

**IS HOME VISITING AN EFFECTIVE STRATEGY
FOR IMPROVING FAMILY HEALTH: A CASE
STUDY IN THE SEKYERE WEST DISTRICT**

BY

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DECLARATION

I declare that this dissertation has been the result of my own field research, except where specific references have been made; and that it has not been submitted towards any degree nor is it being submitted concurrently in candidature for any other degree.

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DEDICATION

This work is dedicated to my dear husband, Mr Samuel Osae Ayensu and our children,
Kate and Vida.

ACKNOWLEDGEMENT

I am most grateful to my academic supervisors, Professor Ofosu-Amaah and Dr. (Mrs) Matilda Pappoe for the direction, support and assistance given me towards this study.

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To the District Director of Health Services, Dr. Jonathan Adda, the District Health Management Team and all the health workers in the Sekyere West District of the Ashanti Region, I say thank you for making it possible for me to undertake the study in the district. My special thanks also go to Mr. Peter Solaga and Mr Stephen Ayinabom for assisting me with the data collection.

I am also grateful to all those who helped in diverse ways to get this work produced. May God Bless you all.

LIST OF ABBREVIATIONS

DHA	District Health Administration
DHMT	District Health Management Team
GAMA	Greater Accra Metropolitan Area
HI	Health Inspector
JSS	Junior Secondary School
KVIP	Kumasi Ventilated Improved Pit
NMC	Nurses and Midwives Council
OPD	Out Patients' Department
P/CHN	Public/Community Health Nurse
CHN	Community Health Nurse
RTI	Respiratory Tract Infection
SSS	Senior Secondary School
UNICEF	United Nations International Children Emergency Fund
UKCC	United Kingdom Central Council for Nurses
WHO	World Health Organization

ABSTRACT

This was a descriptive study carried out in the Sekyere West District of the Ashanti Region of Ghana. The purpose of the study was to review the practice of home visiting in the district.

A hundred households selected from five of the six sub-districts were interviewed. Further, five FGD sessions each comprising six to eight community leaders were also carried out in the study communities. All the sixteen Public/Community Nurses working in the district were interviewed. In addition, participatory observation of home visiting sessions, by Public/Community Health Nurses were carried out, in each of the five study communities. Data were collected by means of a structured questionnaire, interview guide and checklist.

Study findings indicate that although nurses had knowledge of home visiting and had positive opinion of the practice, they could not perform their home visiting tasks/functions up to standard; i.e.57% rate of non-performance; 11% of them performed poorly and only 32% performed up to the standard expected of them. Home visiting practice in the district among nurses, was found to be very low (i.e.7%).

Chi square tests indicate no significant relationship between home visiting by nurses and reduction in child morbidity, sanitation and hygiene practices of households, which might be accounted for by the poor quality of home visiting.

On the other hand, community members desire home visiting and the findings indicate that there is a need for home visiting. In houses visited, 82% had children 0-5years, 33% nursing mothers, 26% aged and 18% pregnant mothers. Also identified were several health hazards, such as uncovered refuse containers, open fires, misplaced sharp objects,

open defaecation and other unhygienic practices, which a proper home visiting regime can address.

A gap, thus exists between what is expected and what is pertains, and efforts such as orientation of nurses, support and good supervision, should help bridge this gap.

TABLE OF CONTENTS

	PAGE
Declaration.....	i
Dedication.....	ii
Acknowledgements	iii
List of Abbreviations.....	iv
List of Tables and Figures.....	vi
Abstract.....	vii

CHAPTER ONE

INTRODUCTION

1.1 Background.....	2
1.2 Rationale of the Study	3
1.3 Problem Statement.....	4
1.4 Study Setting.....	5

CHAPTER TWO

LITERATURE REVIEW AND STUDY OBJECTIVES

2.1 Literature Review	10
------------------------------------	-----------

2.2 Purpose and Objectives	15
2.2.1 Purpose Of the Study.....	15
2.2.2 Specific Objectives.....	15

CHAPTER THREE

METHODS AND PROCEDURES

3.1 Method and Study Design.....	16
3.2 Data Collection Methods and Instruments	19
3.3 Other Procedural Issues.....	19
3.4 Data Analysis	22
3.5 Ethical Considerations	22
3.6 Pre-testing of Survey Instrument.....	22
3.7 Validity and Reliability.....	23
3.8 Limitations of the Study	23

CHAPTER FOUR

RESULTS OF THE STUDY

4.1 Household Survey Results.....	24
4.2 Community Focus Group Discussion Results.....	31
4.3 Assessment of Nurses.....	33
4.4 Participatory Observation.....	36

4.5 Review of Guidelines for Home Visiting.....37

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion.....38

5.2 Conclusion.....42

5.3 Recommendations.....42

REFERENCES.....44

APPENDICES

1 Chi Square Test Showing the Relationships of Home Visiting and Sanitation and Hygiene Practices

2. Chi Square Test Showing the Relationships of Home Visiting and Childhood Morbidity

3. Sample Interview Schedule for Nurses

4. Sample Focus Group Discussion Guide for Community Leaders

5. Sample Household Questionnaire

6. Sample Check-List for Observation

LIST OF TABLES AND FIGURES

Table 1 Ten top diseases reported at the OPD for 1998.

Table 2 Distribution of P /CHNs Interviewed Per Sub-District

Table 3 Number of Households Interviewed in Each Sub-District

Table 4 Activities that can be carried out During Home Visiting at the Three Levels of Prevention.

Table 5 Distribution of Respondents by Age, Educational Status and Occupation

Table 6 Distribution of Respondents by Educational Status

Table 7 Distribution of Respondents by Occupation

Table 8 Sanitation and Hygiene Practices of Visited and Not Visited Communities

Table 9 Diseases of Under 5 Year Olds Within 6 Months Prior to Study in two Communities.

Table 10 What Respondents Know About Home Visiting

Figure1 Cleanliness of the Home

Figure 2 Performance of Nurses, During Home Visiting Sessions

CHAPTER ONE

INTRODUCTION

1.1 Background

Improving the health of the family, in most areas of the developing world, needs multiple strategies. One of the options adopted in Ghana is home visiting. Home Visiting is an essential component of Community Health Nursing, since family nursing activities often occur in the context of a home visit. These activities include family needs assessment and health education. Home visiting enables the nurse to obtain accurate information on the family structure and behaviour. Observations are made in the home environment that help to identify both barriers and support for the achievement of family health promotion goals (McMurray, 1998). Furthermore, family members are more comfortable and relaxed in their own homes, thus making them more receptive to suggestions about their health needs.

Looking at Maslow's hierarchy of needs, human beings have physiological, safety, belongingness, esteem and actualising needs. Examples of the physiological needs are pure air, potable water, nutritious food, good waste disposal system and healthy sexual life. Safety needs include, good housing, good job, and an environment free of hazards, with the other three levels of needs dealing with good social relationships and psychological satisfaction. (Higgs & Gustafson, 1985). In Ghana, about 24%, of the population do not have good drinking water; 45% of households live in mud houses; (38%) of households use ordinary pit latrine and (7%), bucket latrine. Twenty-seven percent of rural households have no access to toilet facility and resort to open defecation (DHS 1998; Ghana Living Standards 2000). Peoples' inability to meet these basic needs, leads to an unhealthy state. Human beings, in their daily life, strive to satisfy these needs

but often through inappropriate means. Such attempts lead to the development of diseases, disabilities and death, particularly in the developing countries, such as Ghana.

Such a situation, therefore, demands that trained persons visit people in their home environments, to assist them meet their needs, satisfactorily and in relative safety.

Home visiting by nurses should be stepped up, to add to the efforts of other health team members, for as stated by Rotem and Nathan (2000), 'the role and responsibilities of team members can complement and support that of the other.' Such efforts would enable the health service to achieve its ultimate goal, i.e. the prevention of diseases and disabilities and the promotion and maintenance of health.

1.2 Rationale For The Study

Although home visiting is a measure taken towards the prevention of diseases, promotion and maintenance of health, reports of the district do not show that the nursing practice takes this principle into consideration.

As preventive Nurses, the P/CHNs are given the necessary skills to enable them practice home visiting as part of their job description but there is no indication that these skills are applied by the nurses in the district.

Nurses in the Sekyere West district do not present reports on home visiting, to the District Health Management Team. Furthermore, only two, (2) of the six, (6) sub-districts have home visiting on their itineraries. Also no specific studies on the topic have been carried out in the district.

On the basis of the concern generated by the above statements, the study was conceived to assess the extent to which home visit was being practised and how well it was being carried out.

1.3 Problem Statement

It has been noted, in the 1998 to 2000 reports of the Sekyere West District Health Services, that most or all of the ten top conditions reported at the OPD are behavioural in nature and as such preventable. The prevalence and incidence of these conditions generated concern at the District Health Management Team meetings. Several strategies were put in place, to improve the health of the people, such as improvement in the immunization coverage, improvement in the quality of care in the health institutions and availability of drugs and health education. Since clients came to the health institutions from their various homes, it becomes necessary for health personnel to visit homes, to assess and identify the situations in the homes that give rise to the conditions with which they come to the health institutions. This latter function is carried out in the context of home visits.

The Public / Community Health Nurses acquired knowledge and skills of home visit, as an integrated part of their training and were expected, as a duty, to put such knowledge and skills into practice, after training. However, only two of the sub-districts had home visits on their itineraries and in neither of these are reports submitted on the activity to the DHMT.

As of now, the assumption is that if home visit is done at all, the impact is not being felt, and this poses the following questions:

- 1) Do Nurses have adequate knowledge on the concept of home visiting?
- 2) Do nurses practice home visiting?

3) To what extent do Nurses practice home visiting?

1.4 Study Setting

Sekyere West is one of the eighteen districts in the Ashanti Region of Ghana, with Mampong as its capital.

The population of the district is 137,603 with a growth rate of 3.1% (2000 Census). The breakdown of the population is as follows:

Age Group	Percentage	Frequency
0-11 months	4	5504
12-23 months	4	5504
24-59 months	12	16512
5-14 years	27	37153
15-49 years (women)	20	27521
15-49 years (men)	20	27521
50-60 years	8	11008
60 ⁺	5	6880

Forty-nine percent (49%) of the population are males and 51%, female

The district covers an area of 2346.02 square kilometres, and is bordered on the North West by Ejura - Sekyedumasi district, North East by Brong Ahafo region and South by Afigya Sekyere district. It lies on latitude 7° 5' N, longitude 2° 35' N, and at an altitude of 178.8m.

Ashantis constitute the major ethnic group, followed by Fantis and other ethnic groups like the Gas, and others of the Northern tribes.

Economic activities in the Sekyere West District include farming, trading, trades such as carpentry, hairdressing and tailoring; industries such as saw-milling, tobacco, bast fibre and kente weaving, as well as sedentary work such as banking, teaching and nursing. Food crops produced include plantain, cocoyam, cassava, beans, pepper, tomatoes, groundnuts, onions and maize. There are ten (10) markets in the district.

The Administrative Set-up of the District

Mampong is the administrative seat for both the traditional and political authorities.

Mampong is a paramountcy and the current chief is Nana Osei Bonsu II.

The political administration is headed by the District Chief Executive, who oversees the activities of the 18 government decentralised departments throughout the district.

The Health Care Delivery System

The health administration is headed by the District Director of Health Services. The health care delivery system operates under the Ghana Health Service and comprises both curative and preventive services. It has three budget management centres, i.e. The District Health Administration, the Hospital and the Midwifery Training School.

Sekyere West district has one hospital, six (6) health centres, four (4) NGO clinics, six (6) private clinics, five (5) family health units, three (3) maternity homes, ninety-one (91) outreach centres and one midwifery training school.

There are nine (9) doctors, sixty-six (66) general nurses and midwives, sixteen (16) public/ community health nurses, four (4) medical assistants, one hundred and thirty-four (134) paramedical staff and thirteen (13) ward assistants, to carry out the health delivery services, in the district. Tables a, b and c present the ten (10) top diseases reported at the OPD, for the years 1998, 1999 and 2000.

Table 1a. Ten Top Diseases Reported At The Out Patient Department For 1998

Condition	Frequency	Percentage
1.Malaria	18861	59.2
2.Acute Respiratory Infections	3798	11.9
3.Gynaecological Disorders	2190	6.9
4.Diarrhoeal Diseases	2152	6.8
5.Accidents	1667	5.2
6.Anaemia	821	2.6
7.Skin Disorders	784	2.5
8.Hypertension	564	1.8
9.Acute Eye Infections	492	1.6
10.Diabetes	485	1.5
Total	31814	100

Table 1b. Ten Top Diseases Reported AT The Out Patient Department For 1999

Condition	Frequency	Percentage
1.Malaria	20179	64
2.Acute Respiratory Infections	3679	11.7
3.Diarrhoeal Diseases	2036	6.5
4.Accidents	1872	6
5.Anaemia	923	3
6.Hypertension	674	2.1
7.Skin Disorders	673	2.1
8.Diabetes	506	1.6
9.Heart Conditions/CVA	463	1.5
10.Gynaecological Disorders	457	1.5
Total	31462	100

Table 1c. Ten Top Diseases Reported At The Out Patient Department For 2000

Condition	Frequency	Percentage
1.Malaria	19872	67
2.Accidents	2062	7
3.Diarrhoeal Diseases	2061	7
4.Acute Respiratory Infections	2058	7
5.Diabetes	718	2.4
6.Hypertension	674	2.3
7.Anaemia	671	2.3
8.Heart Condition/CVA	518	1.7
9.Skin Disorders	509	1.7
10.Gynaecological Disorders	461	1.6
Total	29604	100

CHAPTER TWO

LITERATURE REVIEW AND STUDY OBJECTIVES

2.1 Literature Review

The health of the people is of a major concern to any government, and steps are being taken, constantly, to strengthen health care systems, throughout the world. It is in view of this that Prime Minister Tony Blair launched the campaign 'On Making a Difference-Strengthening the nursing, midwifery and health visiting contribution to health and healthcare' (Department of Health, 2000). The strategy is aimed at developing and strengthening the nursing, midwifery and health visiting contribution, in the United Kingdom, to enable these services continue to make a difference, in the health of the people. As has been emphasized by Pickess (2001), the aim of community nursing practice, is to develop a pro-active approach to health care, which leads to the promotion of health at the individual, group and community levels taking into account policies which influence health care provision.

Home Visiting As An Extension Of Institutional Nursing

As the slogan of the visiting nurse service of New York goes "we bring the caring home", home visits actually send nursing to the home. Family nursing activities occur in the context of home visit (McMurray, 1998). In the home, information on family structure and behaviour may be more accurate, and barriers and support for achieving family health promotion are also identified. As Freeman and Heinrich (1981) stated, family visits might provide an opportunity to estimate the general level of family coping, and provide support to individuals who have problems with illness or family relationships. In addition, family members often feel a greater sense of control and may be more receptive to the idea of active participation in meeting their health needs (Carter & McGoldrick, 1980). Smith

(1992), has demonstrated that health education given during home visiting is more effective, resulting in change more often than other sources such as the mass media. Feldman, (1999), in a study on Outcome Initiative of the Visiting Nurse Service of New York, identified areas of services delivered in the home to include, follow-up care after hospitalisation, care to women before and after delivery, support, education and guidance to the growing family, care of the chronically ill and care of the elderly. Service delivery in the home is based on needs assessment, which involves recognition of needs and linking the assessment into the on-going process of service planning (Bergen et al, 1990).

Environment and Health

The residential environment does not only provide shelter and protection for the members of the family, but it is a major factor in the physiology and emotional health of the residents (Moliner et al., 1961). The relationship between some of the basic amenities in the home, hygienic practices and health cannot be overlooked. Benneh et al., (1993) found an association between the prevalence of diarrhoea among children under six (6) years of age and the types of water storage facilities, disposal of human waste, eating habits and hygiene practices.

Even though water is essential for promoting health, its storage may pose some health hazards. In a study conducted in the Greater Accra Metropolitan Area (GAMA), almost all (90%) of the households had some form of water storage containers in their homes. Water quality test of water in these containers showed that 87% had high counts of faecal coliform. Indoor-storage of water was also associated with more mosquito bites. However, only 17% of households storing water had open containers. (Benneh et al., 1993).

Hand washing after defecation before eating and before preparing food constitute an important method of interrupting the transmission of many diseases such as diarrhoea, scabies and trachoma. (Ghana and UNICEF (1990); World Bank, 1994; Cairncross et al., 1997). In the study by Benneh et al., (1993), about 91% of the principal home makers said they always washed their hands after using the toilet while 74% said they did so before preparing food.

Excreta related infections such as poliomyelitis, enteric fever and ascariasis could be controlled, by improvement in excreta disposal. In the GAMA study, 105 of the respondents admitted that children defaecate openly. Poor refuse disposal encourages the breeding of flies, and may thus promote the transmission of faecal-oral infections (Cairncross et al., 1997).

Injuries in the home are the most common sources of trauma in the population and occur among all ages (Lindquist, 1989) In the State of Michigan, home-accidents killed more children than all other communicable diseases combined (Moliner et al.,1961).

Home Visiting And Child Morbidity And Mortality:

Home visiting offers nurses an opportunity to recognise sick children for early management and recovery since according to the Child Health Division of WHO (1997), parents often fail to recognise when their children are seriously ill and do not seek urgent medical treatment. Dialla et al., (2001), stated in the conclusion of their study that improvement in home care will greatly reduce morbidity and mortality in young children. A Child Welfare Movement led by Dr Josephine Baker in New York, clearly demonstrated that infant death could be greatly reduced, through home visits (Stanhope, 1994).

Home Visiting And Disease Prevention / Health Promotion:

Several people suffer from preventable and behaviour induced diseases, of which a good number lose their lives. According to WHO (1979), 70% of childhood deaths are caused by five conditions all of which are preventable or treatable. In the Sekyere West District of Ghana, all the ten top diseases reported at the Out Patients Department are preventable (MOH Report 2000). Reasons for diarrhoeal diseases as stated in the Mampong Sub-District report (2000), of the Sekyere West District, included poor environmental sanitation; the use of feeding bottles for children; drinking of water from unreliable sources; consumption of partly heated leftover food and the practice of sitting children on the ground. Since most of the behaviours and factors that give rise to these conditions occur in the home, health visiting should be improved in order to attain optimum health.

The description of a study conducted by Baker and Anderson in 1988, in his book entitled "An Introduction to Health", Smith (1992), supports the importance of home visits. In the study, immunization rates rose to ninety percent (90%), as compared to fifty percent (50%), in a comparable area where health visitors spent an hour a month with parents in the study group. Lee (1975), reported a ten percent (10%) increase in family planning acceptance rate as a result of home visit conducted by family planning field workers, in Korea. The above – cited literature supports the need for regular visits to clients' homes to assist them meet their health needs, thus ensuring prevention of diseases and disabilities, and promotion and maintenance of health.

Training For Effective Home Visiting:

The task of home visiting, falls within the domain of Public / Community Health Nurses and Health Inspectors. Community workers therefore, require specific knowledge,

attitudes, skills which ought to be acquired during courses preparing them for qualification (Bergen et al., 1990). Davies et al., (1993), in a study to identify the changing needs of Community Nurses, Midwives and Health Visitors suggested that Nurse Educators in preparing students for placement, should assist them achieve a balance between education and service needs, by improving links between education and practice. Morris, B. (2001), made suggestions for assessing practice in nursing and midwifery towards quality service provision. According to her, there is the need to assess the environment in which the nurses work; opportunity to support nurses in relation to assessment should be examined; complexities in nurses' work that compete with activities such as mentorship and practice should be audited, and lastly, there should be development and sustenance of good assessment within the busy and complex environment of nurses.

In a publication of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (March 2000), it has been stated in an article entitled 'Protecting the Public Through Professional Standards', that the full contribution of the health visitor might not find expression where it is needed. Often, there is a concentration of the role of the health visitor in relation to those under five age group, at the expense of other groups in the community who need her care. There may also be home visit practice that falls short of the standards of the district, as shown in a study conducted by Antwi (1998, Unpublished), in Assin Fosu. Freeman, and Heinrich (1981), have suggested the need for more frequent nurse family visits, to provide for intensive monitoring of mother's condition and to assure concentrated and inclusive teaching, support and referral. Where a gap occurs between what is expected and what actually happens, this adversely affects perceived qualities of a service (Parasuraman et al. 1985). It is in view of the afore-

mentioned, that the Nurses' and Midwives Council in 1995, came out with a standard procedure manual for Nurses in Ghana, to help bridge such gaps.

Literature on home visiting as an essential component of public health nursing practice is scarce but what is available, seem to make a strong case for home visiting. Moreover, being a district in a developing country like Ghana, with poor environmental conditions and preventable diseases, it is obvious that households in the Sekyere West District can benefit from home visits by health personnel.

2.2 Purpose and Objectives

2.2.1 Purpose of the Study

The study was aimed at reviewing the home visit programme for family health nurses in the Sekyere West district.

2.2.2 Specific Objectives

In specific terms, the study aimed at the following:

- 1) Assess what Public / Community Health Nurses in the Sekyere West District, know, feel and do with regards to home visiting.
- 2) Document communities' perception about the practice of home visiting.
- 3) Identify factors influencing the practice of home visiting, by health workers.
- 4) Assess the relationship, if any, between home visiting and household's level of hygiene and environmental sanitation, and the prevalence of specific childhood diseases.

CHAPTER THREE

METHODS AND PROCEDURES

3.1 Methods and Study Design

Type of Study

The study was descriptive in nature, using a blend of qualitative and quantitative methods for the data collection.

Sample Size and Sampling Procedures

The sample size for the household survey was calculated using the following formula;

$$S = Z^2 (P (1- P) / D^2$$

Where $Z = 1.96$

$D = 2.5 \%$

$P = 3 \%$ = Home visit prevalence

Non-response = 10 %

$$= (1.96)^2 [0.03 (1 - 0.03)] / (0.025)^2$$

$$= 3.8416 (0.03) (0.97) / 0.000625$$

$$= 3.8416 \times 3 \times 0.97 \times 10^{-4} / 6.25 \times 10^{-4}$$

$$= 3 \times 3.8416 \times 97 / 6.25$$

$$= 17.9 \times 110 / 100$$

$$= 197 \text{ households}$$

The calculation gave 197 households, as the sample size, and this was approximated to 200. However, for logistical reasons, i. e. inadequate time and money, the sample size was reduced by 50%, to 100 households.

For the health worker study, all the 16 nurses at the Family Health Unit in the district were interviewed. Five out of these were observed, during home visit sessions.

Table 2: Distribution of Public/Community Health Nurses Interviewed Per Sub-

District

Name of SUB-district	No. of Nurses
Mampong	9
Nsuta	3
Kwamang	2
Birem	1
Asubuasu	1
Total	16

2.To obtain the specific households for the study, a multistage sampling method was used.

First Stage:

Five (5) Communities, within each of the five (5) sub-districts were selected from an estimated number of y communities, where y is the total number of communities in the five (5) sub-districts. The five (5) communities were selected from five sub-districts through the lottery method. The Oku sub-district was excluded from the study because the only Nurse had gone on transfer. Furthermore, the area was inaccessible during the rainy season. Mampong was purposively selected because of it being the only urban community. Zongo East was sampled from communities in Mampong, also through the lottery method.

Second Stage:

The quota sampling method was used to select the number of households in each community. With the sample size of hundred (100) in mind, proportionate representation was made. A list of households that fell within the selected communities was obtained

from the District Health Administration. In all, there were 350 households in Zongo East, 102 in Mpentuase, 157 in Aframso Number 3, 201 in Kyeiase and 172 in Asubuasu.

The following steps were followed to arrive at the final quotas:

The number of households in the five communities were summed up, to obtain 982 households, which was further divided by the number of households in each community.

The result was then taken as the proportionate representation.

Table 3 Number of Households Interviewed in Each Sub-District

Name of Sub- District	Name Of Community	No. Of Households
Mampong	Zongo	36
Nsuta	Mpentuase	10
Birem	Kyeiase	20
Asubuasu	Asubuasu	18
Kwamang	Aframso Number 3	16
Total		100

The skip interval method was used to ensure that households had equal chances for selection. The number of households in each community was divided by the final number of households to be studied. All the communities had 9 and every 9th household was interviewed using the distance from the index house.

One adult female aged between 15-45 years in each sampled household was purposively selected as a respondent, since women spend longer periods at home especially, due to pregnancy and delivery and are more likely to meet and know health workers who visit the homes.

A group of between 6-8 community leaders were also purposively selected in each community for Focus Group Discussions.

3.2 Data Collection Methods and Instruments

Instruments for data collection, included the following:

1. A checklist with a numerical rating scale, used to assess the competencies during observation of P/CHNs' home visit sessions based on the guidelines of the NMC and the curriculum of CHNs (Sample as Appendix 6)
2. Focus group discussions with leading community members in five sub-districts were carried out, using an interview guide (Sample as Appendix 4)
3. Structured questionnaires were used to interview selected members of sampled households, (Sample as Appendix 5) and another structured questionnaire administered to P/CHNs (Sample as appendix 3).

Two research assistants were trained for the study.

3.3 Other Procedural Issues

Definition of Terms:

For the purpose of the study, relevant terms and concepts have been defined, as follows:

- a. Home:** An enclosed physical and social environment, which may be shared by a household or a number of households.
- b. Home Visit:** A visit to a patient / client by a nurse in his / her own home environment, to identify his / her needs and problems, so as to help him / her find solutions to them.
- c. Infant Morbidity:** Sickesses among those aged under one year.
- d. Infant Mortality:** Deaths among those age under one year.

- e. Home Nursing:** Rendering nursing care to a sick incapacitated individual in his / her home.
- f. Needs:** The assessed problem or aspiration requiring intervention or fulfilment.
- g. Immunization Coverage:** A percentage of a population that has been protected against a disease through vaccination.
- h. Family Planning Acceptors:** The number of people who are practising family planning using modern contraceptive methods.
- i. Standard Care:** Nursing activities related to home visit according to the standard of the Nurses' and Midwives Council of Ghana.
- j. What Nurses Feel:** Opinion of nurses on home visit, whether bad, good or beneficial.
- k. Household:** A group of people living under the same roof.

Data Analysis Plan

Data Analysis was guided by the following assumption:

That where there was effective and regular home visits, occurrence of childhood ailments would be minimised and even when they occurred, complications would be reduced.

Hypothesis:

1. Homes visited within the six months prior to the study are likely to experience fewer childhood illnesses.

Key Variables for the Analysis Plan Using Diarrhoea as a reference condition:

At the primary prevention Level:

- a) Dependent Variable – Diarrhoea in Children
- b) Independent Variable – Home Visiting (Education on personal and environmental hygiene)

At the Secondary Prevention Level

- a) Dependent Variable – Dehydration resulting from diarrhoea
- b) Independent Variable – Home Visiting (Oral rehydration, referral, home nursing)

At the Tertiary Prevention Level

- a) Dependent Variable – Rehabilitation
- c) Independent Variable – Home Visit (Good nutrition, education on personal and environmental hygiene)

The variables were analysed using the three levels of prevention, i.e. Primary, secondary and tertiary. The assumption was that if home visiting fails the family at the primary level, it would enhance home nursing and referral at the secondary level, i.e. home visits as presented in Table 4. Home visiting has an important role to play, at the tertiary prevention level, towards proper rehabilitation and adjustment of the family (Refer Table 4).

Table 4. Activities that can be Carried out During Home Visiting at the Three Levels of Prevention

Primary Prevention	Secondary Prevention	Tertiary Prevention
Education on personal and environmental hygiene.	First aid management and referral. Home nursing.	Supervision of care. Counselling of family on personal / environmental

		hygiene and good nutrition.
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3.4 Data Analysis:

1. A completed checklist for field observation was analysed manually, to provide an assessment of home visit practice, vis-à-vis set guidelines.
2. Recorded FGD data were transcribed and common themes and options identified and interpreted.
3. The survey data from households and health workers were coded and entered onto a computer and EPI INFO version 6 used for data analysis.

3.5 Ethical Considerations

Respect for the dignity, integrity and privacy of individuals involved in the study were ensured. Permission was sought from study communities and respondents before the study, and procedures explained to them.

3.6 Pre-testing of Survey Instrument.

Pre-testing was done during the questionnaire finalization stage. The first draft of questionnaires for the households, were pre-tested on five households, which were selected purposively at Kofiase. One member of each household was interviewed. The responses showed that the questions were understood.

3.7 Validity and Reliability

To establish validity and reliability of the tools, used for the data collection, the draft data collection tools were shown to other health professionals with insight in research methods who made the necessary corrections, before they were used in the field.

3.8 Limitations of the Study

- It was not possible to interview other health workers who also carry out occasional visits to their clients in the homes.
- The researcher could not interview two hundred respondents as was indicated by the sample size calculation, due to limited time and financial resources.
- Oku Sub-District could not be studied due to inaccessibility of the place during the period of the year.
- There was no home visit guideline prepared for use by the DHMT and as such, no review was done.

CHAPTER FOUR

RESULTS OF THE STUDY

The results of the study are presented under five (5) sub-headings:

Household Survey Results, Community FDG Results, Assessment of Nurses and Findings of Participatory Observation and review of Guidelines for Home Visiting.

4.1 Household Survey Results

Socio-Economic and Demographic Characteristics of Respondents

Information on socio-economic and demographic characteristics was obtained as part of the interview of household members. A total of hundred (100) household members were interviewed. Ninety-four percent (94%) of the respondents were women within the childbearing age, and six (6%) were women above the childbearing age.

The majority, (90%) of respondents were between ages 20 and 44, with 50% being farmers. Forty percent (40%) of the respondents have had no formal education, but as many as 59% have had primary to JSS education (refer Table5)

Table 5: Distribution of Respondents by Age

Characteristics	Frequency	Percentage
Age Group (yrs)		
15-24	23	23
25-34	43	43
35-44	28	28
45+	6	6
Total	100	100

Table 6: Distribution of Respondents by Educational Status

Characteristics	Frequency	Percentage
Educational Status		
Illiterates	40	40
Primary / JSS	59	59
Secondary / SSS /		
Technical / Vocational	1	1
Post Secondary	0	0
Total	100	100

Table 7: Distribution of Respondents by Occupation

Characteristics	Frequency	Percentage
Occupation		
Farming	50	50
Trading	23	23
Artisans	9	9
Unemployed	15	15
Apprentice	3	3
Total	100	100

Communities' Perception about the Practice of Home Visiting

Home Visiting Practice by Nurses

To obtain information on home visit practices by nurses, household members were interviewed.

The interviews showed that 85 (85%) households had never been visited by a health personnel. Fifteen (15%) however had been visited by a health personnel.

With regards to the activities performed by nurses during home visits, responses from household members indicated the following:

- Advice on environmental cleanliness (29%),
- Case finding (57%), and
- Referral (14%).

In the case of convenience of the time of visit, 14 (93%) of the members of households said the time of visits by both P/CHNs and HI was convenient while 2 (12.5%) said the time was not convenient.

Community perception about home visiting, was assessed as part of the household study, and in 14 (93%) out of the 15 households visited, members interviewed assessed home visits as beneficial.

Level of Home Visiting and Households' Level of Hygiene and Sanitation and Prevalence of Childhood Diseases

An attempt was made to relate the level of hygiene and sanitation and prevalence of childhood diseases, in the sampled households. This was to enable the researcher explore any relationships between home visiting and the households' level of hygiene and sanitation, and episodes of childhood illness.

Table 8: Sanitation and Hygiene Practices of Visited and Not Visited Communities

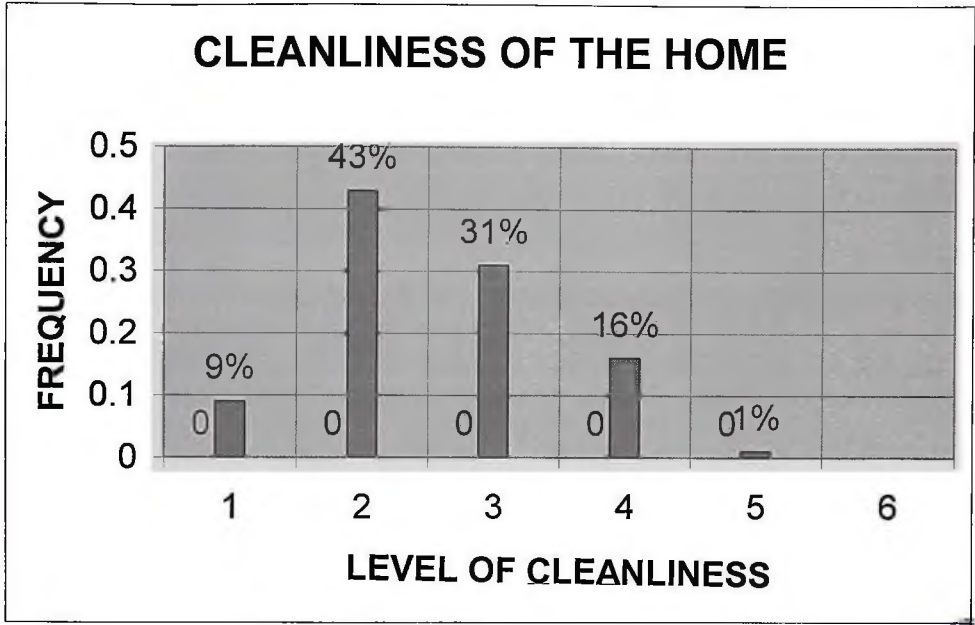
PRACTICE	Homes Visited		Homes Not Visited		Total	
	Yes	No	Yes	No	Yes	No
1. Washing of Hands After Defecation (Children)	10	8	10	10	20	18
2. Open Defecation (Adults)	4	14	6	14	10	28
3. Open Defecation (Children)	5	13	9	11	14	24
4. Coverage of Water Storage Containers	8	10	4	16	12	26

Hygienic Practices

For cleanliness of the environment, 43 (43%) of the homes visited were rated as clean; 9 (9%) as very clean; 31 (31%) as somewhat clean; 16 (16%) as dirty and 1 (1%) as very dirty. Sixty-three of households with children (64%) said their children wash their hands after visiting the toilet with only water. However, only 18 of the 80 (80%) respondents owned up that adults wash their hands after visiting the toilet, using soap.

Study findings do not show any significant relationship between home visiting and children washing their hands after defecation ($X^2 = 0.117$, $df = 1$ $P = 0.732$). (Refer appendix 1 for the calculation).

Figure 1



Key

- 1. Very Clean
- 2. Clean
- 3. Some What Clean
- 4. Dirty
- 5. Very Dirty

Water Storage Practice

Forty percent of the respondents obtained their water from boreholes; another 36% from pipe borne sources; 13% from streams/river and 3% from ponds. The majority of the respondents (99%), had water storage facilities in their homes. A good number of these containers (61%) were covered, with the rest (39%), not covered. Only 6% of the stored water had mosquito larvae in them. There is however no significant relationship between home visiting and covering of water storage containers in the homes ($X^2 = 2.62$, $df = 1$ $P = 0.106$: Refer to appendix 1 for calculation).

Toilet Facilities

Thirty-five percent (35%) of the respondents used public pit latrines; 20% used the bucket type latrine; another 20%, open defecation; 8% used private pit latrine, 7% each, private KVIP and public KVIP respectively and 3% public septic tank toilets.

Sixty three percent of the households used chamber pots for their children while 23% allowed their children to practice open defecation. Eighty one percent of the pots were clean; 49% were overturned, and 51% uncovered. Detailed analysis showed no significant relationship between home visiting and the practice of open defecation; (adults, $X^2 = 0.296$, $df = 1$ $P = 0.106$; children, $X^2 = 1.208$, $df = 1$ $P = 0.272$: Refer Appendix 1 for the calculation).

Dry Refuse / Garbage Disposal

Ninety percent of the households (90%) had refuse containers, which were emptied once daily, in the mornings, and (10%) throw their rubbish at the back of their homes. In most of the homes (89%), the refuse containers were not covered.

4.3 Accident Hazards in the Home

Several accident hazards were identified, with open fires forming the majority (in 80% of homes). The rest were misplaced sharp objects (34%); dangerous stairs and pathways (25%); medicines placed within reach of children 25%, and chemicals and other unlabelled bottles also within easy reach of children (20%).

Table 9: Diseases of Under Five Year Olds Within Six Months Prior to Study in Two Communities

Condition	Homes Visited		Homes Not Visited		Total	
	Yes	No	Yes	No	Yes	No
Malaria	9	9	14	6	23	15
Diarrhoea	8	10	12	8	20	18
RTI	2	16	5	15	7	31
Malnutrition	1	17	1	19	2	36
Home Accidents	0	18	0	20	0	38
Total	20	70	32	68	2	138

Assessment of the Relationship Between Home Visit Practice and Child Morbidity

An attempt was made to explore any relationships between home visit practice and child morbidity. In other words, are homes visited by health workers likely to experience less episodes of childhood illnesses than homes not visited?

Two of the communities with similar characteristics, and both from the northern sector of the district were chosen, to explore such relationships. In the twenty (20) households in the community that had not been visited, thirty-two (32) children had gotten sick within the six months prior to the study; in the other community, which had been visited, had twenty (20) children being sick within the period.

Using Chi Square calculation to test the strength of association between home visiting and episodes of childhood illness, the following results are obtained:

Malaria: $X^2 = 1.586$, $df = 1$ $P = 0.208$ (Statistically insignificant)

Diarrhoea: $X^2 = 0.920$, $df = 1$ $P = 0.378$

RTI: $X^2 = 1.216$, $df = 1$ $P = 0.270$ (Refer appendix 2 for calculation)

Based on the results, the alternate hypothesis (H_1) is rejected and null hypothesis (H_0) is accepted, i.e. study findings do not show any significant relationship between home visits and child morbidity.

4.2 Community FGD Results

Home Visit Practice by Nurses

Nurses carried out Focus Group Discussions to solicit the information on home visit practices. Only 2 of the 5 communities studied said a health personnel had visited them; one of them had a CHN carrying out the visit, while a Health inspector carried out the other visits.

Only one FGD, group agreed that they had been seeing nurses visiting homes, in their community. The others had never seen anything of the sort.

During the FGD, the community leaders also confirmed that the time of home visits was convenient.

Though only one community had been enjoying home visit by nurses, all the 5 FGD groups indicated that home visits would benefit them. The FGD groups went further to cite the following as benefits they expect to gain from home visits:

- Reduction in disease prevalence,
- Prompting clients to seek medical assistance,
- Enhancement of relationship between nurses and clients (three of the groups said their community members were afraid of nurses),
- Home care since most of their members could not afford the hospital cost,
- Identification of hazards at home, and
- health education and health supervision.

With regards to communities' perceived reasons for home visits, responses given were as follows:

- That it is the job specification of nurses;
- For case finding,
- To improve their work;
- To establish good relationship with community members,
- Because they were particular about their work;

- To improve health;
- To do situational analysis;
- To supervise the health of the communities, and
- To manage the sick at home.

From the above it is concluded that community perception of home visiting by health workers as obtained through interview of household heads, is confirmed by data from the FGDs.

4.3 Assessment of Nurses

Questionnaires were administered to the nurses to solicit information about their knowledge and attitude towards the practice of home visiting.

Knowledge and Attitude Towards the Practice of Home Visiting

As Presented in Table 10, the opinion held by the nurses with regards to home visiting was positive. Twelve (75%) said it was beneficial while 4 (25%) said it was good.

Table 10: What Respondents Know About Home Visiting

Responses	Frequency	Percentage (%)
1. Visiting clients in their home, identifying their needs and assisting in meeting them	8	50
2. Making health care accessible to clients	4	25
3. Home visit comprises special and routine visits	2	12.5
No response	2	12.5
TOTAL	16	100

Assessment of Home Visit Practice Among Nurses

All the 16 nurses interviewed said they conduct home visits in their catchment areas and mentioned some of the activities conducted during home visits, which are as follows.

Counselling, mentioned by all the nurses, examination of babies 15 (94%), health education 16 (100%), demonstration 11 (69%), home nursing 7 (44%) and sanitary inspection 8 (50%).

Special visits with health education of client was mentioned by 10 nurses (62.5%); teaching family client care by nurses, by 10 (62.5%); general examination by nurses 5 (31%) and home nursing by nurses, mentioned by 4 (25%) nurses.

Factors Influencing the Practice of Home Visiting by Nurses

Factors influencing home visit practice as identified through the nurses' interviews are as follows:

- Poor reception by household members: 5 (31%),

- Attacks of dogs: 6 (37.5%),
- Heavy workload 3 (19%),
- Failure of community members to practice what is taught 3 (19%), and
- Absence of household members from home 3 (19%).

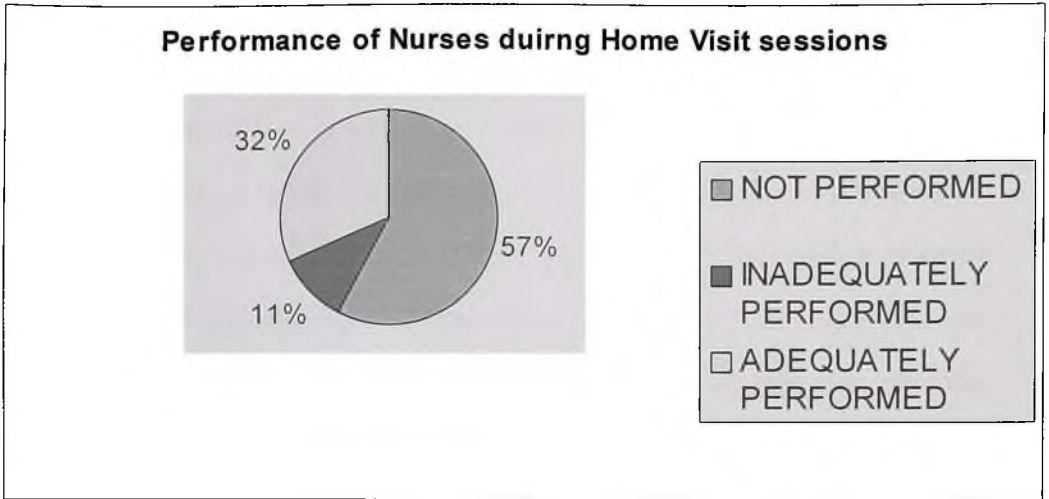
The majority of nurses (81%), indicated that they did report on home visiting without producing evidence; 3 said they did not know whom to report to. They explained that there was no column on the format for reporting on the nurses' activities, for home visiting. Moreover, the findings indicate that the support nurses obtained from their superior officers towards home visiting might not be adequate. Six (37.5%) obtained financial support; 4 (25%) had been provided with transport while 5 (31%) had not received any support toward home visiting.

4.4 Participatory Observation

In order to assess knowledge, attitudes and practices of home visiting by nurses, the researcher conducted nineteen participant observations of nurses during home visiting sessions.

During the participatory observation, it was noted that a hundred and thirty one (57%) of the competencies a visiting nurse is expected to undertake, were not performed. Twenty-five of the competencies (11%) were poorly performed and only 72 (32%), were adequately performed (Refer fig 2).

Figure 2



However, during the participant observation, community members were surprised to see nurses in their homes and wondered why we were in their homes.

Activities that were adequately performed during the 19 home visiting sessions observed, included establishment of rapport 17 (89%), application of good communication skills 14 (74%), discussion of observation and helping clients to identify and meet needs 12 (63%). Activities that were inadequately performed included observation of home environment, in 4 cases (12%); reassurance of confidentiality in 3 cases, (16%) and referral of clients, in 5 cases (26%). In addition to planning for the visiting, nurses did not perform in the following competencies: carrying an equipped bag and using the contents during home visiting; recording findings and reporting on home visiting.

4.5 Review of Guidelines for Home Visiting

There were no guidelines for home visit in the district; neither was there a copy of the guidelines prepared by the NMC. The absence of guidelines is likely to have resulted in the inadequate performance of nurses, as evidenced by the outcome of the observation of home visit sessions. A hundred and thirty one, (57%) of the competencies to demonstrate during home visits were not attempted during the 19 home visiting sessions observed. Twenty five (11%) of these competencies were poorly performed while 72 (32%) were carried out according to standard. In most cases nurses had problems as to what they should do, when they got to the homes.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

The nurses as well as community members perceived home visits to be beneficial, as stated by Freeman and Heinrich (1981), i.e. that family visits provide an opportunity to estimate the general level of family coping and provide support to individuals who have problems.

However, a good number of community members did not know that nurses were supposed to visit their homes. According to responses obtained, most community members were afraid of nurses and dared not go near them. This was confirmed by the astonishment, which household members showed during the participatory observation of home visiting sessions. Many community members had not seen a nurse in their homes, prior to the visit.

The practice of home visiting among P/CHNs in the district was generally very low (7%) and performance fell short of the standard set by the NMC (57% non-performance, 25% inadequately performed with hesitation and 32% inadequately performed), which confirmed the findings of Antwi (1999) that the practice of home visiting in the Assin Fosu was low and fell short of set standards. This low performance might be due to memory decay since the nurses might have stopped or even not practised home visiting since they left school. During the participant observation, nurses were often noted to be at a loss as to what to do in the homes and therefore, either did not perform (57%) or not adequately performed (11%) the competencies.

Further, assessment of the working environment of the nurse, as was suggested by Morris (2001), indicated in this survey that the low level of practice are accounted for, by factors such as lack of transport (5), heavy workload 3, attacks of dogs (3), poor reception of community members (5) and lack of support by superior officers (6). The work of P/CHN had shifted emphasis to other areas; example, immunization (as in NID), and disease surveillance, to mention a few. The new emphasis is good but home visiting is known to enhance the impact of Public Health Nursing, as found by Brugha et al (1996) when they proposed that home visiting maximises immunization coverage.

Nurses who visited homes did so only to see how babies were faring, something that should generate a lot of concern. Meanwhile, the household survey identified vulnerable individuals, i. e. pregnant women 18, nursing mothers 33, and the aged 26, who could benefit from home visiting. This finding confirms the concern of the UKCC for Nursing, Midwifery and Health Visiting (March 2000) that health visitors often concentrate on the under five group at the expense of other groups in the community who need their care.

There is the need for guidelines for home visit practice in the district. The NMC's guidelines for practice (1995), could be adopted and modified to suit home visiting practice in the district.

According to McMurray (1998), family nursing activities occur in the context of home visit. Respondents who suggested activities to be carried out during home visiting, as home nursing, health supervision and health education, all constituting components of family nursing, expressed the same idea.

Potential benefits of home visits as expressed, included the opportunity for nurses to recognise needs, problems and hazards in the home environment and to help communities find the best means towards their solution. In addition, nurses are expected to recognise diseases that the family might miss, and refer for urgent attention.

The residential environment does not only provide shelter and protection for family members, but is a major factor in the physiological and emotional health of residents, as expressed by Moliner et al (1961). Health hazards observed in the home environment included the practice of open defecation, open fires, misplaced sharp objects, dangerous stairs and pathways, medicines placed within reach of children, use of untreated water from rivers and streams, failure to cover water and refuse containers, and other poor hygienic practices. Though the chi square test did not show a significant relationship between home visiting and hygienic practices, as stated by Freeman and Heinrich, (1981) and Cater and McGoldrick (1980), the health visitor has the opportunity to assess the environment and offer situational advice and family members are more receptive in their own homes.

According to Cairncross et al (1997), excreta related infections can be controlled by improvement in excreta disposal. From the study, 52 children from 82 households with children under five years had suffered diarrhoea within six months prior to the study, which might be attributed to the poor excreta system of the homes i.e. 43% using pit latrine, 20% bucket type latrine and 20% open defecation. The poor disposal of excreta creates a conducive medium for fly breeding and subsequent transmission of diarrhoea diseases.

Only 64 % of children in the homes interviewed wash their hands after visiting the toilet. None of the household members who washed their hands after visiting the toilet did so with soap. As shown by World Bank (1993), Cairncross et al., (1997) and Ghana and UNICEF (1990), hand washing after defecation and before preparing food is an important method of interrupting the transmission of diarrhoea and other diseases. Furthermore, poor refuse disposal encourages the breeding of flies and may thus promote the transmission of faecal oral infections, especially in the situations as that of the households interviewed where 80% of the houses, have refuse containers not covered and 10% of the homes threw refuse about.

Children are at a greater risk of accidents because they are at a stage of finding out more about the world around them (King et al, 1986). As emphasised by Deen et al (1999) injuries and non-communicable diseases are emerging health problems of children in developing countries. Also childhood DALY rates attributable to injuries were highest in Sub-Saharan Africa among children under 5 years. Statistics in the Sekyere West District indicated that home and occupational accidents are higher for the year 2000 and the first half of year 2001 (1307 and 1003 respectively) than RTAs for the same period (755 and 488 respectively). Though only two (2) of the households had children been involved in accidents, various hazards were identified that can predispose children to accidents, in the homes. (i.e.,of open fires; 34%, misplaced sharp objects; 25%, etc).

As to whether home visiting reduces child morbidity as proposed by Dialla et al (2001) and Baker in Stanhope (1994), the study found no significant relationship between home visit practice and child morbidity ($X^2 = 0.85$, $df = 1$ $P < 0.5$). However, the study results

could be due to the poor quality of home visiting practised in even those communities, which benefit from visits by nurses.

5.2 Conclusion

Though nurses could define home visiting, they might have forgotten the practice due to long period of disuse. However, their perception of home visiting was positive.

The communities perceive home visiting to be good and beneficial and yearned for it but did not know who should perform that function. They therefore suggested the need for support from community members and health officials for nurses towards improvement of home visiting.

Nurses' attention had shifted to other responsibilities that were being supported by their superiors. Meanwhile, there are lots of health hazards in the home environment that need to be addressed, if the objectives of disease prevention and health promotion being encouraged by the Health Ministry are to be realised.

5.3 Recommendations

Based on the findings of the study, the following recommendations are made:

- 1.The District Health Administration should conduct a study to assess the factors influencing the working environment of nurses working within the communities.
- 2.The DHA should also organise orientation courses on home visiting to refresh the knowledge of nurses on the subject.
- 3.Further, the DHA should prepare standard-guidelines for the practice of home visiting for use, in the district.
- 4.Nurses should be given the maximum support towards home visiting.

5. Finally, after the research based orientation course and the introduction of the standard guidelines, the DHA should carry out another assessment to ensure that home visiting practice in the district is re-established.

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APPENDIX 1

Chi Square Test Showing the Relationship of Home Visiting and Sanitation and Hygiene Practices

The Practice of Open Defecation Among Children in Households Interviewed

	Visited	Not Visited	Total
Yes	5 (6.63)	9 (7.37)	14
No	13 (111.37)	11 (12.63)	24
Total	18	20	38

$$X^2 = 1.208 \text{ value on 1df}$$

$$P = 0.272$$

The Practice of Open Defecation Among Adults in Households Interviewed

	Visited	Not Visited	Total
Yes	4 (4,74)	6(5.26)	10
No	14 (13.26)	14(14.74)	28
Total	18	20	38

$$X^2 = 0.296$$

$$P = 0.587$$

Water Storage Containers

	Visited	Not Visited	Total
Covered	8 (5.68)	4 (6.32)	12
Not Covered	10 (12.32)	16 (13.68)	26
Total	18	20	38

$$X^2 = 2.62$$

$$P = 0.106$$

The Practice of Hand Washing After Visiting The Toilet Among Children in Household

	Visited	Not Visited	Total
Yes	10 (9.47)	10 (10.53)	20
No	8 (8.53)	10 (9.47)	18
Total	18	20	38

$$X^2 = 0.117$$

$$P = 0.732$$

APPENDIX 2

Chi Square Test Showing the Relationship of Home Visit and Childhood Morbidity

Malaria

	Visited	Not Visited	Total
Yes	9 (10.89)	14 (11.11)	23
No	9 (9.11)	6 (7.89)	15
Total	18	20	38

$X^2 = 1.586$ on 1 degree of freedom

P-value = 0.208

Diarrhoea

	Visited	Not Visited	Total
Yes	8 (9.47)	12 (10.53)	20
No	10 (8.53)	8 (9.47)	18
Total	18	20	38

$X^2 = 0.920$ on 1 degree of freedom

P-value = 0.338

RTI

	Visited	Not Visited	Total
Yes	2 (3.32)	5 (3.68)	7
No	16 (14.68)	15 (16.32)	31
Total	18	20	38

$\chi^2 = 1.216$ on 1 degree of freedom

P-value = 0.270

APPENDIX 3

IS HOME VISITING AN EFFECTIVE STRATEGY FOR IMPROVING FAMILY
HEALTH: A CASE STUDY IN THE SEKYERE WEST DISTRICT
INTERVIEW SCHEDULE FOR NURSES

Sample Questionnaire

Please note responses will be treated as confidential

Sub-district:.....

Field Coordinator:.....

Instructions for filling this questionnaire: Tick (✓) in the spaces provided, and write where your answers involve “other (specify)”

1. Category of Nurse

(a) Public Health Nurse []

(b) Community Health Nurse []

(c) Other (specify).....

2.What do you know about home visiting?

.....
.....
.....

3.Do you carry out home visiting in your catchment area?

(a) Yes []

(b) No []

(a) If yes, which other category of health workers join you during home visiting?

.....
.....

(b) If no to question 3 why do you not conduct home visiting in your catchment area?.....
.....

4. Which type of home visiting do you often carry out?

- (a) Routine []
- (b) Special []
- (c) Other (Specify).....

5. Special cases cared for during home visiting? (Rank in order of number of people in category involved)

- (a) Aged
- (b) Disabled
- (c) Malnourished children
- (d) TB
- (e) Others (Specify).....

6. How do you identify your special cases for home visiting?

- (a) During hospital rounds []
- (b) Through routine home visits []
- (c) Through referral system of health facility []
- (d) Other (Specify).....
.....

7. How often do you go on home visiting in a week?

8. How many homes do you normally visit in a day?

- (a) 1-5
- (b) 6-10
- (c) Other (Specify).....

9. At what time of the day do you go on home visiting?

- (a) Morning []
- (b) Afternoon []
- (c) Evening []
- (d) Night []

10. When was the last date you conducted a home visiting? Date

11. What are some of the activities you undertake during routine home visiting?

- (a) Examination of the newborn baby. []
- (b) Counselling []
- (c) Health Education []
- (d) Demonstrations []
- (e) Home Nursing []
- (f) Sanitary Inspection []
- (g) Other (Specify).....
.....

12. What are some of the activities carried out during special home visiting? (Please state the type of conditions)

- (a) Home Nursing []
- (b) General Examination []
- (c) Health Education of client []
- (d) Teaching Family Client Care []
- (e) Other (Specify)

13. Which other activities do you undertake in the home, which you think may not be useful to the family?

.....
.....

14. Which other activities do you think you should undertake during home visiting?

.....
.....

15. What problems do you face with home visiting?

.....
.....

16. Do you report on home visiting?

(a) Yes [] Evidence?.....

(b) No [] Reasons.....

.....

17. What do you consider as the general benefits of home visiting to your work?

.....
.....
.....

18. What is your opinion on home visiting?

.....
.....
.....

19. What support do you get from your superior officer, for home visiting?

(a) Financial Support []

(b) Provide logistics []

(c) Provide Transport []

(c) Other (Specify).....

20. What suggestions do you have for improving home visiting?

.....

.....

.....

APPENDIX 4

IS HOME VISITING AMONG NURSES AN EFFECTIVE STRATEGY FOR IMPROVING FAMILY HEALTH: A CASE STUDY IN THE SEKYERE WEST DISTRICT

FOCUS GROUP DISCUSSION GUIDE FOR COMMUNITY LEADERS

1. How often in one month, do you see nurses and other health workers visit homes in your community? (Probe for adequacy etc.)
2. What time of the day do you usually see nurses visiting homes in the community?
3. What do you think about the time of day nurses visit homes? (Probe for convenience, to community members).
4. What activities do nurses usually carry out when they visit homes?
5. What benefits do you think the community derives from visits by nurses?
6. Why do you think nurses and other health workers carry out home visiting?
7. How do you think the practice of home visiting by nurses / health workers can be improved in the district?

APPENDIX 5

IS HOME VISITING AMONG NURSES AN EFFECTIVE STRATEGY FOR
IMPROVING FAMILY HEALTH: A CASE STUDY IN THE SEKYERE WEST
DISTRICT

HOUSEHOLD QUESTIONNAIRE

Sub-district:.....

Community:.....

House No.:

Personal Data on Responent

1. Age.....

2. Occupation.....

3. Educational Status:

(a) Nil []

(b) Primary/JSS []

(c) Secondary/SSS/Technical/Vocational []

(d) Post Secondary []

Sanitation of the home

4. What is the source of water supply for the homes?

(a) Well []

(b) Bore hole []

(c) Rain water []

(d) Stream / River []

(e) Others.....

5. Are there water storage facilities in the home?

Yes [] No []

6.If YES,

(a) Are the containers covered?

Yes [] No []

(b) Do containers have mosquito larvae (inspect)

Yes [] No []

7. Is there a refuse container in the home?

Yes [] No []

8. If YES, is the container covered?

Yes [] No []

9. How is the cleanliness of the home environment? (observe)

Very clean []

Clean []

So-so []

Dirty []

Very dirty []

10. What type of toilet facility does household use?

Pit latrine (private) [] Bucket Type (private) []

Pit latrine (public) [] KVIP (public) []

KVIP (private) [] Bucket Type (public) []

Water closet (private) [] Open defecation []

Water closet (public) [] Septic tank latrine []

Others (specify).....

11. How is faecal matter of children disposed of in the home?

Use of Chamber pot []

Defecation into pantiy []

Open defecation []

Others.....

12. If children use chamber pot, is it (Observed)

(a) Clean Yes [] No []

(b) Covered Yes [] No []

13. Do children wash their hands with soap and water after defecation?

Yes [] No []

14. Do adults wash their hands with soap and water after defecation?

15. How many people share a sleeping room?

< 4	4	5	>5

Childhood Disease Profile

16. Has any child under 5 years in this house had any of the following conditions?

Condition	No	Yes	No. of children	No. of times/child	Actions Taken
Malaria					
Diarrhoea					
RTI					
Malnutrition					
Home accident					
Others (specify)					

17. Any accident hazards in the home? (Observe)

Accident Hazard	Yes	No	Difficult to tell
Open fire			
Misplaced knives and sharp objects			
Dangerous stairs and pathways			
Medicines within reach of children			
Chemical and other solution in unlabelled bottles			

Home Visiting Profile

18. Has your home ever been visited by a health worker?

Yes [] No []

19. If yes, specify the health worker who visited you, and when last visited.

(a) Community Health Nurse []

Last home visit date/period

(b)Others (Specify).....

Last home visit date/period.....

20. How many times have you been visited by the health worker within the past six (6) months?

(a) Community Health Nurse:.....

(b) Other (Specify):.....

21. At what time of day were you visited?

(a) 9am-2pm []

(b) 3pm-6pm []

(c) Other (State)

22. Was the time convenient?

Yes [] No []

More convenient time?.....

23. What are some of the activities undertaken by health worker during home visiting?

(a) Community Health Nurse?.....

.....

.....

(b) Others?.....

.....

.....

24. How would you assess the benefit of home visiting?

Beneficial	Reasons
Yes []	<p>.....</p> <p>.....</p>
No []	<p>.....</p> <p>.....</p>

25. What other activities would you suggest health workers carry out during home visiting?.....

.....

26. How would you describe the attitude of the health workers who do home visiting?

Health Worker	Assessment		
	Good	Satisfactory	Not Good
a. Public Health Nurse			
b. Community Health Nurse			
c. Others (specify)			

Home Visiting Needs of House

27. Which types of people in your home do you think need home visiting by health workers?

Categories of people	No.	Need for home visits		
		No	Yes	
a. Children 0-5 years				
b. Pregnant Mothers				
c. Nursing Mothers				
d. Age				
e. TB Cases				
f. Disabled				
g. Motherless				
h. Multiple birth babies				

How many of the following categories of people are in this house?.....

28. Are there aged persons in the household, what is his/her state of health?

Number of Aged in House	State of Health		
	Good	Fair	Poor
Number 1			
Number 2			
Number 3			

29. What suggestions would you make for improving home visiting?

.....
.....
.....

30. What do you dislike about home visiting?

.....
.....
.....

APPENDIX 6

IS HOME VISITING AMONG NURSES AN EFFECTIVE STRATEGY FOR
IMPROVING FAMILY HEALTH: A CASE STUDY IN THE SEKYERE WEST
DISTRICT

CHECK-LIST FOR OBSERVATION

Activity	Not Performed	Not Adequately performed	Adequately performed
1.Plans for the visit			
2. Carries an equipped visiting bag.			
3.Observes entry norms.			
4.Establishes rapport with client.			
5.Applies good communication skills.			
6.Observes client e.g. physical condition, mannerism, etc.			

7.Observes the environment e.g. physical, sanitary conditions, social interactions, etc.			
8.Discusses observation with client and helps her to identify needs.			
9. Reassures client of confidentiality.			
10.Uses content in bag to assist client to solve problems/meet needs			
11.Refers client to appropriate person/unit for help if necessary.			
12.Records findings.			
13.Writes report on home visit			