IMPACT ASSESSMENT OF THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES INITIATIVE IN THE BEREKUM MUNICIPALITY

BY:

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CERTIFICATION PAGE

I hereby declare that this submission is my own work towards the Commonwealth Executive Masters in Public Administration and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made in the text.

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DEDICATION

This work is dedicated to all people living and working in the rural areas of the Republic of Ghana for whose improvement in health status and development, the CHPS program was initiated. It is my fervent hope that this Initiative, which is based on the evidence of what works in health delivery, will bring to them the intended benefits of good health and improvement in their living conditions for the development of our nation.

ACKNOWLEDGEMENT

My first thanks go to the Almighty God for helping me go through this programme successfully. I take this opportunity to express my heart- felt appreciation and thanks to all the facilitators and supervisors especially Mr. Joseph Mensah for their efforts and sacrifices to make my completion of this programme a success.

Last but not the least, I wish to express my thanks to my friends and family members for their words of encouragement.

ABSTRACT

This study was about the assessment of the impact of the Community-based Health Planning and Services Initiative in the Berekum Municipality. The purpose of the study was to evaluate the effectiveness of the Initiative in meeting the expectation of bringing quality and affordable healthcare to the people in the rural areas. The Berekum Municipality is a predominantly rural one with severe challenges in accessing quality but affordable healthcare services. In the study the non-probabilistic method of Accidental Sampling method was used to sample subjects from each of the four (4) communities with CHPS compound in the Municipality. Structured interview schedule was the instrument used for these subjects. Also a questionnaire was administered on the Community Health Officers (there was only one from each of the four communities). A number of findings emerged from the study among which is the impression that the nature and purpose of the study, though well appreciated by the Community Health Officers, are not understood by the members of the communities in the study. The distinction between the community-based health care delivery system that CHPS is intended to bring about and the institution-based system that was being abandoned, was not appreciated by the community members. Also CHPS is intended to provide a mechanism that combines the orthodox healthcare delivery system with traditions of the people in the delivery of quality healthcare that is also affordable. The study gave the impression that the CHPS programmes in the various communities were not living up to expectation in this regard. The majority of the interviewees were unaware of their responsibilities towards the management and the decision making of the programme and also the necessity of consensus building in the running of the CHPS program for it to be successful. In the light of these seeming deficiencies in the implementation of the Initiatives, some recommendations were made. On the side of demand, there should be a vigorous use of a kind of Communication System that utilizes the traditional means of communication to

provide community education that would be efficient and effective. Also all the traditional and community resources should be mobilized for the benefit of the Initiative. On the supply side, the government through the Ghana Health Service should provide adequate logistics and equipment including medicines to the CHPS compound for it to function effectively and also to win the trust of the community members. This was imperative for the trust of the members of the communities and the sense of ownership of the programmes is crucial to the success of the CHPS Initiative. To conclude, the step-wise implementation of the CHPS Initiative should be pursued to the letter for the success of improving the health status of the people in the rural setting.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

The provision of accessible but affordable health care for the citizens of the country has been the aim of governments since the attainment of independence in 1957. Deliberations on health sector reforms, with the aim of achieving accessibility for all citizens started in the 1980s but were given impetus in the 1990s by a continuous and growing role of research which sought to bridge the gap between research and policy formulation and program implementation (Nyonator *et al*., 2002)

Credible evidence emerged from these research projects that, there was the need to shift resources from curative institutional-based care to community-based preventive public health services (Nyonator *et al*., 2002). It was in the light of this that CHPS, a program 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.

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 programs. The community needs to be informed and educated about health, health policies and their implications, and their opinions sought in plan formulation.

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. Accessibility here is defined as living within one hour travel time (by any available means) from a health facility; 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.

It is evident that the perception of the members of a beneficiary CHPS community would contribute in no small way to the success or failure of the initiative. Perception here is defined as the way things are noticed, especially with the senses and also the ability to understand the true nature of something (CHPS in this case).

1.2 Problem Statement

Improving the health status of the population of the rural areas is crucial for poverty reduction in any country, given that ill health is a consequence and cause of poverty. As research reports have indicated (Ghana Macroeconomics and Health Initiative, October, 2005), the communities have to be involved in the development of policies and plans and in monitoring and evaluation of the health programs.

They need to know their health rights and responsibilities and appreciate the interdependence of everyone in the society and also the ethical and moral values that are necessary for the development of health.

The community-based health planning and services is designed to meet the above thereby improving the health status of the population through the improvement of accessible, efficient and quality Healthcare and Family Planning Services. In this regard, it is essential that the people perceive the CHPS programme in its right perspective.

In the Berekum Municipality, there is misconception on the part of the community members on the CHPS programme, thus making it difficult for the successful implementation of the programme. Hence, this study, which intends to assess the impact of the CHPS Initiative, in the Berekum Municipality.

1.3 Objectives of the study

The following are the objectives of the study.

1. To trace the history of the CHPS process in the community
2. To assess whether the CHPS programme is fulfilling its role of providing accessible healthcare or not.
3. To assess the level of the community members' involvement in decision-making in the CHPS process.
4. To assess the sense of ownership of the community members of the CHPS programme.
5. To evaluate the level of understanding of the differences between the CHPS approach and the clinical-based approach of the community members
6. To evaluate the effectiveness of community education on the role of community members in the CHPS process.

1.4 Research Questions

The following are the research questions into which this study intends to investigate:

1. What is the history of CHPS process in the community?
2. Is the CHPS program fulfilling its role of providing accessible health-care or not?

3. What is the community members' involvement in decision-making in the CHPS process?
4. What is the sense of ownership of the community members of the CHPS program?
5. What is the level of understanding of the differences between the CHPS approach and the clinical-based approach of the community members?
6. What is the effectiveness of community education on the roles of community members in the CHPS process?

1.5 Relevance of the study

This study will help throw light on how the CHPS program is impacting on the communities of the Berekum Municipality. It will reveal whether the CHPS programs in the various communities are living up to the expectations of the CHPS Initiative or not and so draw attention to any challenges that may be prevailing in the implementation process of the Initiative.

This is important because the CHPS Initiative is a new community-based healthcare delivery system in the country meant to replace the old institution-based system and so needs constant monitoring and evaluation to ensure that the implementation keeps in line with mandated guidelines of the Initiative.

1.6 The Scope of the Study

The study was conducted in four (4) communities that have the CHPS compounds in the Berekum Municipality in the Brong Ahafo Region. These communities were Kotaa, Nkyenkyenmaamu, Amomasu and Anyinasu.

1.7 Organization of the study

This study is organized into five chapters. The first chapter gives the background, the statement of the problem, the objectives and research questions as well as the significance of the study among others. Chapter two is on review of literature, chapter three covers the methodology, while the fourth chapter is on analysis and presentation of data gathered. The fifth chapter deals with the summary, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter deals with work in the areas of CHPS done by policy makers and researchers. It is divided into the following sections; evolution of accessible health policy options in Ghana, organizational of CHPS at the District level, policy on CHPS, implementation of CHPS, benefits to some communities, and other effects observed on some communities.

2.1 Evolution of accessible and efficient health-care policy options in Ghana

In the foreword to a document of the Ministry of Health (November 1999) on the Community-based Health Planning and Services entitled "A Process for Effective Implementation of Primary Health Care Programs" the then Deputy Minister for Health Dr Moses Adibo made the following statement:" The provision of adequate, efficient and equitable Primary Health Care services to all Ghanaians is a crucial policy of the Government of Ghana. The major objective of the Ministry of Health in this regard is the extension of health services to most people through the use of front-line staff i.e. community Health Nurses and Community sponsored service support Volunteer outreach activities. The achievement of this objective involves:

(1) The engagement of the cooperation and authorization of the people themselves at the community level and

(2) The reorientation and deployment of some health workers from hospital and clinical activities to community based activities."

These words amply captured the purpose and essence of the CHPS Initiative which is the current policy option of the Government of Ghana in its attempt to make health care services accessible, efficient and of quality. The CHPS Initiative was preceded by other attempts at improving the quality of health of the population of the country for the purposes of national development and rural poverty reduction as discussed below.

According to Kodjo Senah, in his contribution to a book entitled "The State, Development and Politics in Ghana" by the Council for the Development of Economics and Social Research in Africa (1989), Ghana's experience with the western model of health care (the conventional model of health care) started since 1471 when the white man landed on the shores of the country and has undergone three phases.

The first phase spanned the period from 1471 to 1844; a period that coincided with the growth of the "germ theory" after Louis Pasteur's discovery of germ as the causative factor of infectious diseases.

This period also coincided with the rise of capitalism with its focus on the individual. The result of this was that health and health care come to be interpreted in terms of the individual as against the community in the western model of health care services. During this period western health care services were the exclusive reserves for the white man and involved the use of medicine and medical technology without promotive, preventive or rehabilitative health-care practices.

The second phase started from 1844, when the British entered into a peace treaty with some coastal chiefs and brought much of the country under their dominion, till the down of

independence. During this period, the first hospital of the country was built in 1868 at Cape Coast after the colonial surgeon Thomas Jones submitted his reports to the colonial governor in 1867. The Gold Cost Medical Department was founded at this time.

During this period, health-care services continued to be based on curative practices but were expanded to include the local population especially those in the urban areas and those in the public services. Alongside this expansion in healthcare services was the attempt to liquidate traditional medicine and in 1879 a legalisation was passed to abolish traditional medicine. Preventive medicine got recognition of the colonial government as a result of pressure from the then Sanitary Movement in Britain and the bubonic plaque in 1908. Consequent on these, the Sanitary Branch of the Medical department of Gold Cost was set up. The jurisdiction of this branch was stated in vague terms as removing sources of growth and multiplication of microbes and consisted in jobs like draining gutters, cleaning toilets and the likes. Severe budget cut in 1931 and 1932 forced the Sanitary Branch to restrict its activities to the urban areas and later became defunct-obviously the colonialist was not interested in preventive health. The features of the colonial health care system included the following:

1. A strong curative and urban bias
(2) A centralized medical administration with the least concern for the rural areas
3. The central government was the largest provider of health services
4. The subordination of traditional healing system to bio-medicine.
5. A north-south disparity in the provision of health-care services and facilities with the southern half of the country as the greater beneficiary.

The Ministry of health came into being when the Gold Coast attained self rule after internal arrangement in 1951.

At independence, the national leadership had made a commitment to better the health for the people. Consequently, early development in the health infrastructure took place along two main paths viz: 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).

Disparity between expenditure of the government on health care services and the need of the people become an issue in the post independence era of the nation. Two central issues with immerse social, political and economic implications for the development of the health industry were health financing and coverage. Public health services became an intolerable burden on the exchequer, while it was at the same time, limited to a few Ghanaians (Senah, 1989).

In most developing countries, more than three quarters of the health budget was spent on hospitals which were mainly in the urban areas and cantered on the treatment of diseases whereas the need was for prevention, improved nutrition, personal hygiene and environmental sanitation. Preventive services like the Under Five's and Antenatal care did not receive much emphasis in the national health plan (Ebrahim and Ranken, 1995).

Also, there was the disparity between resource allocation and population distribution. Most of the personnel and capital resources remain sequestered in urban areas catering for the elite even though the population was largely rural or lived in urban squatter areas. A large share of the recurrent expenditure went into servicing the capital resources. (Ebrahim and Ranken, 1995).

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).

The policy at independence to adopt and literally apotheosize western models in our desire to be counted among the comity of "civilized" nations accounted for these inequalities. Also the determination oh health policies seemed to have been affected by prevailing elite and ruling class interests (CODESRIA, 1989).

Also, it seamed 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 to effect a sanitatory environment received very little support from the communities

In conventional health care the regular focus of concern is the individual pathology. This kind of health care based on the western model has been described as the "engineering model" The analogy of the body as a machine and the doctor the medical scientist/ engineer has proved useful to the development of certain aspect of medical care especially in crises intervention and in the treatment of acute clinical disorders.

However the attempt to manage ill health along the lines dictated by this framework has produced some distortions, for example the tendency to focus most efforts and resources on the curative dimensions of health care (Macdonald, 1996) as is shown in the preceding paragraphs.

Progress in medical technology has done little to remove many of the colossal mountains of suffering and ill health which exist in the societies of the third world with their patterns of communicable diseases often rooted in poverty (Macdonald, 1996).According to Macdonald (1996) the engineering model of health can be fairly described as reactive rather than proactive; to reduce ill health to an area susceptible to technical fixes is to ensure that health services will fail poorer countries.

In the 1970s it became clear to health policy makers in the country that something radical had to be done. The thinking was that 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

Hospitals and clinics were such that they could not offer any kind of service to more than at most 20 % of the population.

That, the basic health problem of many countries had not been addressed by considerable investment in institutions of tertiary care and the concomitant neglect of community level initiatives of care and prevention have been two of the major factors which have contributed to the emergence of the alternative approach to health care which is called Primary Health Care (Macdonald, 1996)

In 1975 a joint WHO – UNICEF study estimated that only 1/5 of the rural population in the developing countries received basic health care on a regular basis. This was followed in 1976 by a study from the ILO which estimated that almost 2/3 of the population of the developing countries were living in serious poverty and 700 million of them were destitutes (Ebrahim and Ranken, 1995).

Based on the study, the ILO advocated a "Basic Needs' approach to national development from which the Primary health Care approaches emerged at Alma Ata in 1978 when the Global Health Conference was held.

The Declaration of that conference urges member states:

1. To take appropriate steps for consultation to raise awareness of the general public, political leaders, ministries and other partners concerned with social and economic development policy to the need to place health high on the political agenda in order to address the serious health challenges of the coming decades and to ensure that the foundation is laid for implementation of the global health policy in countries.
2. To adapt the global health policy after its adoption, into national or sub-national context for implementation- selecting approaches specific to their social and economic situation and culture.

Primary Health Care emerged as a strategy when these failures were becoming increasingly obvious. Frustration with existing approaches led to criticisms and innovative practices were tried.

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 meddle-level personnel for the proposed PHC program. 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 program.In1977, the government adopted the PHC program. 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 and constitutes the first element of a continuing health-care care process (Declaration of Alma Ata).

Alma Ata takes a wider view which incorporates a concern for the treatment of individual symptoms but acknowledges that problem of ill-health can have structural causes; causes that lie outside the control of the individual and even sometimes outside the control of a whole

community or country (Macdonald, 1996). It addresses the main problem in the community providing preventive, promotive and rehabilitative services (Alma Ata Declaration).

According to Macdonald (1996) three principles guides the philosophy oh PHC and these are:

(1)Commitment to equity

(2)Adherence to the principle of the right of people to be involved in significant decision concerning their health services and

(3)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 perspective of PHC builds on WHO's definition of health as "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The position of Alma Ata 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. PHC is a reaction to a narrow medical approach to health care. (Macdonald, 1996).

The activities of the Primary Health Care program are as follows

(1) Promotion of nutrition.

(2).Provision of adequate supply of safe water.

(3) Provision of basic sanitation.

(4).Maternal and child care including Family Planning.

(5).Immunization against the major infectious diseases.

(6).Prevention and control of locally endemic diseases.

(7).Education concerning the prevalent health problems and the methods of their prevention and control and

(8) Appropriate treatment for common diseases and injuries.

Secondary and tertiary health care cannot be said to be part of "Primary Health Care" but they must be part of a health care system which is turned towards the needs of the community in the spirit of PHC. All must be integrated into a rational entity (Macdonald 1996).

The PHC program operated at three levels; A,B and C. level A was at the community level and had the Traditional Birth Attendant, Village Development Worker and Village Family Worker as its personnel. The function at this level was preventive and promotive health services, simple curative measures, pregnancy management, environmental protection and community mobilization for health-related community projects.

Level B was at the institution level of health center and had the following as its personnel: a Medical Assistant, Community Health Nurse /Midwife, a Health Inspection Assistant and a Senior Field Technician for communicable disease control. The function at this level was immunization and a referral point for level A.

Level C was the district which had the District Health Management Team (DHMT). This team consisted of a District Medical Officer, a District Public Health Officer, the District Technical Officer for Communicable disease control, a Senior Medical Officer for the hospital and a District Health inspector. The function at this level included planning, implementation and evaluation of health services for the entire district.

In 1984 the government set up the National Primary Health Care Committee made up of 17 governmental and non-governmental organizations to steer the PHC program. They selected

the following functions for the PHC program

(1)Expanded program on immunization.

(2)Control of diarrheal diseases.

(3) Health education.

(4) Environmental sanitation and

(5) Growth monitoring.

Since the International Conference on PHC, held at Alma Ata in 1978, the call for health- for -all by the year 2000 through PHC provided motivational and unifying concept in international health development and made an important contribution to the achievement of better health which has occurred around the world: increased life expectancy, declining infant mortality and improved access to basic health care services (Macdonald, 1996).

However, as the target date approached, it could be seen as limited, may be, misunderstood and above all proposed time frame which was not universally attainable. To cite some few examples, in 53 countries representing 13% of the world's population average life expectancy at birth was less than 60 years, there was wide variation of infant mortality rates between countries and maternal mortality in sub-Saharan Africa was three times greater than in less developed countries as a whole (Macdonald, 1996).

In Ghana the PHC program was fraught with all kinds of problems resulting in the main from its organizational structure (CODESRIA, 1989). The structural problem of the PHC program in Ghana included the following:

(1) Limited support from the regional and national levels.

(2) The National Primary Health Care committee formed to steer affairs of the PHC was inactive.

(3) There was inadequate technical support.

(4) None of the positions in the DHMT was an established one.

(5) The DHMTs had a lot of responsibilities without authority.

(6) Inadequate logistics.

(7) Financially, the district lacked autonomy and since no direct budgetary allocations were made to the PHC program, health personnel allegiance to their original division persisted, a situation that further weakened the basis of commitment to the program.

The PHC program also had challenges in its implementation as follows:

1. Training for the health personnel was limited because of high cost. The result was that teams were left without any program to follow; and since they had not been trained to develop programs to meet health needs, they were left to continue operating as before.
2. There was lack of transportation for supervision.
3. Refusal of communities to pay remuneration to the Traditional Birth Attendants, Village Health Workers, and Village Development Workers as expected.

In the light of the above a new policy based on equity and solidarity, and buttressed by appropriate technical, political, social and economic strategies had to be universally adopted to serve as the objective and guidance for the updating of global , regional and national health for all strategies and **f**or development of means and mechanisms to enable all contributing partners to fulfill their role.

The policy had to be based on a consensus for concepts and action. A framework for the policy had been developed to cover general and individual health situations in the world, to cover a wide variety of political, economic, social and cultural situations to serve as the new concepts and ideas in health development and to serve as a basis for the development of new national policies (Macdonald, 1996).

There were a number of challenges which were underestimated in the initial enthusiasm of health-for all by the year 2000; for example, the importance of community participation and local determination of priorities and programs had been underestimated. The immerse diversity of problems with a bearing on health and the way in which solutions must vary from community to community across the full range of developed and developing countries made decentralization and local determination essential (Macdonald, 1996).

In Ghana, although health policy intended to address primary health care needs had been in place for decades, demonstrations of how to achieve health for all were rare. Rarer still were examples of how research-based demonstration could guide national health sector reforms. In response to the need for improved PHC: a phased program of research was launched to guide the process of changing the system from clinic facility- focused approach to community-based approach.

The CHPS initiative is a program designed to translate innovations from an experimental study at the Navrongo Health Research Centre into a national program for improving the accessibility, efficiency and quality of health care and Family Planning services (Banka et al, 1995).The Initiative employs strategies to guide national health reforms that mobilize

volunteers, resources, and cultural institutions to support community-based Primary Health Care.

(2.2) Definition of CHPS

According to the Ministry of Health (November, 1999), CHPS is a process of health care provision in which health workers and community members are actively engaged as partners in the delivery of primary health Care and Family Planning services and it involves:

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

(2) Locating Community Health Officers in a community Health compound and

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

(2.3) Key players of the CHPS process

According to the Ministry of Health (1999) the key players of the CHPS process are as Follows;

(a) The Community

(1) The Community Members and Leadership including the opinion Leaders.

(2) The Community Health Committee.

(3) The Community Health Volunteers.

(b)***The Ministry of health***

(1) District Director of Health Services

(2) The District Health Management Team (including the health workers-Medical Officers and other health personnel in the hospital the clinics.)

(3) The sub District Health Team.

(4) The community Health Officers.

(b) The District Assembly

(1) The District Chief Executive

(2) The Social services Sub Committee of the District Assembly.

(2.4) Roles and Responsibility of the Key Institutions and Officials

(a) The community Health committee

The following are the roles and responsibilities of the key institutions and officials of the CHPS program;

- Settling of disputes concerning work of the Community Health Volunteers.
- Organizing communal activities in support of the programme.
- Advocating community health and family planning activities.
- Financial management of medical account.
- Managing Community Health Volunteers stock of drug and family planning materials; and
- Supervising bicycle maintenance for Community Health Volunteers.

(c) The community Health Volunteers

- Provide Preventive and curative services for malaria and diarrhoea;
- Provide family planning counseling;
- Refer serious cases to CHO and clinics;
- Provide Health education;

- ❖ Identify children for immunization;
- ❖ Notify disease appearance to CHO.

(d) The District Health Management Team (DHMT)

While the District Director of Health Services (DDHS) is responsible for overall program Management, providing guidance and technical assistance, planning and budgeting, the DHMT members:

- ➢ Assist in overall program management;
- ➢ Provide guidance and technical assistance to sub District Health Team;
- ➢ Plan and budget program activities;
- ➢ Serve as liaison and organize meetings between DHMT and SDHT;
- ➢ Supply essential medical supply to SDHT; and
- ➢ Supervise SDHT activities.

(e) The Sub district Health Team (SDHT)

- ✓ Holding management meetings with Community Health Committees and CHOs;
- ✓ Collecting data on CHO and Volunteer programs for the DHMT;
- ✓ Managing supply and monitoring usage of drugs and family planning materials by CHOs and volunteers; and
- ✓ Writing progress report to the DHMT.

(f) The community Health Officers (CHOs)

(1) Community and Compound level education on primary health care and family planning, Immunizing and providing pre and post natal care

(2) Supervising and monitoring sanitation efforts;

(3) Provision of nutrition education and care;

(4) Primary care for simple cases like diarrhoea, malaria, acute respiratory diseases, wound and skin diseases;

(5) Providing referrals for more serious affliction;

(6) Provision of education on prevention and management of STDs and HIV/AIDS ;

(7) Provision of family planning counseling services and referrals;

Supervision

(8) Submission of written report to the SDHT.

(g)*The District Chief Executive And The District Assembly*

The District Chief Executive as the head of government machinery at the district level serves as the link between the CHIP process and other social services development program in the district. The District Chief Executive and the District Assembly through the Social Services Sub Committee is responsible for:

- Working with the DHMT in the selection and prioritization of communities for participation in the CHIPS process;
- Provision of funding and other material support operating the CHIPS process particularly for the construction of Community Health Compounds and motivation of

CHOs, Community Health Volunteers and the Community Health Committees;

- ❖ Informing and encouraging Members of Parliament in the district, as well as NGOs to advocate for the CHPS process and provide material support for its implementation.
- ❖ Empowering District Assembly, Area Council and Unit Committee members to provide active organizational and material support to the development of CHPS program in their communities; and
- ❖ Receiving quarterly progress report on implementation of the CHPS process in the district from the DHMT and recommending or initiating necessary action.

(2.5) Organizational Structure for Implementing The CHPS Process By The DHMTs

There are three inter-related components of this structure:

- ➢ The community with its operational units the chiefs and elders, the community Health Committees, the Community Health Volunteers and the community members
- ➢ The Ministry of Health; comprising the District Health Management Team the Sub-District Health Team and the Community Health Officer and
- ➢ The District Political Authority made up of the District Chef Executive, Administrative Staff and the District Assembly at large

(2.6) Policy on CHPS

In 1978, at Alma Ata in the United States of America, the Global Health Conference called for "Health for All" by the year 2000. This meant the provision of quality but affordable

healthcare for the citizens of member countries by the year 2000.

In Ghana, despite the fact that, "Health for All" policies had been in existence for many years, the Ministry of Health reported in 1998 that, in 1990, more than 70 percent of all Ghanaians still lived more than eight (8) kilometers from the nearest health services provider and rural infant mortality rates were 50 percent higher than corresponding urban rates (Ministry of Health, 1998).

National policies for healthcare reform during this period were guided by the "sector-wide approach" mandated by the World Bank for integrating healthcare planning, services and budgets (Nyonator *et al*, 2002).

Also, clinic-based health services were the mainstay of primary healthcare in Africa despite several convincing demonstrations that community-based operations can enhance the accessibility, efficiency and sustainability of essential health services (Amonoo-Larsen *et al*, 1984).

Discussions and deliberations on health sector reform actually began in the 1980s but were given impetus in the 1990s by a continuous and growing role of research (Akosa *et al*, 2003). The growing influence of evidence-guided approaches was motivated by research showing that several large-scale national schemes for addressing the need for accessible primary healthcare had been fraught with serious organizational problems and resource constraints (Amonoo-Larsen *et al*, 1984).

Two general goals have guided the primary healthcare policy in Ghana. First, the need to

expand public sector health facilities, under the assumption that convenient facilities providing low cost care will benefit the poor segment of the population. Second, the need to shift resources from curative institution-based care to community-based preventive public health services. But, the impact of strategic change among the poorest segment of the population had been disappointing (Ministry of Health, 1998).

The health sector reform in Ghana was launched in 1993 with the aim of increasing access to health services, improve health services quality and efficiency, decentralize planning and management, foster partnerships between providers and communities and expand healthcare resources (Ministry of Health, 1998)

Two resources for implementing and governing accessible and affordable community health and family planning care came under consideration. First, the UNICEF sponsored "Bamako Initiative" involving potential contribution of volunteer health providers and supporting cultural resources like chieftaincy, lineage and social network, (Knippenberg *et al*, 1990) and second the potential impact of relocating under utilized community nurses to village locations (Amonoo-Larsen *et al*, 1984).

The Navrongo Community Health and Family Planning Project was used to test the relative impact of the two general sets of existing underused resources for primary healthcare. By 1997, evidence suggested that the Navrongo experiment was having an impact; a single nurse equipped with a motorbike outdid an entire sub-district health center, health service encounters increased eight fold, immunization and family planning improved, and fertility and mortality declined (Akosa *et al*, 2003)

Changes in the Navrongo approach to community mobilization were introduced in response to ethnic diversity, and the approach was replicated at Nkwanta to test its efficacy outside a research setting in 1999. In that year, baseline survey family planning usage in Nkwanta District was estimated to be less than 4% (Awoonor-Williams *et al*, 2009). By 2002, prevalence of family planning usage was 14% in communities exposed to the programme, representing three times the prevailing rate in the rest of the district.

Nkwanta had not only validated Navrongo effects but exceeded Navrongo levels of impact on several health indicators (Awoonor-Williams *et al*, 2004). In response to this success, the Ghana Health Service utilized Nkwanta as a demonstration district for building Community Health Planning and Services (CHPS) implementation capacity. CHPS was launched in 2000 after consensus building.

In national policy documents, CHPS is viewed as a mechanism for integrating activities of the formal health sector into traditional institutions that define community leadership, foster consensus building and sustain collective action.

Research reports provided highly credible evidence supporting policy commitment to this model and such evidence has been a determinant of successful scaling-up elsewhere (Simmons and Shiftman, 2006). It is a program of evidence-based organizational change that changes the system from clinical facility-focused approach to a community-based approach and bridges the gap between research and programme implementation.

The purpose of the CHPS initiative is to improve the accessibility, efficiency and quality of health and Family Planning Services (Binka *et al*, 1995; Debpuur *et al*, 2002). With the

advent of CHPS Initiative, the Navrongo experiment became the operational model for healthcare development in Ghana. It guides national health reforms that mobilize volunteers, resources and cultural institutions to support community-based primary healthcare.

At its core, the CHPS Initiative brought to an end various vertical programmes and established mechanisms for the decentralized administration of healthcare.

(2.7) Implementation

The CHPS started as a new initiative of the Ghana Health Service in 1998, and as a process for translating innovations from an experimental study of the Navrongo Health Research Centre into a national community health care programme (GMHI, 2005).

The CHPS, as a close-to-client system, is designed to comprise a set of CHPS zones within sub-District Health Facilities (Health Centers) providing technical backstopping for these zones and at least a district Hospital providing referral services for the sub-district structures. Each sub-district is supposed to be zoned into at least six zones. Given that each sub-district is carved to contain around a population of 30,000 people, each zone may have a population of between 500–5000 people or 3 to 4 Unit Committees grouped together. Accordingly each district is theoretically divided into at least forty-eight zones each with a community Health Officer (GMHI, 2005).

The process of implementing CHPS is in a step-wise manner as follows: Preliminary planning, Community entry, creating Community Health Compounds, procuring essential equipment, posting Community Health Officers to the compounds and deploying volunteers and implementation (Nyonator *et al*, 2002).

The preliminary planning step involves delineating zone boundaries, assessing manpower requirements and capacities, assessing equipment and training requirements and schedule the onset and frequency of nurses to each household in every zone.

Community entry entails developing leadership and initial participation in the program through dialogue with community leaders and residents. Durbars and traditional gatherings that typically include drumming, dancing, speech making, debates and open discussions are convened to foster open discussions of CHPS (Nyonator *et al*, 2002).

Community Health Services require a simple facility that provides a room for the Community Health Officer's living area and another for a clinic. Developing such facilities contributes to community ownership of CHPS initiative by involving leaders in planning and resource mobilization and volunteers for construction work (Nyonator et al, 2002).

The next step is the procurement of essential equipment such as clinical equipment and means of transportation; for example motorbikes.

Posting Community Health Officers to the compounds is the most critical stage. It is the stage in which most communities are enthusiastic about. The responsibility of the Community Health Officer include the following: provision of clinical sessions at the compounds, making household visits to provide Family Planning Services, Health Education and ambulatory care and implementing outreach clinics for childhood immunization (Nyonator *et al*., 2002).

Deploying volunteers is the next step. In doing this a six weeks' course in community

mobilization with particular emphasis on promoting Family Planning and Reproductive Health among men is organized. In some districts volunteers deliver Health and Family Planning Services.

Implementing the program involves a durbar for celebrating the creation of volunteer services, educating communities about referral services, and linking volunteer-based services with the activities of the local health officer and the clinical services of sub-district health centers and district hospitals (Nyonator *et al*, 2003).

Ideas and innovations are spread through social network through mechanisms collectively called diffusion. For decades social theorists have argued that diffusion theory is relevant to health and population policy because official action can be taken to accelerate the onset and pace of social change or expand the scope of informal processes (Rogers, 1995). Diffusion theorists have also noted that exchange and interaction can lead to organizational change (Glaser *et al*, 1983).

Social diffusion refers to the process of ideational or behavioral change fostered by social interaction. Organizational diffusion is an analogous process in which change can occur through the communication of ideas or the demonstration of new methods (GMHI,2005).

The component activities of the CHPS as stated above have been designed to foster the diffusion of operational innovations as derived from the Navrongo experiment and Nkwanta project.

The CHPS activities are designed to maximize the likelihood that the process of diffusion

will begin, be sustained and be amplified by program activities and resources.

(2.8) Other effects observed in some communities

A report of the CHPS Monitoring and Evaluation Secretariat to the Ghana Health Service on February 8, 2002 made the following findings.

1. In the communities where there is moderate development of CHPS there was confusion about the nature of the program. Conventional outreach clinic activities that have been in operation well before the CHPS programmes are sometimes labeled as "CHPS". In communities where the CHPS program is well developed, there was adequate knowledge of its nature.
2. Reports from Hohoe and Keta indicated that, while the community leaders knew about CHPS the male participants of the focal group used in the qualitative assessment did not. This suggested that efforts to inform community members through leaders were insufficient and not wholly effective. While outreach to leaders is essential to getting started, the introductory programme must extend beyond community entry to include the provision of general community information and educational activities.

A report of qualitative assessment in the Volta Region on the perceptions, attitudes and reactions also submitted by the CHPS Monitoring and Evaluation Secretariat to the Ghana Health Service in February, 2002 noted the following.

1. The CHPS programme was widely lauded but there was desire for a resident nurse on 24-hour call. Even where there is little tangible implementation of CHPS activities, and only vague awareness of its elements, community members are universally enthusiastic about

the idea of CHPS and strongly support the commitment of voluntary assistance to making the community Health Officer productive and comfortable.

2. The component of CHPS of most interest is the relocation of nurses from clinics to the community and the perception that this will make curative health services more accessible and affordable by reducing travel costs for first-aid or minor medical treatment. This was reported from Nkwanta.

During the Focal Group discussions the participants raised the following concerns which may shed light on the perceptions of community members of the nature of CHPS.

1. They wanted diverse drugs of lower cost and also the administration of intravenous fluids by nurse. That indicated that the concept of CHPS was not well understood.
2. In general, the concept of referral was not well understood.
3. They wanted two community Health Officers to be at post.
4. They were less enthusiastic about voluntary work.
5. They entertained concerns about the character of a newly posted nurse and also about high rate of turnover.

According to progress report submitted to the Ghana Health Service Monitoring and Evaluation Division on December 31, 2000 and on December, 2002, twenty-two out of the then 110 districts have implemented the CHPS Programme in the year 2000.

A report on a multi–level qualitative assessment in the Volta Region by the CHPS Monitoring and Evaluation Secretariat of the GHS, February 8, 2002 noted the following:

- Implementation of the CHPS initiative had had a dramatic effect on the lives of the Community Health Officers. The remote placement results in the CHO's inability to

visit family members. It has also brought about changes in family life because some CHOs have their husbands working elsewhere and children who attend school elsewhere.

- Despite these hardships, CHOs discussed with pride the remarkable health benefits that the CHPS programme provided for the community. They described CHPS as an initiative which provided coverage, increased antenatal care and reduction in child and maternal deaths. Furthermore, the community's relationship with the CHO was such that the community members were able to talk freely to the CHO about their health problems. In addition CHPS programme provided the community nurse the opportunity to develop new skills from the varied experiences of her work. CHOs have been taught to assist with childbirth and have had additional training in curative treatments.
- The CHOs interviewed had numerous expectations when their districts began initiating the CHPS process. Initially, some CHOs expressed fears about forfeiting their chances to further their education. On the other hand, many CHOs were expecting to become more autonomous in their new professional role and this conveyed a sense of pride and status that was lacking in their role.
- Although CHOs were not looking forward initially to being placed in communities, and have experienced many hardships, they have come to appreciate deeply the professional satisfaction they received from the work.
- The range of services that the CHOs provided to the community was varied and exhausting. The CHOs that were resident in the community were kept busy virtually all day and many nights.
- While CHOs were initially concerned about the many personal and familial problems that they experienced, these subsided if communities were enthusiastic for the

programme and supervisory support helped them overcome these initial concerns and focused more on the professional satisfaction they achieve from their work.

- The Community Health Officers, as reported from Hohoe and Nkwanta in the Volta Region usually had accommodation and utility services problems initially. Many of the initial challenges were resolved through the contributions of the community, the DHMT and the World Vision International.
- The Nurses in both Nkwanta and Hohoe had long list of requirements they felt were important in order to have a reasonably comfortable life and successful work. That list included financial incentives for long hours of work and rural living and hard work allowance. They needed motor bikes, rain coats and boots. They required portable water supplied to their CHC water storage, proper toilets for themselves and a separate facility for their clients. They require electricity - either mains or solar generated to run a refrigerator to store vaccines as well as for the comforts of lights, radio and TV.
- The district manager of Nkwanta had provided poly or cement tanks for water storage, motor bikes and drugs. At the request of CHOs, the District Director had helped build an additional separate structure to provide health services for clients. With this history, the Nkwanta CHOs seemed optimistic about the handling of their requests. The CHOs at Hohoe, however, who had been given little of the support they had requested, seemed less optimistic about their needs been satisfied in the future.
- Developing a capacity to respond to ad hoc living arrangement problems is crucial to sustaining morale among others.

(2.9) Benefits of CHPS to some communities

According to a report by the Ghana Health Service Monitoring and Evaluation Division (GHSMED, 2002) some benefits to the communities include health education on malaria, HIV/AIDS and Family Planning; Immunization services and growth monitoring of healthy children; decrease in maternal and infant mortality, and increase in family planning use.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter gives the methods used in getting the data for the study. It gives the research design, area of study, population and sampling techniques, data collection tools and the methods for the analysis of data.

3.1 Research Design

Research design is the overall plan for collecting data in order to answer the research questions. It also indicates the data analysis techniques or methods used in the study. This study used the survey research design since the focus was on communities that have the CHPS compounds. The survey design was chosen because it is appropriate in describing characteristics, opinions, attitudes, perceptions and behaviors of a group of people. Also, it can be used to gather information from a large number of subjects with comparatively minimal expenditure of time and money.

The structured interview was administered on 100 interviewees consisting of 25 from each of the four communities. The items on the structured interview read and interpreted in the Bono language to the interview. To make sure that the questions were properly understood by the interviews were asked to state the questions in their own ways and then answer.

The answers were then recorded in English and interpreted in Bono to the interviewees for their agreement.

The questionnaires were administered on the four Community Health Officers from the four communities of the study after taking them through to ensure that the items were understood.

3.2 Area of Study

The Berekum District came into existence as a semi-autonomous spatial unit by virtue of the decentralization policy adopted by the government in 1988. It became a municipality in 2008. Geographically, the municipality can be located in the Western part of the Brong Ahafo region and lies between latitudes 7'25' South and 8.00' North and longitudes 2'25' East and 2.50' West. The municipality shares boundaries with Wenchi Municipality to the northeast and Jaman District to the northwest respectively, Dormaa District to the South and Sunyani Municipality to the East (District Medium Term Development Plan (DMTDP)-GPRS 2, 2006-2009)

Berekum, the municipal capital is 32 km from Sunyani, the regional capital and 437 km from Accra, the national capital. Its total area constitute about 0.7% of the entire 233,588 square kilometers (1,633 square kilometers) (DMTDP-GPRS, 2006-2009)

The climate is that of the semi-equatorial climate zone which has abundant sunshine and rainfall. The semi-deciduous forest is the dominant vegetation type with isolated patches of wooded savanna in the northern-most and the eastern corner of the municipality (DMTDP-GPRS, 2006-2009)

T he indigenes are of the'Bono' tribe who speak a language of the same. The dominant economic activity in this area is farming. The crop mostly cultivated are maize and cassava which are the staple food produce.

3.3 Population/Sample

The population of this study consisted of the adult (aged 20 years and above) community members who were present when the CHPS process started till the time of the study. Subjects of this population can provide necessary information to achieve the objectives of the study as stated in chapter one of this study.

Because of limitations in terms of time and other resources, the non-probability sampling method was used. This was a nonrandom sampling of subjects and so there was less chance of obtaining a representative sample. In particular the Accidental or Convenience sampling method was used whereby use was made of only the members of the population that were available to me. The sample size was 100 (n = 100), consisting of 25 respondents drawn from each of the four communities.

3.4 Data Collection Tools/Instruments

The data collection tools/instruments were structured interview with members of the community and a questionnaire for Community Health Officers. The structured interview instrument was selected for the community members because of the low levels of illiteracy prevailing in the area. The questionnaire instrument was selected because it is a very convenient means of obtaining data from subjects with literacy background.

To ensure that the instruments were valid, the items on them dealt with ways of answering the research questions as stated in chapter one. To ensure reliability and objectivity the instruments were pre-tested in a community with similar characteristics as the setting of the study and on subjects with similar characteristics as the sample of the study. This ensured that the items in the final instruments were not vaguely worded or improperly arranged and the form poorly organized.

3.5 Analysis of Data

The statistical software – SPSS for Windows (Version 11) was used to analyze the data generated from the interviews and questionnaire. Generally descriptive statistics were used in the analysis of the data.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.0 Introduction

This chapter depicts, in the form of charts, graphs, texts and tables, the responses to the items on the structured interview schedule with the members of the communities with the CHPS facilities and the questionnaires administered to the Community Health Officers in charge of the CHPS compounds of the communities involved in the study.

4.1 Analysis *of data*

The following charts depict the educational backgrounds of the interviewees from the various communities.

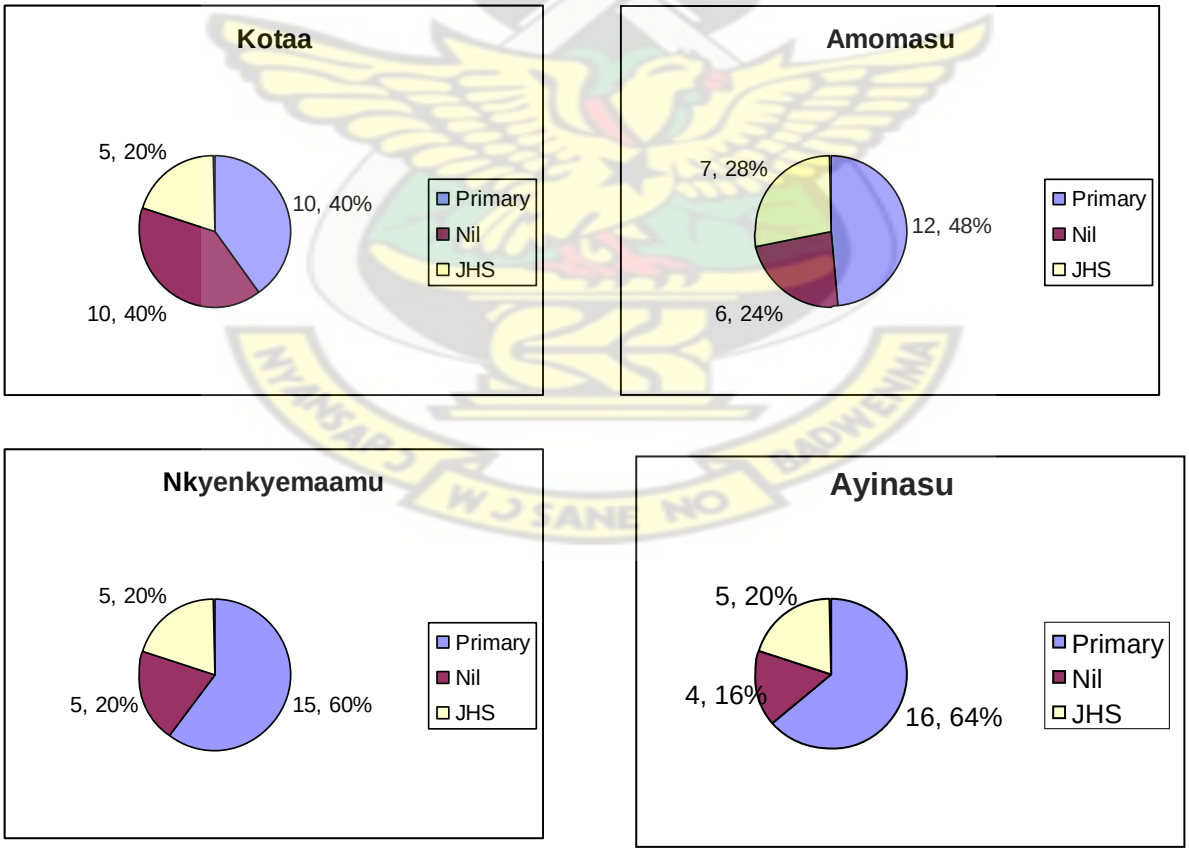


Figure 1: Distribution of Educational Background

From figure 1 above, the educational backgrounds of the interviewees conveniently selected from the communities were low. The majority of them had no formal education or were formally educated up to primary school level. This was likely to pose the challenge of their appreciating the nature and process of CHPS: for example, understanding their personal responsibilities in terms of their contributions towards the successful implementation of the CHPS Initiative. It might also impact negatively on their sense of ownership of the CHPS programme.

The lack of the sense of personal responsibilities and ownership could hinder the CHPS Initiative from living up to its goals and purposes for which it was initiated, namely to utilize the traditional and community resources in making healthcare accessible and affordable to the community members.

Figure 2 shows the distribution of marital status among the subjects of the study.

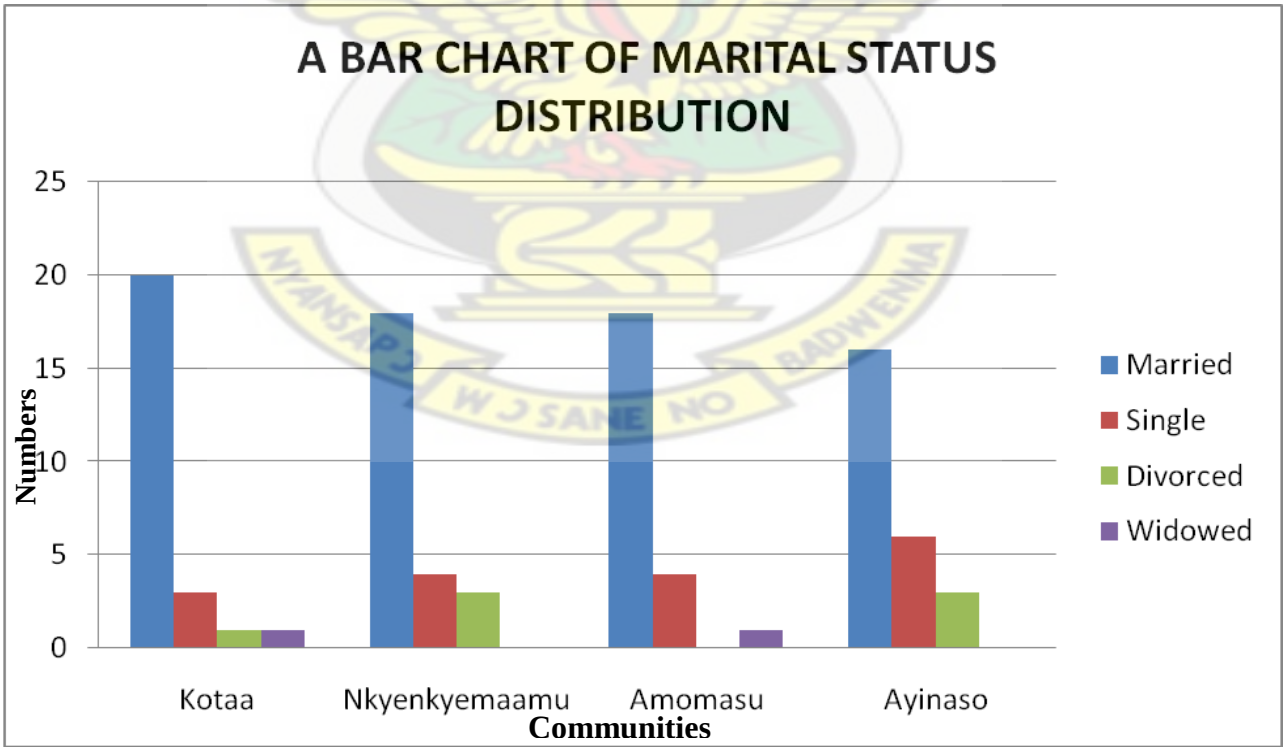


Figure 2: Marital Status of Respondents

The bar graph in figure 2 above shows the marital status distributions of the interviewees selected by means of the accidental sampling method. The relevance of marital status in the CHPS programme was that married couples being the beneficiaries of programmes such as child and maternal welfare clinics, family planning and family health run by CHPS are usually appreciative of such programmes in their communities and therefore patronize them.

Table 1 shows the number of years that the interviewees had lived in their communities.

Table 1: Number of years spent in community

COMMUNITY	YEAR	PROPORTIONS
Kotaa	10 – 15	80%
	15 – 20	20%
Nkyenkyemaamu	10 – 15	16%
	15 – 20	84%
Amomasu	10 – 15	96%
	15 – 20	4%
Ayinasu	10 – 15	88%
	15 – 20	12%

The CHPS programmes started in all the four communities 4 to 5 years ago. From the table above, all the interviewees were in the communities when the programme started and therefore were in the position to answer the structured interview.

Figure 3 below depicts the proportions of the respondents who had CHPS responsibilities in the various communities. It shows that the majority of the interviewees had no responsibility

towards the CHPS programme in their communities with the exception to the community of Ayinasu. The CHPS initiative is based on the utilization of the traditional and community resources including that of human in the delivery of quality, accessible and affordable health-care services for a community as noted in the literature review.

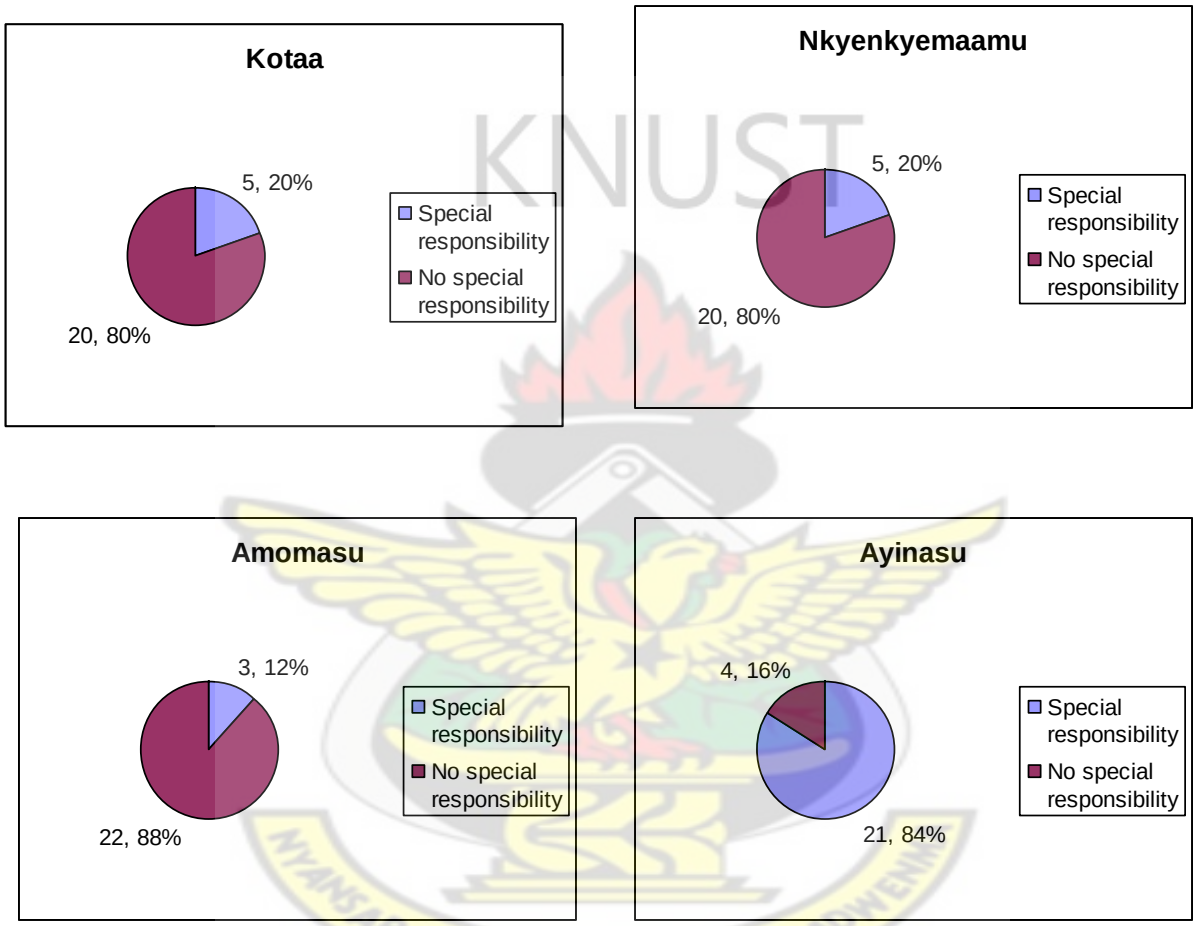


Figure 3: Responsibility toward CHPS Initiative

In line with the purpose of utilizing the traditional and community resources in providing accessible and affordable quality healthcare, the Initiative mandates the formation of functional CHPS committees and volunteer groups in the decision-making and management of the programme, along with the opinion leaders of the community.

The situation regarding CHPS responsibility in these four communities posed a challenge to the successful implementation of the CHPS initiative.

Twenty percent of the respondents at Kotaa, Nkyenkyemaamu, and Ayinasu indicated that they became aware of CHPS when the program was launched in their community while 88% gave similar answer at Amomasu. At Kotaa, Nkyenkyemaamu and Ayinasu twenty percent of the interviewees indicated that they became aware of the program 4-5 years ago. Twelve percent (12%) of the interviewees at Amomasu indicated that they became aware of the programme four years ago. The CHPS programs were launched in all the four (4) communities five (5) years ago.

From the above, the interviewees became aware of the program during the period of launching in the communities. The process of implementation of CHPS is step-wise manner as follows;

- Preliminary planning
- Community entry
- Creating community health compound
- Procuring essential equipment
- Posting Community Health Officer
- Deploying volunteers and
- Implementation.

From above, the majority of the interviewees became aware of the program at the final step of the process – that is at the implementation stage. Thus the majority of the interviewees had

not participated in the decision-making process that led to the implementation of the CHPS program as they should have according to the mandate of the CHPS Initiative.

Table 2 shows the manner by which the CHPS programme was launched in their communities.

Table 2: Manner of launching of CHPS program

COMMUNITY	MANNER OF LAUNCHING
Kotaa	Durbar
Nkyenkyemaamu	Durbar
Amomasu	Durbar – 28% Political Campaign – 72%
Ayinasu	Durbar – 20% Political Campaign – 80%

In the Amomasu and Ayinasu communities, the CHPS process appeared to have taken a political turn as it became launched during a political campaign. This did not augur well for the successful implementation of the program as the real objectives and purposes of the program might be defeated.

The bar chart below shows the distribution of enthusiasm previously prevailing, before the launching, in the CHPS communities according to the interviewees of this study.

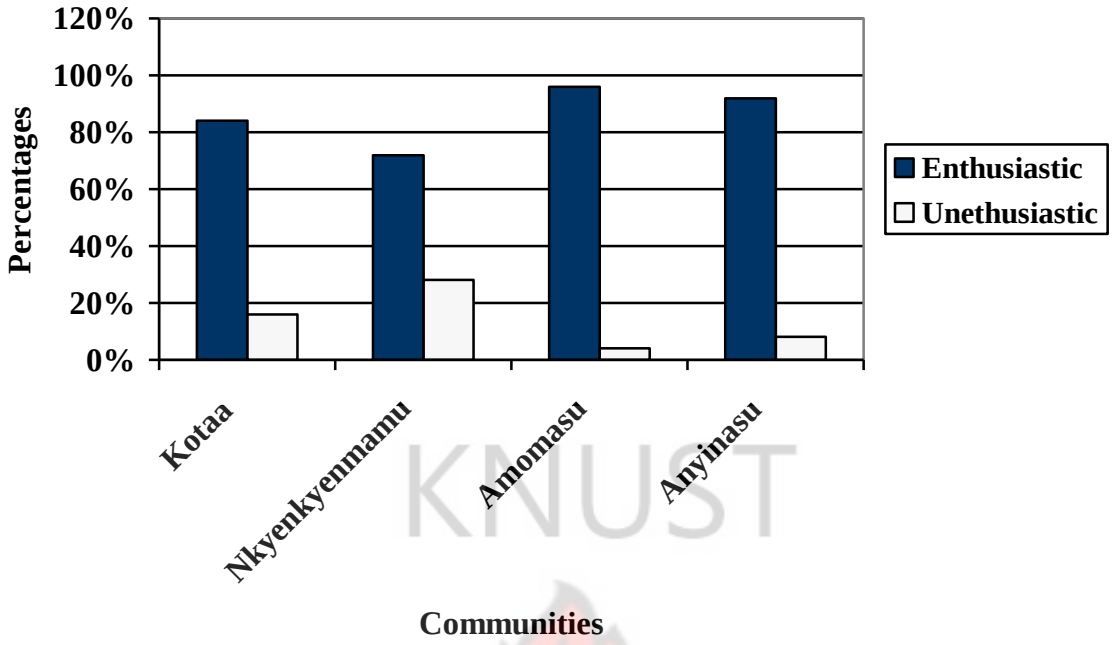


Figure 4: Enthusiasm in CHPS before launching

In the case of Kotaa 16% of the interviewees thought that members of the community were not enthusiastic in the CHPS program and cited high cost of orthodox medical treatment, hostile attitudes of health workers especially nurses, long waiting time before being attended to and inadequate treatment as the reasons. In other words, people did not expect CHPS to function differently from the health posts and the clinics. Four percent cited loss of faith in orthodox medicine as the reason why people were not interested in the CHPS program before its initiation.

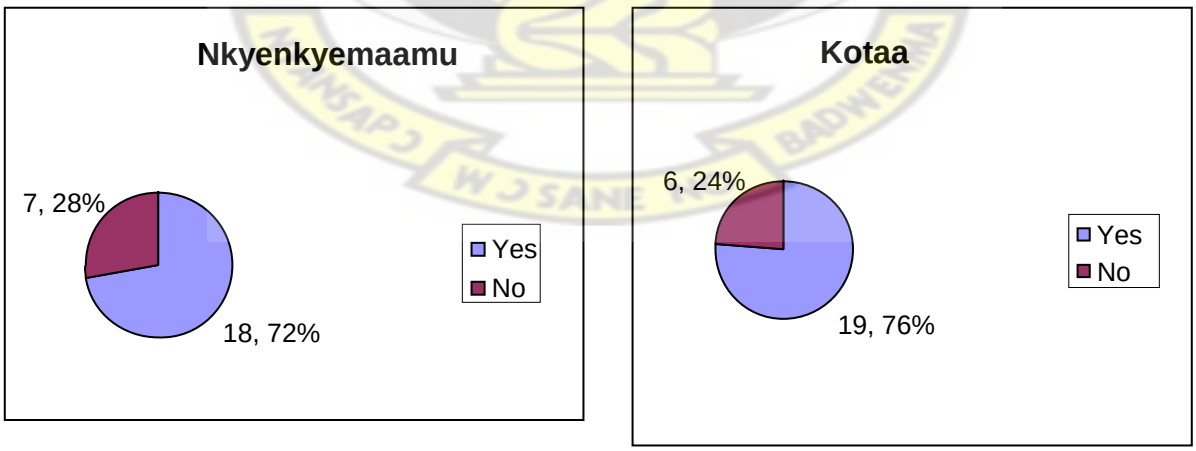
In the Nkyenkyenmaamu and Amomasu communities, 28% and 4% respondents respectively stated that the community members were not interested in the CHPS program because of hostile attitudes of nurses, long waiting time and inadequate treatment.

Eight percent of the respondents who held similar opinions about the lack of enthusiasm of the CHPS program at Ayinasu on its inception stated lack of faith in orthodox medicine as the reason.

The majority of the respondents who believed that there was enthusiasm about CHPS; 72% at Kotaa, 64% at Nkyenkyemaamu, 92% at Amomasu and 88% at Ayinasu – cited the following as the reasons why the members of their communities were enthusiastic about the implementation of the CHPS program.

1. Economic benefits
2. The prospects of having 24 hour healthcare in their communities and the
3. Political advantage of having a health service facility in their communities.

The following pie charts represent the numbers and proportions of the respondents who thought that community members were still enthusiastic about the CHPS program and those who did not.



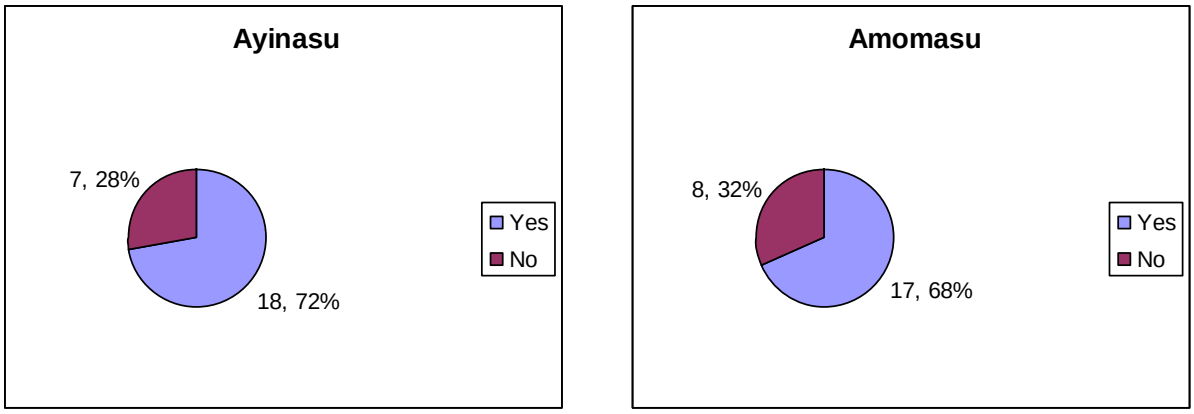


Figure 5: Sustained enthusiasm in CHPS

Comparing figures 4 and 5, it can be seen that the community enthusiasm in all the four communities had been sustained. A report of qualitative assessment in the Volta Region on perceptions attitudes and reactions by CHPS Monitoring and Evaluation Secretariat, GHS in February 2002 indicate that the communities were enthused with the CHPS program. The report therefore correlates with this finding.

In all the communities, the respondents cited good personal attributes of the community health officer, economic reasons and easy accessibility of healthcare services as the reasons for the continuous enthusiasm of the community members in the CHPS program. However, for reasons of not being enthused by the CHPS, they cited inadequate treatment and prolonged absence of community health officer from the community.

The table below shows the perceptions of the respondents on the source of the CHPS program.

Table 3: Perception of source of CHPS

COMMUNITIES	SOURCES	RESPONDENTS
Kotaa	Government and Chief MP and Assemblyman	72% 28%
Nkyenkyemaamu	Government and Chief	58%

	MP and Assemblyman	32%
Amomasu	Government and Chief MP and Assemblyman	40% 60%
Ayinasu	Government and Chief MP and Assemblyman	76% 24%

The CHPS Initiative is expected to be a Government–Community partnership program according to the mandate of the Initiative. The preliminary step of the process involves the delineation of zone boundaries, assessing manpower requirements and capacities, assessing equipment and training requirements and scheduling the onset and frequency of the Community Health Officer to each household in every zone. This step is followed by community entry which entails developing leadership and initial participation in the programme through dialogue with community leaders and residents (Ghana Macroeconomics and Health Initiative, (GMHI), October, 2005)

Table 4, above depicts that the CHPS programme proceeded from politicians namely, Members of Parliament and Assemblymen and traditional authorities such as chiefs. This perception would impact negatively on the sense of ownership of and the level of involvement in the CHPS programme.

The chart below indicates the general proportion of the interviewees who perceived the source of the CHPS program to be the Government (Ghana Health Service) and the traditional authority (Chief) and those who perceived it to be the political leadership (Member of Parliament and the Assemblyman.).

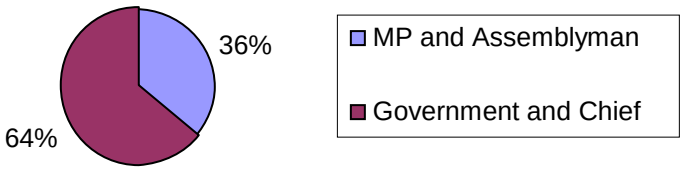


Figure 6: Overall perception of source of CHPS

The table below shows the perception of the Community Health Officers of who the community members perceived to be the owners of the CHPS program.

Table 4: Perception of ownership of CHPS programme

COMMUNITY	PERCEPTION OF OWNERSHIP
Kotaa	Chief and Government
Nkyenkyemaamu	Chief and Government
Amomasu	MP and Government
Ayinasu	MP and Government

Table 4 above depicts the perceptions of the Community Health Officers of the perception of the Community members of the ownership of the CHPS programme.

As revealed by the responses to a similar question posed to the interviewees (Table 3), there appeared to be no clear understanding of the ownership of the CHPS programme by the community members. Again, the impression that the CHPS programme was taking a political turn at Amomasu and Ayinasu as inferred from the responses of the interviewees was being confirmed by the perceptions of the Community Health Officers.

This development might be due to the fact that accessible healthcare delivery had also become part of platforms of political parties who were eager to use it in their campaigns.

The table below depicts the perceptions of the interviewees on the controllers of the CHPS programme.

Table 5: Perception on the controller of the CHPS program

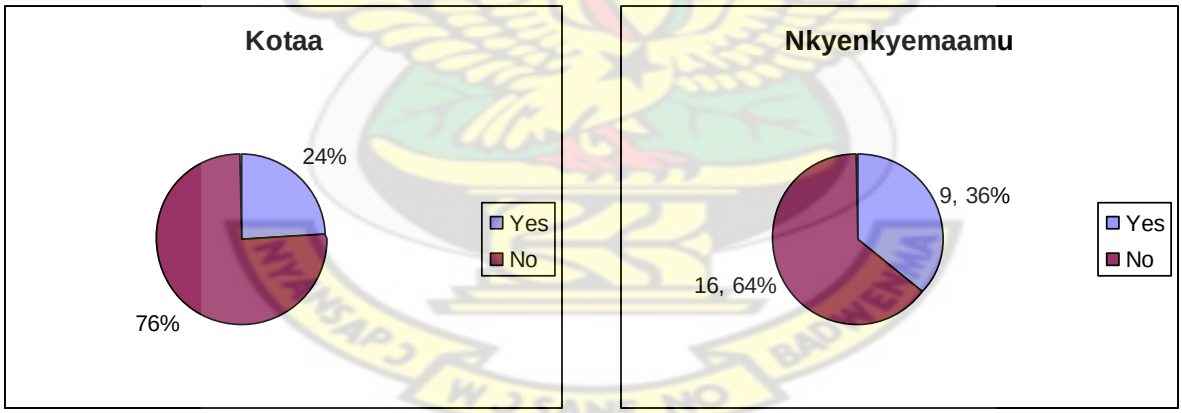
COMMUNITY	CONTROLLING AUTHORITY	PROPORTIONS
Kotaa	Nurse and Government	80%
	MP and Nurse	12%
	Chief and Nurse	8%
Nkyenkyemaamu	Nurse and Government	80%
	MP and Nurse	16%
	Chief and Nurse	4%
Amomasu	Nurse and Government	32%
	MP and Nurse	56%
	Chief and Nurse	12%
Ayinasu	Nurse and Government	24%
	MP and Nurse	72%
	Chief and Nurse	4%

The CHPS Initiative stipulates that the decision making and management of the CHPS programme should be in the hands of a committee on CHPS aided by volunteer groups. The committee members consist of the opinion leaders, community members and officials of the Ghana Health Service such as the Community Health Officer (GMHI, 2005)

From table 5, there appeared to be confusion over who actually controlled the CHPS program. The majority of the interviewees of Kotaa and Nkyenkyemaamu perceived the controllers to be the government – that is the Ghana Health Service and the Community Health Officer, while the majority of them from Amomasu and Ayinasu perceived the controller to be the Member of Parliament and the Community Health Officer.

This misconception of who controlled the CHPS programme could impact negatively on the sense of ownership and the level of commitment of the members of the communities in the CHPS programme.

The following charts indicate the proportions of the interviewees who were aware of the existence of CHPS committees in their communities, and those who were not.



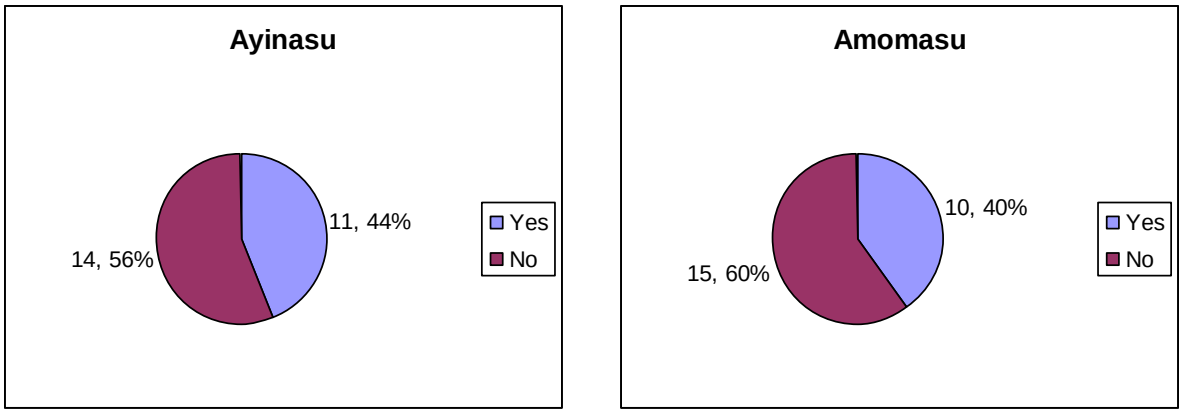


Figure 7: Proportion of awareness of CHPS committees

The CHPS programme is meant to be owned and managed by the community members with the help of the District Health Management Team. This entails the involvement of the community members. In this vein, the existence of the committee on CHPS should be a common knowledge in the communities.

However, from figure 7 the majority of the interviewees from the 4 communities responded that they were not aware of the existence of such committees in their various communities. This shows that the majority of them were not involved in the decision-making process of the CHPS programme in their communities.

The table below indicates the perceptions of whether the CHPS programs were living up to the expectations of the community members or not. It can be seen from the table that in all the 83% at Kotaa, 78% at Nkyenkyemamu 90%at Amomasu and 90% at Ayinasu indicated that the CHPS program was living up to expectation.

Table 6: Perception on whether CHPS is living up to expectation or not

COMMUNITY	RESPONDENTS	
	Living up to expectation	Not living up to expectation
Kotaa	83%	17%
Nkyenkyemamu	78%	22%
Amomasu	90%	10%
Ayinasu	90%	10%

The following were responses of the Community Health Officers (nurses) regarding their perceptions of whether the community members were satisfied with the CHPS program or not.

Table 7: Satisfaction of community members of CHPS programme

COMMUNITY	PERCEPTION OF SATISFACTION
Kotaa	YES
Nkenkyemaamu	YES
Amomasu	YES
Ayinasu	YES

The Community Health Officers of Kotaa and Nkyenkyemaamu perceived the proximity of the health services facilities (the CHPS compound) as well as the availability of services on 24-hour bases as the reasons for the satisfaction. In addition to these reasons the nurses at Amomasu and Ayinasu cited political advantage, home services and economic benefits as the reasons for the satisfaction of the community members with the CHPS program.

The perceptions of the Community Health Officers of the satisfaction of the community members of the CHPS process collaborated with results obtained from the interviewees when the majority of them indicated that the program was living up to their expectations (table 6 above)

None of the communities in the study had volunteers or CHPS committees in place. According to all the Community Health Officers in the survey, the volunteer groups and the CHPS committees were still in the process of being formed.

All the Community Health Officers in the study stated they felt encouraged by the community members and their opinion leaders. All of them stated accessibility of healthcare in terms of distance and cost as well as perceived benefits of healthcare – greater child immunization coverage and home services as the benefits of the CHPS programme derived by the community.

The table below indicates the responses given by the Community Health Officers to the question of how they like their work in the community.

Table 8: Appreciation of work by Community Health Officers

COMMUNITY	RESPONSE
Kotaa	Not much
Nkyenkyemaamu	Not much
Amomasu	Much
Ayinasu	Not much

From table 8 above, three of the respondents answered “not much” to the question of whether they appreciated their work or not while one answered “much”.

A qualitative report on the progress of the CHPS program in the Volta region noted that although Community Health Officers were not looking forward initially to being placed in rural communities, and have experienced many hardships, they have come to appreciate deeply the professional satisfaction they received from their work. Also, despite the hardships (accommodation, utility services etc.) the Community Health Officers discussed with pride the remarkable health benefits that the CHPS programme provided to the community. They described CHPS as an initiative which provided high coverage in immunization, increased antenatal care and reduced maternal deaths.

This difference in appreciation of work between the majority of the Community Health Officers in this study and the Community Health Officers in the reports referred to earlier might be due to situational differences in terms of support and cooperation from both the community and the managers of the CHPS programme at the various levels.

The Community Health Officers at Kotaa and Nkyenkyemaamu were of the view that they worked 24 hours a day, seven days a week, but there were no commensurate compensations for their being at post always. They also expressed frustration due to lack of logistics and equipment to aid them in their work as much as they wished. They had concerns about their professional development which they perceived as being hindered by their being far from Berekum where they could access educational opportunities for further education.

They also felt frustrated from the expectations of the community members who expected to get intravenous therapy and strong antibiotics which are outside their prescription mandate. Volunteers, who are expected to help them, are non-existent thus increasing the enormity of task at their hands.

The Community Health Officers at Amomasu and Ayinasu were appreciative of the help they get from the communities in terms of foodstuff. They also appreciated the social recognition and respect granted them by the communities. They did have concerns about the lack of commensurate incentives stated by their colleagues at Kotaa and Nkyenkyemaamu but were content, nevertheless.

The table below shows the proportions of those who had ever been involved in the decision making of CHPS program and those who had never been involved.

Table 9: Involvement in decision-making in the CHPS program

COMMUNITIES	INVOLVEMENT	PROPORTIONS
The following were responses of the Community Health Officers (nurses) regarding their perceptions of whether the community members were satisfied with the CHPS program or not.		**Table 4: Satisfaction of community members of CHPS programme**
	No	72%
Nkyenkyemaamu	Yes	12%
	No	88%
Amomasu	Yes	12%

	No	88%
Anyinasu	Yes No	16% 84%

The interviewees who responded in the affirmative were some of the representatives of the community members who served as either Assemblymen or Unit Committee members and so had the opportunity to articulate their views at the Unit Committee meeting. It did appear that the majority who were not representatives at the assembly or Unit communities did not have the opportunity to be involved in the decision-making process of the CHPS program. This might impact negatively on the sense of ownership and responsibility of this majority.

The table below indicates the proportion of interviewees who had the perception that the decisions taken in the CHPS program reflected the interests of the members of the communities and those who had the perception that it did not.

Table 10: Reflection of community interest in CHPS decisions

COMMUNITIES	PERCEPTION OF REFLECTION	PROPORTIONS
Kotaa	Yes No	32% 68%
Nkyenkyemaamu	Yes No	40% 60%
Amomasu	Yes No	36% 64%
Anyinasu	Yes No	40% 60%

From the table above, 68% at Kotaa, 60% at Nkyenkyemamu 64% at Amomasu and60% at Anyinasu had the perception that the CHPS decisions did not reflect the interest of the community members. As CHPS, according to its policy document, is meant to generate the sense of ownership of the program, this finding was inconsistent with the Initiative policy.

The following were the proportions of the interviewees who had accessed the CHPS initiative before;

Table 11: Access of CHPS initiative

COMMUNITY	PROPORTIONS WHO ACCESSED CHPS INITIATIVE
Kotaa	72%
Nkyenkyemaamu	80%
Amomasu	80%
Anyinasu	84%

Table 8 above depicts that of the interviewees, 72% at Kotaa, 80% at Nkyenkyemamu, 80% at Amomasu and 84% at Anyinasu patronized the CHPS program. This was in tune with the Initiative's purpose of providing accessible and quality healthcare to the community members so as to improve the health of the population for accelerated national development.

The table below shows the number of people who access healthcare in the four CHPS communities per month on the average.

Table 12: Attendance at CHPS compound

CHPS COMPOUND	ATTENDANCE/month
Kotaa	100
Nkyenkyemaamu	120
Amomasu	90
Ayinasu	125

The reason, according to the four the Community Health Officers was temporal spatial benefits of CHPS compound. The CHOs at Amomasu and Ayinasu indicated that they had established rapport with the community members and that encouraged the community members to trust them and felt safer under their care.

This finding also collaborated with that made from the interviewees about whether they accessed the CHPS services or not.(table 8)

All the four nurses stated that the community members often complained about what they perceived to be inadequate treatment. They expect the CHPS program to render to them services like intravenous therapy and powerful antibiotics (services that are not within the prescription mandate of a Community Health Officer by virtue of training and competence).

The Community Health Officers of Kotaa and Nkyenkyemaamu stated that the community members had been requesting for an additional nurse.

Table 10 below indicates the reasons for the assessment of the CHPS compound by the interviewees.

Table 13: Reasons for accessing the CHPS initiative

COMMUNITY	REASONS FOR ACCESSING	PROPORTIONS
Kotaa	Distance, Time Cost Advantage	89%
Nkyenkyemaamu	Same	90%
Amomasu	Same	95%
Anyinasu	Same	90%

From Table 10 above, 89% at Kotaa,90% at Nkyekyemamu, 95% at Amomasu and 90% at Anyisu indicated that accessibility in terms of distance, time and cost as the reasons for accessing the CHPS program. Thus it appeared that the Initiative was satisfying its purpose of providing affordable, accessible, and quality healthcare for the community members

Table 11 below shows the various reasons why some of the interviewees did not access the CHPS initiative.

Table 14: Reasons for not accessing the CHPS initiative

COMMUNITY	REASONS FOR NOT ACCESSING	PROPORTIONS
Kotaa	Inadequate Treatment	57%
	No Faith in Orthodox Medicine	43%
Amomasu	Hostile Behavior of CHO and	40%
	Inadequate Treatment	
	Preference for Traditional Medicine	60%
Nkyenkyemaamu	Inadequate Treatment	60%
	Absence of Illness	40%
Anyinasu	Traditional Medicine	60%

	Inadequate Treatment	40%

From table 11, perceived inadequate treatment is a major reason why people did not access the CHPS facility in all the four communities. This finding was also made by the CHPS Monitoring and Evaluation Secretariat of the Ghana Health Service in the Volta Region in Febuary, 2002 when a multi-level qualitative assessment was conducted.

This reason, along with the others namely; preference for traditional medicine, no faith in orthodox medicine and absence of illness indicated that the concept of the CHPS Initiative was not well understood by the community members.

The personal characteristics of the CHO as mentioned in this study had also been mentioned in the qualitative assessment reports referred to above in which it was stated that community members entertained concerns about the interpersonal relationships of an in-coming CHO.

The following table indicates the expectations that the interviewees had before accessing the CHPS facility.

Table 15: Expectations of interviewees of CHPS initiative

COMMUNITY	EXPECTATION	PROPORTION
Kotaa	Prompt attention and adequate treatment	89%
Nkyenkyemaamu	Prompt treatment, adequate treatment and good behavior of CHO	90%
Amomasu	Prompt treatment, adequate treatment and good behavior of CHO	85%

Anyinasu	Manageable cost and good behavior of CHO	90%

From Table 11 the expectations of the interviewees included the following; prompt attention, adequate treatment, courteous treatment by the CHO and manageable costs. These expectations were also indicated in a piece of work in qualitative assessment conducted by GHS in the Volta Region.

All the expectations were, according to the interviewees, met except those of adequate treatment and good behavior of the Community Health Officer.

The following table depicts the perceptions of the benefits brought by CHPS to the various communities:

Table 16: Perception of benefits of CHPS

COMMUNITY	BENEFITS	PROPORTIONS
Kotaa	Accessibility of healthcare and economic benefits	84%
	Political Advantage	16%
Nkyenkyemaamu	Accessibility of healthcare and economic benefits	88%
	Political Advantage	12%
Amomasu	Accessibility of healthcare and economic benefits	84%
	Political Advantage	16%
Ayinasu	Accessibility of healthcare and economic benefits	92%
	Political Advantage	8%

Table 12 below indicates that the majority of the interviewees regarded accessibility of healthcare and economic benefits as the main benefits of the CHPS program. In this regard the Initiative appeared to satisfy one of its basic purposes of making healthcare accessible as a means of alleviating poverty in the rural areas.

The charts below indicate the proportions of the interviewees who perceived the CHPS program to be providing accessible healthcare to their expectations and those who did not perceive them thus;

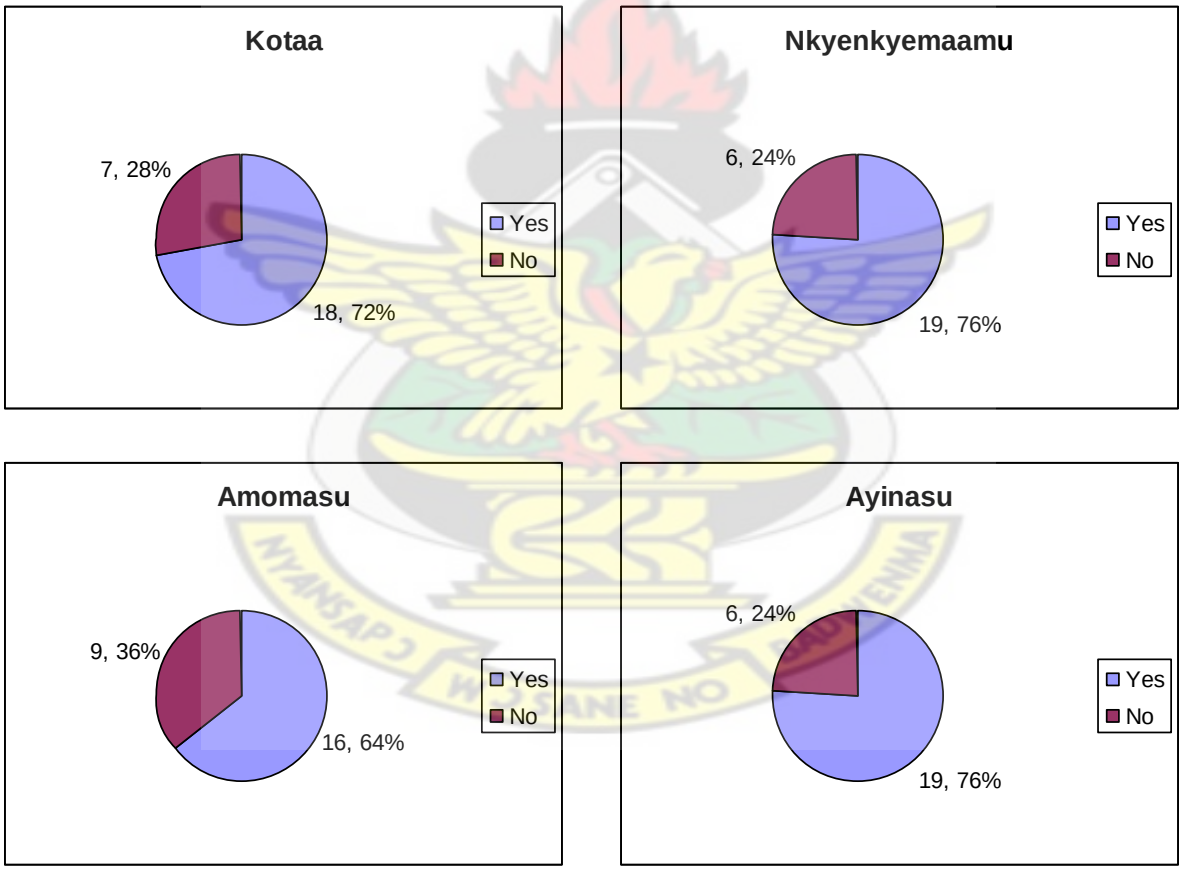


Figure 8: Perception on provision of accessible healthcare by CHPS

Table 12 and figure 8 show that the most of the interviewees from the four communities; 72% for Kotaa, 76% for Nkyenkyenmaamu, 64% for Amomasu and 76% for Ayinasu, perceived the easy accessibility benefit as an important benefit of the CHPS programmes in their

community. Political advantage of the communities with CHPS compounds over the surrounding communities without them was also perceived, to much lesser extent, as a benefit of the CHPS programme.

Accessible healthcare services in terms of distance and cost, were some of the basic tenets of the CHPS initiative geared towards the national programme of poverty alleviation by way of investing in the people. In this regard, the CHPS initiatives in these communities appeared to be fulfilling their tasks.

The following indicates the reasons why the CHPS programmes in the various communities are not providing accessible healthcare services, according to the interviewees who perceived that they were not.

Table 57: Reasons for CHPS not providing accessible healthcare

Community	Reason	Proportion
Kotaa	Logistics and equipment	92%
	Character of nurse	8%
Amomasu	Logistics and equipment	88%
	Character of nurse	12%
Nkyenkyemaamu	Interference by community leaders	92%
	Character of nurse	8%
Anyinasu	Interference by community leaders	96%
	Character of nurse	4%

From table 13 above the interviewees from Kotaa and Amomasu who stated that the CHPS programme in the communities were not delivering accessible healthcare 92% at Kotaa and 88% at Amomasu perceived lack of logistics and equipment as the reasons why the situation obtained while 92% of those from Nkyenkyemaamu and 96% of those at Anyinasu regarded interference from the community leaders as the reason.

It also showed that the behavior of the nurse was also a contributory factor in all the four communities though to a lesser extent.

These two factors therefore appeared to be the dominant ones affecting the accessibility of health care services, according to the perceptions of the interviewees, and so were not conducive for the attainment of the central tenet of accessible healthcare services of the CHPS program.

Before the CHPS program came into being at the four communities of the study, members of the communities used to access healthcare at facilities as indicated on the table below.

Table 6: Access to health care facility before CHPS

COMMUNITY	HEALTH FACILITY	PROPORTIONS
Kotaa	Hospital	80%
	Clinic	12%
	Traditional source	8%
Nkyenkyemaamu	Hospital	80%
	Clinic	8%
	Traditional source	12%
Amomasu	Hospital	80%

	Clinic	20%
Ayinasu	Hospital	76%
	Clinic	24%

The assessment of the appreciation of the differences between the Community-based Health Planning and Services and the Clinical-based approach by the interviewees revealed the following as shown in the table below.

Table 79: Perception of the nature of CHPS

COMMUNITY	PERCEPTION OF NATURE OF CHPS	PROPORTION
Kotaa	Like other health facility	72%
	Government–community partnership	28%
Nkyenkyemaamu	Like other health care facility	56%
	Government–community partnership	16%
	Government alone	28%
Amomasu	Like other health care facility	60%
	Government–community partnership	20%
	Government alone	20%
Anyinasu	Lack other health care facility	64%
	Government–community partnership	28%
	Run by government alone	8%

From the table above, it is obvious that the most of the interviewees from the four communities (72% at Kotaa, 56% at Nkyenkyemamu 60% at Amomasu and 64% at Anyinasu) perceived the CHPS programme to be like an institution–based programme such

as an outreach clinic. A report of the CHPS Monitoring and Evaluation Secretariat of the Ghana Health Service on February 8, 2002 made a similar observation when it reported that, in the communities where there is moderate development of CHPS, there was confusion about the nature of the programme and conventional outreach clinic activities that have been in operation well before the CHPS programme were sometimes labeled as "CHPS" (Nyonator *et al*., 2002)

The CHPS programme in the four communities of the study started 4 – 5 years ago and so there was only moderate development of the CHPS programmes. There appeared to be insufficient community education on the nature of CHPS as a partnership programme that involved a mechanism for integrating formal health sector activities into traditional institutions.

The table below shows the perception of the CHOs on the appreciation of the purpose of CHPS program by the community members.

Table 80: Perception of appreciation of the purpose of CHPS by community members

COMMUNITY	PERCEPTION OF APPRECIATION OF CHPS
Kotaa	No
Nkyenkyemaamu	No
Amomasu	No
Ayinasu	No

All the four Community Health Officers had the perception that the community members did not appreciate the purpose of the CHPS programme in their Communities.

This perception was in consonance with a report submitted to the GHS by the CHPS Monitoring and Evaluation Secretariat on Focal Group discussion in February 2002 also in the Volta Region at Nwanta and Hohoe which made the following observations;

- The participants wanted diverse drugs at lower cost and also the administration of intravenous fluids by the Community Health Officer
- In general, the concept of referral was not well understood by the participants.
- They wanted two Community Health Officers to be at post
- They were less enthusiastic about voluntary work.

These observations clearly indicated that the participants of the Focal Group discussion did not appreciate the nature and purpose of the CHPS programme. For example, the first of these observations is beyond the competences of the Community Health Officer.

The proportions of the interviewees and issues of their interest in CHPS are depicted on the following table.

Table 21: Interests of interviewees in CHPS programme

COMMUNITY	INTEREST	PROPORTIONS
Kotaa	Nurse living with us	40%
	Home services	8%
	24-hour services	32%
	Sympathetic nurse	20%
Nkyenkyemaamu	Nurse living with Us	48%
	Home services	12%
	24-hour services	32%

	Sympathetic nurse	8%
Amomasu	Nurse living with Us	52%
	Home services	12%
	24-hour services	32%
	Sympathetic nurse	4%
Ayinasu	Nurse living with Us	48%
	Home services	12%
	24-hour services	36%
	Sympathetic nurse	4%

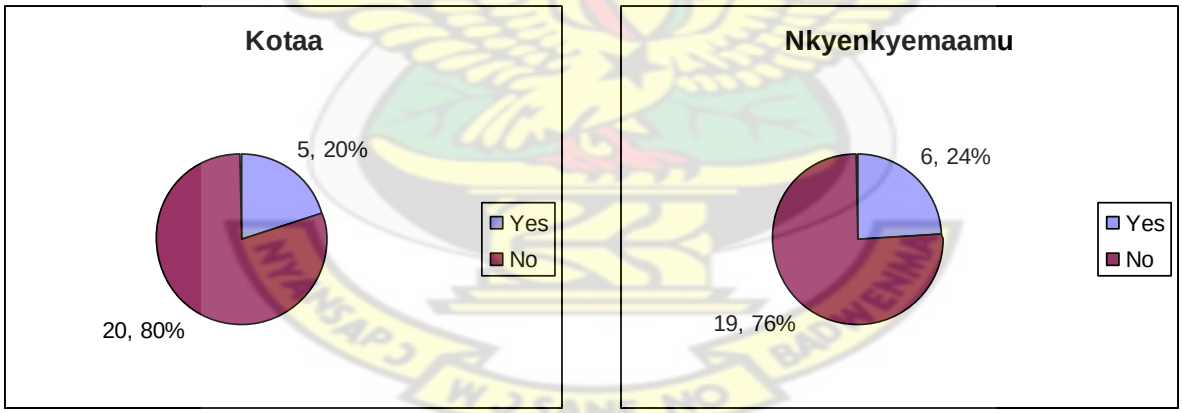
From the above table 40% at Kotaa, 48% at Nkyenkyemamu, 52% at Amomasu and 48% at Anyinasu stated that the Community Health Officer living with them was the factor that interested them most. This collaborated with a report of qualitative assessment in the Volta Region on the perceptions of attitudes and reactions submitted by the CHPS Monitoring and Evaluation Secretarial to the Ghana Health Service in February, 2002 in which it is reported that the component of CHPS which was of most interest to the CHPS communities was the relocation of nurses from clinics to the community an the perception of having curative health care services more accessibly and affordably (Nyonator *et al.*, 2002).

The second factor which, according to the above table, was of interest to the interviewees in all the four communities was the availability of 24–hour, 7 days a week healthcare services in their communities. This again is in collaboration with the report mentioned above (Nyonator *et al*., 2003). In this report, the communities widely lauded the CHPS programme but desired a resident nurse on 24–hour call.

A plausible explanation for these interests of the interviewees might be the fact that, curative health services on 24–hour basis would save them the cost of transportation to clinics and hospital in times of sickness. This translates in economic benefits for them.

A multi-level assessment of impact of CHPS by the CHPS Monitoring and Evaluation Secretariat reported that the presence of a nurse in the community could be a form of health insurance as good rapport between the nurse and the community members sometimes enable the members to access health care services on credit (Nyonator *et al*., 2002)

Figure 9 depicts the proportions of the interviewees who had been told that they had a role to play in the CHPS program and those who had not been told.



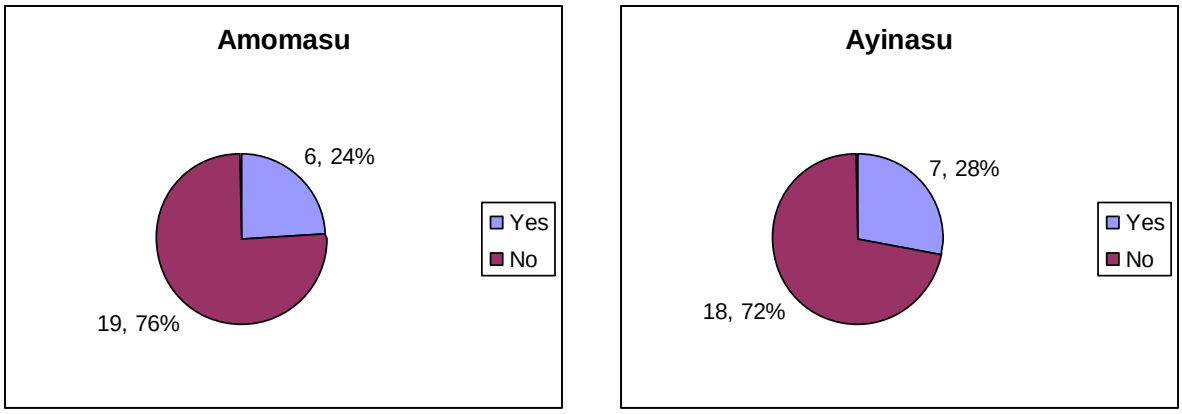


Figure 9: Awareness of roles in CHPS programme

Figure 9 above depicts that 80% at Kotaa, 76% at Nkenkyemamu, 76% of Amomasu and 72% and Anyinasu were not aware of any role that they were meant to play in the CHPS process in their communities.

According to the national policy on CHPS, community education on CHPS should lead to the awareness of the community members about their roles in the Initiative (GMHI, 2005). This was vital if the program was going to be effective in utilizing the community resources in the healthcare delivery.

The following indicates the nature of the roles of those who were aware that they had roles to play in the CHPS program.

Table 22: Nature of roles in CHPS process

COMMUNITY	NATURE OF ROLE	PROPORTION
Kotaa	Fiscal and material resources Communal labour	30% 70%
Nkyenkyemaamu	Fiscal and material resources Communal labour	20% 80%
Amomasu	Fiscal material resources	28%

	Communal labour	72%
Anyinasu	Fiscal and material resource Communal labour	30% 70%

The health sector reforms launched in 1993, have the aim of increasing access to health services, improve health services quality and efficiency, decentralising, planning and management, foster partnership between providers and communities and expand health care resources (Ministry of Health, 1998). It may be infered here that the decentralised nature of CHPS and the partnerships between providers and communities had not been driven home to the interviewees. This might be due to a challenge in th CHPS process.

The table below shows the proportions of the interviewees who said members of their community contribute to the CHPS program and those who said they did not.

Table 23: Contribution of community members to CHPS programme

COMMUNITY	CONTRIBUTION	PROPORTIONS
Kotaa	Yes No	28% 72%
Nkyenkyemaamu	Yes No	20% 80%
Amomasu	Yes No	28% 72%
Ayinasu	Yes No	20% 80%

The total proportions of those who said the community members contributed to the CHPS program and those who said they did not in all the four communities are depicted below.

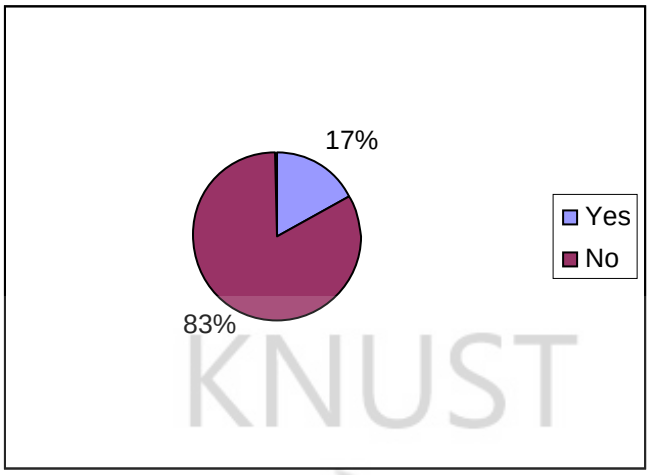


Figure 10: Contribution of community members to CHPS programme

Table 18 and figure 10 above indicate that, the majoriy said their community members did not contribute in anyway to the CHPS programme.

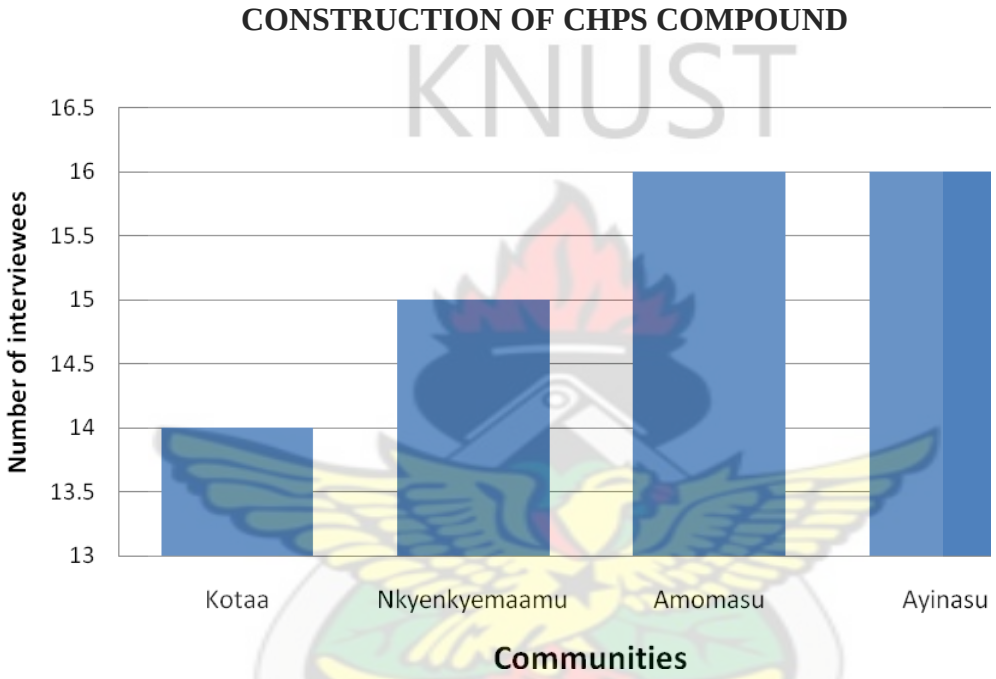
The seventh step of the CHPS implementation process mandates the deployment of volunteers who become involved in promoting Family Planning and Reproductive Health among men (Nyonator ,2002).

Also the second step, indicates that community entry entails the development of leadership and initial participation in the program through dialogue with community leaders and residents (Nyonator, 2002).

Results from both figure 10 and table 18 were not in consonance with the above two steps. However, a report of Qualitative Assessment in the Volta Regionn on the perception, attitudes and reactions submitted by the CHPS Monitoring and Evaluation Secretariate to the Ghana Health Service in February, 2002 noted that the communities involved in that study

were less enthusiatic about voluntary work because they believed that since the community nurse is paid for her job, she should not be helped (Nyonator *et al*., 2003).

The number of the interviewees with their perceptions on the stage of the CHPS process that excited the most enthusiasm of their community members is illustrated on the graphs below.



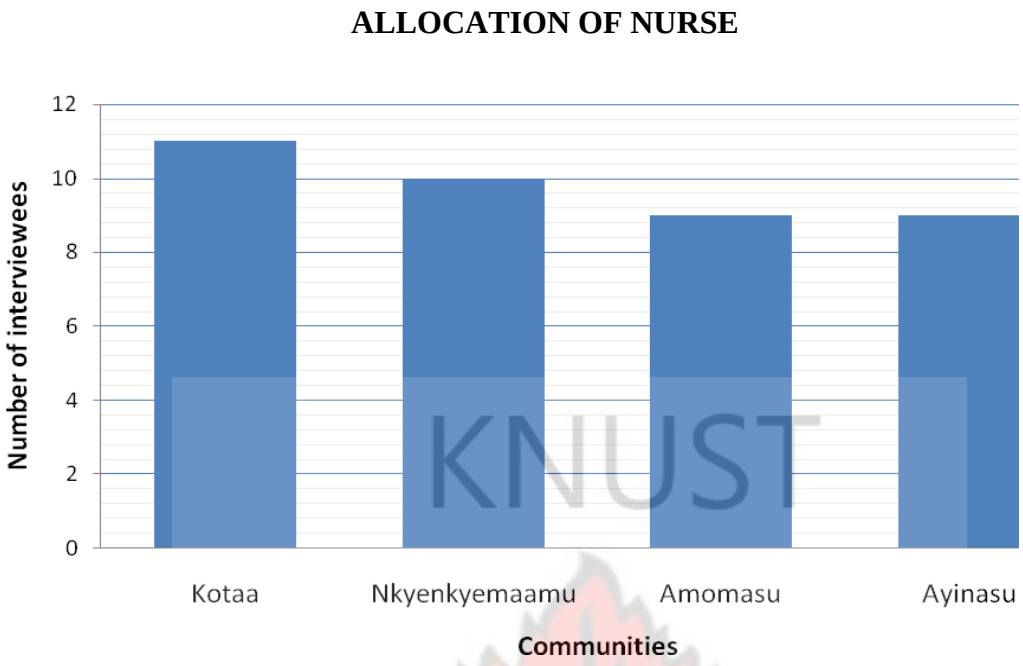


Figure 11: Stages of CHPS process of most interest to community members

From figure 11 the stages of the CHPS process that were of most interest to the four communites were the construction of the CHPS compound and the allocation of the Community Health Officers.

A report of the CHPS Monitoring and Evaluation Secretariat to the Ghana Health Service on February 8, 2002, noted that the component of the CHPS process of most interest to the communities is the relocationn of the Commuity Health Officer to the CHPS compound. It also noted that the posting of a Community Health Officer to the CHPS compund is the critical stage of th CHPS process (Nyonator *et al*., 2002).

This study therefore brought to fore a different view from the studies cited above. This may be because of the political advantage associated with the CHPS compound in the communities in the study.

The following table shows the how the interviewees became aware of the CHPS program.

Table 24: Manner of awareness of CHPS programme

COMMUNITY	MANNER OF AWARENESS OF CHPS	PROPORTION
Kotaa	Durbar	12%
	CHPS compound construction	48%
	Launching	40%
Nkyenkyemaamu	Durbar	16%
	CHPS compound construction	52%
	Launching	32%
Amomasu	Durbar	36%
	CHPS compound construction	16%
	Launching	48%
Ayinasu	Durbar	28%
	CHPS compound construction	20%
	Launching	52%

The table below depicts the age distribution, number of years in service, number of years spent in the communities, marital status, place of origin and manner of posting of the Community Health Officers in charge of the four CHPS centers in the study.

Table 9: Socio-demographic data of Community Health Officers

VARIABLE	COMMUNITY	RESULTS
1. Age (years)	Kotaa	30

	Nkyenkyemaamu	28
	Amomasu	28
	Ayinasu	31
2. Number of Years in Service	Kotaa	3
	Nkyenkyemaamu	4
	Amomasu	4
	Ayinasu	5
3. Number of Years in Community	Kotaa	3
	Nkyenkyemaamu	3
	Amomasu	4
	Ayinasu	4
4. Marital Status	Kotaa	Single
	Nkyenkyemaamu	Single
	Amomasu	Married
	Ayinasu	Single
5. Place of Origin	Kotaa	Native
	Nkyenkyemaamu	Native
	Amomasu	Native
	Ayinasu	Native
6. Manner of postings	Kotaa	Compulsory
	Nkyenkyemaamu	Compulsory
	Amomasu	Compulsory
	Ayinasu	Compulsory

From table 20 above, the ages of the Community Health Officers range from 28 to 31 years. They are all young people who had been in the service for 4 to 5 years and had lived in the community for the past 3 to 4 years.

They were all single except the one at Amomasu. All were natives of the Berekum Municipality and went to their communities as a result of compulsory posting by the Ghana Health Service.

A report on a multi-level, Qualitative, Assessment in the Volta Region by the CHPS Monitoring and Evaluation Secretariat of the Ghana Health Service, February 8, 2002, noted that the remote placement resulted in the Community Health Officer's inability to visit family members and also engender concerns about opportunities for further education (Nyonator *et al*., 2002).

The same report indicated that developing a capacity to ad hoc living arrangement problems by and cooperation of the members of the communities and the DHMT were crucial to sustaining morale among the Community Health Officers and a fall in the rate of turnover.

Table 22 below shows the Community Health Officers who felt encouraged by their communities and District Health Management Team (DHMT) and those who did not.

Table 26: Encouragement from community and DHMT

COMMUNITY	FEELING OF ENCOURAGEMENT
Kotaa	Yes

Nkyenkyemaamu	Yes
Amomasu	Yes
Ayinasu	Yes

The table indicates that all the four Community Health Officers felt encouraged by both their communities and the DHMT.

The report referred to previously also indicated that while Community Health Officers were initially concerned about the many personal and familial problems that they experienced, this subsided if the communities were enthusiastic for the programme and supervisory support helped them overcame those initial concerns and focused more on the professional satisfaction they achieved from their work. So, if they felt encouraged by the communities and the DHMT, then there must have been reasons other than the support from the communities and the DHMT that had resulted in the majority of the Community Health Officers in this study answering 'not much' to the question of whether they appreciated their work in the communities or not (Table 8).

The Community Health Officers were unanimous of the fact that the community members were appreciative of the benefits of the CHPS program such as the 24-hour health services and the temporal spatial advantage of health services that the CHPS compound conferred on them. The nurses at Amomasu and Ayinasu added that some community members sometimes obtain health services on credit: hence, for these communities the CHPS program had become some sort of health insurance for them. All the four nurses were also unanimous that the District Health Management Team co-operate and support them because they want the CHPS program in the municipality, which is a new initiative, to succeed.

The following table depicts the means through which the Community Health Officers were encouraged.

Table 27: Means of motivation of Community Health Officer

COMMUNITY	MEANS OF MOTIVATION
Kotaa	i. Provision of food items
Nkenkyemaamu	i. Provision of food items ii. Help with household chores
Amomasu	i. Provision of farm land and free labour ii. Provision of food items
Ayinasu	i. Provision of farm land, ii. Help with household chores iii. Provision of foodstuff

From table 22, all the Community Health Officers enjoyed some form of motivation from the communities. Most of these means of motivation were geared towards ensuring food security for the Community Health Officer.

According to an earlier study, many of the initial challenges of the Community Health Officers (including that of accommodation), were usually resolved through the contributions of the community along with others (Nyonator *et al*., 2002).

Now, since the four Community Health Officers enjoyed the encouragement and support from both the communities and the DHMT, there should be a different reason that accounted for the lack of much satisfaction of the Community Health Officers with their work.

The GHS report on CHPS (GHS, 2002) indicated that the Community Health Officers at both Nkwanta and Hohoe had a long list of requirements they felt were important in order to have a reasonably comfortable life and successful work.

This list includes financial incentives for long hours of work, rural living and hard work allowance, motor bikes, rain coats and boots. They also required portable water supplied to their Community Health Compounds, water storage facilities, proper toilets for themselves and separate facility for their clients. They required electricity, either mains or solar generated to run a refrigerator to store vaccines as well as for the comforts of lights, radio and TV.

It may be that the provision of the living area for the nurse and the provision of medicine by the DHMT and the provision of food security for them by the communities did not go far enough to engender satisfaction in their work.

The following table shows the nature of the relationship (rapport) between the community members and the CHPS officials as perceived by the community health officers.

Table 28: Nature of relationship between community members and CHPS oficials

COMMUNITY	NATURE OF RELATIONSHIP
Kotaa	Good
Nkyenkyemaamu	Good
Amomasu	Very Good
Ayinasu	Very Good

From Table 23 above, all the Community Health Officers had the perception that there was good rapport between the CHPS officials and the members of the Communities. The provision of foodstuff, farm lands with free labor and help with household chores as indicated earlier may be confirmation to this.

In the GHS reports (GHS, 2002), it was noted that there existed a good interpersonal relationships between the Community Health Officers and the members of the communities which enabled the community members to talk freely about their health problems to the Community Health Officers.

This rapport may be as a result of the appreciation of the community members for the sacrifices of the Community Health Officers and their desire to retain them in their communities.

CHAPTER FIVE

CONCLUSION, SUMMARY AND RECOMMENDATIONS

5.0 Introduction

The purpose of this research was to evaluate the impact of the Community-Based Health Planning and Services Initiative in the Berekum Municipality. Four communities were used in the study and this chapter gives the summary, conclusions and recommendations of the research.

5.1; Conclusion

The CHPS program differs from the conventional model of health-care delivery in one important way: it is a process of health care provision in which health workers and community members are actively engage as partners in the delivery of primary health care and family planning services and involves, among others, community participation in primary health care and family planning services through community health committees and community volunteers.

The appropriate functioning of the community component of the initiative is vital to the successful implementation of the program. The community members need to know their health rights and responsibilities and appreciate the interdependence of everyone in the community and also the ethical and moral values that are necessary for the development of health for the sake of improvement of health status of the population and poverty reduction in the rural population which form about 70% of the national population.

In the Berekum municipality, there was perceived misconception on the part of the community members of the CHPS program making it difficult for the successful implementation of the program; hence the necessity of the study.

One objectives of the study was to trace the history of the CHPS process in the beneficiary communities with the view of assessing whether the program was fulfilling its role of providing accessible health care or not, the level of community members involvement in the decision making in the CHPS process and the sense of ownership of the community members of the CHPS program.

The other objectives was to evaluate the level of understanding of the differences between the CHPS approach and the institution- based approach of the community members and also to evaluate the effectiveness of community education on the role of community members in the CHPS process.

The study was conducted in four (4) communities that had the CHPS compounds in the Berekum municipality in the Brong-Ahafo region; these communities were Kotaa, Nkyenkyemaamu, Amomasu, and Ayinasu.

The survey design was the research design in the study because it was appropriate in describing, characteristics, opinions, attitudes, perceptions, and behaviors of a group of people .Also it could be used to gather information from a large member of subjects with comparatively minimal expenditure of time and money.

The population of the study consisted of the adult (aged 20 years and above) community members who were present when the CHPS process started till now. The non-random sampling of accidental or convenience technique was used, the sample size was 104(n=104), consisting of 25 interviewees drawn from each of the four communities and the CHO from each of the four community.

Two forms of data collection tools or instruments were used, namely, structured interview schedule for the community members who were largely illiterates and questionnaires for the CHOs from the four communities. The statical software-SPSS for windows (version 11) was used to analyze the data generated from the structured interviews and questionnaire. Generally descriptive statistics were used in the analysis of the data

5.2 Summary of findings

The CHPS Initiative was put in place to ensure a kind of healthcare service that is of quality, accessible and affordable to the population of the nation for national development. To achieve these objectives certain policy guidelines were put in place among which were a sense of communal ownership and responsibility as well as trust in the healthcare delivery system.

The Initiative is meant to be community-based utilizing traditional and community resources in the delivery of health as opposed to the institution-based system which was found to be inappropriate in the achievement of desirable goals of the Ministry of Health.

The findings of this study however, was that the majority of the interviewees of the communities in the study were not abreast with the concepts behind the Initiative. They were not aware of the differences in operation between the Initiative and the clinic-based system.

Neither did they appear to be aware of any responsibilities on their part towards CHPS program. There was therefore no sense of ownership

In the light of the above it appeared the community education on the nature and purpose of the Initiative had been ineffective. That situation of knowledge deficit on the part of the community members did not augur well for the successful implementation of the Initiative as it would make the utilization of traditional and community resources difficult in the delivery of accessible health-care services.

Another major finding was that the community Health Officers in all the four communities were of the view that extra allowances should be put in place to compensate them for being at post 24 hours a day and 7 days a week and also for the deprivations, like less educational opportunities they suffer as a result of their being in the rural areas.

It also appeared that traditional medicine was cherished by some community members as these had the perception that it was cheaper and handy.

One result of the misconceptions of the CHPS programme was the misplaced expectations of community members of the Community Health Officers about her/his areas of competence. Another result was that the referral system inherent in the programme was not understood.

It appeared that the medical aspects of the CHPS programme were overstressed to the disadvantage of the environmental sanitation and personal hygiene both by the community members and the Community Health Officers.

5.3 ; Recommendations

As mentioned in the summary of the findings, community education on CHPS had not been effective to the extend that community members had no adequate knowledge on core concepts of CHPS and had no sense of responsibility of ownership of responsibilities towards the programme.

Hence on the demand side, traditional institutions and village governance such as chieftaincy, lineage and family and so on could be utilized in the dissemination of information on CHPS. In this regard, chiefs, head of lineages and families as well as opinion leaders, female and males,could be educated on the distinctive features of CHPS so that these could in turn pass on the information to people who are looking up to them for leadership.

To support these efforts, traditional communication methods like the "gong-gong" and community meetings and durbars could be utilized.

The Community Health Committees and Volunteer groups should be made functional. This could be done through putting in place adequate information system within these committees and groups and doing things in an open and democratic manner. The committees and groups could be helped to have high commitment to the CHPS programme through motivation of a kind agreed upon between these committees and groups and the community members.

As the interaction between man and the environment is a primary cause of infectious diseases (which are the greatest health hazard in the Developing countries like Ghana), environmental sanitation should go hand in hand with medical management of disease conditions. For this to happen there must be great efforts in educating the community members on personal hygiene and environmental sanitation. The same traditional institutions and systems of

communications as mentioned above could be enlisted. Family Planning Services, Immunization, under fives welfare and antenatal issues should be incorporated in the health education package for the community members.

Credibility of the CHPS programme is critical to its successful implementation. This can be ensured through consensus building on the management of the programme by all the stakeholders involved and not just by the political and traditional as well as the officials of the Ghana Health Service. This would heightened the sense of ownership and responsibility of the community members because of the trust engendered.

On the supply side; one of the major factors that militate against the abandoned method of attaining primary health care was the lack of support of the district level from the regional and national levels. Therefore clear communication, equipment and logistics channels should be established throughout the national health delivery system of the nation.

Also since traditional medicine is still preferred to Orthodox medicine in some, a way should be found to incorporate this into the CHPS programme. This could be done by employing graduates of the discipline from the KNUST to do consultations at the community level and also train practitioners of traditional medicine in the communities. This would help alleviate issues of hygiene, dosages and courses associated with traditional medicine practice.

The commitment of the Community Health Officer to the successful implementation of the CHPS programme was crucial. Hence the Ministry of Health through the Ghana Health Service should put in place a compensation package of these officials that work in the rural

areas and so suffer from many deprivations including lack of educational opportunities for themselves and their children and being on duty virtually all the time everyday.

Consistent and periodic training of the CHOs, and the volunteer groups as well as the adequate supply of equipment and logistics would empower them to handle the cases that come to them efficiently and effectively and also conduct their responsibilities well thus winning the trust of the community members.

To accomplish all these, it would be appropriate for the CHPS Initiation to be granted its own adequate budgetary allocation aside from the Ghana Health Services so that it could live up to its financial,equipment and logistics expectations.

Adequate budget allocations to the CHPS Initiative become imperative, when one considers the fact that its successful implementation is crucial to the realization of the Millennium Development Goals. This stems from that fact that about 70% of the population of the country live in the rural areas where infectious diseases, which have their roots in poverty are rift. Improving the health status of the people in communities through the CHPS programme would lead to substantial reduction in poverty level in the country.

Lastly, the DHMTS should strive to achieve a balance between the medical and environmental aspects of the Primary health Care being pursued by the CHPS programme through the channels elaborated above so that the officials involved in the implementation do not slip back to old ways of doing things as happened in the previous attempt of providing primary health care.

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APPENDIX 1

STRUCTURED INTERVIEW SCHEDULE

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY, KUMASI

INSTITUTE OF DISTANCE LEARNING

INTRODUCTION

This research is an academic exercise on the topic "Impact assessment of the Community-based Health Planning and Services Initiative in the Berekum Municipality. The purpose of this research is to find out people's perception of the CHPS initiative in the area and the benefits or otherwise derived from the CHPS compounds in the area.

Your participation in this study is by your free will and absolutely voluntary. The information collected in this research study will be coded without names of participants recorded. Also no name of respondent will be used in any publication or report from this study.

STUDY ID ……..

DATE: ……

A. SOCIO-DEMOCRATIC CHARACTERISTICS OF PARTICIPANTS

1. Age…….

2. Educational background……

3. Marital Status:

    a. Married

b. Divorced

c. Widowed

d. Separated

e. Single

4. How long have you lived in this community? .....

5. Do you have special responsibility towards your community? Yes/No

5a. If yes, specify……

5b. For how long have you held this responsibility? .....

B. HISTORY OF CHPS PROGRAMME IN THE COMUMNITY

1. When did you first hear about CHPS? ……

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

3. 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……..

4. Do you think people were enthusiastic about CHPS?

4a. If yes why? …….

4b. If no why? ……

5. If your answer in (8) is yes, do you think people are still as enthusiastic in CHPS as in the beginning?

5a. If yes why?

5b. If no why?

C. <u>OWNERSHIP OF CHPS PROGRAMME</u>

1. Where did the CHPS programme come from?

    a. the chief
    b. the government of Ghana through MOH only
    c. the community members only
    d. b and c
    e. Others specify ……

2. Who do you think actually controls the CHPS programme?

    a. the chief
    b. the opinion leaders
    c. the community health officer
    d. the volunteers
    e. A CHPS committee
    f. the government through the district health Management team
    g. All the above
    h. Others specify……

3. Are you aware of a CHPS committee in your community? Yes or No

4. If yes do you think this committee is doing what is expected of it? Yes or No

D. <u>INVOLVEMENT IN THE CHPS PROGRAMME</u>

1. 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……

2. Have you ever been involved in decision making in the CHPS programme? Yes or No

2a. If Yes, how?

a. through a representative

b. through public durbar

c. through my capacity as community leader

d. others specify ……..

3. Do you think the decisions taken in the CHPS programme reflect the interest of the members of the community? Yes or No

E. <u>ASSESSMENT OF ACCESSIBILITY OF HEALTHCARE THROUGH CHPS</u>

1. Have you ever been to the CHPS compound for health care for yourself or relative? Yes or No

1a. If yes when and why?

1b. How often do you go there for health care?

1c. If no why?

2. What were your expectation before going there?.....

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

4. What benefits has the CHPS initiative bring to the community?

a. accessibility healthcare

b. Economic benefits

c. Political advantage

d. others, specify……..

5. Do you think that CHPS is providing accessible health care to your expectation? Yes or No

5a. 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 …….

6. Before the CHPS was brought to the community, where were you receiving health care?

F. <u>DIFFERENCES BETWEEN THE CHPS APPROACH AND THE CLINICAL-BASED APPROACH</u>

1. What is CHPS?

a. A new approach of health–care delivery by government
b. It is the usual health care delivery as always by government
c. It is run by government alone
d. It is government-community partnership in healthcare delivery
e. Others; specify…….

2. What have you noticed with CHPS which is of interest to you and is/are not found in clinics, hospital or wherever you were having health care before the CHPS came to your community?

3. In your opinion, how does the CHPS initiative work?

4. Do you think there is any difference between the CHPS process and the health care delivery in a clinic? Yes or No

4a. If yes, mention some of them …….

G. EFFECTIVENESS OF COMMUNITY EDUCATION

1. Have you been told that you have any role to play in the CHPS programme? Yes, No

1a. If yes, specify:

a. 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 …….

2. Do members of your community contribute in any way to the CJPS programme? Yes/No

2a. 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 ……

3. 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……

4. How did you first learn about the CHPS programme in your community?

i. during a public discussion forum

ii. through the opinion leaders

iii. during a durbar

iv. during the launching ceremony

v. when the CHPS compound was constructed

vi. when a nurse was allocated in the community

vii. others specify …….

APPENDIX 2

QUESTIONNAIRE

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY, KUMASI

INSTITUTE OF DISTANCE LEARNING

INTRODUCTION

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Your participation in this research is by your free and absolutely voluntary. The information collected in this research study will be coded without names of participants recorded. Also no name of respondent will be used in any report from this study.

STUDY ID …….

DATE …….

(A) ***SOCIO-DEMOGRAPHIC CHARACTERISTICS***

(1) Age ……

(2) Number of years in service …….

(3) Number of years in the community ……..

(4) Marital status

(a) Married

(b) Divorced

(c) Widowed

(d) Separated

(e) Single

(5) Place of origin

(a) Native

(b) Non-native

(6) How did you come here?

(a) Compulsory posting

(b) Personal option

(c) Through arrangement by the community leaders

(d) Others, specify ……..

(7) How do you like the work here?

(a) Very much

(b) Much

(c) Not much

(d) Not at all

(e) Others, specify …….

(8) Would you prefer working in a clinic or hospital to working here?

(a) Yes

(b) No

(9) Give reasons for your answer in (8)

(10) Do you feel encouraged by the community?

(a) Yes

(b) No

(11) Give reasons for your answer in (10)

(12) Do you feel encouraged by the District Health Management Team?

(a) Yes

(b) No

(13) Give reasons for your answer in (12)

(B) PATRONAGE OF THE CHPS PROGRAM

(1) How many people access the CHPS facility in a month? ……

(2) What are the reasons for this attendance? …….

(3) What do your clients most often complain of? ……

(C) PERCEPTION ON CHPS

(1) What are the expectation of the community of the CHPS programme?

……

(2) Do you think they appreciate the purpose of the CHPS programme?

a. Yes

b. No

(3) What sort of services does the community demand from you? …….

(4) Do you think they are satisfied with the CHPS program?

a. Yes

b. No

(5) Give reasons for your answer in (4)

(D) A REPORT BETWEEN MEMBERS OF THE COMMUNITY AND THE HEALTH OFFICIALS

(1) Do you have volunteers helping you?

a. Yes

b. No

(2) If your answer in (1) is No, what do you think account for that?

…….

(3) Do you feel encouraged by the opinion leaders of the community?

a. Yes

b. No

(4) State the possible reasons for your answer in (3) …….

(5) Do you have CHPS committee in place?

a. Yes

b. No

(6) Do you think it is effective?

a. Yes

b. No

(7) Give reason for your answer in (6) …….

(8) Do you think you have enough cooperation from the community?

a. Yes

b. No

(9) Give reasons for your answer in (8) ……

(10) Who does the community believe is the owner of the CHPS programme?

…….

(11) What is the nature of the relationship between the community and the CHPS officials? ……..