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SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

FACTORS INFLUENCING UTILIZATION OF COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) IN THE OFFINSO NORTH DISTRICT, ASHANTI REGION

BY

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DECLARATION

I, Richard Avagu, declare that this proposal is a result of my independent work. References to other works have been duly acknowledged. I further declare that this proposal has not been submitted for award for any degree in this institution and other universities elsewhere.

…… ……..

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(STUDENT)

…… ……

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(ACADEMIC SUPERVISOR)

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DEDICATION

I dedicate this work to my wife Mrs Mavis Frimpong Avagu for her inspiration and prayers during this course.

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I am grateful to the Highest God Jehovah for his mercies and grace shown on me.

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ABSTRACT

Introduction: Community-Based Health Planning and Services (CHPS) is a national strategy for implementing community-based health care service by reorienting and relocating primary health care from sub district health centers to convenient community locations (Frimpong, 2018). As a step to make health services accessible to Ghanaians, the Government of Ghana in collaboration with the Ghana Health Service (GHS) and Ministry of Health adopted the CHPS concept in 1999 but it became operationalized in 2005 after the GHS made it a national policy for health care delivery (GHS, 2005).

Objectives: The main objective of this study was to assess factors influencing the utilization of health services at the CHPS compounds in the Offinso North District.

Methods: This study was conducted in the Offinso North District. The study was a cross-sectional study design involving both quantitative and qualitative approaches.

In the quantitative approach, a semi-structured questionnaire and observational checklist were used to collect information on factors influencing utilization of health services at the CHPS compound. Multivariate analysis using unadjusted logistic regression was used to look for association between variables.

The qualitative component comprised Focus Group Discussions (FGDs) and In-depth interviews (IDIs) for community members and community health nurses respectively to obtain additional information on factors influencing health services at the CHPS compound.

Results: This study showed low level of knowledge on CHPS services, as 25 (8.4%) of the respondents indicated they had heard about CHPS. It revealed that (83.6%) of the participants were satisfied with the attitude of their attendants. It was also revealed that, a number of essential logistics were not available at CHPS compounds at the time of the assessment.

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Again, the study revealed that women were almost three times more likely to use CHPS services compared to their male counterparts (AOR=2.39; 95% CI: 1.30-4.36; p=0.005) and participants who stayed five kilometers away from the CHPS compound were 88% less likely to use CHPS services compared to those closer to the CHPS compound (AOR=0.12; 95% CI: 0.03-0.57; p=0.008).

Conclusion: Factors that were discovered to influence the utilization of health services at CHPS compounds included gender of respondents, number of children they had, and the distance to the CHPS compounds.

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LIST OF ABBREVIATION

CHMC	Community Health Management Committee
CHPS	Community-Based Health Planning and Services
CHO	Community Health Officers
CHV	Community Health Volunteers
CHW	Community Health Workers
CWC	Child Welfare Clinics
DHD	District Health Directorate
DHMT	District Health Management Team
FGD	Focus Group Discussion
GHS	Ghana Health Service
GSS	Ghana Statistical Service
IDI	In-depth Interview
MOH	Ministry of Health
OFN	Offinso North District
PHC	Primary Health Care
UHC	Universal Health Coverage
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION

1.1 Background

Community-Based Health Planning and Services (CHPS) is a national strategy for implementing community-based service delivery by reorienting and relocating primary health care from sub district health centers to convenient community locations (Frimpong, 2018). The inception of CHPS began following the declaration of Alma-Ata Primary Health Care (PHC) in 1978 by many nations with the aim of making health care accessible, affordable and situated in the cultural context of the people (WHO, 2008).

As a step to make health services accessible to Ghanaians, the Government of Ghana in collaboration with the Ghana Health Service and Ministry of Health adopted the CHPS concept in 1999 but it became operationalized in 2005 as a national policy for the provision of primary health care services (GHS, 2005). The focus of the CHPS strategy was mainly on deprived and remote areas of rural districts, with emphasis on transformation of the primary health care system from facility-based and outreach services to a programme of mobile community-based care provided by a resident nurse (Nyonator, Awoonor-williams, Phillips, Jones, & Miller, 2005).

Since then, CHPS has spread to most remote areas in Ghana (MOH, 2016). It is worth to note that the CHPS programme was a scale-up of the Navrongo experiment that was initiated and piloted in Northern Ghana over decades ago (Adongo et al., 2013). The implementation of CHPS in Ghana is at the local level and requires the cooperation of

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health workers and communities as it involves negotiation with all stakeholders (Adongo et al., 2013).

Several studies have proven the impact of CHPS in terms of coverage and utilization of health services globally (Wiru et al., 2017). A classic example is findings from the Ghana Essential Health Interventions program carried out in the Upper East Region, Ghana. Findings from the programme indicate a 100% coverage for the intervention districts compared to 50 % in the comparison district of essential services (Awoonor-Williams, Philips & Bawah, 2016). Likewise, CHPS in parts of the Philippines has reported an increase coverage of pregnant women receiving tetanus toxoid injections in an intervention community from 58% in preintervention period to 81% at post-interventions while the percentage of pregnant women who made at least 3 prenatal visits in intervention districts increased from 41% to 89% (Wiru et al., 2017). The delivery of family planning services is one of the key activities that CHPS strategies emphases.

The CHPS strategy has led to an increase in patronage of these services mostly by women in remote areas of Ghana (Adongo et al., 2013). The CHPS initiative enables the GHS to reduce disparities and promote equity in health coverage by removing geographic barriers to health care (MOH, 2016). Furthermore, the CHPS offers additional training on preventive health care services in areas such as immunizations, family planning, supervising delivery, antenatal/ postnatal care and treatment of minor ailments (Adongo et al., 2013). With these enormous benefits, one may expect a 100 percent coverage and utilization of CHPS by communities but on the contrary, there are still some underutilization in some areas of the country.

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A number of factors play significant roles in either promoting or hindering the utilization of CHPS services irrespective of the benefits. A study conducted by Wiru et al. (2017) on utilization of CHPS has identified several factors hindering the use of such services. Factors such as inadequate availability of medicines, ability to pay for services and absence of health workers as major barriers to the use of CHPS facilities. They further found that the utilization of such services by men is very low compared to women. This was attributed to the fact that most of the services such as family planning and the availability of maternal and child health services in CHPS compound focus on women and could be the reasons for the high female patronage and low men patronage.

Adongo et al. (2013) indicated that traditionally, family planning services had always targeted females with little or no attention given to men. Uchendu, Ilesanmi, & Olumide (2013) also identified shortage of medicine, lack of skilled personnel, poverty and distance to health facilities as factors hampering health service utilization. In most African societies, men are mostly in domination position when it comes to decision on seeking health care. Due to this situation, men are seen as obstacles preventing women from patronizing family planning and other services rendered by CHPS (Nwokocha, 2008; Tuloro & Deressa, 2006). Wiru el al (2017) again mentioned that the utilization of CHPS to some extent is influenced by marital and employment status. There is high patronage rate among the married people and those employed.

To this end, CHPS concept adversely has improved health service coverage and utilization among communities in remote areas. Despite the benefits however, there is still unsatisfactory utilization and coverage of CHPS strategies in some areas of Ghana. It is also eminent from above discussed that there are a number of related factors that influence

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the utilization of CHPS. Some are due to the deep-rooted cultural heritage held in high esteem by some African societies whilst others are also health system related. By this observation, it is prudent that factors militating the patronage of CHPS services be investigated in the Offinso District. The study assessed the level of knowledge of community members, health care worker's attitude and the availability of logistics and equipment that influence CHPS utilization.

1.2 Problem Statement

In Ghana, geographical access continues to be one of the major barriers to health care service and increase in childhood mortality is related to inaccessibility of health care (GHS, 2016). Approximately, 70% of the Ghanaian population resides in communities that are over 5 kilometres from the nearest health facility. Childhood mortalities in those communities is reported to be 40 % higher than in communities located within 5 kilometres of health services (GHS, 2016; GSS/GHS, 2015). Conversely, there is great disparity in health status between urban and rural areas.

The Ghana Health Service adopted the CHPS concept to extend health care services to the door steps of the people. The CHPS has helped the GHS in reducing health inequalities and promoting equity of health outcomes by removing geographical barriers to some extent (GHS, 2005). CHPS remain an appropriate way of delivering health care to communities in underdeveloped and deprived distant from health facilities. Due to the benefits, efforts were made by the Government to improve coverage and utilization of CHPS. However, not all residents living in remote communities patronize CHPS services despite its enormous benefits.

A number of factors influence the underutilization of CHPS services irrespective of the benefits. Inadequate availability of medicines, ability to pay for services and absence of

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health workers are some barriers to the use of CHPS facilities (Wiru et al., 2017). The deep adherence to culture that places men as head in decision making over health issues in some societies in the country is another hindering factor.

Utilization of CHPS in Offinso North District which is a typical rural district is low. CHPS contributed to only 16% of the total cases of the Out Patients Visits. (OFN DHD, Annual report,2017). Although the DHMT has held series of stakeholder meetings with Community members, the District Assembly and staff of GHS to improve CHPS utilization in the district, there has not been a holistic assessment of the factors influencing the utilization of health services at CHPS compounds in the Offinso North District. Results of this study will prompt recommendations that can improve utilization of CHPS services in the country at large.

1.3 Justification

This study was needed to provide a better understanding of the factors influencing utilization of CHPS in the study area. Understanding issues that influence utilization of health services is crucial in health policy analysis, planning and design of client-centred health interventions and health resource allocation to different levels of the health system.

Understanding issues affecting utilization of health services is useful in designing assessment tools to measure progress towards the achievement of Universal Health Coverage (UHC) by extension as a means to ensuring equity in the use of health services (Ngugi et al., 2017). The findings of this study are likely to prompt recommendations that could be used as a guide in developing more effective strategies to improve the patronage of CHPS among community members.

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1.4. Research Questions

1. What is the level of knowledge of community members on CHPS services?

2. What are the factors influencing the utilization of health services at CHPS compounds?

3. What are the attitudes of Community Health Officers towards users of healthcare services at CHPS compounds?

4. What are the challenges affecting the implementation of CHPS services?

1.5 Study Objectives

1.5.1 General Objective

To assess the factors influencing utilization of health services at CHPS compounds in the Offinso North District.

1.5.2 Specific objectives

1. To assess the level of knowledge of community members on services at CHPS compounds – community factor

2. To identify factors influencing utilization of health services at CHPS compounds – patient factor

3. To assess the attitude of health workers and their competencies – provider factor

4. To explore logistics and equipment challenges that influence CHPS utilization – provider factor

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1.6 Expected Outcomes

At the end of the study, it is expected that factors hampering utilization of healthcare services at CHPS compounds by people of the Offinso District will be determined. Heath worker's attitude and level of competencies in delivering heath care services will be deduced. In addition, the study is expected to determine the capacity of the Offinso CHPS in terms of logistics and equipment. Finally, community member's knowledge and level of participation in CHPS will be assessed.

1.7 Conceptual framework

The framework below conceptualizes the concept of CHPS in this study. The framework portrays factors influencing the utilization of CHPS services and how some of these factors are interconnected.

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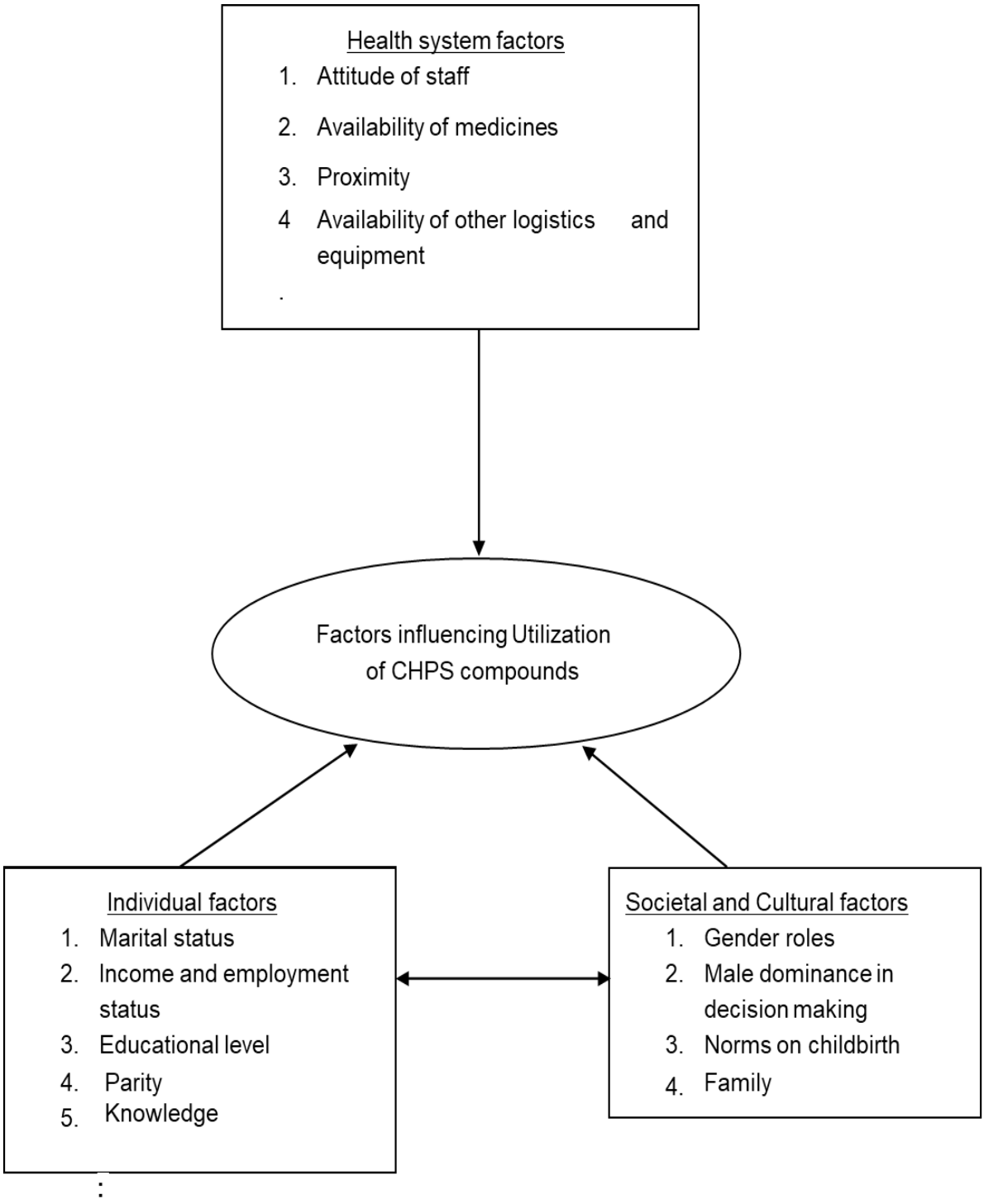

Figure 1.1 Conceptual framework on factors influencing the utilization of CHPS

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In the framework above, it has been conceptualized that three major factors influence CHPS utilization: Health system factors, Individual factors and Societal/cultural factors. While all these factors have direct influence on CHPS utilization, two of the factors, that is, individual and cultural factors also influence each other. The educational status of a person can influence his or her decision-making abilities. Family and societies preference for more children can influence parity. Thus, individuals from a family with more emphasis will not attend CHPS compounds for family planning services irrespective of parity of mother.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter seeks to present discussions of other empirical studies related to factors influencing CHPS Utilization. The literature review is based on the CHPS concept level of community knowledge and participation in CHPS utilization, logistics and equipment issues that influence CHPS utilization and the attitude of health workers and their competencies in delivering CHPS services.

2.2 The CHPS concept

In the 1978, the Alma-Ata Declaration emerged as a major public health milestone, which in the twentieth century identified Primary Health Care (PHC) as the panacea to the realization of "health for all" (WHO, 2018). The Declaration posits that primary health care is an essential health care which is grounded on socially acceptable and scientifically sound methods that are universally accessible to individuals and families with their full participation at costs that countries and communities can afford in a spirit of self-determination and self-reliance (WHO, 2018). In Ghana, the key PHC programme is the CHPS concept which was piloted about two decades ago (1999) (Phillips et al., 2018; Nyonator, Awoonor-Williams, Phillips, Jones, & Miller, 2005). CHPS is a national health policy to reorient primary health care services from sub-district health centers to convenient community locations involving service delivery and health planning with the

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communities. This is done by transforming the dynamics of rural health care service delivery from community health care providers who passively wait for patients into outreach workers who actively seek patients in communities and their homes, also known as doorstep services (Awoonor-Williams et al., 2013).

The CHPS programme was a scale-up of the Navrongo experiment that was initiated and piloted in Northern Ghana over decades ago. The implementation of CHPS in Ghana is at the Local level and requires the cooperation of health workers and communities as it involves negotiation with all stakeholders (Adongo et al., 2013). The general principles of CHPS include: focus on community health needs to determine the package of CHPS services; community participation, empowerment, ownership, gender considerations and volunteerism; communities as social and human capital for health system development and delivery; task shifting to achieve universal access; Community Health Officer (CHO) as a leader and community mobilizer; and health services delivered using systems approach (GHS, 2018). CHPS' aim is to move health services to community locations, develop sustainable volunteerism and community health action, empower women and vulnerable groups, and improve health provider, household and community interaction (GHS, 2018). Increased access to basic health services due to the introduction of the CHPS concept, has reduced infant and child mortality through immunization, reduced water borne diseases, increased breastfeeding, and increased household involvement in treatment of diarrhoea, though not to desirable levels (Magawa, 2012).

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2.3 Community Utilization of CHPS

The key essence of CHPS is to increase the coverage and utilization of health services. The results from the Ghana Essential Health Interventions program that was conducted in the Upper East Region of Ghana showed that the program resulted in a 100% coverage of essential health services in the intervention districts compared to 50 % in the comparison district (Awoonor-Williams, Philips & Bawah, 2016). Likewise, CHPS in parts of the Philippines has reported increase in the proportion of pregnant women receiving tetanus toxoid injections in an intervention community from 58% in the preintervention period to 81% at post-interventions while the proportion of expectant mothers who made at least 3 prenatal visits in the intervention districts increased from 41% to 89% (Wiru et al., 2017). A descriptive cross-sectional study carried out in Komenda-Edina-Eguafo-Abrem Municipality, Ghana to assess the utilization of the CHPS facilities revealed that, only 33.2% of the population utilize the services (Wood, 2013). A study conducted to determine the factors associated with their use and challenges faced by community members regarding the use of CHPS facilities in Kintampo North Municipality indicated that, an increased percentage of the respondents (73.7%), visited CHPS compounds for health care services (Wiru et al., 2017). Findings from the study conducted by Adongo and colleagues in Southern Ghana on CHPS services also showed that, the CHPS strategy has led to an increase in patronage of family planning services mostly by women in remote areas of Ghana (Adongo et al., 2013)

2.4 Community Knowledge and Participation in CHPS Utilization

The CHPS concept was introduced to address health issues like health access and mortality results from disparities in the availability and utilization of health care services especially

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in the low- and middle-income countries. Rural residents are most constrained in patronizing formal sector health services than their urban counterparts in most countries (Strasser, 2003). The implementation of CHPS at the local level requires the cooperation of the health sector and communities as it involves systematic planning and negotiation with all stakeholders, local authority, political establishment and the community members through community mobilization and effective participation. In addition, the communities in consultation with the health sector select community volunteers to support the work of the Community Health Officers (CHOs) in the area of community mobilization and participation, recording vital community statistics and maintaining other essential activities (Nyonator et al., 2005). The CHPS strategy advocates the systematic planning and implementation of primary health care facilities and activities with active participation of community leaders and members. This in practice can be achieved through mobilization of community leadership, decision making systems and resources in within defined catchment areas (zones) (MoH, 2007). A qualitative descriptive study conducted to assess the impact of male involvement in Family Planning (FP) referred to as the Navrongo experiment in Northern Ghana revealed that, the community members perceived CHPS as very helpful with full community participation at all levels of the implementation process. Males were more involved in FP services in communities with functional CHPS than those without functional CHPS (Adongo et al., 2013). Findings from a thematic analysis on community participation in rural Ghana revealed that, participation was sustained through the recognition and use of community resources, CHPS integration with pre-existing community structures, and alignment of CHPS services with community interests. However, the results again indicated that, 'male dominance and didactic community leadership and management styles undermined real opportunities for broad-

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based community empowerment, particularly of women, young people and marginalized men' (Baatiema, Skovdal, Rifkin, & Campbell, 2013). An exploratory study conducted in Nadowli district of the Upper West Region of Ghana to examine the knowledge of CHOs in the CHPS concept and the approaches in facilitating community engagement processes as some of the factors influencing the level of community participation in CHPS indicated that, there was low level of community involvement at the various stages of the CHPS implementation processes. This was partly attributed to inadequate knowledge of CHOs in the CHPS concept and skills in facilitating community engagement processes. It was however concluded that, to enhance community participation in CHPS, practical innovative strategies of improving CHOs' understanding of the CHPS concept, community dynamics and skills in facilitating participatory methodologies must be re-visited (Gyang, 2015).

2.5 Logistics and equipment issues that influence CHPS utilization

The availability of logistics and equipment are very essential to the delivery of health services. A descriptive cross sectional study conducted in [where, indicate location]to assess the utilization of CHPS services indicated that inadequate availability of medicines (41.5%) and inability to pay for services (28.7%) were main barriers to the use of CHPS facilities. A descriptive cross sectional study carried out in Nigeria to assess the factors influencing the utilization of CHPS services revealed that, inadequate skilled personnel, shortage of medicines, poverty and distance to health facilities were factors hampering health service utilization (Uchendu, Ilesanmi, & Olumide, 2013). A cross sectional study conducted in Komenda-Edina-EguafoAbrem Municipality to assess the utilization of the CHPS facilities revealed that, drug unavailability, lack of midwifery services, poor staff

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attitude and fear of blood by some nurses were challenges in the utilization of CHPS services in the municipality (Wood, 2013)

2.6 Attitude of Health Workers and their Competencies in Delivering CHPS Services

The primary health care approach was a paradigm change from curative urban based to preventive rural based care and education through effective community mobilization. Primary health care enjoins people to achieve their health needs through their full participation and at a cost they can afford. It is important to point out that local communities are of prime focus for primary health care activities (WHO, 2006). In this regards, the role of Community Health Workers (CHWs) is to improve access to basic healthcare services, and mobilizing communities for health action. This is recognized as a key strategy to quality health care (WHO, 2008).

The Health Resources and Services Administration (2007) defines CHWs as lay members of communities who work either for pay or as volunteers in association with the local health care system. Also, working in both urban and rural environments, they usually share ethnicity, language, socio-economic status and life experiences with the community members they serve. Indeed, community health workers have gained an increasing role in health care delivery, particularly in support of strategies that recognize the influence of an individual's community and environment on health outcomes (Fisher et al., 2005). There are evidence pointing to the success of CHWs in addressing health problems at the community level.

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Similarly, community health workers have been shown to contribute to reductions in child morbidity and mortality, encourage immunization uptake, promote breastfeeding, and improve outcomes for tuberculosis patients and children suffering from acute respiratory infection or malaria (Lewin et al., 2010). As the impact of health workers is worthwhile, the attitude of health workers towards the delivery of services is very important. A study conducted to determine the factors associated with their use8and8challenges faced by community members regarding the use8of CHPS facilities in Kintampo North Municipality, Brong Ahafo revealed that, absence of Community Health Officers (CHOs) (12.3%) was a major barrier to the use8of the facilities (Wiru et al., 2017).

2.7 Factors that influence the utilization of CHPS

There are factors that may influence the utilization of CHPS. A cross sectional study conducted in New Zealand on factors influencing the utilization of CHPS revealed that, gender and income were significantly associated with CHPS utilization (Jatrana, & Crampton, 2009). Also, similar findings of a study by Blackwell and colleagues also showed that, income and gender were predictors of health service utilization (Blackwell, Martinez, Gentleman, Sanmartin, & Berthelot, 2009).

In Ghana, a descriptive cross-sectional study conducted to assess factors that influence the utilization of CHPS services showed that, sex and income were associated with use of the services. Females were more likely to patronize the CHPS compounds as compared to the males. Also, households who earn GH₵200.00 or more were more likely to access health services compared with households earning less than GH₵ 100.00 (Wiru et al., 2017) In

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conclusion, although several studies by researchers have showed findings on the utilization of CHPS services in some regions in Ghana but not in the Ashanti region. This study however seeks to assess the level of knowledge of community members on CHPS services, assess the attitude of health workers towards users of healthcare service at the CHPS compounds and assess availability of logistics at the CHPS compounds in the Offinso North District, Ashanti region.

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CHAPTER THREE

METHODS

3.0 Introduction

This chapter presents the methods and procedures that were employed to carry out this study. It includes the study design that was used, the study site, study population and sample size. The chapter also highlights the data collection methods used in the study, data collection tools and techniques, ethical considerations as well as data processing and analysis.

3.1 Study design

This study was a descriptive cross-sectional study design involving both quantitative and qualitative approaches. For the quantitative approach, a semi-structured questionnaire and observational checklist were used collect information on factors influencing utilization of health services at the CHPS compound

while the qualitative component comprised Focus Group Discussions (FGDs) and In-depth interviews (IDIs) were used to collect additional information on factors influencing utilization of health services at the CHPS compound.

3.2 Study area

This study was conducted in the Offinso North District. It is one of thirty districts in the Ashanti Region of Ghana. The administrative capital of the district is Akomadan. The district was curved out of former Offinso district in 2008. It is located between latitude 7^0

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20 N and 6^0 50 W as well as longitude 1^0 60 W and 1^0 45 E. The district shares boundaries with Techiman Municipality to the north, Sunyani Municipality to the west, Offinso Municipality to the south and Ejura Sekyeredumasi District to the East. Per the 2010 population and housing censure, the total population of the district is 56,881 comprising 50.2% female and 48.8% male. About 95% of the population is rural. The population of the district is youthful with about 44.0% aged below 15 years with elderly persons (aged 60 years and above) in smaller proportion (3.9%). The total fertility rate of the district is 4.7. Also, the general fertility rate is 141.4 births per 1000 women aged 15-49 years which is the third highest in the region (Ghana Statistical Service, 2014). There are 24 CHPS zones in the district with 3 CHPS compounds. The CHPS compounds serve a population of about 18,556.

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Table 3.1 List of CHPS zones in Offinso North District

Name of sub-district	CHPS Zones
Akomadan	New Atwene
	Old Atwene
	New Mireku
	Old Mireku
	Zongo
	Ahenbronum-Afrancho
	Krofofrom-Afrancho
	Nsuase-Afrancho
	Nyinatase
	Sraneso 1
Nkenkaasu	Ebuom
	Nkramomu
	Dome/Esoro
	Wawase
	Darso
Mankramso	Mankramso
	Tanokwaem
Kobreso	Kobreso
	Nkwakwaa
	Akrofoa
Amponsakrom	Nyamebekyere 1
	Papasi
	Nseoafie / Amponsakrom
	Sarfokrom

Offinso North District Profile, 2018

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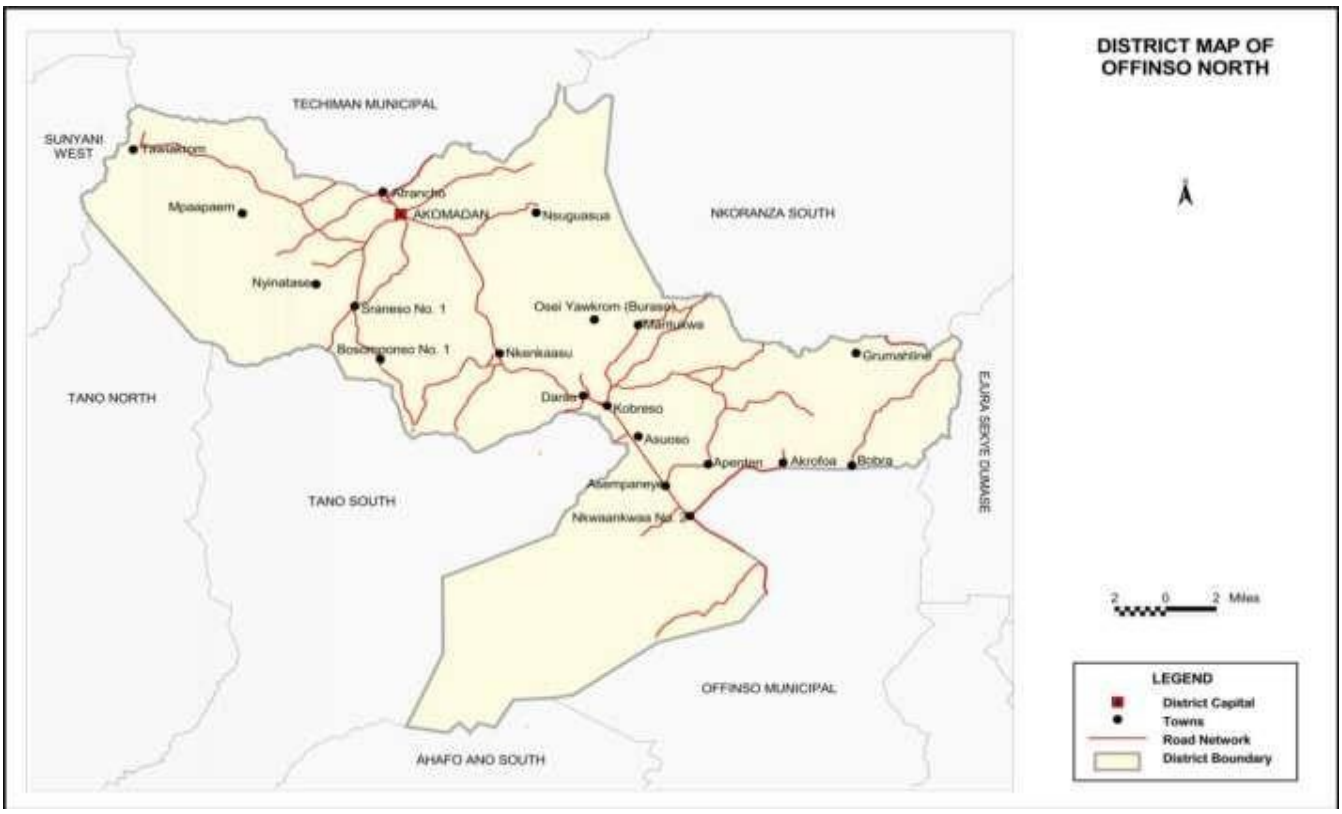

Figure 3.1: Map of Study Site

3.3 Study population

This study involved community members who access any health service at the CHPS compound, who have been residing in the communities within CHPS zones with CHPS compound in the Offinso North District for at least a year. Furthermore, Community Health Volunteers as well as Community Health Workers who are in the CHPS zones with CHPS compound also comprised the source population for this study.

3.4 Inclusion criteria

- Community members and health workers who reside in communities within CHPS zones with functional CHPS compounds were eligible for inclusion in this study.

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- Household heads aged 18 years above residing in communities within CHPS zones with functional compounds were also be eligible for participation in this study.

3.5 Exclusion criteria

Communities with functional CHPS zones without compounds will be excluded from this study.

3.6 Sample size

The Cochran formula was used to determine the sample size for this study. The formula is given as:

n= $\frac{Z^2pq}{e^2}$ (Cochran, 1977)

Where:

- n= required sample size
- Z^2 = standard normal deviate for two tailed-test based on 95% confidence level = 1.96
- p= proportion of community members using CHPS compounds for health care = 73.7%= 0.737 (Wiru et al., 2017)
- q=1-p= proportion of community members not using CHPS compounds for health care = 1-0.737 = 0.263
- e= margin of error = 5% = 0.05
- Therefore, the sample size will be calculated as follows
- N = $\frac{1.96^2 \times 0.737\ (1-0.737)}{0.05^2}$
- N= $\frac{3.8416\ \times 0.737\ \times 0.263}{0.0025}$

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- N= $\frac{0.744621}{0.0025}$
- N= 297.8 = 298 community members

A sample size of 7 and 48 were used for the In-depth Interview and Focus Growth Discussion respectively.

3.7 Data collection methods

Four data collection methods were used in this study; Focus Group Discussions, In-depth interviews, observation and cross-sectional survey.

3.7.1 Qualitative Approach

3.7.1.1 Focus Group Discussion

Focus Group Discussions were used to obtain information on community members' perception on the CHPS service. Furthermore, this technique was also used to explore issues that affect community members' utilization of CHPS services. FGDs was used because it is useful in gathering opinions and perceptions of several respondents systematically and simultaneously in informal and unstructured settings which promotes interaction and participation (Atuoye et al., 2015).

3.7.1.2 In-depth Interviews

In this study, seven in-depth interviews were conducted, one Community Health Officer (CHO), a Community Health Volunteer (CHV) from each CHPS compound and one member of the District Health Management Team (DHMT). The IDIs were conducted to obtain in-depth information with reference to the views of these CHPS stakeholders on

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the CHPS services. The interviews also helped in obtaining information on their experiences as well as perceptions on what they think influences community members use or disuse of CHPS compounds.

3.7.2 Quantitative Approach

3.7.2.1 Cross-sectional survey

A cross-sectional survey was conducted among community members to obtain information on their knowledge of the CHPS concept and services. Furthermore, the cross-sectional survey was done to acquire information on the attitudes of healthcare providers towards healthcare users'. A cross-sectional survey is appropriate because it allowed for a collection of data in a sample population at one point in time. The cross-sectional survey also helped to describe the relationships between study variables of interest.

3.8 Sampling Method

3.8.1 Quantitative Approach

Multistage sampling method was used in this study. First, a purposive sampling was used to select the sub districts and the CHPS zones with a CHPS compound. Then a simple random sampling via balloting was used to select two communities from each CHPS zones with compounds as the study sites. The total populations of the selected communities were obtained, and proportionate sampling was used to assign the number of study participants selected from each community.

The center of each community selected was located and a random direction was chosen via spinning a bottle. The direction of the tip of the bottle was followed and the houses in

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that direction were numbered on pieces of paper to the boundary of the community. Simple random sampling was used to select the first house by selecting a random number between one and the total number of houses in that direction. The first house became the starting point to the survey for all communities selected. Only one household was used in each selected house in this study. When there were more than one eligible household, only one household was selected at random to partake in the study. This procedure was repeated till the required number of participants was obtained in each study site.

In all, six communities from three CHPS zones with a CHPS compound were used in this study.

3.8.2 Qualitative Approach

3.8.2.1 Selection of FGD participants

First, both purposive sampling was used to select both male and female participants aged 18 years and above in the selected communities. Eligibility for participation in the FGDs was limited to individuals who have resided in the community for at least one year and patronize CHPS services. Purposive sampling was used to select sixteen (16) community members (eight (8) males and eight (8) females) from each of the three (3) CHPS zones with a compound (Tanokwaem, Sraneso No. 1 and Amponsakrom) for participation in the FGDs. In doing this, a community leader was engaged in helping the researcher identify eight to twelve participants of both sexes for inclusion into the FGDs. Two separate FGDs, one for each sex, was conducted in each selected community. Community members selected for the cross-sectional surveys were excluded from participating in the FGDs.

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3.8.2.2 Selection of IDI participants

The IDI participants were selected after the selection of CHPS zones and communities for the FGDs. One CHO and a CHV from each of the three CHPS zones with compound were randomly selected and interviewed in this study. Furthermore, a member of the DHMT was also randomly selected for the IDI.

3.9 Data collection technique and tools

Four main data collection techniques were employed in this study. The quantitative component of the study employed a cross-sectional survey technique while the FGDs and IDIs were used for collecting qualitative data from eligible study participants.

Based on the data collection techniques, four data collection tools were used in this study. A semi-structured questionnaire was used in the cross-sectional survey to obtain information on demographic characteristics as well as knowledge on the CHPS concept among community members. This data collection tool was also used to elicit information on the utilization of health services in CHPS utilization. Furthermore, an observational checklist was used to assess logistics and equipment issues that influence CHPS utilization. It also employed interview guides and FGD guides, which contained questions administered during In-depth interviews and FGDs respectively.

3.10 Data quality control

To ensure data quality, the data collection tools used in this study were validated via pre-testing. The pre-testing was done at the Offinso South Municipality which is adjacent to the study area. This helped to identify and address anticipated inconsistencies that could

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have be encountered. At the end of the pretesting, the research team discussed all the data collection tools and made final suggestions for modifications. In addition, to ensure data quality, research assistants used in this study were trained a week prior to the data collection to ensure they are conversant with the data collection tools. Data collectors were trained both in English and in Twi to cater for any language differences that would have been encountered on the field. During the data collection sessions, field supervisors were deployed regularly to monitor research assistants to ensure they adhere to guidelines. Also, at the end of each data collection session, the questionnaires were validated, and all errors were corrected. At the end of the data collection, data collected were double entered by two different data entry clerks to ensure validity. The template for data entry was coded to prevent typographical errors associated with data entry.

3.11 Study variables

3.11.1 Dependent variable

The dependent variable for this study was CHPS utilization in the Offinso North District. The utilization was determined by asking the questions 'do you visit the CHPS compound and how often do visit the CHPS compound'?

3.11.2 Independent variable

These include demographic characteristics of study participants as well as their knowledge on CHPS concept. Other independent variables will include the attitude of health workers, logistics and equipment used in providing services under the CHPS concept.

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3.12 Data analysis

3.12.1 Quantitative Analysis

The data collected were coded and entered using EpiData Manager Version 4.4.2.1 r1493. Data accuracy was checked and the clean database was converted to a Stata Version 15.0 IC file before analysis was done.

Simple descriptive statistics was conducted for categorical variables. Means and standard deviations were determined for continuous variables. Graphs and percentages were used to report on community knowledge, participation in CHPS utilization and attitude of health workers and their competencies.

Pearson Chi-square and Fisher's exact test were used to determine the association between the dependent variable (CHPS utilization) and independent variables (socio-demographic characteristics, knowledge on CHPS and attitude of health workers).

Multivariate analysis using unadjusted logistic regression was used to look for association between variables. Risk factors identified after the multivariate analysis have been fitted into multivariate logistic regression models where appropriate. Reported p-values in this study was two-sided with significance levels of less than 0.05.

3.12.2 Qualitative Analysis

The proceedings during the FGDs and IDIs were explicitly transcribed verbatim and translated into English by experts in local languages. Subsequently, recorded interviews and field notes were used to verify the transcribed recordings. These were done to generate themes and patterns. Participants' names were not used in the analysis and the report writing, however, some verbatim reporting was done in instances where the actual

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words of the participants were needed to make meaning or emphasize important issues. The results from the qualitative data analysis were used to support the quantitative findings.

3.13 Ethical consideration

Ethical approval for the study was obtained from the Ghana Health Service Ethical Review Committee (GHS-ERC 049/04/19). Permission was also sought from the Offinso North District Health Directorate. Each respondent was informed prior to the interview that they are under no obligation to take part and that they can withdraw at any time and that all answers will be treated with paramount confidentiality. All participants who agreed to be part of the study were made to sign or thumb print an informed consent form before the interview.

3.13.1 Consent for participants

Participants' consent was sought and they were informed prior to the interview that they are under no obligation to take part. Information sheet was given to each of the participant to sign or thumb print and after it has been signed or thumb-printed a copy of it was given to each of participant to keep.

3.13.2 Potential Risks and Benefits

This is a minimal risk as the study took only sometime of participants. The study did not present any inconvenience to participants since the time required to answer the questions was adhered to. The responses from participants has help to identify factors influencing

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CHPS utilization and also help to identify challenges when addressed will improve healthcare delivery in Offinso North District.

3.13.3 Privacy and Confidentiality

The interview was conducted in a private room to protect the participants and names of participants were not recorded. Information provided were coded and strictly treated confidential. Apart from the researcher and supervisor of this research, no one else will have access to the information provided whether in part or whole.

In the reporting and dissemination of the findings of this research, no personal identifiers such as name would be used.

3.13.4 Voluntary participation and withdrawal

Participation in this study was voluntary. Participants were free to answer part or the entire questionnaire. They chose to withdraw from the study or stop the interview at any time they wanted. Participants were also free not to answer any question(s) they find uncomfortable about. However, participants were encouraged to participate fully in this study to help identify factors influencing CHPS utilization in Offinso North and beyond.

3.13.5 Compensation

This study was purely voluntary and there was no monetary compensation or incentives for participation, but the information provided will help to improve on healthcare delivery.

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3.13.6 Data storage and usage

Data collected have been kept in a file and stored in a cabinet which is locked with key. Also, the softcopy of the data is stored on a computer and encrypted with password known only to the researcher.

3.13.7 Funding information

The study was self-sponsored.

3.13.8 Data ownership

The data generated will only be shared with stakeholders who will need it to make an informed decision. Findings and recommendations would be available at the School of Public Health.

3.13.9 Conflict of interest issues

No conflict of interest to declare, as this research us solely for academic purposes.

3.14 Expected Outcome

It is expected that the community members' level of knowledge and utilization of CHPS have been determined. Also, logistics and equipment used to render CHPS services has also been determined. Furthermore, the attitude and competencies of health workers on CHPS have been determined.

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CHAPTERS FOUR

4.0 RESULTS

4.1 Introduction

This chapter presents the analysis of data collected. The aim of this study was to determine factors influencing CHPS utilization in the Offinso North District.

4.1 Background characteristics

Two hundred and seventy-nine participants were involved in this study. The mean age of all participants was 35.7± 13.35. More (29.3%) participants were aged between 30 and 39 years with 28.3% aged 20 to 29 years. The least age group was those aged less than 20 years (8.4%). More than half (56.6%) of study participants were females. More than half 59.3% had no formal education, 20.5% had attained JHS education and (0.7%) had tertiary education. With regard to marriage, majority (75.8%) were married with 81.3% being monogamous marriages. Christianity was the dominant religion (89.9%) followed by Islam (6.7%) and African traditional religion (1.4%). Almost half (43.8%) of participants were Dagaatis, followed by Asantes (21.9%) and Kokomba (8.1%). Most participants (63.0%) had family sizes of about 5 to 10 people. Only 14.5% of the participants stated they had no children with 36.7% having more than five children and 20.2% with 1 to 2 children. With respect to monthly income, more than half (58.35) earned less than GHS100 with 4.0% earning more than GHS 500. A little more than half (52.9%) of respondents stated the CHPS compound was 1 kilometer away from their places of residence while 4.7% stated it was 4 kilometers. More than half (55.2%) were non-subscribers of NHIS and 72.7% indicated there was a health facility in their community.

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Table 4.1 Demographic characteristics of respondents

Variable	Frequency	Percentage (%)
Mean age (SD)	35.7(13.35)	
Age (years)		
< 20	25	8.4
20-29	84	28.3
30-39	87	29.3
40-49	47	15.8
50-59	31	10.4
60+	23	7.7
Sex		
Male	129	43.4
Female	168	56.6
Education		
None	176	59.3
Primary	4	1.3
JHS/Middle School	61	20.5
Secondary	54	18.2
Tertiary	2	0.7
Marriage		
Married	225	75.8
Single	52	17.5
Divorced	6	2.0
Widowed	14	4.7
Marriage type		
Monogamous	183	81.3
Polygamous	42	18.7
Religion		

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Christianity	267	89.9
Islam	20	6.7
African Traditional	4	1.4
Others	6	2.0
Tribe		
Dagaati	130	43.8
Asante/Akuapem/Bono	65	21.9
Kokomba	24	8.1
Baasare	16	5.4
Lobi	12	4.0
Mamprusi	10	3.4
Others	40	13.5
Family size		
< 5	76	25.6
5-10	187	63.0
10+	34	11.4
Occupation		
Farmer	261	87.9
Student / Pupil	11	3.7
Teacher	1	0.3
Trader	10	3.4
Unemployed	14	4.7
Number of children		
No child	43	14.5
1-2 children	60	20.2
3-4 children	85	28.6
5+ children	109	36.7
Income (GHS)		
< 100	173	58.3

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100-500	112	37.7
>500	12	4.0
Distance to CHPS compound		
1 kilometer	157	52.9
2 kilometers	88	29.6
3 kilometers	38	12.8
4 kilometers	14	4.7
NHIS status		
Active subscriber	133	44.8
Non-subscriber	164	55.2
Have health facility in community		
Yes	216	72.7
No	81	27.3

4.2 Utilization of CHPS

Utilization of CHPS is summarized in table 4.2 below. A little more than half (51.2%) of participants said they have ever visited CHPS compounds. Out of this proportion, a large proportion (97.3%) indicated they visited the CHPS compound occasionally. The main means of getting to the CHPS compound was via walking (83.5%). The services sought at the CHPS compound included clinical services (42.1%), treatment for malaria (26.3%) and child welfare clinic services (3.3%). Out of the 152 participants who alluded to the fact that they utilize CHPS services, majority (87.5%) were satisfied with the services provided.

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Table 4.2 Utilization of CHPS

Variable	Frequency	Percentage
Ever visit CHPS compound		
Yes	152	51.2
No	145	48.8
How often do you visit CHPS compound		
Once a week	1	0.7
Thrice a week	3	2.0
Occasionally	148	97.3
Means to get to CHPS compound		
Motorbike	25	16.5
On foot	127	83.5
Services sought at CHPS compound		
Clinical services	64	42.1
Malaria	40	26.3
Child welfare clinic	5	3.3
Others	43	28.3
Satisfied with services at CHPS compound		
Yes	133	87.5
No	19	12.5

4.3 Knowledge on CHPS

Participants were assessed on their knowledge on CHPS. Only 8.4% indicated they had heard about CHPS. Out of this number, more (36.0%) stated the concept of CHPS entails bringing health closer to the home of community members while 8% said CHPS meant community ownership and 28% did not know what CHPS was. Among those who stated they heard about CHPS, more than

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half (52.05) opined CHPS functioned to treat minor ailments, provide immunization services, family planning services as well as antenatal care services. With regard to how CHPS enhances access to health care delivery, majority indicated CHPS reduces the cost of health services (Table 4.3).

Table 4.3 Knowledge on CHPS

Variable	Frequency	Percentage
Heard of CHPS		
Yes	25	8.4
No	272	91.6
What is CHPS		
Bringing health closer to your home	9	36.0
Community ownership	2	8.0
Others	7	28.0
Do not know	7	28.0
Functions of CHPS		
Treat minor ailments/immunization/family planning, antenatal care	13	52.0
Can't tell	10	40
Don't know	2	8.0
How does CHPS enhance access to health care delivery		
Located close to people	10	40.0
Reduced cost	15	60.0

4.4 Attitude of Health workers

With regard to health workers' attitude, most (76.1%) of participants had the view that community health officers were always available in the community while 4.2% stated otherwise. Additionally, a large proportion (86.2%) of participants indicated they were attended to by community health

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officers while 87.5% also stated they were welcomed upon arrival at CHPS compounds. Furthermore, 84.2% said they received advice on the conditions they presented with at the CHPS compound, 87.5% opined they received explanation on their conditions and 92.8% were satisfied with services rendered by community health nurses. More (83.6%) of the participants were satisfied with the attitude of their attendants.

Table 4.4 Attitude of Health workers

Variable	Frequency	Percentage
Are Community Health Nurses always available in the community?		
Always	182	76.1
Not at all	10	4.2
Sometimes	47	19.7
Who attends to you when you visit CHPS compound		
Community Health Nurse	131	86.2
Midwife	21	13.8
Are you welcome on arrival		
Yes	133	87.5
No	18	12.5
Are you given advice on your condition		
Yes	128	84.2
No	24	15.8
Are you given explanation on your condition		
Yes	133	87.5
No	19	12.5

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Are you always satisfied with services rendered by Community Health Nurses?		
Yes	141	92.8
No	11	7.2
What is the attitude of your attendant towards you?		
Satisfactory	127	83.6
Not satisfactory	25	16.4

4.5 Factors influencing utilization of CHPS

Multivariate logistic regression was performed to determine factors influencing the utilization of CHPS. Sex of respondents, number of children and distance to CHPS compound were significantly associated with the utilization of CHPS. The logistic regression test showed that women were almost three times more likely to use CHPS services compared to their male counterparts (AOR=2.39; 95% CI: 1.30-4.36; p=0.005). The model also predicted that increasing number of children increases the odds of using CHPS. Participants with 1 to 2 children were 7 times more likely to utilize CHPS compared to those with no children (AOR=7.08; 95% CI: 1.76-28.41; p=0.006). Similarly, those with more than five children were also 6 times more likely to utilize CHPS compared to those who had no children (AOR=6.53; 95% CI: 1.36-31.32; p=0.019). table 4.5 also showed that increasing distance of CHPS compound from the residence of participants decreases the odds of using CHPS. Individuals whose houses were 2 kilometers from the CHPS compound were 52% less likely to use CHPS compared to those closer to the CHPS compound (AOR=0.48; 95% CI: 0.27-0.89; p=0.019). Additionally, participants who stayed five kilometers away from the CHPS compound were 88% less likely to use CHPS compared to those closer to the CHPS compound (AOR=0.12; 95% CI: 0.03-0.57; p=0.008).

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Table 4.5 Factors influencing utilization of CHPS

	Crude Odds Ratio	Adjusted Odds Ratio
Variable	**OR (95% CI) p-value**	**OR (95% CI) p-value**
Age (years)		
< 20		Reference
20-29		0.62(0.12-3.23) 0.569
30-39	1.20(1.02-1.42) 0.032	1.08(0.19-6.16) 0.934
40-49		0.81(0.13-5.15) 0.821
50-59		0.62(0.09-4.26) 0.625
60+		
Sex		
Male	3.48(2.15-5.63) 0.000	Reference
Female		2.39(1.30-4.36) 0.005
Education		
None		
Primary	1.53(1.17-2.00) 0.002	
JHS/Middle School		
Secondary		
Tertiary		
Marriage		
Married		
Single	0.77(0.57-1.06) 0.114	
Divorced		
Widowed		
Marriage type		
Monogamous	0.80(0.41-1.57) 0.514	

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Polygamous		
Religion		
Christianity	1.47(0.91-2.37) 0.112	
Islam		
African Traditional		
Others		
Family size		
< 5	1.77(1.19-2.64) 0.005	Reference
5-10		0.82(0.32-2.15) 0.691
10+		1.26(0.39-4.02) 0.697
Occupation		
Farmer		Reference
Student/Pupil	0.74(0.58-0.95) 0.021	0.12(0.05-2.89) 0.192
Teacher		0.09(0.03-2.57) 0.160
Trader		0.25(0.04-1.41) 0.117
Unemployed		1.37(0.35-5.41) 0.654
Number of children		
No child		Reference
1-2 children	1.46(1.17-1.82) 0.001	7.08(1.76-28.41) 0.006
3-4 children		11.22(2.37-53.16) 0.002
5+ children		6.53(1.36-31.32) 0.019
Income (GHS)		
< 100		
100-500	0.99(0.98-1.00) 0.084	
>500		
Distance to CHPS compound		
1 kilometer		Reference
2 kilometers	0.64(0.53-0.77) 0.000	0.48(0.27-0.89) 0.019
3 kilometers		0.12(0.05-0.31) 0.000

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4 kilometers		0.12(0.03-0.57) 0.008
NHIS status		
Active subscriber	0.55(0.34-0.87) 0.011	Reference
Non-subscriber		0.58(0.32-1.06) 0.079
Satisfied with services at CHPS compound	0.15(0.03-7.58) 0.340	
Yes		
No		
Heard of CHPS		
Yes	0.68(0.29-1.56) 0.359	
No		
What is the attitude of your attendant towards you?	0.20(0.04-10.31) 0.424	
Satisfactory		
Not satisfactory		

4.6 Logistics and equipment availability on CHPS Utilization

In this study, a 42-item checklist was used to assess the logistics and equipment availability at three CHPS compounds. At the Amponsakrom CHPS compound, the following items were available: communication equipment, vaccine carrier, mackintosh sheet, information, education and communication material and methylated spirit. Additionally, alcohol hand rub, bandages. Chlorine solution, cotton swabs, disposable cloves and syringes and malaria rapid diagnostic tests (RDTs) were available.

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Table 4.6 Facility assessment of Amponsakrom CHPS compound

No	Variable/Item			Remarks
	Number of health workers on duty	**Male**	**Female**	
		0	2	
	Total	**0**	**2**	
		Yes	**No**	**Remarks**
	Health promotion posters			
	CHN home visiting bag			
	Availability of community Health Action Plan (CHAP)			
	CHO Movement Wheel			
	Community map for your CHPS			
	Zonal map for your CHPS			
	Report on community needs assessment			
	Detailed Community Profiles			
	Daily activity map for your CHPS/community			
	Reports on Health promotion services (school health, home visits)			
	Weight scale (s)			
	BP apparatus			
	Thermometer			
	Vaccine fridge			
	Rucksack			
	Motorbike (s)			
	Vaccines			
	Essential drugs			
	Contraceptive			
	RDT for malaria			
	Communication instrument			
	Resuscitation kit			
	Vaccine carrier			
	Mackintosh sheet			
	Information, education and communication materials (IEC)			
	Methylated Spirit			
	Alcohol Hand Rub			
	Plastic apron			
	Bandages/plaster			
	Chlorine solution or powder			
	Cotton swabs/gauze			
	Disposable syringes, 1 cc			
	Disposable syringes, 5 cc			
	Gloves, disposable			
	Gloves, sterile			

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	Gloves, utility.			
	Malaria Rapid Diagnostic Test.			
	Scissors.			
	Suturing set			
	Delivery bed			
	Delivery set			

At the Sraneso CHPS compound, the following materials were not available: resuscitation kit, plastic apron, bandages/plaster, suturing set, delivery bed and delivery set (Table 4.7).

4.7 Table Facility assessment of Sraneso CHPS compound

No	**Variable/Item**			**Remarks**
1.	Number of health workers on duty	**Male**	**Female**	
		1	2	
	Total	**1**	**2**	
		Yes	**No**	**Remarks**
2.	Health promotion posters			
3.	CHN home visiting bag			
4.	Availability of community Health Action Plan (CHAP)			
5.	CHO Movement Wheel			
6.	Community map for your CHPS			
7.	Zonal map for your CHPS			
8.	Report on community needs assessment			
9.	Detailed Community Profiles			
10.	Daily activity map for your CHPS/community			
11.	Reports on Health promotion services (school health, home visits)			
12.	Weight scale (s)			
13.	BP apparatus			
14.	Thermometer			
15.	Vaccine fridge			
16.	Rucksack			
17.	Motorbike (s)			
18.	Vaccines			
19.	Essential drugs			
20.	Contraceptive			
21.	RDT for malaria			
22.	Communication instrument			
23.	Resuscitation kit			
24.	Vaccine carrier			

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25.	Mackintosh sheet.			
26.	Information, education and communication materials. (IEC)			
27.	Methylated Spirit.			
28.	Alcohol Hand Rub.			
29.	Plastic apron.			
30.	Bandages/plaster			
31.	Chlorine solution or powder.			
32.	Cotton swabs/gauze.			
33.	Disposable syringes, 1 cc.			
34.	Disposable syringes, 5 cc.			
35.	Gloves, disposable.			
36.	Gloves, sterile.			
37.	Gloves, utility.			
38.	Malaria Rapid Diagnostic Test.			
39.	Scissors.			
40.	Suturing set			
41.	Delivery bed			
42.	Delivery set			

Table 4.8 summarizes the facility assessment for the Tanokwaem CHPS compound. The facility had 2 male community health nurses and one female community health nurse. Community health action plan, resuscitation kit, mackintosh sheet, delivery set and delivery bed were not available at the time of assessment. Furthermore, methylated spirit, alcohol hand rub and cotton swabs were not available.

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Table 4.8 Facility assessment of Tanokwaem CHPS compound

No	Variable/Item			Remarks
1.	Number of health workers on duty	**Male**	**Female**	
		2	1	
	Total	**2**	**1**	
		Yes	**No**	**Remarks**
2.	Health promotion posters			
3.	CHN home visiting bag			
4.	Availability of community Health Action Plan (CHAP)			
5.	CHO Movement Wheel			
6.	Community map for your CHPS			
7.	Zonal map for your CHPS			
8.	Report on community needs assessment			
9.	Detailed Community Profiles			
10.	Daily activity map for your CHPS/community			
11.	Reports on Health promotion services (school health, home visits)			
12.	Weight scale (s)			
13.	BP apparatus			
14.	Thermometer			
15.	Vaccine fridge			Not in use
16.	Rucksack			
17.	Motorbike (s)			
18.	Vaccines			Brought in from another facility
19.	Essential drugs			Not all were available
20.	Contraceptive			
21.	RDT for malaria			
22.	Communication instrument			
23.	Resuscitation kit			
24.	Vaccine carrier			
25.	Mackintosh sheet.			
26.	Information, education and communication materials (IEC).			
27.	Methylated Spirit.			
28.	Alcohol Hand Rub.			
29.	Plastic apron.			
30.	Bandages/plaster.			

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31.	Chlorine solution or powder.		[redacted]	
32.	Cotton swabs/gauze.		[redacted]	
33.	Disposable syringes, 1 cc.	[redacted]		
34.	Disposable syringes, 5 cc.	[redacted]		
35.	Gloves, disposable.		[redacted]	
36.	Gloves, sterile.		[redacted]	
37.	Gloves, utility.	[redacted]		
38.	Malaria Rapid Diagnostic Test.	[redacted]		
39.	Scissors.	[redacted]		
40.	Suturing set		[redacted]	
41.	Delivery bed		[redacted]	
42.	Delivery set		[redacted]	

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4.7 Results from Focus Group Discussions

The Focus Group Discussions were conducted to obtain information on community members' perception on CHPS concept and also used to explore issues that affect community members' utilization of CHPS services. Two (2) groups comprising of eight (8) males and eight (8) females each from three (3) CHPS zones used for the focus group discussion revealed the following results, which are presented under themes identified.

Knowledge about services at CHPS compounds

From the FGD, all male groups had adequate knowledge about the CHPS services.

Most male participants' said, *"CHPS is for treatment of minor illnesses and giving of first aid"*.

Another participant also reported that *"What I know is that in CHPS compound doctors are not there but only community nurses are present".* However, most (20) participants from the female focus group claimed they had no idea about the CHPS concept.

Whether CHPS compound is addressing your health needs

All participants from the two (2) groups were of the view that CHPS compound situated in their catchment area aids in addressing part of their health seeking needs. Most of the participants argued on the back drop that the CHPS compound lack adequate drugs to address all their ailments they present at the CHPS compound. Some were also attributed their reason to the fact that there is no midwife at each of the CHPS compound.

One participant said, *"Somehow because they do not have drugs, there is no midwife too"*.

Other participants reported that: *"The midwife (CHPS doctor) has been transferred to Akumadan"*.

Also, another participant from the male group affirmed this claim by saying, *"Halfway because they do not have drugs, there is no midwife too"*

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Some participants also confirmed that, CHPS compound has fully addressed their health needs. A female respondent said, *"it is easier to access health care since its close to us no transportation is needed"*. Another participant also said, *"it reduces cost because no transport fare is needed"*.

Whether participants access the CHPS compound

From the focus group discussions, most (18 participants) out of the twenty-four (24) participants from the male group, claimed they hardly utilise the CHPS compounds. One male participant said,

"I go there once a while. Only when I get sick and when my children get sick. My farming work doesn't give me enough time to be visiting the health facility".

On the other hand, most of the participants from the female group (21 participants) stated they regularly use the CHPS compound.

A female participant added by saying, "*I go there very often to get my child and myself check anytime I feel I'm getting sick. I also have a one-year baby who is currently receiving her required vaccination. So even if I'm not sick I often go there to get my daughter vaccinated"*.

Another female participant also supported this by saying, "*I often visit the CHPS compound about two times in a month to get health advice to deal with my dysmenorrhea*."

Whether participants are satisfied with the services of the CHPS compound

All participants from both male and female groups were of the view that, services provided by the CHPS compound were to their satisfaction.

One male participant said: *"Yes they work perfectly to my satisfaction"*

Another male participant said: *"Yes I took my child and was treated well"*

A female participant also stated that: *"We cannot say any bad thing against the health workers at the compound"*.

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Attitude of CHOs at the CHPS compound

All participants described attitude of CHOs at the CHPS compound as good with nothing bad to complain of. A female participant said, *"We can't say any negative thing against them. They render better health care to us. Even the way they speak to us give us assurance without medication we are healed"*.

A male participant also said, *"Perfect even when they are eating they will stop and attend to you"*. Another male participant said, *"Best they even visit us in our houses to see how we are doing"*.

4.8 Results from the In-Depth Interview

4.8.1 Community Health Officers / Community Health Volunteers / DHMT member

A total of seven (7) interviewees, two (2) from the three (3) CHPS compounds and a DHMT members were engaged to solicit their views on the CHPS concept and obtaining information on their experiences as well as perceptions on what they think influences community members use or disuse of CHPS compounds.

Staff Strength

The result from the in-depth interview revealed staff strength of four (4) to five (5) each at a CHPS compound, which were mainly CHOs (with Community Health Nursing background) were stationed at the three (3) CHPS compounds used for the study. This according to staff interviewed, staff stationed at the CHPS compounds are not enough to run a quality of care to the inhabitants in the catchment areas.

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One Participant pointed out that, *"No, because some are about to go to school and looking at the population is huge and we don't have a Midwife"*. Another participant also said, *"No because we don't have a Midwife*".

Services provided at CHPS compound

Among the many activities provided in the CHPS compound included CWC, management of minor ailments, family planning as stated by participants during the interview. One participant stated that, *"CWC services, management of minor illnesses, Family planning services when asked for ANC services she said No due to the absence of a qualified midwife"*

Conducting home visit

All participants interviewed confirmed of their regular visit to the communities to offer services. In describing home visit schedules. One participant said, *"We go three times in a month once in a week and are normally Tuesdays to trace for defaulters for CWC and ANC as well as encourage the sick to visit a health facility to seek for medical treatment"*

Functional CHMC

All participants affirmed the existence and functioning of CHMC. They also confirmed that all CHMC members had been trained. When asked about training for CHMC members, a participant said, *"Yes, we were trained by the District health officers. Specifically, the district disease control officer".*

Another participant also added that, *"Yes, we were trained by the District Disease Control Officer from the District Health Directorate*".

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Community engagement at CHPS level by CHOs

All participants revealed they have a high level of community engagement to address their health issues. A participant stated, *"Last time meeting held was last quarter, the meeting is held on every quarter, therefore since I came to this zone, we have meet on sixteen times. We discussed our minor challenges thus weeding of the facility, providing toilet facility and pit. Insurance accreditation and lack of motorbike which have now been provided by the district health directorate. The stakeholders present for the meetings were the chief, assembly member and the CHMC".*

Community participation

The result from the in-depth interview revealed there is a high community participation with respect to health issues and activities concerning them. All participants interviewed agreed to this fact of great community participation.

A participant stated, *"They are very helpful in terms of weeding and cleaning around the facility, they provide basic needs to the CHNs like pit latrine, sometimes gives us food stuffs, organized students to fetch us water, they organize durbars for the facility".*

Another participant also said, *"They weed and clean around the facility, they provide basic needs to the CHNs, they organize durbars etc for the facility".*

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Suggestion to strengthen CHPS implementation

In the in-depth interviews, all respondents suggested that, electricity, adequate supply of drugs and midwife at the CHPS level would go a long way to ensure smooth implementation of CHPS activities.

A participant said, *"We need electricity and a permanent midwife and adequate supply of drugs".* Another participant also stated that, *"We need a permanent midwife and adequate supply of drugs"*

4.8.2 Community Health Volunteer

Knowledge on CHPS and its functions

All participants said CHPS was instituted to provide health care to community members by getting health care close to community members. One participant said. "*CHPS provides health services in rural areas"* Most of the participants also said the function of CHPS is to, "Manage illness and Referral of cases".

Responsibilities as a CHV in relation to CHPS activities

Form the results obtained, the CHVs revealed the various tasks they performed include;

Assists during CWC, carry out Onchocercaisis drug distribution, mobilise community to participate in health programmes.

Services provided at CHPS compound

The result from the in-depth interview revealed that, almost all of them shared a common list of services provided at the CHPS compound. They stated these as services the CHPS compounds render;

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"Treatment of minor ailments, referral of cases, immunization, growth monitoring, conduct regular home visits, Conduct home visit, health education"

Attitudes of CHOs at the CHPS Compound

All participants interviewed affirmed that, Community Health Officers stationed at the various CHPS compounds have good attitudes which really enhances health care delivery.

A male interviewee stated that, *"if I say there is something wrong with their attitude then I am not grateful"*.

Ways to support service delivery by the CHPS

Participants were asked how they can support service delivery at the CHPS level. Almost all the three interviewees seem to provide great assistants to CHOs in their respective CHPS compounds. One participant said. *"I mobilise community members for immunization"*. Another participant also said, *"I conduct home visits for utilization of the compound"*

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CHAPTER FIVE

5.0 DISCUSSION

Introduction

This chapter presents the discussion, conclusion and recommendations of this study. The discussion explains the findings of the study. The conclusion presents a summary of the results that were obtained in the study. The recommendations suggest further areas that need to be considered to improve the study.

The level of knowledge of community members on CHPS services

This study revealed low knowledge level on CHPS services, as 25 (8.4%) of the respondents indicated they had heard about CHPS. A similar result was realized from the focus group discussions as most (20) out of the 24 females who took part in the focus group discussions, claimed they had not heard of the CHPS service.

This could be attributed to the backdrop that, in the rural settings, women are not allowed by their husbands to get into dialogue with 'third parties'. It is essential that, one-on-one health education and promotion are effective for passing information to community members. Most women in the rural settings are deprived of this method as a result of male dominancy, cultural norms undermined real opportunities for broad-based community empowerment, particularly of women (Baatiema, Skovdal, Rifkin, & Campbell, 2013).

Mostly, messages and details about CHPS and other health information are normally discussed with husbands especially during home visits, before they (husbands) pass on the information to their wives which normally doesn't happen as expected.

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However, out of this number (25), more (36.0%) stated the services of CHPS entails brining health closer to the home of community members while 8% said CHPS meant community ownership and 28% did not know what CHPS was. Among those who stated they heard about CHPS, more than half (52.05) opined CHPS functioned to treat minor ailments, provide immunization services, family planning services as well as antenatal care services.

With regard to how CHPS enhances access to health care delivery, majority indicated CHPS reduces the cost of health services (Table 4.3). Similar views were deduced from the in-depth interview done with Community Health Volunteers.

The findings from this study showed that more females than males were more likely to utilize CHPS services (AOR=2.39; 95% CI: 1.30-4.36; p=0.005). The focus group discussion conducted for community members to solicit their utilisation level of the CHPS compound situated in their various communities revealed similar results. In the focus group discussion, it was discovered that, more females (21) out of the 24 who took part in the discussion, visited the CHPS compound more often compare to their male counterparts which revealed only 6 participants out of the 24 male claimed of utilising the facility occasionally.

This may be attributed to the backdrop that, in most rural settings, females' health seeking behaviour and that of their children, is obviously higher since most women are mostly the wardens of children in most family, compared to their male counterpart. This findings in this study contradicts a study by Karbo in 2015 which concluded that more males than females utilised health facilities (Karbo, 2015). The findings in this study however conform to similar study which also stated that health-seeking behaviour has been documented to be influenced by such socio-demographic factors as gender (Thompson et al., 2016). Thompson and

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colleagues further documented that more females than males access health facilities (Thompson et al., 2016).

This study also discovered that, respondents with more children were more likely to utilize CHPS services than respondents without children. This finding was overt during the focus group discussion. Almost all participants with children especially under 5 years were of the view that even if they are no intention to visit the CHPS compound, they often had no choice but to visit because of their children vaccinations. Consistent with the findings of this study, Quansah and colleagues (2016) discovered that due to some social determinants, mothers are quick to report to health facilities in the event of ill-health of their children (Quansah, Ohene, Norman, Mireku, & Karikari, 2016). They documented such social determinants as maternal education, maternal age at birth, family income and rural-urban disparities (Quansah et al., 2016). One of the challenges the CHPS initiative seeks to bring an end to includes childhood mortality, which was documented to be about 40% higher in communities that were located beyond 5 kilometres from health facilities (GHS, 2005). Again, the Ministry of Health (MOH) documented a great disparity in health status between urban and ural areas in the country. An overwhelming 60% mortality rate was recorded in rural areas, higher than rates in urban areas (MOH, 2001). Thus, the response of respondents is encouraging, and proves that the CHPS initiative will go a long way to reduce infant mortality in the country.

The results of this study showed that increasing distance of CHPS compounds from respondents' place of residence decreased their tendency to seek CHPS services. It was discovered that respondents who stayed about 2 kilometers away from CHPS compounds were about 52% less likely to have their health needs met at CHPS compounds. Respondents who stayed about 5 kilometers away were about 88% less likely to visit CHPS compounds. This is similar to a study conducted by Yeleduor (2012 page 44). She documented in her study that

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frequency of visit to CHPS compounds depended on the facility availability within communities. Communities with CHPS compounds had an average of four times visit per individual in a year, whereas communities without CHPS compounds recorded an average of one time visit per individual per year (Yeledour, 2012). The Ghana Health Service (GHS) has defined access as "the ability to reach a health facility within one hour of travel time, or location of facility within 8 kilometers distance (GHS, 2005; Yeledour, 2012). The CHPS initiative was designed with distance from health facilities in view. The gap it sought to fill was to solve the problem of about 70% of Ghana's population who reside in communities that are over 5 kilometers from the nearest health facility (GHS, 2010). The uncooperative response of respondents can therefore be attributed to the long distance of their places of residence from the CHPS compounds.

Community participation has been documented to be a pre-requisite for successful outcome of health service interventions (Baatiema, Skovdal, Rifkin, & Campbell, 2013). This study assessed respondents' knowledge about the CHPS initiative, which ultimately influenced their participation. The findings of this study proved that about 42.1% respondents accessed CHPS compounds for clinical services, whereas 26.3% visited to treat malaria. Overall, only about 51.2% of respondents accessed CHPS compounds to have their health needs met.

Similarly, results from the focus group discussion revealed that, all participants engaged for the discussion claimed their health needs were not met adequately. They attributed this unmet need to fact that almost all the CHPS compound lacks adequate personnel (most especially midwives) coupled with non-availability of needed drugs. A positive and strong relationship between education and health-seeking behaviour has been established in previous studies (Karbo, 2015). This is because educated individuals are better informed to make health-based decisions. About 59.3% of respondents had no formal education and this emphasises why patronage of CHPS compounds was low.

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Attitude of health workers and their competencies

The CHPS initiative was designed to be headed by community health nurses (CHOs) (Woods, Haruna, Konkor, & Luginaah, 2019). The findings of this study proved that respondents were satisfied with the attitude of CHOs. Many reported being welcomed by the nurses on arrival at the CHPS compounds. Others also reported receiving counsel from the nurses on the conditions they presented with at the CHPS compounds.

The findings of this study further revealed that, about (19.7%) of participants claimed that, community health officers are not always available at their post. This finding in this study is significantly higher compare to a descriptive cross sectional study conducted in Kintampo North Municipality to determine the factors associated with the challenges faced and use of CHPS services by community members revealed 12.3%, absenteeism of Community Health Officers (Wiru et al., 2017).

Similar result was revealed in the both the focus group discussions and the in-depth interviews. All participants and interviewees in both the focus group discussions and the in-depth interview commended all CHOs in the various CHPS compound for their good attitude and good conduct towards care provision in their communities.

Consistent with the findings of this study, Karbo (2015) documented that, community members expressed satisfaction with health services provided by community health nurses (Karbo, 2015). Yeledour (2012) documented that midwives, in the place of community health nurses/officers, operate some CHPS compounds (Yeledour, 2012). Several other studies have documented staff members at CHPS compounds to include community health nurses, midwives and general nurses (Assan, Takian, Aikins, & Akbarisari, 2018; Karbo, 2015). In the absence of other staff members, community health nurses have been documented to be trained

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with midwifery roles to improve efficiency of service delivery in CHPS compounds (GHS, 2014; Johnson et al., 2015)

Logistics and equipment challenges that influence CHPS utilization

Quality health care delivery especially at the grassroots, is always an essential means of bridging the gap of inequitable distribution of primary health care between rural and urban dwellers. One major challenge faced by primary care givers at grassroots or hard-to-reach areas is erratic or no supply of drugs and non-drugs to the point of service delivery. For these reasons, some health facilities situated in such geographical location are mostly under-utilized.

A 42-item checklist was used in assessing the logistics and equipment availability at the three CHPS compounds. It was revealed that, a number of essential logistics were not available at CHPS compounds which impedes the quality of health care delivery in the CHPS compounds.

Essential items such as; community health action plan, resuscitation kit, mackintosh sheet, delivery set and delivery bed were not available at the time of assessment at Tanokwaem CHPS compound. Furthermore, methylated spirit, alcohol hand rub and cotton swabs were not available. The facility however, had 2 male community health nurses and one female community health nurse stationed at the CHPS compound.

This study also revealed that Amponsakrom CHPS compound had most of logistics available as the time of assessment. These items included: communication equipment, vaccine carrier, mackintosh sheet, information, education and communication material and methylated spirit. Additionally, alcohol hand rub, bandages. Chlorine solution, cotton swabs, disposable cloves and syringes and malaria rapid diagnostic tests (RDTs) were available.

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This study further revealed that, Sraneso CHPS compound, lacks logistics such as; resuscitation kit, plastic apron, bandages/plaster, suturing set, delivery bed and delivery set. The facility also had one male community health nurse and two female community health nurses.

These shortages or non-availability of essential logistics can be attributed to lack of financial support from both the government agencies (GHS and MOH) and other private agencies or philanthropies. As earlier discussed, most of the people who accessed health care at the three CHPS compounds, stated lack of drugs and no midwives at post as reasons for unmet health needs. This finding confirms another cross-sectional study conducted in Komenda-Edina-Eguafo Abrem Municipality to assess the utilization of the CHPS facilities which revealed that, drug unavailability, lack of midwifery services, were challenges in the utilization of CHPS services in the municipality (Wood, 2013). The unavailability of essential logistics discovered in this study is also in line with a study conducted in Nigeria which also revealed that, inadequate skilled personnel, medicines, poverty and distance to health facilities were factors hampering health service utilization (Uchendu, Ilesanmi, & Olumide, 2013).

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CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Many (51.2%) of the respondents in this study stated that they utilize CHPS compounds in their communities, usually by walking. Health services provided at the several CHPS compounds included clinical services, treatment of malaria and child welfare clinic (CWC) among others. Majority of the respondents were satisfied with the services provided at the CHPS compounds they utilized. Although respondents visited CHPS compounds to have their health needs met, about 28% stated they had no knowledge on CHPS. Respondents, however, indicated that CHPS reduces the cost of accessing health services. Respondents reported health workers present at the CHPS compounds most of the time. Health workers were described to be cordial and provided advice and counsel on disease conditions. Factors that were discovered to influence the utilization of CHPS compounds included gender of respondents, number of children they had, and the distance to the CHPS compounds.

6.2 Recommendations

It is evident from the findings of this study that although CHPS compounds are located within accessible range from residence of respondents, respondents who stay beyond 5 kilometers away from the health facilities refuse to utilize the services.

The Ghana Health Service should organise community engagement activities to encourage residents who live within range of CHPS compounds to utilize the health services at CHPS compounds. The Ghana Health Service should also provide the needed logistics, equipment and adequate staff at the CHPS compounds to improve health service to encourage residents to assess health care services at the CHPS compounds.

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In addition, the central government, district assemblies and other agencies that constructed the CHPS compounds for the district health directorates should make sure the needed logistics and basic equipment are provided for smooth implementation to CHPS services.

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APPENDIX 1

1. DATA COLLECTION TOOL

OBSERVATIONAL CHECKLIST FOR CHPS

Name of Interviewer: …….....

Date of observation (DD/MM/YYY) ...../……/…….....

Time of observation; Start time…… End time…….

Name of district……...

Name of sub-district……...

Name of community …….

Name of CHPS compound……

No	Variable/Item			Remarks
1.	Number of health workers on duty	**Male**	**Female**	
	Total			
		Yes	**No**	**Remarks**
	Health promotion posters			
	CHN home visiting bag			
	Availability of community Health Action Plan (CHAP)			
	CHO Movement Wheel			
	Community map for your CHPS			
	Zonal map for your CHPS			
	Report on community needs assessment			
	Detailed Community Profiles			
	Daily activity map for your CHPS/community			
	Reports on Health promotion services (school health, home visits)			
	Weight scale (s)			
	BP apparatus			
	Thermometer			
	Vaccine fridge			
	Rucksack			
	Motorbike (s)			
	Vaccines			
	Essential drugs			

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	Contraceptive			
	RDT for malaria			
	Communication instrument			
	Resuscitation kit			
	Vaccine carrier			
	Mackintosh sheet			
	Information, education and communication materials (IEC)			
	Methylated Spirit			
	Alcohol Hand Rub			
	Plastic apron			
	Bandages/plaster			
	Chlorine solution or powder			
	Cotton swabs/gauze			
	Disposable syringes, 1 cc			
	Disposable syringes, 5 cc			
	Gloves, disposable			
	Gloves, sterile			
	Gloves, utility			
	Malaria Rapid Diagnostic Test			
	Scissors			
	Suturing Set			
	Delivery Bed			
	Delivery Set			

Observe and tick for availability of the following:

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APPENDIX 2

2. DATA COLLECTION TOOL

QUESTIONNAIRE

A student from School of Public Health, University of Ghana, is conducting this research to identify factors influencing CHPS utilization strength and functionality of CHPS in terms of logistics and equipment issues and attitudes and level of competencies of workers at the Offinso North CHPS

Participant code ☐☐☐
Date: …….
School: …….

Section I: Background Information

S/N.	Questions	Coding	Skip to
	How old (completed years) are you?		
1.	What is your sex?	1=Male 2=Female	
2.	What is your level of education?	1=None 2=Primary 3=JHS/Middle 4=Secondary 5=Tertiary	
3.	What is your ethnicity?	1= Ewe 2= Akan 3= Northerner 4=Guan 5=Ga/Dangme 6=Other…….	
4.	Your marital status	1=Single 2=Married 3=Divorced 4=Widowed	If 1 skip to 6
5.	If married, type of marriage	1=Monogamous 2=Polygamous	
6.	What is your religion?	1=Christian 2=Muslim 3=Traditionalist 4=Other ……..	
7.	Tribe	…… …… ……	
8.	What is your Family size?	☐	

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9.	Occupation		
10.	Number of children		
11.	Monthly income (GHC)		
12.	Distance to CHPS compound (km)		
13.	NHIS Status	1=Active subscriber 2=Non-subscriber	
14.	Do you have health facility in your community?		
COMMUNITY-BASED HEALTH PLANNING AND SERVICES UTILIZATION			
15.	Have you ever visit the CHPS compound in your community?	1=Yes 2=No	
16.	If yes, how often do you visit the CHPS compound?	1=Everyday 2=Once a week 3=Trice a week 4=Four times a week 5=Ocationally 6=Others……	
17.	By what means do you use when visiting a CHPS compound?		
18.	If yes, what services do you seek at the CHPS compound?	…… …… …… …… …… …… ……	
19.	Are you satisfied with services offered at the CHPS compound?	1=Yes 2=No	
20.	If No why	…… …… …… …… …… …… ……	
21.	If yes, why do you think you are satisfied with services rendered at the CHPS compound?	…… …… …… …… …… …… ……	
		…… …… …… …… ……	

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		…… ……	
22.	How do you access health related services	…… …… …… …… …… …… ……	
23.	Have you heard of the Community Based Health and Planning services in your community?	1=Yes 2=No	
24.	If yes, how did you hear of the CHPS?		
25.	If yes, what is CHPS about?	…… …… …… …… …… …… ……	
26.	What are the functions of CHPS?	…… …… …… …… …… …… ……	
27.	How does CHPS enhance access to healthcare delivery?	1=Reduced cost 2=Located close to people 3=Others …… …… ……	
28.	What have been the effects of CHPS in improving your health status?	…… …… …… …… …… …… ……	
	Attitude		
29.	Who attends to you when you visit the CHPS compound?	1=Community Health Nurse	

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		2=Voluneter 3=TBA 4=Midwife	
30.	Were you welcomed upon your arrival?	1=Yes 2=No	
31.	Were you advised on how to manage your condition after treatment?	1=Yes 2=No	
32.	Did your attendant explain your condition to you before treatment?	1=Yes 2=No	
33.	What is the attitude of your attendant towards you?	1=Satisfactory 2=Not-satisifcatory 3=Don't know	
34.	Upon your last visit, were you asked to pay money before health services were rendered to you?	1=Yes 2=No	
35.	If yes, how much?		
36.	If no, were you attended to anyway?	1=Yes 2=No	
ATTITUDE OF HEALTH WORKERS			
37.	Do Community Health Officers always report to work?	1=Yes 2=No	
38.	Are Community Health Officers always available in the community?	1=Yes 2=No	
39.	Are you always satisfied with services rendered by Community Health Officers?	1=Yes 2=No	
40.	If yes why?	…… …… …… …… …… ……	
41.	If No, why?	…… …… …… ……	

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APPENDIX 3

3. DATA COLLECTION TOOL

IN-DEPTH INTERVIEW FOR CHOs

DEMOGRAPHIC CHARACTERISTICS OF CHOs

Age (In completed years)	
Sex	
Marital status	
Religion	
Ethnicity	
Level of education	
CHPS Zone	
Duration of working with GHS	
Duration of working at current CHPS Zone	

QUESTIONS

We are now going to discuss your implementation of CHPS in the zone.

1. How many staff does your facility have?
   (Probe: staff breakdown)

2. *Do you think the numbers are adequate****? (Probe: If No, why?)***

3. Were you deployed as a CHO? If yes, probe

   (Probe: If deployed, ask for period/year of deployment)

4. Do you go for home visiting?
5. If yes, kindly describe your home visiting schedules?
   (Probe for the average number of visits conducted per week and month)

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6. Briefly describe your school health activities in the zone

7. Does your facility have a home visiting bag? Follow-up by asking whether the bag has;
   a) **ever been used since acquired**
   b) **is fully equipped**
   c) **what are supposed to have in the bag)**

8. Do you have a Community Health Action Plan (CHAP) for your zone?
   (Probe:
   a. Ask about individuals involved in the development of the plan (if yes or no)
   b. Relevance to the work of the CHO)

9. Is there a Movement Wheel in your facility?

10. Is there a daily activity plan for your CHPS/community?

11. As a CHN, what are the roles of your CHPS compound in improving health status of this community?

12. What services do you provide at this facility?
13. **What is your operational time in this facility?**

Day	**Open time**	**Break time**	**Close time**
Weekdays (Monday-Friday)			
Saturday			
Sunday			

14. Do you have fa functional CHMC
15. Have members of the CHMC been trained?
    (If yes, probe who trained them)

16. Have you ever conducted a health needs assessment in your zone?

17. Since you started working at this zone, have you identified and held (any) stakeholder meeting(s)?
    (If Yes, probe for number of times this was done and when the last meeting was conducted, purpose of the meeting, stakeholders present, issues discussed, and if a report was written and implemented).
18. How often does the members of the DHMT visit your facility?
    (Probe for the last time they visited and frequency)
19. Tell me about community involvement and support in your activities as a CHO

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(Probe for the involvement of the communities in all the activities of the CHO; organization of community durbars, volunteering to keep the CHPS compound clean and tidy, school health programmes)

20. What do you suggest should be done to strengthen this CHPS?
21. Is there anything else you would like to share with me?

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APPENDIX 4

4. DATA COLLECTION TOOL

IN-DEPTH INTERVIEW FOR COMMUNITY HEALTH VOLUNTEER

Age (In completed years)	
Sex	
Marital status	
Religion	
Ethnicity	
Level of education	

1. How did you become CHV?
2. What informed your decisions to serve as a CHV?

   (Probe: In terms of any financial gain, influence, support)
3. What are some of your responsibilities as a CHV in relation to CHPS activities?
4. What services do this CHPS compound provide to the community members?

   (Probe: Home visits, school health services, treatment of minor illnesses, defaulter tracing, reproductive health services, emergency delivery, health education, community health needs assessment etc.)
5. What do you know about CHPS? ***(Probe; functions of CHPS)***
6. What is your take on attitude of CHOs at the CHPS compound?
7. Are activities of CHOs in the CHPS compound satisfactory?
8. Do you have any challenge using the CHPS yourself?

   (Probe: If yes, ask for specific challenge)
9. In what ways do you support service delivery by the CHOs?
10. Currently, what plan(s) are in place for the involving the community members in the utilization of the CHPS compound?

    (Probe: Ascertain when the plan was developed and how it will be implemented. If no current plan is in place, what was the most recent)
11. What additional responsibilities do you think you can perform to help improve the implementation of CHPS in this zone?
12. Is there anything we have not discussed, but which you would like to share?

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APPENDIX 5

5. DATA COLLECTION TOOL

FOCUS GROUP GUIDE FOR COMMUNITY MEMBERS

Name of respondent …….
Position of respondent …….
Date of interview …….

1. What do know about CHPS services?
2. What are the activities of CHPS compound?
3. Is the CHPS service / compound addressing your health needs?
4. How often do you visit the CHPS compound?
5. Do you always visit the CHPS compound when you are sick? (Probe: why they visit or not?
6. Are you satisfied with the services provided at the CHPS compound? (Probe: why they satisfied or not?
7. Were you all the drugs you needed at CHPS compound when you visited? (Probe: whether he / she was asked to buy drugs outside?
8. What is your take on the attitudes of health workers at the CHPS compound? (Probe: what is making community members not visit the CHPS compound?

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APPENDIX 6

Title of Study: Factors Influencing Community Based Health Planning and Service (CHPS) in the Offinso North District

Introduction: I am Richard Avagu (Post Box 8 Akumadan, Offinso North District Health Directorate, (kinshatters@yahoo.com), a student of the Department of Health Policy Planning and Management in the School of Public Health, University of Ghana, Legon pursuing a Master of Public Health Degree Programme. I am here with my research assistants to carry out a survey to find out **the Factors Influencing Community Based Health Planning and Service (CHPS) in the Offinso North District.**

This is purely for academic purposes and forms part of the requirement for the award of Master of Public Health Degree. The researcher has no conflict of interest in this study.

Background and Purpose of research:

Community-Based Health Planning and Services (CHPS) is a national strategy for implementing community-based service delivery by reorienting and relocating primary health care from sub district health centers to convenient community locations As a step to make health services accessible to Ghanaians, the Government of Ghana in collaboration with the Ghana Health Service and Ministry of Health adopted the CHPS concept in 1999 but became operationalized in 2005 as a national policy for the provision of primary health care services (GHS, 2005). The CHPS initiative enables the Ghana Health Service (GHS) to reduce health inequalities and promote equity of health outcomes by removing geographic barriers to health care (MOH, 2016).

This is to Certified that the Study's Inform Consent form has been Approved By GHS-ERC for the Period 08/07/19 To 08/07/20
Signed... Date 08/07/19
Name... Hannah Frimpong
GHS- ERC Administrator

University of Ghana http://ugspace.ug.edu.gh

Nature of research: The study will employ both quantitative and qualitative study designs. The quantitative aspect will involve household surveys while the qualitative component will comprise Focus Group Discussions (FGDs) and In-depth interviews (IDIs). For the quantitative approach, face-to-face interviews will be conducted using a semi-structured questionnaire to collect information on the knowledge of community members on. You will be required to give us an information with regards to questions in the questionnaire. The questions basically are on factors influencing Community Based Health Planning and Service utilization in Offinso North District. If you meet the requirement, the questionnaire will be administered to you.

Participants involvement: Following your acceptance to participate in this research, you will be required to provide answers to questions relating to yourself as well as factors influencing Community Based Health Planning and Service utilization in the district. This will comprise Focus Group Discussions (FGDs), In-depth interviews (IDIs) and face-to-face interviews will be conducted using a semi-structured questionnaire to collect information on the knowledge of community members with the expected time for completion between 30 to 45 minutes.

Potential Risks: This is a minimal risk study and will not present any inconvenience to you beyond the time that you will be required to answer the questions.

Benefits: You will not benefit directly from this study. However, your responses together with responses from other participants will help to identify factors influencing CHPS utilization in Offinso North District and to identify challenges that will help improve healthcare delivery in your community.

Costs: There will not be any financial lost for taking part in the study as the interviewers will travel to the respondents place of residents however, time will be lost as the studies may take about 45minutes.

This is to Certified that this Study's Inform Consent form has been Approved By GHS-ERC for the
Period 08/07/19 To 07/07/2020
Signed ... Date 08/07/19
Name Hanah Frimpong
GHS-ERC Administrator

University of Ghana http://ugspace.ug.edu.gh

Compensation: The study is purely voluntary and there is no monetary compensation or incentives for participation in the study but in the information you provide will help improve on your health and that of the younger generation.

Privacy and Confidentiality: We will conduct the interview in a private room to protect you. No name will be recorded. Your name and identity are not needed in the study. However the information you are going to provide will be coded and will be treated strictly confidential. You are assured of total confidentiality to the information you will give. Apart from the researcher and supervisor of this research, no one else will have access to the information provided whether in part or whole. Data collected will be stored under lock and key then destroyed after a minimum of three years as per research protocol. In the reporting and dissemination of the findings of this research, we will not use any personal identifiers such as your name.

Voluntary participation/withdrawal: Participation in this study is voluntary. You are free to answer part or the entire questionnaire. You can choose to withdraw from the study or stop the interview at any time you want. You can also choose not to answer any question(s) you find uncomfortable about. Should you choose not to not to participate, it will not affect you or your clinic in any way. However, you are encouraged to participate fully in this study to help identify factors influencing CHPS utilization in Offinso North and beyond.

Outcome and Feedback: The data gathered will be coded, analyzed and findings from the study to help to form better policies for the CHPS implementation in the district.

Feedback to participant: Findings and recommendations would be available at the School of Public Health and it will also be disseminated through a meeting with different stakeholders at the end of the study in the district.

This is to Certify that this Study's Inform Consent form has been reviewed by GHS-ERC for the Period 08/07/19 To 07/07/2020
Signed [signature] Date 08/07/19
Name Hannah Frimpong
GHS-ERC Administrator

University of Ghana http://ugspace.ug.edu.gh

Funding information: The research is self-sponsored by the Principal Investigator Richard Avagu

Sharing of participants Information/Data: The data generated will only be shared with stakeholders who will need it to make an informed decision.

Provision of Information and Consent for participants

A copy of the Information sheet will be given to you after it has been signed or thumb-printed to keep.

Contact for Further Clarification/Questions: If you have any questions about this research, you can ask me now or later. If you wish to ask questions later, you may contact me, Richard Avagu, School of Public Health, University of Ghana on the following number 0243909798.

For your rights as a participant and any clarifications on ethical issues, you can contact:

Hannah Frimpong

The Administrator

GHS Ethics Review Committee

0507041223

This is to Certified that this Study's Inform Consent form has been Approved By the GHS-ERC for the Period 08/07/19 To 07/07/2020
Signed ... Date 08/07/19
Name Hannah Frimpong
GHS-ERC Administrator

University of Ghana http://ugspace.ug.edu.gh

APPENDIX 7

CONSENT FORM

STUDY TOPIC: Factors Influencing Community Based Health Planning and Service (CHPS) in the Offinso North District.

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and all questions satisfactorily explained to me in a language I understand English ☐ Twi☐. I fully understand the contents and any potential implications as well as my right to change my mind (ie withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name or Initials of Participant…….. ID Code ……..

Participants' Signature ……OR Thumb Print……

Date:……

INTERPRETERS' STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the Twi☐. language to his proper understanding.

All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter……

Signature of Interpreter…….. Date:……

This is to Certify that this Study's Inform Consent form has been Approved by GHS-ERC for the Period 08/07/19 To 07/07/2020
Signed ... Date 08/07/19
Name Hannah Frimpong
GHS-ERC Administrator

University of Ghana http://ugspace.ug.edu.gh

Contact Details

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood Twi□.
I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:.....

Signature..... OR Thumb Print .....

Date:.....

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name.....

Signature .....

Date.....

This is to Certify that the Study's Inform Consent form has been Reviewed By the GHS-ERC for the Period 07/07/2020 To 07/07/2020
Signed ... Date 08/07/19
Name Hannah Frimpong
GHS-ERC Administrator

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APPENDIX 8

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

MyRef. GHS/RDD/ERC/Admin/App / 19 / 277
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
GPS Address: GA-050-3303
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
8th July, 2019

Richard Avagu
University of Ghana
School of Public Health
Legon

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 049/04/19**
Project Title	Factors Influencing Community Based Health Planning and Service (CHPS) Utilization in the Offinso North District, Ashanti Region
Approval Date	8th July, 2019
Expiry Date	7th July, 2020
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
Dr. Cynthia Bannerman
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra