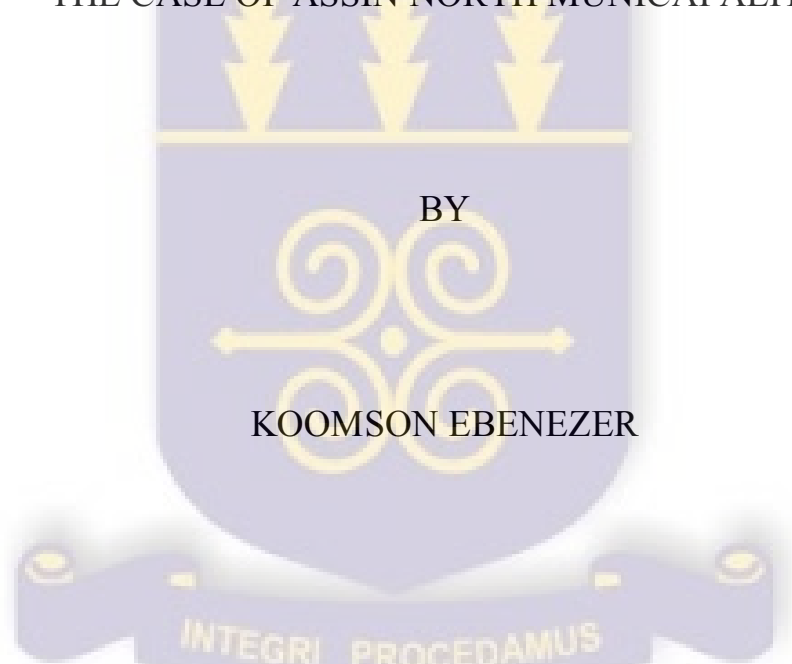


SCHOOL OF PUBLIC HEALTH,  
COLLEGE OF HEALTH SCIENCES  
UNIVERSITY OF GHANA.

ASSESSMENT OF HOME VISITING AS A  
HEALTH CARE DELIVERY STRATEGY:  
THE CASE OF ASSIN NORTH MUNICIPALITY.



A DISSERTATION SUBMITTED IN PART FULFILLMENT FOR THE  
AWARD OF THE MASTER OF PUBLIC HEALTH (MPH) DEGREE.

AUGUST, 2008

## **DECLARATION**

I, KOOMSON EBENEZER, hereby declare that this dissertation is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.

SIGNATURE.....

## **SUPERVISORS' DECLARATION.**

We, hereby declare that the preparation and presentation of this research work was supervised in accordance with the guidelines on supervision of dissertation by the University of Ghana.

**PRIMARY SUPERVISOR- DR.GEORGE AMOFAH.**

SIGNATURE.....

**SECONDARY SUPERVISOR- PROF. B.AWUMBILA**

SIGNATURE.....

## DEDICATION

To GOD, now and forever more.

Amen.



## **ACKNOWLEDGEMENT**

I wish to express my sincere thanks to all whose efforts helped in finishing this study, especially the participants, my teachers, lectures and the supervisors.

May GOD bless you immensely.



## ABSTRACT

**Background:** The delivery of health care services uses numerous strategies to achieve the desired health outcomes in specific geographical areas. One of the strategies for health care delivery in Assin North Municipal Area is home visiting of households. However, this strategy had never been assessed.

**Objective :** Assess the practice of home visiting as a strategy for health delivery in Assin North Municipal Area in order to improve upon it.

**Methods :** The study was a descriptive one that employed both qualitative and quantitative research methods involving health care providers and community members in selected communities in the district. Ethical clearance was given by the Ghana Health Service. Each participant was allowed to declare his or her consent to participate or otherwise. The data was analyzed using Epi Info.

**Results :** The home visiting in place is a universal type backed by comprehensive program goals to serve outreach, case finding needs assessment, illness visits, continuity of care, information giving and referral purposes. More clients are seen in their homes by Community Health Officers at the Community Health Planning and Services zones compared with other health staff operating from health facilities. Documentation and supervision of activities performed on home visitation is weak. The widely accepted nursing diagnosis plan taught in nursing training schools for home visiting is not been used by the home visitors. Main challenges to effective home visitation identified by the home visitors were lack of transportation, inadequate funding, and inappropriate staff attitude and ethnicity difficulties.

**Conclusion :**

Reviewing and strengthening the integration of home visiting as a major service strategy into the continuum of services for families throughout the municipality area will give better health outcomes.

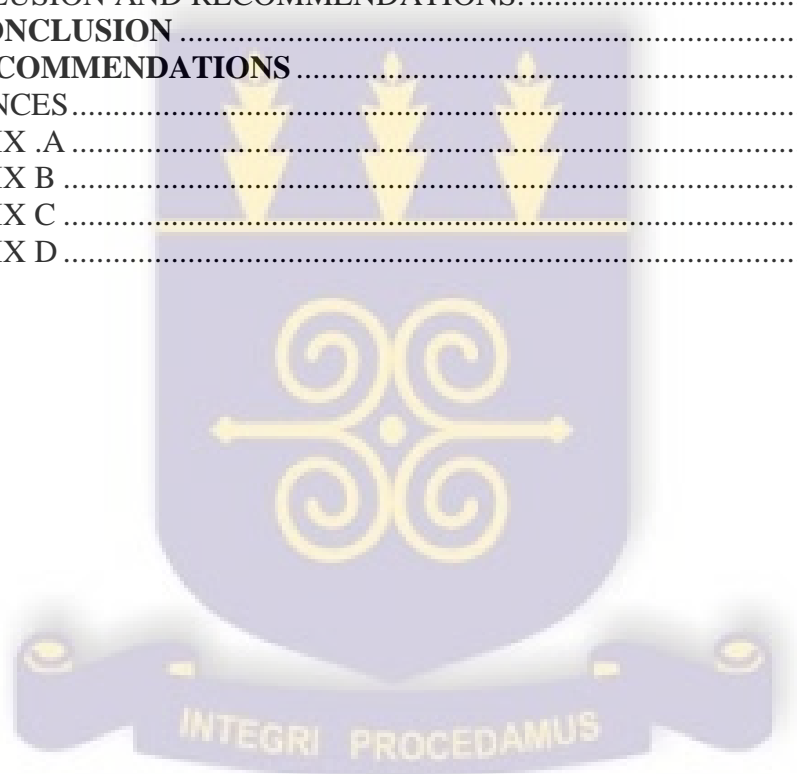
**Key words :** *Assessment, Assin North Municipality, Ghana, Home visiting, health visitor.*



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## **LIST OF ABBREVIATIONS AND DEFINITION OF TERMS**

ANC	Ante Natal Clinic
ANM	Assin North Municipality
CHO	Community Health Officer
CHPS	Community Health Planning and Services
CWC	Child Welfare Clinic
PNC	Post Natal Clinic
MHD	Municipal Health Directorate
MHMT	Municipal Health Management Team
MHMTM	Municipal Health Management Team Members

Community Health Officer- A health staff qualified to work at a CHPS compound.

Health visitor - A health staff, whose training competencies allow her to perform home visiting activities, within a geographical area.

Home visiting - A health care delivery strategy of visiting households to assess their health status, to help them cope with their health needs, and improve their standard of living.

## CHAPTER ONE

### INTRODUCTION.

#### 1.1 BACKGROUND TO THE STUDY

Accessibility to health care can be enhanced by using many strategies, one of which is home visiting. Home visiting has emerged as an important service-delivery strategy (Wasik ,1994), because it potentially affords unique opportunities for reaching psychologically and geographically isolated populations, for gaining a more realistic and complete picture of the home environment, and engaging families with young children in a range of services designed to promote the healthy development of children and the well-being of parents. According to Gomby, et al., (2005) home visiting has emerged as an important service-delivery strategy and has existed in the United States since the 1890s. Home visiting has been used in Ghana since post independence era and has continued to be an essential strategy to reach many clients and their families to sustain meaningful life and also give every child the best possible start in life (Sai., 1972). It is believed that there is much to be learned and gained from efforts that focus on improving the quality of existing programs. Efforts to strengthen home visiting program linkages with other services for children and families, especially centre-based family resource centres, child care providers, and school programs that offer child-focused services, may foster a more integrated and more demonstrably effective early childhood service-delivery system. According to the Assin North Municipal Health Directorate, their health visitors visit clients at home to assess their emotional and social support,

continuity of care, referrals, treatment of minor ailments, immunization, participating in health, education, etc.

Assessments on home visiting undertaken by the Municipal Health Directorate (MHD) using routine data have not been successful to the required standard. The MHD suspects that there is a gap between theory of this strategy in the Municipal area. The aim of this study is therefore to assist the planning and policy-setting process in Assin North Municipality, by highlighting key components and practices of home visiting that have been associated with positive outcomes or otherwise, its effectiveness in terms of home visiting goals, understand some of the system barriers and make recommendations for integrating home visiting programs into the continuum of comprehensive services for young children and their families. The approach is to use the evidence available on home visiting, and to consider at the same time, strategies which will improve the knowledge base about what works, while advancing the goal to build the most effective system of services available for supporting community health and development.

## **1.2 STUDY LOCATION**

Assin North Municipality is located at the north eastern part of the Central Region of Ghana. It has six (6) sub-districts and an estimated population of 126,792. It is one of the largest districts in the Central Region. It lies in the equatorial rain forest vegetation zone with two climatic (dry and wet) conditions. Farming is the most prominent occupation. Especially the production of cocoa occurs throughout the year. Most of the communities are located far away from the main Yamoransa-Anhwia -Nkwanta trunk road and become inaccessible by road during the raining season. Most communities have electricity, but no pipe-borne water. The inhabitants depend on streams and bore holes.

The Assin North Municipality was created out of the Assin District in August 2004 when the district was divided into two, on account of its larger size, and also in line with government of Ghana's policy on decentralization. It has two functional Community Health Planning and Services (CHPS) centres, four health centres and a Municipal hospital.

### **1.3 STATEMENT OF THE PROBLEM**

Clinic-focused services remain the mainstay of health care in Africa, despite several convincing evidences that community-based operations can enhance the accessibility, efficiency and sustainability of essential health services (World Bank Report, 2000). In a study in Ghana, Nyarko ,et al., (2004) found that putting a trained nurse in the community lessened parents' reliance on traditional healers when their children were sick and reduced childhood mortality by more than a third.

The Community Health Officers (CHOs) working in districts with established CHPS centres like Assin North Municipality are expected to make a tremendous improvement in coverage of service delivery through home visiting, for it is an effective and efficient way to realizing the goals of promoting, improving and sustaining quality health status of people in their localities. They are expected to offer treatment of minor ailments, comprehensive family planning, and continuity of care, immunization, surveillance, health education, advocacy and mobilization of human resources within the framework of community needs.

Within a region, different forms of home visiting activities could be performed according to the demand and supply forces for health care. These forces do not act neutrally, but are influenced by the decision making processes and empowerment of the health stakeholders. The CHOs need training, orientation and resource. The community should

be informed of the services available; with the Municipal Health Management Team supervising and monitoring performance periodically. When these structures are not well placed and supported in the health system of a district the home visiting strategy fails, becoming ineffective, wasting economic and human resources.

According to Thompson (2001) home visiting has emerged as an important service-delivery strategy which potentially affords unique opportunities for reaching psychologically- and geographically-isolated populations. She continued that a functional home visiting program is one which has been properly assessed and proven to be effective to the goals of positive health outcomes in communities a reality.

No study has been done to assess for the home visiting program in the Assin North Municipality (ANM) since its creation from the old Assin District in 2004. Numerous health delivery strategies (outreach, targeted, universal, community and facility based, CHPS, and home visiting) are employed by the health staff in this Municipal. It was deemed necessary to undertake a proper study to assess the home visiting in place and improve upon it, hence this study.

#### **1.4 OBJECTIVES**

This section describes the general and specific objectives, study type, research design, population, sample size, sampled population, sampling procedure, and data collection.

##### **(a) GENERAL OBJECTIVE.**

To assess the practice of home visiting as a strategy for health care delivery in Assin North Municipality in order to improve upon it.

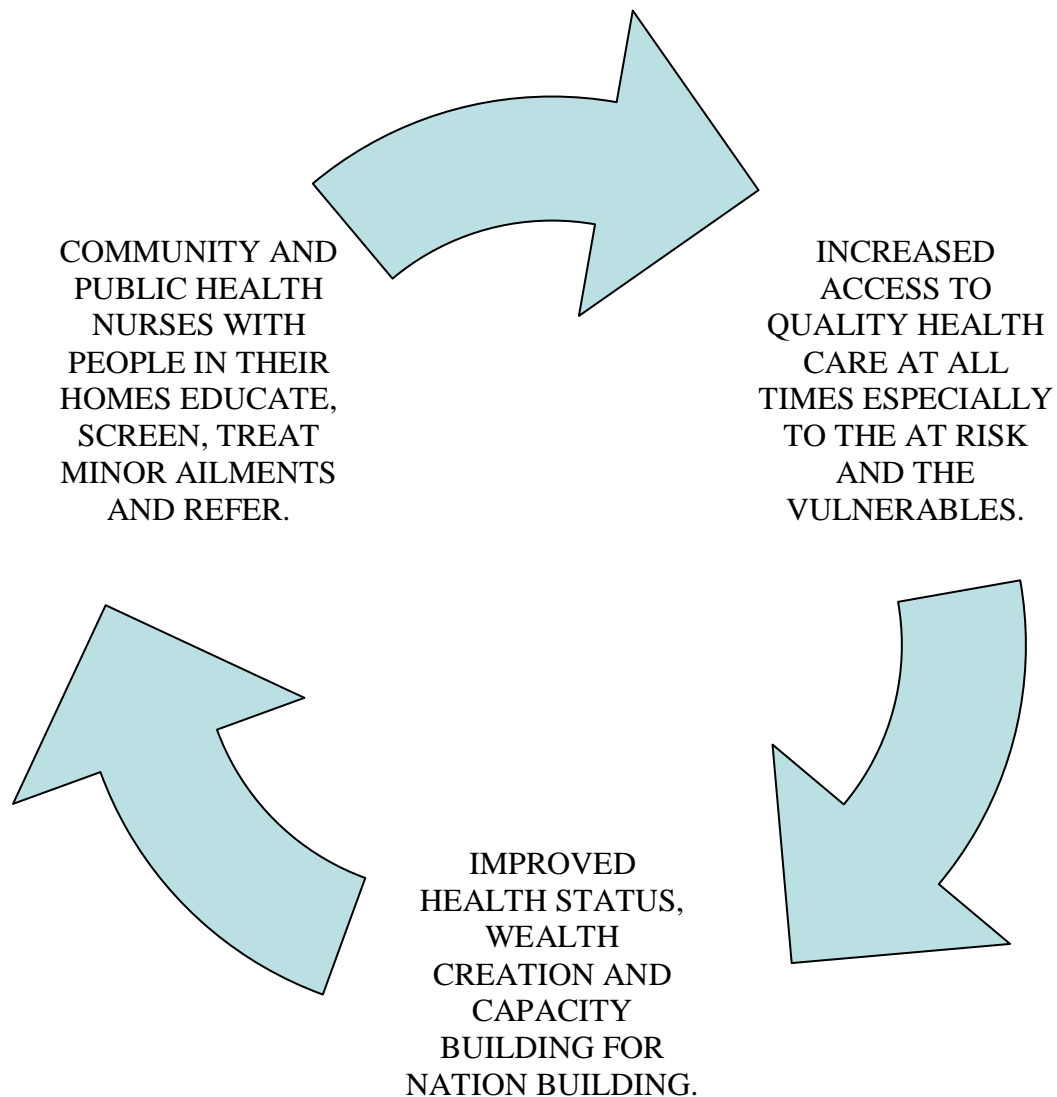
##### **(b) SPECIFIC OBJECTIVES.**

To:

1. Describe the home visiting system in place in Assin North Municipal.

2. Assess the performance of the health visitors.
3. Identify barriers affecting service delivery in home visiting.
4. Make recommendations for further improvement in home visiting system in the Municipality.

**1.5 CONCEPTUAL FRAMEWORK OF HOME-VISITING IN THE HEALTH CARE SYSTEM.**



Under the home visiting strategy of the Ghana Health Service, Community and the Public Health nurses in a district or a locality are supposed to visit community members regularly and frequently to motivate them to participate in the health care services. Clients who need special care are selected for attention. The nursing care plan is supposed to be used to facilitate the systematic process of health care delivery for the selected individuals. The services at the home visiting are at the level A point in the health care system in the primary health care. Patients are screened for medical care, counseled, treated and referred to the next appropriate level as required. Those who would be taken as special clients based on their need and condition are supervised and monitored till they are taken out of the system after the objective set with them by the health staff is achieved or otherwise. The objectives are reviewed systematically for effectiveness and efficiency.

When the objectives set have been achieved by the end of the process then, a valuable access has been created especially and importantly for the at risk group. There is an inherent aspect of improved health status, capacity building and wealth creation as the individuals in the community would have eliminated most man- day periods which could have been lost in chasing difficult to access health services. Most often, the cost may reach levels of prohibition in economic terms. It is not the individuals only who benefit, but the nation as a whole.

To achieve these, the supervisors should guide the health staff to set the proper objective and evaluate it systematically, requesting for help and guidance whenever necessary. The supervisor fails the system if the required supervision and guidance do not come at the right time for the health staff.

## **1.6 JUSTIFICATION**

Health service delivery is meant to be accessible and affordable. It is carried out by strategies which are meant to facilitate it effectively and efficiently. It should not be assumed to be achieving the desired effects when it has not been assessed against the principles it operates upon and the expected performances of its users. An assessment should be an in-built structure of every system to achieve the expected goals easily and encourage proper utilization of the limited economic and human resources.

Health care delivery is not a feeling, but is guided by proven a principle which makes it work for the expected clients. As such, it is necessary to assess periodically, any strategy used for it so that economic and human resources are put into better use.

Assin North Municipality was separated from the Assin district in 2004. It is a long period for a strategy employed in health programme to be assessed to promote efficiency and equity.

This study assessed the home visiting system in place, the performance of health visitors and the system barriers associated with it. It is an adventure worth taken for it would provide health policy makers and service providers an insight into the home visiting strategy, whether it has been successful or not, to scrap it ,re-adjust it or align it with other existing health delivery strategies.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 HISTORICAL PERSPECTIVE OF HOME VISITING.**

Thompson (2001) asserts that home visiting has emerged as an important service-delivery strategy because it potentially affords unique opportunities for reaching psychologically- and geographically-isolated populations. Wasik (1994) also agreed that home visiting has been a long-standing tradition in many European countries and in the United States. Olds and Gomby (2000) stated that home visiting programs, which under certain conditions have been shown to produce positive impacts on mothers and young children, are also frequently employed as a means to reduce barriers to accessing health services. However, evidence on the effectiveness of home visiting and its impact on short- and long-term outcomes has been inconsistent.

Thompson (2001) concluded that home visiting in itself is not an intervention or a program, but rather a strategy for service delivery from which to launch any number of interventions designed to achieve a wide variety of outcomes. She said that at the turn of the twentieth century in England, the public health “nurse and child advocate” Florence Nightingale, through her inspirational writings, was influential in defining the role of nurses and paraprofessionals in preventive health care in the community and establishing nurse training programs for home visiting. She continued that many European countries today, including Belgium, Denmark, France, Germany, Ireland, the Netherlands, Norway, Spain, Switzerland, and the United Kingdom, home visiting is a routine, widely accepted component of a more comprehensive system of care. European practices for maternal and child care are often described as a model for practice in the United States. However, as Kamerman (1993) has described as the lessons from Europe may be complicated because

of the fundamental differences between our systems. In contrast to the United States many European home visiting programs are universal, are provided to and expected by both rich and poor, and thus are well accepted by the general public. Further, many European countries have broad government-funded health and social services systems and therefore can more easily implement and integrate home visiting programs into a comprehensive delivery infrastructure. Humphrey (1987) stated that home care nursing has changed since the first sick poor people were visited in 1877. It is more than caring for an individual or a family at home, but being aware of changing the home climate for a holistic nursing care. Vaughan, et al., (1984) has stated that home visits can reduce mortality and nursing home admissions in some groups of older people.

Today's health care environment offers multiple settings, from the office with a single provider to a comprehensive setting with every possible service and provider under one roof. Regardless of the number of providers or size of the practice, the healthcare system can be a real challenge to those needing access and care and it is very prominent in Ghana.

## **2.2 THEORETICAL BASIS OF HOME VISITING.**

Before describing the different components of and wide variation in home visiting programs, it is important to outline the theoretical underpinnings that describe how home visiting, as a service strategy, is believed to support human development. According to Carrillo, (2000) two influential theories that have guided home visiting model development for health care delivery are Bandura's theory of individual self-efficacy and Bronfenbrenner's ecological model of human development. Self efficacy in the context of home visiting sees the primary role of the home visitor as building confidence and capacity in families to achieve attainable goals. The ecological approach recognizes how

family, friends, and community have an important environmental influence on an individual's life, and take these factors into account in constructing a long-term therapeutic plan. Ramey, et al (1993) also agreed that home visiting programs may be effective by using strategies that are not only directed at the child and family, but also address issues related to the family's relationship in the community. Heinicke ,et al (2001) describe this type of approach as one that focuses on the process whereby a person makes or maintains a positive relationship with another, develops an expectation of mutual satisfaction or trust, and uses that relationship to define and resolve internally and externally focused problems. These concepts, based on both research and strong philosophical beliefs, provide the underlying logic for program design and development of home visiting.

### **2.3 CHARACTERISTICS OF HOME VISITING PROGRAMMES**

Gomby ,et al., (2005); Carrillo (2000); Powell (1993) have all maintained that a home visiting program comprises of many dimensions: its program goals, target population, intensity and array of services, average and maximum caseloads, and staff qualifications. In Ghana, home visiting programs are of two main types, the outreach model and the CHPS model. Under the outreach model, the health visitor moves from the health centre or the hospital level and deliver health services in selected communities at specified periods. Under the CHPS model, the health visitor stays with the community members in a CHPS compound in one of the communities. She visits almost all communities in a day or two with the help of community volunteers and traditional heads. The community members participate fully in the health planning of the services to be delivered.

Some researchers have argued that intensive home visitation should not be considered on a universal basis because research has shown it to be cost effective only for those families at greatest risk (Gomby, et al ;2005, Olds and Kitzman 1993; Kazoly 1998).

Kamerman , et al.,(1993) have stated that an important issue when considering how to approach the design and development of home visiting services for a population is whether home visitation should be targeted to high-risk families or be universal and target all children and families. Advocates for universal home visiting programs (Kamerman and Krujman 1993), argue that the targeted approach stigmatizes the service and prevents families who need it from accepting or staying with services. Guterman, (1999) has stressed that a compromise approach that addresses the issue of stigmatization is necessary.

Gomby et al., (2005) found that when home visiting programs produced benefits, those benefits were often concentrated among particular subgroups of the families, but there was little consistency in these subgroups, even across sites that implemented the same program model.

Studies suggest that home visits can lead to improved medical care through the discovery of unmet health care needs (Arcand et al 1981; Fabacher et al 1981; Ramsdel,1994). One study found that home assessment of elderly patients with relatively good health status and function resulted in the detection of an average of four new medical problems and up to eight new intervention recommendations per patient problems in patient compliance with therapeutic regimens (Bernardini et al., 1998). Tideiksaar (1990) has stated that beyond the potential benefit of improved patient care, health visitors who conduct home

visits report a higher level of practice satisfaction than those who do not offer this service.

#### **2.4 TYPES OF HOME VISITS**

According to Cauthen (1981); Scanameo (1995) there are four major types of home visits are illness visits, visits to dying patients, home assessment visits and follow-up visits after hospitalization. In Ghana, nurses perform illness visits, home assessment visits, and follow-up visits for continuity of care for specific treatment regimen-TB, leprosy, Buruli, HIV/AIDS etc. An assessment visit is often made when a patient is suspected of poor compliance or has been making excessive use of health care resources. Medication use can be evaluated in the case of a patient who is taking many drugs because of multiple medical problems. Evaluation of the home environment of the "at-risk" patient can reveal evidence of abuse, neglect or social isolation.

#### **2.5 SUGGESTED EQUIPMENTS FOR HOME VISITS**

According to Thompson (2001), essentially, the health visitor is expected to carry on her Lubricant, Otoscope and ophthalmoscope, Patient records and charting materials, Prescription pad, Sphygmomanometer, Stethoscope, Sterile specimen cups, Thermometer, dressings, and other first aids logistics and materials.

#### **2.6 CONDUCTING THE HOME VISIT**

According to Thompson (2001) most equipment for a home visit can still be carried in the health visitor's "black bag" . Some additional items may be acquired from the patient's home. One of the keys to conducting a successful home visit is to clarify the reason for the visit and carefully plan the agenda. Preplanning allows the health visitor to gather the necessary equipment and patient education materials before departure. The health visitor should have a map, the patient's telephone number and directions to the

patient's home. The health visitor, patient and home care team should set a formal appointment time for the visit. Coordinating the house call to allow for the presence of key family members or significant others can enhance communication and satisfaction with care. Finally, confirming the appointment time with all involved parties before departure from the office is a common courtesy to the family as well as a wise time-management strategy. This is similar to what pertains in Ghana.

### **2.7 HOME VISITING CHECKLIST: "INHOMESSS"**

The INHOME mnemonic was devised to help family physicians and other health visitors remember the items to be assessed during the home visit directed at a patient's functional status and living environment. This mnemonic can be expanded to "INHOMESSS," which incorporates investigations of safety issues, spiritual health and home health agencies (Knight .et al, 1991). The mnemonic is broken down as follows: Immobility, Nutrition, Home, Environment, and Other-People, Medications, Examination, Safety, and Spiritual Health Services.

### **2.8 EVALUATION OF HOME VISIT**

Various authors (MacLeod, et al.,2000; Kendrick , 2000; Hodnett et.al., 2000) have expressed different views on evaluation about the potential for home visitation programs to improve outcomes for young children and their families. However, they advise that expansions of home visiting programs be reassessed and emphasis be placed on improving the quality of existing services and strengthening the integration of home visiting as a service strategy into the continuum of services for families. In addition, they all present a more optimistic, yet perhaps less rigorous review of home visiting. These authors, however, acknowledge the problems of publication bias that tend to overestimate the positive effects in meta-analyses. Although Heinicke and Ponce (2000) cautioned that

measures used in the studies they reviewed were not always comparable across studies and that they made inferences regarding which findings were relevant to a particular domain, they concluded that, overall, relation-based early family intervention is effective in bringing about changes in the family system. It is important, that these four reviews reflect the complexity and limitations of the field of evaluation research.

Thompson (2001) reported that the most thoroughly studied home visitation model — and perhaps the most consistently successful—is Dr. David Olds’ Nurse Home Visitation Program. In this model, public health nurses visit mothers in the home, and focus on improving maternal health- related behaviors during and after the pregnancy. This program was first developed in Elmira, New York, and then replicated in Memphis, Tennessee and Denver, Colorado, where Dr. Olds is a professor of pediatrics, psychiatry, and preventive medicine at the University of Colorado. The results of two randomized trials, conducted over a period of twenty years, yielded significant positive findings. Very few longitudinal studies of programs that employ home visiting as the primary service strategy exist. Of those that do, the National Family Project studies in the United States, Olds and Gomby (2000) are the most carefully controlled in the home visiting literature, and they have produced the largest and broadest range of outcomes. But, even they illustrate that home visiting results vary across measures, sites, and families. Bull, et al., (2004) concluded that there is insufficient evidence to determine the effect of home-visiting interventions on immunization or hospital admission rates. To them, evidence suggests that home visiting has the potential to encourage and support breastfeeding but more evidence is needed. There is some weak evidence to suggest a positive effect of

home-visiting interventions on children's diets, but further research is needed to assess this effect in the light of methodological issues.

## **2.9 THE FUTURE OF HOME VISITING**

Thompson (2001) concludes that the future for home visiting is promising if policies encourage the following:

- Program expansions of those models that have been proven effective empirically.
- Piloting innovative new home visiting programs that are grounded in epidemiology and developmental research,
- Linkages with a broader set of early intervention and family-support programs from the health, education, developmental, and social services.
- Coordinated, sustainable, and flexible funding sources for home visiting programs.
- Collaboration through technical assistance organizations.

## **2.10 HOME VISITATION IN GHANA**

Home visiting for delivery of care is an integral part of health care delivery system in Ghana. Home visiting has existed in Ghana from the pre independence to the present day, supporting various health projects and programmes, e.g. Danfa Rural Health Project (Sai ,1972), Primary Health Care, Expanded Programme on Immunization; Community based Health Planning and Services etc. A study to validate the necessity for Community Health Planning Services (CHPS) initiative in Ghana showed that the odds of having received antenatal care were more than five times greater among women residing in service communities than for others. Postnatal care odds were four times greater, and the odds of receiving both antenatal and postnatal care were greater as well (Awoonor et al; 2004). The Ghana Health Service's commitment to the initiative ensures that resources

are marshaled to support manpower expansion, and that the overall quality of health-care delivery will be improved as community services is scaled up as a national programme. By contrast, workers actually participating in the programme express satisfaction about their contribution to health service improvements and their appreciation of the support that communities render (Sory et al., 2003) .Community involvement at all stages – planning, implementation and evaluation – has an important effect on utilization of health services, continuing dialogue with the community and establishment of village health committees.

As Williams (1977) puts it, “Patients select themselves into the care system, and provider’s role is to deal with what the patients bring to them”. Proponents of primary health care emphasize the potential impact of relocating underutilized community nurses to village locations to create access to health care and improve the health status of the underprivileged ones (Agyepong et al; 1992; Mitchell ,1997). In the process of implementing CHPS in Ghana, results demonstrated that comprehensive community-based care was not only possible to achieve but also improved immunization coverage, service accessibility and the quantity of maternal and family planning care( Depburr et al., 2002; Phillips, et al., 2003).

In the course of home visiting, problems related to health can be found. In finding solutions to the problems, there should be acceptable correlation which may facilitate the necessary interventions employed. In this vein, the nursing care plan helps a lot.

### **2.11 ASSESSMENTS OF HOME VISITING DOCUMENTATION**

Recent evaluations on home visiting programmes only yielded moderate success (Gomby et al 2005; Peterson 2002). Processes underpinning the programme implementation

warrant further and closer investigation (Peterson 2002). Documentation serves as a reference to establish whether the program had been implemented as planned (Duggan et al 1999). Dowswell et al., (1996) argued that too few apparently successful programmes provided sufficient and detailed information on the processes to allow for their replication.

Assessment must be included as a step in the nursing process and must become inherent and viable tool for each community health nurse (Tinkham and Voorlies, 1977).

Abdellah's definition of nursing diagnosis is an early attempt to define the term: "Nursing diagnosis is a determination of the nature and extent of nursing problems presented by individual patients or families receiving nursing care" (Abdellah , 1975). A nursing care plan outlines the nursing care to be provided to a patient. It is a set of actions the nurse will implement to resolve nursing problems identified by assessment. The creation of the plan is an intermediate stage of the nursing process. It guides in the ongoing provision of nursing care and assists in the evaluation of that care. The determination is a key component of the nursing care process. If it makes a false start the activities become useless. Andrew (1982) in agreement with other nurses, sees diagnosis as a part of the nursing process which is never complete as long there is a nurse – client contact. The emphasis is on completing the assigned task and documenting what was done because, "if you have not written it, you haven't done it" and reimbursement is lost (Morrissey-Ross, 1988). The whole activity of home visitation should be systematically documented to the terminal point of relieving the client out of the process. The health visitor must document every activity performed in addition to resources and support

received from any stakeholder. She should keep a reliable copy of the events, and submit report on schedule to the next level.

## **2.12 BARRIERS AFFECTING HOME VISITATION**

In a study conducted by Daro et al., (2003) in South Africa, they found household location and access, visitor morale, visitor attrition, recipient suspicion and frequency of visits as the social barriers affecting home visiting. It was found that home visitors had to travel longer distances not to meet anyone there or to be turned away by a family. This frustrated most of the participants in the study and affected their morale and the programme. Relationship between visitor and recipient is critical for the success of a programme. Gomby et al.,(2005) have stated that , in any given home visitation programme, approximately 50 percent of the planned visits actually take place, and frequency of visits impacts on the success of home visitation. Given the positive correlation between visitor supervision and commitment, and performance of home visitor (Olds and Gomby , 2000; Slaughter-Defoe,1999; McGuigan et al, 2003) sound relationship should be encouraged. Ideally, visitor characteristics should complement the programme goals and target population as Daro et al 2003; and McGuigan et al, 2003 have said. Ethnicity, local values, age, sex, confidence, patience, good communication, listener, being neat, well mannered are some of the attributes of an ideal visitor (McGuigan et al., 2003). Barnard (1998), stated that, both compatibility between visitor and recipient, as well as visitor characteristics contribute to how relationships will develop. This relationship is pivotal to home visiting. It is recommended to assess how it is established (Wagner, 2003). This information also facilitates an understanding of the nature of clients' engagement with the programme (Wagner, 2003). Other visitation

programmes have indicated that the amount and quality of support offered to visitors has a bearing on effectiveness (Gomby et al 2005, McGuigan et al., 2003; Olds, 2003).

According to Daro et al .,(2003) in a study in South Africa, it was found that , a lower case load allowed much time required to be spent on each visit to be increased and facilitated quality time for the intervention. Higher case load compromises quality of service as the average visit time of 30 minutes was not achieved. Gomby et al., (2005) also asserts that visitor attrition results in a change in visitors to specific homes and this may affect the receptivity of the programme.

## **CHAPTER THREE**

### **METHODS.**

Description of methodology used for the study.

#### **3.1 TYPE OF STUDY:**

This is a descriptive exploratory study. It was meant to explore the home visiting system in place, and describe the factors affecting it. This would make it better to understanding the home visiting system in place for interested individuals to draw informed conclusion and better judgment on it.

The findings were based on outcomes of structured questionnaire interviews conducted on 27 health visitors who were interviewed at their health facilities, 8 Municipal Health Directorate Members, and 60 randomly selected community members.

A team of four research assistants and investigator participated by conducting face to face interview, with the respondents giving their options to the questions posed in the interview schedules.

The health visitors also performed home visiting activities in households for observation based on selected home visiting assessment indicators.

#### **3.2 VARIABLES USED**

The dependent variable was the effective home visiting system. The independent variables were the number of clients visited, home visiting model, documentation processes, community and health visitor perception, training, supervision, resources, funding, and system barriers.

#### **3.3 STUDY POPULATION.**

The population was health providers whose official decisions and practices do affect home visiting, and community members in selected communities in the district.

### **3.4 SAMPLE SIZE.**

The sample size was made up of all the health visitors (28) who are supposed to use home visiting to deliver health services (home visit, MHDT members (8), and 60 community members in the municipal area.

### **3.5 SAMPLING METHOD.**

With the exception of the 60 community members who were randomly selected, the rest were enrolled as identifiable groups whose decisions affect home visiting. The Municipal area was demarcated into three areas of health service delivery namely – health facility, outreaches and CHPS zone communities. The health facility (health centres and Hospital) communities were Assin Foso, Assin Bereku, Assin Akropong, Assin Kushea, Assin Praso, and Assin Bediada. The CHPS zone communities are Assin Engwa and Assin Awisam. The rest of the 93 communities in the municipal area without health facilities were the outreach communities. Two communities were randomly selected in each identified zone-health facility, CHPS, outreach based communities. Ten community members were then randomly selected in each community. The starting point in each community was determined at the community level by the researcher team- by balloting to start from either left or right side of the point of entry into the community. The selected communities were Ningo, Gangan for outreach, Aponsie, Akonfodi for CHPS, and Bereku and Praso for health facility zones respectively.

### **3.6 DATA COLLECTION TECHNIQUES:**

Quantitative and qualitative methods were used to gather and present the data. Pre-tested specific structured questionnaires were used to collect necessary information from all the respondents (MHMT members, health visitors, and selected community members).

To remove data collector bias, national service personnel were employed to collect the data with the investigator after undergoing two –day training orientation on the data

collection instruments used. Health visitors were observed on the field during home visiting. A health visitor is a trained health staff mandated to perform home visiting as part of her schedule in delivering health care. The training should have taken place in a government recognized institution prior to this study. Community members and the health visitors were interviewed at home .A checklist was used to assess how home visiting is performed by health visitors in the homes of their clients. Documentations and reports on home visiting at the MHD office and that of the health visitors' notebooks were assessed to determine the nature and completeness of the collection and documentation processes. The health facilities and the CHPS centres were visited to assess the documentation and reports they have on their activities.

Interviews were conducted by four teams of one person per team. Three were national service personnel, in addition to the researcher. Before conducting the interview, interviewers explained the purpose of the study and the respondent was given the opportunity to ask questions about the survey. Participant's consent was taken before allowed to be interviewed. One health staff declined to participate.

The selected community members were interviewed in their homes. The interviewer on reaching the selected community chose the pre-determined selected position- either left or right, using the entry point to that community as the reference. The closest house by its door to the interviewer was first entered. The next house was chosen by the closeness of its door to the preceding house by the interviewer until the tenth respondent was interviewed. An adult member (18 years and above) of the first contacted household in that house was interviewed. One person per household per house was interviewed. A household was defined as a group of persons who live and eat together;

The health visitors were interviewed at their respective health facilities for the documentation, barriers and perception on home visiting activities. They were later taken to the nearby homes to perform home visitation for observation and assessment, according to a home visiting checklist.

The MHMT members were interviewed at their offices individually.

### **3.7 DATA COLLECTION TOOLS**

A home visiting checklist was used in assessing the health visitors at the community level. Structured questionnaires were used to interview health visitors, community, and MHMT members. Reports and documentations on home visiting at the Municipal Health Directorate (MHD), the health facilities, CHPS, and that of the health visitors were assessed.

### **3.8 DATA HANDLING AND QUALITY CONTROL.**

The data collecting tools were developed, printed and kept by the investigator one week before the research study. The investigator checked with the interviewers the completely answered questionnaire/s, verified its completeness or otherwise. The investigator re-administered a questionnaire from every interviewer to verify its authenticity. The responses were accordingly coded as indicated in the coding manual (instrument). Three interviewers were trained by the investigator for two days before performing a pre-testing of the questionnaire to ensure consistency of the responses and data quality in some communities in Assin South District.

### **3.9 DATA PROCESSING AND ANALYSIS**

EPI Info software was used to perform data processing and analysis. The data was presented in graphical and tabular forms for interpretation and drawing of conclusions.

### **3.10 ETHICAL CONSIDERATION.**

The health staff and community members participating in this study were assured of their anonymity, dignity, respect and the right to withdraw their participation at any point in the study without suffering any harm. Informed consent was acquired from the participants before participating. Ethical clearance was given by the Ghana Health Service. Permission was given by the Assin North Municipal Health Directorate.

### **3.11 PRETESTING**

This was done in Assin South District, the other half of the old Assin District a week before the study.

### **3.12 LIMITATIONS**

In a study in South Africa, (Daro et al.,2003) the home visitors were observed for a month, however, due to lack of funds and time ,each visitor was followed for one day to the field to practice home visitation.

According to Gomby (2005) randomized trials in home visiting have been conducted in many countries before. Findings from cost benefits analysis of home visiting programs have helped in policy making in many countries, but this descriptive and explorative study, could be a stepping stone for future studies in Ghana.

## CHAPTER FOUR

### RESULTS.

#### 4.1 TYPE OF RESPONDENTS

Eight MHMT members participated in the study. Sixty community members participated and were interviewed individually at home. Twenty-seven health service providers (all females) also participated. They were interviewed individually at their health facilities.

#### 4.2 AGE CHARACTERISTICS OF HEALTH VISITORS AND COMMUNITY MEMBERS

The mean, median and modal ages of the community members were 32.2, 42, and 22 years respectively. The age range was 18-85 years. Fourteen males and forty-four females participated. The health visitors had mean, median and modal ages of 36.2, 34, and 26 years respectively. The age range was 24-60 years. All the health visitors were females.

**Table 1. Age structure of the health visitors.**

Category of health visitors	AGE/YEARS				
	24 - 29	30 - 34	35 - 44	45+	TOTAL
CHN	11	3	2	1	17
CHNM	0	1	0	3	4
MW	0	0	1	4	5
PHN	0	0	0	1	1
<b>TOTAL</b>	11	4	4	9	27

**Table 2. Age structure of the Community members.**

Age (years)	Number	Total
<19	4	4
20-29	23	27

<b>30-39</b>	<b>13</b>	<b>40</b>
<b>40-49</b>	<b>11</b>	<b>51</b>
<b>50-59</b>	<b>6</b>	<b>57</b>
<b>60-69</b>	<b>2</b>	<b>59</b>
<b>70+</b>	<b>1</b>	<b>60</b>
<b>Total</b>		<b>60</b>

#### **4.3 Description of the Home visiting system in the Municipality.**

**Table 3. The modes of health service delivery.**

<b>How do the Health facilities in this Municipality deliver health services?</b>	<b>Frequency</b>	<b>Percent</b>
<b>CHPS</b>	7	25.00%
<b>Outreach</b>	7	25.00%
<b>Home Visitation</b>	6	21.40%
<b>Outreach, CHPS</b>	6	21.40%
<b>Outreach, CHPS ,Home visitation,</b>	2	7.20%
<b>Total</b>	28	100.00%

From Table 3, though the health facilities use all the modes – Home visitation, CHPS, Outreach, Targeted and Universal, only two (7.2%) of the responses indicated three of it.

**Table 4. Supervision of home visiting by MHDT members.**

<b>Did you supervise a home visiting activity in the last five months?</b>	<b>Frequency</b>	<b>Percent</b>
<b>No</b>	8	100.00%
<b>Yes</b>	0	0.00%
<b>Total</b>	8	100.00%

From Table 4 above, none of the MHMT members is supervising the health visitors. The following responses came up when asked why? - “I am new here”, “It is not under my jurisdiction”, There is no programme for me to do that”, “Time is limited for me to do that” etc.

**Table 5. Category of staff to perform home visiting.**

Which category of staff should use home visiting as a strategy?	Frequency	Percent
Community Health Officers	4	50.00%
All the staff	3	37.50%
Community Health Nurses	1	50.00%
Total	8	100.00%

From Table 5 above, though greater proportion of the respondents (50%) of the MHMT members thought only Community Health Officers should perform home visiting (37.5%) said all health staff should perform home visiting.

**Table 6. Benefits of home visiting to service delivery.**

What are the benefits of home visit to service delivery?	Frequency	Percent
Access increases	5	45.40%
Community ownership is boosted	4	36.40%
Coverage increases	1	9.10%
All of the above	1	9.10%
Total	11	100.00%

From Table 6, most of the respondents asserted that home visiting does increase accessibility and also boost community ownership to health service delivery coverage. All the members have a positive attitude towards home visiting as a health delivery tool.

**Table 7. Last time training was organized for home visiting.**

When was the last training organized for health staff on home visiting?	Frequency	Percent
Don't know	5	62.50%
Never	3	37.50%
Total	8	100.00%

From Table 7 above, training had never been organized for the health visitors in the municipality. Five of the members stated that they did not know the last time, and three said it has never been organized.

**Table 8. Documentation by health visitors on activities performed during home visiting**

<b>Do you have the note book for documenting the activities performed during home visiting?</b>	<b>Frequency</b>	<b>Percent</b>
<b>Yes</b>	5	19.00%
<b>No</b>	22	81.00%
<b>Total</b>	27	100.00%

From Table 8, only five health visitors (19%) were able to provide their note books. However, the health facilities have institutional home visiting notebooks. However, the average documentation was just on two cases. There was no indication of monitoring, and evaluation by a superior officer. Most of the health visitors indicated that “The MHD should provide us note books for home visiting”.

**Table 9. Clients have you visited in the last five months**

<b>Number of clients</b>	<b>AREA OF ACTIVITY</b>	
	<b>Health facility/CHPS based</b>	<b>Health facility based</b>
<b>0</b>	<b>0</b>	<b>8</b>
<b>&lt; 50</b>	<b>0</b>	<b>2</b>
<b>&gt; 50</b>	<b>0</b>	<b>12</b>
<b>&gt; 75</b>	<b>0</b>	<b>3</b>
<b>&gt; 100</b>	<b>1</b>	<b>0</b>
<b>&gt; 150</b>	<b>1</b>	<b>0</b>
<b>Total</b>	<b>2</b>	<b>25</b>

From Table 9 above, the highest number of home visitation was done by the two CHO managing the CHPS centres (100-150 clients' visitations) in the municipality.

**Table 10. Tools used for client assessments.**

<b>Tools used to facilitate client assessments.</b>	<b>Frequency</b>	<b>Percent</b>
observation	8	29.60%
Physical Examination	10	37.10%
None	9	33.30%
<b>Total</b>	<b>27</b>	<b>100.00%</b>

From Table 10, though observation and physical examination of clients are the assessment tools used, nursing diagnosis which is a better and an effective tool was not mentioned.

**Table 11. Supervision of home visiting activities**

<b>Who supervises your home visiting activities?</b>	<b>Frequency</b>	<b>Percent</b>
Nobody	10	37.00%
Do not perform field activities	8	30.00%
Sub-district head	8	30.00%
Programme head	1	3.00%
<b>Total</b>	<b>27</b>	<b>100.00%</b>

From Table 11 , a third of the health visitors claimed they were supervised by a superior officer. This was not documented in any book.

**Table 12. Referral of patients**

<b>How patients are referred to the next level.</b>	<b>Frequency</b>	<b>Percent</b>
Use of referral notice	2	11.00%
Verbal statement	16	89.00%
<b>Total</b>	<b>18</b>	<b>100.00%</b>

From Table 12 above, though patients' referral books were available it was hardly used. Only 2/18 of the health visitors did use it. Most of them (89.00%) said the book was bigger and only one is available at a time at the facility.

**Table 13. Perception of health visitors on home visiting.**

<b>What is your perception of home visiting in your sub-district?</b>	<b>Frequency</b>	<b>Percent</b>
<b>Access is increased</b>	15	44.40%
<b>It is part of my job</b>	5	27.80%
<b>People are mobilize</b>	7	27.80%
<b>Total</b>	27	100.00%

From Table 13, though all the respondents have a good perception about home visiting, greater proportion (44%) mentioned that it creates better access to health care. The rest either said that it is part of their job or it is used to mobilize people for health care delivery.

**Table 14. Motivation of health visitor.**

<b>How do you think a health visitor should be motivated?</b>	<b>Frequency</b>	<b>Percent</b>
<b>Cash</b>	15	68.18%
<b>Uniform</b>	2	9.10%
<b>Leave</b>	1	4.54%
<b>Scholarship</b>	1	4.54%
<b>Uniform</b>	1	4.54%
<b>Cash, Citation</b>	2	9.10%
<b>Total</b>	22	100.00%

From Table 14, most of the respondents (68%) think giving cash to reward health visitors is the best motivation. The MHD provides cash as a major support for the home visiting, so it could be the reason why most of them reported as such.

**Table 15. Services received from other health workers**

Which services do you receive from other health workers in this community?	Frequency	Percent
Birth Attendants	20	33.30%
Faith healers	12	20.00%
Drug peddlers	7	11.70%
Herbalist	4	6.70%
Herbalist, Birth Attendants	3	5.00%
Birth Attendants, Faith healers,	5	8.30%
Herbalist, Birth Attendants, Faith healers	3	5.00%
Drug peddlers, Faith healers	6	10.00%
<b>Total</b>	<b>60</b>	<b>100.00%</b>

From Table 15, the service mostly received from other health workers was Traditional Birth Attendants (33.3%) and faith healing services (20%). This shows that, it is not only the health visitors who matter in the health care delivery, but they do compete with other players on the field.

#### **4.4 Assessing the performance of the health visitors.**

**Table 16. Documentation on home visiting.**

Do you have documentation on your activities related to home visiting?	Frequency	Percent
Yes	1	12.50%
No	7	87.50%
<b>Total</b>	<b>8</b>	<b>100.00%</b>

From Table 16, only one member of the MHMT (12.5%) N=8 , the accounts officer indicated that he has a documentation on home visiting- monies paid for the staff for health visits.

**Table 17. Services provided during home visiting by health visitors.**

What service/s does the staff provide during home visits?	Frequency	Percent
child welfare clinic	6	33.30%
post natal	3	16.70%
referral	2	11.10%
Education	1	5.60%
CWC, ANC,PNC,	3	16.60%
referral, health education, CWC	2	11.10%
All of the above	1	5.60%
<b>Total</b>	<b>18</b>	<b>100.00%</b>

From Table 17, greater number of the responses (33.30%) stated that child health; postnatal and antenatal are provided during home visiting. Other services indicated were referral, education. Only one person (5.6%) knew that child health, postnatal, antenatal, referral, and health educational services were necessary during home visiting.

**Table 18. When to stop home visiting.**

When should home visiting be stopped in this sub-district?	Frequency	Percent
Should not	17	63.00%
Don't Know	10	37.00%
<b>Total</b>	<b>27</b>	<b>100.00%</b>

From Table 18, almost all the respondents (63.00%) maintained that home visiting should never be stopped. Asked why they have such a response for home visiting but only 18 were performing home visiting, five (5) said they are at the district hospital and it is not their duty to perform such an activity, for it is the community nurses at the sub-district level who are supposed to. Three sub-district heads thought their position does not warrant them to perform home visiting. One (1) person thought a busy schedule at outreach would not make it possible for making home visiting in addition.

**Table 19. OBSERVATION OF HEALTH VISITORS PERFORMING HOMEVISITING (N=18)**

<u>ACTIVITY</u>	<u>PERFORMANCE (Number of health visitors)</u>	
	<u>YES</u>	<u>NO</u>
Identified herself	13 (72.2%)	5 (27.8%)
Assessed Activities of daily living	13 (72.2%)	5 (27.8%)
Assessed Balance and gait problems	14 (77.7%)	4 (22.3%)
Assessed Sensory impairments	9 (50.0%)	9 (50.0%)
Assessed Variety and quality of foods	16 (88.9%)	2 (11.1%)
Assessed Nutritional Status	17 (94.4%)	1 (5.6%)
Assessed Alcohol Presence/use	1 (5.6%)	17 (94.4%)
Assessed Home Environment	12 (66.7%)	6 (33.3%)
Assessed Social Supports	7 (38.9%)	11 (61.1%)
Assessed Financial Resources	7 (38.9%)	11 (61.1%)
Assessed Patient Attitudes	13 (68.4%)	5 (27.8%)
Assessed Medications	10 (55.5%)	8 (44.5%)
Assess General Physical Condition	13 (72.2%)	5 (27.8%)
Assess Home Safety	6 (33.3%)	12 (66.7%)
Assess Health Services	10 (55.5%)	8 (44.5%)
Assess Spiritual Needs	2 (11.1%)	16 (88.9%)
Home Health Services	7 (38.9%)	11 (61.1%)
Summarize to conclude	11 (61.1%)	7 (38.9%)

From Table 19, the performance greatly exhibited during the study by health visitors was the assessment of nutritional status of clients (17) (94.4%). Assessing for alcohol presence and or use at home was the least performance exhibited (1) (5.6%). Though every community visited in the study had at least a church or a spiritual/faith based organization , only two of the home visitors (11.1%) assessed it when visiting clients. Identifying one's self could be very important in community entry, and 13/19 home

visitors did that. Summarizing to conclude the activity was performed by 11 (61.1%) health visitors. None of the health visitors could exhibit all the expected performance. Assuming 80% as the better level of performance to be exhibited; only two assessable activities were carried out well-assessing variety and quality of foods eating (88.9%) and Assessing Nutritional status of the clients visited- (94.4%).

**Table 20. Performance of home visitation by location**

Location of Service delivery	Receiving Home visitation in the last three months	
	Yes	No
Health facility/CHPS	10 (50%)	10 (50%)
Health facility	5 (25%)	15 (75%)
Outreach	3 (15%)	17 (85%)
Total	18 (30%)	42 (70%)

From Table 20, whereas 50% of the respondents in the Health facility/CHPS based communities did receive home visitation, the health facility and outreach based communities were receiving less frequent visits (25% and 15%) respectively.

**Table 21. Services provided during home visiting**

Which services were provided?	Frequency	Percent
Health Education	12	34.60%
Immunization	10	28.40%
Postnatal	7	20.00%
Immunization, Health education, Postnatal	5	14.20%
Immunization, Antenatal	1	2.80%
Total	35	100.00%

From Table 21, most of responses by the community members indicated that health education (34.60%) and Immunization (28.40%) were the services mostly delivered during home visit.

**Table 22. Told of importance of service delivered**

Were you told of its importance	Frequency	Percent
No	9	50.00%
Yes	9	50.00%
Total	18	100.00%

From Table 22, fifty percent of the 18 respondents who were visited were informed. Sixty community members were interviewed during the study.

**Table 23 .Knowledge of health visitation by health staff**

<b>Knowledge of health visitation by health staff</b>	<b>Frequency</b>	<b>Percent</b>
No	32	63.40%
Yes	28	46.60%
<b>Total</b>	<b>60</b>	<b>100.00%</b>

From Table 23, greater proportion of the community respondents (N=60) (63.40%) did not know that health staff should visit clients at home.

#### 4.5 Identify barriers affecting service delivery by home visiting

**Table 24. Barriers affecting home visiting.**

<b>What are the barriers to home visiting in this district?</b>	<b>Frequency</b>	<b>Percent</b>
Vehicle	6	33.00%
Funding	4	22.00%
Staff attitude	2	11.00%
Ethnicity	1	6.00%
Funds, vehicle	4	22.00%
Ethnicity, staff attitude	1	6.00%
<b>Total</b>	<b>18</b>	<b>100.00%</b>

From Table 24 above, a higher proportion of the responses (33%) indicated that vehicle is the major barrier affecting home visiting. Other barriers noted were funding, staff attitude, and ethnicity.

**Table 25. The kind of support received from the MHD.**

<b>State the kind of support you receive from the MHD</b>	<b>Frequency</b>	<b>Percent</b>
Cash	9	33.00%
Fuel	8	29.00%
Vehicle	4	15.00%
Award	1	4.00%
Fuel, cash, Vehicle	2	7.00%
Fuel, vehicle	3	11.00%

<b>Total</b>	27	100.00%
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From Table 25, cash is the single most frequent support (33%) received for home visiting. However, other supports were in the form of fuel (29%), vehicle (15%), and award (4%).

**Table 26. Mode of transportation used for home visiting**

What is the mode of transportation you use for home visiting?	Frequency	Percent
Taxi	14	44.00%
Motorbike	4	12.00%
District 4WD Pickup	1	3.00%
Taxi, Motorbike	6	19.00%
Walk, Motorbike, Taxi	7	22.00%
<b>Total</b>	<b>32</b>	<b>100.00%</b>

From Table 26, the single most utilized mode of transportation was taxi. The geographical and the climatic condition make it proper to use varied forms of transport to facilitate health care delivery. The funds come from the Municipal Health Directorate (MHD) and the Internally Generated Fund (IGF).

**Table 27. Proportion of the hard-to-reach areas visited in the last five months**

Proportion of the hard-to-reach areas have visited in the last five months?	Frequency	Percent
<50%	23	85.20%
>50%	4	14.80%
<b>Total</b>	<b>27</b>	<b>100.00%</b>

From Table 27 above, there are 12 hard-to-reach areas in this municipal area. However, 23 (85.20%) had visited less than half of it.

**Table 28. Training on home visiting after your basic nursing training**

How many times have you been trained on home visiting after your basic nursing training?	Frequency	Percent
>Twice	4	22.20%
Once	2	5.60%
None	21	72.20%
<b>Total</b>	<b>27</b>	<b>100.00%</b>

From Table 28, most of the responses (72.20%) indicated that the health visitors have never been trained after their basic training. Another 27.8% said they have been trained at least once. These could not have been in the Municipality, for the MHD stated otherwise.

**Table 29. Performance of home visiting by location of health delivery**

<b><u>Health Visitors by location.</u></b>	<b><u>Performance</u></b>		<b>Total</b>
	<b><u>Yes</u></b>	<b><u>No</u></b>	
<b>CHPS/Health facility</b>	<b>2 (100%)</b>	<b>0 (0%)</b>	<b>2 (100%)</b>
<b>Health facility</b>	<b>16 (64%)</b>	<b>9 (36%)</b>	<b>25 (100%)</b>
<b>Total</b>	<b>18 (66%)</b>	<b>9 (34%)</b>	<b>27 (100%)</b>

From Table 29, all the health visitors in the CHPS/health facilities do perform home visiting. However, only 64% of the health facility based home visitors do same.

**Table 30. Contribution of a CHPS centre to service delivery in Assin North Municipal Area. (Jan - June 2008)**

<b>TOTAL POPN.</b>	<b>CHILD HEALTH</b>	<b>OPD CASES</b>	<b>MALARIA &lt; 5YEARS</b>
<b>5478</b>	<b>1532</b>	<b>2548</b>	<b>834</b>

From Table 30, shows what a CHPS/health facility can contribute to health care delivery in a locality using home visiting a strategy at a time.

**Table 31. Health Services needed to be delivered at home.**

<b>Which services do you want to receive at home?</b>	<b>Frequency</b>	<b>Percent</b>
<b>Selling of Drugs</b>	18	26.00%
<b>Giving of Injection</b>	18	26.00%
<b>Health education</b>	13	18.80%
<b>Farming</b>	2	2.90%
<b>None</b>	8	11.70%
<b>Selling of Drugs, Giving of Injection</b>	8	11.70%
<b>Family Planning</b>	2	2.90%
<b>Total</b>	69	100.00%

From Table 31, most of the responses indicated - selling of drugs (26.00%), giving of injection (26.00%), health education (18.80%) as services which they think needs to be received at home. Eight (11.7%) of the responses indicated that people should receive no health service at home.

## **CHAPTER FIVE**

### **DISCUSSION.**

#### **5.1 Describing the home visiting system in place.**

The home visiting program in place showed a great variety in the experience and backgrounds of its professional staff- CHOs, CHNs, CHNMW, and MW, their clients - everyone within a given service area, the intensity and duration of services they provide- once weekly at the health centres and four times weekly at the CHPS centres ; the administrative auspices is under the auspices of the Municipal Health Directorate; with home visiting as the primary service provided. The goals of the home visiting program in the Municipal is comprehensive in nature- to serve outreach, case-finding, needs assessment, information and referral purposes.

The study revealed that home visitation is mostly performed by CHOs, and CHNs at the health centres and the CHPS centres. By the itinerary prepared at the sub-district levels the CHO are supposed to perform home visitation four times a week, and the health facility based staff once. The documentation on the activity showed that less than 50% of it is performed by the health facility based staff. This agreed with the findings of Gomby, et .al. (2005) that in any given home visitation programme, approximately 50 percent of the planned visits actually take place. However, in the CHPS facilities, the visitation goes on smoothly as planned. The documentation on home visiting is incorporated in the routine data but not on its own as a health service delivery indicator.

Out of the 27 health staff who participated in the study, a significant number (74%) reported using home visitation as a health care delivery tool. The CHPS facilities scored 100% with the health facilities having 25%.

The health facility based staff (CHN) stay in communities on their own according to where they could find accommodation and visit clients in their homes. The CHOs at the CHPS facilities stay on the CHPS compound and move daily to visit community members and their households to deliver health care.

As indicated by Carrillo (2000), Powell (1993) a home visiting programme comprises of many dimensions: its program goals, target population, intensity and array of services, average and maximum caseloads, and staff qualifications.

The programme goal is to deliver quality health care services to all community members and their families at their door steps to eliminate minor ailments , create easier access to health facilities and foster stronger links with them to ensure collaboration , participation and ownership. The services provided are Health education, Immunization, CWC, ANC, PNC, Maternal and Family Planning services. The maximum case load per visit was stated as five at the health facility based staff and twenty at the CHPS based staff. The staff grades were CHNs, CHOs, MWs, CHNMWs and PHNs.

Though Scanameo,(1995) , Cauthen D.B.(1981), have stated that there are four major types of home visits as-illness visits, visits to the dying patients, home assessments visits and follow –up visits after hospitalization, this study showed that the home visiting system here is used for illness visits, follow-up visits, and continuity of care on CWC services and maternal services.

The sources of funding come from the MHD and some NGOs-World Vision and New Life. The mode of transportation is usually by Taxi and the funds simply support that.

The health visitors perform their activities with their bags containing charting materials, sphygmomanometer, dressings and other first aid logistics. One can compare this with what Thompson (2001) has argued that essentially, the health visitor is expected to carry on her: lubricant, otoscope and ophthalmoscope, patient records and charting materials, prescription pad, sphygmomanometer, stethoscope, sterile specimen cups, thermometer, dressings, and other first aids logistics and materials.

The health visitors expressed satisfaction about their contribution to health services improvements and their appreciation of the support that communities render in the light of reducing their burden of traveling longer distance for health care if it has not been available. When asked when home visiting should be stopped in the municipal area, almost all of them emphasized the need to sustaining it forever. Similar remarks have been made in by health staff in a study conducted by Sory (2002) in Ghana.

Duggan et.al (1996), have maintained that documentation serves as a reference to establish whether a home visiting has been implemented as planned. Dowswell et.al (1996) has argued that too few apparently successful programmes provided sufficient and detailed information on the processes to allow for their replication. The programme at the CHPS facilities could be replicated for the documentation was updated and available for usage anywhere everywhere. However, it is sad, that there was no indication of supervision of home visiting activities at the MHD and the sub-district levels. The sub-districts health team leaders are yet to monitor, supervise and evaluate the performance of the health visitors. Morrissey –Ross (1988) has stated that “if you have not written it, you haven’t done it”.

Observation and physical examination were the tools of assessments used by the health visitors. It was expected that nursing diagnosis plan which is an effective tool used during nursing training school periods must be used wherever home visiting is employed.

Andrew (1982) in agreement with other nurses sees diagnosis as part of the nursing process which is never complete as long as there is a nurse-client contact. Abdellah (1975) has said that nursing diagnosis is a determination of the nature and extent of nursing problems presented by the individual patients or families receiving nursing care.

The thrust of the above arguments shifts to the apex of public health demand, that every health activity must be documented to prove performance and for future reference.

Training is not organized for the health visitors after their basic training, though other training programmes are organized periodically. Hard - to - reach areas would need frequent visits to create access for the inhabitants who have limited contact with the health facilities for services. Eighty –five percent (85%) of the health visitors had visited less than half of the total hard -to-reach areas in their sub-district. Most of the health visitors (68%) stated that cash incentive is a motivator for them.

On performance of home visiting, the study revealed that a greater number of the health visitors were able to assess nutritional status (94%), variety and quality of foods (89%). Out of the 19 key indicators generally identified for better assessment in home visiting, only the six were assessed properly by 70% of the visitors when asked to perform for observation in randomly selected clients by themselves. It is expected that when the health visitors are supervised, monitored, and given the necessary guidance by their superiors, the performance would see exceptional improvement, for it has been identified that there is a positive correlation between visitor supervision, commitment and

performance of home the visitor (Olds and Gomby, 2000; Slaughter-Defoe,1999; McGuigan et al., 2003) .

Other visitation programmes have indicated that the amount and quality of support offered to visitors has a bearing on effectiveness (Gomby et al 2005; McGuigan et al., 2003; Olds, 2003). The study also found Ethnicity, language, and age as the greatest barriers which affect the programme.

## **5.2. Assessing the performance of the health visitors.**

This study got 27 health visitors to participate fully in the assessment activity. Though almost all the participants stated emphatically that home visiting should be sustained , 74% said they use it as a health delivery tool. The others (26%) who do not use it, thought working at the Municipal hospital at Assin Foso exclude them from using it. The two health facility/CHPS based CHOs perform home visiting four times a week through out the year. However, the health facility based health visitors were supposed to perform home visiting once a week. This was not strictly adhered to. Thirty percent (30%) of the 60 community members interviewed indicated that they have been visited by a health visitor in the last three months before the study. Fifty percent (50%) of the community respondents indicated that they have been visited at least once. Respondents from health facility communities had 25%, with outreach communities recording 15%. This was confirmed in a study organized by Daro et al., (2003) that client's location and frequency of visits affects health visitor's performance. The health visitors deliver mostly health education and immunization, though other services rendered were CWC, PNC, ANC, Maternal and Family planning. However, documentation is not done properly compared with what is done during the training period at school. Less than fifty percent (46%) of the community members (N=60)

interviewed indicated that they knew that a health visitor must pay them regular visits at home to deliver health care services. If it is done properly and frequently, it is the duty of the health visitors to create awareness for the community members that it a duty they have to perform, even if the community members were not inquisitive.

McGuigan et.al., (2003) asserts that good communication is one of the attributes of an ideal visitor. In this study, only fifty percent of the community members (30/60) were informed by the health visitors the importance of home visiting for health service delivery. Every member of the community who is visited by a health visitor should be informed of the importance of the activity. As summarized in a recent overview of home visiting research, (Gomby et al., 2005) there is still lack of clarity as to if, how, and for whom home visiting produces positive outcomes. This study made it clear that the health visitors were active in the CHPS facility- based communities than health facility or outreach based communities. It is obvious that home visitation is the most important health delivery tool in the CHPS facility-based communities.

Abdellah (1975) has argued that “Nursing diagnosis is a determination of the nature and extent of nursing problems presented by individual patients or families receiving nursing care”. The health visitors did not use it in their documentation processes. What was used is physical examination and observation. The documentation of activities performed during visitation was done poorly. The information recorded was uncoordinated in terms of problem identification, nursing diagnosis, objective setting, care giver and health visitor intervention and evaluation. Greater number of the health visitors was not able to produce their home visiting notebooks or any proof to that effect. A well coordinated

system established to manage home visiting is needed to create the necessary demand and readjustment for better action for health service delivery.

None of the health visitors was able to assess the general home visitation indicators identified in the study. About seventy percent of the health visitors were able to assess at most six of the 19 indicators identified.

### **5.3 Barriers affecting service delivery in home visiting.**

In this study the major barriers affecting home visiting are poor communication, supervision and transportation. Frequency of visits, availability of cash, vehicle, fuel and ethnicity were identified as barriers affecting home visitation. For example, when a CHO has recorded 1532 child health services, treating 835 cases of malaria in under fives, a health facility made up of a medical assistant, and seven other health staff recorded 1555 child health services, and treated 1000 cases of malaria in under fives. Household locations in hard –to- reach areas, and other outreach locations associated with health facilities other than health facility recorded minimal service delivery from the health visitors.

In a study conducted by Daro et al (2003) in South Africa, they found household location and access, visitor morale, visitor attrition, recipient suspicion and frequency of visits as the social barriers affecting home visiting. In this study, numerous barriers were identified.

Lack of supervision by superiors for the health visitors is also a major barrier to home visiting. However, at the health facilities/CHPS, there was no supervision, by the concept and the principles of the initiative it was amazing to realize that it did not affect it at all. But still, a little push from the MHD would yield more significant results than what it was recognized in this study. According to Olds and Gomby (2000); Slaughter –Defoe,

(1999); Mcguigan et al.,(2003), there is a correlation between visitor supervision and commitment and performance of the home visitor.

As studies suggest that home visits can lead to improved medical care through the discovery of unmet health care needs (Arcand, 1981; Fabacher, et al 1981; Ramsdel, 1994) this study also revealed a similar scenario in which many unmet health needs like provision of family planning services, treatment of minor ailments, effective health communication, and home visitation were realized. One study found that home assessment of elderly patients with relatively good health status and function resulted in the detection of an average of four new medical problems and up to eight new intervention recommendations per patient (Ramsdel, 1994) problems in patient compliance with therapeutic regimens (Bernardini, et al., 1998). The investigator facilitated the referral of three medical conditions to some health facilities during the study and also coached health visitors how to document health services provided.

Lack of training is also a barrier to home visiting. After the basic training at the nursing training schools, the municipality is yet to organize a training programme, specifically for home visiting. The public health unit staff at the Municipal Hospital should be involved extensively to re-shape their understanding of home visiting. When this is done there would be major boost in efficiency and coverage for service delivery through out the municipality, especially in outreach and hard-to-reach areas.

According to Daro et al., (2003) in a study in South Africa, a time limit less than the average visit time of 30minutes per case during home visitation compromises quality of service. This was confirmed in this study where the time range for assessing clients at home was 7-22minutes. Of the 19 assessment indicators adopted from other home

visitation programmes from South Africa, and the United States for this study, only two (11%) were able to assess at least 80 percent of the indicators. Training, supervision and monitoring of the health visitors are vehicles which can improve this phenomenon.

## **CHAPTER SIX**

### **CONCLUSION AND RECOMMENDATIONS.**

#### **6.1 CONCLUSION**

The home visiting system in place is a universal type backed by comprehensive program goals to serve outreach, case-finding, needs assessment, illness visits, continuity of care, information giving and referral purposes.

The home visitation is carried out by the Community Health Officers and nurses, with greater activity in the CHPS facility –based community. It is organized by the health visitors daily and weekly by the health centres and the CHPS facilities respectively, and is used to provide mostly child welfare, ante-natal, post-natal, referral services.

Communities away from health centres and CHPS facilities receive lesser visits. The health visitors at the public health unit of the Municipal Hospital do not perform home visiting thinking it is out of their schedule. Cash support from the MHD makes the activities easier for the health visitors.

Poor communication, documentation, supervision and transportation are the major barriers affecting the home visiting system in place. Training of health visitors after their basic nursing training school has not taken place. The use of nursing care plan to facilitate effective home visiting is missing and observation and physical examination are the only tools used.

Training, supervision, and monitoring of the health visitors backed by vehicular support would create the necessary demand for improving health care delivery and management for better health outcomes. The home visiting system and practice in the Assin North Municipality stands the chance of yielding immense benefits for families in the municipal area as already evidenced in the CHPS based communities.

## **6.2 RECOMMENDATIONS**

The Municipal Health Directorate should:

1. Provide necessary incentives continually for health visitors and commend staff who excel in it. Some of the incentives indicated by the health staff were scholarship awards, cash, and uniform.
2. Train health visitors periodically-(at least once a year) - to appreciate home visitation as a necessary strategy for health delivery.
4. Supervise and monitor health visitor activities regularly - (weekly) -to motivate health visitor participation and satisfaction.
5. Review and strengthen the integration of home visiting as a service strategy into the continuum of services for families throughout the municipal area.

## REFERENCES

1. Abdellah F.G. and Levine, E (1975). Better Patient Care Through Nursing Research Macmillan Co. New York
2. Adelman A.M, Fredman L, Knight A.L(1994). House call practices: a comparison by specialty. J Fam Pract 1994;39:39-44.
3. Agyepong I .A. (1999). Reforming health service delivery at district level in Ghana: the perspective of a district medical officer. Health Policy and Planning, 1999, 14:59–69
4. Akosa BA, Nyonator F.K, Phillips J.F. Health sector reform, field experiments, and systems research for evidence-based programme change and development in Ghana. Paper prepared for: From Pilot Projects to Policies and Programmes, Rockefeller Foundation Conference, Bellagio Study and Conference Center, 31 March–5 April 2003.
5. Andrew P. B. (1982) .Nursing Process: Application of Theories, Frameworks and models. Mosby of Lious. New York
6. Arcand M, & Williamson J.(1981). An evaluation of home visiting of patients by physicians in geriatric medicine. Br Med J 1981;283:718-20.
7. Awoonor-Williams J.K, Feinglass E.S, Tobey R. (2004). The impact of a replication project on safe motherhood and family planning behavior in Nkwanta District of Ghana. Studies in Family Planning, 35:161–177.
8. Barnard K.E. (1998). Developing, Implementing, and documenting interventions with parents and children. Zero to Three , 23-29.
9. Barium B. J. S. (1994). Nursing Theory, Analysis, Application, Evaluation 4<sup>th</sup>Ed.. J. B. Lippicott Co. Philadelphia
10. Better health in Africa: experiences and lessons learned. Washington, DC, The World Bank, 1994.
11. Bernardini J, & Piraino B.(1998). Compliance in CAPD and CCPD patients as measured by supply inventories during home visits. Am J Kidney Dis 1998;31:101-7.
12. Byrd, M.E. (1999). Questioning the quality of maternal caregiving during home visiting. Image J Nurs Sch, 1999. 31(1): p.27-32.
13. Better health in Africa: experiences and lessons learned. Washington, DC, The World Bank, 1994.
14. Behrman, B.E. (1999). The Future of Children. Spring/Summer ed. Home Visiting: Recent Program Evaluations,

15. Cauthen D.B.(1981). The house call in current medical practice. *J Fam Pract* 1981;13:209-13.
16. Carrilio, T.E. (2000). Considerations in developing a comprehensive, integrated system of support for families and children. 2000, San Diego State University, Social Policy Institute
17. Daro, D.A., & Harding, K.A.(1999), Healthy Families America: Using research to enhance practice. *The Future of Children*, 1999. 9(1).
18. Debpuur C, Phillips JF, Jackson E.F (2002). The impact of the Navrongo project on contraceptive knowledge and use, reproductive preferences, and fertility. *Studies in Family Planning*, 33:141–164.
19. Duggan, A. (2000). Hawaii's healthy start program of home visiting for at-risk families: evaluation of family identification, family engagement, and service delivery. *Pediatrics*, 2000. 105(1 Pt 3): p. 250-9.
20. Dowswell T, Towner E.M.L , Simpson G, Jarvis S.M. (1996). Preventing Childhood Unintentional Injuries-What Works? *Injury Prevention* 2,140-149
21. Eckenrode, J. Preventing child abuse and neglect with a program of nurse home visitation: the limiting effects of domestic violence [see comments]. *Jama*, 2000. 284 (11): p. 1385-9
22. Fabacher D, Josephson K, Pietruszka F, Linderborn K, Morley JE, Rubenstein LZ.(1994). An in-home preventive assessment program for independent older adults: a randomized controlled trial. *J Am Geriatric Soc* 1994; 42:630-8.
23. Fahy, E.T.( 1994). Healing at home: New York visiting nurse service. *Nursing and Health Care*, 1994. 15(2): p. 66-73.
24. Gomby, D.S., P.L. Culross, and R.E. Behrman, (2005). Home visiting: recent program evaluations--analysis and recommendations. *The Future of Children*, 2005. 9(1): p. 4-26, 195-223.
25. Guterman, N.B.(1999). Enrollment strategies in early home visitation to prevent physical child abuse and neglect and the "universal versus targeted" debate: a meta-analysis of population-based and screening-based programs. *Child Abuse Neglect*, 1999. 23(9): p. 863-90
26. Hanchett E.S. & Clarke P.N (1988). Nursing Theory and Public Science: Is Synthesis Possible *Public Health Nursing* 5 (1): 2-6
27. Hayes, C.D., (2000). Financing early childhood initiatives: Making the most of Proposition 10. 2000, UCLA Center for Healthier Children, Families, and Communities & The Finance Project.

28. Heinicke, C.M., Fineman, N.R., Ruth, G., Recchia, S.L., Guthrie, D.(2001). Relationship-based intervention with at-risk mothers: Outcome in the first year of life. *Journal of Infant Mental Health*, 2001. 22(4): p. 431-462. 11.
29. Heinicke, C.M.& Ponce, V.A. (2000).Relation-based early family intervention, in *Developmental Approaches to Prevention and Intervention*, D. Cicchetti, Sheree, T.L., Editor, University of Rochester Press: Rochester. p. 153-193.
30. Hodnett, E.D. & I. Roberts (2000). Home-based social support for socially disadvantaged mothers. *Cochrane Database System Rev*, 2000(2): p.107
31. Humphrey, C. J. (1987).The practice of Home Nursing Care. *Public Health Nursing* 4.No.2: 79-83
32. Huyer D.W & Corkum S.H.(1997). Reducing the incidence of tap-water scalds: strategies for physicians. *Can Med Assoc J* 1997;156: 841-4.
33. Julie Bull, Geraldine McCormick, Catherine Swann, &Caroline Mulvihill (2004) Ante- and post-natal home-visiting programmes: a review of reviews. Health Development Agency.UK.
34. Kendrick, D. (2000).Does home visiting improve parenting and the quality of the home environment? A systematic review and meta-analysis. *Archives of Disease in Childhood*, 2000. 82(6): p. 443-51.
35. Krugman, R.D.,(1993) Universal home visiting: A recommendation from the U.S. Advisory Board on Child Abuse and Neglect. *The Future of Children*, 1993. 3(3).
36. Karoly, L.A., Greenwood, P.W.,(1998).Investing in our children. 1998: RAND.
37. Kamerman, S.B., & Kahn A.J.,(1993). Home health visiting in Europe. *The Future of Children*, 1993. 3(3). ):
38. Knight AL, & Adelman AM.(1991).The family physician and home care. *Am Fam Physician* 1991;44: 1733-7
39. Knight A.L, Adelman A.M, Sobal J. (1991) .The house call in residency training and its relationship to future practice. *Fam Med* 1991;23:57-9.
40. MacLeod, J. & G. Nelson,(2000). Programs for the promotion of family wellness and the prevention of child maltreatment: a meta-analytic review [In Process Citation]. *Child Abuse Neglect*, 2000. 24(9): p. 1127-49.

41. McGuigan W. M, Katzev A.R., Pratt C.C (2003). Multi-level determinants of retention in a home visiting child abuse prevention program. *Child Abuse Neglect*27(4), 263-280
42. McNaughton D. B.(2000). A synthesis of qualitative home visiting research. *Public Health Nurs.* 2000;17:405–414
43. Morrissey – Ross. M (1988).Documentation if you haven't written it, you haven't done it. *Nursing Clinics of North America* 1988;23,363-374.
44. Myers, M (1988).Health Care Nursing – A view from field. *Public Health Nursing.* 5, 65-67.
45. Norman-Murch, T.(1996). Reflective supervision as a vehicle for individual and organizational development. *Zero to Three*, 1996. 17(2).
46. Olds, D. & Gomby D.S,(2000).Update on home visiting for pregnant women and parents of young children. *Current Problems in Pediatrics*, 2000. 30(4): p.107-41.
47. Olds, D. & Kitzman, H.(1993) Review of research on home visiting for pregnant women and parents of young children. *The Future of Children*, 1993. 3(3).
48. Patton, M.Q.(2002).Qualitative Research and Evaluation Methods. 3<sup>rd</sup> Ed California: Sage.
49. Peterson, K.A (2002) .Reflection on the Challenge of program Evaluation. *Early Childhood: Special Edition*.
50. Powell, D.R.(1993). Inside home visiting programs. *The Future of Children*, 1993. 3(3).
51. Phillips JF, Jackson E.F, Bawah A.A .(2003) .The fertility impact of the Navrongo project. Paper presented at: Population Association of America Annual Meeting, Minneapolis, MN.
52. Ramey, C.T.,&Ramey, S.L.(1993).Home visiting programs and the health and development of young children. *The Future of Children*, 1993. 3(3).
53. Ramsdell S.W, Swart J, Jackson J.E, Renvall M.(1989). The yield of a home visit in the assessment of geriatric patients. *J Am Geriatric Soc.* 1989;37:17-24.
54. Sai. F.T (1972). The Danfa/Ghana comprehensive rural health and family planning project - a community approach. *Ghana Medical Journal* 11(1): 9-17. March 1972. .
55. Saucier A. K. (1991). *Perceptive in Family and Community Health*; Mississippi Mosby Year Book

58. Slaughter-Defoe, D. F. (1993). Home Visiting with Families in Poverty: Introducing the Concept of Culture. *The future of the Children*. 3 (3) 172-182
59. Scanameo A.M, & Fillit H.(1995).House calls: a practical guide to seeing the patient at home. *Geriatrics* 1995;50:33-9
60. Spradely B.W. (1990).Community Health Nursing – Concepts and Practice 3<sup>rd</sup> Edition. Foreman and Co.USA.
61. Sory E.K, Jones T.C, Nyonator F.K (2003).Grassroots mobilization to accelerate the introduction of community-based health service delivery in Ghana: strategic assessment of the CHPS program in the central region of Ghana. Paper presented at: American Public Health Association Annual Meeting, San Francisco, CA, 15–19 November 2003.
62. Thompson, L.M. (2001).The Los Angeles County Home Visiting Survey, Unpublished Report. 2000, County of Los Angeles, Department of Health Services: Los Angeles.
63. Tideiksaar R. (1990). Environmental adaptation to preserve balance and prevent falls. *Top Geriatric Rehabilitation*. 1990;5:178-84.
64. Tinkham C.W. and Voorhies E.F. (1977).Community Health Nursing – Evolution and Process. Prentice – Hall Inc. London.
65. Wagner , M (2003). Dimensions of Parental Engagement in Home Visiting Programme : Exploratory Study. *Topics In Early Childhood Special Education* .23 (4) 171-187
66. Wasik, B.H. & R.N. Roberts, (1994). Survey of home visiting programs for abused and neglected children and their families. *Child Abuse Neglect*, 1994. 18(3): p. 271-83.
67. Williams C.A. (1977). Community Health Nursing – What is it? *Nursing Outlook* 25: 250-254

## APPENDIX .A

INTERVIEWER SAYS: In its efforts to improve the health of all Ghanaians, the School of Public Health, Legon, in collaboration with the District Health Directorate – Assin North, is taken this study to assess the home visiting program as a health care delivery tool in this district. This study is intended to guide the Ghana Health Service and the District Health Directorate -Assin North District in particular in designing effective programmes that will best meet the needs of all the residents in this district. I appreciate your time and cooperation and assure you that your responses to the following questions will be kept confidential.

Participant's Consent :

I agree.....

I don't agree.....

### QUESTIONNAIRE FOR HEALTH VISITORS.

Please ask the following questions and indicate the responses accordingly. Direct the questions to him/her alone. Check for evidence wherever possible

INTERVIEWER.....

### DEMOGRAPHIC DATA

RESPONDENT'S NAME / ID.....

AGE.....

NURSING CATEGORY.....

### SECTION A.

(Tick all that apply).

#### USE OF HOME VISITING

1. Have you used home visiting as a health delivery tool in this Sub-district in the last for the past five (5) months?

A. Yes B. No. If No ask why, and stop the interview.

2. Which services do you deliver during home visit?

A. Immunization. B . ANC C. hReferral. D. PNC E. Health Education F. Other

3. How do you document your activities?

A. In my field report book B. Use reporting forms C. Other .....

4. Do you have a note book documenting the activities performed during home visiting?

A .Yes B. No . If No, ask why?.....

5. How does your report on home visiting reach the District Health Directorate?

Through the:

A .Medical Assistant. B. Disease Control Officer C .Public Health Nurse

6. How many clients have you visited in the last five months?

A. one B. two C. three D. four E. 5+

7. Which tool/s do you use to facilitate client assessments?

A. Nursing diagnosis plan B. Observation C. Physical examination

8. Who supervises your field activities?

A. Sub- district Head B. Program head C. Other

9. How many clients have you referred within the last five months?

A. one B two C three D four E 5+

(Check for evidence and state the number)

10. Which health facility did you refer them to?

A .The District Hospital 2. Sub –District Health Centre C. Other .

11. How do you refer patients to the next level?.

A. Use of referral notice B. Verbal statement

12. How do you get feedback on referred clients from the level?.

A. Through the patient B. Health Staff

13 What proportion of the clients utilized the referral facility?.

A. <0.50      B >0.50

14. What is the mode of transportation you use for home visiting?

A . District 4 WD Pick-Up   B. Motor-Bike   C. Other

15. How many hard-to –reach areas there are in this sub-district?

A..1   B. 2   C.3   D.4   E.5   F. +5   G. Don't know

16. What proportion of the hard-to- reach areas have you visited in the last five months?

A. <50%      B >50%

## **SECTION B.**

### **BARRIERS AFFECTING HOME VISITING**

17. What are the barriers affect home visiting?

A. Age   B. Sex   C. Ethnicity.   D. Social Status   E. Language   F. other

18. What makes your option/s a barrier?

A. It obstructs easy work schedule   .   B Difficult to reach people.   C Other

19. How have you tried to limit its effect on home visiting?

A. Talked to the community members .   B. I have informed the DHMT .   C. Other

20. Have you informed your supervisor?

A. Yes   B. No

21. Which other service/s do you like to provide in home visiting. Tick all that applies.

A. Educating   B. Food fair   C. Giving injections   D. Other

22. State the kind of support you receive from the DHMT. (Tick all that apply).

A. Fuel.   B. Cash   C. Vehicle   D. Awards  .

23. Is the support enough ?

- A. Yes B. No

24. Which other agencies support home visiting

- A. District Assembly B. Community members 3. NGOs . D. Other

25. How many times have you been trained on home visiting after your basic nursing training?

- A. Once B. Twice C. More than twice D. None

**SECTION C.  
PERCEPTION OF HOME VISITING**

26. Are you motivated to use home visiting as a health delivery tool in you work?

- A. Yes B. No .Explain your option.....

27. What is your perception of home visiting in your sub-district?

- A. Access is increased . B. People are mobilize C. It is part of my job

28. What is the community perception of home visiting in your sub-district?

- A. Very good B. Good C. Bad Explain your option.....

29. How did you know?

- A. I enquired from the community. B. By research C. Other

30. Which other ways do you perform home visiting?

- A. Outreach B. Supervisory-Visits. C . Durbars D. None. E. Other

31. How do you think a health visitor should be motivated?

- A. Cash B. Leave C. Scholarship D. Citation E. Uniform. F. Other

32. How many times have you been trained on home visiting after your basic nursing training?

## APPENDIX B

### QUESTIONNAIRE FOR COMMUNITY MEMBERS.

NAME / ID OF THE RESPONDENT.....

AGE.....SEX.....VILLAGE.....

LOCATION.....INTERVIEWER.....

**Please, ask the following questions in the respondent's home.**

**Direct the questions to him/her alone. (Tick all that apply).**

1. How long have you lived in this community?

A. > 2yrs    B. >1yr    C.>6months    D. >3months

2. Has a health staff visited your household to deliver service in the last three months?

A. Yes                      B. No

3. Which service/s was provided?

A. Immunization. B. Referral. C.Treatment. D. Education E. Antenatal. F. Post natal care

G. Other..... Tick all that applies.

4. Were you told of its importance?            A Yes.                      B No

5. Were you satisfied?            A Yes                      B. No

6. Will you cooperate with the health staff again?

A. Yes            B. No                      (State reason/s).....

7. Do you know that health staff should visit households to deliver services?

A. Yes                      B. No

8. Which services do you wish to receive at home?

A. Selling of drugs B. Giving of Injection C. Political D. Farming . E other.....

9. Which services do you receive from other health workers in this community?

A. Drug peddlers B. Herbalist. C. Birth Attendants D. Faith healers E. Other

10. Which health problems are prevalent in this community? A. Infectious Diseases B. Body Pain C. Joint Aches D. Headaches E.other...

## APPENDIX C

### QUESTIONNAIRE FOR MHMT MEMBERS

RESPONDENT'S NAME / ID.....

SEX.....

CATEGORY OF STAFF..... (Please ,Tick all that apply)

1. What is your position in the DHMT?

A . Leader B. Secretary. C. Sub –district Head. D Program Head E. Other

2. Have you (DHMT) ever taken decision on Home visiting?

A. Yes B. No

3. What was the decision?

A. Planning B. Supervision . C Funding. D. Disciplinary. E. Other

4. Which form of home visiting is in place in this district?

A. Home Visitation B. Outreach C. Mobile Team D. Targeted.

E. Universal F. CHPS . (Tick all that apply)

5. How does the DHMT support home visiting in the district?

A. Funding. B. Supervision C. Logistics D. Awards E. Advocacy F. Other

6. Where in the district do you like home visiting to be promoted?

A. Health Centre Communities B. Hard –to –reach C. Remote areas D. Bigger

Communities

7. What service/s does the staff provide during home visits?

A. Child Welfare Clinic B. Post natal C. Ante-natal D. Referral E. Continuity of care F. Education G.

8. Which category of staff should use home visiting as a strategy?

A. All the staff B. Community Health Nurses. C. Public Health Nurses  
D. Community Health Officers E. Other

9. Have you supervised a home visiting activity in the last month?

A. Yes. B. No Explain your option.

10. In which community did you supervise the activity? .....

11. How many staff did you supervise?

A.1-3 B. 4-6 C. 6-9 D 10+

12. Do you have documentation on your activities related to home visiting?

A Yes B. No

13. What will you do if a CHPS centre is not using home visiting in its activity?

A. Will train the staff B. Inform the DHMT C. Encourage them to do so. D. Other....

14. What are the benefits of home visit to service delivery?

A. Access increases B. Community ownership is boosted C. Coverage increases

15. When was the last training organized for health staff on home visiting?

A. Last year B. Last six months C. Last three months D. Last month E. Never

16. State a reason for the option to the question above.....

## APPENDIX D

### HOME VISITING CHECKLIST FOR HEALTH VISITORS.

Please, observe the health visitor assess the client. Indicate on the checklist accordingly as an activity is performed. Performance should be measured by assessment of the patient and documenting it in her (the visitor's) note book.

Health Visitor's name.....

Health visitor's ID.....

Investigator's name.....

Time Started.....Time Finished.....

EXPECTED ACTIVITY TO BE PERFORMED BY THE HEALTH VISITOR.	INDICATOR	
	YES	NO
Identifies herself to the client		
Ask Activities of daily living		
Assess Balance and gait problems		
Assess Sensory impairments		
Assess Variety and quality of foods		
Assess Nutritional Status		
Assess Alcohol Presence/use		
Assess Home Environment		
Assess Social Supports		
Assess Financial Resources		
Assess Patient Attitudes		
Assess Medications		
Assess General Physical Condition		
Asses Home Safety		

Assess Health Services		
Assess Spiritual Needs		
Home Health Services		
Summarize to conclude		