EVALUATION OF THE ROLE OF COMMUNITY HEALTH OFFICERS IN THE COMMUNITY HEALTH AND FAMILY PLANNING PROJECT IN THE KASSENA-NANKANA DISTRICT

BY
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DECLARATION

I DECLARE THAT ALL THE WORK IN THIS STUDY HAS BEEN THE RESULT OF MY OWN RESEARCH, EXCEPT WHERE SPECIFIC REFERENCES HAVE BEEN MADE; AND THAT IT HAS NOT BEEN SUBMITTED TOWARDS ANY OTHER DEGREE, NOR IS IT BEING SUBMITTED CONCURRENTLY IN CANDIDATURE FOR ANY OTHER DEGREE.

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DEDICATION

This work is dedicated to my wife Victoria, and my Mum Theresa, both of whom supported me in prayer and in deed and also encouraged me to undertake this task!

GOD RICHLY BLESS YOU ALL

ACKNOWLEDGEMENT

Thank you Father, for seeing me through. Your word says, "In all things we should be careful to give you the praise and adoration". I wish to express my heartfelt appreciation to my academic supervisors; Prof. Fred. N. Binka and Dr. Clement Ahiadeke for guiding me through this work.

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MAY ALMIGHTY GOD RICHLY BLESS YOU ALL!!

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LIST OF ABBREVIATIONS

CHC	Community Health Compound
CHFP	Community Health and Family Planning Project
CHN	Community Health Nurse
CHO	Community Health Officer
DHMT	District Health Management Team
FGD	Focus Group Discussion
FP	Family Planning
GSS	Ghana Statistical Service
HRU	Health Research Unit
IDI	In-Depth Interview
KII	Key Informant Interview
MIS	Management Information Systems
NDSS	Navrongo Demographic Surveillance System
NHRC	Navrongo Health Research Center
NPC	National Population Council
NRHC	National Reproductive Health Service
PHC	Primary Health Care
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YZ	*Yezura Zenna* (Community Health Volunteer)
YN	*Yezura Nakwa* (Community Health Committee)

ABSTRACT

The success or otherwise of most health related programs in most developing countries are judged using many indicators, among which is the beneficiary communities' perception of the program.

This study examined or probed into the perceptions of the communities with regard to the services rendered by Community Health Officers (CHOs) as front liners in the Community Health and Family Planning (CHFP) project being executed by the Navrongo Health Research Center (NHRC) in the Kassena-Nankana District of Northern Ghana. The subjects of the study were adult males and females who were in three age categories; below thirty years, between thirty-one and forty-nine years and those who were fifty years and above. This was done in order to provide information that would help improve upon CHO services in the treatment cells to project implementers.

Qualitative methods i.e. Focus Group Discussions, Key Informant Interviews and In-depth Interviews were mainly used to capture information related to the communities' access to health information, health services, the nature of the referral system, treatment and preventive care, family planning services and general acceptability of the CHO services. The study also used Focus Group Discussions and structured questionnaire to examine the work, social and welfare concerns of the CHOs.

Most discussants believed that the CHO services have brought a drastic improvement in their lives and have resulted in the elimination of most childhood killer diseases in the community. Family planning services have also improved lifestyles and they now have healthier mothers and children. However it is their

wish that the CHOs spent more time with them in the community, make drugs available to them; put a good referral system in place and provide diversified family planning methods.

The CHOs also expressed varying degrees of concerns that militated against their effectiveness. These concerns include their inability to have many basic tools to work with; the deplorable conditions of the Community Health Compounds; non-availability of drugs; marital insecurity and the lack of motivation in terms of letting them attend refresher courses.

The conclusions drawn from this study are that communities in the project area recognize the immense contribution CHO services have brought to their lives. But there are certain basic issues that need to be tackled to ensure the desired results of the project.

It is recommended that for the program to have its desired impact, the issue of payment for services has to be addressed, more efficient referral system should be put in place, the CHOs need to be given more training and their welfare concerns need to be adequately tackled.

INTRODUCTION

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND

Although levels of mortality and fertility in rural Sahelian populations rank among the highest of any setting in the world, little is known about feasible strategies for addressing these critical problems. Basic health and family planning technologies have been developed and are available at low cost, but profound social, economic, and institutional obstacles prevent the delivery of even the most basic technologies to target groups. And yet, practical examples of how to achieve community involvement in public sector health programs are rarely documented in the policy or scientific literature.

Instead, policy documents engage in generalities without clear implications for the administrators that policies are intended to direct. Evidence that powerful social institutions promote high fertility suggests to some observers that socio-economic change must occur before family planning programs can succeed in the region, but the evidence indicates to others a need for concerted effort to develop community-based primary health care and family planning services.(see Pritchett and Lant 1994).

Resolving the policy debate is complicated by the absence of practical demonstrations of what works in traditional African communities. Although family planning and primary health care programs are being organized throughout the region, strategies pursued retain an imported character.

Despite considerable investment in community health and family planning programs in Africa, little is known about what works best, or even if strategies that have been tried work at all. Family planning and primary health care programs now exist in most countries in sub-Saharan Africa, but as yet not a single controlled appraisal has tested hypotheses about their demographic role on the sub-continent (Phillips, Greene and Jackson, 1993).

Much is known about the mortality impact of immunization, treatment of respiratory infections, and various other modalities but precise appraisals of the impact of systems of care are much needed (UNICEF, 1987).

Primary health care and family planning programs in Ghana are not new. Ghana was the second country in Africa to promulgate a national population policy and typically ranks among one of the first countries to adopt regional initiatives for improving primary health care. Yet, health services are poorly utilized, preventive health programs rarely reach the people in greatest need. At the heart of the problem is the tradition of organizing health services hierarchically, according to the technological requirements of dealing with clinical problems___ an institutional philosophy that characterizes health system bureaucracies elsewhere.

Top of the hierarchy are the District facilities where hospital care is provided to those who can reach facilities and afford to pay for ambulatory care (known as *level C*). Second, in rank, are the clinics dispersed in rural areas, staffed entirely by paramedics (*level B).* Finally, at the periphery, are village health posts that are staffed by volunteers or organized by outreach workers (*level A).* The result of

this structure is an institutional culture that is fundamentally shaped by the requirements of treating illness rather than the requirements of preventing health problems. Resources were committed in top-down fashion to static facilities. Staffs in turn, were assigned to facilities, provided housing to remain there, and denied logistics resources that would enable them to provide community-based care.

This top-down institutional style of the Ministry of Health in Ghana was poorly suited to fostering the involvement of traditional community organizations in family planning (Rattray, 1932). Primary institutions of family, kinship, chieftaincy, and paramouncy were of overwhelming importance; and secondary institutions organized by the government for human services were of no practical significance to rural families.

Other operational problems hampered the introduction of community health services. Community Health Nurses (CHN) have been community workers in name only. In general, the two-year training program for CHN has not served them well because it was too theoretical with little practical training. Work routines were not community-related. Outreach services were not reliably scheduled. Communities, in turn, never knew what to expect from the system, and have learned to keep their hopes to the minimum.

In 1993, the Ministry of Health conducted a focus group investigation of community explanations for the failure of the family planning outreach schemes (See Health Research Unit 1991a, 1991b, 1991c, 1992). To session participants, the staffing pattern was controversial, communication themes were culturally

inappropriate, and service regimens omit key elements. Particular criticism was directed to the absence of a primary health care orientation to family planning outreach activities. Respondents appealed for a more broad-based domiciliary health service approach, suggesting approaches to meeting the demand for primary health care to be designed in ways that foster demand for family planning.(Caldwell and Caldwell 1990a and 1990b)

Recognizing the need for practical guidance from field research, Ghana's Ministry of Health mandated the Navrongo Health Research Centre to: i) develop new approaches to village-based health and family planning services in a micro-pilot trial and ii) assess the impact of the scheme in a district-wide experiment. The experiment- The Community Health and Family Planning Project (CHFP) aimed at clarifying the nature of health problems in the community, offer technologies to address these problems, and develop services in a manner that utilized social resources for developing health care delivery.

The central conclusion that emerged from these studies was that services were oriented to facilities and technologies rather than to the needs of the people and communities. The absence of a community perspective in the Ministry of Health approach had led to a failure to develop work systems that were oriented to appropriate preventive health care. The challenge that confronted the experiment was achieving a fundamental reorientation of MOH staff and activities, which were initially focused on facilities, to a more genuine focus on health care delivery and family planning problems of the community.

DESIGN

"Mobilizing the Health Care System" and "Mobilizing Traditional Society" were two distinct dimensions of the experimental project and adopted inside Kassena-Nankana District. Since the hypothesized mobilization could occur separately, jointly, or not at all, these dimensions implied a four-celled design.

- **Mobilizing the Health Care System**

A key purpose of the project was to mobilize the outreach system of the Ministry of Health bureaucracy; thus Community Health Nurses were removed from clinics and posted to village locations and provided with motorbikes for village outreach work. This process of changing their roles to Community Health Officers (CHOs) was to emphasize their new identity as agents of change in the various communities.

- **Mobilizing traditional social institutions for Primary Health Care:**

  The *Zurugelu* Approach.

  This involved disbanding a discredited volunteer worker scheme and developing a new and comprehensive community-managed program. In consultation with community leaders and guided by focus groups, village health committees were constituted and trained to manage volunteer workers also known as *YZ; Yezura Zenna* (Health Volunteer). Supervisors were trained to guide committees in the selection of volunteers, train volunteers in recurrent training sessions and provide community health committees also termed *Yezura Nakwa (YN)* with simple-to-use village-based MIS for the

volunteers. Close supervisory liaison procedures were designed to develop community-based accountability for volunteer service activities.

1.2 PROBLEM STATEMENT

The CHFP project has been delivering Primary Health Care and Family planning services and has tested project impact over the years. Although other components have been evaluated and success of the program has been well documented, such as increased contraceptive use among the women; and drastic reduction in infant morbidity and mortality rates; little is known about the community perceptions on how the program could be more effective or improved upon; particularly with respect to the services of the Community Health Officers. How do we deal with this component in order to improve upon the CHO services?

1.3 OBJECTIVES OF THE STUDY

1.3.1 GENERAL OBJECTIVES

The general objective of the study was to evaluate communities' perception of the Community Health Officers' (CHOs) services in the Kassena-Nankana District of the Upper East Region.

1.3.2 SPECIFIC OBJECTIVES

a. To describe the pattern of utilization of the CHO services

b. To determine the communities' perception s about the quality of the CHO services

c. To identify communities' perceptions of the strengths and weaknesses of the CHO services.

CHAPTER TWO
2.0 LITERATURE REVIEW

Access to Health Information and Services

Information and education provide the informed base for making choices. They are necessary and core components of health promotion, which aims at increasing knowledge and disseminating information related to health.

Access to health information and services has been widely investigated in countries in the developed world by a host of researchers from disciplines including medical sociology, medical geography and health planning (Bailey, W. and Phillips, D.R. 1990)

In the developing world, however, such studies are few as illustrated by important reviews of health and the urban poor by Harpham et al, (1986). It has been observed by some researchers that factors affecting access to health services show certain variations in developed and developing countries. Thus in a third world setting, people have a wide choice of therapies to utilize (although cost and distance may rule out some.)

In economic studies, low household income has often been identified as a barrier to the use of modern health services even when they are publicly provided. However, even economically oriented studies have frequently acknowledged the related issue of physical accessibility. Distance to health care has also been cited as a major variable influencing services in Iraq and many other settings (Habib O.S., and Vaughan, J.P. 1986, Gesler,W. 1979, Morrill, R.L., Earickson, R.J. and Rees, P. 1970).

Bailey, W. and Phillips D.R. (1990) conducted a study focusing on the influence of distance, transport and accessibility on the use of health services in Jamaica. They observed that most respondents were not using their nearest facilities for varying reasons which included, for poorer respondents, need to attend frequently distant public facilities and for wealthier respondents, loyalty to old family doctors and use of company-related doctors. It is interesting to note that in places where walking distance is short, more use has been made of clinics.

Besides all the above factors, McKinlay (1972) identified socio-cultural factors as being of major influence in the use of health services. Researchers in the area of safe motherhood have also identified that certain cultural attitudes and practices, like perceptions of women's roles, block the ability of women to get care for themselves, hence impeding their use of available health services (Leslie and Gupta, 1989).

Treatment and Preventive Care Services

The cost of services is known to be a barrier to utilization of health facilities. Among the case studies of countries that have introduced user fees, Waddington and Enyimayew (1990) found a substantial decline in utilization levels at rural health centers in the Volta Region of Ghana after user fees were introduced and this decline had not been reversed three years later. The extent to which such a decline could be attributed to changes in factors other than charges that would

influence demand is not clear. Yoder(1989) also found a decline in the use of Government health facilities following an introduction of user fees in Swaziland with the greatest decline for those who had previously been choosing the lowest cost care available

Weaver (1994) studying the effect of fees on behavior at Niamey National Hospital indicated that prices can have three effects on utilization such as delay in seeking care or making fewer visits or avoiding altogether seeking care at public hospital or seeking care from alternative sources. However, the pattern of demand in the presence of charges conveys more information to planners about how clients value different services (Griffen 1987)

The central issue is whether demanding money make poor people stop using modern health facilities altogether, public, or private and encourage them to fall back on self-medication or traditional healers (Mwabu *et al* 1993)

Family Planning Services

In sub-Saharan Africa, several influential observers have argued that the future of fertility control is bleak in the region owing to deeply rooted cultural and social institutions that encourage high fertility (Boserup 1985, Caldwell and Caldwell 1987). Thus African family and gender relations invariably emphasize the pronatalist influences of the institutions of lineage, polygyny, and the family in which husbands are the dominant fertility decision makers (Lloyd and Brandon 1993). Gender dynamics between males and females weaken the autonomy of women to implement their preferences.

That family planning programs can affect contraceptive behavior and fertility positively is widely accepted (Bongaarts et al. 1990; Freedman 1987; and Simmons and Young 1996). That appropriately designed and implemented family planning programs can have positive effects even in adverse social and cultural settings is also beginning to be established. The Matlab Maternal and Child Health and Family Planning Project has received widespread international recognition for demonstrating such results in a conservative, traditional, remote, and economically disadvantaged region of rural Bangladesh (Phillips et al. 1988). Subsequently, the national family planning program also showed remarkable results (Cleland et al. 1994).

Success or failure of family planning programs in most parts of the world has been judged in terms of their contributions to increases in contraceptive use or decreases in fertility and population growth (Bongaarts et al. 1990). Two extreme views on this subject have been expressed: The view re-iterated by Pritchet (1994) is that fertility is principally determined by the desire for children and that the family planning program in a country is not a major factor in determining fertility differences among countries. The other extreme, prevalent in the population field, is that these programs can reduce high fertility in almost all settings.

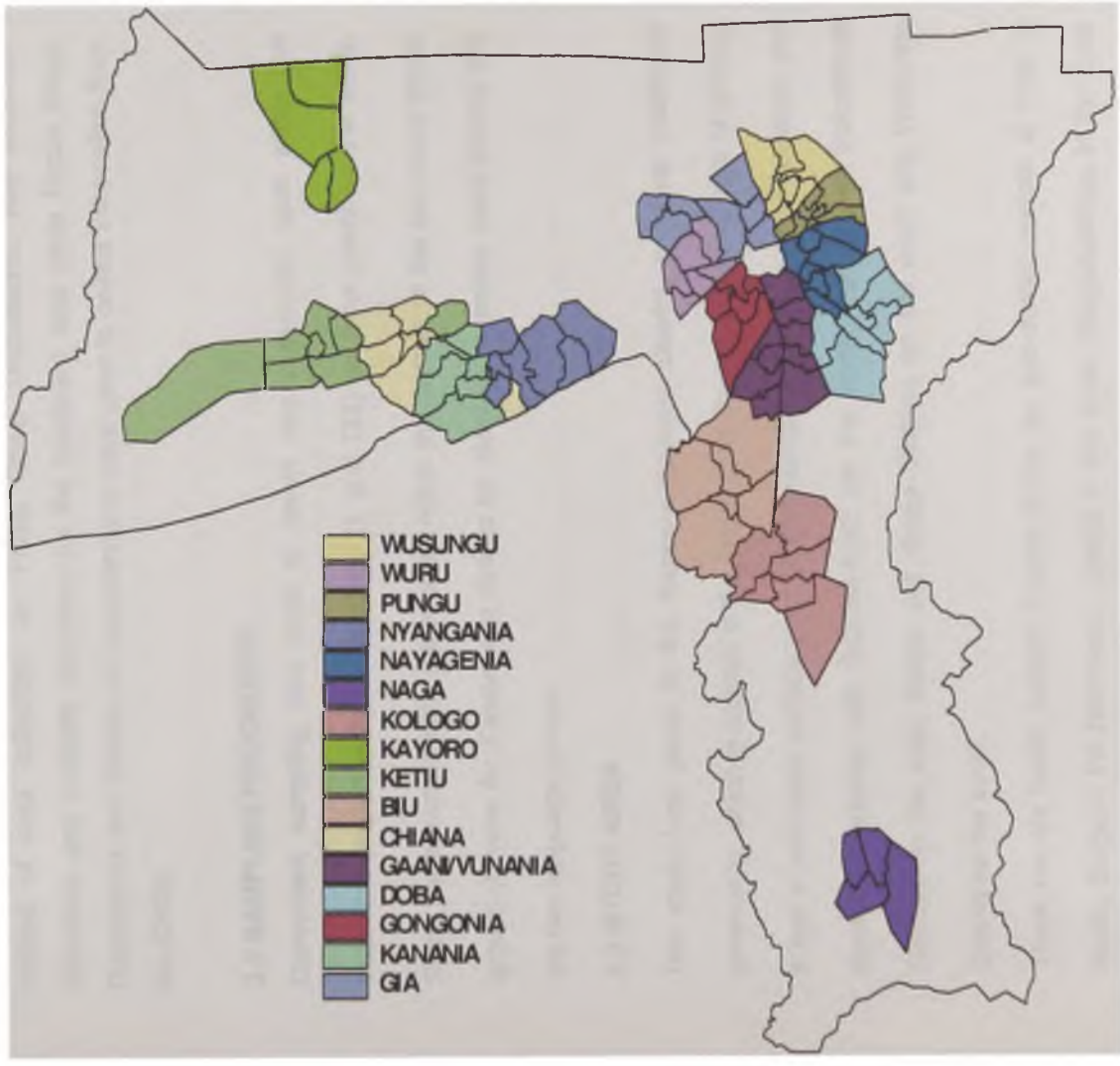
Current prescriptions for resolving the problem of high fertility in rural Ghana focus on making contraceptives available to women in convenient village locations (National Population Council. 1994). This policy is derived from survey findings that many women have more children than they desire and that family

planning would be used if methods were available. (Ghana Statistical Service, 1994). But this desire according to Debpuur et al (1994) and Agula et al (1998) is hampered by spousal miscommunication, mistrust and fear of violence that ultimately weakens the significance of a woman's reproductive preferences in deciding the number of children she will conceive.

FIGURE - 1

The Navrongo Community Health and Family Planning Project:

FIG. 2 Map of KND showing CHO Catchment areas



CHAPTER THREE

3.0 METHODOLOGY

3.1 STUDY DESIGN

The study, which was a descriptive cross-sectional one, used mainly qualitative method of data collection; i.e. Focus Group Discussions, Key Informant Interviews and In-depth Interviews for the treatment cells while Focus Group Discussions and Structured Questionnaire were used to collect information from the CHOs.

3.2 SAMPLING PROCEDURE

Convenient sampling was used to select one community each within the treatment (experimental) cells (Cells II and III) as focal points for the study. Since the treatment cells are situated within the domain of the two major ethnic groups (Chiana for Kassim and Kologo for Nankam) sessions were divided into the two language groups.

3.3 STUDY AREA

The study took place in the Kassena-Nankana District, a typical traditional community, which is located in the Upper East Region in the Republic of Ghana. It has a total land surface area of approximately 1,674 square kilometers and shares boundaries with Burkina-Faso on the north, Bongo and Bolgatanga Districts on the east, Builsa and Sisala Districts on the west; and Walewale District on the south.

There are six health centers located in the six sub-district capitals of Paga in North, Sirigu in the North-east, Chiana in the West, Mirigu/Kandiga in the East, Biu in the South and the Central Health Center in Navrongo. The Catholic Church owns the southern and northeastern clinics but the DHMT supervises both of

them. In addition there is the War Memorial Hospital, which serves as the only referral hospital in the district.

The district has an estimated current population of approximately 157,949 (141,940 under the NDSS) people located in 14,500 compounds in 151 communities, of which 41% are below the age of 15 years. The population distribution is 10% urban and 90% rural. Those under five years make up 13% of the population, which continues to experience high rates of mortality; even though this is generally on the decline. The crude death rate for 1999 was estimated to be 14 per 1000 person years; infant mortality rate was 93 deaths per 1000 live births, while under-five mortality rate was 93 deaths per 1000 live births. Fertility levels are also high as a woman in her reproductive age group bears 4.3 births on the average in her lifetime.

The social demography of the study area is typical of areas of the Sahelian Region. The societal context remains traditional and the settlement pattern is highly dispersed with only Navrongo town in the center of the district providing links with the outside world. Rainfall patterns are typical of the Sahelian regions where nearly all precipitation is concentrated in a four-month period severely constraining agricultural productivity and subjecting the population to seasonal diversity and food shortages. Nearly all families reside in traditional extended family compounds that are highly dispersed with very few infrastructural

facilities.. Traditional religions predominate and traditional forms of village government and social organization persist.

About three-quarters of the women aged between 15-49 years in the Kassena-Nankana District are married and nearly a third of all currently married women are in polygamous unions. Most of the population consists of Kassim and Nankam speakers, while a third ethnic group, Buli are in the minority and located in the southern sub-district, which shares boundary with the Builsa District. Female literacy is only 12% further isolating women from the outside world. Various cultural traditions restrict the autonomy of women and impede the introduction of new ideas and technologies. (Adongo et al. 1995).

3.4 COMMUNITY ENTRY AND ETHICAL CLEARANCE.

Community entry was undertaken by the District Director of Health Services (DDHS) with the principal investigator to the study sites. Thus the group met with the paramount chiefs and sought permission to undertake the study.

Ethical clearance was also sought from the participants by administering consent forms (see appendix 5) before the start of each interview.

3.5 DATA COLLECTION PROCEDURE

Research was based on 13 groups or panels, each comprising of 10-12 focus group respondents. Seven different types of participants were included: both sexes each comprising those below 30 years, those between 31-49 years, and those above 50 years. The 7^{th} group comprised Community Health Officers who

were in two groups. In-depth interviews were conducted with one paramount chief and two opinion leaders to assess the validity of conclusions arising from focus group appraisals while 2 key informant interviews were conducted on the District Public Health Nurse and the Coordinator of the CHFP program. Structured questionnaire were also administered on all the sixteen CHOs.

In the course of the field phase of this study, particular attention was addressed to insulating group discussions from distractions or the causal participation of non-respondents, while conducting discussions in a language familiar to all participants. During discussions, participants were arranged in a semi-circle to ensure eye contact.

Two teams comprising one male and one female facilitator in each group were trained to conduct the sessions using conventional techniques for guiding focus group discussion. (see appendix 6 & 7). Sessions were moderated to ensure that the views of the more vocal participants were balanced by the views of the more reticent individual. Guidelines were imposed to structure discussions, but the actual flow of discussions within a given topic was quite free and all participants joined in the discussions. Care was also taken to ensure that all topics on guidelines received equivalent emphasis. The female assistant had the prime responsibility of leading and moderating discussions while the male observed and took notes.

3.6 PROCESSING AND ANALYSIS OF DATA

Data collected from interviews were initially processed by grouping them into themes and key messages based on the tape-recorded materials and field notes taken by both the principal investigator and the research assistants. These were then used to form matrices. The findings are described in nine categories: access to health information, health services, referral services, preventive care and health promotion, family planning services and general acceptance of the CHO services. The rest include work, social and welfare concerns of the CHOs, their challenges and message for policy makers.

The questionnaire that was administered to the sixteen CHOs was analyzed using EPI INFO 6 software program.

(NOTE: There are a total of sixteen CHOs currently working on the project. Fifteen of them responded to the questionnaire whilst one failed to submit her questionnaire)

3.7 LIMITATIONS OF THE STUDY

- Respondents for group discussions were selected for interview using convenience-sampling method. Thus those who responded to the village chief's call and made themselves available and were willing to participate were selected. But these may not be representative of all the views of community members.
- Second, although the focus group discussions were anonymous, participants are likely to have given socially desirable answers. Hence the

extent of how the community members perceive the CHO services would be under-estimated.

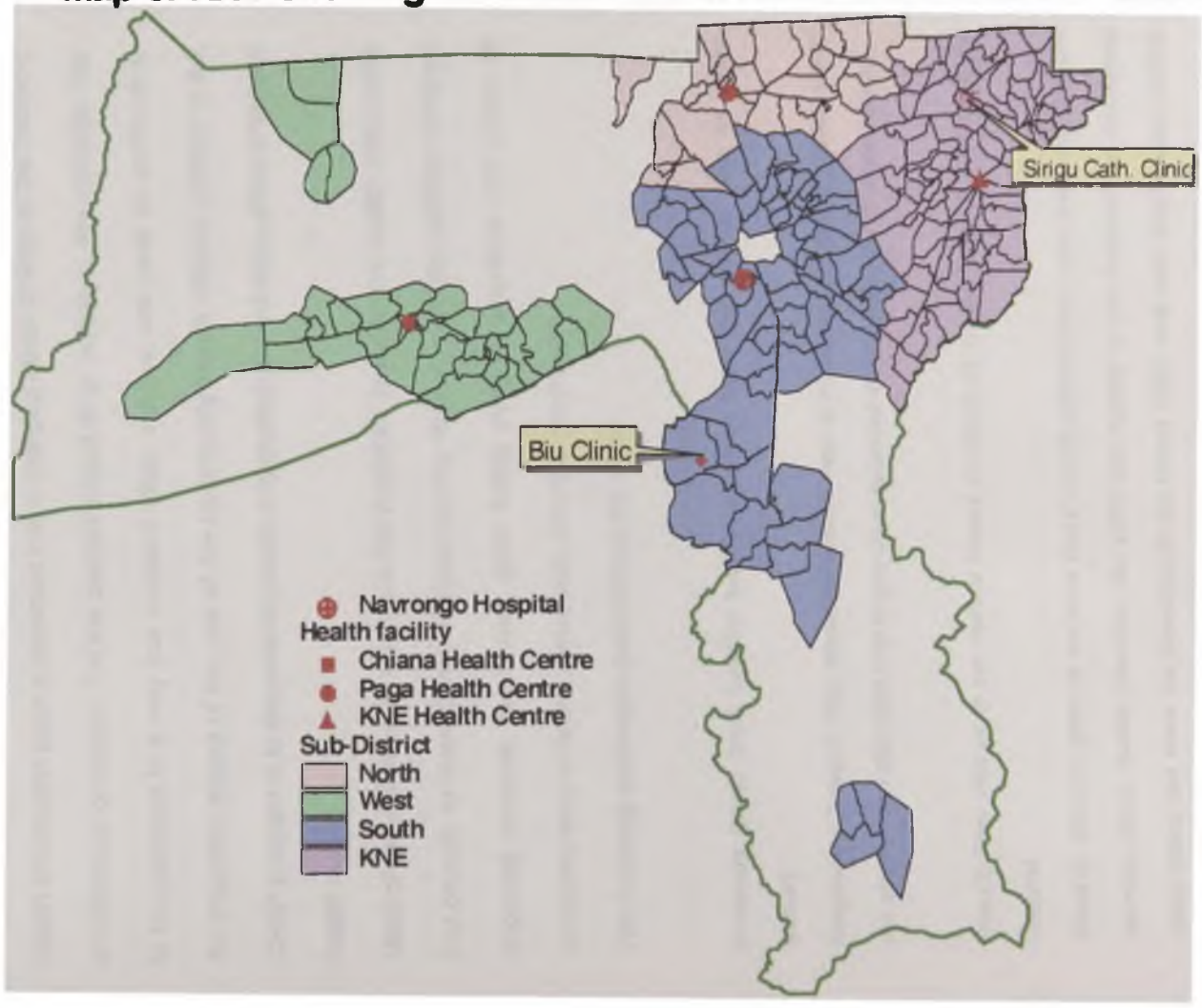
- Respondent bias: responses of respondents may not be a true reflection of the situation due to lack of confidence in the research team and also due to the fact that unsavory comments may incur the wrath of policy makers so that the program may not continue.
- Recall bias: respondents may not have given exact accounts of past events.
- Interviewer bias: the interviewers may not have captured the exact account or may not have translated well enough to convey the desired message.

3.8 INDICATORS/VARIABLES USED

- Access to Health Information
- Access to Health Services
- Access to Referral Services
- Access to Treatment and Preventive Care
- Family planning Services
- General Acceptability of CHO services

FIG. 3

Map of KND showing the DHMT Sub-Districts and Health Facilities



CHAPTER FOUR

RESULTS

4.1 Access to Health Information

Health information plays a dominant role in bringing about change in the behavior of individuals or people. For the desired impact to be achieved, the message has to be packaged in a way that makes it clear, concise, and must be continuous. An important aspect of the role of the Community Health Officers (CHOs) in the CHFP program is to disseminate health information that will bring about improved health status.

Most of the discussants recognize the important benefits that health information has brought to them. Some of these include: they now having healthier children, improved personal cleanliness, good family planning practices and above all increased level of health awareness amongst the people.

The following exchanges summarizes the view:

Moderator (Mod): What benefits have you derived from their (CHOs) talks on health issues?

Respondent (Resp):1 ***They discussed with us ways in which we can take very good care of our children and then also how to give them balanced diet.(female FGD 31-49yrs Kologo)***

Resp(2):They visit us at our various homes to advice us to take our sick children to the hospital

Resp(3): .Since we grew up we knew that if a child suffered from 'niila',(measles) 'zunzure' (worms), fever, 'zukila',(diarrhea) the child was rushed to the herbalist but sometimes these failed. But since the inception of the Ghana VAST with their field workers (CHOs)

going round the various homes talking to us about our health matters, we have noticed all the changes that have come about with these health services.(female FGD Kologo, 31-49yrs)

Resp(4):The CHOs interact with everybody in the community they live and at home. As a health worker, it doesn't even matter whether you are at the work place or doing your private thing. People will always meet you and ask you questions. Like the CHOs, they stay in the community from Monday to Friday afternoon. For these five days they are out in the community and even during their weekend break, (Friday afternoon to Monday morning), they still have interaction with people not necessarily with members of the community they are working with. But as they keep rotating in the communities, they always get people especially women to ask them questions even in the market, church or wherever they find themselves, they are always interacting with the people.(CHFP Coordinator)

Even though the people realize the importance of health information, there have been some reservations with regards to the frequency of the visits as indicated in the exchange below:

Mod: Do you have any misgivings about the information being offered to you?
Resp: ***As for me, I have never heard or seen that we are meeting our CHO here in Chiana to discuss health issues that will improve our health in the community. What I see is when people are coming from far away, it is then that we are informed to meet. Sometimes they come from Navrongo or Bolgatanga or from elsewhere. It is rather them that bring such information but not those here in Chiana (FGD male in Chiana 31-49yrs).***

4.2 Access to Health Services

One of the cardinal pillars upon which the CHFP project was initiated was the fact that most of the communities in the district did not have access to basic health services. There was the need therefore to bring health services closer to the doorsteps of the people. The CHOs' posting to the communities, to live in Community Health Compounds (CHC) provided the condition to promote this concept.

The people recognize the health services offered by the CHOs and the immense benefits these services have brought to them. The following exchanges among discussants about health services are illustrative of this view.

Mod: What are your impressions about the services rendered by the CHO in this community?

Resp(1): ***They have thought us so many ways of keeping ourselves healthy. How we lived with diseases always in the past is no longer the case today(FGD Kologo 31-49yrs female)***

Resp(2): .It is true that when we were small children, we did not see our fathers suffer from such illnesses. If an elderly person became sick, it was an illness of death. But these days, there is no disease that endangers our health (FGD males at Kologo 50yrs+)

Resp(3): When you go out into the community to find out the work of the CHOs they tell you that now the nurse is nearby and I can go there anytime my child is sick instead of having to travel to a far place. Like a woman in Naga having to travel to Navrongo by being picked by the husband on a bicycle or having to wait for a market truck to carry her to the Navrongo Hospital; she easily goes to the CHOs so they talk about it.(CHFP Coordinator)

Resp(4): Previously, pregnant women stayed at home ignorantly without knowing when she is due to give birth and the methods to apply in order to keep the baby healthy and other lectures on safe delivery. Now pregnant women come for weighing and drugs are given to them to keep her and the child healthy. Secondly, reptiles use to bite us and we went looking for herbal cure. But now when you are bitten by a snake you have to rush to the hospital for snake injection, making the effect come down. (FGD Males in Chiana 31-49yrs)

There are certain adverse comments about the services rendered which need to be addressed.

Mod: Have there been situations where services rendered fall short of your expectations?
Resp(1): When one is attacked with body pains at night, and you visit the CHOs, you don't get the drugs. Also, other health workers do not have the drugs to help us personally. We mostly come here only to be told that there is nothing and this does not help us health-wise at all. So we will plead with you to get us the drugs because we the old ladies cannot travel to far places for treatment.(Chiana FGD females 50yrs+)

Resp(2): To be frank with you, and as you have already warned us not to accuse anybody of what she thinks or feels, I will like to say, the CHOs don't actually visit all the compounds. They only visit a few where they have age mates and friends. I for instance has never seen a CHO in my compound before; meanwhile I am also a member of the Chiana community. Yes I only have to rush my patients to the health center in cases of emergency but no CHO has ever knocked at my door and to be frank with you I am not happy about it. .(Chiana FGD females 50yrs+)

Resp(3): Actually speaking, they don't visit us in our homes but rather we look for them because we are in need and I also think a law should be passed so that the CHOs visit our compounds. .(Chiana FGD females 50yrs+)

4.3 The Referral System

The referral system is a network among health care providers and facilities that makes emergency treatment more accessible more quickly to the target population (Bailey *et al;* 1998, Fig-Talamanca *et al*; 1986). It offers clients some degree of care at every level of the health care system, while linking the different levels through an established communication and transport system.

In a well-designed referral system, client care is decentralized as much as possible with each level of care playing a specific role (McLaurin *et al*; 1991). Within the referral system, providers at all levels of the health care system are trained to

- Recognize complications and gauge their severity
- Treat complications promptly when they have the skills and equipment; and
- Refer patients they are unable to treat to a facility where they know adequate treatment is available.

But it seems most of these ideals were not factored into the program as discussants in focus groups have negative impressions about the current referral system. The following views explain this point.

Mod: What is your level of satisfaction about the referral system as it is currently?

Resp(1): ***Some CHOS have really embraced the referral system because she must not treat certain illnesses that she cannot manage and they do understand that it is necessary they go further for other technical or even more sophisticated treatment so they do understand. But their only problem is the transportation from where the CHO is and the clinic (KII, DPHN)***

Resp.(2): I think maybe the sicknesses brought her(CHO) are beyond her capabilities and she thinks when you are referred it will save your life.

Resp(3): I think the CHOs should first give you first aid before you are referred.(females 15-30 yrs Chiana)

Resp(4): If it does not coincide with a market day, and the patient is in too much pain, we have to hire a car and take the patient to the hospital. If the patient can sit on a bicycle then we use that as the means of transport.(IDI Kologo)

Resp(5): They talk to us about ways that we must follow to improve upon our health status, including how to prevent disease occurrence. For instance they teach us how to protect ourselves from contracting diseases especially during outbreaks (IDI Chiana)

Resp(6): We always see it to be a big problem and difficult because someone cannot say that he is sick and come to the hospital only to be told that there are no drugs or there is no vehicle to take the person to a big hospital. (FGD male 31-49 yrs Chiana)

Resp(7): Assume that I have brought a patient to the hospital and I am not financially strong. When I was here I knew that the small money I have can cater for me and take me back, but if they refer me to Sandema or Navrongo, the burden becomes huge making me

unhappy. The vehicle taking you there is also not for free because the hospital has no lorry, and so referrals make us unhappy.(FGD male 31-49yrs Chiana)

Resp(8): The referral system has been a problem. In areas like this when means of transport is not all that regular and the clinic has also not got a means of transport, when someone is referred, it actually becomes a problem. You either go and sit by the roadside and wait for any truck that will be passing which may take a day or two. And when they finally get to the hospital, they are new there so handling the patient becomes a problem, how to see the doctor and even how to obtain drugs. The community members are not happy when they are referred. (IDI with Chiana chief)

Resp(9): Actually, it is always hard for them because sending a patient to a place like Navrongo is not an easy task since they don't have the means to send them and it is a very big problem. They don't like it at all so they will prefer to be treated here. (IDI Chiana)

4.4 Access to Treatment and Preventive Care

One of the responsibilities of CHOs as they live in the communities is to ensure prompt treatment of minor ailments and disease prevention. This field of activity has received tremendous improvement as community members hardly experience the occurrence of diseases that were so prevalent at first. The following exchanges among discussants clearly demonstrate this view.

Mod: What do you have to say about the occurrence of diseases and preventive care that the CHOs give you?

Resp (1): ***There was measles resulting in their death. There were also many diseases attacking children anyhow, they say 'ninla' (convulsions) or whatever. You take your child***

and rush to the herbalist and before you get there the child would have been dead. But these days when you give birth to a child, they are immunized and nothing disturbs you again. There are no measles attacking children, anything attacks the children again; you see? So that is good

Resp(2): What is it that is a wonder to me? We used to witness women giving birth to children who grow up to a year and do not walk. And they say that this person's child is a cripple; Mr. A's child is a cripple. But since the CHOs arrived we do not see such things again. You sometimes see a child who is like this (demonstrates a short child) and you say ' oh, such a tiny tiny little child and he can walk. And I know that it is because of the presence of the CHOs that we have this help.(Kologo FGD)

Resp(3): Now that they are there, it is better than before because measles was a big problem in the past but in these present times it has reduced drastically.

Resp(4): These days, because of the immunizations given to both pregnant women and their children, protection is given against morbidity and mortality.

Resp(5): In the olden days when modern contraceptives were not there, we just gave birth to any number of children at any time, but now that we are aware of modern contraceptives, we space our children and regulate the number we can cater for. **(FGD Chiana females)**

Resp(6): It is true that hospitals and the clinics help us a lot because the illnesses of the past and the present are not the same. The CHOs help us with cases such as yellow fever, diarrhea, TB Tetanus and what have you. In cases of old age, we don't have treatment for locked knees, waist pains etc. for child health, it is no more of a problem but with old age we still face a lot of problems. Also with their present advice like 'do not give water to your

baby till six months' is very helpful and the babies don't fall sick anyhow.(FGD women in Chiana 50yrs+)

Resp(7): It has helped in a way that sometimes they come and carry out mass immunization exercises which helps. But in the past they wait until there is an epidemic before they come to vaccinate (IDI Chiana Chief)

Despite all these positive achievements there have been a few instances where adverse comments were passed.

Resp(1):. ***Health wise, when we are sick, we actually need treatment. Sometimes when we are sick and come to them, we need the drugs but the money we have may not be enough. Sometimes when we visit them and they prescribe the drugs for us to buy from the drug store, and we get there, the amount mentioned cannot be afforded and therefore we go back home and sit with the sickness and finally we die through the sickness. So we ask that the CHOs should try as much as possible to give us the drugs because we don't have the money to buy from the drug stores.(FGD females in Chiana 50+)***

4.5 Access to Family Planning Services

There is a great desire to use modern contraceptive methods among the population. Even though there have been some spousal disagreements especially on the desired number of children, the practice is receiving wider patronage. The following exchanges among discussants portray these views:

1. Mod: What are your opinions about family planning?

Resp(1): ***It promotes our good health. it enables our children to grow well and be healthy and at the same time promotes good spacing of the children.***

Resp(2): Also, one good thing about it is that when you have 2 or 3 children, you can look after their education very well and when they are sick, you can send them to the hospital for treatment.

Resp(3): It also makes the woman strong and healthy enough to work to assist the man in the maintenance of the family.(female FGD Kologo 31-49 yrs)

Resp(4): *The FP is sending the message that when you want to have 2 children, space them reasonably so that they can grow well. But you see the problem is that my mother for instance gave birth to 10 children but we have only 3 survivors. If they decided that they were giving birth to 3 children, what will be the situation today? Left to me, I support the idea of spacing but if she can give birth to more children, she should do so. But again we know that there is no food to feed the people, so the problem is with how to look after the children. However, this should not prevent people from having the number of children they can possible have. What if everybody chooses to cut down the number of children they have and there is an outbreak of measles? So I think that if the woman can give birth to 10 children, she should do so; if she can also have only 5 children, fair enough(FGD male 50+ Kologo)*

Resp(5): They have made us to know the different kinds of medicine that they have brought to enable us sleep with our wives without them becoming pregnant, thus reducing childbirth and making us not to give birth anyhow. Formally, I could see a man and the wife fighting because of sex, thus the women feared they could become pregnant. Since the introduction of these drugs, there has been calm and we no longer hear of fights concerning sexual issues (FGD males Chiana 31-49yrs)

2. Mod: Have you heard of anything that has discouraged you from practicing Family Planning?

Resp(1): ***With the loop, I think they need to give the nurses more training because I heard that a woman gave birth and the baby had the loop in its hand. Therefore education on how to fix it is very important.***

Resp(2):. For me, I think there should be a review on the injectables. A friend complained to me of not being able to get pregnant after she used the injection and also she had severe menstrual problems afterwards.(Chiana females 15-30yrs)

Resp(3): They have introduced FP to us but I think the message has not gone down well. The whole idea is that a man and his wife should unanimously agree to go for the FP but some women go for it without the consent of their husbands, which I think, is not the best. Sometimes these women can go for abortion after they have noticed that the FP has failed them resulting in pregnancy. If these women are not fortunate, they may die and whom do you think will share the blame? We know that government is paying them to work in our community and if they then decide to give FP drugs to women without the consent of their husbands, will it help? I think they are doing us a disservice in that direction. The government did not bring them here to destroy and so if I had the opportunity to meet the CHOs, I will tell them that, what they are doing, I disagree with them. If my wife goes for FP drugs and anything happens, I am going to the CHOs to inform them that they are responsible (Chiana male 50+)

Resp(4): I want to ask a question; "before FP many of us women here whose husbands were good knew that if you had a breastfeeding child, he had to grow well and be strong so they abstained for four (4) years. If she were a girl a period of three (3) years before you would get pregnant again. But these days I hear there is family planning so we shouldn't let our husbands go out and then we go for the "adogmake"(family planning). Thus when

the child is about sitting like this one says that she is in this adogmake" business so she goes for the injection. The next day she will be pregnant and the other child is just sitting. I always wonder, they say this "adogmake" FP has come to help us. But here is the case one used not to litter her children and because this thing (FP) has come one starts to have sex by force". I don't know whether this problem comes from the nurses, or that the injection is not the right one for them. " neriba la zim n ka magse" or it is that they don't understand how to take the dosage hence do not take it well? That is what I want to know. If it is that we are ignorant, teach us so that those of us here may know its rules.

Resp(5): I went to Kumasi with this child. by then he was still a little baby. And talked about that FP any time I am pregnant you will see a vein here (on her leg) and they told me that vein makes it impossible for the drugs to work effectively. That is why I get pregnant in spite of coming for the FP. So they advised me to go for that one you showed (Norplant) and that I shouldn't try the injection again. But they don't test here. When you get there they ask what you want and when you say the injection they just inject you. Then you go home and give it to the man. The next day you will be pregnant. You wouldn't know how. So when I went I did it I was free with my husband on my return not avoiding him. Not knowing the method (injection) wasn't good for me. If they had tried and known that "my blood is stronger than the injection" they wouldn't have done that one for me. They would have given me the one you mentioned (Norplant) but because here they do not test it tends to be useless "basa" so I don't think I will try it again (Kologo female 15-30).

From the interactions with the CHOs there seems to be the indication that FP methods that the community members are conversant with are The Pill, Norplant and the Injectable (Depo-Provera). This is because their patronage among the community members is very high.

The coordinator outlines some challenges that the program faces especially with the acceptance and use of modern contraceptives. These challenges she indicate are:

1. ***To be able to maintain a constant supply: For one reason or the other, if a known nurse is on leave and a new one replaces her, then the acceptor rate drops; the people look at the new person with suspicion. They have to be assured of confidentiality once again, so as to be able to maintain a constant supply of contraceptives and***
2. ***To be able to keep confidentiality of the usage and then also some think the contraceptives are expensive and can't really afford; some come to buy them on credit and then find the money later to pay.***
3. ***Also when the usage is not well explained to the user, and they experience some side effects, they may not like to use the contraceptives again.***

4.6 General Acceptability of the Program

Focus group discussants consistently indicate that the program is welcome in their communities. Participants were clearly convinced that the CHO presence was having an impact on health. Community members have knowledge about the nature and scope of the CHO activities and the content of the talks that she organizes. Although it is unlikely that activities have impacted on mortality, respondents believe that the number of children dying has been reduced. The following exchanges explain this view.

Mod: What are your views about the general services of the CHOs?

Resp(1): ***The truth is that their work has been good. This is because initially, many people did not understand this issue of FP because they say their grandfather did not know what FP was. But since the coming of the CHO, there has been some understanding now as far as FP is concerned. Initially, many people gave birth to children with the fear that they may die through a disease like measles but since the coming of the CHO we have not been hearing of such cases in the community. Death among children is no longer common***

Resp(2): When a sick child is in a critical condition, the CHO could volunteer to take this child and the mother to the hospital. Even sometimes when we are not able to get a vehicle to convey a patient to the hospital, the CHO volunteers to take the patient to the hospital and this we feel she has our health concerns at heart.

Resp(3): Then also at times when your child is sick and you don't have the money to buy drugs, the CHO gives you the drugs free. .(female, Kologo 31-49yrs)

Resp(4): They are generally doing well. They are helping us in our everyday life, including the cleaning of the environment and this FP we are talking of. In everything, they are very helpful. They teach us on health matters including how to take care of our babies, what to do during pregnancy and the rest. We appreciate all that. (IDI Chiana)

Resp(5): For me, I think the CHO services have been very supportive. They have improved our health status and they have also reduced significantly a lot of diseases in our community. They go round our various compounds to treat our children of diseases. So there has been a supportive service delivery.**(IDI Kologo)**

Resp(6): I think they have started well and I won't say that it has ended because as the community grows, problems also grow with them. So the best thing is when you start

something you analyze it from time to time and find the problems and be able to correct them. (IDI with Chiana Pio)

Rep(7): For me, I will say that there is room for improvement. Now we are able to cover a large area but we still have to look at the quality of the services. Looking at accessibility, we have to be able to reach about 80% of the population in the Kassena-Nankana District, but now we are looking at the quality and it seems there is more to do on the quality of their services. Being available to answer questions and to answer them correctly is what the clients want but we are still not at that level especially with regards to contraceptives. And the other thing I will say is services at the price that the people can afford. Also we still need more training for the nurses so that they can do more and a larger number to cover a large area. And finally, the nurses need motivation. Under the circumstances that they are working, I think they are doing well.(CHFP Coordinator)

The men passed most of the adverse comments about family planning.

Men do not want their wives to practice family planning because they associate reproductive control with "women's liberation or emancipation," and feel that allowing their wives to practice family planning will lead to loss of control over their own reproductive future.

Resp(1): We don't want them to let the women know the drugs for preventing pregnancies. They should also not inject the women when they come to them. Our local people have herbs that can be used to prevent pregnancies. If your wife delivers once and you don't want to have any more children, you can do so. If you people come here with the intention of helping us but end up doing us harm, is your mission fulfilled? I think that this attitude should be changed,

Resp(2): The FP has come as a relief to women. This is because these women who grow up and have no children yet already have gone in for drugs to prevent pregnancies. They don't want even to sweat, as is the case with nursing mothers. Some too after giving birth to one child go in for FP. Who has given them the go ahead? You people should explain to the people here that the FP means that you should space your children reasonably. But do they even ask such questions as to what the whole thing is about? Are we not all in confusion? Who buys FP drugs frequently here? Most of the women have now taken to buying FP drugs. Have they given the women a donkey to ride or not (meaning have they given the women freedom or not)? Anyway nobody knows how a human being is made, only God knows. If a woman has never given birth before, then it is God's making. But has the FP not given freedom to the women? What for; so that the earth will go deeper or higher?

Resp(3): Most of the men lack understanding. When the woman wants to do FP, the husband will never agree for her to do it and this result in quarrels. The man will never give money to the woman to go and do FP and if she insists, because the man will always want to have an affair with her, he may even beat her. The only option for the woman is for her to secretly go and do it because it is she who bears the pain during labor and not the man. For this reason I think both the men and women are blame worthy. However I will like to also reiterate that the CHO should also do well to see both husband and wife before doing FP for them. (Kologo male 50+)

4.7 CHOs' OWN ASSESSMENT OF THEIR SERVICES

4.7.1 Work, Social and Welfare Concerns

The CHOs think there are a lot of issues that militate against their perceived 'ineffectiveness' at their workplace. Some of these issues include the workload,

lack of equipment to work with among others. The following exchanges explain these views:

1. Mod: how much time do you have for your private activities?

Resp(1):. ***We don't get so much time because you are always there throughout the week. And at weekends at times too you are engaged in other work, and you have to go back to the community to do something. So we don't get so much time to take care of our families.***

Nine (75%) out of 12 CHOs stated overwork leading to severe exhaustion.

Resp(2): Some of us don't get the weekends because we are just staying in the station there. And at times when you get a labor case you cannot ignore the laboring woman and come down to town, or be doing something else. You have to attend to the woman and a labor case can take up to 12 or 24 hours. And after that you have to refer the patient to the hospital in case of any complications. And the curative side too the same thing. There are cases you may treat them and you still have to refer them for immediate medical intervention for better treatment.

All the fifteen (100%) CHOs mentioned lack of basic facilities to work with.

Resp(3): If you don't take care, your marriage will end somewhere. You either go there and someone will snatch your husband from you. Because we don't get adequate time to pay attention to the men and the men always need us by them, so if they have to go and throw you somewhere because of somebody's health and that is what you have to do because that's your profession.

Thirteen (92.9%) out of 15 CHOs site marital insecurity as a welfare concern.

Resp(4): Most of the men in the community think that family planning is just to stop the woman from delivering but don't really know the actual definition for family planning like good spacing and some of these things. So the men should be sat down and talked to.

Twelve (92.3%) out of 13 CHOs think there is the need to involve men in FP activities.

2.Mod: What are your relations with them (patients) on other issues apart from family planning?

Resp(1): On the part of treatment, they feel they should be treated free. At times when they go to the hospital and hear that 0-5yrs and the aged are entitled to free treatment they expect us to treat them free. So they should be educated on how we obtain the drugs so that they don't demand or expect free treatment.

Resp(2): It is true; not only the aged or the under 5 but some just come to you to say they are sick but don't have money. If you just dish out the drug to them, you are losing and will not get the money again to go and pay for and purchase another set of drugs. So this is the problem we are facing.

3. Mod: What other problems do you encounter apart from what has been discussed?

Resp(1): I must say that the compound visits are tedious. There are no better paths especially in the rainy season. You get to the compounds and some of the houses have collapsed and if you are not lucky, a house can collapse on you. So these are some of the problems; but with all these, we still relate nicely with the people. Majority of them accept us.

Resp(2): Staying there alone too is risky. We need to be two, or they should get security officers for us.

Thirteen (92.9%) out of fifteen respondents mentioned lack of personal security as a major concern.

Resp(3): On the part of injections, I will say we should be trained and given the go ahead to inject because some people visit the hospital and are given chloroquine injection, which is to be repeated after 6 hrs, but when such a person brings it to us, we are not allowed to inject

Resp(4): Not that we don't know how to do it (inject) but it is just because we are not allowed. So the community members think we don't know anything; we don't know our work. So they lose confidence in you.

4.7.2 What are the Challenges facing these CHOs?

Quite a number of them are reeling under pressure from the marital home as expressed by discussants in the following answers

Resp(1): If you don't take care, your marriage will end somewhere. You either go there and someone will snatch your husband from you. Because we don't get adequate time to pay attention to the men and the men always need us by them, so if they have to go and throw

you somewhere because of somebody's health and that is what you have to do because that's your profession. They all laughed!

Resp(2): That is what is discouraging more men to marry nurses because when we are going on transfer, let's say that I am a nurse sitting down here. Maybe my husband will be a teacher or another government worker somewhere else. The Ministry of Health will not allow me to stay by my husband and say that I'm to go on transfer. Then I leave my husband and before I go somebody has seized my power and then I become what? A frustrated woman. The work cannot go on effectively.

Resp(3): And our children too, they lack our care. And in fact some of our children have stopped schooling. Because in the communities there are no better facilities maybe you can't send them there and they end up joining bad groups

Resp(4): And more to the point, the structures they have kept in the communities for he CHOs are not the best.

Resp(5): Even your husband will not like it. He will say if you want to be there then you will lose him.

Res(6): Apart from midnight, they will come and wake you up. And security, you are at risk; sometimes you are sleeping and they come and you don't know whether that is actually a patient or they are just coming to distract your sleep.

Resp(7): At times, they buy our drugs on credit and when you follow up to get the money, they fail to do so. So you have to go and use your own money to go and balance the drug. You know you can't be chasing them to collect that money but when they also come to you, you have to give them the drugs.

Resp(8): Some cases, even when you refer them, they will simply tell you that they don't have the money to come to the hospital. It is a major problem. You see the patient suffering but you don't have what it takes so how do you come to somebody's aid? So it is a problem to some of us

Resp:9 If there were to.... something like communication and the patient is willing to go and there is no means of transport, you can just ring the hospital and within the next 5 or 10 minutes, a means will be there to convey the person to the hospital. Now, that one too is not there so it's a big problem.

4.7.3 Message from CHOs for Policy Makers

Optimal performance among any group of people is largely determined by the people's level of training, resources available to facilitate prescribed work, staff development plan and the people's zeal and commitment to perform the tasks prescribed.

The training given to the CHO over a 2-year period undoubtedly prepares her to effectively give out her best to health care development. However the story as far as availability of resources and staff development is concerned is not very encouraging. Below are some remarks that need the attention of policy makers:

- *We should* ***go to school. That one is very important ....even those in the city are being promoted at the correct time but we those in the community, they promote us only after a century.***

- *We don't even attend workshops to update our knowledge. In other places, our colleagues go to Accra, Kumasi, to attend workshops. We also want to go to the city, since we are in the village. Anytime that they are holding small workshops they should make sure to include us.*

- *Even the motivation is that if we are attending, our juniors who are in school will also want to come to this district, or others would like to join the profession.*

- *I think the CHO compounds should be built with block, painted nicely and should have enough rooms so that if you choose to move in with your family, you can do so or if your family wants to visit you they can do so and be happy there. And things like TV, fridges, etc should be in the houses so that it will motivate you to stay there throughout.*

- *We should also have mobile phones or walkie-talkies so that we can communicate with other health workers in the district in cases of emergency in the sub-districts.*

- *We should be given security because in the community where we are living alone; at times our lives are at risk. And I think the community members themselves should do this security work.*

CHAPTER FIVE

5.0 DISCUSSIONS

The study was well conducted and the findings are consistent with the specific objectives as it gives a fairly realistic impression on the issues studied. The method, though qualitative provides insights into the communities' perceptions and assessment of the CHO services.

One of the World Health Organization's (WHO) global indicators for monitoring progress toward Health For All (HFA) is the availability of Primary Health Care (PHC), (WHO,1988). According to the Alma–Ata document of the WHO, "Primary health care is essential care based on practical, scientifically sound and socially accepted 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 to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work."(WHO, 1978).

5.1 Access to Health Information

The study revealed that the information being disseminated to the people has had the desired effects. They recognize most of the benefits of these information

but some communities have problems with the timings and the frequency of the meetings. There is the need for the project implementation team to have durbars and discuss days that will be convenient for both the target population and the CHOs.

5.2 Access to Health Services

Access to and cost of health services are an important determinants to service utilization. Other factors may include opening times of service delivery points (SDP), the number of days and hours within a day that services are available; the proximity of the SDP with respect to the time taken to reach it.

The findings of this study showed that access to health services may not be considered as a problem in the study area, since one of the cardinal goals of the CHFP program is to bring health closer to the doorsteps of the people. In this case health workers rather have the task to visit compounds and give ambulatory care to those in need. Thus the CHOs rather visit the communities to offer them services. But some of the community members see these visits as not being very regular and also they are not punctual. Others go to the (SDP) which in this case are the Community Health Compounds (CHC) at their own convenience. Thus, while community members may come to the CHC depending on what services they need, most FP consultations are carried out in the night. For effective work therefore, the CHO will have to be in the CHC throughout the day.

Whilst some of these assertions may be true, part of the problem is also due to the fact that these CHOs have to visit seven to eight compounds a day as a routine. The area generally has a difficult terrain and bad or mostly inexistent access routes coupled with occasional floods during the rainy season further reduce the mobility of the CHOs. This confirms the findings of some earlier workers in this field that geographical access is an important determinant of utilization (Andy T.C. 1990, Clark J. D. 1990, Philips 1996, Stock 1987, Tettekpoe 1997, Yoder1989, Weaver 1994.)

Other problems highlighted include the unavailability of the CHOs when the community members need them most especially during weekends. This is an administrative concern since the CHOs indicated that they are expected to park all their motorbikes at the NHRC premises on Fridays and come for them on Mondays before going back to the communities. This means that in effect the CHOs provide effective health services from Tuesdays to Thursdays. Thus they all come back to Navrongo on Fridays, spend the weekends and by the time they go back to the community on Monday, the day is far spent.

5.3 Access to Referral Services

Primary care facilities include first aid stations, nursing posts, dispensaries, family planning clinics, and health clinics. Primary care providers –the first level of the formal health care system- usually offer health education and basic medical treatment. In an effective referral system, primary level providers such as

the CHOs should be able to recognize complications quickly and distinguish between cases they can **treat** and those they must **refer**.

When the CHOs are unable to provide necessary medical treatment for complications--either because they lack the skills, equipment, or drugs or because the complication is severe—they would have to refer the person to a facility where treatment is available. (Hord and Delano, 1994; IPAS, 1995)

The perceived 'incompetence' of the CHOs on the part of the community members can therefore not be attributed solely to lack of skills of the CHOs since the referral system is almost non-functioning.

A very critical ingredient in any referral system is the **means** by which a patient who has been referred gets to the next level of treatment. Transport is therefore an essential tool in setting up a good referral system. The only means of transport that was provided was the 'Bajaj" tricycle that was supplied to ail the Level B Health Centers. Unfortunately, almost all of them have either broken down or are functioning below capacity. In an environment where poverty levels are so high vehicles ply most routes only on market days; one's effort at saving lives will never be appreciated if the ill in that society cannot have easy access to referral facilities. In their desperation the CHOs try to make do with what they have to save the situation but they end up being labeled as 'incompetent'.

It would therefore be very prudent to ensure that the referral services are tackled so that the people feel the actual benefits of the program.

5.4 Access to Treatment and Preventive Care Services

There have been very pleasant remarks on the whole on these services. The community members appreciate the drastic reduction in the disease burden and the almost total elimination of certain ailments such as measles and malnutrition. But a very important drawback is the cost of treatment. Financial access is a big problem. Some community members are even aware of government policy on exemptions for the vulnerable in society such as children under five, pregnant women and those who are above the age of seventy years. Findings revealed that even though the study area is highly deprived and ranks among the poorest in Ghana, the irony of the situation is that government's exemption policy is virtually non-functional. The poor folks would have to pay for all services rendered.

5.5 Access to Family Planning Services

Though the community members claimed to have realized the disadvantages of unregulated fertility, couples seem to be in disagreement with appropriate action. Such spousal disagreement on the desired number of children has been reported elsewhere (Bankole and Singh, 1998; Dodoo *et al,* 1997). There is therefore the need to intensify family planning counseling, diversify the methods and more especially involve the men in the counseling programs in order to allay their fears.

This research has brought to the fore some indicators of reproductive preferences that have implication for fertility and family planning behavior. Thus, there is an indication that decline in family-size preferences, which is a necessary precursor of decline in actual fertility, tends to occur first among women, who probably have a better understanding of the benefit of spacing their children and the dangers associated with having births in quick succession.

Thus women appreciate the usefulness of family planning services (there are a few reservations however concerning effects from use), the men on the other hand are often skeptical about 'new-found freedoms of women'. This is because the men perceive the women as becoming promiscuous and also women going in for the various methods without the consent of their husbands.

The women are therefore calling for improved training so that the CHOs can administer the family planning methods more professionally; whilst the men on the other hand would like to be part of the woman's decision to use contraceptives. This confirms an earlier research done in this field by Agula *et al* (1998) on men's anxieties and women's fears.

5.6 General Acceptability of the CHO Services

"The presence of the CHOs has reduced our disease burden; it has improved our health status and we are now having healthier children and mothers. They have thought us how to keep our surroundings clean thereby reducing the prevalence of common diseases." (KII, Chiana Chief). These are some of the positive comments from the communities.

However, there are certain rough edges that the people 'perceive' as drawbacks. These include:

- The need for the CHOs to be trained more on the administration of Family Planning methods
- The need to provide those entitled with free medical treatment
- The need to increase their compound visits
- The need to seek the consent of husbands before administering family planning methods to women. This point runs into conflict with the Ghanaian National policy on reproductive health which states that the woman does not need the consent of her husband in order to go in for family planning services.(NRHS, 2000)

These perceived drawbacks could be remedied if these concerns are promptly addressed, for much can be learned about the problems that the communities perceive.

For as a prominent figure recently said: "There is now a general understanding on the idea that "investing in health" means to mobilize new financial resources, coming from the international solidarity, to remove the many barriers to access to health care in developing countries: financial barriers due to the general situation of poverty; but also physical barriers, such as lack of basic infrastructure, roads transportation, health care facilities, staff and equipment...which make difficult access to health information and compliance to treatments. (Bertrand, 2002)

5.7 CHOs' OWN ASSESSMENT OF THEIR SERVICES

CHOs are the 'front-line' staff in the battle to provide " adequate, efficient and equitable Primary Health Care services to all Ghanaians", yet their experiences and perspectives have not been systematically sought, documented or disseminated.

There is overwhelming evidence from this study to suggest that they have serious concerns regarding their general welfare as well as problems regarding more technical issues such as their ability in insert the IUD and the injectables and also social concerns as outlined in the results from Focus Group Discussions.

There is therefore the need for policy makers and implementers of the program to make strenuous efforts to address these concerns in order to sustain the program and also make it attractive for other districts to emulate thereby facilitating their implementation of the CHPS program.

6.0 RECOMMENDATIONS

1. In order to solve the problem of manpower requirements that often lead to the CHOs claiming that they are overstretched, and the community members thinking that they are not regular;

- Candidates including males (who can best contain the problem of male involvement in FP practices), should be recruited from the communities and trained as CHOs. This will forestall the problem of CHOs not being used to and therefore willing to stay in the communities.
- Increased staff strength will also enable CHOs to run shifts so that while one is on compound visits, another will be in the CHC to treat patients. It will also enable them to work even on weekends.

2. Although physical access to health care facilities has generally improved financial access remains problematic. Thus, the issue of payment for services needs to be looked at again to solve the irony of the "have not" rather paying for medical services while well endowed areas of the country are enjoying exemptions for medical services.

3. There is the need to improve upon the facilities in the CHCs; improve upon the skills of the CHOs, by organizing regular workshops for them and supply them with the basic tools to work with so that they are not termed "inefficient" by community members.

4. The issue of means of transport for referrals is very critical. This is because the purpose of the program offering health services is defeated if complications cannot be readily referred to the District Hospital in Navrongo.

Since most of the 'Bajaj' tricycles have broken down and their parts are difficult to come by; an alternative means such as the Korean multi-purpose tractor could be made available to the farmers and placed under the care of the community leaders. This machine can apart from transporting the sick, be used for irrigation and tilling the land for farming purposes; thereby generating some incomes for maintenance purposes.

5. The Community Health Officers should be allowed to keep their motorbikes and only send them to the NHRC for routine maintenance. This will eliminate limitations placed on them over the weekends. This is because most of them would have loved to be in the communities and work on weekends also.

6. This referral system can further be boosted if every CHC is fitted with simple wireless systems so that the CHOs can readily call for help when the need arises.

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APPENDIX 1

FOCUS GROUP DISCUSSION GUIDE
EVALUATION OF COMMUNITY'S PERCEPTION OF THE CHFP PROGRAM IN THE KASSENA-NANKANA DISTRICT

The CHFP Project in the Kassena-Nankana District is aimed improving on the health status of the people in the district through enhanced health care delivery and reduction in morbidity and mortality cases. Different strategies were developed and adopted based on initial formative research that was carried out in the district to test the impact of this health development program on fertility and child survival. A core part of the program was the retraining, reorienting, and relocating Community Health Nurses (CHN) in ways that would make community health care a reality.

The aim of this evaluation is to assess how the community perceives the services of the Community Health Officers and design appropriate strategies to improve upon their services.

The evaluation targeted young men and women (15-30 years), middle-aged men and women (31-49 years), elderly men and women (50+). We held in-depth interviews with, two opinion leaders in the communities, while Key Informant Interviews were held with the District Public Health Nurse, and Program Coordinator of the CHFP Program. The evaluation was mainly qualitative and consisted of Focus Group Discussions (FGDs), In-depth Interviews (IDIs) and Key Informant Interviews.

QUESTIONS

For sometime now the NHRC has been working with you in the CHFP Program. We all know the state of our health prior to this project and also have been witnesses to what the program staff especially the CHOs have been doing. We have come here today to have a free and open discussion with you on the community perception of the CHOs services over the past couple of years.

i. What are some of the activities that you remember that the CHOs have carried out in your community?
ii. You have mentioned a number of activities that the CHOs have been undertaking in you communities. What are some of the key messages or information or things that you would like to talk about?

A. SERVICE DELIVERY

1. What do you like about the delivery of services by the CHOs?
    1. How would you describe the availability of the CHO to members of the community?
    2. How often does she make basic health information available to the community when required?
    3. What benefits have you derived from these health informations?

4. What don't you like about their service delivery?
5. What are your general impressions service delivery in terms of referrals?
6. What would you like to be done differently in terms of service delivery?

B. CHILD MORBIDITY AND MORTALITY

1. What has been the situation with regards to infant/child morbidity or mortality before the introduction of the CHO services?

2. What has been the contribution of the CHO services (if any) in your view to the improvement of the health status of the children in your community?

3. If you had the opportunity, which aspect(s) of the CHO services would you like changed or modified with regards to child welfare services?

4. What suggestions would you make in order to improve upon the services?

C. FAMILY PLANNING PROGRAMS

1. What are your opinions about Family Planning?(FP)

2. Has the CHO services changed your thoughts about FP?

3. Do you have any misgivings about the FP services provided by the CHOs?

4. Which aspect(s) of the FP services would you like modified or changed?

5. Would you like to participate in any of such FP programs in future? Give reasons for your answer(s).

6. Have you heard about any issues that have discouraged others from participating in the program?

7. What suggestions would you like to make in order to improve upon the program?

OTHER KEY ISSUES

- General approval of the CHOs
- Improved assess and convenience
- Belief that their health status has improved
- Belief that someone cares about them
- Perception of health because someone cares about me and has therefore visited me!
- Neighbors who do not participate in the program but know about it.
- Would they be interested to participate in it?
- Backlash about invasion of privacy

- Have they heard about things that has discouraged them from participating in the program
- What decisions do we have to make in order to improve upon their lot

APENDIX 2

FOCUS GROUP DISCUSSION (II) & IN-DEPTH INTERVIEW GUIDE FROM CHOs' OWN ASSESSMENT

The objective of this guide is to conduct a study into the experiences gained and the lessons learned from the CHFPP from the perspective of the CHOs. The CHO experience cannot be appreciated without an exploration of the other roles that these women have besides their jobs such as domestic, community, as well as parental obligations.

1. **This Focus Group Discussion** (FGD) with the CHOs is to ascertain their group reactions (areas of common and diverging opinions) on their professional and personal experiences. Areas earmarked for discussion include the following:

a). Actual nature; extent and intensity of the CHO experiences.

- What does the work involve? (Compound visits/ organizing clinics/ travelling/ counseling/ situational talks etc.)
- How much time do they spend proportionally on the various professional and private tasks? (Compound visits/ clinics/ travel/ domestic chores/ time with family/ resting etc.)

b). What are the welfare, work and social concerns of the CHOs?

- Prioritization of their different roles such as (wives/ mothers/ community members/ nurses/ partners etc.)
- What satisfaction and rewards (both economic and social) do they gain from these roles?
- Do they experience any desires for change, deprivation and strains in their encounter with their clients?

c). What lessons would they like policy makers and potential CHOs to learn from their own experiences in order to improve upon their own performance?

3. Participant Observation

This involved involve spending extended periods of time with some of the CHOs to observe and "experience" their daily work schedules and welfare concerns.

APPENDIX 3
KEY INFORMANT/IN-DEPTH INTERVIEW GUIDE

1. How often do the CHOs interact with people in the community?

2. What are the subject areas they dwell on in terms of preventive and curative health services?

3. Do the local people have any way of recognizing that the CHO services has resulted in an improvement in their health status, and how are these expressed?

4. What has been the community's perception about the referral system?

5. What are some of the challenges facing the referral system?

6. What has been the community's response to early warning systems?

7. Do the people realize that the CHO services have largely accounted for a change in their lives such as a decline in infant and child mortality cases; and how do they express these feelings?

8. How has the CHO services contributed to an improvement in immunization coverage and a total reduction of the disease burden in the communities?

9. What evidence is there to demonstrate any change in acceptor rate and user rate with regards to the use of modern contraceptive methods?

10. What are some of the challenges in the acceptance and use of modern contraceptive methods?

11. What are your general impressions the about the CHO services?

12. What modifications (if any) would you like to be made to the CHO services?

THANK YOU FOR YOUR CO-OPERATION!

APPENDIX 4

ORAL INFORMED CONSENT FORM FOR FOCUS GROUPS

A STUDY ON THE COMMUNITY'S PERCEPTIONS OF THE SERVICES OF THE CHOs IN THE CHFP PROJECT IN THE KASSENA-NANKANA DISTRICT

Principal Investigator: Jones M. Blantari

Reason for research

We would like to talk to you about taking part in discussion group(s) conducted by the School of Public Health, University of Ghana, in conjunction with the DHMT of the K-N District and the NHRC to solicit information from you about your perceptions so far about the CHO services in the CHFP project that has been undertaken in your community.

You are being asked to take part in the group discussion comprising about 8-10 women/men, and there will be other groups from the cells in which the CHOs are currently working.

Your participation is voluntary and there is no penalty for refusing to take part. If you do not take part, it will not affect any health care that you would normally receive. Also, you may quit being in the groups at any time of the study.

Possible Risks and Benefits.

There is a small chance that what people talk about in the group will make you feel uncomfortable. There is also the small chance that others in the group may tell someone what you said.

Confidentiality.

The groups will be tape recorded with voices only. Note-takers will write down opinions and what the group thinks during the sessions. We will not record your name or any other personal things about you during the groups. **We ask that participants not reveal outside the group information they may have heard in the group.** We will protect information about you and your taking part in this research to the best of our ability. If the results of this research are published, your name will not be shown.

I have reviewed this fact sheet with the research participants, and they have fully agreed to be in this focus group research. I further agree to keep confidential anything that is said in the discussion group.

.....

.....

(Moderator's name)

(Moderator's signature)

.....

(Date)

APPENDIX 5

ORAL INFORMED CONSENT FORM FOR SURVEYS

A STUDY OF THE COMMUNITY HEALTH OFFICERS' PERCEPTIONS OF THEIR OWN SERVICES IN THE CHFP PROJECT IN THE KASSENA-NANKANA DISTRICT

This interview is for a research study that is being done by the School of Public Health, University of Ghana, in conjunction with the DHMT, Kassena-Nankana District, and the Navrongo Health Research Center to gather information about the perceptions of the CHOs about their own services within the CHFP project.

The research will gather information about the perceptions of the target beneficiaries towards the services of the CHOs.

The interview will include questions on general service delivery, issues related to infant/child morbidity and mortality and family planning. It will take most people about thirty minutes to answer the questions.

The names of the people who agree to be interviewed will not be recorded without their permission.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in the interview or stop the interview at any time.

You may contact the Principal Investigator on the address given below:

JONES M. BLANTARI
C/O DHMT, KASSENA-NANKANA DISTRICT,
NAVRONGO
TEL. NO.0742-22227/22313

Every aspect of the research outlined above has been fully explained to the volunteer in English language.

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(Signature of Person Obtaining Consent) (Date)

APPENDIX 6
TRAINNING SCHEDULES FOR FIELD ASSISTANTS CONDUCTING FGDs IDIs AND KIIs

In conducting interviews and discussions, there are some few things that both the moderator and the note-taker need to take into consideration. These include

1. Ensuring the groups are homogenous ie composed of people who are similar with respect to characteristics related to the topic.
2. The group should be of the same sex and age grouping.
3. Group should be between 8-10 persons.
4. Ensure that you will not select people who will dominate the discussions or inhibit the participation of others.

THE MODERATOR/NOTE-TAKER TEAM

1. All discussions should be taped but do not over rely on the tapes as they can fail.
2. Take good notes and expand them after the interview regardless of whether the discussion has been taped.
3. Enrich the transcript with non-verbal messages that have bearing on the discussion.
4. Code the participants and the note-taker must identify participants with their codes
5. The moderator should encourage participation and guide the discussion.
6. He should seat the participants in a circle and the note-taker should be seated outside the circle to avoid distracting the group.

THE MODERATOR

1. You must welcome the group, introduce yourself and the note-taker.

2. You must explain the purpose of the purpose of the tape recorder(to capture ideas that emerge from the discussion and not to identify the speakers by name.)
3. Assure participants that written reports will not include names and tapes will not be shared outside the research team.
4. Administer informed consent.
5. Ensure that the participants accept the ground rules: ie.
   - speaking one at a time
   - not interrupting each other
   - speak clearly and slowly so that the tape can pick up the words
6. Encourage participants to speak freely and address questions anyway they want.

At the end.....

1. Ask participants to summarize what they have said, adding any additional comments where possible.
2. Clarify issues and give the group the group a sense of work accomplished.

DEBRIEFING

Invite feedback on the discussion experience.

- Did they feel included?
- Were they comfortable with the topics?
- Do they think the questions were fully explored?
- Were there topics or questions which could have been discussed but were not?

- Can they think of how the discussions could have been conducted differently?

COMMON ERRORS IN MODERATING FGDs

1. Allowing 1 or 2 participants to dominate the discussion, or not enabling other participants to speak.
2. Remaining too long on a topic; continuing to repeat questions even after participants have nothing additional to say.
3. Using the same words to repeat a question instead of probing what has just been said or noticing new ideas and asking participants to elaborate.
4. Interrupting people who begin to express a different point of view by repeating the original questions as if the speaker were not addressing it.
5. Accepting comments on what people should do without probing what they actually do and why there is a difference.
6. Not probing the logical conclusions of ideas ("if that, then what"? or simply "why"?)
7. Not probing assumptions to see where they come from ("why do people say that"?)
8. Letting a good question drop off if it is not answered immediately.
9. Asking leading questions that might bias the answers.

APPENDIX 7

QUESTIONNAIRE FOR CHOs ON THEIR PERFORMANCE IN THE CHFP PROJECT

A. SOCIO-DEMOGRAPHIC CHARACTERISTICS

1.Name:.....2.Age..... 3.Sex.....

4.Educational Background -

- Primary [ ]
- Middle/JSS [ ]
- Secondary/SSS [ ]
- Tertiary [ ]
- No School [ ]

5. Marital Status

- Single [ ]
- Married [ ]
- Divorced [ ]
- Separated [ ]
- Widowed [ ]

6. Current Position/Rank .....

B. SERVICE DELIVERY

1. How many times do you make basic health information available to the community in a month?

- 1-3x [ ]
- 4-6x [ ]
- 7-9x [ ]
- > 10x [ ]

2. How would you access the acceptor rate of the community in terms of basic preventive health information?

- Poor [ ]
- Fair [ ]
- Good [ ]
- Very good [ ]
- Excellent [ ]

3. How many clients do you refer to an appropriate health facility on average within the month?

- <5 [ ]
- 5-9 [ ]
- 10-14 [ ]
- 15-19 [ ]
- 20+ [ ]

4. Are you satisfied with the referral systems currently operating? Yes [ ] No [ ]

5.IfYes/No,why?.....
.....
.....

6. What would you have suggested in order to improve upon the service delivery?....
.....
.....
.....

C. INFANT/CHILD MORBIDITY & MORTALITY.

1.What has been the pattern for infant/child morbidity in your coverage area for the past three years?

Decrease/increase [ ]
Decrease/decrease [ ]
No Change [ ]
Increase/decrease [ ]
Increase/increase [ ]

2. What has been the pattern for infant/child mortality in your coverage area for the past three years?

Decrease/increase [ ]
Decrease/decrease [ ]
No Change [ ]
Increase/decrease [ ]
Increase/increase [ ]

3. What has been the trend in post-natal attendance in your area of coverage for the past three years?

Decrease/increase [ ]
Decrease/decrease [ ]
No Change [ ]
Increase/decrease [ ]
Increase/increase [ ]

4. What in you view do you think accounted in the trend as indicated in 1,2 & 3 above?
.....
.....
.....
.....
.....
.....

5. What are some of the most common diseases that you encounter? Tick whichever is applicable in your circumstance.

i. Malaria [ ]
ii. Diarrhoea [ ]

iii. URTI [ ]
iv. Skin Infections [ ]
v. Anaemia [ ]
vi. Abdominal Pains [ ]
vii. Any Other(s) .....
viii. .....

6. What are some of the causes of these diseases? Tick whichever is applicable in your circumstance.
   i. Poor environment/sanitation [ ]
   ii. Poor source of drinking water [ ]
   iii. Poor Diet [ ]
   iv. Frequent Mosquito bites [ ]
   v. Any other(s) specify .....
   .....
   .....

D. FAMILY PLANNING PROGRAMS

1.How many Family Planning methods are available to the women in your area of coverage? Tick whichever is applicable.

i. The Pill [ ]
ii. Norplant [ ]
iii. Injectable (Depo Provera) [ ]
iv. Female Condom [ ]
v. Foaming Tablets [ ]
vi. IUD [ ]

7. How many people use a particular Family Planning (FP) method per cluster on the average in a month? Indicate A, B, C etc.

(A. 1-5 B. 6-10 C. 11-15 D. 16-20 E. >20)

i. The Pill [ ]
ii. Norplant [ ]
iii. Injectable [ ]
iv. female Condom [ ]
v. Foaming Tablet [ ]
vi. IUD [ ]

8. What are the preferred FP method(s) among the women in your area of coverage? (Rank them eg 1 for most preferred etc)

i. The Pill [ ]
ii. Norplant [ ]

iii. Injectable [ ]
iv. Female Condom [ ]
v. Foaming Tablets [ ]
vi. IUD [ ]

9. What are the common complaints associated with contraceptive morbidity in your area of coverage?(tick whichever is applicable)
   i. Contraceptive Amenorrhoea [ ]
   ii. Spotting [ ]
   iii. Heavy bleeding [ ]
   iv. Nausea [ ]
   v. Other(s) Specify.....
   .....
   .....
   .....

10. What accounts for the difference between contraceptive acceptor rate and the user rate in your area of coverage? (tick whichever is applicable)
   i. Traditional Beliefs [ ]
   ii. Lack of interest [ ]
   iii. Lack of money [ ]
   iv. Pressure from Husbands [ ]
   v. Lactating mothers [ ]
   vi. Other(s) .....
   .....
   .....

E. GENERAL

1. Can you indicate the number of times that you undertake the following activities in a week? (a=<5x, b=5-9x, c=>10x) Compound visits [ ]
   Organizing clinics [ ]
   Travelling [ ]
   Consultations [ ]
   Counseling [ ]
   Situational talks [ ]

2.What are some of your work and social concerns? (Tick which ever is applicable. Indicate **Y for YES and N for NO**)
- Need to involve men in FP activities [ ]
- Fear of women to practice FP methods [ ]
- Community demanding more from you [ ]
- Lack of money to patronize products and services [ ]
- Non-compliance and misconceptions [ ]
- Overwork leading to exhaustion [ ]

- Lack of basic facilities in areas of operation [ ]
- Lack of improved conditions of service [ ]
- Personal safety and marital security [ ]