SCHOOL OF PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES,

UNIVERSITY OF GHANA

ASSESSMENT OF COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) BASIC PACKAGE OF SERVICES IN THE SHAI OSUDOKU DISTRICT OF THE GREATER ACCRA REGION OF GHANA.

BY

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Declaration

I, Leonard A. Anaman, declare that except for other researcher's work and quotations which have been fully acknowledged, this work is the result of my own original research work with the supervision of my supervisor, Professor Moses Aikins and that this thesis, either in part or in whole, has not been presented elsewhere for another degree.

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(Student)

Prof. Moses Aikins Signature: ……Date: …….……

(Academic Supervisor)

Statement of Compliance to Ethical Principles

The research was conducted in accordance with all the ethical principles on research. The scope of the research was within the guidelines stipulated by the Ethics Review Committee (ERC). There were no subsequent amendments to the research work which necessitated any further Ethics Review Committee (ERC) clearance.

……. ……

Date Leonard A. Anaman

Dedication

This work is dedicated in memory to my late mum, Mrs. Gladys Esther Anaman, a.k.a. Nana Ama Ahiakwa II, former Queen mother of Asebu Traditional Area, and my my surviving dad, Mr. Joseph David Anaman, as well as my siblings, my wife, kids and friends for their love and prayer support.

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However, I hereby wish to declare that all shortcomings that may be contained in this work is wholly and solely mine.

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List of Abbreviation

AIDS: Acquired Immuno-deficiency Syndrome

ANC: ante natal care

ARI: Acute Respiratory Infection

BF: Breastfeeding

BPoS: Basic package of services

CHAP: Community Health Action Plan

CHPS: Community based Health Planning and Services

CHN: Community Health Nurse

CHFP: Community Health and Family Planning

CHO: Community Health Officer

CHMC: Community Health Management Committee

CHV: Community Health Volunteer

EN: Enrolled Nurse

FP: Family Planning

GAR: Greater Accra Region

GHS: Ghana Health Service

HFDQC: High Frequency Data Quality Check

HOD: Head of Department

HIV: Human Immuno-deficiency syndrome

IMNCI: Integrated Management of Neonatal and Childhood Illness

MOH: Ministry of Health

NCD: Non-Communicable Diseases

NHIA: National Health Insurance Authority

NTD: Neglected Tropical Diseases

PHC: Primary Health Care

P.I.: Principal Investigator

PMTCT: Prevention of Mother to Child Transmission

PNC: Post Natal Care

STI: Sexually Transmitted Disease

TBAs: Traditional Birth Attendants

TB: Tuberculosis

Operational Definitions

For the purposes of this study, the following terminologies are applicable to this work.

1. **Community-orientated primary care**: is a continuous process by which primary health care is provided to a defined community on the basis of its assessed health needs, by the planned integration of primary care practice and public health (Mash, 2018).

2. **Definition of CHPS**: The community-based Health Planning and Service (CHPS) is defined "as the mobilization of community leadership, decision making systems and resources in a defined catchment area (zone), the placement of reoriented frontline health staff known as Community Health Officers with logistics support and community volunteer systems to provide services according to the principles of primary health care (PHC-Plus)" (GHSPD,2005:6).

3. **CHPS Compound**: An approved structure consisting of a service delivery point and CHO residential accommodation complex, both of which must be present.

4. **Community Health Officer (CHO):** A trained and oriented (in CHPS) Health Staff working in a CHPS zone. The CHO may be assigned to live in a community within the zone.

5. **Community Health Volunteers (CHVs):** Non-salaried community members identified and trained to support CHOs in a community within the CHPS zone.

6. **Community Health Management Committee (CHMC):** A group of community leaders with different competencies and responsibilities drawn from the communities within the CHPS zone. CHMC members volunteer to provide community-level guidance and

mobilization for the planning and delivery of health activities and to see to the welfare of CHOs in their communities.

7. **Availability**: in this study denote the presence or absence of the provision of such service by the CHPS facility.

8. **Functionality**: in this study simply denotes how well or effective is that service delivered by the CHPS facility by assessing this on the basis of how frequent it is delivered to the community members under the CHPS catchment zone.

9. **Challenges**: in this study denotes factors that derail the provision of services by the CHPS facilities in line with the prescribed basic package of services.

10. **Logistics**: as defined in the CHPS Implementation Manual refers to the basic tools required for effective operations at the CHPS zones. Such tools shall usually include vaccines, vaccine carriers, commodities, registers, fuel, and many other apparatuses required for effective service delivery at the CHPS zones.

11. **Dysfunctional:** for the purposes of the study here refers to the inability to execute the services as required in line with industry standards or the CHPS guideline manual.

12. **Motivation:** in this study refers to financial and other support in kind given to cadres such as the CHOs, the CHVs and the CHMCs in recognition of their role and work towards the operations Of the CHPS facility.

13. **Security:** in this study refers to provision of day and night security to the CHPS facilities.

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Abstract

Background

CHPS zones are largely defined by what kind of basic package of service they offer. Whilst basic package of services defines the key services that the CHOs, CHVs and CHMCs are to perform under the CHPS service delivery, the 2018 CHPS Verification Survey shows that only 21.1%, 52.5% and 37% of CHPS zones undertook home visitations, ANC services and deliveries which are key components of CHPS basic package of services. Many reasons have been adduced to these sub-optimal performances.

Objective

The purpose of the study was to assess CHPS basic package of services in Shai Osudoku District

Methods

A descriptive quantitative study was conducted using a census approach to assess the delivery of services delivered by CHOs, CHVs and CHMCs in the studied selected CHPS zones. This was done using frequencies and percentages to analyze categorical responses from the study participants. The study also determined the challenges in delivering this basic package of services.

Results

Though CHO, CHV and CHMC availability of services were 77%, 60% and 71% of defined CHPS services to be rendered, its functionality dipped to 68%, 60% and 69% respectively with key sub-performances recorded in Home Visitations (2 instead of 3 times in a week), Health Education and Promotion (2 instead of 4 times), School Health Outreach (1 in a quarter instead of 1 in a month)

and Outreach Activities (3 instead of 6 in a month). Identified commonality of challenges confronting CHOs, CHVs and CHMCs delivery of services included funding, logistics, training and personnel related challenges.

Conclusion

Though general delivery of services by CHOs, CHVs and CHMCs were satisfactory, it could be far better with very basic interventions. It is thus recommended basic logistics, funding, training and personnel reinforcements be prioritized

CHAPTER ONE

INTRODUCTION

1.1 Background

Globally, serious public health concerns like morbidity and health inequity result from disparities in the availability, access and utilization of health services especially in low and middle-income countries. It is established that rural dwellers are more restricted in their use of formal sector health services than their urban counterparts in most of these countries due to numerous socio-economic and health systems factors (Wiru, Kumi-kyereme, Mahama, Amenga-etego, & Owusu-agyei, 2017).

Ghana, with its population fast expanding and its health systems becoming inadequate launched the Community-based Health Planning and Services (CHPS) initiative in the year 2000 in support of the ideals of primary health care (Ghana Health Service, 2005). The CHPS strategy was adopted by the MOH as a national programme to bridge the gap in access to healthcare (Ghana Health Service, 2005). The Community based Health Planning and Services (CHPS) concept began as a continuity to the defunct Community Health and Family Planning (CHFP) project based on lessons learnt from the Bangladesh (Phillips, 1988). The Community based Health Planning and Service provides for a Community Health Officer (CHO) to be resident in a community and with the help and support of the community members, to render some basic packages of Primary Health Care (PHC) especially preventive services including home visiting, educational programmes and other health promotion activities and not sedentary clinical services at the health facility (Ghana Health Service, 2016).

In Ghana, Community based Health Planning and Services (CHPS) drives primary health care services and it is managed at the back of a well-designed health care package system properly defined called

the “basic package of services”(Ghana Health Service, 2016). This basic package of services refers to basic services that are considered essential to ensure comprehensive care to the needs of the communities as provided by the Community Health Officers (CHOs), the Community Health Volunteers (CHVs) and the Community Health Management Committee (CHMCs).

However, though the Community based Health Planning and Services (CHPS) is known to hold the promise to bridge the health equity gap of almost majority of citizens who live in the rural settings, there are still challenges with CHPS contribution to national health outcomes though currently 5,918 of GHS Facilities out of 8,820 total facilities are Community based Health Planning and Services (CHPS) zones (Ghana Health Service, 2018). These challenges have been attributed to inability of many of the CHPS zones to offer the basic package of services expected of them as spelt out in the CHPS implementation Guideline Manual. The 2018 Ghana Health Service (GHS) CHPS Verification Survey Report showed only 21.1% of CHPS zones carry out home visits, whilst only 52.5% of CHPS zones conduct ANC services and only 37% of CHPS zones engage in deliveries (Ghana Health Service, 2018).

Meanwhile, some studies have identified many factors as key threats to effective delivery of primary health care by the CHPS zones. They cited inadequate transport, equipment, medicines, poor supervision of CHPS programme, weak or destroyed health infrastructure, physical inaccessibility, insufficient trained community health workforce and high attrition rate, cultural and behavioral beliefs, poor referral support, and financial insufficiency as some of these factors (Assan, Takian, Aikins, & Akbarisari, 2018).

They also bemoaned the over emphasis placed on communities for commitments to their health developments as misplaced, since according to their study, these communities lack the needed

resources, and mobilization to effect any positive change in the health well-being of the community they are serving. Such responsibilities, according to them are better placed in the hands of the government (Assan et al., 2018).

The study also cited the lack of security for CHO activities in most Community based Health Planning and Services (CHPS) as a demotivator for health professionals accepting to stay at the community, or even refusing to attend to client late in the nights, and those who accept to work in the community, later change their minds and demand for transfers. The study also cited instances where health professionals vacate their post, citing security concerns (Assan et al., 2018).

Other studies such as Sakeah et al. (2014) recognized the importance of CHOs being residents in communities as catalyst to delivering effective healthcare to the community. This study saw a positive effect on the health outcome of community members when CHO-midwives are able to interact with the people at the community with the aim of knowing their problems. Interestingly, the CHO-midwives reported that these stronger relationships and 'inside knowledge' built through home visitations also sharpened their skills and confidence as health practitioners (Sakeah, McCloskey, et al., 2014).

The study also recognized the correlation between motivation and output of CHOs (midwives) such as provision of financial incentives, according respect & recognition to CHOs from the community, accelerated promotion of CHOs from the Ghana Health Service etc. and concluded that all those who enjoyed these privileges performed better on the job (Sakeah, McCloskey, et al., 2014). There were also cited attempt in the study to link CHOs output to resident status in the community by concluding that CHOs who are provided accommodation in the community end up performing better than those who do not (Sakeah, McCloskey, et al., 2014).

Meanwhile, Community Health Volunteers (CHVs) are unable to perform their prescribed duties well because working tools such as bicycles and other basic logistics that include equipped home bag containing basic first aid materials (oral rehydration salts (ORS), pain killers etc.) are not supplied (Ampiah, n.d.). Furthermore, the study identified high level of attrition and role laxities among Community Health Volunteers (CHVs) because they are not remunerated and this is affecting their ability to discharge their services well (Ampiah, n.d.). The Community Health Management Committee's (CHMCs) lack of capacity to play the role of raising funds to cater for the upkeep of the CHPS facilities is affecting the effective discharge of this CHMC responsibility (Assan et al., 2018).

The issue of inequity in health distribution affecting rural health care, the subsequent successful pilot of the Community Health and Family Planning project that led to the scaling up of CHPS, the sustenance of CHPS impinging on the core delivery of basic package of services as defined in the CHPS manual, the issue of assessment of CHO services especially in respect of service delivery gaps, the challenges associated with providing effective CHO/CHV services including security and residence concerns especially relating to CHOs, motivations and logistics support to CHOs/CHVs in urging them to work at their best as well as CHMCs nebulous role as CHPS fundraisers are some of the reasons why this study is necessary to help identify the best ways of making the CHPS function effectively.

1.2 Problem Statement

Even though CHOs are expected to visit pregnant women, lactating mothers and their newborns at home, yet maternal and neonatal mortality are still high in Ghana (Baatiema, Sumah, Tang, & Ganle, 2016) . In 2014, for instance, close to 50% of under-five mortality occurred during the first 28 days after birth ; a period where neonates and their mothers are expected to be visited at home (Bang, Bang, Baitule, Reddy, & Deshmukh, 2005 and Rosato et al., 2008).These early neonatal visits offer the

opportunity for physical examination of the mother and baby, providing health education and referral services whilst empowering the significant others in health decision making on the clients (Bang et al., 2005).

The 2018 CHPS Verification Study showed only 21.1% of CHPS zones carried out home visits whilst only 52.5% of CHPS zones conducted ANC services. The findings also showed that only 37% of CHPS zones engaged in deliveries (Ghana Health Service, 2018). The causes of these low level or non-existent delivery of services are because the CHPS basic package of services are not adhered to (Ghana Health Service, 2018). The factors leading to low performances of tasks under the CHPS prescribed basic package of services are multi-faceted and some of these are described by Assan et al., (2018) as deeply entrenched that include low level of community participation, inadequate logistics, lack of security guarantees for CHOs, lack of accommodation resulting in high turnover of staff, inexperience CHOs, inadequate resource capacities, poor attitude from CHOs, ill-trained CHOs & CHVs, non-remunerative de-motivated CHVs, improper community entry among many others. These findings above are not surprising as the 2018 CHPS verification showed only 21.7% of CHPS facilities have functioning Vaccine Fridges. 31% of CHPS facilities have all the basic equipment to work with whilst 20% of these CHPS facilities do not have the commonest working tool, which is the weighing scale. Only 6% of all CHPS CHOs are midwives and 17% of these CHOs are enrolled nurses. Twenty-four percent of these CHOs were ever trained before being posted. About 34. 3 % of the CHPS in the country have purposively built CHPS compounds (Ghana Health Service, 2018).

Whilst Bonenberger, Aikins, Akweongo, & Wyss, (2014) and Assan et al., (2018) revealed the lack of accommodation support from CHMCs to CHOs is the cause of high attrition rates and high staff turnover among CHOs (i.e., the consequence of which include low team morale, work process

disruptions and inefficiencies) this challenge is leading to CHOs being unable to deliver their basic responsibilities effectively (Bonenberger et al., 2014 and Assan et al., 2018).

Poorly trained CHOs and poorly equipped community health volunteers (CHVS) have implications on health equity in the community they operate from. CHVs thus become health havoc wreckers except they are supervised and supported by a CHO (Awoonor-williams, Sory, et al., 2013).

Whilst the CHPS concepts that have been studied and written on have sought to look at one form of basic services or the other that are provided by the CHOs such as impact on maternal and child health by Binka et al., (2007); integrating skilled birth attendance in CHPS by Sakeah, Mccloskey, et al., (2014), assessment of implementation of home visiting strategy Chandi, (2017) or even attempt to look at the CHPS concept in totality, such as from supervision for improvement in service delivery by Aikins et al., (2013); system approach to attaining universal health coverage by Assan et al., (2018); lessons from the scaling up in experimental communities by Awoonor-Williams et al., (2013); implementing CHPS in impoverished urban communities by Nwameme, Tabong, & Adongo, (2018), to possible replication in urban settings by Adongo et al., (2014) or the other; my work attempted to holistically look at all the CHPS basic package of services that are rendered by the CHOs, CHVs and the CHMCs in terms of its availability and functionality and what challenges exist that confront the effective delivery of such services at the CHPS level which has not yet been studied before.

1.3 General Objective

The general objective of the study was to assess CHPS basic package of services in Shai Osudoku District of Greater Accra Region.

1.4 Specific Objectives

The specific objectives were:

1) To assess the services provided by Community Health Officers (CHOs)
2) To assess the services provided by Community Health Volunteers (CHVs)
3) To assess the services provided by Community Health Management Committees (CHMCs)
4) To assess the challenges of the basic package of services of CHPS

1.5 Research Questions

Some of the research questions posed to respondents included the following:

1) What are the CHPS basic package of services provided by the CHOs
2) What are the CHPS basic package of services provided by the CHVs
3) What are the CHPS basic package of services provided by the CHMCs
4) What are the challenges limiting delivery of such basic package of services by the CHOs, the CHVs and the CHMCs

1.6 Justification of the Study

The choice of Dangme East District of Greater Accra Region for the study was borne out of the region's inherent floating population profile and the associated key features the region possesses that fits into the characteristics needed to carry out an effective study of this magnitude.

Furthermore, previous researches done on CHPS have concentrated on areas such as assessment of the implementation of home visiting strategy by Chandi, (2017) system approach to UHC using CHPS initiative by Assan et al.(2014), supervision for improvement in service delivery by Aikins et al, (2013), CHPS verification Survey study by Ghana Health Service (2018), impact on maternal and child health by Binka et al, (2007), lessons from the scaling up in experimental communities by Awoonor -Williams et al, (2013), the role of community based surveillance in health outcomes measurement by Kyei-Faried, Appiah-Denkyirai, Brenya, Akuamoa-Boateng, & Visser, (2006) and CHPS replication in urban settings by Adongo et al, (2014) among others. But none of these research works done on CHPS had touched on assessing the basic package of services holistically provided by the CHOs, CHVs and the CHMCs.

This study outcome would be most useful especially to GHS as it has the potency to inform policy on areas and modalities of CHPS basic package of services that require redesigning and retrofitting as the study would sought to unearth and highlight on services that are available, functional and/or dysfunctional and what challenges hinder the delivery of such services to the CHPS catchment communities.

1.7 Conceptual Framework for the assessment of CHPS Basic Package of Services

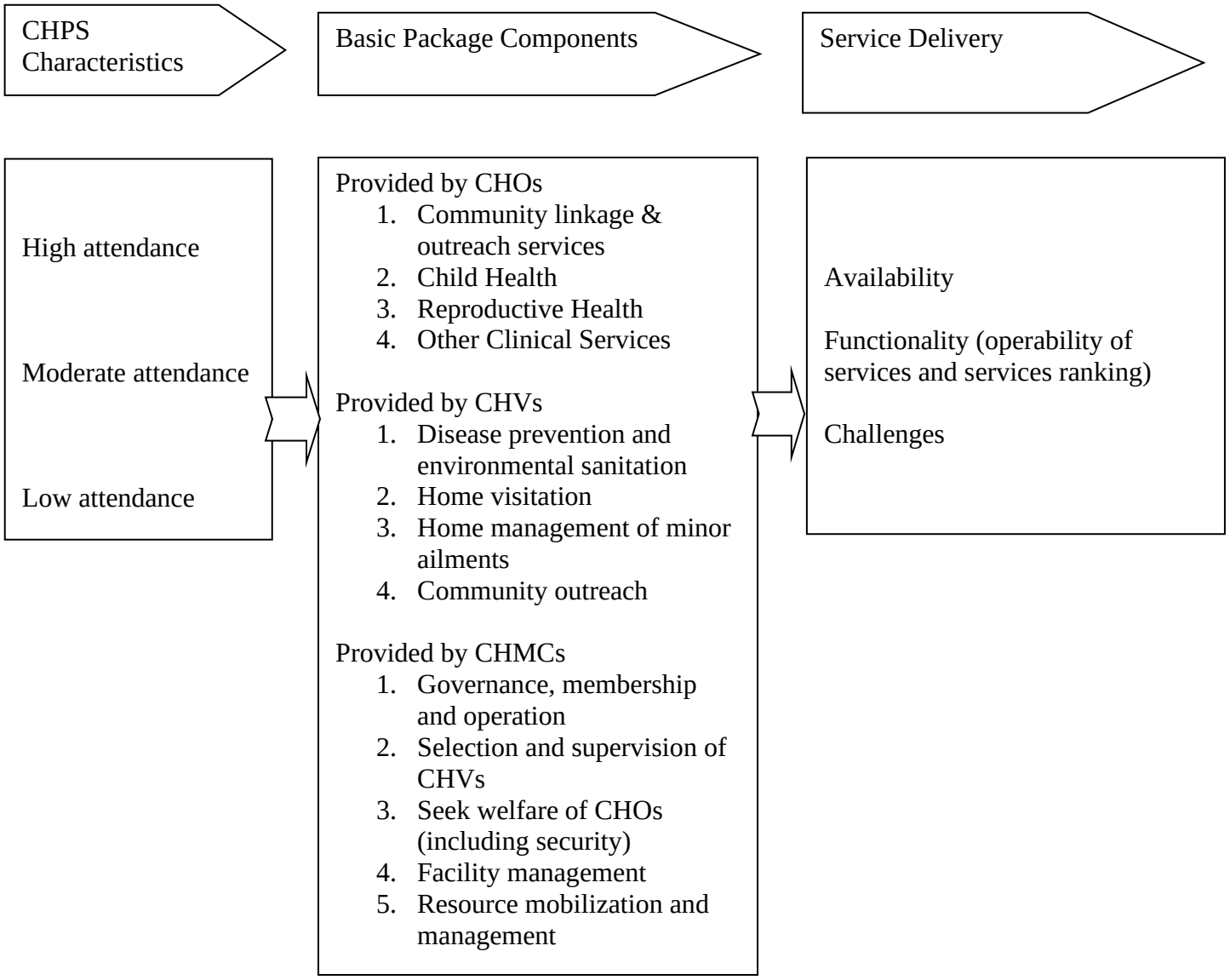
Miles & Huberman, (1994) defined a conceptual framework as a visual or written product, in that "it explains, either graphically or in narrative form, the main things to be studied and the key factors, concepts or variables as well as the presumed relationships among them. The conceptual framework based on the literature and the existing CHPS Implementation Manual looks at the inter relationships that exist between CHPS prescribed basic package of services that are to be provided and what the CHPS zones are delivering now.

The conceptual framework south to draw a link between the availability and functionality of CHPS package of services, the categories of CHPS basic package of services and CHPS characteristics. The conceptual framework attempted to explain how the availability and functionality of CHPS basic package of services result into a facility becoming a high attending, moderate attending or low attending CHPS facility. Community-based Health Planning and Services (CHPS) are set up to provide certain specific services to the demarcated zone they are to serve. These services and functions, expectedly, are to contribute to CHPS being run well. However, the inability of the services not to be provided fully or as frequently as it is wished can also affect the eventual performance outcome of that CHPS facility.

The conceptual framework assumed that certain characteristics of CHPS such as ones that are "high attendance", "moderate attendance" or even "low attendance" are as a result of those CHPS zones either being able to abide by the provision of those prescribed CHPS basic package of services or otherwise. It is empirically proven from literature and previous studies that CHPS zones that perform poorly with low attendances are those that are unable to perform many of the prescribed CHPS basic service packages or even if they do, they are either do not perform all of them or they are rarely performed. The same studies have proven that CHPS that perform averagely or moderately well are those CHPS that averagely ensure that the prescribed basic package of service is offered. It could also denote that the frequency at which these services are provided are moderate.

The conceptual framework in figure 1 profiled the study CHPS zones into CHPS characteristics categorized into high attendance, moderate attendance or low attendance using CHPS OPD, ANC and Family Planning activities as proxy indicators that links basic package of services CHOs, CHVs and CHMCs render in those categorized CHPS zones to further explain why service delivery at that categorized CHPS zone was either available and functional or not and what explained them.

Figure 1: Conceptual framework of CHPS basic package of services



NOTE: Functionality connoted two things, first, the operationality of the service that exist in terms of its availability at the CHPS level and then secondly, the number of times such available and operational services are carried out, percentiled to know components of services that are functional out of the total expected number as prescribed in the CHPS National Implementation Guideline 2016 updated.

1.8 The Scope of the Study

Geographically, the study was limited to Shai Osudoku District of Greater Accra Region. Contextually, the study focused on assessing the CHPS basic package of services as provided by the CHOs, the CHVs and the CHMCs.

1.9 Organisation of the Work

The output of the study was organized into six chapters. The chapters were preceded by an abstract, which was a summary of issues, methods used and conclusions from the study.

Chapter One gave a background information about the study & introduced the problem and its context. This also included the objectives of the study. It also presented the statement of problem, the scope, and justification for the study. Also included in this chapter was the general outline of the proposal.

Chapter two provided a detailed review of related literature on the primary health care delivery systems and attempted to narrow it to CHPS which was the center of the study. This involved the review of existing literature on primary health care concept in general & CHPS in particular in Ghana & global in context. Lessons from the literature were used to fill the research gaps.

Chapter three presented detailed Methodology and Conceptual Framework that were relied upon to undertake the study.

Chapter four looked at the results from the field of study whilst **Chapter five** focused on discussions of the study. **Chapter six** of this study finally looked at the conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Literature review is important in such a work because it captures a cross section of views and positions on the subject matter and contextualizes the study (Oquaye, 2004). It is in this light that, an overview of some relevant literature on the subject matter is pursued.

This chapter is the review of various literatures on primary health care delivery especially Ghana's CHPS using basic package of services to drive access to health at the primary level. Ghana's attempt to drive primary health care is driven largely at the back of the CHPS concept (Ghana Health Service, 2016). The CHPS concept relies on certain prescribed basic package of services that are considered comprehensive enough to deal with the majority of the core health challenges at the community levels (Ghana Health Service, 2016). The concept of the basic package of services is that all of the services in the package should be available as an integrated whole, rather than being available piecemeal or as individual services or only through vertical programs (Ministry of Public Health, 2005).

The Community based Health Planning and Services (CHPS) basic package of services has two purposes: (1) to provide a standardized package of basic services which forms the core of service delivery at the primary health care (PHC) facilities and (2) to promote a redistribution of health services by providing equitable access, especially in underserved areas (Ministry of Public Health, 2005). However, the adoption and implementation of prescribed basic package of services at the primary care level does not guarantee effective outcome since certain condition precedent are to be in existence before the ideal situations could be actualized since the CHPS implementation has implications for

budget allocations; essential medicine supply; the distribution and training of health workers; and information systems among other things (Assan et al., 2018).

Various literatures have spoken extensively and justified the usefulness of prescribed basic package of services but Waddington, (2013) gave the following 4 reasons listed below as key: 1) Priority setting on the grounds of effectiveness and relative cost., 2) Equity, 3) Poverty reduction and 4) Political empowerment and accountability.

Ghana has been implementing the Community-based Health Planning and Services (CHPS) program for over 15 years. Considered one of the pragmatic strategies for achieving universal health coverage of a basic package of essential primary health services, CHPS has gained international recognition. Led by a Community Health Officer and supported by volunteers drawn from the area of service, the CHPS strategy is a breakthrough in enhancing community involvement and ownership of primary health care interventions towards achieving universal health coverage (UHC) that is a continuation of what began as the Community Health and Family Planning (CHFP) (Phillips, 1988).

The project was launched in Navrongo as an operation in 1994 in 3 sub-districts. 4 different models of delivering community services were experimented to treat malaria, acute respiratory infections, diarrheal diseases and other childhood illnesses as well as providing family planning services and immunization outreach. Each experiment was referred to as a cell with different configuration of organization of services (Nyonator, Awoonor-williams, Phillips, Jones, & Miller, 2005a).

The concept of primary health care mainly began with the Alma Ata conference in 1978 that formally launched Primary Health Care (PHC) as the main thrust and focus for the promotion of world health (Nyonator et al., 2005a).

2.2 Primary Health Concept in Ghana

Ghana's significant focus on primary health care started when the Ministry of Health developed a 10-year plan for establishing and implementing primary healthcare services (PHCs) in 1977 after a successful implementation of the Danfah rural and family health project. A year later to this, the government signed up to the 1978 Alma-Ata agreement (de-Graft Aikins, Kushitor, Koram, Gyamfi, & Ogedegbe, 2014). PHCs have been a key focus in healthcare delivery in the country since then. Within this framework are two central strategies.

The first strategy was to, as it were, in 1989 embark on construction of additional health centers to expand primary health care to about 60 percent of the rural community. Hitherto, less than 40 percent of the rural population had access to primary health care, and less than half of Ghanaian children were immunized against various childhood diseases (Ghana Health Service, 2005). The training of village health workers, community health workers, and traditional birth attendants was also intensified in the mid-1980s in order to create a pool of personnel to educate the population about preventive measures necessary for a healthy community (Ghana Health Service, 2005).

The second strategy and of course the most significant of all has been the provision of community - based health planning and services (CHPS) to deepen primary health care with the aim of attaining universal health coverage (de-Graft Aikins et al., 2014). These significant events have occurred in between key global declarations such as the 1978 alma-ata, the 1987 Bamako declaration, the 1998 Ouagadougou framework for achieving primary health care and of late the 2018 Astana declaration on primary health care that have only emboldened government's resolve to continue to strengthen the primary health care by providing more CHPS facilities.

Primary health care (PHC) has been generally explained as the method and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance system, of which it is the central function and main focus, and of the overall social and economic development of the community (Ministry of Publ;ic Health, 2005) It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care (Ministry of Public Health, 2005).

In Ghana, Primary Health Care (PHC) post Alma Atta, operated on a multi structure or three tier system known as levels A, B and C. Services based at level A (village or community) included preventive services, simple diagnosis and treatment, antenatal and postnatal care. The level B (health centre and health post) provided preventive, curative, promotive and rehabilitation. Level C (district or administrative level) had the District Health Management Team (DHMT) to provide oversight (Abor, Abekah-Nkrumah, & Abor, 2008). Services were also rendered from hospitals under the PHC system. Their core functions included referral to tertiary hospitals at the regional level, monitoring and evaluation of health programmes in the district, financial administration through budgeting, training of various categories of health and health related staff. They also carry out research work in the district they serve, liaise between the district and the region in matters related to health and liaise with the district political and traditional administration on health issues (Abor et al., 2008). Other structures put in place at the Level A were the introduction of Traditional Birth Attendants and Village (Community) Health Attendants. These community workforces were to be the first point of call to the community members in the provision of first aid services maternal health and general health issues (Abor et al., 2008). The village attendants became quack doctors with time (Abor et al., 2008). In effect,

participation, equity, and access were not optimized. With time the health sector, in trying to meet the tenets of Primary Health Care (PHC) piloted what later became the CHPS concept.

The Community-based Health Planning and Services (CHPS) viewed as a process of provision of a range of acceptable health care services through the revised primary health care strategies to people in their own setting with their full participation (Nyonator, Awoonor-williams, Phillips, Jones, & Miller, 2005) was as a consequence of Ghana's health reform undertaken to deepen primary health care services at the inception of the year 2005 (Adongo et al., 2014). Kyei-Faried, Appiah-Denkyirai, Brenya, Akuamoa-Boateng, & Visser (2006), termed it a major game changer in the health reforms pedestal and likened CHPS to a strategy which found its roots in the primary health care component of community participation in health care. The CHPS is a community- initiated & driven health intervention programme, first piloted in Navrongo in the Upper East Region of Ghana (Nyonator et al., 2005b). The essence of the CHPS initiative is to translate innovations from the Navrongo experimental design into a national programme for improving accessibility, equity, efficiency, and quality health care services. It involves community participation in primary health care services delivery through Community Health Management Committees and Community Health Volunteers. It operates mainly by locating CHOs in communities in a Community Health Compound by mobilizing and re orienting Ministry of Health and District Assemblies to support the initiative at the District level (Nyonator et al., 2005).

In this strategy, a trained nurse called a Community Health Officer (CHO) is reoriented and deployed to live directly in the community they serve, providing health services to a catchment area called a zone. The CHO, with the assistance of trained community members known as community health volunteers and community health management committee, render door-to-door health care to the

community. CHPS has become an initiative aimed at increasing rural access to health care service while empowering local communities to take greater control over their health (Baatiema et al., 2016).

This system of health service delivery was structured to have the ability to tremendously improve coverage of maternal, child health, and family planning services. Evidence from the Navrongo experiment suggests that this strategy of delivering health services to underserved communities can tremendously influence maternal and child health indicators (Nyonator et al., 2005).

2.3 Community-Based Health Planning and Services (CHPS)

The Community-based Health Planning and Services (CHPS) is a national health policy initiative that aims to reduce barriers to geographical access to health care (Nyonator et al., 2005a). With an initial focus on deprived and remote areas of rural districts, CHPS endeavors to transform the primary health care system by shifting to a programme of mobile community-based care provided by a resident nurse, as opposed to conventional facility-based and 'outreach' services (Nyonator et al., 2005a). The CHPS initiative represents the scaling-up of the Navrongo model into a national movement for health care reform. Regarded as the primary strategy for reaching the unreached, CHPS has, thus, become an integral part of the current Ghana Health Service Five Year Programme of Work and represents one of the health sector components of the national poverty reduction strategy (Nyonator et al., 2005a).

The introduction of CHPS into districts occurs through extensive planning and community dialogue on the part of the Health Service and the community. A key principle of CHPS introduction is that traditional leaders of the community must accept the CHPS concept and commit themselves to supporting it. CHPS relies on participation and mobilization of the traditional community structure for service delivery. District Health Management Teams must augment the skills of CHNs (or other cadre of staff) to prepare them for the delivery of preventive and curative care while residing in the

community. These health staffs, known as CHOs, provide mobile doorstep services to community residents. By travelling from compound to compound on motorcycle, CHOs cover a catchment area of approximately 3,000 individuals but now revised to 1,500 individual population as recommended by the new CHPS Implementation Guidelines (Nsuta et al., 2012). CHO services include immunizations, family planning, supervising delivery, antenatal/postnatal care, treatment of minor ailments and health education. CHOs are supported by community volunteers who assist with community mobilization, the maintenance of community registers and other essential activities (Ngom, Debpuur, Akweongo, Adongo, & Binka, 2006 and Ntsua et al., 2012).

Further literature from Ntsua et al., (2012) points to the fact that community involvement enhances the CHO-CHV working relationship. It argued that communities develop and manage a local (under a subdistrict) health governance system through a community health management committee (CHMC) that oversees and supports the network of CHVs. The Community Health Management Committees (CHMC) maintain CHPS compounds, facilitate organization of durbars (community meetings) for health education activities, mobilize emergency service transportation, and mediate conflicts between CHVs, or the CHO, and community (Ntsua et al., 2012). Its duties also include monitoring and supervising CHVs and supporting CHOs with regular monthly meetings, involving both, that address health-related issues (Ntsua et al., 2012).

2.4 The Evolution of CHPS

In response to preliminary evidence from Navrongo, the Ministry of Health (MOH) convened a national managers' conference in 1998 to deliberate on the implications of the experiment's model for national action, and to review a draft policy statement declaring the Navrongo community health care system as the national model for community-based care (Ministry of Health, 2014).

2.5 The Nkwanta District Replication

The first practical experience with Navrongo utilization was launched in Nkwanta District with the establishment of a CHPS pilot programme. In Nkwanta District, a new generation of questions could be addressed concerning the transferability and sustainability of the Navrongo model in a non-research setting. The success of the Nkwanta District Health Administration's implementation of CHPS was encouraging. Results of this effort were disseminated at a 1999 MOH National Health Forum convened to disseminate results from Navrongo and Nkwanta, and to discuss a draft policy statement designed to legitimize the change process and sustain CHPS activity over time (Awoonor-Williams et al., 2013).

The Community based Health Planning and Services (CHPS) approach thus focuses on achieving three key objectives namely, 1) to improve equity in access to basic health services, 2) improve efficiency and responsiveness to client needs and develop effective inter-sectorial collaboration. Consequently and 3) the CHPS thrives on effective role performance by all key actors in the CHPS service delivery process (as service enabling factors) and as catalyst to addressing effectiveness in the CHPS operations (Ghana Health Service, 2016). Consequently, the CHPS strategy recognizes the following basic elements including the community (as a social capital), households and individuals (as targets), planning with the community (community participation) and service delivery with the community (client focused). All of the above components of CHPS underpin the centrality of compliances to minimum services packages to be rendered by the CHOs, the CHVs, & the CHMCs as key in ensuring the effectiveness of CHPS zones operations (Awoonor-Williams et al., 2013). Home visiting is no doubt an effective intervention for solving maternal and neonatal deaths as opined by (Lawn et al., 2005) and (Luckow et al., 2017).

However, there are identified activities that are considered key threats to the effective operations of the CHPS zones. Assan et al., (2018) study identified many of these factors being key threats to effective delivery of primary health care at the CHPS zones. They cited inadequate transport system or non-existence of transportation system, inadequate or non-existence of equipment, inadequate or non-existing medicines, poor supervision of CHPS programme, weak or destroyed health infrastructure, physical inaccessibility, inexperienced CHOs, insufficiently trained community health workforce and high attrition rate among them, cultural and behavioral beliefs, poor referral support, and even financial insufficiency as some of these factors.

They also bemoaned the over emphasis placed on communities for commitments to their health developments as misplaced, since according to their study, these communities lack the needed resources, and mobilization to effect any positive change in the health well-being of the community they are serving. Such responsibilities, according to them are better placed in the hands of the government (Assan et al., 2018).

The lack of security in most CHPS, according to the study is affecting health professionals accepting to stay at the community, or even refuse to attend to client late in the nights, and those who accept to work in the community, later change their minds (Assan et al., 2018). There are instances, according to the study, health professionals vacating their post, citing security concerns (Assan et al., 2018).

The study also attempted to drive the relationship between well-trained CHOs & CHVs and service delivery performance. According to the study, the larger proportion of CHOs who have not had adequate training lack community mobilization skills, resource mobilization capacity, and even community entry skills, to effectively render improved services (Assan et al., 2018). Further studies in America have also corroborated and shown that nurse-based home-visiting programmes tend to have

better staff retention and benefits to clients compared with those that employ para-professionals (Olds & Kitzman, 1990, Rotheram-fuller et al., 2019).

Daro, Mccurdy, Falconnier, & Stojanovic, (2003) compare home visit service provision and workloads and cite reasons for why there is low recorded home visits. In Ghana, CHOs in the Brong Ahafo region were making one (1) home visit per week instead of the stipulated ten (10) visits per day due to their workload (Ntsua, Tapsoba, Asare, & Nyonator, 2012).

Sakeah et al., (2014) recognized the importance of CHOs being residents in communities as catalyst to delivering effective healthcare to the community. Her findings unearthed CHO-midwives who are able to interact with the people and know their problems, eventually improve their relationship with community members, and thereby offer better health service because they live in the community where accommodation is offered them. Interestingly, the CHO-midwives reported that these stronger relationships and 'inside knowledge' also sharpened their skills and confidence as health practitioners.

Sakeah et al., (2014) further recognized the correlation between motivation and output of midwives such as financial incentives, respect & recognition from the community, accelerated promotion from the Ghana Health Service etc. and concluded that all those who enjoyed these privileges performed better.

Sakeah et al., (2014) concluded that the integration of skilled delivery program with the CHPS program appears to be an effective model for improving access to skilled birth attendance in rural communities.

Evidences from (Nwameme, Tabong, & Adongo 2018) study also showed reduced number of visitations conducted by CHOs. According to their study, CHOs instead of doing at least 10 home visitations a day are now doing 4 a day due to work overload sometimes and inadequate staff

(Nwameme et al., 2018). Evidence suggests that availability of service providers and volume of work to accomplish has an influence on regularity of home visiting services (Daro et al., 2003 and Cowley, 2009).

Even earlier work done by Ntsua et al., (2012) pointed to the fact that CHOs were conducting just one (1) home visitations instead of ten (10) for purposes of health prevention education. Other studies have pointed to home visitations as contributing largely to reducing childhood illnesses, improving family health and helping patients to comply with health instructions (Kishi et al., (2016); Cowley et al., (2015); Olds & Kitzman, (1990). Further studies have also shown that home-based newborn care interventions can prevent 30–60% of newborn deaths in high mortality settings under controlled conditions (Bang et al., 2005).

Yeji, Shibanuma, Oduro, & Debpuur, (2015) identified Continuum of Care completion from the pregnancy stages to postpartum stages as constituting less than 10% among women served and the biggest gap and contributor to this low level in Continuum of Care (CoC) completion was between delivery and PNC services within 48hours after delivery. Uzondu, Doctor, Findley, Afenyadu & Ager, (2015) also concluded from their work that harm associated with deliveries at the community level are reduced significantly if Community Health Workers (CHEW) are involved.

Other studies such as one carried out by Nwameme et al., (2018) showed that moving about in the communities that have inaccessible roads or poor road paths, poorly constructed drainage systems, rugged topography, unpredictable weather conditions, high temperatures as well as unfriendly domestic animals pose significant constraints to the effective delivery of care by CHOs (Nwameme et al., 2018). Further findings from Nwameme et al., (2018) study also showed that the CHOs regard the supervision of their home visiting activities as insufficient. The supervisory activities that are carried out by the

CHPS Coordinators at the district and regional levels and involves periodically accompanying the CHOs on home visits to supervise their activities within the community and offer support where needed are not done on regular basis as expected (Nwameme et al., 2018).

Community-based Health Planning and Services (CHPS) Operational Policy requires that CHOs provide CHPS services by focusing on outreach, house-to- house services, and establishing community decision systems, using the community register for tracing defaulters and special conditions, such as pregnant women. CHOs also are to organize community child welfare (well child) sessions and school health education. Although CHOs were to be trained and equipped for basic treatment for minor ailments, this was never to be their main occupation: CHOs were expected to visit at least 10 homes every day for preventive health education, returning later in the afternoon to attend to clients' health needs. Now CHOs are completing in some cases only four home visits a month (Ntsua, Tapsoba, Asare & Nyonator, 2012).

Some CHOs reside at subdistrict levels and travel to communities. This can be a problem if the CHO lack equipment such as motor bikes to commute "to and fro" and this may deprive CHOs the opportunity of keeping in regular touch with communities and conducting home visits constantly, if operating from the subdistricts (Nstua, Tapsoba, Asare & Nyonator, 2012). The absence of data capture tools such as computers and personal data analyzers (PDAs) also affects CHOs' ability to effectively undertake data collection which is one of her functions (Ntsua, Tapsoba, Asare & Nyonator, 2012)

Other studies have also pointed to other factors such as cultural practices, language barrier as influencers in how effective CHPS service delivery could be provided and that for these to be scaled over, there should be concerted efforts to deeply understand how the community operates in terms of their value systems. One study even went to the extent of explaining the predicament of women by

citing that in some communities, women cannot access health care without the explicit permission from their husbands (Ngom et al., 2006). Whilst another study recognized the deep acceptance of the ladies leaving key decision making and participation in CHPS activities to largely men with the notion that they are more wise and can take better decisions on their behalf (Baatiema, Skovdal, Rifkin, & Campbell, 2013).

There were also evidences from literature that point to the fact that most communities vigorously engage in resource mobilization to support the activities of their local CHPS zones and these support are not only restricted to cash but other forms of support in-lieu of cash (Baatiema et al., 2013). Literature also pointed to the fact that though CHPS was to close the gap between the distance of community residence and where the CHPS are located, most of them still commute not less than 10kms on uncharted routes just to access healthcare (Atuoye et al., 2015) but Buor, (2016) revealed that health service utilization in Ashanti Region where CHPS operate from are low due to long distance and inaccessible roads.

Literature further point to the fact that high staff turnover among CHOs affect CHO workload and also cause valuable institutional memory needed for effective operations to be lost (Bonenberger et al., 2014). Other authorities unearthed evidence that showed that from the Navrongo CHFP program that relocating trained nurses to village residences where they are easily accessible to the community was a contributor factor to reduced child mortality (Pence, Nyarko, & Phillips, 2007).

Meanwhile, the Astana declaration in 2018 which is a follow up to the Alma Ata 1978 declaration promised the world a Primary health care (PHC) and primary health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated

and committed (Global Conference on Primary Health Care, 2018). And it is in the accessibility gap bridge that the Ministry of Health (MOH) embarked on the CHPS concept which Tsegay et al., (2013) called it a strong predictor of the utilization of antenatal care services especially among women in rural folks that lived close to the facilities.

2.6 CHPS basic package of services

The CHPS intervention package to be delivered by the CHO is in line with the Primary Health Care concept which is "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford" (Ministry of Public Health, 2005).

The concept of the basic package is that all of the services in the package should be available as an integrated whole, rather than being available piecemeal or as individual services or only through vertical programs (Ministry of Public Health, 2005). The basic package of health services has two purposes: (1) to provide a standardized package of basic services which forms the core of service delivery in all primary health care facilities and (2) to promote a redistribution of health services by providing equitable access, especially in underserved areas (Ministry of Public Health, 2005).

In Ghana, primary health care is delivered mainly through the CHPS concept and the basic package of services are services that are designed to be offered at these CHPS zones by the CHOs, the CHVs and the CHMCs. They are categorized into various integrated basic health services that are to be offered to the communities that the CHPS facilities serve (Ghana Health Service, 2015).

And since CHPS and health centers are seen to increase accessibility to health care by at least 50% as some studies in Wa West District of Upper West Region of Ghana reveal (Agbenyo, Nunbogu, &

Dongzagla, 2017), CHPS overall potential contribution to health outcomes cannot be underestimated. CHPS zones that are thus able to offer all or most of the basic package of services prescribed in the CHPS operational guideline are most likely to do better and thereby contribute more to national health indicators than those that are unable to perform most or all of the basic package of services (Ghana Health Service, 2016). For instance, Haines, Sanders & Lehmann (2007), pointed out in their study that outreach services and family-community care in combination at 90% coverage could result in an 18–37% reduction in neonatal mortality whilst case management of ill children by community health workers reduces mortality among children by 24% and further training of mothers to give anti-malarial treatments promptly to their children reduces under 5 mortality by 40% (Haines et al., 2007).

It is noteworthy to recognize that CHPS was conceived as a community-based health care system organized on the triple cadre model, with the CHO fulfilling the middle-level technical position, trained formally in health promotion and clinical services, the CHV being the lower technical cadre, facilitating community relations and diplomacy, creating a good environment for CHO activities and CHMC providing oversight and logistics support to CHO/CHV/ CHPS operations (Ntsua et al., 2012). Awoonor-Williams, Bawah, et al.,(2013) has also identified health education as largely contributing to changing women behavior towards health seeking interventions in Northern rural settings in Ghana whilst Singh & Jain, (2009) pointed to health education among adolescent as key in creating awareness on health issues and also helping to demystify their thoughts on certain health issues. Their study, for example, saw adolescent attitude towards HIV/ AIDS as different when they were educated compared to when they were not educated. Another aspect of success their study chalked was the significant 42% of adolescents seeing menstruation as a bad thing and thus girls having menstruation never to be allowed to enter the kitchen. Their study pointed to the power of health education as key game changer to reforming the perceptions of these adolescents. Mogre, Dery, & Gaa, (2016) established the link

between health education among women to influencing their quest to engage in exclusive breast feeding after birth whilst Nina, Kirkwood, Tawiah-agyemang, Owusu-agyei, & Adongo, (2008) identified empowerment to women through health education on skilled delivery as having the potency to reduce home delivery and the minimal use and resort to Traditional Birth Attendants (TBAs).

CHPS compounds are also ideally supposed to be staffed with not less than 3 CHOs who should ideally have backgrounds such as being Enrolled Nurse (E.N.), Community Health Nurse (C.H.N.) or a Midwife (Ghana Health Service, 2016). Meanwhile, there are 2 types of volunteerism in CHPS operations and management and these are the CHVs and the CHMCs (Ghana Health Service, 2016). CHVs recruited for each facility are expected to be at least 2 in number who must undergo a minimum of 1 week orientation training in addition to continuous in-service refresher training in in the areas of community mobilization, family planning, reproductive health, as well as be oriented in how diagnoses and management of minor ailments are handled (Ghana Health Service, 2016). CHMCs are also by virtue of their role expected to be trained in order to help them understand the CHPS concept and the role they are expected to play in its implementation (Ghana Health Service, 2016). Community Health Workers (CHW) who are otherwise recruited and deployed by the Youth Employment Authority (YEA) to augment CHPS operations in the roles CHVs are to play are expected to be trained for a minimum of 6 weeks (Ghana Health Service, 2016) and their core role is to support the CHOs in delivering their mandate as they seek to ensure all the CHPS basic package of services are delivered (Ghana Health Service, 2016).

Table 1: List of CHPS basic package of services

CHPS basic package of services provided by CHOs			
Item Numbers	**Community linkage & outreach services**	**Key tasks**	**Measurement indicator(s)**
1.0	Promoting Health as well as Giving Education on Health	Organise durbars and home visits; undertake community walkabouts relating to promotion of Healthy living as well undertaking education on Health living whilst making sure records and reports are written and kept	Existence of such service. Number of times durbars and home visits are conducted as well as frequency of times records are kept on such activities and reported and through which medium are they reported?
?2.0	Surveillance of Disease	Identifying diseases that need quick reporting, undertaking investigations on outbreaks, carry out surveillance and report according to standard operating protocol (SOP)	Existence of such service. Number of times surveillance are done, Number of times investigations on outbreak of diseases ae conducted. Nature and mode of reporting.
3.0	Home Visit	i. Routine House to house visitations: Providing Health Services on daily basis to individuals and households in their homes. ii. Special/Targeted Clients: Assign CHOs to clients with special needs; be ready and carry out visits to their homes.	Existence of such service. Number of times routine visits are done in a week to individual homes. Number of times special clients are visited Number of times defaulters are traced and visited and

		Identify defaulters by following up on patients recommended by hospital(s) after discharge, and counselling and supporting clients with Non-Communicable Diseases such as Diabetes and Hypertension. Keep documentations on them and report accordingly on these activities.	follow up done to patients discharged. Number of NCD Patients located supported and advised. Nature and type of documentations carried out and check report remittals
4.0	School Health Activities	Prepare for School Health activities, carry out health education & physical examinations in Schools, undertaking inspection of environment, briefing school authorities on outcome of visitations and writing report.	Existence of such service. Number of health education, physical examination, environmental inspections, school authority's interactions carried out in a week Type and nature of reports written
5.0	Health Outreach Activities	Preparing and carrying out Health Outreach activities and recording and reporting on them.	Existence of such service. Number of outreach activities carried out in a week Documentations and reports done
6.0	Managing CHVs	Carry out meetings, revise Community Health Action	Existence of such tasks. Number of meetings done with CHVs, number of times

		Plan (CHAPs), and submitting reports.	CHAP revised, and reports submitted
7.0	Working with CHMCs	Carry out meetings, putting together community profiles, drawing up map of community, and giving technical assistance.	Existence of such tasks. Number of times meetings with CHMCs are conducted
A1	**Basic clinical services**	**Key tasks**	**Measurement indicator(s)**
8.0	Immunisation	Carry out education, administration and management on vaccines, documenting and reporting.	Existence of such service. Number of children immunized Number of households sensitized and educated on immunization
9.0	Breastfeeding (BF), growth monitoring, and nutrition	Provide Breastfeeding support and education, carry out weighing of babies and children, documenting and recording, whilst noticing malnourished children as well as giving education on prevention of malnutrition.	Existence of such service. Number of times BF education carried out. Number of children weighed Number of children found to be malnourished
10.0	Integrated Management of Neonatal and Childhood Illness Acute care of Infants and Children [IMNCI]	Taking History, doing preliminary assessment, examining the Child physically, identifying, classifying and managing (jaundice, diarrhoea, ARI, fever, measles, ear infection);	Existence of such services. Number of children handled in terms of history taking, physical examination, classification & management.

		as well as recording and referring where necessary.	Number of Referrals carried out and recordings made
A2	**Reproductive health**	**Key tasks**	**Measurement indicator(s)**
11.0	Family Planning Activities	Giving counselling on all methods of family planning, giving education on choices and preferred methods and administering method (i.e. condoms, combined oral contraceptive, injectables, implants), and referral for other or permanent methods.	Existence of such services. Number of patients counselled Number of times education carried out Number of patients provided with condoms, contraceptives, injectables, implants Number of referrals made
12.0	HIV/AIDS and Sexually Transmitted Infections (STIs)	Carry out education on HIV/AIDS & STIs, teach condom use, carry out physical examination, get clients ready for testing by using rapid diagnostic test and giving feedback test outcome. Give appropriate management to positive cases by treating and/or referring where necessary.	Existence of such service. Number of times of education on HIV/AIDS carried out Number of tests conducted on patients and referrals made where necessary Number of times physical examinations are carried & patients are prepared before testing.
13.0	ANC	Carry out history taking, identifying and managing anaemia, malaria in pregnancy,	Existence of such service. Number of patients treated with anaemia

		syphilis in pregnancy and implementing Prevention of Mother to Child Transmission (PMTCT) activities. Carry out counselling for pregnant women using findings arrived at whilst teaching danger signs in pregnancy.	Number of patients handled with malaria in pregnancy Number of patients handled with syphilis in pregnancy Number of patients counselled on PMTCT etc.
14.0	Safe emergency delivery and new-born resuscitation	Immediately assess mother, make ready for delivery, monitor labour, deliver baby, revive baby if baby is not breathing well, and carry out active management of the third stage of labour.	Existence of such service. Number of mothers assessed. Number of mothers prepared for delivery Number of mothers monitored for labour
15.0	Postnatal care (PNC) and key new-born care.	Carry out immediate Post Natal Care (PNC) to mother and baby, educate family on PNC, assess baby and mother at 6 weeks after delivery.	Existence of such service. Number of mothers that had PNC care Number of mothers that had PNC education Number of mothers & babies assessed
A3	**Other clinical services**	**Key tasks**	**Measurement indicator(s)**
16.0	Infection Prevention	Supply management; decontamination, cleaning, sterilising, and storing instruments properly. Carry out disposal of waste well.	Existence of such service. Number and frequency of equipment sterilized and properly stored Check how wastes are disposed and frequency of it

17.0	Communicable Diseases (HIV, Malaria, TB)	Know signs and symptoms of Communicable Diseases, refer, follow up, carry out home visitations to Tuberculosis (TB) patients. Carry out HIV rapid test as well carry out Malaria rapid test and treat to cure if manageable and/or refer.	Existence of such service. Number of communicable diseases detected Number of cases referred Number of home visits to patients with TB. Number of patients that had malaria rapid test and HIV rapid test.
18.0	Neglected Tropical Diseases (NTDs)	Notice signs and symptoms, refer where necessary, follow up, carry out home visits.	Existence of such service. Number of NTDs detected and referred Number of cases followed up through home visit
19.0	Adolescent Health	Carry out Adolescent related health services, give counselling on FP, STIs and HIVs, nutrition; support services by giving referral if needed and doing follow-up as well as pursue home visits.	Existence of such services. Number of adolescent friendly health services carried out Number of Counselling carried out
20.0	Non-Communicable and chronic Diseases (Hypertension, Diabetes)	Know and notice signs and symptoms of Non-Communicable diseases such as Hypertension and Diabetes by referring, following up and/or carrying out home visits activities.	Existence of such services. Number of non-communicable chronic diseases detected and referred Number of home visits conducted

21.0	Mental Health	Carry out assessment and diagnosis of clients by giving appropriate care and treatment where possible.	Existence of such services. Number of clients assessed and diagnosed number of cases if available treated or referred
22.0	Minor Ailments	Carry out assessment and diagnosis as well as giving appropriate treatment.	Existence of such services. Number of minor ailments assessed & treated
23.0	First Aid and Home Emergencies	Notice signs and symptoms; do diagnosis and manage shock, snake bite, poisoning, convulsion and seizures, burns, sprains and strains, fractures and dislocations, and epistaxis; and carry out wound dressing.	Existence of such services. Number of first aid and home emergencies care given. List them individually Number of the complicated cases referred
24.0	Caring for the Aged	Carry out home visitations to the aged to give education on proper care and balanced nutrition need for aged.	Existence of such services. Number of aged patients visited at home Type of education, care & nutrition advice given
A3	**Resources management**	**Key tasks**	**Measurement indicator(s)**
25.0	Planning	Plan activities monthly and implement them.	Existence of such services. Number of plans carried out in the month and implemented
26.0	Logistics Management	Order supplies and ensure proper management, manage vaccines well, and keep CHPS compound clean.	Existence of such services. Number and type of logistics supplied

			The mode of maintaining vaccines and how CHPS zones are kept
27.0	Financial Management	Store value books, take custody of completed value books, order for value books, and receive cash using GCR and banking afterwards on daily basis. Receive cheques and pay them into bank accounts; managing petty cash	Existence of such services. Type of value books used, books kept, procurement utilized books, cash revenue book and banking processes. Mode of payment and receipt of services carried out
28.0	NHIA	Record and submit NHIS claims.	Existence of such services. Mode of keeping NHIA records and submitting claims on
29.0	Data collection, reporting, analysis and use	Compile all data; analyse, interpret, and use to take decisions fore facility. Ensure that data is keyed into DHIMS2 on behalf of the CHPS zone.	Existence of such services. Mode of collecting data, analysing, interpreting The frequency reporting on DHIMS 2 and accuracy of use of DHIMS 2 etc.
CHPS basic package of services provided by CHVs			
2.0	**Provided by CHVs**	**Key tasks**	**Measurement indicator(s)**
30.0	Helping to Prevent Diseases as well as Promoting Environmental related Sanitation practices at Homes and Communities.	Inform CHO of any suspected epidemic-prone disease as well as educating Community members on effective Environmental Sanitation practices in their Communities and Homes.	The existence of such services. Number of cases reported to the CHOs Number of times education is carried out on Environmental Sanitation practices

31.0	Visiting Homes	Get ready, carry out and end visits to Homes properly.	The existence of such services. Number of supportive home visits carried out
32.0	Home Management of Minor Ailments (Integrated Community Case Management).	Notice signs and symptoms of fever, diarrhoea and take steps to manage them at homes.	Existence of such services. Number of fevers identified and managed at home. Number of diarrhoeas managed at home
33.0	Community Outreach Activities	Involve in, carry out health education, carry out promotions on BF, family planning, as well as wearing and removal of condoms. CHVs visiting home with working tools/logistics bag.	Existence of such services. Number of times health education, BF promotion, family planning, condom use given during home visitation have been carried out
CHPS basic package of services provided by CHMCs			
3.0	**Provided by CHMCs**	**Key tasks**	**Measure indicator(s)**
34.0	Governance, Membership, and Operation	Ensure community recognizes CHPS and community members know their responsibilities, write down minutes during meetings, support health education activities, and resolve conflicts.	Existence of such services. Number of times it engages the community to recognize the CHPS and support the CHPS facility. Extent of community ownership of the CHPS through community involvement (Check records) Awareness of the role of CHMCs

			Number of times minutes are written in their meetings
35.0	Selection and supervision of CHVs	Supervise CHVs and provide motivation for CHVs.	Existence of such services. Nature and type of supervision it conducts over CHVs The type of motivation given to CHVs
36.0	Welfare of CHO (including provision of Security for CHOs)	Care for CHOs and ensure security for CHOs.	Existence of such services. Nature and type of care provided for CHOs Type and nature of security given to CHOs
37.0	Facility Maintenance	Manage waste properly and create community ambulance system.	Existence of such services. Systems in place to provide basic maintenance to CHPS zones How wastes are managed and what community ambulatory system exist
38.0	Resource Mobilisation and Management	Keeps CHPS compound clean; records contributions made by others and all financial transactions.	Existence of such services. How resources are mobilized to support the CHPS operations and the frequency of such mobilization How records of such contributions to manage the CHPS zones are kept etc.

Source: CHPS National Implementation Guideline Manual (Amended) 2016

For these CHOs and the CHVs to be able to deliver their mandate in accordance with the basic package of services as spelt out in the national policy document on CHPS, they are expected to be well trained and provided with requisite working materials and logistics to work with which shall include support to carry out effective home visits and outreaches (Ghana Health Service, 2016).

2.7 Summary and Conclusion from Literature Reviewed

Literature reviewed pointed to basic package of services as driving the impact of CHPS delivery of services on community healthcare with its attendant accrued advantages such as bringing standardization to service delivery and ensuring equity in health distribution. It also cited support regimes such as adequate budget allocations, training of CHOs, CHVs and CHMCs and existence of logistics as ingredients needed to manage services provided under the basic package of services very well. Meanwhile, literature reviewed also summarized reasons why creation of basic package of services (BPoS) is good and mentioned factors such as priority setting in healthcare, equity, poverty suppression, political empowerment and accountability as the core reasons. Ghana's Primary Health Care deepening, according to the reviewed chapter, was also a consequence of the success story of the Danfah rural and family health project, the 1978 alma-ata, the Navrongo pilot and the Nkwanta replication that led to the introduction of the CHPS concept. The CHPS concept dwelt on bringing healthcare to the doorstep of the community with a population of 1,500 that carries its core work with community participation and engagement as key.

The literature cited challenges such as inadequate logistics, inaccessible roads to CHPS centers, ineffective or non-existent transportation system, non-existent emergency referral system, CHMCs inability to address CHO-CHV conflict, ineffective or non-existent supervision over CHPS operations, posting inexperienced CHOs, lack of accommodation and security to facilitate CHO

work, lack of effective resource mobilization, lack of training of CHOs, CHVs and CHMCs, high CHO turnover and CHO attrition rates leading to work overload on the few left especially with respect to CHOs duties, general motivation to CHOs and CHVs and linked these to accounting for core services of CHOs such as home visitations not being able to be rendered to the minimum of 10 homes per a day visit by a CHO. Other cultural beliefs and male-gendered superiority beliefs also affected women participation especially in CHPS durbar and community engagements. The chapter ended with listed basic package of services CHOs, CHVs and CHMCs are to provide in a tabular form by aligning them to key tasks to be performed and how these key tasks are to be measured.

However, in all the literatures reviewed in this chapter, all pointed to only one form of basic package of services or the other that are rendered by CHOs, CHVs and CHMCs with their associated challenges in delivering them cited but none looked at the totality of the basic package of services that are provided holistically by the CHOs, CHVs and the CHMCs and this study is being undertaken to fill that knowledge gap.

CHAPTER THREE

METHODS

3.1 Introduction

The research methods that was used in this study is outlined in this section. The research study type/ design, study area, study variables, study population, inclusion/exclusion criteria, sample size determination, sampling procedure/approach, data collection technique/tools, data processing, data statistical analysis, quality control and study limitations are outlined here. This section also includes ethical considerations, timelines and ends with the budget used for the study.

3.2 Research Design

This was a facility based cross sectional study of purposively selected 3 CHPS compounds using a quantitative method to assess CHPS basic package of services. The study participants included all CHOs, CHVs and CHMCs operating in these 3 CHPS facilities.

3.3 Study Area

The study was conducted in the Shai Osudoku District of the Greater Accra Region of Ghana. The Shai Osudoku District is situated in the southeastern part of Ghana, one of the 16 districts in the Greater Accra Region as shown in figure 2. The district was re-demarcated in June 2012 when it was carved out of the Dangme West District by L.I. 2137, one of the four purely rural districts in the region.

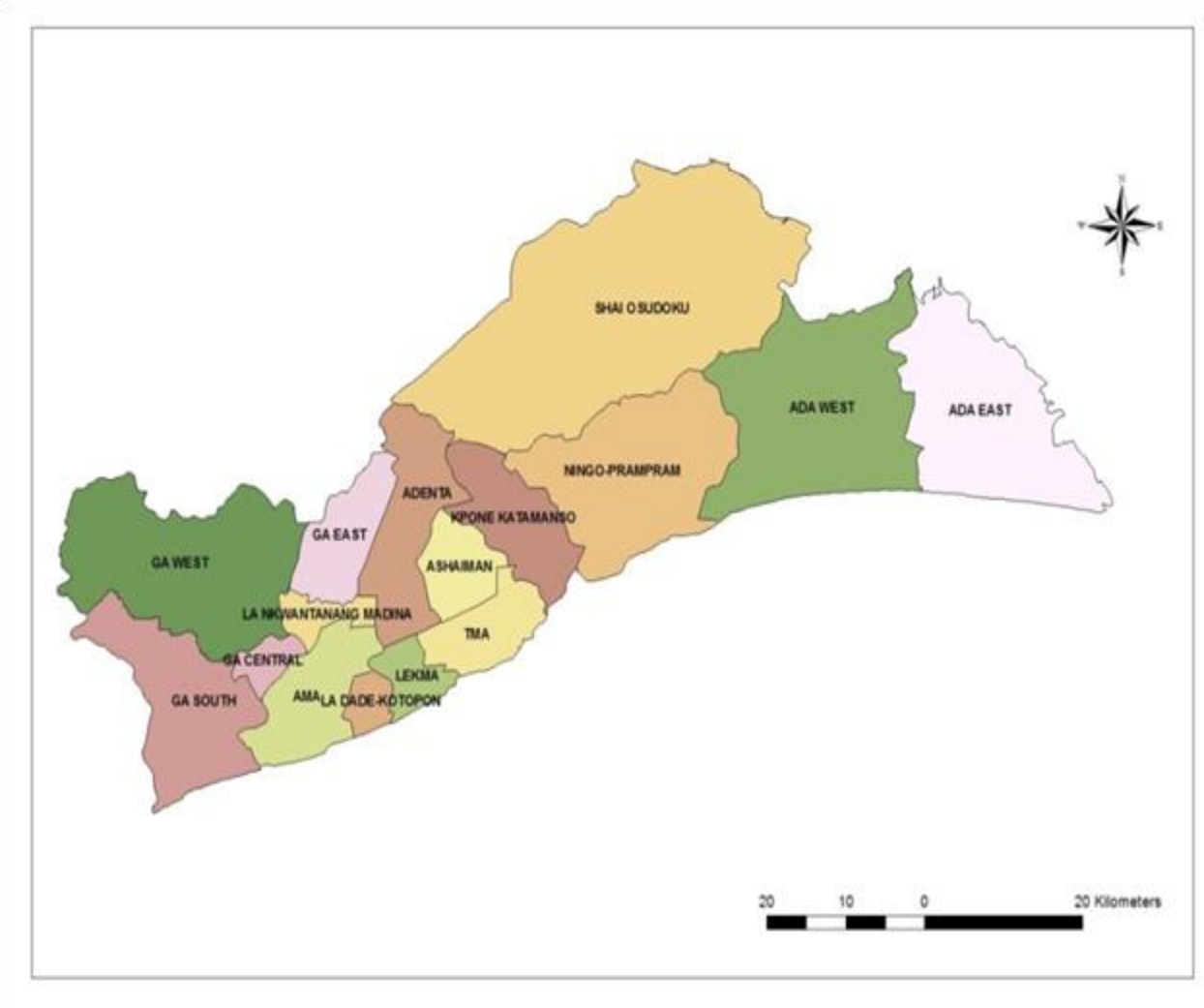


Figure 2: Geographic location of Shai Osudoku District in the Greater Accra Region

It occupies a total land surface area of about 721 square kilometers and the largest land surface area in the Greater Accra region. It is bounded on the North-Eastern by North Tongu District; to the North West by Yilo and Manya Krobo Districts; to the West by North Akwapim Districts; to the South-West by the Kpone Katamanso District; to the South by the Ningo/Prampram District; and to the East by Ada West District as shown in the map. The District has a 2018 projected population of about 60,915. The major Communities include Dodowa (being the District Capital), and other major towns such as Asutsuare, Osuwem, Ayikuma and Kordiabe.

3.3.1 Healthcare Provision in the District

The District has a District Hospital, 3 Health Centres, 11 CHPS with compounds in 25 demarcated CHPS Zones, a private Hospital, a mission clinic and a maternity home.

3.3.2 Distribution of Health Facilities by Sub-District 2018

The distribution of health facilities in the Shai Osudoku district is shown in Table 2.

Table 2: List of health facilities in Shai Osudoku District

Health Facility	Sub-District					District Total
	Dodowa	Agomeda	Ayikuma	Doffour	Osudoku	
District Hospital	1	0	0	0	0	1
Health Centre	0	1	0	1	1	3
CHPS compounds	1	1	2	2	5	11
CHPS without comp.	5	2	2	3	3	14
Maternity Homes	1	0	0	0	0	1
Private Hospital	1	0	0	0	0	1
Mission Clinics	0	1	0	0	0	1
Total District Health Facilities	9	5	4	6	8	32

Source: Shai Osudoku Annual Performance Report 2018

3.3.3 CHPS Facilities in the District

There are presently 11 CHPS facilities with compounds in the district and the district ranks CHPS performances based on attendances to OPD, ANC & family planning. Tokpo, Osuwem and Ayikuma have high level of attendance in OPD, ANC and family planning acceptors. Asutuare Junction, Natriku and Ayerna CHPS are classified as having medium range level of attendance. The rest of the facilities that include Kasunya, Ayernya, Sota and Volivo and Lower Dodowa CHPS are amongst the facilities that have low level of attendance as per the Dangme East 2018 annual report.

Table 3: List of CHPS facilities with compound in Shai Osudoku District

Facility	Total OPD Attendance	ANC Registrant	Family Planning Acceptors
CHPS with high level of attendance			
Tokpo CHPS	1,940	144	515
Osuwem CHPS	1,939	94	2,751
Ayikuma CHPS	1,295	103	1,091
CHPS with medium level of attendance			
Asutuare Junction	785	94	337
Natriku CHPS	900	76	324
Agortor CHPS	495	55	365
CHPS with low level of attendance			
Ayerna CHPS	359	15	235
Kasunya CHPS	262	13	198
Volivo CHPS	253	17	157
Lower Dodowa	145	11	186
Sota CHPS	110	10	195
Total	8,483	632	6,354

Source: Shai Osudoku Annual Performance Report 2018

3.4 Study Variables

Table 4 details out the independent and dependent variables of the study.

Table 4: List of independent and dependent variables of CHOs, CHVs and CHMCs

No.	Category	Independent variable	Dependent variable
1.	CHOs	Community linkage and outreach services, child health, reproductive health and other clinical services	Availability and functionality
2.	CHVs	Disease prevention and environmental sanitation, home visitation, home management of minor ailments, community outreach	
3.	CHMCs	Governance, membership and operation, selection and supervision of CHVs, welfare of CHOs, facility	

3.5 Study Population

The study population of this study were CHOs, CHVs and CHMCs. These study population manage the CHPS facilities in the district.

3.6 Inclusion and Exclusion Criteria

3.6.1 Inclusion Criteria

The inclusion criteria were:

1. CHPS with compounds in Shai Osudoku District
2. Selected CHPS zones with high, medium and low level of attendance in Shai Osudoku District.
3. All CHOs, CHVs, and CHMCs in the three selected facilities in Shai Osudoku District selected for the study.
4. All CHOs, CHVs and CHMCs in the selected study facilities who consent to participating in the study.

3.6.2 Exclusion Criteria

The exclusion criteria were:

1. All CHOs, CHVs and CHMCs who are working in the selected study CHPS compounds in the Shai Osudoku District but did not consent to be part of the study.

3.7 Sample Size

The sample size for the study consisted of all the CHOs, CHVs and CHMCs in the 3 study CHPS zones. An estimated number of 57 made up of 14 CHOs, 8 CHVs and 35 CHMCs.

3.8 Sampling Procedure

Three (3) randomly selected CHPS zones from amongst 11 CHPs zones with compounds were selected for the study. The three randomly selected were made up of 1 CHPS zone each from CHPS facility with high attendance, CHPS facility with medium attendance and CHPS facility with low attendance with 57 participants broken down into CHOs numbering 14, CHVs making up 8 and CHMCs consisting of 35. The breakdown was as follows as shown in table 5.

Table 5: List of number of CHOs, CHVs, and CHMCs selected to participate in the study

CHPS	CHOs	CHVs	CHMCs
Osuwem	4	4	13
Asutuare Junction	6	2	10
Volivo	4	2	12

Source: Facility based verification and validation, July 2019

3.9 Data Collection Techniques

There were 3 sets of structured questionnaires each targeted at the CHOs, CHVs and the CHMCs of the 3 selected CHPS zones. Paper based structured questionnaire was used for the data collection. Research assistants used for the study were well trained to understand the structured questionnaire. Data collection was preceded by a pilot test at Tokpo CHPS to validate the reliability and appropriateness of the questions and the expected responses by the sampled population made up of the CHOs, CHVs and the CHMCs. A revision of the questionnaire in the light of any error detected was duly carried out to reflect those corrections. Participants were also given a consent form (Appendix 1) to read and sign prior to answering the questionnaire. Questionnaires and consent forms were read out

and explained to participants who were not be able to read or write and all the consent form(s) signed by a witness(es).

3.10 Data Processing & Analysis

3.10.1 Data Processing

The collected paper base questionnaire was entered in an Excel spreadsheet with validated and restricted fields. The data collected was cross-checked and validated to ensure that responses were correct.

3.10.2 Data Analysis

3.10.2.1 Background Characteristics of the Respondents (CHOs, CHVs and CHMCs)

The study centred on CHOs, CHVs and CHMCs of the 3 selected CHPS facilities who consented to participate in the study. Background characteristics such as age, sex, qualification, experience, residence status etc. of participants were extracted for the study.

3.10.2.2 Determination of CHO, CHV and CHMC services and approach to data analysis

Data analysis was presented in tables depicting outcomes of results on CHOs, CHVs and CHMCs as well as the challenges in delivering such services. Data analysis was descriptive. Frequencies and percentages were used to analyse categorical responses from study participants. Availability of services were, however, computed as percentages using number of CHOs, CHVs and CHMCS who indicated as responsive those services that were available averaged over the total number of services expected to be available. The individual percentages of services available arrived at, were further grouped into sub-broad themes of services such as activities that constituted “family

planning", for example, and percentages averagely arrived at to know what percentage of services were available for the sub-broad theme. Services were also further categorized into broad themes such as "Basic Clinical Services" that, for example, were groupings of sub-broad themes of services such as Family Planning, HIV/AIDS & STDs, ANC, Safe Emergency Delivery & New Born Rescuscitation, PNC, & Other Clinical Services to averagely arrive at total percentage availability of broad theme of services such as in respect of "Basic Clinical Services". The rest followed in similar suits. Functionality of services also followed the same suit except in respect of this, functionality was first determined by the "operationalization" of the "available service" by determining the number of times such operational service was carried out per each activity, sub-theme and broad-theme and their averages each was carried out. Secondly, functionality was further determined by the total percentage of services operationally functional at any point in time. This was to help bring clarity and determination to services that were "available" and not necessarily "functional".

3.11.1 Training of Field Staff

To ensure quality of data collected and to reduce the level of errors, training was conducted for enumerators/ interviewers and field supervisors in the proper administration of questionnaires such as the introduction of one's self to respondents, the explanation of the right of the respondents to have access to the information sheet that explained the study before consent form was read and signed as testimony to agreeing to freely participate in the study. It also included training on entry responses, language translation without changing the focus of the questions, organization by respondents to aid effective statistical analysis as well as how to exit from field work study.

3.11.2 Pre-testing of Data Collection Instruments

After the training of field staff, the questionnaire was pre-tested before the main survey begun. This aided in providing feedback and the inclusion of vital queries in the questionnaire as well as provided the platform for enumerators and field supervisors to further practice the administration of the tools. During the pre-testing, the survey particularly observed feedback on the content, sequencing and pacing of the questions that informed the final revision of the survey instruments.

3.11.3 Editing and Revision of Questionnaires

After pre-testing to validate the reliability and appropriateness of the questions and expected responses by respondents, a revision of the questionnaire in respect to corrections was made.

3.11.4 Supervision of Field Work

Two teams were formed for the data collection across all the selected CHPS facilities. Each team had 2 enumerators who worked under the supervision of one Team Leader (Supervisor). This was to ensure that the data collection exercise went on simultaneously across all the selected CHPS facilities, and also ensured timely execution of the exercise. The supervisor (team leader) monitored the activities of the enumerators closely to ensure that data quality was not compromised. Also, at the end of each day of enumeration, the supervisor went through the filled or completed questionnaires to ensure completeness of responses from study participants. Furthermore, there was a Research Assistant (RA) who coordinated, monitored and had an oversight control of the teams' activities throughout the entire period for the field exercise. Finally, the researcher for this study was on the field to monitor the exercise throughout the period assigned for the field work. This was in conformity to data quality protocols that was put in place to ensure high data quality for the study.

3.12 Study Limitations

The following were the limitations to the study:

1. The study was just limited to a study of 3 CHPS facilities in the district. Time did not allow for more expanded work.

2. Responses to some of the questions might have been false or biased because some respondents might want to shield their inefficiencies.

3.13 Ethical Considerations

3.13.1 Ethical Clearance

Ethical clearance for the study was obtained from the Ghana Health Service Ethics Review Committee (GHS-ER 021/07/19) before commencement of field work data collection from the Shai Osudoku District.

3.13.2 Other Ethical Considerations

Consent was also sought from all CHOs, CHVs and CHMCs respondents before they were allowed to participate in the study. All available explanations in the language of their choice was used to explain the purpose of the study.

3.13.3 Permission

Permission was obtained from the Regional Director of Greater Accra Region and the District Director of Shai Osudoku District all of the Ghana Health Service as well as the School of Public Health Legon, University of Ghana before the research was conducted in the facilities chosen.

3.13.4 Informed Consent

Written consent was obtained from each participant and this was obtained through a signature (see consent form attached in appendix I). During the consenting process participants were made aware that they would be required to fill out a form by responding to the questionnaire. They were also be made aware that participation was voluntary and that there was neither reward nor penalty for accepting or refusing to participate in the study.

3.13.5 Confidentiality

Throughout the study, all information provided was kept under lock by the Principal researcher (P.I.) and was only used for its intended purpose. Soft copies of information with password protected and hard copies were kept under lock and key. Only the PI and the Supervisor in the research where necessary had access to it. Assurances of confidentiality allayed the fear and the mistrust the respondents might have had with respect to how information gathered was going to be handled.

3.13.6 Anonymity

Participants were assured of anonymity once they consented to participate. Names of the study participants were not captured during the data entry phase but replaced with codes to ensure the anonymity of study participants and their responses. Data was analyzed in such a manner that the respondent's names or other forms of identification was not used. Each respondent was identified with a unique code or a study number.

3.13.7 Voluntary Withdrawal

All research participants were duly informed of their right to decline participation in the study and the right to withdraw from the study anytime at their own behest.

3.13.8 Privacy

Participants were made aware of their rights to privacy and the steps taken to safeguard those rights by the researcher. As such all participants were interviewed in a secluded place where no one heard what was discussed and also had access to.

3.13.9 Potential Risk

There was minimum physical, psychological, social, legal, or economic risks associated with one's participation in this research.

3.13.10 Potential Benefits

There was no direct benefit in this study. However, findings from the research was to help improve CHPS operations particularly in the delivery of the CHPS prescribed basic package of services.

3.13.11 Cost/Compensation

There was no direct cost incurred in this study by the participants. The study did not provide compensation of any form to the participants.

3.13.12 Data Usage, Storage and Security

Data collected from the study was strictly used for the purposes of this academic research and none was appropriated for any other use. The data collected was stored under a password for the soft copy and under cabin lock for the hard copy.

3.13.13 Protocol Funding Information

This study was solely funded by the Principal Investigator (P.I.).

3.13.14 Declaration of Conflict of Interest

This study was intended to be used for academic purposes only and that there was no other conflict of interest.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the results from the field survey administered through questionnaire on CHOs, CHVs and CHMCs. Issues such as the background of respondents in terms of age, sex, educational level, staff category, years of working experience, duration at current post, residence status as well as training level before and after engagements are presented in this piece. In addition, results from questionnaire administered to CHOs, CHVs and CHMCs on availability of services rendered, functionality of such services, the yearly average of work undertaken under each service and the challenges confronting CHOs, CHVs and CHMCs in delivering their defined roles are all provided here.

4.1 Background characteristics of CHOs, CHVs and CHMCs analyzed by facility type

Tables 27, 28 and 29 show the background characteristics of CHOs, CHVs and CHMCs. In all, 14 CHOs, 8 CHVs and 35 CHMCs were involved in the study, made up of participants from Asutuare Junction CHPS, Osuwem CHPS and Volivo CHPS.

Table 27 shows that majority of CHOs (64.3% (9)) were in the age group between 20-29 whilst the least number (14.3% (2)) were part of the 40-49 age group. By sex distribution, 92.9% (13) were women and all CHOs were educated up to the post-secondary certificate level. Most of the CHOs (50% (7)) were enrolled nurses (EN) whilst 14.3% (2) were midwives. Amongst the 14 CHOs, 92.9% (13) have worked for less than 10 years whilst 71.4% (10) had spent less than 5 years in their various facilities of work. About 57.1% (8) of CHOs resides within the CHPS facility. On mandatory training designed for CHOs, majority (64.3% (9)) were not trained whilst only (21.4% (3)) had received some form of accelerated training.

Table 28 shows that for CHVs, most of them, (37.5% (3)) were in the 40-49 age group. About 50% (4) of the CHVs were male whilst most (50% (4)) had senior high school education. The working experience of CHVs shows that 62.5% (5) of CHVs have been volunteers for less than 5 years. The study further revealed 50% (4) had either been untrained or just given partial training before or during assumption of duty as CHVs.

Table 29 further shows that for CHMCs, majority (37.1% (13)) were in the 40-49 years group. By sex distribution, 65.7% (23) were women. Educationally, 51.5% (18) had only reached primary school level. About 80% (28) had assumed duty as CHMC member for a period spanning less than 10 years. On CHMCs training status, more than a third (37.1% (13)) were not trained before assuming the CHMC role.

Table 6: Background Characteristics of CHOs analyzed by facility type

Items	Asutuare Junction	Osuwem	Volivo	Total
	n (%)	n (%)	n (%)	n (%)
Age (years)				
20-29	4(66.7)	2 (50.0)	3 (75.0)	9 (64.3)
30-39	0 (0.0)	2 (50.0)	1 (25.0)	3 (21.4)
40-49	2 (33.3)	0 (0.0)	0 (0.0)	2 (14.3)
Sex				
Male	0 (0.0)	0 (0.0)	1 (25.0)	1 (7.1)
Female	6 (100)	4 (100)	3 (75.0)	13 (92.9)
Education				
Diploma	0 (0.0)	0 (0.0)	0 (0.0)	0(0.0)
Certificate	6 (100)	4 (100)	4 (100)	14 (100)
Category of Staff				
Midwife	1 (16.7)	1 (25.0)	0 (0.0)	2 (14.3)
CHN	2 (33.3)	1 (25.0)	2 (50.0)	5 (35.7)
EN	3 (50.0)	2 (50.0)	2 (50.0)	7 (50.0)
Years of working experience				
< 10	5 (83.3)	4 (100)	4 (100)	13 (92.9)
> 10	1 (16.7)	0(0.0)	0 (0.0)	1 (7.1)
Duration of posting in current facility				
< 5	5 (83.3)	2 (50.0)	3 (75.0)	10 (71.4)
> 5	1 (16.7)	2 (50.0)	1 (25.0)	4 (28.6)
Residence Status				
Resident in the community but not on facility premises	2 (33.3)	0 (0.0)	4 (100)	6 (42.9)
Resident in the community and on the facility premises	4(66.7)	4(100)	0(0.00)	8 (57.1)
CHO Training Status				
Accelerated Training (Trained)	2 (33.3)	0 (0.0)	1 (25.0)	3 (21.4)
Accelerated Training (Partially Trained)	1 (16.7)	0 (0.0)	1 (25.0)	2 (14.3)
Accelerated Training (Not trained)	3 (50.0)	4 (100)	2 (50.0)	9 (64.3)
Total	**6 (100)**	**4 (100)**	**4 (100)**	**14 (100)**

Table 7: Background Characteristics of CHVs by facility type

Items	Asutuare (N=2)	Osuwem (N=4)	Volivo (N=2)	Total (N=8)
	n (%)	n (%)	n (%)	n (%)
Age (years)				
< 30	0 (0.0)	2 (50.0)	0 (0.0)	2 (25.0)
30-39	1 (50.0)	0 (0.0)	1 (50.0)	2 (25.0)
40-49	1 (50.0)	1 (25.0)	1 (50.0)	3 (37.5)
≥ 50	0 (0.0)	1 (25.0)	0 (0.0)	1 (12.5)
Sex				
Male	2 (100)	2 (50.0)	0 (0.0)	4 (50.0)
Female	0 (0.0)	2 (50.0)	2 (100)	4 (50.0)
Educational level				
Certificate	1 (50.0)	0 (0.0)	0 (0.0)	1 (12.5)
WASSCE	0 (0.0)	2 (50.0)	2 (100)	4 (50.0)
Others	1 (50.0)	2 (50.0)	0 (0.0)	3 (37.5)
Years of working experience as CHV				
< 5	2 (100)	2 (50.0)	1 (50.0)	5 (62.5)
5-9	0 (0.0)	0 (0.0)	1 (50.0)	1 (12.5)
≥ 10	0 (0.0)	2 (50.0)	0 (0.0)	2 (25.0)
CHV Training Status				
CHV Trained (accelerated)	0 (0.0)	2 (50.0)	0 (0.0)	2 (25.0)
CHV Partially Trained	2 (100)	0 (0.0)	2 (100)	4 (50.0)
CHV Untrained	0 (0.0)	2 (50.0)	0 (0.0)	2 (25.0)
Total	**2 (100)**	**4 (100)**	**2 (100)**	**8 (100)**

Table 8: Background Characteristics of CHMCs by facility type

Items	Asutuare (N=10)	Osuwem (N=13)	Volivo (N=12)	Total (N=35)
Age (years)				
< 30	0 (0.0)	1 (7.7)	3 (25.0)	4 (11.4)
30-39	1 (10.0)	1 (7.7)	2 (16.7)	4 (11.4)
40-49	4 (40.0)	2 (15.4)	7 (58.3)	13 (37.1)
50-59	3 (30.0)	5 (38.4)	0 (0.0)	8 (22.9)
60+	2 (20.0)	4 (30.8)	0 (0.0)	6 (17.2)
Sex				
Male	6 (60.0)	8 (61.5)	9 (75.0)	23 (65.7)
Female	4 (40.0)	5 (38.5)	3 (25.0)	12 (34.3)
Educational level				
Degree	0 (0.0)	1 (7.7)	1 (8.3)	2 (5.7)
Diploma	0 (0.0)	2 (15.4)	0 (0.0)	2 (5.7)
Certificate	1 (10.0)	1 (7.7)	0 (0.0)	2 (5.7)
WASSCE	0 (0.0)	2 (15.4)	9 (75.0)	11 (31.4)
Others	9 (90.0)	7 (53.8)	2 (16.7)	18 (51.5)
Years of being CHMC member				
< 10	10 (100)	6 (46.2)	12 (100)	28 (80.0)
≥ 10	0 (0.0)	7 (53.8)	0 (0.0)	7 (20.0)
CHMC Training Status				
CHMC Accelerated Training (Trained)	3 (30.0)	12 (92.3)	7 (58.3)	22 (62.9)
CHMC Accelerated Training (Partially trained)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
CHMC Accelerated Training (Untrained)	7 (70.0)	1 (7.7)	5 (41.7)	13 (37.1)
Total	**10 (100)**	**13 (100)**	**12 (100)**	**35 (100)**

4.2 Availability of services as provided by CHOs, CHVs and CHMCs.

The Community-based Health Planning and Services (CHPS) Implementation Manual Guidelines specifies CHOs are to perform 105 tasks. The CHO tasks (105) in number are further categorized into three (3) broad themes made up of Community Linkage and Outreach Services, Basic Clinical Services and Resource Management responsibilities. Community Linkage and Outreach Services is categorized into sub-themes consisting of sub-broad activities made up of Health Promotion and Education, Disease Surveillance, Home Visits, School Health, Health Outreach Activities Preparation,

Community Health Volunteer (CHV) Management and Working with Community Health Management Committee (CHMCs). CHOs Basic Clinical Services comprises sub-broad areas that include Child Health activities, Reproductive Health activities and Other Clinical Services. The Resource Management task of the CHO however, comprises responsibilities on Planning, Logistics Management, Financial Management, NHIA Management, Data Collection, Reporting and Analysis. Total average availability of CHO services was 77.3% with the following breakdowns. The average percentage availability of services under Community Linkage and Outreach Services (7 tasks in all) was 66.7% with preparation of Health Outreach activities being the most available service whilst "Working with CHMCs" was the least available service. For CHO services under Basic Clinical Services, there were 17 tasks grouped under Child Health, Reproductive Health and Other Clinical Services. Average percentage availability of Basic Clinical Services was 76.3% with Child Health being the most available services (80.1%) whilst Reproductive Health was the least available service (73%). The most available task was Minor Ailments treatment with 93% availability. Tables 30-33 further shows detailed CHO availability of services on Community Linkage and Outreach Services, Basic Clinical Services and Resource Management.

Table 34 shows that CHV tasks (11) that are to be carried out in respect of their role of ensuring Disease Prevention and Environmental Sanitation; Carry out Educating on Community Members on Safe Environmental Sanitation Practices in their localities was the most available activity (100%) whilst Carrying Along Home Visiting Bags during community visitations had none carried along when visiting the communities.

Table 35 shows that out of CHMC specific tasks (14) categorized under 5 sub-broad themes comprising Governance, Membership and Operations, Selection and Supervision of CHVs, Welfare of CHOs, Facility Maintenance, Resource Mobilization and Management; Resource Mobilization and

Management were the most available task (100%), whilst Selection and Supervision of CHVs were not performed at all.

Table 9: Summaries of CHOs availability of services undertaken

<table>
<tr><th>No.</th><th>Community linkage & outreach services</th><th>Specific Averages (%)</th><th colspan="2">General Sub-Averages (%)</th><th>General Average (%)</th></tr>
<tr><td>1.</td><td>Health promotion & education</td><td>72.6</td><td colspan="2" rowspan="7">66.7</td><td rowspan="15">77.3</td></tr>
<tr><td>2.</td><td>Disease surveillance</td><td>71.4</td></tr>
<tr><td>3.</td><td>Home visits</td><td>63.1</td></tr>
<tr><td>4.</td><td>School health</td><td>71.4</td></tr>
<tr><td>5.</td><td>Preparation of outreach activities</td><td>85.7</td></tr>
<tr><td>6.</td><td>Managing CHVs</td><td>57.2</td></tr>
<tr><td>7.</td><td>Working with CHMCs</td><td>57.1</td></tr>
<tr><td></td><td>Basic clinical services</td><td>Specific Averages (%)</td><td>Sub-theme Averages (%)</td><td>General Sub-Averages (%)</td></tr>
<tr><td></td><td>Sub-theme: child health</td><td></td><td rowspan="4">80.2</td><td rowspan="9"></td></tr>
<tr><td>1.</td><td>Immunization</td><td>83.3</td></tr>
<tr><td>2.</td><td>Breastfeeding, growth monitoring and nutrition</td><td>78.6</td></tr>
<tr><td>3.</td><td>Acute care of infants and children (IMNCI)</td><td>78.6</td></tr>
<tr><td></td><td>Sub: reproductive health</td><td></td><td rowspan="4">73.0</td></tr>
<tr><td>4.</td><td>Family planning</td><td>80.4</td></tr>
<tr><td>5.</td><td>HIV/AIDS and STIs</td><td>86.9</td></tr>
<tr><td>6.</td><td>ANC</td><td>71.4</td></tr>
</table>

7.	Safe emergency delivery & essential new born	52.4		76.3	
8.	Post-natal care (PNC)	73.8			
	Sub: other clinical services		75.8		
9.	Infection prevention	88.1			
10.	Communicable disease (HIV/AIDS, Malaria, TB)	91.1			
11.	Non-communicable diseases (hypertension and diabetes)	85.7			
12.	Neglected tropical diseases (NTDs)	53.6			
13.	Adolescent Health	80.0			
14.	Mental Health	42.9			
15.	Minor ailments	92.9			
16.	First aid and home emergencies	76.2			
17.	Caring for the aged	71.4			
	Resource Management		95		
18.	Planning	100			
19.	Logistics Management	100			
20.	Financial Management	75			
21.	NHIA management	100			
22.	Data management and use	100			

Table 10: Availability of Community Linkage & Outreach Services provided by CHOs

Broad theme	Sub-themes	Key Tasks	Asutuare (N=6) n (%)	Osuwem (N=4) n (%)	Volivo (N=4) n (%)	Total (N=14) n (%)	Total Averages n (%)	Total Average n (%)
Community linkage and outreach services provided by CHOs	Promoting Health and providing Health Education	Use durbars to give health education	4 (66.7)	3 (75.0)	3 (75.0)	10 (71.4)	10.2 (72.6)	9.8 (66.7)
		Organize health promotion through durbars	4 (66.7)	3 (75.0)	3 (75.0)	10 (71.4)		
		Organize health education through home visits	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)		
		Organize health promotions through home visits	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)		
		Conduct community walk about	5 (83.3)	4 (100)	2 (50.0)	11 (78.6)		
		Record and report all health promotion and education activities	4 (66.7)	3 (75.0)	3 (75.0)	10 (71.4)		
	Surveillance of Diseases	Identify disease requiring prompt reporting	5 (83.3)	4 (100)	2 (50.0)	11 (78.6)	10 (71.4)	
		Investigate outbreaks in the community	5 (83.3)	3 (75.0)	1 (25.0)	9 (64.3)		
		Undertake surveillance in the community	5 (83.3)	4 (100)	1 (25.0)	10 (71.4)		
		Report all disease surveillances according to protocol	5 (83.3)	4 (100)	1 (25.0)	10 (71.4)		
	Home visits	Undertake routine house-to-house visits	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)	8.8 (63.1)	
		Provide daily health services through visiting Homes and Households to check on well-being of individuals in their various homes	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
		Prepare and conduct special targeted home visits to designated special clients such as tracer defaulters	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)		
		Follow up patients referred by hospital at a discharge	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)		
		Counsel and give clients support on non-communicable diseases such as Diabetes and Hypertension	5 (83.3)	4 (100)	4 (100)	13 (92.9)		
		Document and report on all home activities	4 (66.7)	4 (100)	2 (50.0)	10 (71.4)		
	School Health	Prepare towards school health activities	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)	10.0 (71.4)	
		Carry out education related to health in schools	5 (83.3)	3 (75.0)	3 (75.0)	11 (78.6)		
		Undertake physical checks on students in schools	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)		
		Conduct inspection of the environment in schools	5 (83.3)	3 (75.0)	1 (25.0)	9 (64.3)		
		Brief school authorities on findings from school health related visitations	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)		
		Write report on school health visitations	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)		

Table 11: Availability of Community Linkage & Outreach Services provided by CHOs (continues)

Broad theme	Sub-themes	Key Tasks	Asutuare (N=6)	Osuwem (N=4)	Volivo (N=4)	Total (N=14)	Total Averages n (%)	Total Averages n (%)
			n (%)	n (%)	n (%)	n (%)		
	Carry out Health Outreach Programs	Be Ready to carry out Health Outreach Programs	5 (83.3)	3 (75.0)	4 (100)	12 (85.7)	12 (85.7)	
		Compile and Disseminate to authorities on Health Outreach Programs	5 (83.3)	3 (75.0)	4 (100)	12 (85.7)		
	Managing CHVs	Organize meetings to revise CHAP with CHVs	2 (33.3)	3 (75.0)	4 (100)	9 (64.3)	8 (57.2)	
		Submit reports on meetings organized with CHVs concerning chaps	1 (16.7)	3 (75.0)	3 (75.0)	7 (50.0)		
	Working with CHMCs	Carry out meetings, draft community profile, come up with a map of community and give technical support to CHMCs	5 (83.3)	3 (75.0)	0 (0.0)	8 (57.1)	8 (57.1)	

Table 12: Availability of Basic Clinical Services provided by CHOs

Broad theme	**Sub-theme**	**Key Tasks**	**Asutuare (N=6)**	**Osuwem (N=4)**	**Volivo (N=4)**	**Total (N=14)**	Total Averages	Total Averages	Total Averages
	Child Health		**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**
Basic Clinical Services	Immunization	Undertake education of vaccines	5 (83.3)	4 (100)	4 (100)	13 (92.9)	11.7 (83.3)	11.2 (80.1)	10.7 (76.3)
		Undertake administration and management of vaccines	5 (83.3)	4 (100)	1 (25.0)	10 (71.4)			
		Undertake recording and reporting of immunization activities	5 (83.3)	3 (75.0)	4 (100)	12 (85.7)			
	Breastfeeding (BF), growth monitoring and nutrition	Undertake education on breast feeding	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)	11 (78.6)		
		Provide breast feeding support	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)			
		Carry out weighing of babies and children	5 (83.3)	4 (100)	4 (100)	13 (92.9)			
		Record identified malnourished children	5 (83.3)	3 (75.0)	4 (100)	12 (85.7)			
		Educate the community on prevention of malnutrition	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)			
	Infants and Children Care with Acute Challenges (integrated management of Neonatal and childhood illness (IMNCI)	Taking History, doing initial assessment, examining physically clients, classifying and managing jaundice	5 (83.3)	4 (100)	0 (0.0)	9 (64.3)	11 (78.6)		
		Taking History, doing initial assessment, examining physically clients, classifying and managing diarrhea	6 (100)	4 (100)	3 (75.0)	13 (92.9)			
		Taking History, doing initial assessment, examining physically clients, classifying and managing acute respiratory infection (ARI)	5 (83.3)	3 (75.0)	3 (75.0)	11 (78.6)			
		Taking History, doing initial assessment, examining physically clients, classifying and managing fever	6 (100)	4 (100)	4 (100)	14 (100)			
		Taking History, doing initial assessment, examining physically clients, classifying and managing measles	5 (83.3)	3 (75.0)	1 (25.0)	9 (64.3)			
		Taking History, doing initial assessment, examining physically clients, classifying and managing ear infection	5 (83.3)	3 (75.0)	3 (75.0)	11 (78.6)			
		Carry out documentations and referring where necessary cases on infants and children with acute care challenges (integrated management of neonatal and childhood illnesses, IMNCI)	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)			

Table 13: Availability of Basic Clinical Services provided by CHOs (continues)

Broad theme	Sub-theme	Key Tasks	Asutuare (N=6)	Osuwem (N=4)	Volivo (N=4)	Total (N=14)	Total Averages	Total Averages	Total Averages
	Rep. Health		n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Basic Clinical Services	Family Planning	Provide family planning counselling on all methods available under family planning?	5 (83.3)	4 (100)	4 (100)	13 (92.9)	11.3 (80.4)	10.2 (73.0)	
		Provide education on preferred methods on family planning	5 (83.3)	4 (100)	4 (100)	13 (92.9)			
		Administer various methods of family planning such as condom use, oral contraceptives, injectable implants to clients	6 (100)	4 (100)	3 (75.0)	13 (92.9)			
		Support clients by referring for other or permanent methods of family planning if they need them	2 (33.3)	3 (75.0)	1 (25.0)	6 (42.9)			
	HIV/AIDS and Sexually Transmitted Infections (STIs)	Conduct education on HIV/AIDS and sexually transmitted infections (STIS)	5 (83.3)	4 (100)	4 (100)	13 (92.9)	12.2 (86.9)		
		Educate the community on condom use	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)			
		Prepare clients by counselling them on HIV/AIDS and STIS before testing is conducted	5 (83.3)	4 (100)	4 (100)	13 (92.9)			
		Test clients on HIV/AIDS and STIS using rapid diagnostic test	6 (100)	4 (100)	4 (100)	14 (100)			
		Provide feedback on the outcome of test on HIV/AIDS etc.	6 (100)	4 (100)	4 (100)	14 (100)			
		Provide appropriate management of care for positive cases	5 (83.3)	3 (75.0)	1 (25.0)	9 (64.3)			
	ANC	Taking History, identifying and managing anemia	6 (100)	3 (75.0)	2 (50.0)	11 (78.6)	10.0 (71.4)		
		Taking History, identifying and managing of Malaria in pregnancy	6 (100)	3 (75.0)	2 (50.0)	11 (78.6)			
		Taking History, identifying and managing Syphilis in pregnancy	4 (66.7)	3 (75.0)	1 (25.0)	8 (57.1)			
		Carry out implementable programs on PMTCT	5 (83.3)	3 (75.0)	1 (25.0)	9 (64.3)			
		Undertake counselling pregnant women based on findings and teaching danger signs in pregnancy	5 (83.3)	4 (100)	2 (50.0)	11 (78.6)			
	Safe emergency delivery and new born resuscitation	Assess and prepare mothers who are about to deliver	5 (83.3)	3 (75.0)	1 (25.0)	9 (64.3)	7.3 (52.4)		
		Observe carefully labor, deliver baby and revive baby if baby is not breathing well	4 (66.7)	3 (75.0)	0 (0.0)	7 (50.0)			
		Carry out third stage of labor	5 (83.3)	1 (25.0)	0 (0.0)	6 (42.9)			

Table 14: Availability of Basic Clinical Services provided by CHOs (continues)

Broad theme	**Sub-theme**	**Key Tasks**	Asutuare (N=6)	Osuwem (N=4)	Volivo (N=4)	Total (N=14)	Total Averages	Total Averages	Total Averages
	Rep. Health-end		**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**
Basic Clinical Services	Postnatal care (PNC) and key newborn care	Carry out quick post-natal care (PNC) to mother and baby	6 (100)	3 (75.0)	0 (0.0)	9 (64.3)	10.3 (73.8)		
		Carry out to community family members education on post-natal care (PNC)	6 (100)	3 (75.0)	2 (50.0)	11 (78.6)			
		Assess mothers and babies during 6 weeks after delivery	6 (100)	3 (75.0)	2 (50.0)	11 (78.6)			
Basic Clinical Services	**Other clinical services**	Manage supplies in your facility	5 (83.3)	3 (75.0)	1 (25.0)	9 (64.3)	12.3 (88.1)	10.3 (75.77)	
	Infection Prevention	Conduct decontamination, cleaning, sterilizing and storing of instruments appropriately	6 (100)	4 (100)	4 (100)	14 (100)			
		Dispose of waste properly in your facility	6 (100)	4 (100)	4 (100)	14 (100)			
	Communicable diseases (HIV, Malaria, TB)	Recognize signs and symptoms of communicable diseases such as HIV/AIDS, TB, and malaria	6 (100)	4 (100)	4 (100)	14 (100)	12.8 (91.1)		
		Follow up and conduct home visits for TB	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)			
		Perform HIV/AIDS rapid test	5 (83.3)	4 (100)	4 (100)	13 (92.9)			
		Perform malaria rapid test and treat	6 (100)	4 (100)	4 (100)	14 (100)			
	Non-communicable and chronic diseases (hypertension and diabetes)	Able to recognize signs and symptoms of non-communicable diseases (NCDS) such as diabetes and hypertension	6 (100)	4 (100)	4 (100)	14 (100)	12.0 (85.7)		
		Do you refer, follow up and conduct home visits to treat diabetes and hypertension	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)			
	Neglected Tropical Diseases (NTDs)	Able to recognize signs and symptoms of neglected tropical diseases (NTDS)	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)	7.5 (53.6)		
		Refer, follow up and conduct home visits on NTDS	5 (83.3)	0 (0.0)	0 (0.0)	5 (35.7)			
	Adolescent Health	Conduct adolescent friendly services	5 (83.3)	4 (100)	3 (75.0)	12 (85.7)	11.2 (80.0)		
		Conduct counselling on family planning, STIS, HIV/AIDS and nutrition targeted at adolescents	5 (83.3)	4 (100)	4 (100)	13 (92.9)			
		Provide services to adolescents on family planning, STIS, HIV/AIDS and nutrition	5 (83.3)	4 (100)	4 (100)	13 (92.9)			

Table 15: Availability of Basic Clinical Services provided by CHOs (continues)

Broad theme	Sub-theme	Key Tasks	Asutuare (N=6)	Osuwem (N=4)	Volivo (N=4)	Total (N=14)	Total Averages	Total Averages	Total Averages
	Other clinical services		n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Basic Clinical Services	Adolescent Health	Provide referral services to adolescents on services such as family planning, STIS, HIV/AIDS and nutrition	3 (50.0)	3 (75.0)	2 (50.0)	8 (57.1)			
		Conduct follow up and home visits on family planning, STIS, HIV/AIDS and nutrition services provided to adolescents	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)			
	Mental Health	Assess and diagnose clients with mental health cases	2 (33.3)	2 (50.0)	0 (0.0)	4 (28.6)	3 (42.9)		
		Give appropriate care and treatment to mental health ailments cases	1 (16.7)	1 (25.0)	0 (0.0)	2 (14.3)			
	Minor Ailments	Assess and diagnose minor ailments	6 (100)	4 (100)	3 (75.0)	13 (92.9)	13 (92.9)		
		Give appropriate treatments to minor ailments	6 (100)	4 (100)	3 (75.0)	13 (92.9)			
	First Aid and Home Emergencies	Able to identify signs and symptoms of shock, snake bite, poisoning, convulsion and seizures, burns, sprains and strains, fractures and dislocations and epistaxis of community members who may be affected	6 (100)	3 (75.0)	2 (50.0)	11 (78.6)	10.7 (76.2)		
		Undertake wound dressing	6 (100)	4 (100)	3 (75.0)	13 (92.9)			
		Manage Diagnosis of shocks, snake bites, poisoning, convulsion and seizure, burns, sprains and strains, fractures and dislocations and epistaxis of affected community members	5 (83.3)	3 (75.0)	0 (0.0)	8 (57.1)			
	Care for the Aged	Carry out Visitation to Homes to the Aged to provide Health Education, Support on care and nutritional support	5 (83.3)	3 (75.0)	2 (50.0)	10 (71.4)	10 (71.4)		

Table 16: Availability of Resource Management tasks provided by CHOs

Broad theme	Sub-theme	Key Tasks	Asutuare (N=6)	Osuwem (N=4)	Volivo (N=4)	Total (N=14)	Total Averages	Total Averages	Total Averages
			n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Resource Management	Planning	Plan activities of the CHPS facility on monthly basis	1 (100)	1 (100)	1 (100)	3 (100)	3 (100)	2.8 (95)	
		Implement planned activities of the CHPS facility	1 (100)	1 (100)	1 (100)	3 (100)			
	Logistics Management	Request supplies for use by the CHPS facility	1 (100)	1 (100)	1(100)	3 (100)	3 (100)		
		Manage supplies requested by the CHPS facility	1 (100)	1 (100)	1 (100)	3 (100)			
		Manage vaccines well	1 (100)	1 (100)	1 (100)	3 (100)			
		Keep your compounds clean	1 (100)	1 (100)	1 (100)	3 (100)			
	Management of CHPS Finances	Take custody of value books	1 (100)	1 (100)	1 100)	3 (100)	2 (75)		
		Take custody of completed value books	1 (100)	1 (100)	1 (100)	3 (100)			
		Order value books for use	1 (100)	1 (100)	1 (100)	3 (100)			
		Use GCR to receive cash from Clients	1 (100)	1 (100)	1 (100)	3 (100)			
		Make sure Cash collected are banked on daily basis	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)			
		Have permission for your current banking arrangement if your answer to question 193 is no	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)			
		Manage petty cash	1 (100)	1 (100)	1 (100)	3 (100)			
		Bank all cheques collected	1 (100)	1 (100)	1 (100)	3 (100)			
	NHIA processes & Management	Record and process NHIS claims for submission	1 (100)	1 (100)	1 (100)	3 (100)	3(100)		
		Send NHIS claims for re-imbursement	1 (100)	1 (100)	1 (100)	3 (100)			
	Data Gathering, Documenting, Reporting, Analysis and Use	Gather, document, analyze, generate meaning out of the data through analysis and using information for taking decisions	1 (100)	1 (100)	1 (100)	3 (100)	3 (100)		
		Take steps to make sure data is keyed into the DHIMS 2	1 (100)	1 (100)	1 (100)	3 (100)			

NOTE: Resource management tasks at the CHPS are handled by the CHO in-charges

Table 17: Availability of CHV Services (Disease Prevention and Environmental Sanitation services) categorized by facility type

Broad Theme	Key Tasks	Asutuare Junction (N=2)	Osuwem (N=4)	Volivo (N=2)	Total (N=8)
		n (%)	n (%)	n (%)	n (%)
Disease prevention and environmental sanitation	Report any suspected disease that is epidemic in nature to the CHO	0 (0.0)	4 (100)	2 (100)	6 (75.0)
	Give community members education on safe environmental sanitation practices in their communities	2 (100)	4 (100)	2 (100)	8 (100)
	Prepare, conduct, and end visits appropriately during home visitations	0 (0.0)	4 (100)	2 (100)	6 (75.0)
	Identify and manage fevers at home	0 (0.0)	1 (25.0)	2 (100)	3 (37.5)
	Identify and manage diarrhoea at home	0 (0.0)	4 (100)	0 (0.0)	4 (50.0)
	Participate in health education in the community	2 (100)	4 (100)	2 (100)	8 (100)
	Give health education in the community	2 (100)	4 (100)	0 (0.0)	6 (75.0)
	Promote breast feeding in the community	0 (0.0)	4 (100)	0 (0.0)	4 (50.0)
	Promote family planning in the community	0 (0.0)	4 (100)	0 (0.0)	4 (50.0)
	Teach wearing and removal of condoms in the community	0 (0.0)	4 (100)	0 (0.0)	4 (50.0)
	Equip yourself with home visiting bag when visiting the community	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Averages (%)		**6 (27.3)**	**37 (84.1)**	**10 (45.5)**	**53 (60.2)**
Availability (%)		**-**	**-**	**-**	**60.2%**

Table 18: Availability of CHMC Services as provided by CHMCs by facility type

Sub-broad themes & N (summation)	Key Tasks	Facility Type			Total availability Of CHMC services on sub-broad themes	Total average availability of CHMC tasks on sub-broad themes (%)
		Asutuare (14)	Osuwem (14)	Volivo (14)		
Governance, Membership and Operation **(15)**	Ensure community recognizes CHPS	+	+	+	14	93.3
	Ensure that community members know their responsibilities to the CHPS zones	+	+	+		
	Write down minutes during meetings	+	+	+		
	Support health education activities	-	+	+		
	Resolve conflicts	+	+	+		
Selection and supervision of CHVs **(6)**	Supervise CHVs	-	-	-	0	0.0
	Provide motivation for CHVs	-	-	-		
Welfare of CHOs **(6)**	Care for CHOs	+	+	+	4	66.7
	Ensure security for CHOs	-	-	+		
Facility Maintenance **(6)**	Manage waste well	+	+	+	3	50.0
	Create community ambulance system	-	-	-		
Resource Mobilization & Management **(9)**	CHPS compounds clean	+	+	+	9	100
	Record contributions made by others	+	+	+		
	Record all financial transactions of the CHMC	+	+	+		
Total (42)		**9**	**10**	**11**	**30**	
Averages (%)		**21.4**	**23.8**	**26.2**	**71.4**	
Availability (%)					**71.4**	

NOTE: (+) sign means services are performed by CHMCs and (–) means services are not performed by CHMCs.

4.3 Functional services of CHOs, CHVs and CHMCs

Table 35 shows basic package of services of CHOs were functionally assessed on (105) tasks and the results summarily showed that basic package of services were 68.3% functional. The absolute breakdown of figures showed there were 7 sub-broad activities undertaken by CHOs under the broad task of Community Linkage and Outreach Services. These 7 sub-broad activities included Health Education and Promotion, Disease Surveillance, Home Visits, School Health, Outreach Activities, Managing CHVs and Working with CHMCs. On Health Education and Promotion category, the task that required Conducting Community Walk About was the most functional of all the services (11), whilst Organizing Health Education through Home Visits was the most carried out task with a yearly average of 202 times with Osuwem performing it most (329 times). However, Organizing Health Education through Durbars was the least performing task (1.6 times) with Asutuare Junction CHPS being the facility with the worst performing record. Disease Surveillance had the task of Identifying Disease Requiring Prompt Reporting as the most functional service (11) whilst Undertaking Surveillance in the Community recorded the most task carried out, with Osuwem being the best performing facility (50.5 times). The task of Identifying Disease requiring Prompt Reporting (1.5 times) was the lowest task carried out. Home visitation, the third sub-broad theme, had the task, Counselling and providing Clients with Non-Communicable Diseases (diabetes and hypertension) with Support as the most functional (13) whilst Undertaking Routine House-to-House visits recorded the highest a task was carried out (270 times) with Osuwem CHPS being the star performer (500 times). Following Up Patients Referred by hospitals at a discharge was the least carried out task (18 times) where Asutuare CHPS recorded the lowest (13 times approximately). Under School Health, Conducting Health Education in Schools was the most functional (11) with Preparing Towards School Health Activities

was the task most carried out with Osuwem CHPS undertaking more of this task (12) times. Conducting Physical Examinations in Schools was the least carried out task with Volivo CHPS undertaking this task only once (1). Under Outreach Services, Preparing and Conducting Outreach Activities recorded the highest task carried out (33.5 times) with Asutuare CHPS performing (57) times approximately. Documenting and Reporting on Outreach Activities was the most functional task under outreach activities (12). Under Managing CHVs, Organizing Meetings to Revise CHAP with CHVs was the most functional activity as well as the most task carried out (9) and (4) times respectively. Finally, under Working with CHMCs, the most functional and highest performing task ever carried out under this category was the task on Carrying out Meetings, Drafting a document on Profiling of Community, Crafting a Map of the Community and Giving Technical Support with CHMCs (8) and (19) times approximately respectively with Asutuare CHPS performing this task (29) times approximately.

Table 36 shows CHO Child Health Services that are carried out which consist of Immunization, Breastfeeding, Growth Monitoring and Nutrition and Acute Care of Infants and Children (IMNCI). Under Immunization, the task of Undertaking Education on Vaccines was the most functional (13) whilst Undertaking Administration and Management of Vaccines was carried out (238) times approximately with Volivo CHPS undertaking it (365) times. However, undertaking Recording and Reporting of Immunization Activities was the least carried out task (12). With respect to Breast Feeding, Growth Monitoring and Nutrition, Carrying out Weighing of Babies was both the most functional service (13) and the most carried out task (601 times approximately). The least carried out task was Recording Identified Malnourished Children (3 times approximately) with Osuwem not recording any activity. On the Service of Acute Care for Infants and Children, Taking History, carrying out Initial Assessment, carrying out Physical Examination, Classifying and overseeing Fever care was

the most functional service (14) whilst the least undertaking was Taking History, carrying out Initial Assessment, carrying out Physical Examination, Classifying and overseeing Measles care (9). However, Taking History, doing Initial Assessment, carrying out Physical Examination, Classifying and overseeing Jaundice care recorded the highest task carried out (203 times approximately) with Osuwem CHPS carrying it out (358 times approximately). The least carried out task was Recording and Referring on Acute Care of Infants and Children (IMNCI) carried out (56 times approximately). Volivo CHPS, however, carried out more tasks there than any facility (209 times).

Table 37 shows CHO services on Reproductive Health that are functional and under this theme, there are five sub-themes consisting of Family Planning, HIV/AIDS and STIs, ANC, Safe Emergency Delivery and Newborn Resuscitation and Post-Natal Care. Under Family Planning, providing Referral for Other or Permanent Methods of Family Planning was the least functional service whilst the 3 other services in this category all functioned at par (13). Providing Education on Preferred Methods on Family Planning was carried (758 times approximately) the highest being Osuwem CHPS (2,207 times). Providing Referral for Other or Permanent Methods of Family Planning recorded the least times that a service was carried out (2.5 times). Under HIV/AIDS and STIs, the most functional service was testing clients of HIV/AIDS and STIs status and Providing Feedback to the Tested Clients (14). Educating the Community on Condom Use was the task with the highest yearly average (209 times) with the least task being HIV/AIDS and STIs as well as Providing Appropriate Management of Care and Referral for Positive Cases (6 times approximately). Osuwem CHPS carried out the most service (300 times) under Educating the Community on Condom use, whilst Volivo CHPS performed poorly (2 times) on the provision of Appropriate Management of Care and Referral for Positive Cases. Under Antenatal Care (ANC), tasks such as Taking History, Identifying and overseeing Anaemia Care,

Malaria in Pregnancy as well as Carrying out Counselling to Pregnant Women Based on Findings and Teaching Danger Signs in Pregnancy had the most functionality of service (11) each whilst the least functional of the tasks under ANC was Undertaking History Taking, Identification and Management of Syphilis in Pregnancy (8). On the other hand, Undertaking History Taking, Identification and Management of Anaemia (203 times). Osuwem (400 times) with the highest tasks was carried out. The least undertaken task which was Carrying out Counselling on Pregnant Women Based on Findings and Teachings on Pregnancy Signs that are Dangerous was carried out (87 times). On Safe Emergency Delivery and New Born Resuscitation, the most functional task was Monitoring Labour, Delivering Baby and Resuscitating Baby if Baby is not Breathing Well (7), it was carried out 74 times approximately with Osuwem CHPS recording 112 times. Conducting Third Stage labour was the least functional task (6) carried out (48 times approximately) with Volivo CHPS not carrying this task. Post-natal care (PNC) saw Assessing Mothers and Babies at 6 weeks as the most functional activity whilst conducting immediate Post-Natal Care (PNC) to Mother and Baby recording (9), being the least. Assessing Mothers and Babies at 6 weeks of Delivery topped with Asutuare CHPS carried out 90 times. The least task undertaken under this category was Conducting Immediate Post-Natal Care (PNC) to Mother and Baby (35 times) where Volivo CHPS carried out no task.

Table 38 shows CHO services on Other Clinical Services categorized into 8 sub-themes made up of the following: Infection Prevention, Communicable Diseases (HIV/AIDS, TB, Malaria), Non-Communicable Diseases (Hypertension and Diabetes), Neglected Tropical Diseases (NTDs), Adolescent Health, Mental Health, Minor Ailments, First Aid and Home Management and Caring for the Aged. Under Infection Prevention, Disposal of Waste properly in one's facility and Conducting Decontamination, Cleaning Sterilizing as well as Storing of Instruments Appropriately were the most

functional (14). Disposal of waste was also the most carried out task (365) times. The least carried out task was Decontamination, Cleaning, Sterilizing and Storing of Instruments Appropriately (205 times). Under Communicable Diseases (HIV/AIDS, TB and Malaria), Recognizing Signs and Symptoms of Communicable Diseases such as Malaria, TB, HIV/AIDS and Performing Malaria Rapid Test and Treat were the most functional (14). The least functional Following Up and Conducting Home Visits for TB (10). However, Performing Malaria Rapid Test and Treatment was the most carried out task (370 times). The least carried out was Following Up and Conducting Home Visits for TB at only (15 times). Under Non-Communicable Diseases (Hypertension and Diabetes), Recognizing Signs, and Symptoms of Non-Communicable Diseases (NCDs) such as Diabetes and Hypertension was the most functional (14) as well as the most carried out task (175 times), whilst Referral, Following Up and Conducting Home Visits to Treat Diabetes and Hypertension was the least functional (10) and the least carried out task (51 times approximately). However, under Neglected Tropical Diseases, Ability to Recognize Signs and Symptoms of Neglected Tropical Diseases (NTDs) was the most functional (10) and the least carried out task (110 times) whilst Referring, Following Up and Conducting Home Visits on Neglected Tropical Diseases (NTDs) was the least functional (5) and the most carried out task (173 times approximately). Under Adolescent Health, Conducting Counselling on Family Planning, STIs, HIV/AIDS and Nutrition targeted at Adolescents Health was the most carried out task (229 times approximately whilst the most functional (13) was Providing Services to Adolescents on Family Planning, STIs, HIV/AIDS and Nutrition. On the other hand, Providing Referral Services to Adolescents on Services such as Family Planning, STIs, HIV/AIDS and Nutrition was both the least functional (8) and the least carried out task (19 times approximately). Mental Health had Assessing and Diagnosing Clients with Mental Health Cases as the most functional (4) and the least carried out (2 times approximately), whilst Giving Appropriate Care and Treatment to Mental Health Ailments Cases

was the most carried (5 times) and the least functional (2). Minor ailments had Assessing and Diagnosing Minor Ailments and Giving Appropriate Treatments to Minor Ailments as the most functional (13) whilst the most carried out task was Giving Appropriate Treatments to Minor Ailments (735 times approximately), the least carried out was Assessing and Diagnosing Minor Ailments (733 times approximately).

First aid and Home Management, had Wound Dressing as the most functional (13) and the most carried out task (343 times approximately) whilst Managing Diagnosis of Shocks, Snake Bites, Poisoning, Convulsion and Seizures, Burns, Sprains and Strains, Fractures and Dislocations and Epistaxis of Affected Community Members had the least functional (8) and the least carried out task (62 times approximately). Care for the Aged had Carrying out Visitations to the Homes of the Aged and Providing Education on Proper Care and Nutritional Needs functionality of service was (10) and carried out tasks (82 times approximately).

Table 40 shows CHOs responsibilities under Resource Management categorized into Planning, Logistics Management, Financial Management, NHIA Management and Data Management and Use. Whilst under Planning; Planning Activities of the CHPS Facility on Monthly Basis was the least carried out task (15 times approximately), Implementing Planned Activities of the CHPS Facility was the most carried out task 19 times approximately). Both activities had equal functionality of (3). Logistics Management had activities such as Requesting Supplies for use by the CHPS Facility, Managing Supplies Requested by the CHPS Facility, Managing Vaccines well, and Keeping CHPS Compounds Clean functionally at par (3), the least carried out task was Requesting Supplies for use by the CHPS Facility but Managing Vaccines Well and Keeping Compounds Clean were the most carried out tasks

(365 times each). Financial Management that had activities such as Keeping Value Books, Receiving Completed Value Books, Receiving Cash Revenue with GCR, Banking Cash Collected on Daily Basis, Having Permission for Banking Arrangements, Managing Petty Cash and Banking All Cheques Collected were also functionally the same (3) whilst Receiving Cash with GCR was the most carried out task (263 times approximately), Procuring Utilized Value Books was the least carried out task (5 times approximately). NHIA Management consisted of Recording and Processing NHIS Claims and Submitting Claims to NHIS and their functionality of services were the same (3) and both were carried out (12 times). Data Management and Use had Collecting, Recording, Analyzing, Interpreting and Using Data for Taking Decisions and Ensuring Data is keyed into the District Health Information Management Systems 2 (DHIMS 2) as its tasks. Both tasks were functionally at par (3) and were each carried out (12 times).

Table 41 shows Community Health Volunteers (CHVs) main task of Ensuring Disease Prevention and Environmental Sanitation which includes tasks such as Reporting any Suspected Diseases that are epidemic in nature quickly to the CHO, Ensuring Community Members are Educated on Safe Environmental Sanitation Practices in their Communities, Preparing, Conducting, and Ending Visits Appropriately during Home Visitations, Identifying and Managing Fevers at Home, Identifying and Managing Diarrhoea at Home, Participating in Health Education in The Community, Giving Health Education in the Community, Promoting Breast Feeding in the Community, Promoting Family Planning in the Community, Teaching Wearing and Removal of Condoms in the Community as well as Equipping Oneself (CHV) with Home Visiting Bag when Visiting the Community. The most functional tasks were Educating Community Members on Safe Environmental Sanitation Practices in their Communities as well as Participating in Health Education in the Community (8) whilst Equipping

CHVs with Home Visiting Bags when Visiting Communities was the least functional and had no task performed. Promoting Family Planning in the Community was the most carried out task (14 times) with Osuwem CHPS undertaking this task 42 times.

Table 42 shows CHMC categorized into five (5) sub-broad themes namely Governance, Membership and Operations, Selection and Supervision of CHVs, Welfare of CHOs, Facility Maintenance and Resource Mobilization and Management. Under Governance, Membership and Operations; tasks such as Ensuring Community Recognition of CHPS, Ensuring that Community Members Know their Responsibilities to the CHPS and Writing Down Minutes during Meetings except Supporting Health Education Activities and Resolving Conflicts had the same most functionality of services (3). Supporting Health Education Activities and Resolving Conflicts had the least functionality of service (2) and the least carried out task (1). On the other hand, Writing Down Minutes during Meetings was the most carried out task (12). Selection and Supervision of CHVs had tasks such as Supervising CHVs and Providing Motivation for CHVs and interestingly none of the tasks was either functional nor was ever carried out. Welfare of CHOs had Care for CHOs and Ensuring Security for CHOs as the 2 tasks. Caring for CHOs was the most functional (3) and the most carried out (6 times) whilst the least functional was Providing for Motivations for CHOs (1) and the least carried out task (3). Under Facility Maintenance, there were 2 tasks namely Managing Waste Well and Creating Community Ambulance System. Whilst Managing Waste Well was the most functional (3) and the most carried out task (20), Creating Community Ambulance System, however, had no task performed as well as carried out. Finally, under Resource Mobilization and Management had 3 tasks namely Keeping CHPS Compounds Clean, Recording Contributions made by Others and Recording All other Transactions. Whilst all the 3 tasks had the same functionality of service (3), Keeping Compounds Clean was the

most carried out task (20) and Recording Contributions made by Others was the least carried out task (1).

In summary, amongst the 5 sub-theme areas, Governance, Membership and Operations was the most functional (3 times approximately) whilst Selection and Supervision of CHV had no functionality at al making it the least functional. However, interestingly, whilst Facility Maintenance was the most carried out task (10) Selection and Supervision of CHVs, was the least carried out as no task was performed under this.

Table 19: CHO Community Linkage and Outreach functional Services & average number of tasks undertaken

Broad theme	Sub-themes	Key Tasks	Functionality of services				Yearly average tasks undertaken			
			Asutuare n (6)	Osuwem n (4)	Volivo n (4)	Total n (14)	Asutuare n (6)	Osuwem n (4)	Volivo n (4)	Total n (14)
Community linkage and outreach services provided by CHOs	Health education and promotion	Organize health education through durbars	++++	+++	+++	10	1.0	1.0	2.0	1.6
		Organize health promotion through durbars	++++	+++	+++	10	1.0	12.0	3.7	5.1
		Organize health education through home visits	+++++	+++	++	10	135.6	329.7	189.3	202.0
		Organize health promotions through home visits	+++++	+++	++	10	55.6	329.7	480.0	194.1
		Conduct community walk about	+++++	+++	+++	11	195.8	281.3	31.5	197.0
		Record and report all health promotion and education activities	+++++	+++	++	10	9.6	9.3	6.5	8.5
	Disease Surveillance	Identify disease requiring prompt reporting	+++++	++++	++	11	2.8	0.5	0.0	1.5
		Investigate outbreaks in the community	+++++	+++	+	9	2.4	1.0	1.0	1.8
		Undertake surveillance in the community	+++++	++++	+	10	3.8	50.5	0.0	22.1
		Report all disease surveillances according to protocol	+++++	++++	+	10	1.6	6.8	0.0	3.5

Table 20: CHO Community Linkage and Outreach functional Services & average number of tasks undertaken (continues)

Broad theme	Sub-themes	Key Tasks	Functionality of services				Yearly average tasks undertaken			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Community linkage and outreach services provided by CHOs	Home visits	Undertake routine house-to-house visits	+++++	+++	++	10	138.8	500.0	255.0	270.4
		Carry out daily health service deliveries home visits to households and individuals in their homes	++++	-	+	5	53.5	-	30.0	48.8
		Be ready to carry out targeted home visits to assigned clients who need special attention such as TB & HIV defaulters	+++++	+++	++	10	22.0	33.3	31.0	27.2
		Follow up patients referred by hospital at a discharge	+++++	+++	++	10	12.8	30.0	16.0	18.6
		Counsel and give assistance to clients with non-communicable diseases such as Diabetes and Hypertension	+++++	++++	++++	13	85.2	377.5	163.3	199.2
		Document and report on all home activities	++++	++++	++	10	42.0	9.3	12.0	22.9
	School Health	Prepare towards school health activities	+++++	+++	++	10	2.6	12.0	10.0	6.9
		Conduct health education in schools	+++++	+++	+++	11	2.8	12.0	6.7	6.4

Table 21: CHO Community Linkage and Outreach functional Services & average number of tasks undertaken (continues)

Broad theme	Sub-themes	Key Tasks	Functionality of services				Yearly average tasks undertaken			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Community linkage and outreach services provided by CHOs	School Health	Conduct physical examinations in schools	+++++	+++	++	10	1.6	3.0	1.0	1.9
		Conduct inspection of the environment in schools	+++++	+++	+	9	2.8	3.0	1.0	2.7
		Brief school authorities on findings from school health related visitations	+++++	+++	++	10	7.0	3.0	11.0	6.6
		Write report on school health visitations	+++++	+++	++	10	4.4	4.0	6.5	4.7
	Outreach activities	Prepare and conduct outreach activities	+++++	+++	++++	12	56.8	12.0	20.5	33.5
		Document and report on outreach activities	+++++	+++	++++	12	12.0	12.0	6.5	10.2
	Managing CHVs	Organize meetings to revise CHAP with CHVS	++	+++	++++	9	12.0	4.0	1.7	4.1
		Submit reports on meetings organized with CHVS concerning CHAP	+	+++	+++	7	8.0	4.0	1.5	3.8
	Working with CHMC	Carry out meetings, draft community profile, come up with map of community and give technical support to CHMCs	+++++	+++	-	8	28.8	2.0	-	18.8

Table 22: CHO Child Health functional Services & average number of tasks undertaken

Broad theme	Sub-themes	Key Tasks	Functionality of services				Yearly average tasks undertaken			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Basic Clinical Services	**Child Health**	Educate Community on vaccines	+++++	++++	++++	13	76.0	9.3	9.0	34.8
	Immunizat-ion	Administer and Manage vaccines	+++++	++++	+	10	177.2	281.3	365.0	237.6
		Document and report activities on immunization	+++++	+++	++++	12	12.0	12.0	12.0	12.0
	Breast feeding, growth, monitoring and nutrition	Educate Community on breast feeding	+++++	+++	++	10	50.4	12.0	28.0	34.4
		Provide breast feeding support	+++++	+++	++	10	50.4	150.0	28.0	75.8
		Carry out weighing of babies and children	+++++	++++	++++	13	61.6	1207.5	669.0	601.1
		Record identified malnourished children	+++++	+++	++++	12	2.8	0.0	4.5	2.7
		Educate the community on prevention of malnutrition	+++++	+++	++	10	26.6	240.0	26.0	90.5
	Acute care of infants & children (IMNCI)	Taking History, doing initial assessment, examining physical clients, classifying and managing jaundice	+++++	++++	-	9	79.8	357.5	-	203.2
		Taking History, doing initial assessment, examining physically clients, classifying and managing diarrhea	+++++ +	++++	+++	13	72.3	357.5	58.7	156.9

***NOTE**: (+) means functionality of a task under each service per CHO and (-) means CHO task not functional

Table 23: CHO Child Health functional Services & average number of tasks undertaken (continues)

Broad theme	Sub-themes	Key Tasks	Functionality of services				Yearly average tasks undertaken			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Basic Clinical Services (Child Health)	Acute care of infants and children (integrated management of neonatal and childhood illness) (IMNCI)	Taking History, doing initial assessment, examining physically clients, classifying and managing acute respiratory infection (ARI)	+++++	+++	+++	11	90.6	233.3	81.0	126.9
		Taking History, doing initial assessment, examining physically clients, classifying and managing fever	+++++ +	++++	+++ +	14	136.8	352.5	95.5	186.6
		Taking History, doing initial assessment, examining physically clients, classifying and managing measles	+++++	+++	+	9	75.4	433.3	0.0	186.3
		Taking History, doing initial assessment, examining physically clients, classifying and managing ear infection	+++++	+++	+++	11	78.0	433.3	17.0	158.3
		Recording and referring cases on care to infants and children that are acute (integrated management of neonatal and childhood illnesses, IMNCI)	+++++	+++	++	10	5.6	36.7	209.5	55.7
Basic Clinical Services (Reproductive Health)	Family planning	Provide family planning counselling on all methods available under family planning	+++++	++++	+++ +	13	125.0	682.5	112.5	292.7

Table 24: CHO Reproductive Health functional Services & average number of tasks undertaken

Broad theme	Sub-themes	Key Tasks	Functionality of services				Yearly average tasks undertaken			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Basic Clinical Services (Reproductive Health)	Family planning	Provide education on preferred methods on family planning	+++++	++++	++++	13	117.0	2,207.5	108.0	757.5
		Provide administration of methods on family planning such as condoms, combined oral contraceptives, injectable implants	++++++	++++	++++	13	178.3	1,507.5	150.3	580.8
		Provide referral for other or permanent methods of family planning	++	+++	+	6	1.0	3.0	4.0	2.5
	HIV/AIDS and sexually transmitted infections (STIs)	Conduct education on HIV/AIDS and sexually transmitted infections (STIS)	+++++	++++	++++	13	119.0	126.3	15.3	89.3
		Educate the community on condom use	+++++	+++	++	10	161.0	300.0	195.0	209.5
		Prepare clients by counselling them on HIV/AIDS and STIS before testing is conducted	+++++	++++	++++	13	125.2	226.3	20.3	124.0
		Test clients on HIV/AIDS and STIS using rapid diagnostic test	++++++	++++	++++	14	70.8	226.3	20.3	100.8
		Provide feedback on the outcome of test on HIV/AIDS and STIs	+++++	++++	++++	14	55.2	226.3	46.8	101.6
		Provide appropriate management of care and referral for positive cases	+++++	+++	+	9	3.6	10.0	2.0	5.6

Table 25: CHO Reproductive Health functional Services & average number of tasks undertaken (continues)

Broad theme	Sub-themes	Key Tasks	Functionality of services				Yearly average tasks undertaken			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Basic clinical services	Antenatal care (ANC)	Taking History, identifying and managing anaemia	+++++ +	+++	++	11	161.7	400.0	32.0	203.1
		Taking History, identifying and managing malaria in pregnancy	+++++ +	+++	++	11	66.0	146.7	25.5	80.6
		Taking History, identifying and managing syphilis in pregnancy	++++	+++	+	8	15.0	60.7	48.0	36.3
		Carry out implementable PMTCT activities	+++++	+++	+	9	31.0	60.0	6.0	37.9
		Give advise to pregnant women on examination findings and teach them danger signs in pregnancy	+++++	++++	++	11	87.4	88.8	81.0	86.7
	Safe emergency delivery & newborn revival	Assess and prepare mothers who are about to deliver	+++++	+++	+	9	64.4	22.3	20.0	45.4
		Observe carefully at labor stage, deliver baby and revive baby if baby is not breathing well	++++	+++	-	7	112.3	24.0	-	74.4
		Carry out third stage of labor	+++++	+	-	6	45.0	64.0	-	48.2
	Post-natal care (PNC) and essential newborn care	Carry out quick post-natal care (PNC) to mother and baby	+++++ +	+++	-	9	38.8	27.7	-	35.1
		Carry out education to community family members on post-natal care (PNC)	+++++ +	+++	++	11	43.3	38.0	9.5	35.7
		Assess mothers and babies at 6 weeks after delivery	+++++ +	+++	++	11	90.3	52.3	162.0	93.0

Table 26: CHO Other Clinical functional Services & average number of tasks undertaken

Broad theme	**Sub-themes**	**Key Tasks**	**Functionality of services**				Yearly average tasks undertaken			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Other Clinical Services	Infection prevention	Manage supplies in your facility	+++++	+++	+	9	294.4	12.0	365.0	208.1
		Conduct decontamination, cleaning, sterilizing and storing of instruments appropriately	+++++	++++	+++	14	206.7	281.3	127.8	205.4
		Dispose of waste properly in your facility	+++++	++++	+++	14	365.0	365.0	365.0	365.0
	Communic-able Diseases (HIV, malaria and TB)	Recognize signs and symptoms of communicable diseases such as HIV/AIDS, TB, and malaria	+++++	++++	+++	14	365.0	365.0	365.0	365.0
		Follow up and conduct home visits for TB	+++++	+++	++	10	5.2	6.3	53.0	15.1
		Perform HIV/AIDS rapid test	+++++	++++	+++	13	126.0	103.8	35.3	91.2
		Perform malaria rapid test and treat	+++++	++++	+++	14	512.5	240.0	286.3	370.0
	Non-communicable diseases (Hypertensi-on & Diabetes)	Able to recognize signs and symptoms of non-communicable diseases (NCDS) such as diabetes and hypertension	+++++	++++	+++	14	134.5	165.0	246.0	175.1
		Do you refer, follow up and conduct home visits to treat diabetes and hypertension	+++++	+++	++	10	79.8	25.0	16.0	50.6
	Neglected Tropical diseases	Able to recognize signs and symptoms of neglected tropical diseases (NTDs)	+++++	+++	++	10	219.4	0.0	1.5	110.0

Table 27: CHO Other Clinical functional Services & average number of tasks undertaken (continues)

Broad theme	**Sub-themes**	Key Tasks	**Functionality of services**				**Yearly average tasks undertaken**			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Other Clinical Services	NTDs	Refer, follow up and conduct home visits on NTDS	+++++	-	-	5	172.4	-	-	172.4
	Adolescent Health	Conduct adolescent friendly services	+++++	++++	+++	12	151.6	240.0	153.7	181.6
		Conduct counselling on family planning, STIS, HIV/AIDS and nutrition targeted at adolescents	+++++	++++	++++	13	313.2	305.8	45.0	228.4
		Provide services to adolescents on family planning, STIS, HIV/AIDS and nutrition	+++++	++++	++++	13	191.8	306.3	32.8	178.1
		Provide referral services to adolescents on services such as family planning, STIS, HIV/AIDS and nutrition	+++	+++	++	8	50.0	0.3	1.0	19.1
		Conduct follow up and home visits on family planning, STIS, HIV/AIDS and nutrition services provided to adolescents	+++++	+++	++	10	174.8	166.7	5.5	138.5
Other clinical services	Mental Health	Assess and diagnose clients with mental health cases	++	++	-	4	3.5	1.0	-	2.3
		Give appropriate care and treatment to mental health ailments cases	+	+	-	2	10.0	0.0	-	5.0
	Minor ailment	Assess and diagnose minor ailments	+++++ +	++++	+++	13	1,110.0	282.5	577.3	732.5

Table 28: CHO Other Clinical functional Services & average number of tasks undertaken (continues)

Broad theme	Sub-themes	Key Tasks	Functionality of services				Yearly average tasks undertaken			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Other clinical services	Minor ailment	Give appropriate treatments to minor ailments	+++++ +	++++	+++	13	1,111.7	282.5	584.0	734.8
	First aid and Home Management	Be able to spot signs and symptoms of shocks, snake bite, poisoning, convulsion and seizures, burns, sprains and strains, fractures and dislocations and epistaxis of community members who may be affected	+++++ +	+++	++	11	141.7	4.3	11.0	80.5
		Manage diagnosis of shock, snake bite, poisoning, convulsion and seizures, burns, sprains and strains, fractures and dislocations and epistaxis of affected community members	+++++	+++	-	8	97.0	4.3	-	62.3
		Undertake wound dressing	+++++ +	++++	+++	13	659.7	82.5	58.3	343.3
	Care for the aged	Carry out home visitation to the aged to support them on key care and guide them on their nutritional needs	+++++	+++	++	10	151.8	11.7	11.0	81.6
Resource Management	Planning	Plan activities of the CHPS facility on monthly basis	+	+	+	3	22.0	-	6.8	15.2
		Implement planned activities of the CHPS facility	+	+	+	3	37.2	4.0	7.0	18.8
	Logistics Management	Request supplies for use by the CHPS facility	+	+	+	3	134.8	9.3	7.3	56.9

Table 29: CHO Resource Management functional Services & average number of tasks undertaken

Broad theme	Sub-themes	Key Tasks	Functionality of services				Yearly average tasks undertaken			
			Asutuare	Osuwem	Volivo	Total	Asutuare	Osuwem	Volivo	Total
Resource Management	Logistics Management	Manage supplies requested by the CHPS facility	+	+	+	3	90.0	120.0	60.0	88.6
		Manage vaccines well	+	+	+	3	365.0	365.0	365.0	365.0
		Keep your compounds clean	+	+	+	3	365.0	365.0	365.0	365.0
	Financial Management	Keep value books	+	+	+	3	81.8	281.3	40.5	118.7
		Receive completed value books	+	+	+	3	11.2	9.3	2.8	8.0
		Procure utilized value books	+	+	+	3	6.0	6.0	4.0	5.3
		Receive cash revenue with GCR	+	+	+	3	221.8	276.3	312.0	262.5
		Bank cash collected on daily basis	-	-	-	-	12.0	12.0	12.0	12.0
		Have permission for banking arrangement	-	-	-	-	-	-	-	-
		Manage petty cash	+	+	+	3	12.0	12.0	12.0	12.0
		Bank all cheques collected	+	+	+	3	12.0	12.0	12.0	12.0
	NHIA processes	Record & process NHIS claims	+	+	+	3	12.0	12.0	12.0	12.0
		Submit to NHIS claims	+	+	+	3	12.0	12.0	12.0	12.0
	Data collection, reporting, analysis and use	Collect, record, analyze, interpret and use data for decision making	+	+	+	3	12.0	12.0	12.0	12.0
		Ensure data is entered into the DHIMS 2	+	+	+	3	12.0	12.0	12.0	12.0

Table 30: CHV functional Services and yearly average number of tasks undertaken

Broad Theme	Key Tasks	Functionality of Tasks				Average yearly tasks undertaken			
		Asutuare N=2	Osuwem N=4	Volivo N=2	Total N=8 n (%)	Asutuare	Osuwem	Volivo	Average Total n (%)
Disease prevention and environmental sanitation	Reported any suspected disease that are epidemic in nature quickly to the CHO	- -	++++	++	6(11)	0.0	10.0	6.0	5(7)
	Give community members education on safe environmental sanitation practices in their communities	++	++++	++	8(15)	3.0	8.0	5.0	5(7)
	Prepare, conduct, and end visits appropriately during home visitations	-	++++	++	6(11)	0.0	8.0	4.0	4(6)
	Identify and manage fevers at home	-	+	++	3(5))	0.0	14.0	6.0	7(10)
	Identify and manage diarrhea at home	-	++++	-	4(8)	0.0	10.0	0.0	3(4)
	Participate in health education in the community	++	++++	++	8(15)	8.0	22.0	6.0	12(17)
	Give health education in the community	++	++++	-	6(11)	8.0	14.0	0.0	7(10)
	Promote breast feeding in the community	-	++++	-	4(8)	0.0	25.0	0.0	9(12)
	Promote family planning in the community	-	++++	-	4(8)	0.0	42.0	0.0	14(20)
	Teach wearing and removal of condoms in the community	-	++++	-	4(8)	0.0	15.0	0.0	5(7)
	Equip yourself with home visiting bag when visiting the community	-	-	-	0(0)	0.0	0.0	0.0	0(0)
Total n (%)		**6(11)**	**37(70)**	**10(19)**	**53(100)**	**19(9)**	**168(79)**	**27(12)**	**214(100)**
Functionality n (%)		-	-		60.2	-	-	-	214

Table 31: CHMCs functional Services and yearly average number of tasks undertaken

Broad Themes	Key Tasks	Functionality of CHMC services					Average yearly tasks undertaken				
		Asutuare Junction	Osuwem	Volivo	Total n (%)	Sub Total n (%)	Asutuare Junction	Osuwem	Volivo	Average Total	Average Totals n (%)
Governance, membership and operation	Ensure community recognizes CHPS	+	+	+	3(20)	13/15 (87)	2.0	15.0	3.0	7.0	25(32)
	Ensure community members know their responsibilities to the CHPS	+	+	+	3(20)		5.0	4.0	3.0	4.0	
	Write down minutes during meetings	+	+	+	3(20)		24.0	8.0	3.0	12.0	
	Support health education activities	-	+	+	2(13)		0.0	2.0	2.0	1.0	
	Resolve conflicts	+	+	-	2(13)		2.0	2.0	0.0	1.0	
Selection and supervision of CHVs	Supervise CHVs	-	-	-	0(0)	0/0(0)	0.0	0.0	0.0	0.0	0(0)
	Provide motivation for CHVs	-	-	-	0(0)		0.0	0.0	0.0	0.0	
Welfare of CHOs	Care for CHOs	+	+	+	3(50)	4/6(67)	12.0	4.0	3.0	6.0	9(12)
	Ensure security for CHOs	-	-	+	1(17)		0.0	0.0	10.0	3.0	
Facility Maintenance	Manage waste well	+	+	+	3(50)	3/6(50)	24.0	24.0	12.0	20.0	20(26)
	Create community ambulance system	-	-	-	0(0)		0.0	0.0	0.0	0.0	
Resource mobilization and management	CHPS compounds clean	+	+	+	3(33.3)	9/9 (100)	24.0	24.0	12.0	20.0	23(30)
	Record contributions made by others	+	+	+	3(33.3)		2.0	1.0	1.0	1.0	
	Record all financial transactions	+	+	+	3(33.3)		2.0	2.0	2.0	2.0	
Total n (%)		9(31)	10(34.5)	10(34.5)	29(100)	-	97(42)	86(37)	51(22)	234(100)	
Functionality		-	-	-	**69.0%**	-	-	-	-	**234**	-

4.4 Service delivery challenges of CHOs, CHVs and CHMCs

Table 43 shows that there were 93 different challenges identified as affecting Community Health Officers (CHOs) grouped under Utility, Minor Logistics, Major Logistics, Lack of Personnel, Capacity Development, Accommodation within Facility Premises, Unfulfilled Political Promises, Workload, Funding, Security and Lighting System for CHPS, Supervision, Renovations/Facility Improvements, Personnel Welfare and Motivations, CHV apathy, Language Barrier (Indigenes and Fulanis). The main challenges identified as affecting CHOs in delivering their defined basic package of services as spelt out in the CHPS National Implementation Guidelines were Minor Logistics (21.5% (20)), Capacity Development (10 (10.7%)), Renovations/ Facility Improvements/Wall (9(9.7%) and Security and Facility Lighting System (7(7.5%)), with Volivo CHPS having the most chunk of the share.

Table 23 shows there were 40 identified challenges affecting service delivery of CHVs categorized under Minor Logistics, Major Logistics, Capacity Development, CHV Welfare, Community Cooperation, Language Barrier, Demarcated Zone and Accessibility to Communities. The main challenges identified were minor logistics (10 (25%)), CHV Welfare (9(22.5%)), Capacity Development (6(15%)) and Demarcated Zone Size (4(10%)) were the main reasons given as challenges facing service delivery of Community Health Volunteers (CHVs), with Osuwem CHPS having the greatest share of them.

Finally, Table 44 shows there were 77 identified CHMC challenges noted to be affecting their delivery of services. These were categorized under Funding, Lack of Community Ambulatory System, Language Barrier, Mino Logistics, Major Logistics, Community Participation and Cooperation, Demarcated Zone size, Capacity Development, CHMC Welfare, Lack of Government Support and Facility Upgrade. Capacity Development (Training) (13(16.9%)), Funding (12 (15.9%)), Major logistics (9(11.6%)), Community Participation and Cooperation (9(11.6%)), CHMC Welfare (9(11.6%)), Minor Logistics (8(10.4)), formed the main challenges that affected CHMC service delivery with Osuwem CHPS topping.

Table 32: Service delivery challenges of CHOs by facility type

Challenges identified	Facility type			Total number of Challenges n (%)
	Asutuare Junction n (%)	Osuwem n (%)	Volivo n (%)	
Utility	+	-	++	3 (3.3)
Logistics (minor)	+++++	+++++	++++++++++	20 (21.5)
Logistics (major)	+	+	+	3(3.3)
Lack of personnel	-	-	+	1(1.1)
Capacity development	+++	++++	+++	10(10.7)
Accommodation within facility premises	++	-	++++	6(6.5)
Unfulfilled political promise	+	-	-	1(1.1)
Workload	+	+++	++	6(6.5)
Funding	++	+	+++	6(6.5)
Security and facility lighting system	++	+++	++	7(7.5)
Supervision	+	+	+	3(3.3)
Renovations/ Facility improvements/wall	+++	++	++++	9(9.7)
Personnel welfare & motivations	++	++	++	6(6.5)
CHV apathy	++	++	++	6(6.5)
Language barrier (indigenes & fulanis)	++	++	++	6(6.5)
Totals	**28 (30)**	**26 (28)**	**39 (42)**	**93 (100)**

Table 33: Service delivery challenges of CHVs by facility type

Challenges identified	Facility type			Total number of Challenges n (%)
	Asutuare Junction n (%)	Osuwem n (%)	Volivo n (%)	
Logistics-minor	++++	+++	+++	10(25)
Logistics-major	+	+	+	3(7.5)
Capacity development	++	++	++	6(15)
CHV welfare	++	+++++	++	9(22.5)
Community cooperation	+	+	-	2(5)
Language barrier	+	+	+	3(7.5)
Demarcated zone size	+	++	+	4(10)
Accessibility to communities	+	+	+	37.5)
Total	**13 (32)**	**16 (40)**	**11 (28)**	**40 (100)**

Table 34: Service delivery challenges of CHMCs by facility type

Challenges identified	Facility type			Total number of Challenges n (%)
	Asutuare Junction n (%)	Osuwem n (%)	Volivo n (%)	
Funding	+++++	+++	++++	12(15.9)
Lack of community ambulatory system	+	+	+	3(3.9)
Language barrier (fulanis)	+	+	+	3(3.9)
Logistics-major	+++	++++	++	9(11.6)
Logistics-minor	+	+++++	++	8(10.4)
Community participation & cooperation	++	+++	++++	9(11.6)
Demarcated zone size	++	+++	++	7(9.1)
Capacity development (Training, etc.)	+++++++	+	+++++	13(16.9)
CHMC welfare	+++	+++	+++	9(11.6)
Lack of Government support	+	++	+	3(3.9)
Facility upgrade request from community to HC	-	+	-	1(1.2)
Totals	**26 (34)**	**27 (35)**	**24 (31)**	**77 (100)**

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This study was an assessment of Community-based Health Planning and Services (CHPS) basic package of services in Shai Osudoku District of Greater Accra Region. The findings of the study have been discussed according to the study objectives divided into sections. The first section discusses the background characteristics of the participants. The other sections look at the evidences of the basic package of services CHOs, CHVs and CHMCs offer and the challenges they encounter in providing these defined services in accordance with the CHPS National Implementation Guidelines.

5.1 Background characteristics of CHOs, CHVs and CHMCs

Though majority of CHOs (64%) were between the 20-29 age group with most having worked for less than 5 years with their present facility of work being their first posting, with all CHOs resident in the Community. Sakeah et al., (2014) iterated the importance of CHOs being residents in communities as catalyst to delivering effective healthcare to the community. This assertion is in consonance with the findings on the field that shows that CHOs resident in the community that constituted 100% of the CHO population largely influenced their availability, commitment and dedication to duty.

Sakeah et al., (2014) who spoke about the integration of skilled delivery program with the CHPS program being an effective model for improving access to skilled birth attendance in rural communities. The study found out that midwives constituted only 14% of the CHO population

and in one facility did not have a midwife at all and this denied that facility (Volivo CHPS) from offering delivery services.

Assan et al. (2018) mentioned training as key in extracting optimum performances from CHOs especially. Awoonor-Willams et al. (2013) also highlighted the effect of poorly trained CHOs and CHVs having implications on health delivery in the community they operate from. The findings of the study attested to this assertion as many CHOs and CHVs who were not trained could not appreciate the full duties of a CHO. Osuwem CHPS scenario, however, debunked this literature assertion since none of the CHOs were formally trained though they were taken through on-the-job training which seemed to have equipped them equally good enough to provide their CHO required services. The average years of experience of CHVs was around 2 years pointing to the incessant attrition rate amongst CHVs and CHMCs skewed sex composition (66% (23)) largely being women nullified the literature assertion that seems to suggest that ladies leave key decision making and participation in CHPS activities to largely men with the notion that they are more wise and can take better decisions on their behalf (Baatiema, Skovdal, Rifkin, & Campbell, 2013).

5.2 CHPS basic package of services provided by the CHOs

The study found out that whilst CHO availability of service was approximately 77%, CHO functionality of service was 68%, implying that not all services available were equally functional. This means that whilst 77% of all defined basic package of services that are supposed to be carried out by CHOs exist at the facilities, only 68% of it are functional and are rendered.

This is in sharp contrast to the CHPS National Implementation Guidelines (2016) requirements that all the 105 CHO tasks are to be carried out.

Whilst the CHPS National Implementation Guidelines (2016) specifies how many times home visitations are to be carried out per week by CHOs, there are also district specific targets set by Shai Osudoku District under the district's own Standard Operating Protocol (SOP) Guidelines (unpublished) to guide delivery of some CHPS activities. The results from the field showed that whilst the Shai Osudoku District Standard Operating Protocol (SOP) on CHPS activities expected CHOs to carry out Health Education and Health Promotion (4 times in a week), it was able to do 2 times. The findings further pointed to the fact that whilst Disease Surveillance was to be carried out (2 times in a week), it was done once in a week (1 time in a week). Home Visitations that was to be done (3 times a week), was however, done 2 times in a week approximately whilst School Health Visitations that was to be done (1 time in a month) was done once every quarter (1 time in every 3 months). Outreach Activities that was to be carried out (6 times in a month) was done 3 times in a month.

The findings on Home Visitations, for example also contrast to findings from literature that says that CHOs were expected to visit at least 10 homes every day for preventive health education, returning later in the afternoon to attend to clients' health needs (Nwameme et al. 2018) but were found eventually doing 4 times in a month (Ntsua, Tapsoba, Asare & Nyonator, 2012). It also contrasts with CHPS National Implementation Guideline (2016) benchmark that requires CHOs to undertake 3 visitations a week or 24 households in a week or district benchmark of 3 visitations a week or 30 households a week. There are also notable differences between targets achieved on the field such as on Health Education and Promotion, School Health Activities,

Disease Surveillance and Outreach Activities. All the actuals attained were virtually below the expected district benchmark. These lower than expected performances of CHOs could be attributed to many of the challenges that are bedeviling them that are multi-faceted in nature thus hindering their ability to do more.

5.3 CHPS basic package of services provided by the CHVs

Though the CHPS National Implementation Guideline (2016) requires CHVs to carry out all the defined 11 tasks under the role of ensuring Disease Prevention and Environmental Sanitation, the findings showed that only 60% approximately of all CHV services were rendered. Findings further showed evidences of significant CHV service delivery gaps on activities such as Having Home Visitation Bags during Community Visit (Logistics), Teaching wearing of Condoms in the Community, Promoting Family Planning in the Community, Promoting Breastfeeding in the Community Giving Education in the Community, Identifying and Managing Diarrhoea at Home and Identifying and Managing Fevers at Home. This is in agreement with Awoonor-Williams et al. (2013), that poorly trained and poorly equipped Community Health Volunteers (CHVs) have implications on health delivery in the communities they operate from and that CHVs become health havoc wreckers except they are supervised and supported by a CHO (Awoonor-Williams, Sory, et al., 2013).

5.4 CHPS basic package of services provided by the CHMCs

The findings of this study under CHMC CHPS basic package of services indicated significant differences in the number of services currently delivered by CHMCs in comparison to the CHPS National Implementation Guideline (2016), (21% service delivery differences). Activities such as

Resource Mobilization, Supervision of CHVs and Security for CHOs were notable services that were hardly ever carried out. This is in line with literature as suggested by Assan et al. (2018) that CHMCs are not principally skilled to provide lead role in resource mobilization among others and that Government must take over that role if CHPS are not to suffer unnecessarily as most CHMCs instead of supporting CHPS they oversee rather rely on these facilities heavily to operate and be financially incentivized.

5.5 Challenges limiting Basic Package of Services provided by CHOs, CHVs and CHMCs

Findings of this study also reveal gaps and challenges associated the delivery of services by CHOs, CHVs and CHMCs. These share similarities with findings of other multiple studies authored by Assan et al. (2018), Sakeah et al (2014), Ntsua et al. (2012), Ngom et al. (2006) which identified critical challenges that act as hindrances to execution of CHO, CHV and CHMC duties which include Minor Logistics, Funding, Community Participation and Cooperation, CHO/CHV/CHMC Welfare, Capacity Development, Community Ambulatory System, Language Barrier etc. Firstly, some of the identified challenges affecting CHOs includes utility challenges made up of either electricity not connected to the facility and/or water not connected to the facility. Others included logistics (minor), logistics (major), lack of personnel, capacity development, accommodation especially within facility premises, unfulfilled political promise, workload, funding, security and facility lighting system, supervision, renovations/ Facility improvements/wall, personnel welfare & motivations, CHV apathy, language barrier (indigenes & fulanis). These challenges are not different from challenges earlier identified from literature. For example, Assan et al. (2018) cited inadequate transport system or non-existence of transportation system, inadequate or non-existence of equipment, inadequate or non-existing

medicines, poor supervision of CHPS facilities, weak or destroyed CHPS health infrastructure, physical inaccessibility, inexperienced CHOs, insufficiently trained community health workforce and high attrition rate among them, cultural and behavioral beliefs, poor referral support, and even financial insufficiency and security as some of the reasons why CHOs underperform, refuse to accept postings to the facility or even ask for transfers. Daro, Mccurdy, Falconnier, & Stojanovic, (2003) also relate CHO work overload as contributing to lower than expected home visitations performance and evidences on the field are not largely different from this literature finding since one of the key challenges CHOs gave as affecting their output was their workload. Sakeah et al., (2014) also point to the relationship between motivation and output and cited that all CHOs who are motivated financially and otherwise end up doing better. This assertion is in congruence to findings on the field that identified lack of Human Resource policy of Ghana Health Service on out-of-turn promotions that discriminates against rural settings in Greater Accra Region. This derecognition of such rural areas as not qualified for out-of-turn promotion and study leave preferential treatments are contributors to low morale amongst them in delivering their CHO services since according to them, it seems their sacrifices are not being taken notice of. Nwameme et al. (2018), Daro (2003) and Cowley (2009) also point to workload arising out of inadequate CHO staff as accounting for low delivery of CHO services, a fact that is corroborated by evidences on the field., Nwameme, Tabong, & Adongo (2018) and Daro et al. (2003) and Cowley (2009).

The significant number of logistics both minor and major that CHOs lack to work with coupled with some facilities not having the full compliments of all the categories of health staff especially midwives clearly sync with recently sanctioned Ghana Health Service (2018) that only

22% approximately of CHPS facilities have functioning Vaccine Fridges and that a further 31% of all CHPS facilities only have all the basic equipment to work with whilst 20% of these CHPS facilities do not have the commonest working tool, which is the weighing scale. The report further revealed only 6% of all CHPS CHOs are midwives and 17% of these CHOs are enrolled nurses (Ghana Health Service, 2018).

Field data analyzed point to CHVs on the other hand having the following challenges that included logistics-minor, logistics-major, capacity development, CHV welfare, Community cooperation, language barrier, demarcated zone issues and their easy operability as well as accessibility to communities in the catchment area. The findings especially on tooling and re-tooling, incentivization and apathy are not totally different from what literature has already re-emphasised that poorly equipped community health volunteers (CHVS) have implications on health equity in the community they operate from. CHVs thus become health havoc wreckers except they are supervised and supported by a CHO (Awoonor-Williams, Sory, et al., 2013).

CHMCs were also identified to have some challenges that affect their smooth operation. Some of them included funding challenges, lack of community ambulatory system, language barrier especially dealing with the fulani population, logistics-major, logistics-minor, Community participation & cooperation, demarcated zone size challenges, Capacity development (Training, etc.), CHMC welfare, lack of Government support and facility upgrade request from community to Health Center (HC). The recourse to over relying on the CHPS facilities and the government to be able to function effectively as CHMC has given credence to Assan et al. (2018) position

that classified the role assigned to CHMC to ensure they galvanize financial support and other community support for the CHPS as too over ambitious (Assan et al., 2018).

5.5 The Correlation between the Study Results and the Conceptual Framework selected

The results generated clearly prove the model used as perfectly right and fit for the study as it points to a relationship between the current state of attendance of the selected facilities and the services they render as defined in the CHPS implementation guidelines and how this consequently influence functionality and availability of CH, CHV and CHMC services.

The results have affirmed the fact that basic services offered influence total cases seen (total attendance) and this is also largely influenced by how many tasks are available and functional as well as what drawbacks exist along the delivery process chain. In other words, there was a positive correlation between high turnout of activities at CHPS facilities and the propensity of that facility to have more functional services as well as more services being available. It also correlated with more of the services being carried out in nominal terms more than those with lower attendances. Volivo CHPS expectedly had the least availability and functionality of services and this was reflected in the number of cases they saw as compared to Osuwem and Asutuare Junction CHPS that had more availability and functional visibility because their treated and attended cases were relatively higher.

5.6 Limitations of the Study and Unexpected Findings

Since this study only involved 3 facilities that seek to generalize an outcome for over 5,000 CHPS facilities, it is most likely that though the methodology was robust, there could be exceptions to some of the facilities that may fall within the categories used as basis for the study. The study also relied on the trust that all the respondents did their best to provide the researcher with the accurate information as it should be and that there was no embellishment. In studies like this where human responses are elicited, it is also likely that some of the respondents may attempt to be inordinate and that could also significantly sway some of the outcomes if such biases are detected.

The most unlikely findings of the study relate to the opposite correlation between training as CHO and CHO performance and Osuwem CHPS case testify that though you could be untrained formally, you could still use other methods to learn the job of a CHO and be as effective as the one trained. The trainer-of-trainers adopted meticulously by Osuwem CHPS where any newly posted CHO is taken through on-the-job training is what is the game changer at that facility and is making all the difference.

5.7 Summary of Work with Results and Findings

The study sought to review CHPS basic package of services rendered by CHOs, CHVs and CHMCs. At the end of this study, it has emerged from the key findings the averagely low execution out-turn of tasks as expected to be performed by CHOs, CHVs and CHMCs (68%, 60% and 69%) with enormous challenges confronting CHOs, CHVs and CHMCs affecting largely the delivery of CHPS basic package of services tasks, as the findings point to the fact

that, many of the CHPS facilities are working under constraining working circumstances (financial, personnel, logistics etc.), that necessitates the need to convey meetings among all key stakeholders to address these structural deficiencies that is gradually impairing the full realization of the aspired vision of the CHPS concept.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents a summary of the study and the conclusions drawn from the study research findings. The chapter also highlights some suggestions for future research and presents some recommendations that could be adopted to help improve CHPS basic package of services that are principally provided by CHOs, CHVs and CHMCs.

6.1 Conclusion

The evidences gathered by this study point to the fact that basic package of services rendered by CHOs, CHVs and CHMCs are satisfactory though there is more room for improvements if bottlenecks identified are addressed. The main challenges, however, affecting CHOs, CHVs and CHMCs from effectively rendering their defined basic package of services are largely related to Capacity Development, Funding and Logistics.

6.2 Recommendations

Based on the conclusion of this study, it is recommended that;

1. Training of CHOs, CHVs and CHMCs be prioritized by Ghana Health Service (GHS) and the Ministry of Health (MOH) across all CHPS facilities targeted especially majority of the untrained service providers. The training concept could be re-designed to incorporate the Osuwem CHPS model of “on-the-job training and coaching” if funds are not available to undertake the bigger scale nationwide training.

2. The Ghana Health Service (GHS) and the Ministry of Health (MOH) must address the lack of basic working tools (minor logistics) at the majority of CHPS facilities by acquiring these Logistics for distribution to these CHPS facilities.
3. Funding of CHPS remains a huge challenge as it slows down most CHPS outreach activities. The Ghana Health Service (GHS) and the Ministry of Health (MOH) in consultation with government must prioritize financing of CHPS to support their outreach services since NHIA do not re-imburse preventive and public health activities.
4. The CHPS National Implementation Guidelines requires staff posted to be made up of Enrolled Nurses (EN), Community Health Nurses (CHN) and Midwives. Most facilities, however do not have Midwives (94%) though most CHO services are Midwife related activities. Ghana Health Service (GHS) and Ministry of Health (MOH) could take a look at beefing up the skill sets of Enrolled Nurses and Community Health Nurses to possibly offer such services until such a time that enough Midwives can be posted to the CHPS zones who may not have Midwives.

6.3 Suggested for future work

In lieu of the findings of this study, it is suggested that similar work be carried out in other districts that will enable us understand further the real issues related to CHPS basic package of services and the challenges confronting its delivery. It will also help to compare with the outcome of this work.

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Appendix A

QUESTIONNAIRE
SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA, LEGON

ASSESSMENT OF CHPS BASIC PACKAGE OF SERVICES IN THE SHAI OSUDOKU DISTRICT OF THE GREATER ACCRA REGION OF GHANA

QUESTIONNAIRE – TARGETTED AT COMMUNITY HEALTH OFFICERS (CHOs)

I am a student of the School of Public Health, University of Ghana. In partial fulfillment of the award of MPH degree, I am to conduct a research on the above topic. The questionnaire is needed for the completion of my thesis. Please answer all questions as frankly as possible. Information gathered from this interview would be used solely for research purposes. Your identity would be protected. These, however do not affect your legal rights to refuse to participate in the study nor stop from discontinuing participating in the study when you even have started.

Yours faithfully,

LEONARD A. ANAMAN

INTERVIEW DATE	
NAME OF INTERVIEWER	
NAME OR INITIALS OF CHO OR STAFF ID	
CHPS FACILITY	

SECTION 1: Background Information

NO.	QUESTION	RESPONSE
1.	AGE	1. 15-30 |_____| 2. 21-25 3. 26-35 4. 36-50
2.	SEX	1. MALE 2. FEMALE
3.	EDUCATIONAL LEVEL	1. DEGREE 2. DIPLOMA 3. CERTIFICATE 4. WASSCE 5. OTHERS
4.	CATEGORY OF STAFF	1. MIDWIFE 2. CHN 3. EN 4. OTHERS……
5.	YEARS OF WORKING EXPERIENCE	1. 0-2 |_____| 2. 3-5 3. 6-10 4. 11-25
6.	DURATION OF POSTING IN THIS FACILITY	1. 0-2 |_____| 2. 3-5 3. 6-10 4. 11-25
7.	RESIDENCE STATUS	1. RESIDENT IN COMMUNITY 2. NON-RESIDENT
8.	STAFF TRAINING/ORIENTATION AS CHO	1. TRAINED 2. PARTIALLY TRAINED 3. NOT TRAINED

SECTION 2: Community Linkage and Outreach Services

No.	Question	Availability	Functionality
1.	Do you organize health education through durbars?	1. Yes |___| 2. No	N/A
2.	Do you organize health promotion through durbars?	1. Yes |___| 2. No	N/A

3.	How many durbars on health education have you organized in the past year?	N/A	Number……
4.	How many durbars on health promotion have you organized in the past year?	N/A	Number……
5.	Do you organize health education through home visits?	1. Yes |___| 2. No	N/A
6.	Do you organize health promotions through home visits?	1. Yes |___| 2. No	N/A
7.	How many times have you organized health education through home visits in the past year?	N/A	Number……
8.	How many times have you organized health promotions through home visits in the past year?	N/A	Number……
9.	Do you conduct community walk about?	1. Yes |___| 2. No	N/A
10.	How many times have you conducted community walk about in the past year?	N/A	Number……
11.	Do you record and report all health promotion and education activities?	1. Yes |___| 2. No	N/A
12.	How many times have you recorded and reported all health activities within the past year?	N/A	Number……
13.	Do you identify disease requiring prompt reporting?	1. Yes |___| 2. No	N/A
14.	Have many times have you identified diseases requiring prompt reporting in the past year?	N/A	Number……
15.	Do you investigate outbreaks in the community?	1. Yes |___| 2. No	N/A

16.	How many times have you investigated outbreaks in the community in the past year?	N/A	Number……
17.	Do you undertake surveillance in the community?	1. Yes |___| 2. No	N/A
18.	How many times have you undertaken surveillance in the community in the past year?	N/A	Number……
19.	Do you report all disease surveillances according to protocol?	1. Yes |___| 2. No	N/A
20.	How many times have you reported all disease surveillances according to protocol in the past year?	N/A	Number……
21.	Do you undertake routine house-to-house visits?	1. Yes |___| 2. No	N/A
22.	How many times have you undertaken routine house-to-house visits in the past year?	N/A	Number……
23.	Do you undertake day-to-day service delivery visits to households and individuals in their homes?	1. Yes |___| 2. No	N/A
24.	How many times have you undertaken day-to-day service delivery visits to households and individuals in their homes in the past year?	N/A	Number……
25.	Do you prepare and conduct special targeted home visits to designated special clients such as Tracer defaulters?	1. Yes |___| 2. No	N/A
26.	How many times do you prepare and conduct special targeted home visits to designated	N/A	Number……

	special clients such as Tracer defaulters in the past year?		
27.	Do you follow up patients referred by hospital at a discharge?	1. Yes |___| 2. No	N/A
28.	How many times have you followed up patients referred by hospital at a discharge in the past year?	N/A	Number……
29.	Do you advise and support clients with non-communicable diseases such as diabetes and hypertension?	1. Yes |___| 2. No	N/A
30.	How many times have you advised and supported clients with non-communicable diseases such as diabetes and hypertension in the past year?	N/A	Number……
31.	Do you document and report on all home activities?	1. Yes |___| 2. No	N/A
32.	How many times have you documented and reported on all home activities in the past year?	N/A	Number……
33.	Do you prepare towards school health activities?	1. Yes |___| 2. No	N/A
34.	How many times have you prepared towards school health activities in the past year?	N/A	Number……
35.	Do you conduct health education in schools?	1. Yes |___| 2. No	N/A
36.	How many times have you conducted health education in schools in the past year?	N/A	Number……
37.	Do you conduct physical examinations in schools?	1. Yes |___| 2. No	N/A

38.	How many times have you conducted physical examinations in the past year?	N/A	Number……
39.	Do you conduct inspection of the environment in schools?	1. Yes |___| 2. No	N/A
40.	How many times have you conducted inspection of the environment in schools in the past year?	N/A	Number……
41.	Do you brief school authorities on findings from school health related visitations?	1. Yes |___| 2. No	N/A
42.	How many times have you briefed school authorities on findings from school health related visitations in the past year?	N/A	Number……
43.	Do you write report on school health visitations?	1. Yes |___| 2. No	N/A
44.	How many times have you written reports on school health visitations in the past year?	N/A	Number……
45.	Do you prepare and conduct outreach activities?	1. Yes |___| 2. No	N/A
46.	How many times have you prepared and conducted outreach activities in the past year?	N/A	Number……
47.	Do you document and report on outreach activities?	1. Yes |___| 2. No	N/A
48.	How many times have you documented and reported on outreach activities in the past year?	N/A	Number……
49.	Do you organize meetings to revise CHAP with CHVs?	1. Yes |___| 2. No	N/A

50.	How many times have you organize meetings to revise CHAP with CHVs in the past year?	N/A	Number……
51.	Do you submit reports on meetings organized with CHVs concerning CHAPs?	1. Yes |___| 2. No	N/A
52.	Have many times have you submitted reports on meetings organized with CHVs concerning CHAPs in the past year?	N/A	Number……
53.	Do you conduct meetings, write community profiles, draw map of community and give technical assistance with CHMCs?	1. Yes |___| 2. No	N/A
54.	How many times have you conduct meetings, write community profiles, draw map of community and give technical assistance with CHMCs in the past year?	N/A	Number……
55.	Do you undertake education of vaccines?	1. Yes |___| 2. No	N/A
56.	Do you undertake administration and management of vaccines?	1. Yes |___| 2. No	N/A
57.	How many times have you undertaken education of vaccines in the past year?	N/A	Number……
58.	How many times have you undertaken administration and management of vaccines in the past year?	N/A	Number……
59.	Do you undertake recording and reporting of immunization activities?	1. Yes |___| 2. No	N/A
60.	How many times have you undertaken recording and reporting of immunization activities in the past year?	N/A	Number……
61.	Do you undertake education on breast feeding?	1. Yes |___| 2. No	N/A

62.	How many times have you undertaken education on breast feeding in the past year?	N/A	Number……
63.	Do you provide breast feeding support?	1. Yes |___| 2. No	N/A
64.	How many times have you provided breast feeding support in the past year?	N/A	Number……
65.	Do you carry out weighing of babies and children?	1. Yes |___| 2. No	N/A
66.	How many times have you carried out weighing of babies and children in the past year?	N/A	Number……
67.	Do you record identified malnourished children?	1. Yes |___| 2. No	N/A
68.	How many times have you recorded identified malnourished children in the past year?	N/A	Number……
69.	Do you educate the community on prevention of malnutrition?	1. Yes |___| 2. No	N/A
70.	How many times have you educated the community on prevention of malnutrition	N/A	Number……
71.	Do you undertake history taking, initial assessment, physical examination, classification and management of jaundice?	1. Yes |___| 2. No	N/A
72.	How many times have you undertaken history taking, initial assessment, physical examination, classification and management of jaundice in the past year?	N/A	Number……
73.	Do you undertake history taking, initial assessment, physical examination, classification and management of diarrhoea?	1. Yes |___| 2. No	N/A

74.	How many times have you undertaken History taking, initial assessment, physical examination, classification and management of diarrhoea in the past year?	N/A	Number……
75.	Do you undertake history taking, initial assessment, physical examination, classification and management of Acute Respiratory Infection (ARI)?	1. Yes |___| 2. No	N/A
76.	How many times have you undertaken history taking, initial assessment, physical examination, classification and management of Acute Respiratory Infection (ARI) in the past year?	N/A	Number……
77.	Do you undertake History taking, initial assessment, physical examination, classification and management of fever?	1. Yes |___| 2. No	N/A
78.	How many times have you undertaken history taking, initial assessment, physical examination, classification and management of fever in the past year?	N/A	Number……
79.	Do you undertake history taking, initial assessment, physical examination, classification and management of measles?	1. Yes |___| 2. No	N/A
80.	How many times have you undertaken History taking, initial assessment, physical examination, classification and management of measles in the past year?	N/A	Number……
81.	Do you undertake history taking, initial assessment, physical examination,	1. Yes |___| 2. No	N/A

	classification and management of ear infection?		
82.	How many times have you undertaken history taking, initial assessment, physical examination, classification and management of ear infection in the past year?	N/A	Number……
83.	Do you record and refer, if needed cases on acute care of infants and children (Integrated Management of Neonatal and Childhood Illnesses, IMNCI)	1. Yes |___| 2. No	N/A
84.	How many times have you recorded and referred, if needed cases on acute care of infants and children (Integrated Management of Neonatal and Childhood Illnesses, IMNCI)?	N/A	Number……
85.	Do you provide family planning counselling on all methods available under family planning?	1. Yes |___| 2. No	N/A
86.	How many times have you provided family planning counselling on all methods available under family planning in the past last year?	N/A	Number……
87.	Do you provide education on preferred methods on family planning?	1. Yes |___| 2. No	N/A
88.	How many times have you provided education on preferred methods on family planning in the past year?	N/A	Number……
89.	Do you provide administration of methods on family planning such as condoms, combined oral contraceptives, injectable implants?	1. Yes |___| 2. No	N/A
90.	How many times have you provided administration of methods on family planning	N/A	Number……

	such as condoms, combined oral contraceptives, injectable implants etc. in the past year?		
91.	Do you provide referral for other or permanent methods of family planning?	1. Yes |___| 2. No	N/A
92.	How many times have you provided referral for other or permanent methods of family planning in the past year?	N/A	Number……
93.	Do you conduct education on HIV/AIDS and sexually transmitted infections (STIs)?	1. Yes |___| 2. No	N/A
94.	How many times have you conducted education on HIV/AIDS and sexually transmitted infections (STIs) in the past year?	N/A	Number……
95.	Do you educate the community on condom use?	1. Yes |___| 2. No	N/A
96.	How many times have you educated the community on condom use in the past year?	N/A	Number……
97.	Do you prepare clients by counselling them on HIV/AIDS and STIs before testing is conducted?	1. Yes |___| 2. No	N/A
98.	How many times have you prepared clients by counselling them on HIV/AIDS and STIs before testing is conducted in the past year?	N/A	Number……
99.	Do you test clients on HIV/AIDS and STIs using rapid diagnostic test?	1. Yes |___| 2. No	N/A
100.	How many times have you tested clients on HIV/AIDS and STIs using rapid diagnostic test in the past year?	N/A	Number……
101.	Do you provide feedback on the outcome of test on?	1. Yes |___| 2. No	N/A

102.	How many times have you provided feedback on the outcome of test to patients in the past year?	N/A	Number.....
103.	Do you provide appropriate management of care for positive cases?	1. Yes |___| 2. No	N/A
104.	How many times have you provided appropriate management of care for positive cases detected in the past year?	N/A	Number.....
105.	Do you undertake history taking, identification and management of anaemia?	1. Yes |____| 2. No	N/A
106.	How many times have you undertaken history taking, identification and management of anaemia in the past year?	N/A	Number……
107.	Do you undertake history taking, identification and management of malaria in pregnancy?	1. Yes |____| 2. No	N/A
108.	How many times have you undertaken history taking, identification and management of malaria in pregnancy in the past year?	N/A	Number……..
109.	Do you undertake history taking, identification and management of syphilis in pregnancy?	1. Yes |____| 2. No |	N/A
110.	How many times have you undertaken history taking, identification and management of syphilis in pregnancy in the past year?	N/A	Number……..
111.	Do you undertake implementation of PMTCT activities?	1. Yes |____| 2. No	N/A

112.	How many times have you undertaken implementation of PMTCT activities in the past year?	N/A	Number……
113.	Do you undertake counselling pregnant women based on findings and teaching danger signs in pregnancy?	1. Yes |____| 2. No	N/A
114.	How many times have you undertaken counselling pregnant women based on findings and teaching danger signs in pregnancy in the past year?	N/A	Number……
115.	Do you assess and prepare mothers who are about to deliver?	1. Yes |____| 2. No	N/A
116.	How many times have you assessed and prepared mothers about to deliver in the past year?	N/A	Number……
117.	Do you monitor labour, deliver baby and resuscitate baby if baby is not breathing well?	1. Yes |____| 2. No	N/A
118.	How many times have you monitored labour, delivered baby and resuscitated baby if baby is not breathing in the past last year?	N/A	Number…….
119.	Do you conduct third stage of labour?	1. Yes |____| 2. No	N/A
120.	How many times have you conducted third stage of labour in the past year?	N/A	Number……
121.	Do you conduct immediate post-natal care (PNC) to mother and baby?	1. Yes |____| 2. No	N/A

122.	How many times have you conducted immediate post-natal care (PNC) to mother and baby in the past year?	N/A	Number……
123.	Do you educate community family members on post-natal care (PNC)?	1. Yes |____| 2. No	N/A
124.	How many times have educated community members on post-natal care (PNC) in the past year?	N/A	Number……..
125.	Do you assess mothers and babies at 6 weeks of delivery?	1. Yes |____| 2. No	N/A
126.	How many times have you assessed mothers and babies at 6 weeks of delivery in the past year?	N/A	Number……..
127.	Do you manage supplies in your facility?	1. Yes |____| 2. No	N/A
128.	How many times have you managed such supplies in your facility in the past year?	N/A	Number……
129.	Do you conduct decontamination, cleaning, sterilizing and storing of instruments appropriately?	1. Yes |____| 2. No	N/A
130.	How many times have you conducted decontamination, cleaning, sterilizing and storing of instruments appropriately in the past year?	N/A	Number……..
131.	Do you dispose of waste properly in your facility?	1. Yes |____| 2. No	N/A
132.	How many times have disposed off waste properly in your facility in the past year?	N/A	Number……..

133.	Are you able to recognize signs and symptoms of communicable diseases such as HIV/AIDS, TB, and Malaria?	1. Yes |____| 2. No	N/A
134.	How many times have you recognized signs and symptoms of communicable diseases such as HIV/AIDS, TB and Malaria in the past year?	N/A	Number……
135.	Do you follow up and conduct home visits for TB?	1. Yes |____| 2. No	N/A
136.	How many times have you followed up and conducted home visits for TB in the past year?	N/A	Number…….
137.	Do you perform HIV/AIDS rapid test?	1. Yes |____| 2. No	N/A
138.	How many times have you performed HIV/AIDS rapid tests in the past year?	N/A	Number…….
139.	Do you perform malaria rapid test and treat?	1. Yes |____| 2. No	N/A
140.	How many times have you performed malaria rapid test and treatment in the past year?	N/A	Number: …….
141.	Are you able to recognize signs and symptoms of non-communicable diseases (NCDS) such as diabetes and hypertension?	1. Yes |____| 2. No	N/A
142.	How many times have you been able to recognize signs and symptoms of non-communicable diseases (NCDS) such as diabetes and hypertension in the past year?	N/A	Number…….
143.	Do you refer, follow up and conduct home visits to treat diabetes and hypertension?	1. Yes |____| 2. No	N/A

144.	How many times have you referred, followed up and conducted home visitations to treat diabetes and hypertension?	N/A	Number……
145.	Are you able to recognize signs and symptoms of neglected tropical diseases (NTDs)?	1. Yes |____| 2. No	N/A
146.	How many times have you been able to recognize signs and symptoms of neglected tropical diseases (NTDs) in the past year?	N/A	Number…….
147.	Do you refer, follow up and conduct home visits on NTDs?	1. Yes |____| 2. No	N/A
148.	How many times have you referred, followed up and conducted home visits on NTDs in the past year?	N/A	Number…….
149.	Do you conduct adolescent friendly services?	1. Yes |____| 2. No	N/A
150.	How many times have you conducted adolescent friendly services in the past year?	N/A	Number
151.	Do you conduct counselling on Family Planning, STIs, HIV/AIDS and nutrition targeted at adolescents?	1. Yes |____| 2. No	N/A
152.	How many times have you conducted counselling on family planning, STIs, HIV/AIDS and nutrition targeted at adolescents in the past year?	N/A	Number……
153.	Do you provide services to adolescents on family planning, STIs, HIV/AIDS and nutrition?	1. Yes |____| 2. No	N/A

154.	How many times have you provided services to adolescents on family planning, STIs, HIV/AIDS and nutrition in the past year?	N/A	Number…….
155.	Do you provide referral services to adolescents on services such as family planning, STIs, HIV/AIDS and nutrition?	1. Yes |____| 2. No	N/A
156.	How many times have you provided referral services to adolescents on services such as family planning, STIs, HIV/AIDS and nutrition in the past year?	N/A	Number……
157.	Do you conduct follow up and home visits on family planning, STIs, HIV/AIDS and nutrition services provided to adolescents?	1. Yes |____| 2. No	N/A
158.	How many times have you conducted follow up and home visitations to adolescents on services such family planning, STIs, HIV/AIDS, nutrition to adolescents in the past year?	N/A	Number…….
159.	Do you assess and diagnose clients with mental health cases?	1. Yes |____| 2. No	N/A
160.	How many times have you assessed and diagnosed clients with mental health cases in the past year?	N/A	Number……
161.	Do you give appropriate care and treatment to mental health ailments cases?	1. Yes |____| 2. No	N/A
162.	How many times have you given appropriate care and treatment to mental health ailments cases in the past year?	N/A	Number…….

163.	Do you assess and diagnose minor ailments?	1. Yes |____| 2. No	N/A
164.	How many times have you assessed and diagnosed minor ailments in the past year?	N/A	Number……..
165.	Do you give appropriate treatments to minor ailments?	1. Yes |____| 2. No	N/A
166.	How many times have you given appropriate treatments to minor ailments in the past year?	N/A	Number……..
167.	Are you able to identify signs and symptoms of shock, snake bite, poisoning, convulsion and seizures, burns, sprains and strains, fractures and dislocations and epistaxis of community members who may be affected?	1. Yes |____| 2. No	N/A
168.	How many times have you been able to identify signs and symptoms of shock, snake bite, poisoning, convulsion and seizures, burns, sprains and strains, fractures and dislocations and epistaxis of community members affected in the past year?	N/A	Number…….
169.	Do you diagnose and manage shock, snake bite, poisoning, convulsion and seizures, burns, sprains and strains, fractures and dislocations and epistaxis of affected community members?	1. Yes |____| 2. No	N/A
170.	How many times have you diagnosed and managed shock, snake bite, poisoning, convulsion and seizures, burns, sprains and strains, fractures and dislocations and	N/A	Number…….

	epistaxis of affected community members in the past year?		
171.	Do you undertake wound dressing?	1. Yes |____| 2. No	N/A
172.	How many times have you undertaken dressing of wounds in the past year?	N/A	Number……..
173.	Do you undertake home visitation to the aged to provide education on care and nutrition?	1. Yes |____| 2. No	N/A
174.	How many times have you undertaken home visitations to the aged to provide care and nutrition in the past year?	N/A	Number…….
175.	Do you plan activities of the CHPS facility on monthly basis?	1. Yes |____| 2. No	N/A
176.	How many times have you planned activities of the CHPS facility in the past year?	N/A	Number……..
177.	Do you implement planned activities of the CHPS facility?	1. Yes |____| 2. No `	Number……
178.	How many times have you implemented planned activities of the CHPS facility in the past year?	N/A	Number……
179.	Do you request supplies for use by the CHPS facility?	1. Yes |____| 2. No	N/A
180.	How many times have you requested supplies for use by your CHPS facility in the past year?	N/A	Number……..
181.	Do you manage supplies requested by the CHPS facility?	1. Yes |____| 2. No `	N/A

182.	How many times have you managed such supplies by your CHPS facility in the past year?	N/A	Number…….
183.	Do you manage vaccines well?	1. Yes |____| 2. No	N/A
184.	How many times have you managed vaccines well in the past year?	N/A	Number……..
185.	Do you keep your compounds clean?	1. Yes |____| 2. No `	N/A
186.	How many times have you kept your compounds clean in the past year?	N/A	Number……
187.	Do you keep value books?	1. Yes |____| 2. No	N/A
188.	How many times have you kept value books in the past year?	N/A	Number……
189.	Do you receive completed value books?	1. Yes |____| 2. No	N/A
190.	How many times have you received value books completed in the past year?	N/A	Number……
191.	Do you procure utilised value books?	1. Yes |____| 2. No	N/A
192.	How many times have you procured utilized value books in the past year?	N/A	Number……..
193.	Do you receive cash revenue with GCR?	1. Yes |____| 2. No	N/A
194.	How many times have you received cash revenue with GCR?	N/A	Number……
195.	Do you bank cash collected on daily basis?	1. Yes |____| 2. No	N/A

196.	Do you have permission for your current banking arrangement if your answer to question 193 is no?	1. Yes |____| 2. No	N/A
197.	How many times have you banked cash collected on daily basis in the past year?	N/A	Number……
198.	Do you manage petty cash?	1. Yes |____| 2. No	N/A
199.	How many times have you managed petty cash in the past 1 year?	1. Yes |____| 2. No	N/A
200.	Do you bank all cheques collected?	1. Yes |____| 2. No	N/A
201.	How many times have you banked cheques collected in the past year?	N/A	Number……
202.	Do you record and submit claims to NHIS?	1. Yes |____| 2. No	N/A
203.	How many times have you recorded and submitted claims to NHIS in the past year?	N/A	Number……
204.	Do you collect, record, analyse, interpret and use data for decision making?	1. Yes |____| 2. No	N/A
205.	How many times have you collected, recorded, analyzed, interpreted and used data for decision making in the past year?	N/A	Number……
206.	Do you ensure data is entered into the DHIMS 2?	1. Yes |____| 2. No	N/A
207.	How many times have you ensured data is put into DHIMS 2 for the CHPS over the year?	N/A	Number…….

SECTION 3: Challenges affecting delivery of services as CHOs

NO.	QUESTION	CHALLENGE(S)
1.	Do you have challenges that affect delivery of services as CHOs?	1. Yes |____| 2. No
2.	What are the challenges affecting delivery of services as CHO?	1…… 2…… 3…… 4…… 5…… 6…… 7…… 8…… 9…… 10…… 11…… 12…… 13…… 14…… 15……

THANK YOU

Appendix B

CHVs QUESTIONNAIRE

SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA, LEGON

ASSESSMENT OF CHPS BASIC PACKAGE OF SERVICES IN THE SHAI OSUDOKU DISTRICT OF THE GREATER ACCRA REGION OF GHANA

QUESTIONNAIRE – TARGETTED AT COMMUNITY HEALTH VOLUNTEERS (CHVs)

INTRODUCTION

I am a student of the School of Public Health, University of Ghana and in partial fulfilment of the award of MPH degree, I am to conduct a research on the above topic. The questionnaire is needed for the completion of my thesis. Please answer all questions as frankly as possible. Information gathered from this interview would be used solely for the research purpose. Your identity would be protected. These, however, do not affect your legal rights not to participate nor even discontinue when you have started.

Yours faithfully,

LEONARD A. ANAMAN

NAME INITIALS OF CHV MEMBER	
CHPS FACILITY	
INTERVIEW DATE	

SECTION 1: BIO DATA OF PARTICIPANTS

NO.	QUESTION	RESPONSE

1.	AGE	☐☐
2.	SEX	1. MALE ☐ 2. FEMALE ☐
3.	EDUCATIONAL LEVEL	1. DEGREE 2. DIPLOMA 3. CERTIFICATE 4. WASSCE 5. OTHERS
4.	YEARS OF WORKING EXPERIENCE AS CHV	
5.	CHV ORIENTATION BEFORE POSTING	1. TRAINED 2. PARTIALLY TRAINED 3. UNTRAINED

SECTION 2: CHV's FUNCTIONAL ROLES

No.	Question	Availability	Functionality
1.	Have you reported any suspected epidemic prone disease immediately to the CHO in the past year?	1. Yes |___| 2. No	N/A
2.	How many times have you reported any suspected epidemic prone diseases to the CHO?	N/A	Number……

3.	Do you educate community members on proper environmental sanitation practices in their communities?	1. Yes |___| 2. No	N/A
4.	How many times have you educated community members on proper environmental Sanitation practices in the past year?	N/A	Number……
5.	Do you prepare, conduct, and end visits appropriately during home visitations?	1. Yes |___| 2. No	N/A
6.	How many times have you prepared, conducted and end visits appropriately during home visitations in the past year?	N/A	Number……..
7.	Do you identify and manage fevers at home?	1. Yes |___| 2. No	N/A
8.	How many times have you managed fevers at home in the past year?	N/A	Number……
9.	Do you identify and manage diarrhoea at home?	1. Yes |___| 2. No	N/A
10.	How many times have you managed diarrhea at home in the past year?	N/A	Number……
11.	Do you participate in health education in the community?	1. Yes |___| 2. No	N/A

12.	How many times have you participated in health education in the past year?	N/A	Number…….
13.	Do you give health education in the community?	1. Yes |___| 2. No	N/A
14.	How many times have you given health education in the past year?	N/A	Number…….
15.	Do you promote breast feeding in the community?	1. Yes |___| 2. No	N/A
16.	How many times have you promoted breast feeding in the community in the past year?	N/A	Number…….
17.	Do you promote family planning in the community?	1. Yes |___| 2. No	N/A
18.	How many times have you promoted family planning in the community in the past year?	N/A	Number…….
19.	Do you teach wearing and removal of condoms in the community?	1. Yes |___| 2. No	N/A
20.	How many times have you taught wearing and removal of condoms in the past year?	N/A	Number…….
21.	Do you equip yourself with home visiting bag when visiting the community?	1. Yes |___| 2. No	N/A

22.	How many times have you equipped yourself with home visiting bag when visiting the community in the past year?	N/A	Number……..

SECTION 3: CHALLENGES AFFECTING CHVs DELIVERY OF SERVICES

NO.	QUESTION	CHALLENGES
1.	Do you have challenges providing services as CHVs?	1. Yes |___| 2. No
2.	What are the various challenges confronting CHVs in delivering its mandate according to defined roles?	1…… 2…… 3…… 4…… 5…… 6…… 7…… 8…… 9…… 10……

THANK YOU

Appendix C

CHMCs QUESTIONNAIRE
SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA, LEGON

ASSESSMENT OF CHPS BASIC PACKAGE OF SERVICES IN THE SHAI OSUDOKU DISTRICT OF THE GREATER ACCRA REGION OF GHANA

QUESTIONNAIRE – TARGETTED AT COMMUNITY HEALTH MANAGEMENT COMMITTEE MEMBERS (CHMCs)

INTRODUCTION

I am a student of the School of Public Health, University of Ghana and in partial fulfilment of the award of MPH degree, I am to conduct a research on the above topic. The questionnaire is needed for the completion of my thesis. Please answer all questions as frankly as possible. Information gathered from this interview would be used solely for the research purpose. Your identity would be protected. These, however, do not affect your legal rights not to participate nor even discontinue when you have started.

Yours faithfully,

LEONARD A. ANAMAN

SECTION 1: BIO-DATA AND OTHER INFORMATION OF PARTICIPANTS

NAME INITIALS OF CHMC MEMBER	
CHPS FACILITY	
INTERVIEW DATE	

NUMBER	QUESTION	RESPONSE

1.	AGE	☐☐
2.	SEX	3. MALE ☐ 4. FEMALE ☐
5.	EDUCATIONAL LEVEL	6. DEGREE 7. DIPLOMA 8. CERTIFICATE 9. WASSCE 10. OTHERS
6.	DURATION OF BEING A CHMC MEMBER	……
7.	CHMC ORIENTATION	1. TRAINED 2. PARTIALLY TRAINED 3. UNTRAINED

SECTION 2: GOVERNANCE, MEMBERSHIP & OPERATIONS

NUMBER	QUESTION	AVAILABILITY	FUNCTIONALITY
8.	Do you ensure community recognizes CHPS?	1. Yes |___| 2. No |___|	N/A
9.	How many times have you ensured the community recognizes CHPS in the past year?	N/A	Number……

10.	Do you ensure that community members know their responsibilities to the CHPS zones?	1. Yes |___| 2. No |____|	N/A
11.	How many times have you ensured that the community members know their responsibilities to the CHPS zones?	N/A	Number……
12.	Do you write down minutes during meetings?	1. Yes |___| 2. No |___|	N/A
13.	How many times have minutes been written during meetings in the last past year?	N/A	Number……
14.	Do you support health education activities?	1. Yes |___| 2. No |___|	N/A
15.	How many times has the CHMC supported health education activities in the past last year?	N/A	Number……
16.	Do you resolve conflicts?	1. Yes |___| 2. No |___|	N/A

17.	How many times has the CHMC resolved conflicts in the last past year?	N/A	Number……

SECTION 3: SELECTION AND SUPERVISION OF CHVs

NUMBER	QUESTION	AVAILABILITY	FUNCTIONALITY
18.	Do you supervise CHVs?	1. Yes |___| 2. No |___|	N/A
19.	How many times has the CHMC supervised CHVs in the past last year?	N/A	Number……
20.	Do you provide motivation for CHVs?	1. Yes |___| 2. No |____|	N/A
21.	How many times has the CHMC provided motivation for CHVs?	N/A	Number……

SECTION 4: CATERING OF WELFARE OF CHOs (INCLUDING SECURITY)

NUMBER	QUESTION	AVAILABILITY	FUNCTIONALITY
22.	Do you care for CHOs?	1. Yes |___| 2. No |____|	N/A

23.	How many times has the CHMC cared for the CHOs in the past last year?	N/A	Number…….
24.	Do you ensure security for CHOs?	1. Yes |___| 2. No |___|	N/A
25.	How many times has the CHMC ensured security for CHOs in the past last year?	N/A	Number…….

SECTION 5: CHMC FACILITY MAINTENANCE ROLE

NUMBER	QUESTION	AVAILABILITY	FUNCTIONALITY
26.	Do you manage waste well?	1. Yes |___| 2. No |____|	N/A
27.	How many times has CHMC managed waste well in the past last year?	N/A	Number…….
28.	Do you create community ambulance system?	1. Yes |___| 2. No |___|	N/A
29.	How many times has the CHMC created community ambulance system in the past last year?	N/A	Number…….

SECTION 6: CHMC's RESOURCE MOBILIZATION AND MANAGEMENT ROLE

NUMBER	QUESTION	AVAILABILITY	FUNCTIONALITY
30.	Do you keep CHPS compounds clean?	1. Yes |___| 2. No |___|	N/A
31.	How many times has the CHMC kept the CHPS compounds clean in the past last year?	N/A	Number…….
32.	Do you record contributions made by others?	1. Yes |___| 2. No |___|	N/A
33.	How many times has the CHMC recorded contributions made by others in the past last year?	N/A	Number……..
34.	Do you record all financial transactions?	1. Yes |___| 2. No |___|	N/A
35.	How many times has CHMC recorded all financial transactions in the past last year?	N/A	Number……..

SECTION 7: CHALLENGES AFFECTING DELOIVERY OF CHMC SERVICES

NO.	QUESTION	CHALLENGES

1.	Do you have challenges affecting delivery of your mandates as CHMC?	1. Yes |___| 2. No |___|
2.	What are some of the challenges affecting the work of CHMC in delivery their mandates?	1…… 2…… 3…… 4…… 5…… 6…… 7…… 8…… 9…… 10…… 11…… 12…… 13…… 14…… 15……

THANK YOU

Appendix D

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

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

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
22nd July, 2019

MyRef. GHS/RDD/ERC/Admin/App/19/827
Your Ref. No.

Leonard A. Anaman
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 021/07/19**
Project Title	Assessment of CHPS Basic Package of Services in Shai Osudoku District of Greater Accra Region of Ghana
Approval Date	22nd July,2019
Expiry Date	21st 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

Appendix E

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

My Ref. No. ***GHS/GARHD/007/19***

Your Ref. No.

GHANA HEALTH SERVICE
REGIONAL HEALTH DIRECTORATE
GREATER ACCRA
P. O. BOX 184
ACCRA

Tel: +233-0302-234225/226203

E-mail:c_brako@yahoo.com

8th July, 2019

THE DISTRICT DIRECTOR OF HEALTH SERVICES
SHAI OSUDOKU DISTRICT HEALTH DIRECTORATE
DODOWA

RE: LETTER OF INTRODUCTION:
LEONARD A. ANAMAN

This is to introduce to you **Leonard A. Anaman** a Master of Public Health (MPH) student from the Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon who has approval from the Regional Health Directorate to conduct a research on the topic: ***"Assessment of Community-Based Health Planning and Services (CHPS) Basic Package of Services at Shai Osudoku District"*** in your District/Facility as per the attached documentations.

You are kindly entreated to provide the needed assistance.

Thank you.

MR. LUCIO GBEDER DERY
DEPUTY DIRECTOR (ADMINISTRATION)
FOR: REGIONAL DIRECTOR OF HEALTH SERVICES
GREATER ACCRA

Appendix F

CONSENT FORM FOR CHOs, CHVs, AND CHMCs IN ASUTUARE JUNCTION CHPS IN SHAI OSUDOKU DISTRICT OF GREATER ACCRA REGION OF GHANA

STUDY TITLE: ASSESSMENT OF CHPS BASIC PACKAGE OF SERVICES IN THE SHAI OSUDOKU DISTRICT OF THE GREATER ACCRA REGION

PARTICIPANT'S STATEMENT

I acknowledge that I have read the purpose and contents of the participant's information sheet and all questions satisfactorily explained to me in English language. I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of the research.

INITIALS OF THE PARTICIPANT: .....

PARTICIPANT'S SIGNATURE: ..... OR THUMBPRINT.....

DATE: .....

INVESTIGATOR'S STATEMENT AND SIGNATURE

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

I further attest to the fact that this research is purely an academic research and that the participant's anonymity and confidentiality are guaranteed.

RESEARCHER'S NAME: .....

SIGNATURE: .....

DATE: .....

This is to Certify that the above Consent Form has been approved by the Ethics Committee for the Period 22/07/19 to 21/07/2020

Appendix G

PARTICIPANT'S INFORMATION SHEET FOR CHOs, CHVs AND CHMCs IN ASUTUARE JUNCTION CHPS IN SHAI OSUDOKU DISTRICT OF GREATER ACCRA REGION OF GHANA

TITLE OF THESIS: "ASSESSMENT OF CHPS BASIC PACKAGE OF SERVICES IN SHAI OSUDOKU DISTRICT OF GREATER ACCRA REGION OF GHANA".

INTRODUCTION

This information sheet provides information about the research for you as a participant to make an informed decision as to whether to participate in the study or not. It also outlines the nature of the research, what the research involves, risks, benefits and compensation if any.

PRINCIPAL INVESTIGATOR: LEONARD A. ANAMAN, SCHOOL OF PUBLIC HEALTH, DEPARTMENT OF HEALTH POLICY, PLANNING AND MANAGEMENT (HPPM), UNIVERSITY OF GHANA, LEGON. **Mobile number:** +233243274204 **& Email address**: leomandous@yahoo.com

Purpose and Background of Research

Your consent is being sought to take part in a research project which forms part of my Masters' thesis titled **"Assessment of CHPS Basic Package of Services in Shai Osudoku District of Greater Accra Region of Ghana".** Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you in any way. You are also free to withdraw from the study at any point, even after agreeing to participate.

Nature of Research

This is a descriptive quantitative study that seeks to look into services rendered by CHOs, CHVs & CHMCs at Osuwem CHPS, Asutuare Junction CHPS and Volivo CHPS. You are expected to assist in answering basic questions on CHPS basic package of services that are rendered at your various facilities.

Aim of the study

To assess CHPS basic package of services in Shai Osudoku District.

Procedure

I will be administering questionnaires to CHOs, CHVs and CHMC to gather information on basic package of services that are provided by them and to them in the selected CHPS zones. A minimum of 45 minutes is required to answer the questionnaire for the CHOs whilst not more than 30 minutes is required for the CHVs and the CHMCs to answer the questionnaires relating to them.

This is to Certified that this Study ... ...nt form
has ... GHS ... for the
Period 22/07/19 to 21/07/2020
Signed ... 22/07/19
Name Hannah ...

Appendix H

CONSENT FORM FOR CHOs, CHVs AND CHMCs AT OSUWEM CHPS IN SHAI OSUDOKU DISTRICT OF GREATER ACCRA REGION OF GHANA

STUDY TITLE: ASSESSMENT OF CHPS BASIC PACKAGE OF SERVICES IN THE SHAI OSUDOKU DISTRICT OF THE GREATER ACCRA REGION OF GHANA

PARTICIPANT'S STATEMENT

I acknowledge that I have read the purpose and contents of the participant's information sheet and all questions satisfactorily explained to me in English language. I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of the research.

INITIALS OF THE PARTICIPANT: .....

PARTICIPANT'S SIGNATURE: ..... OR THUMBPRINT.....

DATE: .....

INVESTIGATOR'S STATEMENT AND SIGNATURE

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

I further attest to the fact that this research is purely an academic research and that the participant's anonymity and confidentiality are guaranteed.

RESEARCHER'S NAME: .....

SIGNATURE: .....

DATE: .....

This is to Certified that this Study's Informed Consent form has been Approved for the Period 22/07/19 To 21/07/2020
Signed ... Date 22/07/19
Name Hannah Frimpong
GHS- ERC Administrator

Appendix I

PARTICIPANT'S INFORMATION SHEET FOR CHOs, CHVs AND CHMCs IN OSUWEM CHPS IN SHAI OSUDOKU DISTRICT OF GREATER ACCRA REGION OF GHANA

TITLE OF THESIS: "ASSESSMENT OF CHPS BASIC PACKAGE OF SERVICES IN SHAI OSUDOKU DISTRICT OF GREATER ACCRA REGION OF GHANA".

INTRODUCTION

This information sheet provides information about the research for you as a participant to make an informed decision as to whether to participate in the study or not. It also outlines the nature of the research, what the research involves, risks, benefits and compensation if any.

PRINCIPAL INVESTIGATOR: LEONARD A. ANAMAN, SCHOOL OF PUBLIC HEALTH, DEPARTMENT OF HEALTH POLICY, PLANNING AND MANAGEMENT (HPPM), UNIVERSITY OF GHANA, LEGON. **Mobile number:** +233243274204 & **Email address**: leomandous@yahoo.com

Purpose and Background of Research

Your consent is being sought to take part in a research project which forms part of my Masters' thesis titled **"Assessment of CHPS Basic Package of Services in Shai Osudoku District of Greater Accra Region of Ghana".** Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you in any way. You are also free to withdraw from the study at any point, even after agreeing to participate.

Nature of Research

This is a descriptive quantitative study that seeks to look into services rendered by CHOs, CHVs & CHMCs at Osuwem CHPS, Asutuare Junction CHPS and Volivo CHPS. You are expected to assist in answering basic questions on CHPS basic package of services that are rendered at your various facilities.

Aim of the study

To assess CHPS basic package of services in Shai Osudoku District.

Procedure

I will be administering questionnaires to CHOs, CHVs and CHMC to gather information on basic package of services that are provided by them and to them in the selected CHPS zones. A minimum of 45 minutes is required to answer the questionnaire for the CHOs whilst not more than 30 minutes is required for the CHVs and the CHMCs to answer the questionnaires relating to them.

Appendix J

PARTICIPANT'S INFORMATION SHEET FOR CHOs, CHVs AND CHMCs IN VOLIVO CHPS IN SHAI OSUDOKU DISTRICT OF GREATER ACCRA REGION OF GHANA

TITLE OF THESIS: "ASSESSMENT OF CHPS BASIC PACKAGE OF SERVICES IN SHAI OSUDOKU DISTRICT OF GREATER ACCRA REGION OF GHANA".

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This information sheet provides information about the research for you as a participant to make an informed decision as to whether to participate in the study or not. It also outlines the nature of the research, what the research involves, risks, benefits and compensation if any.

PRINCIPAL INVESTIGATOR: LEONARD A. ANAMAN, SCHOOL OF PUBLIC HEALTH, DEPARTMENT OF HEALTH POLICY, PLANNING AND MANAGEMENT (HPPM), UNIVERSITY OF GHANA, LEGON. **Mobile number:** +233243274204 & **Email address**: leomandous@yahoo.com

Purpose and Background of Research

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This is to Certified that this Study's Inform Consent form has been Approved By GHS-ERC for the Period 22/07/19 To 21/07/2020
Signed Date 22/07/19
Name Hennah Krimpong
GHS- ERC Administrator

Appendix K

CONSENT FORM FOR CHOs, CHVs AND CHMCs IN VOLIVO CHPS IN SHAI OSUDOKU DISTRICT OF GREATER ACCRA REGION OF GHANA

STUDY TITLE: ASSESSMENT OF CHPS BASIC PACKAGE OF SERVICES IN THE SHAI OSUDOKU DISTRICT OF THE GREATER ACCRA REGION OF GHANA

PARTICIPANT'S STATEMENT

I acknowledge that I have read the purpose and contents of the participant's information sheet and satisfactorily explained to me in English language. I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of the research.

INITIALS OF THE PARTICIPANT: .....

PARTICIPANT'S SIGNATURE: ..... OR THUMBPRINT.....

DATE: .....

INVESTIGATOR'S STATEMENT AND SIGNATURE

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

I further attest to the fact that this research is purely an academic research and that the participant's anonymity and confidentiality are guaranteed.

RESEARCHER'S NAME: .....

SIGNATURE: .....

DATE: .....

This is to Certify that ... Study's Inform ... consent form