village level health committees that integrate volunteers, community representatives, opinion leaders, women's groups, and the poor in the management of their own health programmes in many developing nations (Blas 2005; Lewis and Hinton 2008; Mubyazi et al., 2004). Community participation is imperative in health care delivery in order to integrate local knowledge in the implementation of programmes. Community Participation is a structured process whereby consumer, career, and community views are integrated into the health service's operational planning and policy development process (Lewis and Hinton, 2008). This includes active partnerships between the community and the health service facilitated by implementers or stakeholders.

Several studies point to the fact that the rapid expansion and involvement of local communities particularly in the CHPS strategy in several rural communities in Ghana have contributed to generating the resources (land and personnel) needed in establishing the CHPS compound while at the same increasing rural people's access to health care services and empowering them to take greater control over their health (Ghana Health Service 2011; Sakeah et al. 2014; Tierozie 2011; Nyonator et al. 2005). In health programme implementation, communities where programmes are implemented constitute the end users or targets for such programmes because they are often direct beneficiaries (Shediac-Rizkallah & Bone, 1998) and hence there is the need to consider their participation.



Including stakeholders in health care decision-making for the purpose of implementing health programmes has become an essential component of health care strategic management in most countries worldwide and Ghana nor the West Mamprusi District is no exception. Participation is an essential part of the collaboration where stakeholders are actively involved in critical decisions that relate to the design and implementation of the health problems and the actual programmes to be implemented (Berry et al., 2008). Stakeholders pursue dialogue and reciprocity in the discussions of programmes about the best and cost-effective ways to achieve successful healthcare outcomes (Berry et al.).

Reutter et al. (2005) examined participation and collaboration in health research in poor communities and observed that adopting collaboration and participation among stakeholders help stakeholders to contribute their expertise for the overall success of programmes. The author also contends that views from diverse groups and perspectives are considered to enrich decision-making. Contrary, Lindamer et al., (2008) indicated that rather than focussing directly on collaboration, there is the need to look at early involvement of stakeholders in active decision making related to programmes. One advantage of including stakeholders is that it enables them to know the difference between what health care providers perceive as quality service and what users themselves perceive (Cooper & Spencer-Dawe, 2006).

To Shediak-Rizkallah and Bone (1998) community participation in the process could also be useful for long term sustainability of the programme. They argued that in the course of programme implementation communities could sustain the long-term goals of such programmes by initiating steps to keep it



going. Another way the community could sustain the long-term goals of the programme is through monitoring (Seshadri, 2003). Yet, the extent to which communities can play these roles have been questioned. First, it is often difficult to determine the level of technical expertise and knowledge of local communities on technical and scientific health issues (El Ansari, et al., 2004).

This situation is particularly potent in most developing countries such as sub-Saharan Africa where illiteracy is relatively high (Omelewa, 2008). The relevance of such communities in the programme implementation decision-making if they lack the requisite technical and scientific knowledge is often therefore downplayed. However, Akukwe (1999) and Seshadri (2003) argues that while the communities may lack such knowledge, their understanding of local health, social, economic, and political backgrounds could be useful.

Consequently, in such situations it will be appropriate for technocrats and health experts in relevant sectors to focus on areas the communities can make meaningful contributions. Health experts and other technocrats have also been criticized for their reluctance to acknowledge and utilize local community participation. A study by El Ansari et al. showed that while local communities recognized the significant expertise of health professionals, the health professionals had relatively lower perception of the skills of the communities in the collaborative relationship.

This raises questions as to whether all stakeholders have the capacity and knowledge to make any meaningful contributions to health care programmes. This is because, as earlier noted, in most developing countries, illiteracy levels are high, while educational variations and gaps exist. These factors can have



immense impact on the ability of a group to participate meaningfully and effectively. Also, the participation of communities as beneficiaries and targets of specific programmes has raised critical questions in collaborative relationships. First, to what extent should such communities be included in the implementation process? Second, do such communities possess the relevant knowledge to make meaningful contribution to the implementation process? And which groups should be targeted in the communities? For instance, in the case of the West Mamprusi District with fewer CHPS compounds, these are important in order to conduct a comprehensive assessment of the programme.

Weeransinghe, Makrides and Coward-Ince (2005) contend that the participation of local communities in the process results in first-hand knowledge of community-level health factors and circumstances that could be used as inputs for decision-making and designing the overall health programme. Using this local knowledge to design and implement programmes reduces misunderstandings and conflicts between local communities and health programmes stakeholders over programme goals and the means to accomplish them. Wong et al., (2005) attributed the success of the programme to the inclusion of these black community (end users) members because they provided relevant knowledge of the community which was valuable in the effective implementation.

According to Akukwe (1999), non-health factors such as socio-cultural issues of communities may also be critical both to understanding actual health conditions in such communities and for ease of the entire implementation. Understanding cultural factors (Cultural sensitivities and norms) could be important in considering diverse factors that influence community



acceptability of the programme. Consequently, the participation of local communities can lead to gaining knowledge of critical non-health information to increase programme acceptance.

Also, through community participation, user communities can help determine what their health priorities are and how the intended health programmes fits into them. By this approach, not only will local communities make critical inputs into the overall health programme implementation, but it can also reduce potential resistance to the entire implementation process (Wong et al., 2005). Also, this method is viable means to encouraging such communities to develop ownership responsibility for the success of the programmes (Seshadri, 2003). According to Seshadri (2003) an important way to accomplish this is to offer such communities specific roles and responsibilities as part of their overall contribution to the process.

Against this background, it can be deduced that failure to take into consideration prevailing societal concerns, stakeholder expertise and the power relations in communities may mask real issues associated with community participation in rural health care. In light of this, mechanisms are therefore needed to streamline the CHPS concept in order to utilize these factors to enable the CHPS to achieve its close-to-client strategy as indicated in the Policy document.

## **2.6 Barriers to healthcare and the CHPS in Ghana**

Krumholz et al., (2014) conducted a study on the factors facilitating and constraining the scaling up of an evidence-based strategy of community-based





primary care in Northern Ghana. Their investigation was based on 12 in-depth interviews with local managers who are knowledgeable about current CHPS operations as well as the operational details of the original Navrongo Project. The authors found that CHPS is not involving beneficiary communities as suggested by the programme's policy document in order to achieve its close-to-client strategy. Aside the study also highlighted weaknesses in current CHOs' skills and capacity for managing their job responsibilities. However, Binka et al., (2009) noted that there is different understanding of CHPS among the Health sector leadership. According to the evaluative work by the understanding of CHPS differs even among MOH and GHS leadership at all levels. This has led to a misdirected implementation measure toward curative services to the detriment of promotive and preventive services.

Nyonator et al., (2005) also conducted a study on Ghana's Community-based Health Planning and Services Initiative for scaling up service delivery innovation and found that the implementation gap arises, in part, because few programme resources are directed to starting district pilots. Instead, donor assistance has been targeted on technical training, which upgrades skills, but fails to produce change in work systems. Also, Binka et al., (2009) and USAID (2006) identified inadequate resources with the programme. They noted that the MOH and GHS have no specific budget to support the CHPS programme. This has resulted in incoherent partnership and overemphasis on some CHPS compounds to the detriment of the other components.

Similarly, the Ghana Health Service (2007: 53-54) noted that 'the scaling up of the CHPS process has been hampered by inadequate resources and to some extent, inadequate understanding of CHPS by some people in various

leadership positions within the Service.’ The problem is compounded by a general lack of urgency on the part of policymakers to realise the goals set for the initiative. Not surprisingly, Binka et al., (2009) posited that there was no dedicated funding for the programme at the national level.

Furthermore, Rishworth (2014) conducted a study on women’s navigation of Maternal Health Services in Ghana’s Upper West Region in the context of the NHIS and found that, the further the distance a woman must travel for care increases her personal out of pocket cost for transportation. Insufficient personal finances, scarcity of public transportation, and poor roads, were discussed as a main deterrent to utilizing health care. The case of the NHIS is relevant to the current study because, even when community members have a CHPS facility, it serves as unlimited access to those in these areas.

Studies by Apetorgbor in 2009 on a review of the implementation process of the CHPS also found that although USAID is supporting the programme, the implementation process to be low throughout the country. Most importantly, the CHPS Policy Document itself espoused that the implementation of CHPS is not only fraught with several policy and systems level challenges but some districts commissioned CHPS compounds which have not yet started operations after several years of commissioning. The document also reveal that most of the compounds (about 60%) are partially equipped and without accommodation. Although the study failed to account for specific equipment that constitute the 60% threshold, the finding is critical to the current study in analysing the facilities and equipment that are available to the communities in question.



Another challenge is lack of communication and engagement that make community members not understanding the distinction between community-based health service and services at a higher level health facility (Tierozie, 2011). Like Apetorgbor (2009), this was necessary since it will provide the researcher the opportunity to place the current study within a proper context. Thus, an understanding of respondent will expose the linkages between these studies.

Also, the review document indicated that though the Community Health Management Committees (CHMCs) were formed in most CHPS zones, members were inactive or not trained in 65% of the CHPS zones (MoH, 2014). Community entry and appropriate community mobilisation to support the CHPS programme were hardly done. Aside, there are issues of inappropriate siting of CHPS compounds. In some instance land allocated for CHPS are either in sacred groves, insanitary environments and not sensitive to the cultural setting and taboos. There are also issues of security and availability of water and electricity. These will impact negatively on the implementation of the CHPS programme since the absence of such facilities will deny indigenes the opportunity to access healthcare.

Similarly, Frimpong, Hellinginger, Awoonor-Williams, Aguilar, Phillips, & Yeji, (2013) observed that the location of Anti-Natal Clinics (ANCs) influenced location of delivery, where women who sought ANC in hospitals or health facility were more likely to deliver in a health facility compared to women who sought ANC at a CHPS. Higher quality maternal health services were found to be associated with seeking treatment at a hospital, compared to women who received treatment at CHPS, where women received fewer



diagnostic tests, were less extensively counselled about safe motherhood and were less likely to be vaccinated against tetanus toxoid than non-registered clients.

According to the authors, primary care provider availability and distribution is yet another barrier. Like the West Mamprusi District, rural communities are the hardest hit communities when it comes to lack of healthcare providers. Some areas, (“geographically designated health professional shortage areas”), do not have midwives and community health nurses to take care of their health needs. In many communities, these health professionals are available but not enough to serve the health needs of the whole population especially mothers and children.

Most importantly, socioeconomic status has also been found to play an important role both independently and as a mediating factor in determining access of MHC and delivery in a facility (Moyer, et al., 2013). Indirect consumer costs such as transportation, purchasing of drugs during pregnancy (both in hospital and clinic), food, and lodging for the mother and accompanying family members also affect use and access of maternal health care (Abel-Smith & Rawal 1992). Indirect costs also encompass the opportunity costs lost from seeking care, which relate to reduced family wellbeing in the absence of a primary caregiver, or the income/ employment lost due to health seeking behaviour (McIntyre et al., 2005).

Other studies indicate women in rural and urban areas experience vast inequalities in the location and attendance of birth, revealing urban women are twice as likely to deliver with a health professional at a facility than a woman



in a rural area (GDHS, 2008; GDHS, 2009) with only 30% of rural births attended by a skilled professional (WHO, 2009; GDHS, 2009). Northern Ghana experiences significant shortages in health personnel and health facilities compared to significantly higher concentrations in the south, due to higher rates of industrialization and urbanization (Dovlo, 1998).

There is also a strong association between a woman's education level and their utilization of doctors and nurse/midwives during pregnancy. Conversely, women with no education have significantly lower rates of utilization of doctors and nurse/midwives (11.4% & 66%, respectively) (GDHS, 2009). Results also indicate the use of family planning services is directly related to women's educational level (GDHS, 2009). Findings indicate the Ghana fertility rate is inversely related to education and wealth as fertility decreases with higher education and increased wealth (Solo, et al. 2005). Hence, the study concludes that socio-economic factors influence the rate of contraceptive use.

Religion also acts as a significant factor in maternal health care utilization. Even after controlling for socioeconomic variables, Muslim and Traditionalist women were less likely to use health care facilities compared with Christian women (Gyimah, Taki, Addai, 2006). Various studies indicate use of these facility services is influenced by religious background (Addai, 2000). Traditional views are intertwined with deprived socio-economic settings, which influence the vulnerable particularly, women's perspectives on modern health practices and thus shape their decisions to seek facility delivery (Gymiah, Takyi, Addai, 2006; Gyimah, 2007; Tabi, Powell, & Hodnicki, 2006). Religious affiliation and socioeconomic status indicate beneficiaries



(mostly women) of lower socioeconomic position are linked to more traditional healthcare practices, often due to lower costs of Traditional methods compared with professional health care (Gyimah, Takyi, Addai, 2006).

Similarly, Binka et al., (2009) also found that there is insufficient CHPS Zones. Even where the zones are demarcated, they are not functional because there are no CHPS compounds. In Ashanti region for example, 140 CHPS zones have been earmarked to cover about a quarter of the population but most of these are not functional. Aside, the author contend that, most CHPS compounds lack the CHO's Toolkit made up of basic clinical tools such as BP apparatus, weighing scales and thermometers. Furthermore, some compounds do not have fridges, televisions and basic furniture to motivate the staff. Communication equipment is also critical to their work i.e. cell phones, especially when it comes to referrals.

Inadequate means of transport is yet another challenge. There are inadequate motorbikes for their visitations. Maintenance of the broken-down motorbikes is generally poor and reflects in what prevails in GHS. The Jialing motorbikes purchased by the GHS for the CHO were of poor quality and they often break down within a year. However, the Yamaha motorbikes procured by Community based Health Planning and Services –Technical Assistance (CHPS-TA) often last 5 years and beyond. There are also periodic difficulties in the supply of fuel and lubricants (Nyonator et al., 2006; WHO, 2006; USAID, 2006; Binka et al., 2009).

There is also inadequate skill mix of CHOs. Given the wide range of services expected of the CHOs, their skills need to be upgraded to improve their



functionality, especially needed skills in midwifery. It is also known that some communities resent young and youthful midwives who have no birth experiences to assist them in delivery (USAID, 2006; Binka et al 2009). Community participation and mobilization component of the CHPS programme which forms the backbone of the preventive activities and home visitation is completely absent in the programme leading to more static curative services. Most of the CHOs lack the requisite skills to engage the community in the CHPS activities.

According to Binka et al., (2009) there seem to be conflict between CHPS and HIRD. The HIRD was supposed to build on the CHPS program and not replace it. The HIRD deployed 8000 community health volunteers (CHVs). Where there were CHOs, the HIRD was successful because the CHVs implementing the HIRD worked with the CHOs who gave them leadership and direction. Training of new staff at the community level should be integrated into the CHPS programme.

There is also low commitment by politicians to scale-up. CHPS is considered a key health delivery strategy, but MOH/GHS lack the political will and power with the requisite resources to enhance a scale up. Anecdotal evidence indicated that the support for CHPS was reduced when MOH decided to fund High Impact Rapid Delivery (HIRD) instead of CHPS, because they were unhappy with the progress CHPS was making to rapidly achieve the MDGS 4 and 5.



## 2.7 The Theory of Empowerment

The empowerment theory was adopted for this study. Power play is ubiquitous in daily household relationships, but power is most of the time concealed making it quite difficult to isolate for exploration (Kabeer 2004, 134). Hence, a person may be dispossessed of power without being conscious of it. According to Kabeer (2005, 13-14), “empowerment refers to the processes by which those who have been denied the ability to make choices acquire such ability”.

From the above definition, empowerment can be said to be an ongoing change process that involves self-determination through the making of choices that can improve a person’s wellbeing. It has been argued that for a development intervention like CHPS to engender change, it should “...contribute to people’s sense of independence, rather than simply meeting survival needs” (Kabeer, 2005: 15). This may enable people to make “choices” that act against structures or individuals that draw back the pursuit of their interests and potentials. Kabeer (2005: 14) argued that for an individual to make meaningful choices “*there must be alternatives [and these] alternatives must be seen to exist*”. Eventually, people should be free to make their choices and be responsible for the choice they made.

Further, Kabeer (1999; 2005, 14-15) suggested that empowerment could be examined through three interrelated dimensions: “*agency*”, “*resources*”, and “*achievement*”. Resources may entail all material and non-material things that are necessary for the maintenance and development of the person or wellbeing of a group (for example capital, knowledge, labour, etc. as exist in the West Mamprusi District), which “are the medium through which agency is



exercised” (Kabeer, 2005: 15). What then is agency? According to Kabeer (2005: 14) *agency* “entails a person’s ability to make choices and being able to put them into action even in the face of others “opposition”. For a person to exercise his/her agency, the person must be conscious of the immediate circumstances, have the desire for change and the resources to effect the change. In other words, *resources* plus *agency* makes achievement (otherwise called “capabilities”) possible. *Achievement* is defined as the potential for a person to live a life the person wants (Kabeer, 2005: 15). In sum, the three dimensions: *resources*, *agency* and *achievements* are interdependent. Thus, “changes in anyone dimension can lead to changes in others” (Kabeer, 2005: 15).

In practical terms, achievement involves the exercise of agency that is facilitated by access to resources (for example healthcare support) and the outcome thereof. These “resources” may not only strengthen people’s socio-economic position but also make them conscious of their conditions. People may then be motivated to take actions (agency) to determine the use of their labour and credit. If they succeed through their action to take control of use of their labour and credit; then we say that there is achievement. For this study, the theory of empowerment provided the analytical tools to examine how opportunity to participate in CHPS has served as enabling “resources”. Also, it helped the researcher to examine the extent to which these “resources” have enhanced development in healthcare delivery and “agency” in their households.



### 2.7.1 Conceptual Framework

A conceptual framework is a model that allows the researcher to explore the relationship among variables in a logical and prescribed fashion (Anderson, 1990). According to Anderson, it allows the researcher to explore the relationship among variables in a logical and a prescribed fashion. Governments and communities have a role to play in attaining a comprehensive and quality health care. Government policies and investments must be directed towards poverty reduction and the creation of economic opportunities for communities. This will empower people particularly the vulnerable to access health care. Also, the establishment and location of health facilities should also be paramount in government policies and investments. These will in the long run lead to improved access; efficiency; quality; reduce mortality as well as enhancing collaboration among stakeholders.

As indicated in Figure 2.2, Government policies and investments in Health facilities and services for Communities through the Ministry of Health, Ghana Health Service, Community Health Organizations/ Community Health Management Committees/ Community Health Volunteers will enhance economic activities and poverty reduction efforts. These are manifested in the form of Empowerment of Community Members (access to healthcare), locating CHPS in communities, expansion of opportunities for basic healthcare and above all the development of Human Resource and Facilities for Healthcare. Finally, these interventions will improve access and efficiency, enhance quality, enhance stakeholders' collaboration and improved maternal mortality. It is envisaged that, the presence of CHPS by government will enhance access and in the long run improve the lives of people in such

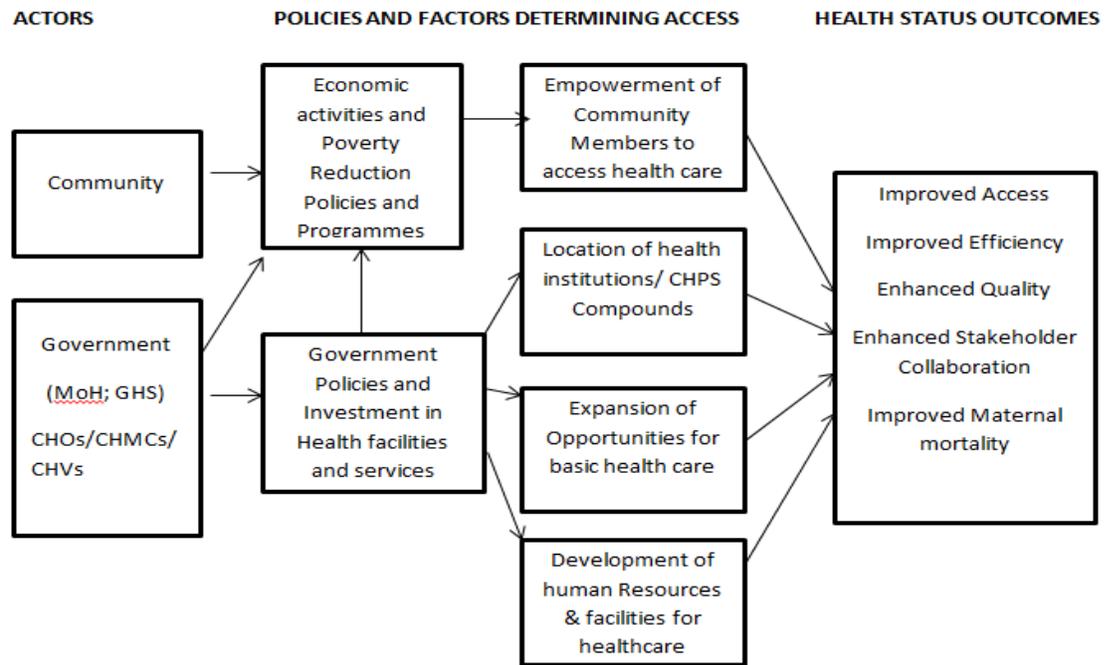


communities. Also, empowerment of community members through access to healthcare will provide the necessary impetus for community members and leaders to collaborate with other stakeholders to achieve the goal of the CHPS programme.

The policies and factors determining access including the Health Status outcomes were modified by the author to achieve the objectives of the current study. They were guided by Yeleduor's (2012) framework on the CHPS programme. The focus of Yeleduor's (2012) research was on improvement in healthcare delivery, human resource needs, physical accessibility, funding of CHPS, beneficiaries, affordability and challenges in the implementation of CHPS programme in the Ashanti region. Although the study revealed interesting findings on the CHPS programme, variables that were utilized are partly different from the current study. For instance, the current study seeks to examine community perception on the responsiveness of CHPS to the primary health care needs of communities, accessible to CHPS services by communities in the District, level of community stakeholders' participation in the implementation of the CHPS programme, how effective is the implementation process of the CHPS programme in the District and the challenges communities face in accessing primary healthcare offered by the CHPS. Aside improvement in healthcare delivery, accessibility and challenges covered in the current study, Yeleduor's (2012) research did not cover other areas as captured in this study and hence, the need for modification of framework for this study to bridge the literature gap. Figure 2.2 illustrates the conceptual framework.



**Figure 2.2 Conceptual Framework**



Source: Adopted from Yeleduor (2012) and Modified by Author, 2017

## 2.8 National Community-based Planning Health Planning and Services (CHPS) Policy

In the year 2016, the Government of Ghana through the ministry of Health launched a national policy on CHPS, the policy aims to attain the goal of reaching every community with a basic package of essential health services towards attaining Universal Health Coverage and bridging the access inequity gap by 2030. (CHPS Policy,2016). This was after a decade of scaling up CHPS across the entire country. The new policy is expected to help in recalibrating the implementation of CHPS to ensure is more comprehensive, realistic and streamlined with other national health system (CHPS Policy,2016)

According to the national CHPS policy,2016. There are five policy directives which guide the implementation of the National CHPS Policy which is expected to provide guidance and clear direction on the scale up of CHPS

across the country. The chances of CHPS succeeding is as a close-to-client health service provider depends on the ability of Ghana health service to closely adhere to the policy guidance during implementation. Efforts to scale up CHPS has been faced with numerous problems.

As implementation of CHPS system progressed, the Ghana health services based on lessons introduced the term ‘functional CHPS zone’, the introduction of this term further complicated the concept. Under the functional CHPS zone concept, compounds were no longer a mandatory requirement. Zones were now ranked on a scale of fractional degrees of partial or incomplete depending on how many of the six steps have been completed. Under the new definition it was difficult to determine precisely what ‘functional’ meant (Awoonor-Williams et al., 2013; Baatiema et al., 2013).

Furthermore, Service delivery was in a constant flux with ever changing definitions of the standard basic package of interventions to be delivered in a CHPS zone (MoH, 1999, GHS, 2005, GHS, 2010 and GHS, 2013). New services were constantly layered onto existing ones with supervisors and communities coming to expect an increasing variety and complexity of clinical services to be delivered at the CHPS level.

All disease specific programmes see the CHPS platform as an opportunity to reach the communities with their programmes. There was also push for CHOs to include deliveries in the CHPS portfolio of services, this situation led to the overburdening of health workers at the CHPS center.



Additionally, the lack of communication and engagement has led to community members not understanding the distinction between community-based health service and services at a higher-level health facility (Tierozie, 2011). Communities expect that every facility should deliver clinical care when required including CHPS. This problem of lack of understanding on what CHPS stands for among community members was revealed during this investigation and has affected the level of support CPS enjoy from the community stakeholders.

One other major issue CHPS implementation has suffered across all regions is the nonfunctional Community Health Management Committees (CHMCs). Though they were formed in most CHPS zones, members were inactive or not trained in 65% of the CHPS zones (MoH, 2014). Community entry and appropriate community mobilization to support the CHPS programme were hardly done. There are issues of inappropriate siting of CHPS compounds. In some instance land allocated for CHPS are either in sacred groves, insanitary environments and not sensitive to the cultural setting and taboos. There are also issues of security and availability of water and electricity. (Ghana National community health planning and services policy,2014)

Financing CHPS remains unclear. Although different development partners have funds for supporting the development and scale up of CHPs, there is no coordination and harmonization of the various funds. The NHIA does not reimburse for CHPS services directly. Where services are provided and qualify for NHIA reimbursement, the cost is claimed through the Health Centers as part of the services provided by the Health Centre. Under



capitation, individuals will prefer to select health centers and hospitals as their preferred primary provider. (Ghana National community health planning and services policy, 2014)

### **2.8.1 Policy directive 1: Duty of care and minimum package of services**

1. Package will include:
  - a. Maternal and reproductive health (emphasizing FP, ANC+, providing relevant information and motivating pregnant women to seek appropriate services including PMTCT and ANC, and to deliver under trained health worker supervision and ASRH)
  - b. Neonatal and Child Health services (Neonatal care, EPI, nutrition education and support and Growth monitoring and promotion, Community Integrated Management of Childhood Illnesses, etc.) c · Management of minor ailments according to national protocols for the community level including fever control, first aid for cuts, burns and domestic accidents, and referrals
  - c. Health education, sanitation and counselling on healthy lifestyles and good nutrition
  - d. Follow up on defaulters and discharged patients
2. Information and Surveillance: CHOs will keep records and report regularly according to standard protocols. The reports will include vital events in the CHPS zone and prompt notification of strange diseases or deaths and increased occurrence of known diseases such as diarrhea, neglected tropical diseases and jaundice.



3. Deliveries may not be performed by CHOs. They are expected to refer all delivery cases to a higher level of care. Based on need, the District Director of Health Services may include midwifery services in the package of services for a specific CHPS zone and post a qualified resident midwife to the zone.
4. Where there is already a competent midwife operating in an accredited private maternity home within the zone, such a facility shall be the referral point for the CHPS zone.
5. Any earmarked or project services to be implemented at the community level and financed by any persons, institutions or development partners shall be implemented using the CHPS strategy according to the laid down district guidelines.

#### **2.8.2 Policy directive 2: Human resources for CHPS**

1. CHN is a classified trained cadre by the Nurses and Midwives Council for persons qualified and issued with the recognized specific license. A CHN who undergoes the prescribed in-service training and orientation and posted as a staff in a CHPS zone is designated as a CHO.
2. There shall be established a CHN grading system for the purpose of providing career progression for the certificate and diploma or any higher class of this cadre. Scheme and Conditions of Service shall be developed to make that category of cadre attractive.
3. Any Community Health Nurse acquiring a professional nursing grade or a degree level qualification shall migrate onto the new profession



grade categories for their promotions. For avoidance of doubt a CHN acquiring a professional qualification and licensed to practice in a nursing profession above a CHN licensure shall move from the CHN category onto the new qualification and license and progress from there. The professional may continue to serve at the CHPS level where appropriate as in for example a CHN being designated a midwife.

4. There shall be up to three (3) CHOs of appropriate staff mix to a CHPS zone who may serve for specified periods depending on the level of deprivation and shall rotate out. After three years the CHO is eligible for reposting.
5. An appropriate incentives scheme shall be developed and instituted to reward CHOs depending on performance, duration of stay and category of deprivation of the CHPS zone. The incentive scheme will recognize staff opting to serve in very deprived areas.
6. Community Health Volunteers shall continue to be an integral part of CHPS zone service delivery. Each CHPS Community shall have at least two volunteers selected by the community and trained by the sub district health team. These will be the recognized volunteers for the CHPS strategy.
7. An appropriate incentives scheme shall be developed and instituted to reward Volunteers depending on performance, duration of stay and category of deprivation of the CHPS zone.



### 2.8.3 Policy directive 3: Infrastructure and equipment for CHPS

1. A CHPS compound is a basic structure consisting of accommodation of CHOs and a service delivery point. To promote efficiency and cost effectiveness in the construction, maintenance and management of CHPS compounds across country, all CHPS compounds shall be standardized across the country using approved design options. For the purpose of consistency in nomenclature, the complex of residence and health post shall be referred to as a 'CHPS Compound'.
2. Sites for hospitals, health center and CHPS compounds shall be determined as part of the District Health Strategic Development Plan. CHPS compounds are therefore not expected to progressively grow into Health Centers.
3. Where a community has provided a temporary structure to serve as a CHPS compound, this should be replaced in due course with the standard approved design.
4. Where maternity services have been approved for a CHPS compound a separate maternity facility co-located within the CHPS compound shall be constructed based on a standard design approved by the Minister of Health.
5. A CHPS compound shall be equipped and furnished in accordance to the standard list defined for the approved designs as attached in annex CHPS compounds located in deprived areas without power grid or safe water shall have solar power and boreholes as part of the standard requirements.





6. All on-going construction of CHPS compounds shall be completed with their planned design; or modified to the new design where applicable except that the cost due to modifications shall not be more than 15% of the suggested cost of construction of the new prototype. All CHPS compounds not started shall comply with the approved prototype and be constructed in line with the principles set out in this policy.
7. The establishment of CHPS zones and location of CHPS compounds shall be determined by the District Assembly on the advice of the District Director of Health Services and consistent with the District Strategic Health Plan.
8. The land for the construction of CHPS Compounds shall be provided by the host community as a freehold with appropriate documentation sealed at the land title registry. The government on receipt shall have a right to vest the land in a third party for the sole purpose of achieving the objective of establishing a CHPS Compound.
9. Where a CHPS compound is constructed by a private individual or organization as their contribution to the health of the community, the ownership of the structure shall be transferred with proper documentation to the Ghana Health Service.
10. In urban areas and around hospitals and health centers, the CHPS strategy is applicable, except that the services will be provided from an existing facility as the host facility. The accommodation component

may be provided to the CHOs if no accommodation already exists for the CHOs. CHPS compound construction will be prioritized for rural and deprived areas

#### **2.8.4 Policy directive 4: Financing**

1. The primary responsibility for financing the scale up of CHPS rests with government. Government shall allocate dedicated resources for the scaled-up operations of CHPS.
2. Additional funds may be mobilized from the following sources:
  - a. Allocation of the portion of National Health Insurance Fund to the Ministry of Health
  - b. Development partner contributions including establishment of a common funding basket.
  - c. Contributions from benefactors and philanthropists
3. All services delivered in CHPS compounds shall be delivered free of charge at the point of use. All CHPS services on the NHIS benefit package shall be reimbursed. CHOs and their volunteers will facilitate the registration of their populations onto the NHIS.

#### **2.8.5 Policy directive 5: Supervision, monitoring and evaluation**

1. The District Director of Health Services being the technical lead in the District and reporting to the District Chief Executive and the district assembly shall have overall responsibility for guiding service delivery in the CHPS zones in the district.



2. Direct supervision of CHOs shall be the responsibility of the Officer in charge of the health center in the sub-district. Where there is no public health center, The District Director shall delegate an appropriate officer to be responsible.
3. Medical officers in the District Hospital shall be assigned several sub-districts for which they shall have mentoring and technical supervision responsibility and shall visit a CHPS zone in their assigned sub-district at least once every quarter.
4. The District Chief Executive shall in collaboration with the District Director of Health Services commission annual reviews of progress in CHPS implementation in the district and make the report available to be discussed by the District Assembly. The report and recommendations of the district assembly shall be made available to the Director General of the Health Service and the Minister of Health by June of the reviewing year. (CHPS Policy,2016).



## CHAPTER THREE

### METHODOLOGY

#### 3.1 Introduction

This chapter present procedures on how the study was conducted. This chapter discusses the study design, the target population, sample size and sampling procedure, sources of data, instruments for data collection, confidentiality issues, data analyses and presentation as well as the study limitations.

#### 3.2 Research Design

Research design according to Kerlinger et al. (2010) forms the architecture of every study and explains how the study is going to be constructed. Kirshenblat Gimblett (2006) noted that the function of research design is to ensure that the evidence obtained enables you to effectively address the problem as unambiguously as possible. According to Bryman (2008: 54) the research design is guided by the specific research questions that derive from theoretical concerns. Three main research approaches exist, qualitative, quantitative and the mixed method.

Qualitative research is concerned with the interpretation and understanding of social phenomenon, usually used to study a particular subject in depth in social, cultural and political aspects of people and organization (Myers, 2009). Qualitative data come in the form of photos, written words, phrases, or symbols describing or representing people, actions, and events in social life (Neuman, 2007). Qualitative study seeks to provide insights but no to measure



(Hinson et al., 2012). This is particularly so when an issue has to be explored through one or more cases in a bounded system (Creswell, 2007). Qualitative research method is applicable in research that uses exploratory research design (Hair, Push, & Ortinau, 2003).

Quantitative research methods, places emphasis on using formalized standard questions and predetermined response options in questionnaires or survey administered to large number of respondents. Normally, in quantitative research, the information on the research problem are specific and well defined, and the decision maker and researcher have agreed on what the precise information needs are. Quantitative research methods are more directly related to descriptive and causal research design. (Hair Jr et al., 2003).

On the other hand, the mixed research methods combine the qualitative and quantitative approaches. According to Creswell (2014) mixed methods involve combining or integration of qualitative and quantitative research and data in a research study. For Johnson & Onwuegbuzie (2004), mixed method research enables the researcher to also combine approaches and concepts into a single study. Mixed methods research is also an attempt to legitimate the use of multiple approaches in answering research questions, rather than restricting or constraining researchers' choices. It expansive and creative forms of research not a limiting form of research. It is inclusive, pluralistic and complementary, and suggests that researchers take an eclectic approach to method selection, the thinking about and conduct of research (p.17-18).

The description research approach which utilizes the qualitative method was employed for this study. The reasons for the choice of this method stem from



the following reasons: The idea of investigating the effectiveness of the CHPS requires the researcher to explore and understand the phenomenon being investigated very well through lived experiences and opinions of respondents to enable the researcher analyse and report on their CHPS activities accurately as possible. Thus, this method enabled the researcher to obtain the views of all the major stakeholders in the CHPS concept to make a better judgment on the quality of services, access to services and the challenges faced by CHPS.

It allowed the researcher to also interpret the data to come out with appropriate construct, themes and explanations in line with predetermined variables with the view to confirming a theory. The data can then be triangulated in order for inferences to be derived. To achieve this objective, both qualitative and quantitative data were obtained using appropriate data collection instruments such as interview guides, questionnaire, observation guide/ check-list and Focus Group Discussion Guide.



### **3.3 Target Population**

Trochin (2000) describes a research population as a group that the researcher wants to generalise to and the sample as the group that are selected to be in the study. Sekaran (2000) supported this when he defined a sample as a subset of the population in question and comprises a selection of members from that particular population. The target population for this study consisted of household heads, health workers or officers, community health volunteers, the District Assembly, Chiefs and/ or Opinion leaders in the 10 CHPS

communities, as well as staff of the West Mamprusi District Health Directorate with oversight responsibility in the CHPS activities.

The West Mamprusi District has five (5) Health Centers namely; Walewale District Hospital, the Janga Polyclinic, Kpasenkpe Health Centre, Kparigu PPAG clinic, Mandela and Our Lady of Roccio private clinic. The Walewale District Hospital serves as the highest healthcare delivery system and a referral point. The District also has 10 functional CHPs compounds at Gbeo, Nabri, Duu, Nasia, Tinguri, Duu, Arigu, Tinguri, Yama and Guabuliga communities (Ghana Statistical Service, 2014).

### 3.4 Sampling Technique

A sample is a carefully selected portion of the population, which is considered to be representative of the total population as to the aspects to be investigated and enumerated (Kumekpor, 2002). The study employed both probability and non-probability sampling methods. A sample of 389 was used for this study. The sample size was calculated using the formula for sample size determination given by Miller and Brewer (2003). This formula allows for a geographically dispersed sample to be used, with participants simultaneously responding to the study from the study area, hence taking advantage of existing social groups to achieve the study objectives.

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

Where n; required sample size, 1; constant, N; sample frame,  $\alpha$ ; level of significance or margin of error. The study areas have a total population of



14,432 (Ghana Statistical Service, 2010). In order to have a fair representative sample, the sample size is determined at 95% confidence level (0.05 margin of error);

$$n = \frac{14432}{1+14432(0.05)^2} = 389$$

Therefore the sample for households (14432) was 389. For the sake of conducting an assessment on the programme, 195 (50%) of 389 household heads was used for the study. To obtain this number, the sample size of each of the four (4) study (randomly sampled) areas were determined using the proportional method of sample size distribution as follows;

**Table 3.1: Distribution of Respondents by communities**

CHPS Communities	Population	Sample Size (Household Heads)
Tinguri	567	31
Nasia	1234	68
Duu	1007	56
Gbeo	731	40
Total	3539	195

Source: Ghana Statistical Service, 2014

The study also included a sample of twenty-four (24) key informants as follows: Chiefs and/ or opinion leaders (4), Assembly member (1), four CHPS management members, three staff of the District Health directorate, twelve (12) health workers or officers from selected CHPS compounds in the communities. Two focus groups were conducted per community, one male and one female focus group discussion.





Simple random sampling is a probability sampling technique and was used to sample CHPS communities', health workers and household heads in the various CHPS compounds. To select this sample the list of all health workers (professionals) from and the three CHPS compounds was generated to form the sampling frame. Then, Microsoft Excel 2016 was then used to select three (3) professionals each. Simple random sampling technique will also be used to select four CHPS communities out of the 10 CHPS communities. This is to ensure that every CHPS community have equal chance of being selected. Finally, 195 household heads within these communities were selected for interviewing. Thus, Tinguri (31), Nasia (68), Duu (56) and Gbeo (40). This was done by generating the least of all households in the CHPS communities and randomly selecting 195 household heads from each household.

Also, purposive, and convenient sampling techniques were the non-probability sampling techniques employed for the study. First, purposive sampling was used to select; three chiefs and/ opinion leaders from the three communities; an assembly member; as well as three (3) management members from the CHPS compounds for key informant interviews. Furthermore, the West Mamprusi District Hospital was also chosen purposively because it is the highest healthcare delivery system and a serves as a referral point for the other health centers within the District.

Purposive sampling is also called purposeful or judgemental sampling as the units observed are selected on the basis of the researcher's judgement about which ones were the most useful or representative (Babbie, 2007). Bryman (2008) also argues that, the essence of purposive sampling is to sample people or cases strategically so as to ensure that those sampled are relevant to the

research questions being posed. Based on this, key informant or focal persons were selected because of their in-depth knowledge and position as focal persons respectively.

### **3.5 Sources of Data**

Data collection is very critical in the field of research. It then becomes imperative to select the manner of obtaining data and from whom the data is acquired especially since no amount of analysis can make up for improperly collected data (Tongco, 2007). Data were obtained from primary and secondary sources. Primary sources of data were generated via interviews, questionnaires, observations and Focus Group Discussions.

This is expected to generate firsthand information. Primary Data were obtained from health workers or officers, community health volunteers, the District Assembly, Chiefs and/ or Opinion leaders in the three CHPS communities, as well as staff of the West Mamprusi District Health Directorate with oversight responsibility in the CHPS activities. Secondary data were also generated from journals, books, institutions health reports, reports from the Ghana Statistical Service and the internet.

The use of secondary data in the form of documentary sources in social science research is supported by Miller and Brewer (2003). They believe that documentary sources in social science research include reports, periodicals, newspapers, articles, photographs, letters, diaries and many more. Hence as part of gathering information for the study, these sources were employed to draw data relevant to the study.



### 3.6 Data Collection Instruments

The instruments for obtaining primary data included interview guides, questionnaire, observation guide/ check-list and Focus Group Discussion Guide. In-depth interviews were conducted with focal persons of the CHPS to supplement the quantitative survey to obtain additional information to buttress the responses that were gathered from the questionnaires. The author interviewed 12 staff who oversee the activities of the CHPS and therefore have expert knowledge on the quality of care and challenges facing the facilities with regards to service delivery in the District.

Hence, Key informant interviews with focal persons of the CHPS were used to collect data from staff and opinion leaders from the sampled communities as well as the Mamprusi District Hospital. Questionnaire was administered to heads of households within the four communities. Questionnaire was also administered to 12 health workers or professionals (including general nurses, enrolled nurses, midwives, laboratory technicians, pharmacy technicians, radiography technicians and other support staff). This was done to solicit information on whether or not the programme works as planned.

A focus group discussion was conducted in each of the CHPS centres, each consisting of 12 participants (clients) from the communities. It lasted for one hour and thirty minutes each. This is necessary in order to solicit collective information on the operations of the CHPS concept in the various communities. Efforts were made to ensure that groups are balanced in terms of gender.



### **3.7 Confidentiality Issues**

Ethical dilemmas are embedded in any social research endeavour. Research participants as individuals or groups have their personal rights which must be protected and respected. Notable among the ethical issues in research are voluntary participation, informed consent, confidentiality, right of withdrawal and anonymity. These ethical considerations were addressed during the data collection in a number of ways. In the first place, the purpose of the data collection was made known to the interviewees. Respondents participation was voluntary.

All interviews were scheduled at the convenience of respondents. Again, the interviews were conducted on the cardinal ethical principles of confidentiality and anonymity. Names and personal details of interviewees were not obtained in all the interviews and therefore the responses given by interviewees were not identified with their names or personal details. Finally, permissions were sought from all the interviewees to audio-record the interviews.

### **3.8 Data Analysis and Presentation**

The quantitative data were entered into a computer and analyzed using Statistical Package for the Social Scientist (SPSS) version 20.0 and Microsoft Office Excel 2016. SPSS was used for the construction of tables, while Excel was used for the graphs because it is easy calculating the percentages and the graphs are more presentable.

During the process of analysis, frequencies and percentages of different variables were obtained to determine the association of these selected



variables. According to Babbie (2007) qualitative data analysis involves the non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships. Qualitative data were transcribed and translated under themes based on the question guides and summarized manually.

Responses from the interview guide were analysed and interpreted to arrive at a generalized conclusion. Taped interviews from the key informants were transcribed verbatim and the resulting texts analysed by using thematic analysis. Maynard and Purvis (1994) state that repeated listening to tapes of interviews with participants is an essential, yet often neglected area of analysis.

Finally, all focus group discussions were recorded by tape and transcribed after the data collection process. The data will be summarized on master sheets according to the type of response and analysed.

### **3.9 Validity and Reliability in qualitative research**

Validity is concerned with integration of the conclusions that are generated from a piece of research while reliability is concerned with the question of whether the results of a study are repeatable (Bryman 2008). According to the Bryman, internal validity relates mainly to the issue of causal relationship between two variables and external validity addresses the question of whether the results of a study can be generalised beyond the specific research context.

On the other hand, external validity has been recognised by Bryman as a major challenge for qualitative researchers particularly in case studies. External reliability, which also measures the degree to which a study can be replicated,



has also been a difficult criterion to meet in qualitative research (Bryman, 2008) because human behaviours (including their perceptions and experiences) are not static and no study can be replicated exactly, in social research regardless of the methods and designs employed (LeCompte and Goetz, 1982).

Validity and reliability of the survey instrument is critical for the success of the study (Trochim & Donnelly, 2007). To ensure the validity and reliability of the research instruments, the instruments will be pre-tested on the sampled respondents in Gbeo. The purpose was to remove ambiguities and unnecessary items in the questionnaire. It enables us to finalise the wording and the sequence of questions, the length and the clarity of instruction. The pilot test revealed other potential areas of the instruments that needed revisions so that the instruments meet the validity and reliability standards (Singleton & Strait, 2005). To certify the validity and reliability of the interview data, the author allowed participants reviewed completed interviews for accuracy and completeness (Creswell, 2007).



### **3.10 Study Limitations**

The major limitation of this study it covered only those communities with operational CHPS compounds as compared to the total population of the entire District. Getting information for the questionnaire delayed due to the perceived reluctance on the part of key informants to share their thought concerning the programme. Also, financial and logistical constraints may affect the study taking into consideration accessibility to study communities. Another limitation was the high number of respondents who are unable to read the

questionnaires. Notwithstanding all this hindrance this study was completed successfully as various strategies such as translating questions by the researcher (here, the researcher employed the services of a translator who translated the written English words to the local dialect for understanding), scheduling interviewing with focal persons and the adoption of good sampling methods were employed to address these issues.



## CHAPTER FOUR

### RESULTS AND DISCUSSIONS

#### 4.1 Introduction

This chapter presents findings of the specific research questions which sought to assess effectiveness of the Community Based Health Planning and Services (CHPS) as a close-to-client strategy in health care delivery within the West Mamprusi District. The demographic characteristics of respondents were presented first. This was followed by the findings on the specific objectives of the study.

#### 4.2 Demographic Characteristics

**Table 4.1: Demographic Characteristics of Respondents**

Variables	Responses	Frequency	Percent
Age	20-29 years	40	20.5
	30-39 years	56	28.7
	40-49 years	59	30.3
	50-years and above	40	20.5
Level of Education	Primary	30	15.4
	Middle/JHS	20	10.3
	Secondary/Vocational	10	5.1
	Tertiary	10	5.1
	Non-formal	49	25.1
	None	76	39.0
Marital Status	Single	10	5.1
	Consensual Union	20	10.3
	Married	108	55.4
	Widowed	47	24.1
	Never Married	10	5.1
Household Size	One	10	5.1
	Two	10	5.1
	Three	48	24.6
	Four and above	127	65.2

Source: Field Survey, 2018



Research by Tierozie (2011), Apetorgbor (2009) and Frimpong et al. (2013) identified age, education, marital status and household size as critical variables in dealing with health care in Ghana. Therefore, there was the need to find out the age, education, marital status and household size of participants. These demographic characteristics are presented in Table 4.1. From the table, 20.5% of respondents are between the ages of 20 to 29 years, while 28.7% aged between 30 to 39 years.

Participants who were between 40 to 49 years were 59 representing 30.3%. However, 20.5% was found to be 50 years and above. Notwithstanding, it was difficult ascertaining the real ages of some of these participants. In some instances, the author asked respondents to mention any age mate in the community so that the age bracket of these participants can at least be determined. Hence, for those who could not reveal their real ages, the author referred to age-mates to determine their ages for this study. These confirm report by Gyimah et al (2006) that the age of some inhabitants is difficult to sometimes determine partly due to traditions and beliefs practiced.

On educational background, the study found that 39% of the respondents had not being to school at all. Most of these respondents reside in the communities with little or no employment opportunities. This was partly attributed to the absence of schools in some of the communities by the opinion leaders in Duu and Gbeo respectively. It was also realised that even in communities with basic schools, familial duties and other activities influence inhabitants to ignore the call to go school. One respondent from Tinguri asserts, *“I am aware of a school in this community but couldn’t go to school because of the work on the farm. If I stop farming my family will struggle to survive”*



Again, 15.4% of the total respondents have had primary education while those who are educated up to the middle or Junior High School Level were 10.3%. Even for those who have gone up to the J.H.S level, some of them indicated that they dropped out and couldn't complete the basic level. This raises questions on their understanding and appreciation of modern healthcare delivery. This finding confirms report by the Ghana Statistical Service (GSS, 2014) on the lack of educational infrastructural facilities in the West Mamprusi District.

The nature of preventive services provided at the CHPS zones requires that some members have some kind of educational background even though some members had no formal education at all. As shown in Table 4.1 only 5.1% of the respondents attained both secondary and Tertiary education. Importantly, the study found that majority of those educated were males. Very few females are educated. As reported by GDHS (2009), that there is a strong association between a woman's education level and their utilization of doctors and nurse/midwives during pregnancy. They maintained that women with no education have significantly lower rates of utilization of doctors, nurse/midwives and family planning services. Additionally, 25.1% maintained that they have received training (non-formal) from other individuals and groups.

The author also assessed the marital status of participants in the selected communities and found that 55.4% were married, 24.1% were widowed, 10.3% were living together (concensual) while only 5.1% were single. For those who are married, the data was evenly spread across the four communities (Tinguri, Nasia, Duu and Gbeo). The implication of this is that, they require



the services of CHPS to provide them with the necessary healthcare in times of child birth control or any other health related issue. The findings also revealed that majority of the respondents representing 65.1% are in households numbering four (4) and above. Against this backdrop, the study also investigated the number of children respondents had, their employment status, economic activity and residential status. Findings are presented in table 4.2.

**Table 4.2: Demographic Characteristics of Respondents**

Variables	Responses	Frequency	Percent
<i>Number of Children</i>	One	20	10.3
	Two	39	20.0
	Three	28	14.4
	Four(4) and above	78	40.0
	None	30	15.4
<i>Employment status</i>	Yes	155	79.5
	No	40	20.5
<i>Economic Activity</i>	Agriculture	147	75.4
	Service	20	10.3
	Commerce	10	5.1
	Others	18	9.2
<i>Residency status</i>	Permanent	126	64.6
	Seasonal	49	25.1
	Occasional	10	5.1
	Others	10	5.1

Source: Field Survey, 2018

Findings from Table 4.2 show that 40% of respondents have four (4) children and above while 20% indicated that they have only three (3) children. This implies that birth rate is high in the selected communities. With respect to employment status, 79.5% maintained that they are employed or engaged in an economic activity (ies). However, 20.5% of the respondents assert that they have no employment or engage in any economic activity. The study found that those within this bracket were mostly youth.



Furthermore, majority of participants (75.4%) indicated that they were farmers who are either into subsistence or commercial farming. It was realised that most of these inhabitants were actually into subsistence farming. This was mainly due to the vast land that was available. This may impact negatively on the livelihood of participants since support mechanisms and interventions are also not forthcoming and, in some cases, completely absent in such communities.

As a result of this, the author curiously questioned participants on their residential status and found that 126 (65%) of them are actually from these communities and hence, permanent dwellers. Also, the study found that 25% of respondents in the four communities are not permanent dwellers since they regularly visit and return to their original places of abode. Only 5.1% indicated that they are neither permanent dwellers nor visiting but they reside there due to other reasons such as the presence of CHPS. As indicated by one respondent in Tinguri, *“I am from the nearby community but since we do not have any clinic, I decided to stop work and come and stay with a family friend here. I will go back after delivering I deliver my baby”*.

### **4.3 Operations of CHPS Zones**

This section of the study consists of the opinions expressed by Community Health Officers on the operations of CHPS zones in the West Mamprusi District. Their demographic information was obtained. Responses were to enable the researcher to examine from the perspective of key informants how the operations of CHPS zones either enhance or impede rural access to Primary Health Care services in the District.



Community Health Officers' (CHOs) opinions on operations show that, services were not carried out to their full capacities. This suggests that, the operations of CHPS zones could be a challenge when promoting community members' access to the CHPS zones.

The study found out that the relationship between the CHOs and the communities were cordial in the program execution in the various zones with the exception of few incidences in some zones, like Nasia and Gbeo where the CHOs said they encountered difficulties with some community members. Reasons for these difficulties in Nasia was that some community members did not like the structure of the facility since it was an abandoned building which was later converted into a CHPS compound and that it had no waiting space during visit, they also complained of the limited services they provided and that community members often fought CHO when they refer them to other facilities for further treatment after a long wait.

At Gbeo, the compound too often could not provide all the medicine needed by clients even though they were health insured clients thus, compelling all who sought services at the compound to seek access to the medication elsewhere, resulting in poor patronage of the compound.

Across all four CHPS zone, results obtained demonstrate that outreach service which is a key component in promoting public health was virtually non-existent and community members had not role in the process, this revelation further demonstrate a constrain in the operation of CHPS.

A little over half of the respondents fell into the category of 20-29 years constituting 54.5% of the sample which could be described as youth. All of the



respondents were Senior High School graduates and later obtained the Community Health Nursing (CHN) grade which qualified them to the rank of CHO. They possessed similar characteristics as far as the rank and duties performed at the compounds were concerned. As indicated by Seshadri (2003) that an important way to sustain the programme is to offer such communities specific roles and responsibilities as part of their overall contribution to the process. The findings also suggest prospects of the concept because of the age at which the CHOs start work, since the youth are full of energy and can move the programs forward into the foreseeable future.

#### **4.4 Community perception on the responsiveness of CHPS to the primary health Care needs of communities**

This section of the study presents community perception on the responsiveness of CHPS to the primary healthcare needs of Tinguri, Nasia, Duu and Gbeo communities. This was necessary in order to assess the close-to-client strategy of CHPS in health care delivery. Table 4.3 presents findings on community awareness of the CHPS programme in the communities.

**Table 4.3 Awareness of CHPS in the community**

Responses	Frequency	Percent
Yes	155	79.5
No	40	20.5
Total	195	100.0

Source: Field Survey, 2018

As shown in Table 4.3, majority of the respondents (79.5%) indicated that they are aware of the CHPS in the communities while only 20.5% of them maintained otherwise. It was also found that, Chiefs and community leaders in

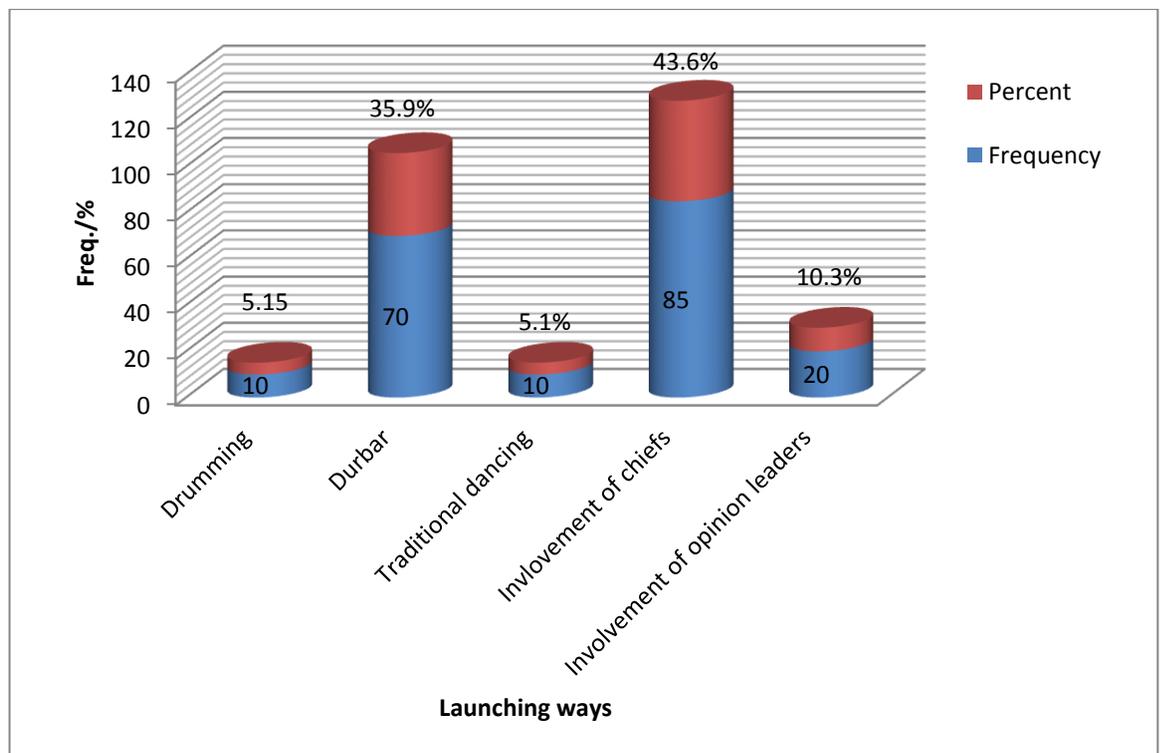


Nasia and Duu were not aware of the Community Health Committee (CHC) which is important medium through CHPS facilitate community participation in decision making for CHPS.

Finding shows that some community members heard CHPS only when construction of the compound began and when the compound started running, thus indicating that some members were more likely to have minimal understanding of the concept largely due to poor community mobilisation prior to launch of CHPS in the communities.

As a result of this, the researcher explored how CHPS was launched and awareness creation method use in the communities. Findings are presented in Figure 4.1.

**Figure 4.1: Launch of CHPS and community awareness**



Source: Field Survey, 2018



Figure 4.2 presents findings on how CHPS was launched in the communities. 43.6% of respondents reported that the Chiefs were involved in the launching of CHPS in their communities. Although not all respondents confirmed this, 35.9% indicated that a durbar was organized with the Chiefs, District Chief Executives (DCEs) and other government officials in attendance. Some respondents from Duu community emphasized that they witnessed the opening of the CHPS compound and can attest to the fact that important personalities were involved. Yet, 5.2%, 5.1% and 10.3% of respondents asserted that CHPS was launched through Drumming, Traditional Dancing and the involvement of opinion leaders.

This finding confirms earlier finding of this study that most respondents were aware of the CHPS in the communities but may have been less involved. One elderly person from Gbeo asserted; *“I decided not to go to the farm that day because I really want to experience the launch of this programme in our community. I stayed and witnessed it together with my children and wife. I have hope that it will really help us”*. Another woman from Tinguri indicated that, *“...urh, yes I was there when it was launched. Although my husband wasn't around I told him everything that took place and we decided not to go to Yama, Wulugu or Walewale the District Capital to access healthcare”*. The implication of this is that some residents have the belief that the programme will empower them through healthcare delivery in the communities and they will longer have to travel to Tamale the regional capital to access healthcare.



#### 4.5 Meeting Primary Healthcare needs of Communities

**Table 4.4: Opinion on whether the primary health care needs of the communities are catered for through CHPS**

Responses	Frequency	Percent
Yes	166	85.1
No	10	5.1
No responds	19	9.7
Total	195	100.0

Source: Field Survey, 2018

From Table 4.4, majority of the respondents (85%) reported that, their primary healthcare needs are catered for through the CHPS. They explained that, they had to previously travel to Walewale, Bolgatanga, Tamale, or Wulugu for healthcare but CHPS has intervened on their behalf. Alternatively, 5.1% of respondents maintained that CHPS has not met their primary healthcare needs. They attributed this to low satisfaction, frequent shortage of medicine and frequent referral to other health centres, and lack of finance among others.

Furthermore, 9.7% of respondents did not respond to this question. Upon interrogation. One respondent had this to say, *“our hospital is a very small one and we have no doctor, we don’t even get the medicine we need”*.

Another person had this to say, *“I have visited our hospital on three occasions and in all the three occasion I was told to go to Tamale or Walewale, so I stopped going there now”*. This finding is contrary to report by Gnawali and others (2009) that utilization of CHPS is high since patients are able to get access to drugs and Doctors.

This implies that not all respondents feel that CHPS provide services that meet their health needs. The study also assessed respondents’ satisfaction with



respect to the CHPS programme in the communities. The findings are presented in Table 4.5.

**Table 4.5 Satisfaction of community members with the CHPS**

Responses	Frequency	Percent
Yes	60	30.8
No	135	69.2
Total	195	100.0

Source: Field Survey, 2018

Table 4.5 shows that majority of the respondents (69.2%) reported that they are not satisfied with the services they receive from the CHPS officials. Only 30.8% of respondents said they are satisfied with the services. Some of them attributed this to just the '*presence of the CHPS*'.

Also, Focus Group Discussions were held on the operations of CHPS zones using indicators such as; Community Health Officer willingness to help clients and provide prompt services, trained and experienced Community Health Officer, volunteer services, availability of essential drugs and equipment, rendering all day Primary Health Care services, successful treatment of minor ailments and satisfaction of overall services rendered.

From the focus group discussions, all the groups were very satisfied with two or three indicators under the operations of the CHPS zones. Men focus groups in Tiguri, Nasia and Gbeo were however were unsatisfied with two indicators each. In Duu CHPS zones, the groups were also very unsatisfied with one and four indicators respectively. The focus group were unsatisfied with the availability of essential drugs and the fact that not all their healthcare needs



could be quickly resolved in the CHPS zone and very unsatisfied with volunteer services in the CHPS zone.

Apart from Duu where the focus group indicated its satisfaction with all the indicators, the rest of the groups were either unsatisfied or very unsatisfied with one or four indicators. By that, it suggests that, CHPS zones operations were efficiently and effectively carried out in Duu than in the other CHPS zones. It was revealed from the discussions that, except the men within the focus group in Duu who were unsatisfied with the level of volunteer services in the CHPS zone, the rest of the women focus groups were very satisfied and satisfied respectively with all the indicators.

#### **4.6 Understanding of the CHPS Concept**

Another key intention of the study was to find out the community's understanding of the programme. In order to achieve this, questions were asked to solicit information as to whether the concept was understood at the FGD. A female respondent at Duu pointed out:

*...in this community, we have no knowledge about CHPS and do not get the difference between CHPS compound and the Clinic, all we know is that they are all hospitals.*

The deficiency of understanding of CHPS was not peculiar to some members in Duu alone, a male respondent in Gbeo also shared his view, thus *“we see the place as a maternity home where our women go to give birth and their babies are taken care of”* The study noted further that some mothers even thought that CHPS was meant to bring them food for sick children. In contrast to this



encounter, it was different at Tinguri where one male respondent expressed his understanding when he said. *“CHPS is here for our welfare and of health because, the nurse goes around educating us on diseases and giving us treatment when the need arises, we suppose to partner the community Health officer in improving our health”*.

Another respondent from the same zone intimated that *“We are also supposed to be directed to Walewale Hospital for treatment if the nurse cannot handle the situation, because not all the disease should be treated there”*. They all were of the opinion that everyone in the community was aware that the nurse was to sensitize them on communicable disease, provide reproductive health services, personal hygiene and sanitation issues especially pregnancy and its associated matters with child care. That their children were taken care of anytime they fell sick especially in the night and besides, the nurse was there to educate them on how to live in a hygienic way and also get treatment from her when they were ill. They said the presence of CHPS in their community also offered them the opportunity to access health care easily.

Importantly, poor understanding of the program results in the fact that Chiefs and community members take the CHPS compounds to be hospitals or clinics where all the essential services could be provided. This, the study found negatively impacted on healthcare delivery in the District. As reported by Tierozie (2011) and Apetorgbor (2009) that understanding of beneficiaries in the CHPS concept will influence the implementation of the programme greatly.



#### 4.7 Accessibility of CHPS services to communities in the District

In this study, access to CHPS services was categorized into Physical (reachability), Economic (direct and indirect cost) and Socio-cultural (indigenous practices). Enhancing healthcare in Ghana through the CHPS is a step in the right direction as it will enable those at the grassroots to access health services and desist from travelling long distances for same. This is also captured in the policy framework of the CHPS after piloting it in Navrongo (Upper East Region).

##### Physical Access

**Table 4.6: Coverage of the CHPS Outreach programme in the community**

Responses	Frequency	Percent
Yes	19	9.7
No	157	80.5
No responds	19	9.7
Total	195	100.0

Source: Field Survey, 2018

Findings from Table 4.6 indicate that, of the 195 respondents, 19 (9.7%) of them maintained that the CHPS programme cover the entire community (Thus, Tinguri, Nasia, Duu and Gbeo). Contrary to this finding, 157(80.5%) of respondents lamented that the programme and its officials (volunteers and nurses) do not cover the entire community. This is contrary to assertion of Awoonor (2012) that the CHPS is working, promoting access for maternal healthcare at every part of rural communities and mobilizing local resources for the provision of healthcare.



However, the study found that for those who reported that the programme does not cover everywhere, indicated the programme is not operated 24 hours and that they do not get the services they require especially during emergency.

Yet, some also where of the view that, where the CHPS compound is situated is far from reach and hence, do not think the programme is meant to cover everyone in the community. A respondent from Nasia had this to say;

*“For me I came to this community last two years from Kumasi to join my husband. I think the CHPS has really helped us but where it is situated is not good. I think it is far and they mostly complain of inadequate vehicles and fuel. If there is a woman like me in labour she will suffer”. So it needs to be made to cover the entire community.*

This agrees with Nyonato et al. (2006), USAID (2006) and Binka et al., (2009) that a major challenge of the programme is inadequate means of transport. Others they mentioned are the supply of fuel for Motor bikes.

Furthermore, 19(9.7%) of respondents did not provide answers to this question. The author realized that for this group, most of them do not know what the CHPS is about and hence, they cannot tell whether or not it covers everywhere.

#### 4.8 Visits to CHPS Compounds

**Table 4.7 Frequency of respondents’ visits to the health facility**

Responses	Frequency	Percent
Weekly	10	5.1
Monthly	47	24.1
Annually	108	55.4
No responds	30	15.4
Total	195	100.0

Source: Field Survey, 2018



From Table 4.7, findings on the regularity of visits to the CHPS are presented. Majority of respondents (55.4%) indicated that, they visit the CHPS annually. Also, 24.1% and 5.1% of respondents reported that they visit the CHPS monthly and weekly. Although, some respondents reported utilizing local medicines and midwives, they also asserted that sometimes when they cannot deal with certain ailments, they recommend the place to other relatives or visit themselves. Similarly, 30% of them did not provide answers to this question.

The study further found that, the health facilities are inadequate for effective health delivery in the district as the population within these communities increase. Before the introduction of the CHPS compounds, the situation was worse, as all communities access health care at Walewale the District capital. Accessibility affects the frequency of visit to health facilities as the longer the distance, the less the frequency. Also owing to bad road network, it was found that transportation has become disincentive for people to travel to access health care.

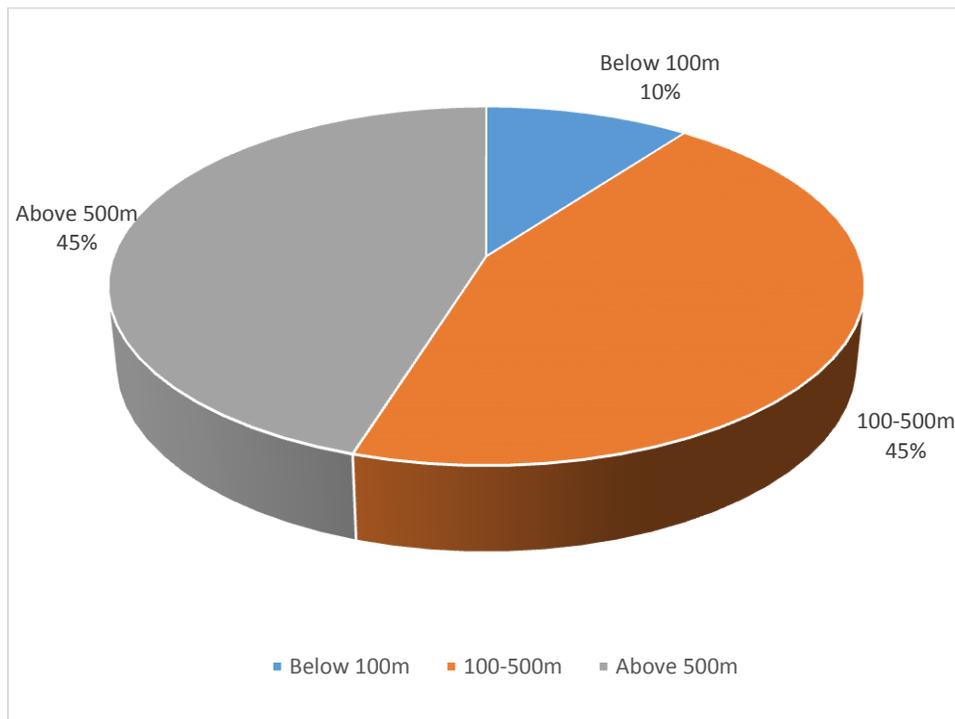
It was also revealed from the information obtained from the field that, frequency of visit to health facilities depended on the facility availability within communities. The average number of visits to a health facility in communities with CHPS compound was four times in a year; while communities without the CHPS compound had an average of one visit in a year.

This means that for communities that have CHPS compounds, there is the frequency of visit, which greatly helps improve the health of community members. For other communities without health facilities, they are tempted to



wait till the condition worsens before being taken to a health facility. Often, because their conditions have already deteriorated, there is the need to refer cases to a higher level of care. Against this backdrop, the study investigated the distance to the nearest health facility. Findings are presented in Figure 4.2.

**Figure 4.2: Distance to the nearest health facility**



Source: Field Survey, 2018

Distance travelled by patients in communities with the CHPS compound in the District average between 100 metres and 500 metres. In Nasia and Duu in the District, the average distance covered by patients is less than 200 metres, but the other catchment communities travel an hour average distance thereby increasing patronage and easing access to the facility. In Tinguri, the average distance is less than 500 metres and an average travel of 60 minutes for other catchment communities. The above is well within range using the standard of



an hour travel time or eight kilometres away from the CHPS facility. However, because the roads are bad and not motorable they distance seems far. This confirms report by Simmons et al., (2007) that distance from the CHPS compounds to the nearest homes are usually far, covering between 100 and 500 meters.

In these communities where the CHPS compounds are located, the preferred mode is walking. It was found that, the means of transport in these communities are bicycles, motorcycles, vehicles (scarce). Also, where higher health care is required, referral is made.

On the part of the Community Health Officers on the physical factors that could undermine community members' access to Primary Health Care services in the CHPS zones, a scale ranging from very satisfactory to very unsatisfactory was used to measure accessibility. Very satisfactory was the highest rating and meant very good impression. Satisfactory stood for good impression. Unsatisfactory and very unsatisfactory meant poor and very poor impressions respectively. Community Health Officers and community members' opinions on physical access to PHC services are contrary. This means report from the key informants is different from that of the community members.

In the community focus groups, physical access of community members to the CHPS zones was measured by using the following indicators; distance from homes to CHPS zone (not more than 5km), travel time from homes to CHPS zone (not more than 30 local language in CHPS zone, all-weather motorable



roads to CHPS zone; available transport to CHPS zone and access to Community Health Officer without difficulty.

It is evident from the data collected on all the indicators that, the focus groups were very satisfied with the physical access of community members to the CHPS zones on three or five indicators and satisfied with one or two indicators. They were however very unsatisfied with one or two indicators. The focus groups in Nasia were unsatisfied with access to the Community Health Officers without difficulty. Results here reveal further that, majority of the opinions were very satisfactory and satisfactory respectively.

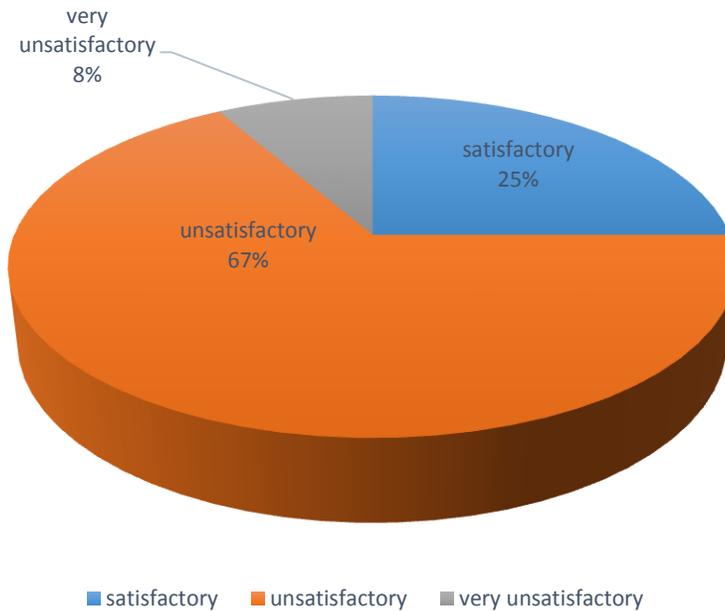
The unsatisfactory and very unsatisfactory of some of the opinions of the focus groups suggests that, physical access of community members to the CHPS zones cannot be described as entirely high and that, physical access could be an important factor in determining total access to the CHPS zones.

Based on the indicators used, majority of the opinions from all the CHPS zones suggests that, physical access of community members to the CHPS zones is quite satisfactory.



#### 4.9 Economic (Financial) Access

**Figure 4.3: Opinions on Economic (Financial) Access**



Source: Field Survey, 2018

Opinions on economic (financial) access to the CHPS were solicited from officials and community members. From figure 4.3, opinions of CHO(s) about community members' financial access to the CHPS zones' services ranged from satisfactory to very unsatisfactory. 25% of total opinions were satisfactory about community members' financial access to CHPS zones' services. Also, 66.7% of total opinions were unsatisfactory about community members' financial access to CHPS zones' services. Finally, 8.3% of total opinions were very unsatisfactory about financial access to CHPS zones' services.

Opinions expressed here by respondents also differentiated between insured and uninsured community members. For insured clients, financial access to CHPS zones' services was not really a challenge. On the other hand, financial



access was a major challenge among uninsured community members who were also in the majority. This therefore confirms earlier report by the GSS (2014) on low health insurance coverage and utilization of health insurance benefits in the District. This is contrary to findings of Ayizem (2012) that the utilisation of health care services had increased under the CHPS initiative in Ghana.

Data collected in the focus groups discussions on the financial access of community members to CHPS zones' services indicate that, all focus groups were not very satisfied on the ability of community members to pay for transport, diagnosis and medical drugs.

Also, the focus groups from all the CHPS zones were each very unsatisfied. It reveals further that, the focus groups from Gbeo and Duu were either unsatisfied or very unsatisfied with the ability of community members to pay for diagnosis and drugs, suggesting that, financial access is quite difficult in these CHPS zones.

Even with this position, the groups maintained that, it was exclusive for only members of the District Mutual Health Insurance Scheme. The focus groups from all the four CHPS zones indicated that, major cases need vehicle to transport the patients to the facility and at present, the cost charged by vehicle owners is on the high side.

It was clear that, focus groups held similar opinions on the ability of community members to pay for diagnosis and drugs. Community members in focus groups revealed further that, they did not rate the ability of community members to pay for diagnosis and drugs as entirely satisfactory because,



community members who were not covered by the District Mutual Health Insurance

It was also found that, although CHPS have been introduced in these communities, the compounds are not budgeted for by the Regional Health Directorate. They depend on Internally Generated Funds (IGF) and also from the district health directorate. It is interesting however to note that community preference for orthodox medical care over traditional medicine is not limited by affordability. With the introduction of the National Health Insurance Schemes people are able to access health care without money being an issue at all at the point of service delivery. Where some people pay for basic services, as confirmed by some respondents, reasons assigned for paying basic health care include: cost of drugs, the expiry of health insurance membership or non-renewal of membership; or not registered with the scheme at all.

The current economic profile of the region is typical of a developing country: low per capita income, which translates into low spending on health (Ghana Statistical Service, 2014). In cases where transportation cost is high, it is detrimental to access health facilities. For communities that have the CHPS compounds, transportation cost is negligible. For serious cases or where the patient cannot walk (thus, women in labour), average transport cost is high which may not be affordable to some patients (USAID, 2006).

### **Socio-cultural**

On cultural access, most respondents who were interviewed in the four communities (Tinguri, Nasia, Duu and Gbeo) maintained that it is only when their ailments or diseases cannot be solved or healed by traditional medicines



that they resort to the CHPS compound located in the community. Living and sharing things in common is vital in these communities. Findings on this are presented in table 4.

**Table 4.8: Where respondents access healthcare before the coming of CHPS**

Responses	Frequency	Percent
Orthodox	40	20.5
Traditional	79	40.5
Others	76	39.0
Total	195	100.0

Source: Field Survey, 2018

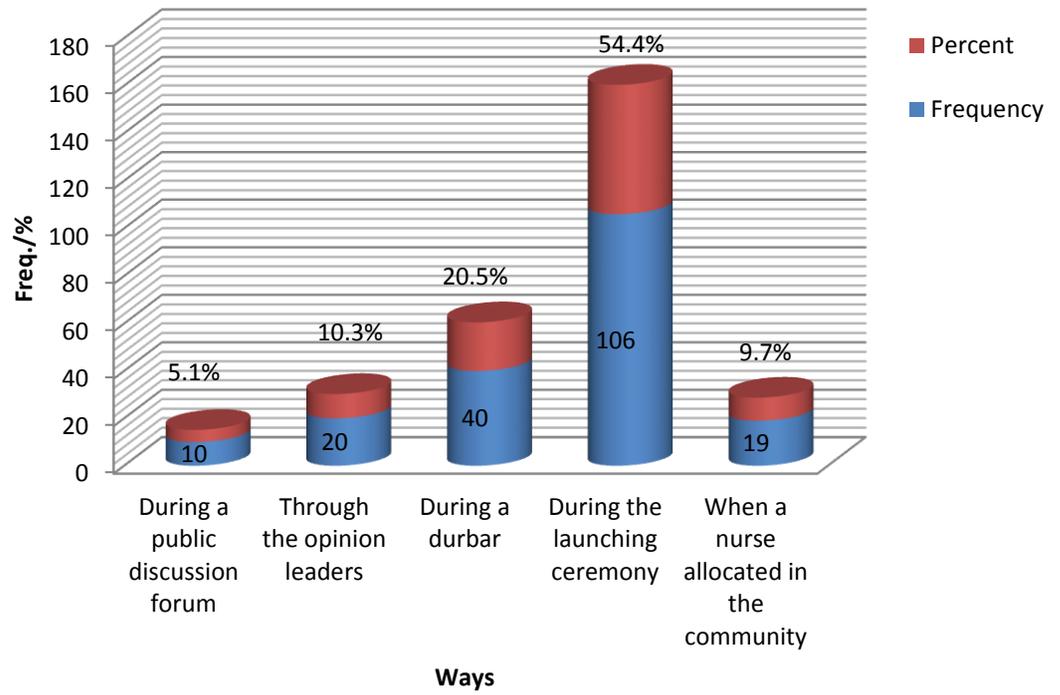
Against this backdrop, some respondents reported that on cultural access, no one prevents them from accessing the healthcare. They indicated that although their belief system endorses traditional medicines, it doesn't forbid attending CHPS compound for health care. In sum, it can be concluded that on socio-cultural issues no one is forbidden from accessing healthcare.

#### **4.10 Community stakeholders' participation in the implementation of the CHPS programme in the District**

This section presents findings on stakeholder participation in the implementation of the CHPS programme in the District. To this end, the researcher asked respondents on how they first heard of the CHPS. Responding to this, about 54.4% of them maintained that they heard of it during the launching ceremony. Also, 20.5%, 10.3%, 9.7% and 5.1% reported that they heard of it during a durbar, through the opinion leaders, when a nurse visited them and during a public discussion forum. Figure 4.4 presents these findings.



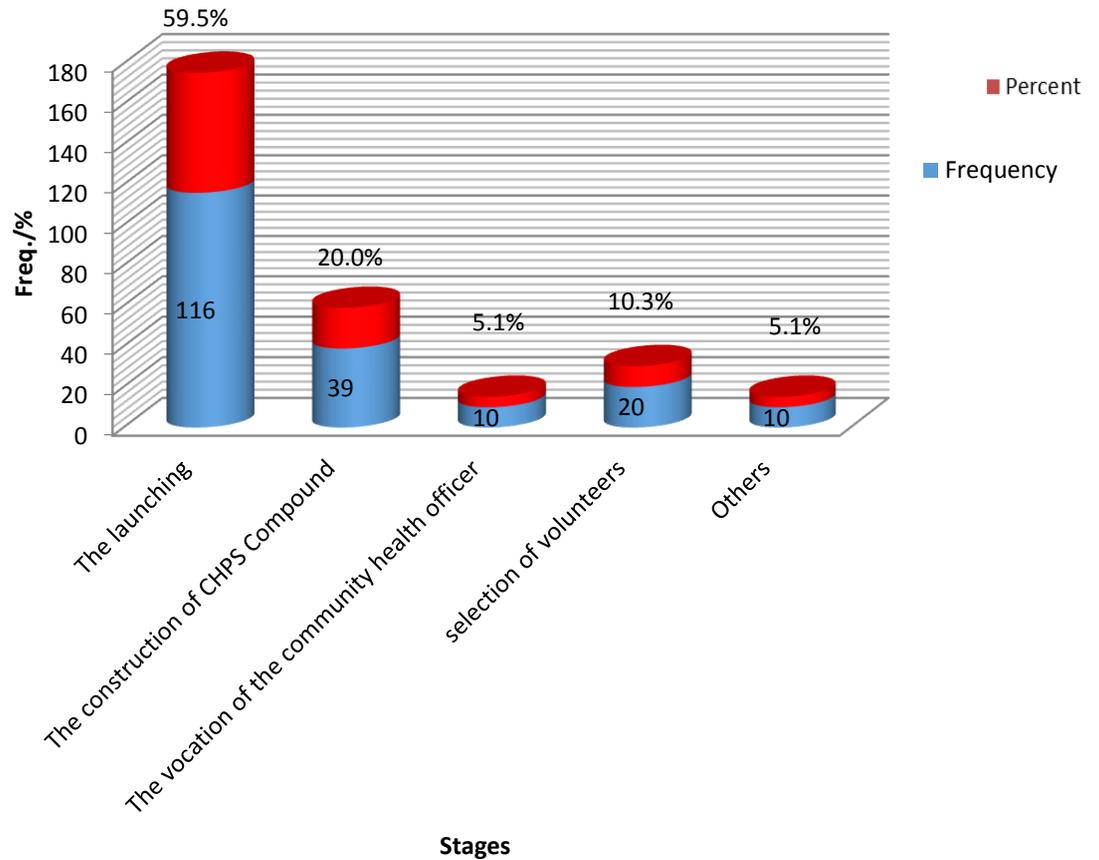
Figure 4.4: How respondents first heard of CHPS



Source: Field Survey, 2018



**Figure 4.5: Community Members Enthusiasm Per Stage of CHP**



Source: Field Survey, 2018

Figure 4.5 presents findings on the stage of the CHPS that respondents were enthusiastic about. Responding to this, 59.5% reported they were enthusiastic during the launching, 20% said during the construction of the CHPS compound, 10.3% said during the selection of volunteers while 5.1% said it was the vocation or position of the community health officer.

In the study areas in the District, the CHPS compounds are managed by nurses, who serve as first point of call for medical cases. They attend to minor cases, responsible for medical outreach and public health education. Most CHPS compounds are managed by Community Health Officers (CHOs) or midwife with some supporting staff like security, health extension workers among



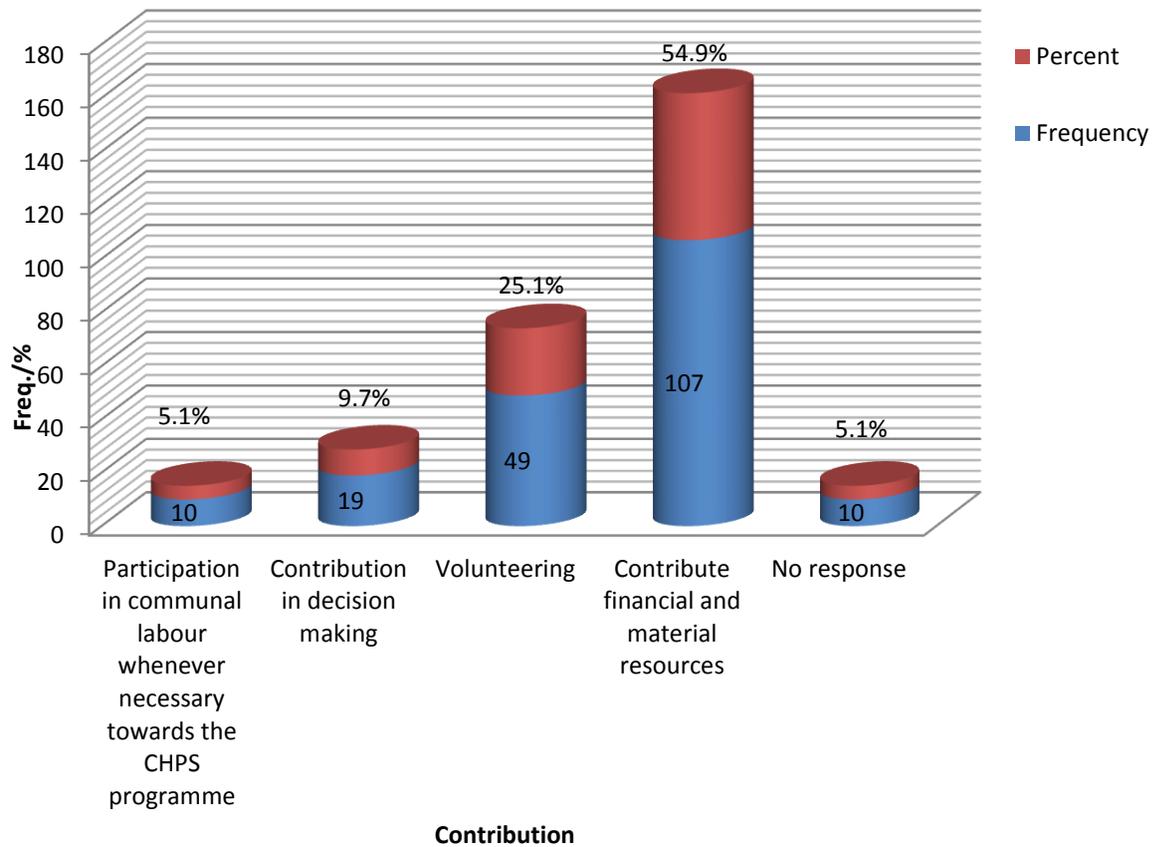
others. However, the CHOs or midwives are oriented in community entry skills and mobilisation in order to manage the compounds well. Without these health workers manning the compounds, the communities would not have access to quality health service.

Supporting staff as used here refers to a security man, auxiliary nurses, health extension workers among others. The study also found that, although community members were enthusiastic about certain stages of the CHPS programme, the programme lacked adequate midwives. This is because, delivery is one of the major services that is rendered by CHPS and this requires a qualified midwife yet only few of them work in the four CHPS compounds.

Respondents in the four communities also indicated their participation in the CHPS as follows; 54.9% contribute financial and material resources, 25.1% volunteer their services, 9.7% contribute in decision making, 5.2% participate in communal labour. However, only 5.1% of respondents did not provide responds to these questions. This means that to some extent members in the four study communities participate in the CHPS programme (Weeransinghe, Makrides and Coward-Ince, 2005). The findings are presented in Figure 4.6.



**Figure 4.6: How respondents participate in the CHPS programme**



Source: Field Survey, 2018

Additionally, it is evident that, 12.5% of total number of opinions on community participation strongly agreed that community members participate actively in CHPS activities. 50% of total opinions agreed that community members participate actively in CHPS activities. The remaining 37.5% of total opinions disagreed that community members participate actively in CHPS activities. This shows that, there were mixed opinions on the participation of community members in CHPS activities, suggesting further that, community participation could influence the smooth operations or otherwise of the CHPS zones since community members have key roles to play in the implementation of the CHPS initiative. The study also found that through this participation



critical decisions are arrived at which in the long run improves the success of the programme. This agrees with Weeransinghe, Makrides and Coward-Ince (2005) assertion that participation of local communities could be used as inputs for decision-making and designing the overall health programme.

Data collected from community members in focus groups on their level of participation in CHPS activities was also measured against indicators such as; strong sense of ownership of CHPS zone, available labour for CHPS activities, attend durbars to discuss issues related to CHPS, preparedness to contribute money and material resources towards CHPS activities, volunteerism and satisfaction of overall community participation.

All the focus groups strongly agreed on one or three indicators and agreed on two or three indicators. Two focus groups disagreed on one indicator each. The focus group in Nasia also strongly disagreed on two indicators.

This shows that, community participation in CHPS activities in all the four CHPS zones cannot be said to be the same. What appears clear is that, community participation seems to be low in some areas than others. That notwithstanding, community participation cannot be described as high in the other CHPS zones as focus groups in these CHPS zones did not all strongly agree on the indicators.

Regarding the opinions of CHO(s) on their participation in CHPS activities, 81.2% of total opinions strongly agreed that CHO(s) participate actively in CHPS activities. The remaining 18.8% also agreed that CHO(s) participate actively in CHPS activities. In all, majority of the opinions strongly agreed



that, CHO(s) participate actively in CHPS activities in all the CHPS zones selected for the study.

In finding out from community members in focus groups the level of participation of the Community Health Officers in charge of the CHPS zones, indicators such as; lives in the community, render mobile services, constant communication with community members about their health and carries Ministry of Health decisions on Primary Health Care issues to the community and community decisions to the health authorities were used. It suggests from the ratings of the focus group in the CHPS zones that, they were not impressed about the participation of the Community Health Officer in CHPS activities. The result from other group was quite different and shows that, they were not impressed about the participation of the Community Health Officer in CHPS activities. This is contrary to findings of Wong et al., (2005) that participation in the programme is high for rural communities.

Women who happen to form the majority of clients in the CHPS zones are likely to understand more about the participation of the Community Health Officers in CHPS activities than their male counterparts and for that matter are most likely to give a true account of their participation in CHPS activities. It is therefore not surprising that, in the cases of some CHPS zones, women ratings within focus groups were quite different.

Furthermore, community involvement and participation are key elements of the CHO-CHV working relationship, with communities developing and managing their local health governance system through a health committee overseeing and supporting CHVs. Because of CHPS implementation's



perceived complexity, however, community entry and mobilization are often ignored, with CHOs posted to CHPS zones without community members' prior knowledge. A CHO from district said:

*“It is the community’s responsibility to keep the health compound clean but they don’t. The Compound is often overgrown with weeds and I have to plead with the community to clear the weeds.”*

This, the author realized was a deviation from the programmes policy directive on how the CHPS compound is to be maintained.

#### **4.11 Effectiveness of the implementation process of the CHPS programme in the District**

**Table 4.9: Effectiveness of the implementation process**

Response	Frequency	Percent
Effective	59	30.3
Not effective	136	69.7
Total	195	100.0

Source: Field Survey, 2018

From Table 4.9, 69.7% of respondents asserted that CHPS implementation process is not effective in their communities. They attributed this to the quality of service that they receive, insufficient drugs, nature of roads and inadequate staff capacity. Alternatively, 30.3% of respondents reported that the CHPS implementation process is effective. For this group, they attributed this to their visit to the compound. The researcher realized that for this group (those who



indicated that CHPS is effective) they had either visited the compound once or twice.

#### 4.12 Whether CHPS is Equipped with Facilities

**Table 4.10: Whether CHPS is fully equipped in the community**

Response	Frequency	Percent
Yes	67	34.4
No	128	65.6
Total	195	100.0

Source: Field Survey, 2018

Table 4.10 presents findings on whether or not CHPS is fully equipped to perform its function as expected. Majority of the respondents indicated that the programme is not fully equipped with the needed resources. However, the significance of CHPS as a pro-poor strategy improving access to health is acknowledged by stakeholders at all levels. For instance, a management member from the District said:

*“CHPS as a strategy cannot be questioned in any bad way; you can only make it work better.”*

In spite of this assertion, the study found that, no administrator works full-time on CHPS, from the district and sub-district levels. This confirms USAID (2006) finding on the limited human resource for the programme. The district public health nurse or district disease control officer, who, by default, doubles as the district CHPS coordinator, dedicates 30 to 40% of her time to CHPS. This lack of dedicated staff creates the impression of a lack of commitment and support for CHPS.



Under CHPS, CHOs and CHVs were meant to complement and support each other. CHOs are sent to communities for three main functions: as a Reconnaissance Agent who understands community needs and communicates them to sub-districts, enabling DHMT planning for more effective and relevant service delivery intervention; as a TA Provider for better home management of common ailments, through health education activities; and as a Change Agent facilitating adoption of better health-seeking behaviours. CHVs' skills in community diplomacy create good environments for CHO operations.

The CHPS operational plan recommends identifying areas with low service coverage and “zoning” those district areas into CHPS zones. DHMTs are then encouraged to launch the programme in steps, starting with hardest-to-reach locations, and phasing in operations, wherein components are implemented according to staff capacity, resource availability, and community readiness. In each zone where CHPS is implemented, 20 implementation activities are embedded in 15 steps, which result in six CHPS Implementation Milestones: planning, community entry, community health compound (CHC), community health officer (CHO), essential equipment, and health volunteer (CHV).

Policymakers, however, view the completion of 20 activities, 15 steps, and six milestones for a CHPS zone as unnecessarily complex, and claim existing infrastructure is inadequate and that CHC provision can be too expensive. A Deputy Director at GHS's Family Health Division views this arrangement as cumbersome: *“CHPS is a great idea; we just have to be able to implement it properly, in a more simplified manner than making it very complex and academic ...”*





To address this, the researcher was informed that GHS has reviewed CHPS implementation procedures, which state CHCs are not sine qua non for CHPS implementation and that CHOs may reside at sub-district levels and travel to communities. This creates another problem: Lack of equipment for mobility may deprive CHOs opportunity for keeping in regular touch with communities and conducting home visits, if operating from sub-districts. The policy shift also calls for re-demarcating CHPS zones to populations of 1,500, corresponding to an electoral area, implying huge CHPS expansion requiring large human resources and logistics.

Although this strategy seemingly decentralizes CHPS further, at least on paper, relations between CHOs and CHVs, as a dual cadre model, may not benefit clients in communities, as long as CHOs are not residents. CHO-collected data include ANC attendance, emergency deliveries, TBA records, immunizations, malaria cases treated, LLINs distributed, minor ailments treated, expectant pregnancies, home visits, but also, increasingly, OPD attendance focus.

The absence of data capture tools such as computers and PDAs affects CHOs' ability to effectively undertake such data collection; computerized data collection and entry ends at districts, as sub-district facilities do not have computers, let alone CHPS. CHO data are sent to the region via the sub-district and district, and are eventually fed back into programs and activities at district, sub-district, and CHPS zone levels.

A CHO stated: *"It is good working with the health volunteers because they help us during Immunizations by giving the vaccine. They also assist us to do home visits."* Another indicated, *"Health volunteers help mobilizes the people,*

*they also carry information from the community to us, especially when they come across a sick person, they inform us.”* Despite the cordial working relationship between CHOs and CHVs, key relationship elements necessary for improving and sustaining community-based care are missing, which leads to a feeling among CHVs that their services are not only pro bono, but also thankless. Consequently, it was found that, CHVs are not always available, especially when services are most needed. This is the biggest challenge to the CHO-CHV arrangement: *“The only problem is that the work is voluntary, and sometimes they expect us to give them something small, even though they understand that it’s voluntary.”*

Further, CHPS Operational Policy requires that CHOs provide these services by focusing on outreach, house-to house services, and establishing community decision systems, using the community register for tracing defaulters and special conditions, such as pregnant women. CHOs also organize community child welfare (well child) sessions and school health education. Although CHOs were to be trained and equipped for basic treatment for minor ailments, this was never to be their main occupation: CHOs were expected to visit at least 10 homes every day for preventive health education, returning later in the afternoon to attend to clients’ health needs. Now CHOs are required to complete only four home visits a month.

In assisting CHOs’ service delivery, CHVs conduct home visits, organize CHO outreach by mobilizing community members for durbars, arrange outreach, weigh children, and plot health charts during outreach. Some volunteers also run errands for CHOs and, in some circumstances, take CHOs for home visits



on their motorbikes. *“In theory, CHOs are doing home visits, but in practice they are not. My observation is that they are running mini health centers.”*

A regional CHPS coordinator said: *“CHPS has influenced the uptake of family planning because access ... has improved. People can now have access at any time they want. Noticeably, unwanted pregnancies and abortion cases have reduced.”*

A District Director in the same region shares a different opinion: *“The CHOs are not doing very well in family planning. A district director of health services indicated:*

Another official indicated; *“After a training programme on family planning last year, I made a follow up monitoring to see if the women were patronizing the female condom”*. Most CHPS zones are far from the district capital, and many are hard to reach. Supervisory visits demonstrate concern and support for peripheral staff, but, the study discovered, most CHOs in remote areas receive little or no supportive supervision. CHOs often feel neglected and abandoned. Surprisingly, some of these challenges have been in existence till now as Green (2007) and the WHO’s (2008) intervention mechanisms on the implementation of CHPS programmes failed to yield the necessary results. This the current study found to be worrying.

A CHO, during a FGD, said: *“We feel disappointed that no one visits us. It’s like having a baby and not caring for the baby.”* The Director of GHS’s Institutional Care Division (ICD) bemoaned the situation: *“Supervision is also a problem. Where it is weak, the CHOs are not happy, because they need to make reports and assess their working conditions as well in the communities.”*



CHOs are responsible for determining CHVs' day-to-day activities, as well as supervising and monitoring a minimum of two CHVs per CHPS zone. CHOs do not regularly supervise and monitor CHVs, however; most CHOs do not even have supervisory plans and checklists. As indicated by Gobah (2011) that although the CHPS has achieved a lot, there are still challenges that are supervisory related.

From the discussions so far, communities with CHPS compounds benefit in terms of the following services; Door-to-door health service delivery for those that cannot come to the facility, provision of preventive health education, quick delivery of pregnant women, antenatal, postnatal and child welfare clinics, treatment of minor ailments before they get complicated, Before the introduction of the CHPS compounds in District, the above health care services stated were not available to community members.

They consider it as health care in comfort. The services mentioned above are absent and every case has to be treated as emergency because of the distance to the nearest facility and the uncertainty of seeing a health worker upon arrival. In other words, they do not have the comfort of waiting for cases to be 'emergency' before taken the patient to the nearest facility. Though health care has improved considerably in the region and the communities in the two districts, communities with the CHPS compound are better off in terms of access to the facility than their counterparts, who have to travel not less than 500 metres to access a health facility.



#### 4.13 Challenges communities face in accessing primary healthcare offered by the CHPS

Despite the immense contribution of the compounds to the health care of community members in the four communities in the West Mamprusi District, there are some challenges that confront the service delivery. The study also sought the challenges that communities' face in accessing primary healthcare offered by the CHPS. Both members of the communities and the key informants responded to this question. According to the CHPS policy document, the following basic facilities/equipment are to be available in all CHPs compounds: accommodation for staff, delivery set, beds, dressing set, weighing scales, motor bikes, fridges, vaccine carriers, stationeries, thermometers and medicines. However, the study found that in the four communities' lack of examination beds, means of transport (motorbikes), medicines, lamps, stationeries, and accommodation for staff are woefully inadequate. The situation is more serious in communities like Duu and Gbeo.

Another challenge that communities face was power outages or no power at all. Aside, standby generators which can replace these facilities were also absent. The absence of standby generators hampers activities at these compounds, making '24 hours' or an all-day service impossible. In events where medicines are prescribed, they may not be available and patients will have to purchase them outside the communities. A respondent from Tinguri had this to say, "*.....most of the drugs are not covered by the NHIS so when I went to the clinic (referring to the CHPS) they referred me to other places in Walewale to buy drugs for myself, they do not even provide services as much*



*as is done in Walewale and I will prefer to go straight to Walewale next time”.*

This confirms Binka et al. (2009) and Ntsua et al. (2012) findings on the lack of critical resources like drugs that the CHPS programme faces.

Another respondent indicated that, *“because we are not given all the drugs you can’t complain than to go elsewhere”*. The implication of this is that some patients may not have money to buy these drugs and also suffer complications due to long distances between these towns. Contrary to these findings, one key informant from the District Health Directorate said, *“people no longer have to travel long distances or pay transportation cost to access health services, especially the family planning services ... I would say accessibility is the biggest advantage of the CHPS program.”* Meanwhile assistant to women was not underestimated. For instance, another key informant reported that, *“CHPS has helped in the timely referral of pregnant women to hospitals for safe delivery.”* This finding is consistent with findings of Ntsua et al. (2012) that although CHPS is flawed with some challenges it helps in referrals of pregnant women.

In addition to the challenges above, complaints from community members (all four communities) were that they are not involved in some of the decision making processes like in the construction of the compounds. For instance, in Gbeo, some of the respondents reported that because they did not partake in the decision making, they had no option than to watch the contractors who came from elsewhere helplessly do the work.

As a result of this, it can be observed that the work that was done was shoddy and hence, uncompleted. Therefore, they recommended that a few of them who



can work be always made part of the construction committee to be empowered to make viable contribution into whatever work is being carried out to support them. This agrees with Kabeer's (2005) assertion on the need for participation in her empowerment theory.

Furthermore, all three stakeholders confirmed that water, electricity and public toilet facilities were major issues being grappled with at the compounds. This issue came up in almost all four communities. To ensure a hygienic and healthy society, water, electricity and public toilet facilities play very significant roles. In some of the communities (Duu and Nasia), the researcher observed that, women fetch water for CHOs on daily basis and most compounds use solar and some still use lanterns. This does not promote quality health service delivery.

Chief from Duu and Nasia expressed graved concerns on these developments. Some recommended that even before the program is launched these services should be made available by the provision of generators for light, for compounds that use lamps and borehole for compound exclusive use for effective service provision.

Against this background, the researcher asked some management members of the CHPS why these are happening. Responding to this, they indicated that, funds allocated to the CHPS compounds are inadequate from the District. In fact, there is no earmarked funding for the program such that basic requirements like vaccine fridges are regularly run short in most zones.

Similarly, another respondent from Tinguri community lamented on the number of staff that the CHPS has. According to the respondent, staff



numerical strength is woefully inadequate and that to him, the main difficulty in the progress of the CHPS program was the inadequate supply of skilled personnel. Contrary to this, another respondent in the same community maintained that the challenge is about lack of understanding on the operations of CHPS.

Responding to this, some Community Health Officers (CHOs) who were interviewed and community members through Focus Group Discussions also suggested that, regular sensitization should be embarked on to educate community members on their roles and responsibilities in the CHPS programme. By so doing, community members could begin to participate actively in CHPS activities anytime or where necessary. The Community Health Officer in Gbeo CHPS zone had the following to say;

*"One major problem making CHPS zones not to respond fully to Primary Health Care delivery in the District is that, most of the people here do not have adequate knowledge about the CHPS concept."*

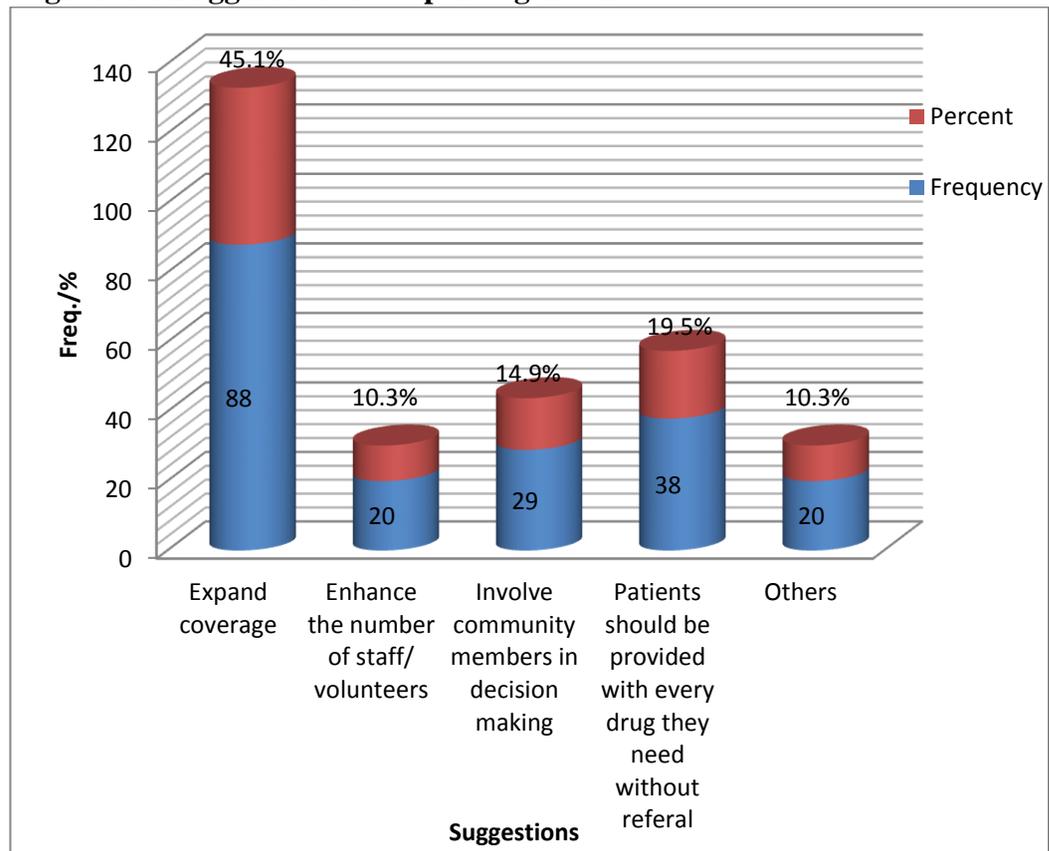
Poor community participation caused by officials for not involving them in programmes may have resulted in lack of interest in the compound activities. This needs a second look by the officials for a remedy. Also, both FGDs and in-depth interviews showed that the security of the compound is very important for the smooth running of CHPS because the safety of the CHOs and their logistics must be protected for the service delivery. Another aspect that also came out clearly from the study was the lack of entertainment for the CHOs to maintain them at post. It was evident that, there was unequal distribution of these facilities across the District.



From empirical evidence gathered on CHPS challenges, it can be concluded that although CHPS is seen to be succeeding country wide, there are still a number of challenges that it faces in its operations. These difficulties include understanding of the concept, the issue of no proper security measures; poor community participation; lack of finances; bad road network; lack of water and electricity; and lack of CHO motivation. The following were recommended by the respondents to make CHPS a viable health delivery system not only in the West Mamprusi District but Ghana as a whole.



**Figure 4.7: Suggestions for improving CHPS**



Source: Field Survey, 2018

From Figure 4.8, majority of the respondents indicated that due to the poor road networks, expanding the coverage (45.1%) of the CHPS should be prioritized by programme implementers. About 19.5% of respondents also were of the view that supplying patients with the drugs they need, will also help the programme achieve its objectives since community members do not have enough money to purchase new drugs. More so, 14.9% and 10.3% were also of the opinion that involving community members in decision making and enhancing the number of CHPS staff will be helpful. This agrees with Krumholz et al., (2014) assertion that CHPS is not involving beneficiary communities as suggested by the programme's policy document in order to achieve its close-to-client strategy. The only solution preferred by Krumholz et al. (2014) is to involve community members.



## CHAPTER FIVE

### SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

#### 5.1 Introduction

This chapter summarizes the study findings based on evidence from the data. The study examined the effectiveness of the Community Based Health Planning and Services (CHPS) as a close-to-client strategy in health care delivery within the West Mamprusi District. The study also looked at community perspective on the CHPS, accessibility of CHPS, level of community stakeholders' participation, effectiveness of implementation processes and the challenges the programme faces. It gave a conclusion to the study and outlined a number of recommendations that the DHA, MOH/GHS, Government and health related NGOs could adapt to overcome these challenges. The chapter finally ends with suggestions for further research.

#### 5.2 Summary of Findings

The main objective of this study was to examine the effectiveness of the Community Based Health Planning and Services (CHPS) as a close-to-client strategy in health care delivery within the West Mamprusi District. The empowerment theory was employed to guide the study. The study outlined five specific objectives that could enable us to determine the viability or otherwise of the program. In the first place, it tried to find out the perception of the CHPS program among the people in the communities and secondly; it sought to find out how accessible the CHPS is.



It also looked at the level of community stakeholders' participation, effectiveness of implementation processes and the key implementation challenges of the CHPS program. From these objectives, the study examined responses from the point of view of the community members, the Director and Supervisors (D/S) of the concept as well as the Community Health Officers (CHOs) who are the gatekeepers of the program, in the form of FGD and in-depth interviews. Responses were examined from these perspectives. A summary of the findings is presented below;

### **5.2.1 Community perception on the responsiveness of CHPS to the primary health care needs of communities.**

The general finding of the study relating to the first objective indicated a weak understanding of the purpose and service CHPS is intended to serve. Community members demand same curative services as offered in the clinics when they visit the CHPS compound, this lack of understanding on the services CHPS is allowed and able to provide weaken the trust of communities in the ability of CHPS to meet their health needs. Some community members avoided CHPS and travel to Walewale for services that could have been provided by the CHPS compound largely due to low trust in the services provided by CHPS and the frequent referrals from CHPS.

### **5.2.2 How accessible is CHPS services to communities in the District**

Results from the in-depth interviews and focus group discussion indicate community members have unrestricted physical access to the CHPS compound and the services provided for an average of 8 hour during the day for Nasia and Duu while Tinguri and Gbeo has an average of 18 hours within which



community members have access to health services. CHO in Duu and Nasia who provide services at these facilities are not resident in the compound due to lack of accommodation and leave the community at the end of a working day. The absence of the CHO in the community poses a challenge to access to health services during the night and when emergencies occur outside the working hours. The lack of transport and logistical support for outreach services within the CHPS zone has restricted access to health services to mainly host communities to the detriment of the entire zone.

Services provided include malaria treatment, cutlass cuts, snakebites, ANC, emergency delivery, dressing and minor suturing, change of wound dressing, post-natal care, family planning services and child welfare clinics.

### **5.2.3 The level of community stakeholders' participation in the implementation of the CHPS programme in the District**

Stakeholder involvement and contribution based on the finding was low, interviews with community leaders reveals the implementation process of CHPS in the research communities was not applied to the fullest and community leaders and members played very little role in the rollout process. Important decisions such as where the compound should be sited, which community should host the compound were determined by district implementation teams and the information relayed to community leaders, this gap took away the element of community participation and ownership in the opinion of the research.



#### **5.2.4 How effective is the implementation process of the CHPS programme in the District**

The Concept of CHPS based on finding from the initial pilot is intended to make health care delivery a shared responsibility between service providers and clients. This objective thus makes the community participation in decision making in the implementation process key to the success of the programme. . It was evident that health professionals were inadequate, and respondents reported that the implementation process is not effective as it should be by their expectation. They explained that they could not participate in the decision making and hence, have limited knowledge on the CHPS.

Community participation after the roll out process has been high and community members actively participate in CHPS activities.

#### **5.2.5 Challenges communities face in accessing primary healthcare offered by the CHPS**

The Challenges identified from the perspective of community members are limited scope of the services provided by CHPS, frequent referral to bigger and far way facilities, frequent shortage of drugs, the environment such as no comfortable sitting place as they await to be receive health services. The issue of Non-resident CHO In the compound, lack of running water and electricity; and over reliance on CHVs, remain the top challenges respondent mentioned.



### 5.3 Conclusion

The study set out to examine the effectiveness of the Community Based Health Planning and Services (CHPS) as a close-to-client strategy in health care delivery within the West Mamprusi District. The main lesson of this study is that the effectiveness of a health system like CHPS is not solely reliant on the commitment of health professionals, but it is largely dependent on the proper understanding of the program by individual community members as well as effective adherence to the implementation mechanisms by implementers, the contribution of communities and ownership by stakeholders.

The objectives of the study were to assess community perspective on CHPS, accessibility of CHPS, level of community stakeholders' participation, effectiveness of implementation processes and the challenges the programme faces and make recommendations based on findings that may influence national policy on health care delivery in the region and country as a whole. At the end of the study, it was found out that, CHPS have helped improved access to health care in communities and most importantly host communities. However, most community members do not fully understand the CHPS concept.

It can be concluded that, the implementation process is not as effective as planned and stakeholder participation is low. The programme is faced with challenges such as; poor community participation; inadequate stakeholder understanding of CHPS concept, under resourcing and logistic; bad road network and lack of accommodation for CHO; all these challenges has undermined the potential of the CHPS programme as a Close-to-client strategy



and addressing these issues will enable the CHPS programme attain its goals of Primary Healthcare Delivery.

#### **5.4 Recommendations**

From the findings, the following are recommended by the researcher;

In order to encourage community participation and ownership of the program, special interest should be taken in the program with the chiefs and elders spear playing active roles in the education of their own people rather than just dealing with the volunteers.

The district implementation team must increase sensitization on CHPS, particularly focusing purpose, services provided and role of community members in making CHPS succeed.

Financial access of community members to the CHPS zones' services was seen to be relatively good in that, fees charged by the CHPS zones did not pose financial access challenges for insured clients. Instead, it posed a challenge to uninsured clients who happened to be the majority. What could be done to increase financial access among uninsured community members is to embark on a vigorous sensitization programme on the need for all community members to register with the District Mutual Health Insurance Scheme by making community members know the benefits attached to the insurance package. Again, community members who cannot pay the health insurance premium because they are very poor should be made to understand that, there is a component under the scheme which allows all persons identified by fellow community members as very poor to register at no cost.



It is also revealed in the study that, the irregular supply of some essential medicals such as medical drugs and equipment posed major challenges for Community Health Officers to run their CHPS zones efficiently and effectively. The operations of the CHPS zones in the District could be enhanced if all essential medical drugs and equipment are supplied regularly by the District Health Directorate through the sub-districts to the CHPS zones.

It is also recommended that government of Ghana and Ministry of Health should build more health facilities, especially CHPS compounds and locate them in the rural and peri-urban communities in the region to improve access to health care. The current system where a CHPS compound serve about six communities or based on zones should be looked at again because the other communities where the CHPS compound is not located yet it is supposed to serve people there as well, access is hindered by distance, condition of road and high cost of transportation.

CHPS compounds should be well equipped with human resource and other materials by Ghana Health Service and District Assemblies to facilitate effective health delivery. The human resource situation should be improved to reflect the standard requirement of a midwife, CHO and other supporting staff in every CHPS compound. GHS in collaboration with the District Assemblies should train more health professional of the various categories and be bonded to service the districts and communities within the region in order to fill the gap.

The rural community where the program is mostly implemented is composed largely of low literate population. A durbar or meeting once or twice is not



sufficient for remembrance or acceptance of a program. The finding revealed that even though several durbars and meetings were held with all the communities, they still could not differentiate activities of a clinic from that of the CHPS compound. The lesson here therefore is that, health professional should not take it for granted that the only durbar ushering in the CHO is sufficient for the community members to accept and understand the work of the compound and support the CHO in the required duties. There should be constant meetings with community members for them to ask questions for clarification.

Volunteerism does not thrive. It was realized that the volunteers were doing well in assisting the CHOs in the health delivery but some of them kept on wondering how long they could continue to volunteer. It will do the system good and sustain it if after some time of impressive performance volunteers are put on a stipend to keep them motivated, their work as volunteers demand the most productive hours of the day and often stop them from engaging in gainful economic activities.

The bad road during the rainy season is yet another factor militating against physical access to the CHPS zones. In this direction, respondents suggested that, authorities concerned such as the District Assembly and the Feeder Roads Department should improve conditions of roads during the rainy seasons to enable CHO(s) reach out to all the surrounding communities under the CHPS zones.



### **5.5 Suggestions for further research**

The study was unable to look at the activities performed by the Health Volunteers who work closely with the CHOs to ensure that the routine duties of the compound are achieved. It may also interest a future researcher to investigate into why there is no financial allocation from the National budget for the CHPS program in the Districts and it has to depend on the mercy of donors and the good will of the District Chief Executives. It is therefore recommended that future research does an in-depth study into these areas. Also, a Multi-Level Stakeholder Assessment of the CHPS zones in the Mamprusi West District is imperative.



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## APPENDIX I

### QUESTIONNAIRE FOR COMMUNITY MEMBERS

*This research instrument is designed to solicit for empirical data for the conduct of academic exercise on the above mentioned topic for the award of Mphil degree. Your support and cooperation is very much anticipated as information given will be treated with utmost confidentiality. Your candid views are important in this research.*

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#### A: Demographic Characteristics

1. Age a. 20 – 29yrs [ ] b. 30 – 39 yrs [ ] c. 40 – 49 yrs [ ] d. 50 yrs and above [ ]
2. What is your level of education? a. Primary [ ] b. Middle/JHS [ ] c. Secondary/Vocational [ ] d. Tertiary [ ] e. Non-formal [ ]
3. What is your marital status? a. Single [ ] b. Consensual Union [ ] c. Married [ ] d. Widowed [ ] e. Never Married [ ]
4. What is the size of your household? a. 1 [ ] b. 2 [ ] c. 3 [ ] d. 4 and above [ ]
5. Household Head. a. Yes [ ] b. No [ ]
6. Number of Children a. 1 [ ] b. 2 [ ] c. 3 [ ] d. 4 and above [ ]
7. What is your religious background? a. Christianity [ ] b. Islamic [ ] c. Traditional [ ] d. Others [ ]
8. Are you employed? a. Yes [ ] b. No [ ]
9. If yes to Q 8, which economic activity are you engaged in? a. Agriculture [ ] b. Service [ ]  
c. Industry [ ] d. Commerce [ ] e. Others (specify).....
10. How long (in years) have you been in the community?.....years.
11. What is your residency status? a. Permanent [ ] b. Seasonal [ ] c. Occasional [ ] d. Others (specify) .....

#### B. Community perception on the responsiveness of CHPS to the Primary Health Care Needs of Communities

12. Are you aware of the existence of Community Based Health Planning and Services (CHPS) a. Yes [ ] b. No [ ]





13. What do you know is involved in the concept?  
.....

14. Do you think the community knows about the concept?  
.....

15. When did the CHPS process start in your community?  
.....

16. How was the process launched? a. Drumming b. Durbar c. Traditional dancing d. Involvement of Chiefs e. Involvement of opinion leaders f. Involvement of lineage groups g. Others specify.....

17. Are you aware of a CHPS committee in your community? a. Yes [ ] b. No [ ]

18. If yes do you think this committee is doing what is expected of it? a. Yes [ ] b. No [ ]

19. Do you think the CHPS program is responsive to the Primary Health care needs of community members? a. Yes [ ] b. No [ ]

19a. If Yes, why?

19b. If No, why?

20. Do you think community members are satisfied with the CHPS program? a. Yes [ ] b. No [ ]

21. What are your expectations of the CHPS concept to the community?  
.....

**C. Extent to which CHPS services are accessible to communities**

22. Does your household seek services from the compound?  
.....

23. How does CHPS enhance access to healthcare delivery? a. Less costly [ ] b. Located close to the people [ ] c. Others (specify)  
.....

24. Do the activities of CHPS cover the entire community? a. Yes [ ] b. No [ ]

25. Have you ever been to the CHPS compound for health care for yourself or relative? a. Yes [ ] b. No [ ]

25a. If Yes, when and why?

25b. If No, why?

26. How often do you visit a health facility? a. Weekly [ ] b. Monthly [ ] c. Annually [ ]

d. Others (specify).....

27. What is the distance to the nearest healthcare facility? a. Below 100m [ ] b. 100-200m [ ]

c. Above 200m [ ]

28. By what means do you use when visiting the facility? a. Walking [ ] b. Motor [ ] c. Vehicle [ ]

**D. Level of stakeholder participation in the implementation of the CHPS programme**

29. Community participation is critical to the success of the scheme, to your candid opinion; does the community know what CHPS is all about? a. Yes [ ] b. No [ ]

29a. If Yes, enumerate some of their contributions indicating their awareness. ....

29b. If No, what is the reason for their ignorance? .....

30. What roles does the community play in promoting CHPS? .....

31. Have you ever been involved in decision making in the CHPS programme? a. Yes [ ] b. No [ ]

31a. If Yes, how? a. through a representative b. through public durbar c. through my capacity as community leader d. others specify .....

32. Do you think the decisions taken in the CHPS programme reflect the interest of the members of the community? a. Yes [ ] b. No [ ]

33. What was your actual experience at the CHPS compound? .....

34. What benefits has the CHPS initiative brings to the community? a. accessibility healthcare b. Economic benefits c. Political advantage d. others, specify.....



35. Do you think that CHPS is providing accessible health care to your expectation? a. Yes [ ] b. No [ ]

36. Before the CHPS was brought to the community, where were you receiving health care? a. Orthodox [ ] b. Traditional [ ] c. Others (specify).....

37. Have you been told that you have any role to play in the CHPS programme? a. Yes [ ] b. No [ ]

37a. If yes, specify:

38. Contribute in decision making to the CHPS programme [ ] b. Participate in communal labour whenever necessary towards the CHPS programme [ ] c. Become a volunteer if I chose [ ] d. Others, specify

.....

39. Do members of your community contribute in any way to the CJPS programme? a. Yes [ ] b. No [ ]

39a. If yes, in what way? a. As volunteers [ ] b. As contributors to communal labour on the CHPS compound [ ] c. As contributors of financial and material resources [ ] d. As decision makers in the CHPS programme [ ] e. Others, specify .....

40. What stage of the CHPS process do you think people were most enthusiastic about? a. The launching [ ] b. The construction of the CHPS compound [ ] c. The vocation of the community health officer [ ] d. the selection of the volunteers [ ] e. others, specify.....

41. How did you first learn about the CHPS programme in your community? a. During a public discussion forum [ ] b. Through the opinion leaders [ ] c. During a durbar [ ] d. during the launching ceremony [ ] e. When the CHPS compound was constructed [ ] f. when a nurse was allocated in the community [ ] g. others specify .....

**E. Whether the implementation process of the CHPS programme is effective in the District**

42. Are the compounds fully equipped with the necessary health commodities e.g. motor bike, fridge for vaccine storage, drugs for emergency treatment among others? a. Yes [ ] b. No [ ]

42a. If Yes, can you list the available commodities.....



42b. If No, why are they not available.....

43. Does the design of the compound meet the basic necessities of accommodation e.g. supply of water, bathhouse and toilet facilities? a. Yes [ ] b. No [ ]

43a. If No, how do they live in the compound?  
.....

44. What are the main challenges threatening the effective implementation of this CHPS concept?  
.....  
...

45. In your view, do you think the implementation process of the CHPS programme is effective in the District? a. Effective [ ] b. Somewhat effective [ ] c. Not effective [ ]

**F. Challenges that communities' face in accessing primary healthcare offered by the CHPS**

46. What are the existing channels for complaints? -----  
-----

47. Have you ever made one? How was it handled? -----  
-----

47a. If No, what do you think are the problems? a. community health officer b. lack of equipment and logistics c. community members d. community larders e. others, specify .....

48. What other problems exist?  
.....

49. CHPS is a strategy meant to improve rural health by bringing health close to the door steps of the people, what suggestions do have you to offer for the improvement of the concept?  
.....

50. What role does the community play in supporting the CHPS programme?



## APPENDIX II

### INTERVIEW GUIDE FOR VOLUNTEERS/ STAFF/MANAGEMENT

This interview is seeking your opinion about services you often undertake in the CHPS program. Your candid views are important since they would help to improve upon its implementation.

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1. Probe on community perception on the responsiveness of CHPS to the Primary Health Care needs of communities
2. Probe on the extent to which CHPS services are accessible to communities
3. Level of stakeholder participation in the implementation of the CHPS programme
4. Whether the implementation process of the CHPS programme is effective in the District
5. How many CHPS zones have been established that you know?  
.....
6. How the CHPS compounds in the District managed.
7. Roles Directorates play in promoting CHPS in the District
8. Challenges Administration face in collaborating with the other stakeholders.
9. Other factors impede the operations of CHPS
10. What are the sources of funds for CHPS? a. Central Government [ ] b. Donor partners [ ] c. NGOs [ ] d. Internally Generated Funds of CHPS compounds [ ] e. Others (specify) .....
11. Effects of CHPS on healthcare delivery in the Region
12. Suggestions to improve the activities of CHPS?  
.....
13. Do you charge people who visit the facility? a. Yes [ ] b. No [ ]
14. Does your institution receive external support in the implementation of CHPS? a. Yes [ ] b. No [ ]
15. If Yes, what type of support?  
.....
16. Who are the main decision makers in the CHPS programme? a. Community Health Officer (Nurse) b. District health directorate c. The Chief d. The opinion leaders e. Representatives from groups in the community f. Others, specify.....
17. Challenges that communities' face in accessing primary healthcare offered by the CHPS



## APPENDIX III

### FOCUS GROUP DISCUSSION GUIDE

1. Introduction
2. Community perception on the responsiveness of CHPS to the Primary Health Care Needs of Communities.  
Use the following indicators as well; Community Health Officer willingness to help clients and provide prompt services, trained and experienced Community Health Officer, volunteer services, availability of essential drugs and equipment, rendering all day Primary Health Care services, successful treatment of minor ailments and satisfaction of overall services rendered.
3. Extent to which CHPS services are accessible to communities.
4. Level of stakeholder participation in the implementation of the CHPS programme
5. Whether the implementation process of the CHPS programme is effective in the District
6. Whether CHPS committee is effective
7. Cooperation from the community.
8. Nature of the relationship between the community and the CHPS officials
9. Challenges that communities' face in accessing primary healthcare offered by the CHPS
10. Conclusion

