

**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**

**FACTORS INFLUENCING UTILIZATION OF COMMUNITY-BASED HEALTH
PLANNING AND SERVICES IN BUNKPURUGU/YUNYOO DISTRICT IN NORTHERN**

REGION OF GHANA

BY

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DECLARATION

I, Abdul-RahamanYakubu, hereby declare that except for other investigations which have been duly acknowledged, this work is the result of my own original research, and that this dissertation, either in whole or in part has not been presented elsewhere for another degree.

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DEDICATION

This piece of work is humbly dedicated to all underprivileged women and children in Bunkpurugu/Yunyoo district, and in Ghana as a whole, to whom the CHPS programme is most useful.

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ABSTRACT

Background

The Community-based Health Planning and Services (CHPS) was adopted in 1999 as a national health policy initiative in Ghana, with the aim of reducing barriers to geographical access to healthcare. The CHPS strategy focuses on rural communities, with the goal of providing primary healthcare supported by a system of referrals across the various levels of care. CHPS relies mobilization of grass-roots action, resources and leadership in promoting quality health care in marginalized communities.

Government and development partners have been investing heavily in the scaling up and community mobilization activities for CHPS nationwide. As a result of that there has been significant increment in the number of Functional CHPS in Bunkpurugu/Yunyoo district. Despite the increased investment in the scaling up CHPS resulting in primary health care services being brought closer to the doorsteps of many more communities and households, there has not been a corresponding improvement in utilization of CHPS in the district. This study was therefore aimed at identifying the health service delivery factors and socio-cultural and economic factors that influence the utilization of CHPS in Bunkpurugu/Yunyoo District.

Methods

This study was exploratory cross-sectional in design. A combination of qualitative data collection methods including Focus Group Discussions (FGD), In-depth Interviews (IDIs) and Key Informant Interviews (KII) were used to obtain in-depth information about participants' experiences and perceptions about factors influencing the utilization of CHPS among community members in the study area. Twelve (12) FGDs were conducted with male and female community members in the study area. Four (4) IDIs and KIIs were also conducted with health workers and the District Health Management Team. QSR Nvivo 12 was used to code data from transcripts of the audio-recordings of discussions and interviews for analysis. The

coded data was transformed into themes and sub-themes by application of the technique of thematic analysis.

Results

Utilization of antenatal and postnatal services provided through the CHPS strategy was hampered by health service delivery factors including inadequate number and skills of Community Health Officers; poor availability of health commodities; illegal charges by community health officers; and ineffective community mobilization and poor accessibility to health insurance. In addition, absence of supervised delivery services in almost CHPS in the district as well as limited availability of curative services under the strategy were perceived as unmet needs of community members that had consequences on the patronage of CHPS.

On the demand side, utilization of maternal and child health services was hindered by poverty as well as unfavourable sociocultural norms that conferred much power on men over their spouses in the control of household resources and decision-making processes. The relegation of male involvement in preventive maternal and child healthcare by these sociocultural norms adversely impacted on the utilization of CHPS by community members.

Conclusion

On overall, the CHPS strategy improved physical access to designated CHPS services, however, other dimensions of accessibility such as the range of services and service readiness; financial accessibility and certain sociocultural norms and beliefs regarding gender roles thwarted the utilization of services of delivered through the strategy in the study area.

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
ASRH	Adolescent Sexual Reproductive Health
CETC	Community Emergency Transport Committee
CHFPP	Community Health and Family Planning Programme
CHMC	Community Health Management Committee
CHNs	Community Health Nurses
CHOs	Community Health Officers
CHVs	Community Health Volunteers
CHPS	Community-based Health Planning and Services
CMAM	Community-based Management of Acute Malnutrition
DHIMS 2	District Health Information Management System
EN	Enrolled Nurse
EPI	Expanded Programme on Immunization
FGD	Focus Group Discussions
fhi 360	Family Health International
FMCP	Free Maternal Care Programme
FP,	Family Planning
GEHIP	Ghana Essential Health Interventions Program
GHS	Ghana Health Service

HAC	Health Assistant Clinical
HSS	Health Systems Strengthening
IDI	In-Depth Interview
JICA	Japan International Cooperation Agency
KII	Key Informant Interviews
KOICA	Korea International Cooperation Agency and the USAID a
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
OECD	Organization of Economic Development
OPD	Out-Patient Department
PHC	Primary Health Care
PI	Principal Investigator
PMTCT	Prevention of Mother-To-Child Transmission
RA	Research Assistant
TBAs	Traditional Birth Attendants
UN	United Nations
UHC	Universal Health Coverage
WHO	World Health Organization
WRA	Women of Reproductive Age

CHAPTER ONE

1.0 Introduction

This chapter covers background information about the CHPS strategy; a statement of the problem that this study sought to investigate; the objectives of this study; the justification for this study and a conceptual framework of determinants of utilization of CHPS.

1.1 Background

Good health is crucial to sustainable economic and social development and poverty alleviation. Poor health perpetrates great hardships on households, including debilitation, financial catastrophe, loss of work and sometimes death. The health status of adults determines their ability to work, and hence impacts on the welfare of the household, including the growth and development of children (Wiru, Kumi-Kyereme, Mahama, Amenga-Etego, & Owusu-Agyei, 2017). Health status indicators are, therefore, undoubtedly, a key measure of the level of development of any nation.

Due to the central role that health plays in the development of nations and the world at large, there has been so much focus on population health improvement by various organizations at various levels; ranging from the community, district, regional, national and international levels. World Health Organization (WHO), with 194 Member States, across six regions of the world, its health policies and programmes mostly serve as sources of policy direction and the guidelines for its member states including Ghana. The policies of WHO are aimed at building a better and healthier future for people all over the world. As a step toward this vision, the WHO made the Alma Ata Declaration of 'Health for All by year 2000' in 1978 that focused on Primary Health Care (PHC). This declaration charged nations to put people at the centre of their healthcare systems by making health services accessible, affordable, and consistent with the cultural context of the people (WHO, 2008). Following the WHO's Alma Ata declaration, many studies have been conducted to identify ways and means to fulfil the declaration,

and evidences from most researches on healthcare access and utilization across the globe demonstrated that hospital-oriented health delivery landscape was unsuitable to delivering the vision of Alma Ata. The evidences from these studies indicated, rather that, a healthcare delivery system that is focused on strong primary care produces better population health outcomes, and even at lower cost (Rao & Pilot, 2014). A comparison of the traditional hospital-based healthcare and primary healthcare oriented systems indicates that the latter is associated with “lower infant mortality, especially post-neonatal mortality, fewer years of life lost due to suicide, fewer years of life lost due to all except external causes and higher life expectancy at all ages except at 80 years” (Starfield & Shi, 2002; Rao & Pilot, 2014).

Research evidence also pointed out that up to 80% of illnesses could be prevented by the combination of good nutrition, and water, sanitation and hygiene (WASH) practices as well as family planning, immunizations treatment of common ailments and injuries (Ghana Health Service, 2016). It was also noted that greater availability of primary care was associated with improved satisfaction with the health care system and decrease utilization of in-patient services in hospitals (Rao & Pilot, 2014).

Based on several evidences it was widely recognized all over the world that the provision of first contact, person-centred, ongoing care over time was crucial in meeting the health needs of people (Ghana Health Service, 2005). However, emphasis was laid on referring to a hospital only health conditions that are too uncommon to maintain competence and coordinates care when people receive services at the lower levels of care (Ghana Health Service, 2005) in order to enhance good health among individuals. In line with the Alma-Ata declaration and based on evidence from Ghana and elsewhere, Ghana adopted the Community-based Health Planning and Services (CHPS) strategy as its primary health care delivery model following impressive findings from studies regarding its effectiveness in promoting accessibility and utilization of

health services as well as the impact it made on health outcomes from experimentation and replication sites in the country.

The CHPS strategy was adopted in 1999 as a national health policy in Ghana, with the aim of reducing barriers to geographical access to healthcare. The focus of the CHPS strategy is mainly on deprived and remote areas of rural districts, with emphasis on transformation of the primary health care system from facility-based and outreach services to a programme of mobile community-based care provided by a resident nurse (Nyonator, Awoonor-williams, Phillips, Jones, & Miller, 2005). The implementation of the policy was based on an experimental trial of the Community Health and Family Planning Programme (CHFPP) in Kassena-Nankana East district in the Upper East Region, popularly known as the “Navrongo Experiment” and a successful replication of the concept in Nkwanta district of the Volta Region. Based on the lessons learned from the Navrongo experiment and the Nkwanta district adoption/pilot project, CHPS was designed “as a community-based service delivery point that focuses on improving partnership with households, community leaders and social groups addressing the demand side of service provision and recognizing the fact that households are the primary producers of health” (Ghana Health Service, 2005)

In implementing CHPS, the health sector provides to community health nurses, supplementary training on primary care services such as immunizations, Family Planning, supervised delivery, antenatal/ postnatal care, treatment of minor illnesses as well education and counselling on good health practices. Following the training, trainees are posted to a CHPS zone to provide door-to-door services (Adongo et al., 2013). “A CHPS Zone refers to a demarcated geographical area of up to 5000 persons or 750 households in densely populated areas and may be coterminous with electoral areas where feasible”(Ghana Health Service, 2016, p.22). CHPS was designed to be the first point of a client’s contact with the health system in the country’s three tiered Primary Health Care system made up of the Community/CHPS (Level A); Sub-

district Health Centre (Level B) and the District Hospital (Level C), which were designed to operate seamlessly to deliver the appropriate quality primary health care services supported by an effective system of referrals to the appropriate levels of care when needed (Ghana Health Service, 2016). There exists a referral system among the various levels of care in order to ensure continuity in care for clients. Patients who cannot be handled at the CHPS level are “referred to a Health Centre, district hospital and regional hospital in that order of upward referral”(Ghana Health Service, 2016 p.8). In addition, the communities in the CHPS zone in consultation with sub-district health team select Community Health Management Committee (CHMC) members and Community Health Volunteers (CHVs) to help the Community Health Officers (CHOs) in their operations, especially in the area of community mobilization and participation, enumerating vital community statistics through surveillance activities.

Since the adoption of the CHPS policy almost two decades ago, various stakeholders such as government, donor partners, politicians, traditional leaders, philanthropists and many others) have shown substantial interests in the implementation of the policy. A lot of these stakeholders have been able to translate their interests into actions leading to a massive scale up of CHPS throughout the country. Across the country, CHPS compounds are being constructed by District Assemblies, Members of Parliament, Philanthropists, and Non-governmental Organizations. Traditional leaders and community members have also often advocated and lobbied politicians and organizations for the construction of CHPS compounds in their various localities. These have collectively led to a rapid scale up of CHPS recently. The (Ghana Health Service, 2016) for instance, indicated that there were “3,175 functional CHPS zones and 1,410 functional CHPS compounds” in the country by the end of 2015(Ghana Health Service, 2016).

It is worth mentioning that the CHPS concept emphasizes “decentralization and adaptation of service strategies to local realities and needs”(Nyonator et al., 2005, p.29). As a result of that,

various districts in the country have implemented CHPS in ways they found suitable to their circumstances. Partly due to that, three categories of CHPS have emerged and have been recognized by the Ghana Health Service. These categories include: Functional CHPS Zone (whereby there is no compound in the CHPS zone and the CHOs stay in the sub-district Health Centre or in a near CHPS Compound and move out daily to the zone to provide door-to-door services by applying a few of the CHPS implementation steps); Functional CHPS Compound (with Compound constructed but without fulfilment of all the CHPS implementation steps); and a Completed CHPS Compound with all the steps implemented). Northern Region is seen as a priority region for the scaling up of CHPS because of the poor health status of its population, especially of women in reproductive age and children, attributable to poor accessibility and utilization of health services among individuals and households. Poor accessibility and utilization of health services in the region is largely attributed to its vast nature with few numbers of health centres and hospitals, as well as poor road network, high cost of and poor transport system, high prevalence of poverty, high level of illiteracy and high prevalence of cultural practices that present barriers to the maintenance good health (MOH, 2014; GSS, GHS & ICF International, 2015).

1.2 Problem Statement

There has been a growing interest by the government and donor partners in the implementation of the CHPS strategy in the Northern Region of Ghana. These organizations are investing heavily in the scaling up and community mobilization activities for CHPS in the region. This, in fact, has led to an increment in the number of Functional CHPS in Bunkpurugu/Yunyoodistrict from 7 in 2014 to 23 in 2017. As a result of that in 2017, the district had 61% of its population living within the catchment of area of Functional CHPS.

Despite the increased investment in the scaling up CHPS resulting in primary health care services being brought closer to the doorsteps of many more communities and households,

there has been no improvement in overall utilization of CHPS. For instance, data from the monthly midwife returns dataset in the District Health Information Management System (DHIMS 2) indicates the Functional CHPS in the district registered only 1,597 (46%) of the 3500 pregnancies expected in their catchment areas in 2017.

It has been noticed in the district that, a lot of individuals living within the catchment areas of CHPS Compounds still seek treatment for minor illnesses and basic preventive services in farther and crowded health centres and hospitals in the sub-district capitals, while the CHPS compounds in the CHPS zones are deserted.

This study, therefore, was aimed at identifying the specific factors that affect the utilization of CHPS in Bunkpurugu/Yunyoo District and to make recommendations to guide future planning and execution of strategies to improve the utilization of primary healthcare services at the CHPS level in the district, which may also be useful elsewhere.

1.3 Objectives

1.3.1 General Objective:

To explore factors that influence the utilization of CHPS in Bunkpurugu/Yunyoo district in Northern Ghana.

1.3.2 Specific Objectives:

1. To explore health service delivery related factors that influence the utilization of CHPS among community members.
2. To identify socio-cultural and economic factors that influence CHPS utilization among community members.

1.4 Research Questions

1. How health services are related factors influencing the utilization of CHPS?
2. What are the socio-cultural and economic factors influencing utilization of CHPS?

1.5 Justification of Study

This study was needed in order to provide a better understanding of the factors that influence utilization of CHPS in the study area. Understanding issues that influence utilization of health services is crucial in health policy analysis, planning and design of client-centred health interventions and health resource allocation to different levels of the health system. In addition, an understanding of issues affecting the utilization of health services is useful in designing assessment tools to measure progress towards the achievement of Universal Health Coverage (UHC) by extension as a means to ensuring equity in the use of health services (Ngugi et al., 2017). Therefore, the findings of this study could serve as a significant resource to the Ghana Health Service, the District Assembly, International Non-governmental Organizations and other organizations that operate (or intend to operate) in the health sector within the district, as it could be used as guide to develop more effective strategies to improve the patronage of CHPS among community members. The findings in of this study may also be useful elsewhere outside the study area, in the district and even beyond.

1.6 Conceptual Framework of Factors associated with utilization of CHPS

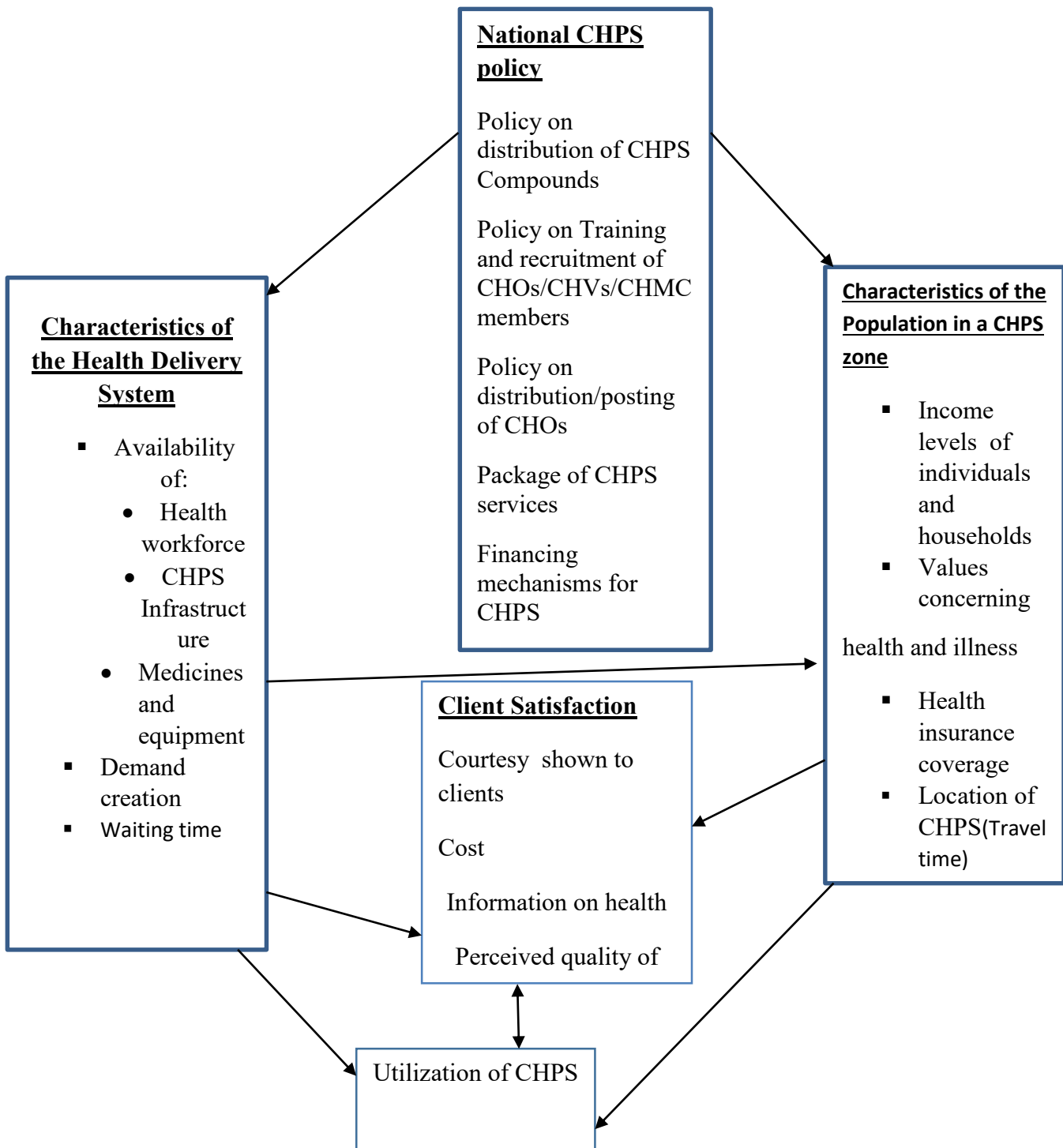


Figure 1. Factors Associated with Utilization of CHPS

Adapted from Lu Ann Aday and Ronald Andersen's "Framework for the study of access"(Aday & Andersen, 1981);and "Framework for Viewing Health Services Utilization by Ronald Andersen and John F. Newman"(Andersen & Newman, 1973).

In figure 1, health policy is often considered as the starting point for the study of access to healthcare (Ehrlich, 1982) and utilization of services. Health policy embodies actions and guidelines that directly affect the delivery system (CHPS) in terms of how it is governed and provides services to clients. These actions and guidelines determine the characteristics of the CHPS strategy in terms of resources and organization of the CHPS strategy. CHPS resources and organization may tend to impact on physical availability of services to community members and hence influence the utilization of CHPS. Also, availability of resources and organization of CHPS delivery system can influence the characteristics of the people in a CHPS zone such their purchasing power, norms and values, ultimately can affect utilization of CHPS. Furthermore, the characteristics of the CHPS delivery system determines how satisfactory the people in a CHPS zone perceived it be, and that goes a long way to affect their patronage of it. CHPS policy is also seen to affect the characteristics of the population in terms of the size of a CHPS zone; purchasing power of individuals/households; and acceptability of CHPS services. For instance, the policy directly affects the purchasing power of community members by removing financial barriers to CHPS services (Ehrlich, 1982) through the National Health Insurance Scheme (NHIS).The CHPS policy also defines the size of a CHPS zone, and this has influence on community members' access to and utilization of CHPS services. The CHPS policy also defines the size of a CHPS zone, and this has influence on community members' access to and utilization of CHPS services. In addition, the policy prescribes community involvement and ownership through the formation CHMCs and recruitment of CHVs in CHPS delivery that is aimed at shaping the norms and values of community members about healthcare, hence improving access to and utilization and satisfaction of CHPS services by

breaking sociocultural barriers to CHPS services. Also, the impact of the changes in socioeconomic and cultural norms among community members may reflect in their entry into the healthcare system. Following their contact with CHPS strategy, their “subjective evaluation of how satisfactory they found the experience of care-seeking in the CHPS strategy to be” can influence their decisions on whether or not to reuse CHPS. In addition, individual experiences with CHPS can form a general community (including individuals who have never even used CHPS) view about its quality (community satisfaction with CHPS) as community members share ideas and experiences, and that affects their utilization of CHPS. The double-headed arrow between utilization and satisfaction in the diagram represents a sequence in which, over time, the patronage of CHPS services is apt to influence a client's satisfaction with the system (CHPS), and in turn, the satisfaction or dissatisfaction he/she experiences from this encounter influences his/her subsequent use of services.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter provides an overview of previous studies on issues concerning the utilization health primary health care services in particular and healthcare utilization in general. Health policy issue some existing health policy issues that are relevant to the research questions in this study have also been presented in this Chapter.

2.1 Health service delivery related factors influencing the utilization of CHPS

Health care delivery system represents the supply side of the health services, and it concerns issues such as the location, availability, cost and appropriateness of healthcare services (Levesque et al., 2013). The health service delivery system is seen as occupying a central role in the utilization of health services by the population that is meant to serve. The existing literature on the influence of the health service delivery factors on utilization of health services are enumerated below.

2.1.1 Physical Access to Health Facility

The most important variable associated with utilization of Maternal and Child Health services is the physical accessibility of these services (Bari & Akhter, 2003). Studies have shown that physical accessibility of health care services, in the developing countries, plays a vital role in utilization of these services (Stock, 1983; Bari & Akhter, 2003). Distance factor is a key concern in rural settings where health facilities are sparsely distributed. In such environments, many clients are likely to embark on the journey for treatment as pedestrians due to scarce transportation services.

In a study in rural Nigeria, per capita utilization of health services was shown to decrease exponentially with distance (Stock, 1983, p.567). In another study in rural Nigeria, it was

observed that rural people tend to depend on self-medication and traditional care closer to their residences in order to reduce their cost of transportation and severity of accessibility to distant healthcare services (Titus et al., 2015).

In Ghana, it was reported that the Northern Region performed poorly in Child and maternal health indicators because of the region's large landmass that service providers had to cover with sparsely located health facilities to provide health services (MOH, 2014). The issues of access routes and inadequate means of transport were directly ascribed to the poor show of the region's performance. In Kumbungu, the District has no car and all the Nanfang motorbikes are not roadworthy. The entire DHMT relied on only one Yamaha motorbike for monitoring and supervision (MOH, 2014).

2.1.2 CHPS infrastructure

In a rapid assessment of CHPS in the Western and Central Regions, about 77% of CHPS compounds were identified to be in a poor state of repair. It was also noticed that some districts commissioned CHPS compounds that could not start operations after several years of commissioning because of lack of equipment. Most of the compounds (about 60%) were poorly equipped and without accommodation for CHOs (MOH, 2014).

In the initial implementation of CHPS, the structure needed for the compound was a simple facility, comprising a room for the CHO's accommodation and another room for clinical services (Ghana Health Service, 2016). However, over the years, the ministry of health of Ghana has observed that a two room facility was not suitable for long-term stay and comfort of the CHOs (MOH, 2014). As a result of that in 2011 new designs were suggested. "The new design consists of two (2) residential units and a clinical area.

Construction of CHPS compounds using different designs and standards at varying costs by different stakeholders in CHPS has been an issue in the implementation of the CHPS concept (Ghana Health Service, 2016). The Ministry of Health observed that the sizes of CHPS

facilities varied from “simple two-room structures to complex facilities the size of some health centres”. The different specifications for CHPS structures made it difficult to equip, maintain and manage these facilities (Ghana Health Service, 2016).

2.1.3 CHPS Financing

In a review of studies on access to healthcare in developing countries, it was revealed that, in most cases, healthcare financing favours the rich in the distribution of public primary care even though this is exactly the type of health care that is supposed to best meet the health needs of the poor (O’Donnell, 2007).

There exist evidences that many richer countries have “used general revenue funded health systems to reduce the discontinuity of care experienced by patients if out-of-pocket payments are required to be made at each point of contact, and by introducing into primary care a strong gate-keeping function to restrict referrals to the more expensive secondary care” (Rao & Pilot, 2014). “The tradition of donor agencies to finance the delivery of targeted health services rather than encourage the reorientation of health systems to establish strong primary care reduces the opportunities for low-income countries to adopt best practice from the richer countries” (Rao & Pilot, 2014).

2.1.4 Availability of Health Personnel

Utilization of health services has a crucial link with availability of health workforce. For example, the Ministry of Health of Ghana reported that in 2011, the Upper East Region made significant improvements in health status indicators. Key to the success of the region was the posting of midwives to the CHPS facilities to perform deliveries. Due to improved staff strength in its CHPS facilities, CHPS in the Upper East Region also provided a substantial part of the OPD services in the Region (MOH, 2014).

Inadequate number of health professionals in remote rural areas has been a serious challenge for public health organizations of many countries (Lori et al, 2012). In a study in Ghana it was

found that, for many final year students of health institutions, aspects of their personal lifestyles de-motivate them from taking up positions in rural areas. Rejections of posting to rural settings was perceived to be based on rural conditions such as “unacceptable housing accommodations, no access to potable water, impassable roads, no access to entertainment, no transportation, poor or nonexistent schools for future children, insufficient lighting and local people who are ignorant and, therefore, do not make ideal patients” and would not make suitable marriage partners (Lori et al, 2012). In addition, the results of a systematic review indicated that preferences of job setting for health professionals may be determine by what kind of living conditions health personnel are used to (Lehmann, Dieleman, & Martineau, 2008). Students who experienced rural upbringing had increased chances of returning to practice in rural communities than those whose geographical origins were non-rural (Lehmann et al., 2008).

A survey in rural Rajasthan (India) found that staff absentee rates were high, contributing to the closure of health facilities during regular hours 56% of the time, and also, without a predictable pattern of opening hours (O’Donnell, 2007). Utilization is lower at centers that open less often. It was revealed that due to the erratic operation hours of public health facilities, clients often bypass them to seek health care in low quality (and sometimes, dubious) private health facilities (O’Donnell, 2007). Individuals bother much more about the availability of care than the effectiveness of the care on offer, and the private sector services appear much more available to clients (O’Donnell, 2007).

The consequence could be neglect of lower level facilities, overload of hospitals as seen here and increased financial burden to clients resulting from high out-of-pocket payments for use of private facilities (Manzi et al., 2012). This may weigh down heavily on the underprivileged in society by increasing poverty through health care cost (Manzi et al., 2012). In order to raise access and client confidence in health service, it is required that there is

constant availability of skilled and committed health workers as well as improved service management (Manzi et al., 2012).

The Ministry of Health of Ghana in its “Holistic Assessment of 2014 Programme of Work”, was concerned that there was no human resource production plan to meet the demand for CHPS scale up (MOH, 2014). The ministry found that in admitting candidates into the ministry’s training institutions, no consideration was given to the real need for the various categories of health professionals in the health sector (MOH, 2014). This resulted in the excessive availability of some categories of health professionals. The ministry noted, that there was excess number of health assistant clinical (HACs) have been trained whereas other categories of health staff are still in short supply. For instance, Northern region exceeded its requirements for HACs (MOH, 2014). The ministry also noted that skewed distribution of health workforce was a major challenge as it resulted in excessive shortages of critical staff in some areas whereas other areas were overstaffed (MOH, 2014).

2.1.5 Pre-service and In-Service Training of Primary Health Care Providers

In Ghana, the guidelines for CHPS implementation states that Community health volunteers should be recruited by Community Health Committees, and provided with a 6-week course in community health mobilization, tailored towards promoting family planning and reproductive health among men (Nyonator et al., 2005). For a district to make use volunteers to family planning services, it is required that the volunteers and the Community Health Committee be given training in pharmaceutical procurement and volunteer programme management (Nyonator et al., 2005).

A study in Sierra Leone revealed that rural health workers lack supportive supervision from their immediate superiors making them to develop a sense of feeling detached from the health service delivery system (Wurie, Samai, & Witter, 2016). The study further reported

that, health workers posted to rural health facilities took up leadership roles but were not supported or trained with the required skills to enable them function effectively in their managerial roles.

2.1.6 Range of services available in CHPS

A study in thirty-four countries has shown that the “range of services provided within primary care is positively associated with patient perceived quality of care”(Schäfer, Boerma, Schellevis, & Groenewegen, 2018). In addition, broader range of services provided within a primary health care programme is found to be related to better health outcomes for clients (Starfield, Shi, Macinko, Starfield, & Shi, 2005; Kringos, Boerma, van der Zee, & Groenewegen, 2013). In the Navrongo experiment that gave birth to CHPS, CHOs provided immunization services, family planning, supervising delivery, antenatal/postnatal care, treatment of minor ailments and health education (Nyonator et al., 2005). Also in Vietnam, the lowest health care level known Commune Health centre (CHC) services provided at that level included: “family planning, antenatal care, STI diagnosis or treatment excluding HIV, services for TB, services for malaria, NCDs management, and minor surgery” (Van Huy et al., 2018).

2.1.7 Availability of medicines and equipment

Inadequate availability of essential medicines remains a challenge in developing countries. Almost half of the population on the African continent, lacks consistent access to essential drugs (World Health Organization, 2004; Vledder, Sjöblom, Friedman, Yadav, & Ross, 2015)

Availability of essential medicines in health facilities in Ghana has continuously been below the reference median and mean availability of essential medicines(WHO, 2010). The median availability of essential medicines for LMICs is 56% and Ghana has been reported to have 17.9% in public health facilities and 44.6% in private facilities (WHO, 2014). Data required

for estimation of essential medicine availability remains low and sometimes unavailable due to lack of monitoring (United Nations, 2015).

It is important for policy makers and implementers to note that when available infrastructure and human resources are used in an appropriate way and are fully utilized, then introduction of additional interventions will need extra human resources, space and equipment to work with (Manzi et al., 2012).

2.1.8 Poor quality of health services

Poor quality of health services is a major problem in many, but not all, developing countries. Facilities open and close irregularly; absenteeism rates of doctors and nurses can be very high (Nazmul Chaudhury & Hammer, 2004; O'Donnell, 2007); staff can be hostile, or even violent to patients; misdiagnosis is not uncommon; medicines are all too often unavailable, sometimes due to staff pilfering for use in private practice (O'Donnell, 2007). Inappropriate prescribing and treatment is also rife in rural health facilities. These deficiencies in quality have direct implications for access to effective health care (O'Donnell, 2007).

Utilization of health services responds to the law of demand and supply, and therefore, if the services provided are perceived by clients to be poor, their demand for those services will diminish. For instance, it has been reported that a “decline in quality of public health care in Ghana was associated with 40% fall in utilization within only five years (1979-1983)” (O'Donnell, 2007). Low quality of public primary health care can result in patients forgoing (“bypassing”) care at the nearest facility and seeking care at a higher level public facility or in the private sector.

In Sri Lanka, the lower the quality of the public primary care facilities, the more likely it is that patients will bypass them (O'Donnell, 2007). There is similar evidence from Pakistan, Indonesia, and El Salvador. Linked surveys of both health care utilization and facilities in a rural Rajasthan (India) find very low use of public health care, despite the fact that there are no

formal charges. The population is mainly using private care. This is in response both to the informal charges levied for public care and its very low quality (O'Donnell, 2007). This is an indication that the supply and demand side issues are crucially linked to together. If the available health care is poor quality, the demand for it will be low.

Adequacy relates to the appropriateness (what services are provided) and quality (the way in which they are provided) of health services and its integrated and continuous nature (Levesque et al., 2013). Clearly, the content and effectiveness of health services and goods one has the opportunity to utilise matters (Murry & Evans, 2003). Opportunity to utilise only services of poor quality in this sense is seen as restriction of access to health care (Levesque et al, 2013). Studies have also shown that quality of health services depends on the planning and management of health interventions. Implementation strategies such as good governance, maintaining of quality standards and targeting vulnerable groups are critical elements in primary health care (Rao & Pilot, 2014). Unfortunately quality assurance and patient safety issues in primary care has received little attention (Rao & Pilot, 2014). Serious gaps in data and knowledge exist for many regions, particularly for developing and transitional countries (Sheikh, 2014)

2.1.9 Cost of health Services

Studies have demonstrated that expenditure on medicine accounts for the largest component of out-of-pocket expenditure in both public and private facilities. An analysis of the 2003 World Health Survey data collected from 39 low- and middle-income countries showed that on average, medicines represented over 57% of outpatient out-of-pocket expenditure at public facilities and over 45% of outpatient out-of-pocket expenditure at private facilities (WHO, 2010; Rao & Pilot, 2014). Consultation fees were the second largest component, representing on average, 22% of out-of-pocket expenditure at public facilities and 40% of out-of- pocket expenditure at private facilities (WHO, 2010). Recent research indicates that broadened health

coverage with extended risk pooling and prepayments rather than out-of-pocket payments leads to better access to necessary care and improved population health, with the largest gains for the poorer section of society (Rao & Pilot, 2014).

The government of Ghana has the primary responsibility for financing the scale up of CHPS in order to cater for the health needs of the citizenry (Ghana Health Service, 2016). The CHPS policy binds government to allocate dedicated resources for the scaled up operations of CHPS (Ghana Health Service, 2016).

Furthermore, in order to enhance the use of CHPS and services at the higher levels of care services delivered by CHPS facilities shall be free of charge at the point of use (Ghana Health Service, 2016), and hence CHOs and their volunteers have the duty to facilitate the registration of their catchment area populations onto the National Health Insurance Scheme (NHIS).

According to the CHO services expand financial access to health services. The Service revealed that the trust that has been developed between CHO and communities translates into social arrangements that permit mothers to defer payment for health care until extended family support can be arranged. CHPS thereby translates

Ghanaian social customs for sustaining traditional healer services into insurance to be used instead for modern health care financing, gradually setting the stage for the formation of mutual health organizations. Mutual health organizations are under trial in several CHPS districts.

2.1.10 CHPS Policy issues

“Implementation of CHPS is fraught with several policy and systems level challenges” (Ghana Health Service, 2016). There has also been issues of “lack of clear policy direction, unclear definitions and an unending conceptual debate” about how CHPS should operate (Ghana Health Service, 2016) According to the Ministry, “there were also issues in relation to effective leadership and technical direction. Planning and budgeting for CHPS at the national, regional and district levels. Planning as a process at the community level is also not enough” (Ghana

Health Service, 2016) The Ministry also indicated that in 2008 a new terminology "functional" was defined and added to the demarcation of CHPS zones. This definition stated: *'where all the milestones have not been completed... but a community health officer has been assigned and provides a defined package of services to the catchment population, from house to house in the unit area'*. In practice the definition was open to different interpretations (Ghana Health Service, 2016)).

The term 'functional CHPS zone' introduced another confusion among stakeholders in the CHPS. Under the functional CHPS zone label, compounds were no longer a mandatory requirement. Zones were now ranked on a scale of fractional degrees of partial or incomplete depending on how many of the six steps have been completed (Ghana Health Service, 2016). Under the new definition it was difficult to determine precisely what 'functional' meant (Awoonor-Williams et al., 2013).

Among the policy directives in the revised CHPS policy are :

Policy directive 1: Duty of care and minimum package of services

1. Package will include:
 - a. Maternal and reproductive health (emphasizing FP, ANC+, providing relevant information and motivating pregnant women to seek appropriate services including PMTCT and ANC, and to deliver ASRH)
 - b. Neonatal and Child Health services (Neonatal care, EPI, nutrition education and support and Growth monitoring and promotion, Community Integrated Management of Childhood Illnesses, and other child health issues)
 - c. Management of minor ailments according to national protocols for the community level including fever control, first aid for cuts, burns and domestic accidents, and referrals
 - d. Health education, sanitation and counseling on healthy lifestyles and good nutrition
 - e. Follow up on defaulters and discharged patients

2. Information and Surveillance: CHOs will keep records and report regularly according to standard protocols. The reports will include vital events in the CHPS zone and prompt notification of strange diseases or deaths and increased occurrence of known diseases such as diarrhoea, neglected tropical diseases and jaundice.(Ghana Health Service, 2016)

3. Deliveries may not be performed by CHOs. They are expected to refer all delivery cases to a higher level of care. Based on need, the District Director of Health Services may include midwifery services in the package of services for a specific CHPS zone and post a qualified resident midwife to the zone. (Ghana Health Service, 2016. p.23)

4. Where there is already a competent midwife operating in an accredited private maternity home within the zone, such a facility shall be the referral point for the CHPS zone.

5. Any earmarked or project services to be implemented at the community level and financed by any persons, institutions or development partners shall be implemented using the CHPS strategy according to the laid down district guidelines.(Ghana Health Service, 2016, p.24)

The Ghana Health Service (2016) observed that the new services in the revised CHPS policy were constantly layered onto existing ones with supervisors and communities coming to expect an increasing variety and complexity of clinical services to be delivered at the community level using the CHPS strategy. The ministry noted that disease specific programmes saw the CHPS strategy as an opportunity to reach the communities with their programmes. There was also push for CHOs to include deliveries in the package of services to be delivered with the CHPS strategy. Lack of communication and engagement has led to community members not

understanding the “distinction between community-based health service and services at a higher level health facility”(Ghana Health Service, 2016). Communities expect a facility to be able to deliver clinical care when required.

2.1.11 Leadership and governance

The National CHPS policy mandates the District Director of Health Service (DDHS) to take the overall responsibility for guiding service delivery in the CHPS zones in the district. He or she is also charged to report on CHPS to the Chief Executive of the District Assembly to ensure good governance in the strategy.

The CHPS policy also stipulates that the “District Chief Executive shall in collaboration with the District Director of Health Services commission annual reviews of progress in CHPS implementation in the district and make the report available to be discussed by the District Assembly”(Ghana Health Service, 2016). In addition, “the report and recommendations of the District Assembly shall be made available to the Director General of the Health Service and the Minister of Health by June of the reviewing year”(Ghana Health Service, 2016).

At the CHPS zone level, the CHMC, made of CHOs and representatives community members (preferably opinion leaders) oversee the development and implementation of annual Community Health Action Plans (CHAP) and also supervises CHVs. They are the committee works to facilitate community mobilization and also to see to the welfare of CHOs in the community (Ghana Health Service, 2016).

2.1.12 Monitoring, Supervision and Evaluation

According to the World Health Organisation (WHO, 2010), an increasing number of stakeholders, including global health partnerships, bilateral donors, UN agencies, and academic institutions, are involved in health-related monitoring and evaluation (M&E) activities. These activities include the “financing to strengthen monitoring and evaluation systems and the

development of frameworks; standards; tools and methods for data generation; collection; compilation; analysis and dissemination” (WHO, 2010). The World Bank and the WHO, for instance, have developed strategies for health systems strengthening (HSS) and M&E of HSS implementation (WHO, 2010). The two organizations emphasize the advantages of harmonised approaches to HSS M&E which include reduced transaction costs, increased efficiency and diminished pressures on countries. Monitoring and evaluation is, therefore, an essential component of the health service delivery programmes and should not be overlooked by any organisation implementing a health-related programme.

In Ghana, the Ministry of Health and Ghana Health Service see monitoring and supervision of CHOs as key to the effectiveness of CHPS. As a result of this the ministry stipulated that CHOs should receive regular supervision from subdistrict leaders or from the DMHT in case where (Ghana Health Service, 2016). In addition, medical officers in the District Hospital have the responsibility to provide regular mentoring and coaching to subdistrict and CHPS facilities (Ghana Health Service, 2016).

2.2 Sociocultural and economic factors associated with utilization of health services among community members

A community is defined as a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings (MacQueen, Mclellan-lemal, Metzger, Kegeles, & Francisco, 2002).

2.2.1 Community participation in health service planning and delivery

The CHPS programme by its initial design requires social capital from communities for construction, service delivery and programme oversight (MOH, 2011). CHPS aims to provide essential primary health care services and health education within CHPS zones by planning and delivering health services with community members. The programme therefore places much emphasis on community participation in its activities requiring the involvement of key

partners from the community such community volunteers, community health committees and traditional health care providers including native doctors, Traditional Birth Attendants (TBAs) and herbalists (Johnson et al, 2015).

2.2.2 Influence of cultural beliefs and norms on health service utilization

Acceptability of health services relates to cultural and social factors determining the possibility for people to accept the aspects of the service (e.g. the sex or social group of providers, the beliefs associated to systems of medicine) and the judged appropriateness for the persons to seek care (Levesque et al, 2013). They observed that in a certain society casual physical contact between unmarried men and women would reduce the recognition and use of care by women if health service providers are mostly men (Levesque et al., 2013). It may be that some services are inequitable in the way they are organized, making them unacceptable to some sections of the population that they are intended to serve. According to them, the ability to seek health care to a large extent depends on the autonomy and capacity of person to choose to seek care. Knowledge about health care interventions available coupled with an individual's freedom determines the persons willingness to seek health care (Levesque et al., 2013). It has been established that low demand for health interventions often attributed to deep-rooted attitudes that mostly reflect the culture and social norms of society (O'Donnell, 2007). However, the fact that use of indigenous medicine generally decreases with income and education suggests that social norms are not unbreakable (O'Donnell, 2007)). Loyalty to norms is mostly influenced by the socioeconomic environment of an individual or household.

Gender attitudes and roles are particularly important elements of health seeking behaviour. Increasing access to maternal, reproductive, and child health interventions has been a major challenge within societies that restrict the public lives of women (O'Donnell, 2007). Again, the social is not completely divorced from the economic. There is evidence from Indonesia that the utilization of prenatal care increases with the control a woman has over household

resources(O'Donnell, 2007). Causality is a moot point. In Africa, women make more use of public health care than men in the highest income group but the gender bias is the opposite in the lowest income groups (O'Donnell, 2007).

In Ghana, involvement of men in family planning programmes at the CHPS level has been recommended, considering the fact that most men in developing countries tend to be abrasive towards FP and contraceptive use (Adongo et al., 2013). The patriarchal nature of most African societies often put men in a dominance position over women. The power that men have as a result social norms often transcends all spheres of life including maternal and reproductive health decisions (Adongo et al., 2013). A study in Nigeria elaborated that women are expected to kowtow to men when it comes to matters affecting their reproductive rights and their ability to take decisions on contraceptive use and birth control (Nwokocha, 2007).

Owen (2007) in a systematic review of studies on health service access and utilization in developing countries, noted that because of gross underutilization of effective health care, there exist large unrealized health gains in developing countries. He observed that child deaths could be cut by 63% worldwide if coverage rates of effective prevention and treatment interventions were to increase from current levels to 99%.

A multitude of factors is responsible for these missed opportunities to realize major gains in population health(O'Donnell, 2007). On the demand side, cultural and educational factors may obscure the recognition of illness and the potential benefits from health care, while economic constraints may suppress utilization, even if benefits are recognized (O'Donnell, 2007).

In a study of the implementation challenges associated with the implementation of the Prevention of Mother-To-Child Transmission (PMTCT) of HIV/AIDS, it was identified that low male involvement was one of the barriers to the implementation of PMTCT services (Osei, Fosu, &Der, 2016). Their study suggested that , “a household head, who is usually a husband, greatly influences the woman’s ability to seek health care, and implement health

practices and interventions” (Osei et al., 2016). Based on that finding, they (Osei et al., 2016) recommended that involvement of males was crucial to successful implementation of health programmes.

They also made an observation that care for pregnancy is as the duty of women, and it was perceived to be so weird for a man to accompany his wife to a health facility. They noted that it was considered socially demeaning for a man to visit a health facility with his pregnant wife to be part of PMTCT services (Osei et al., 2016).

2.2.3 Perspectives about illness/health

A review study has indicated that the recognition of illness and the potential benefits of treatment are prerequisites for health care demand(O’Donnell, 2007). He stated that “where a large proportion of the population is in poor health, this becomes the norm and illness is not easily recognized”. If treatment coverage is low, there is less opportunity to learn of its benefit. The unfortunate outcome can be the continued toleration of illness and disease (O’Donnell, 2007).

In a study of access to health services in rural Ghana, it was realised that although the acceptance of family planning methods among community members was high, only small proportion(21 percent) of users practised the usage of contraceptives as prescribed to them, while majority (79%) of family planning users were inconsistent in terms of usage and did not follow the routine visits as prescribed by the service providers (Sulemana & Dinye, 2014).

CHAPTER THREE

METHODS

3.0 Introduction

In this chapter, descriptions of the study design, the study area as well as the methods, data collection tools, and techniques employed in this study have been outlined. In addition, this chapter also highlights the justification for the use of those methods, tools and techniques in this study.

3.1 Study Design

This study was exploratory cross-sectional by design. A combination of qualitative data collection methods was employed in this study to obtain from the various participants in-depth information on their views about CHPS and what influenced their use or disuse of services provided under the CHPS strategy the point of data collection. Details information about the methods has been provided in the Data collection methods section of this Chapter.

3.2 Study Area

The study was conducted in Bunkpurugu/Yunyoo district in the Northern Region. Bunkpurugu/Yunyoo district is one of the twenty-six districts in the Northern Region. It shared boundaries with Garu-Tempene district in the Upper East Region to the North and the Republic of Togo to the east. It is bordered to the west by East Mamprusi and to the South by Gushegu, Saboba and Chereponi Districts. The district had an estimated total land size of 1,257 square kilometres.

Bunkpurugu is the capital town of district. The District Assembly, headed by the District Chief Executive, was the agency that coordinated the activities all decentralized departments (the District Health Directorate inclusive) in the district. The predominant tribes in the district included Bimoba, and Konkombas. These two major tribes in the district were, generally,

spatially divided along the northern and southern parts of the district with a few settlements of Mamprusis sandwiched between communities in each of these two major ethnic Areas. The languages of the two major ethnic groups (that is Likpangkpan by Konkombas and Moah by Bimobas) were the widely spoken languages in the district. The inhabitants in both Cultural Areas were mostly peasant farmers and petty agribusiness persons. The projected population of the district for 2018 was 146,565 spread over 262 communities. It was estimated that 86% of the population of the district lived in rural communities (GSS, 2013). In terms of literacy in English language, the district had 31.5% which was the highest in the Northern Region (Cudjoe, Azure, Assem, & Nortey, 2013). However, the distribution of literate population was uneven with high disparities between the ethnic groups. Whereas literacy among Bimobas was high, that of the Konkombas was at the other extreme of very low literacy in English language. The total fertility rate in the district was estimated to be 3.77 children per woman aged 15-49 in 2010 (GSS, 2014).

The district was made of five sub-districts with the Konkomba dominated Area covering 2 subdistricts while the remaining 3 subdistricts were inhabited mainly by Bimobas. The table below gives details about the population and facility distributions in the district.

Table 1. Distribution of Health Facilities in the district

Sociodemographic Characteristics	Bimoba Area			Konkomba Area			District
	Bimbagu CHPS	Kambatiak CHPS	Entire Bimoba Cultural Area	Mozio CHP3S	Temaa CHPS	Entire konkomba Area	
Population	9,451	5,255	89, 653	2,898	2,723	56, 912	146,5 65
Number of Functional CHPS Compound	1	1	5	1	1	4	9
Number of Functional zones (with compounds not yet in use)	0	1	4	0	1	3	7
Number of Functional zones (without Compounds)	2	0	4	0	0	3	7
Number of Health Centres/Clinics	0	0	3	0	0	3	6
Number of Hospitals	0	0	2	0	0	0	2

Number of CHNs	1	1	12	1	1	7	19
Number of CHNs in CHNs in trained as CHOs	0	0	0	0	1	2	2
Number of ENs	5	2	48	1	2	13	61
Number of Active CHVs	18	16	107	6	17	97	204
Number of Active CHMC members	8	7	86	11	9	64	150
Number of Staff Nurses/Nursing officers	0	0	15	0	0	3	18
Number of midwives	1	0	9	0	0	3	11
Number of Physician Assistants (PAs)	0	0	5	0	0	0	5
Number of medical officers	0	0	4	0	0	0	4

Note: CHOs in Bimbagu CHPS had additional responsibility of operating two other Functional CHPS zones with a total population of 14,863 for the three CHPS zones; Kambatiak CHPS had the responsibility running an additional Functional CHPS with total population of 7,387 for the two CHPS zones; and CHOs in Temaa were also in charge of an additional CHPS zone with a total population of 4, 330 for the two CHPS zones.

Total number of Health professionals in Bimoba Area=93

Total number of health professional in Konkomba Area=26

3.4 Study Population:

Focus groups for the study were drawn from young adults (separately for males and females) aged 19-25 years, older adults (separately for male and female) aged 35 years or above, pregnant women, and mothers of children aged less than five years from the two Cultural Areas in the district. In this study, young adults referred to persons aged 19-25 years and persons aged 35 years or more were considered as older adults. It is worth stating that community members aged between 25 and 35 years were also important stakeholders in CHPS, but due to inadequate resources, the principal investigator had to prioritize and involve those at both extreme ends of that particular age group. The decision to choose the adult age groups 19-25 and 35 or above over those aged between 25 and 35 years was based on the need for adult subgroups who were likely to have much different lived experience from the other. Hence the decision to select adult subgroups that were 10 years apart. One FGD was held with each of the population subgroups (mentioned above) in each of the Cultural Areas. In addition, interviews were conducted with one CHV, CHMC member, CHO, and a DHMT member. It is worth mentioning that participation of community members in this study was limited to communities within CHPS zones with Functional CHPS Compounds (Functional CHPS zones without compounds were not involved). These stakeholders were included in the study based on the fact that analysis of

the relationship between health services and health service utilization requires data from both health service providers and their target beneficiaries in order to capture both the service environment and that of community members (Wenjuan Wang, Rebecca Winter, Lindsay Mallick, Lia Florey, Clara Burgert-Brucker, 2015).

3.5 Sample size

A total of 105 individuals participated in this study including 101 FGD participants, 3 IDI with a CHV, CHMC member and a CHO, as well as 1 KII with a DHMT member. It is worth stating that this sample size was not meant to be a representative sample of the population, because “sampling in qualitative research is not to generalize but rather to provide a rich, contextualized understanding of some aspect of human experience through the intensive study of particular cases”(Polit & Beck, 2010).The Details of FGD participants are contained in Table 2

Table 2. Composition of Study Participants

Subgroup	Bimoba Area	Konkomba Area	District Health Directorate	Total
Young Adult (Male)	9	9	0	18
Older Adult (male)	8	8	0	16
Young Adult Female)	8	8	0	16
Older Adult (Female)	8	10	0	18
Pregnant women	9	8	0	17
Mothers of children aged less than 5 years	8	8	0	16
CHV(IDI)	0	1	0	1
CHMC member (IDI)	0	1	0	1
CHO(IDI)	1	0	0	1
DHMT (KII)	0	0	1	1
Total				105

3.6 Selection of FGD participants.

The district was divided, based on the major tribes in that area, into two Cultural Areas namely Bimoba Area and Konkomba Area. Four of the five sub-districts in the district participated in the study including two of the three sub-districts in the Bimoba Area and the two sub-districts

from the Konkomba Area. One Functional CHPS zone (with a compound) was selected from each of the four selected sub-districts. Three communities were then selected from each of the selected CHPS zones to participate in the study, implying that 6 communities from the Bimoba Area and another 6 communities from the Konkomba Area. The FGDs with various subgroups were held in the selected communities in each Cultural Area.

Both random and non-random sampling techniques were employed in the data collection: First, Simple random Sampling technique was used to select two (2) subdistricts from the three (3) subdistricts in the Bimoba Area for the study. In the random selection process, the names of the three sub-districts were written on separate pieces of paper, and each paper folded into a ball-like object. The 'balls' bearing the names of the sub-districts were put together in bowl and stirred thoroughly. Then two different individuals other than the person who prepared the ballots (balls) were made to select one ball each, and the subdistricts whose names were contained in the selected balls were chosen for the study. For the other Cultural Area (Konkomba Area) which was made of only two subdistricts, both subdistricts were automatically selected for the study. Then, in each of the 4 selected sub-districts, one Functional CHPS compound was selected randomly (using the same procedure for the sampling of the sub-districts as described above) or purposively depending on the number of Functional CHPS Compounds in the subdistrict. If in a selected subdistrict there was more than one Functional CHPS compound, simple random sampling was used to select one CHPS compound for the study. However, in a situation where there was only one Functional CHPS compound in a Sub-district, that compound was automatically selected. To select the 3 communities from each CHPS zone, a list of the communities in each of the selected CHPS zones was obtained from the DHMT and used to select the communities for the study. In the selection of communities in a CHPS zone, the names of all the communities in the catchment area of that CHPS zone was written on small pieces of paper, then folded into a ball-like object

as and balloting used to select 3 communities as described earlier in this subsection of Study Methods. Through this means, 6 communities were selected from each of the Cultural Areas. The six(6) population subgroups of study were then randomly assigned among the six (6) selected communities. The random assignment involved writing a community-subgroup pair on pieces of paper and using the lottery technique to assign subgroups to the communities. Each community had six entries consisting of the community name and each of the 6 subgroups (that is, community-subgroup pair such as Bimbagu-Young adult Males, Bimbagu-older adult Males, Bimbagu-young adult females, Bimbagu-older adult females, Bimbagu-pregnant women, and Bimbagu-Mothers of children under-five on separate pieces of paper folded as balloted). In all there were 36 entries for the selected communities in a Cultural Area. The first six draws that produced distinct community-subgroup pairs were considered, such that if a community was selected for a particular subgroup, no other community subsequently selected with the same subgroup was considered. Therefore, only the first, six draws that produced distinct community-subgroup pairs were selected for the study.

Participation in the study was limited to individuals in the above mentioned population subgroups who had been resident in the selected community continuously in the last two years before the commencement of this study, and therefore, purposive sampling was used to select participants from communities: that is, a lead person from the community was engaged to help the Research Team identify (8-10) qualified participants of each of the population subgroups to participate in the study.

3.7 Selection of IDI and KII participants

Selection of IDI respondents was done after the selection of CHPS zones and communities for the FGDs. In order minimize bias and to ensure that IDI participants cut across the Cultural areas, random selection and random assignment techniques were used. Firstly, three of the 4 CHPS under study were randomly selected for interviews with a CHV, a CHO, and a CHMC

member. The process included random selection of the 3 CHPS from the 4 CHPS already selected for the study and then the three different CHPS stakeholders (CHV, CHMC member and CHO) were randomly assigned to the three CHPS for IDIs.

Furthermore, one of the 3 study communities in the CHPS zone that had been designated for CHV interview was then randomly selected for interview with the CHV for that community. The random selection and random assignment procedures were carried out as described earlier in the selection FGD participants.

3.8 Data Collection Methods

The study used FGDs, IDIs and KIIs to gather primary data from participants as described in details below:

3.8.1 Focus Group Discussion:

FGD was employed to obtain perceptions of community members about issues that affect their use of CHPS. This technique was used for the communities for the main reason that it has strength over other qualitative data collection methods (namely, individual interviews) in gathering perceptions and opinions of several respondents simultaneously and systematically (Atuoye et al 2015; Babbie, 2011) in informal and unstructured setting, which promotes participation and interaction (Atuoye et al, 2015; Yin, 2009; Wong, 2008).

Further, focus groups were purposively drawn to create separate harmonious groups young adults (separately for males and females), older adults (separately for male and female), pregnant women, and mothers of children aged less than five years to enhance participation of group members and also ensure that gender, age and special needs groups (of pregnant women and mothers and their children) undertones were captured (Bender&Ewbank,1994; Atuoye et al, 2015). Ultimately, FGDs are grounds for peer learning as debates and intense interaction on varied individual perceptions and opinions settle down to consensus group opinions and

perceptions, serving as a form of education in several respects and truly becoming the prototype of society (Atuoye et al, 2015).

In all, 12 FGDs were conducted with young adults (separately for males and females), older adults (separately for male and female), pregnant women, and mothers of children aged less than five years. In this study, young adults referred to persons aged 19-25 years and persons aged 35 years or more were considered as older adults. It is worth stating that although in the study persons aged between 25 and 35 years were also older adults, the need for participants who had much different lived experience from those aged 19-25 made the study team to include only adults who were at least 10 years older than the young adults aged 19-25. One FGD was held with each of the population subgroups (mentioned above) in each of the Cultural Areas. Each FGD was made up of a minimum of 8 and a maximum of 10 people. Each FGD lasted between 45 minutes to 1 hour. FGDs were conducted by two Research Assistants (RAs). During an FGD, one of the RAs moderated the discussion while the other one took field notes on the discussion. The notes were taken to serve as backup in case the recoding failed. The field notes also contained important observations made during the discussion. To ensure confidentiality of participants, each participant was assigned a unique number instead of using their names. The group discussion helped to provide normative information about the research problem. Again, FGD was used because it was considered a good technique for an inquiry into the knowledge, perspectives and attitudes of people about the problem under investigation and to seek explanations for their behaviours regarding the issue under investigation (Wong, 2008).

3.8.2 In-Depth and Key informant interviews

Three (3) In-depth Interviews (IDIs) were conducted with CHOs and a CHMC (Community Health Management Committee) member of a Functional CHPS Compound. A member of the District Health Management Team (DHMT) also participated in this study as a Key Informant.

With the help of interview guides, this study obtained in-depth information regarding views of these CHPS stakeholders about the CHPS strategy as well as their experiences and perceptions about what influenced community members to use or neglect CHPS.

3.8.3 Training of data collectors

For each Cultural Area, two Research Assistants (RAs) proficient in both English language and the local dialect of the area were recruited and trained to support the Principal Investigator (PI) to conduct the group discussions and in-depth interviews. That is, two persons proficient in both English and Moah were trained for the Bimoaba Area, and another two RAs from the Konkomba Area who were proficient in English and Likpankpain (the Konkomba language) were recruited and trained to assist in the study. The training covered areas such as the rationale and objectives of the study and qualitative data collection methods and transcription techniques. During the training two RAs from each of the different Areas were made to independently translate the interview and discussion guides into the local language of the Cultural Area that they were to work in. Role-play was done during the training by the RAs during the training to help them have a better understanding of how to ask the questions appropriately in the local language during the actual discussions and interviews. At the end of the training, the two groups of RAs went to their various Areas and pre-tested the guides after which they transcribed the recordings therein. Based on the pre-test the guides were modified to ensure that they were suitable for soliciting information regarding the objectives of the study.

3.8.4 Data collection technique and tools

Interview guides were developed in English language and used to conduct the FGDs, IDIs and the KIIs with study participants. The interviews were conducted in Moah and Bimoba by Research Assistants who have practiced the translation of the interview questions during the standardization/pre-testing of the interview guides prior to the data collection exercise. The guides explored thematic areas such as socio-cultural and other factors affecting the utilization

of CHPS in the study area. Appointments were booked with study participants on their availability, suitable date and time for the interviews.

All FGD and IDI interviews were audiotape-recorded with the permission of the participants.

To ensure quality control, the data collectors were supervised by the Principal Investigator to make sure that the data collection was done accurately. The Principal Investigator was involved actively in the data collection activities.

3.9 Data Analysis

In each Cultural Area, each of the two RAs independently transcribed all six FGD recordings done in the area and the two sets of transcripts. The transcripts contained typed translation of the recorded discussions in English language by each of the RAs. As a way of ensuring reliability of the data in the transcripts, pairs of transcripts from the two RAs in a Cultural Area were compared for consistency, and any differences in the transcripts were discussed with the two individuals until a consensus was reached on a common translation of the sentences involved. The IDIs and KII were recorded in English language, and transcribed verbatim by the principal investigator. The transcripts were then edited by the principal investigator to correct grammatical mistakes. The guided by the study objectives, the PI then scanned through a few of the transcripts to identify common key words or phrases and concepts in them. These key words or phrases were noted and written on a piece of paper. Soft copies of the textual narrative data in the transcripts in Microsoft format were then imported into QSR Nvivo 12 in appropriately labelled files namely: “FGDs” (containing all the transcripts from FGDs); “IDIs” (containing all the transcripts from the IDIs); and “KII”(containing the transcript of the KII).In the coding process, nodes were created and labelled with the key words or phrases identified earlier. In these nodes labelled with the key words, similar units of text from the transcripts were put together in a pile. To code the textual data in the transcripts, the PI opened the

transcripts in Nvivo, one after the other, and read through them to identify any sentences or meaning units that gave the PI an impression of a being related to a particular code in the nodes. Through this technique, relevant segments of the textual data were highlighted and dragged into various nodes that they were related to in terms of meaning. In the coding process, the key words (codes) were modified iteratively in order to ensure that they were relevant to the study objectives and directly reflected the views of participants as captured in the transcripts. This procedure represented the initial coding of the data. After the initial coding, the coding process was repeated in order to check the codes for consistency, in terms of the codes put under each node. Under each node, any differences between the initial coding and the second coding were noted and the transcripts and coded data were re-read to gain more understanding of that text and to code it under the appropriate node.

Using the technique of thematic analysis, patterns of meanings within the coded data were identified and transformed into themes and sub-themes, by combining some nodes and subdividing other nodes based on the patterns of meanings within the coded data under them.

The PI then finalized the name of each theme, wrote its description and illustrated it with a few quotations from the original text as a finding from the study.

The transcripts were classified based on variables such as cultural area (Konkomba Area or Bimoba Area), gender and age group (older adult male/female or younger adult male/female), pregnant women, or mothers of children. These variables were captured in the NVivo software as attributes. This technique helped the PI to interpret and compared views expressed by the various population subgroups in the study by running queries based on these attributes. The major and sub-themes were then discussed in the results section, supported by relevant quotes from the transcripts.

3.10 Presentation of Results

Following the analysis of data obtained from the discussions and interviews as described in the data analysis section above, the results were presented based on the major and sub-themes, and supported by relevant quotes from the transcripts. Also, the study findings were discussed by reporting the incidence of codes that represented factors that had influence on the utilization of health services by comparing and contrasting the findings of this study with those of previous studies and other existing literature on the themes, has been outlined in Chapter five of this dissertation.

3.11 Ethical Approval

The protocol for this study was approved by the Ghana Health Service (GHS) Ethics Committee (with ethical Clearance Number: GHS-ERC066/02/18) before the commencement of the activities of the study. Written Informed Consent obtained from study participants prior to their participation in the FGDs and in the interviews. In addition, before the commencement of FGDs, KII and IDIs, consent was sought from participants before audio-recording and notes taking of any discussions/interviews.

In addition, the study participants were told about the purpose of the study, the objectives of the study and their rights as respondents. They also informed about any risks, discomforts, benefits, and the right to refuse or withdraw from the study anytime they wanted to without suffering any consequence. They were informed that participation was strictly voluntary.

Participants were informed that they were not to receive any direct benefits for participating in this study. They were also informed that the study was purely for academic purposes, and that it might, however, be useful to some stakeholders who might wish to improve the health situation in the district through the CHPS concept.

Furthermore, participants were assured that adequate measures were put in place to keep their responses confidential. These measures included: first, no identifying information of respondents were captured in the transcripts. Second, in presenting the findings, only the sex of the participant and a general description of his/her community based on the two categorization used in this study (“Konkomba Area” or “Bimoba Area”) were used. Only the research team (the PI, the two RAs and three language experts, and the Research Supervisor) had access to the data collected. They also informed that any tapes and transcripts of the focus group and interviews would be destroyed at the end of the study to prevent any possible leakage of the recordings. Also, while the process of analysing data obtained from the participants, all recordings were strictly accessible to the research team only to prevent any possible use of information on them by a third party to identify any participant. In effect, data was stored in an encrypted folder on my password protected laptop. Only the research team had access to study data. No identifying information was used in this dissertation. Also, there would be not be any identifying information in any subsequent presentations or publications based on this research.

3.12 Limitations of this study

Due to limited resources of money and time available to the Principal Investigator for this study, only one of each of CHV, CHO and CHMC member were involved in the study. The PI noted that conducting IDI with at least one more of each category would have improved the rigour of the study through triangulation of perceptions of these key stakeholders.

A trend analysis of the utilization specific services of CHPS in the two cultural areas would have provided a better understanding of the effects of the identified factors on the utilization of various CHPS services. However, due to insufficient time and data errors in the District Health Information Management System (DHIMS 2), that could not be done.

Furthermore, member checking was done only for the CHO and the key informant. Due to time constraint, validation of interview and discussion reports was not done by the other IDI respondents and the FGD participants.

CHAPTER FOUR

RESULTS

4.0 Introduction

4.1 Factors Influencing the Utilization of CHPS

This study was conducted to explore factors that influence the use of CHPS by community members. The study was specifically intended to explore health service delivery related factors as well as socio-cultural and economic factors that influence the utilization of CHPS among the study population. In this study, the study area was divided into two Cultural Areas, Bimoba Area and Konkomba Area, representing the two main ethnic groups in the district. This stratification was done in order to identify the specific factors affecting the utilization of CHPS in the respective Cultural Areas since the differences socio-cultural context between the two ethnicities could result in different issues that influenced the patronage of CHPS in the areas.

The results of this study captures the views and experiences of the following stakeholders in the CHPS strategy: pregnant women, mothers of children aged 0-5 years, young adults (both males and females) and older adults (both males and females), a Community Health Volunteer (CHV), a member of the Community Health Management Committee (CHMC), a Community Health Officer (CHO) and a member of the District Health Management Team (DHMT). The composition of the study participants has been presented in the table 2.

4.2 Physical Accessibility of CHPS

The study solicited views from participants on availability of CHPS services in their communities and whether it was easy for them to have access to the services provided at the CHPS compounds and at outreach sites. They explained that through outreach visits by CHPS health staff to their homes and communities for health services provision enabled community members to have access to the services. Similar views were expressed by both health workers

and community members in the interviews. The following quotes from community members and health workers illustrate this construct:

“It’s not far. (Going to) Mozio (CHPS) is like going to fetch fire (from within your neighbourhood). When Mozio was not having (a CHPS compound) we use to go to Gbintiri. You carry your child on your back and go to Gbintiri. Sometimes even Binde (the community hosting the district hospital, which is several kilometres away). When you didn’t sleep well the previous night, you can get up in the morning and get to Mozio before sunrise. If there is no money, then that is when you be sitting down handling your sickness and managing with it. It’s just because of lack of money, but if there is money it’s not far. As for Mozio is not far” (FGD, Mothers, Konkomba Area).

An FGD participant also reported as follows:

“from time to time, Jacob (a CHO) goes round the houses here to look after us. If the women don’t go to weigh the children, he comes here and go round their houses to find out what has happened. There is no path in this community that Jacob hasn’t stepped on” (FGD, older adult, male, Bimoba).

Despite that many of the participants in the FGDs claimed that they had easy physical access to CHPS, the coverage of CHPS in the district, according to few participants, was poor. They perceived that so many communities shared the same CHPS, and as such, some communities within CHPS zones were far away from the CHPS compounds. They added that poor road network within CHPS zones; and/or separation of communities by a stream from the CHPS compound or even the nearest outreach point contributed to poor accessibility of CHPS by few communities. Below are quotes from participants that attest to the above claim:

“...one of the communities is Nagbant. Between Nagbant and here, there is a river, and when it is in the rainy season, they can't cross to here, so they normally go to Mozio (CHPS) where they will not cross a river” (IDI, CHMC member, Konkomba Area).

The following extracts from an IDI with CHO indicates that some communities in the CHPS zones still face challenges with physical access to CHPS:

“We are having 18 communities. But we don't carry out outreach in all of them. We have 14 communities that we go to provide outreach services, plus the static one that we do here. We ask some communities join other communities for CWC or ANC..... Because of the number of communities, we go to every outreach site once in a month..... Usually, one staff and two volunteers go. One person will do home visits, the other will do weighing and you the staff you do immunization and health education” (IDI, CHO, Bimoba).

A Key Informant from the DHMT also reported as follows:

“Ideally, we are supposed to have CHPS operating in all the Electoral Areas. There are some Electoral Areas self that are big and requires more than one CHPS. Since we do not have CHPS in all the Electoral Areas, I wouldn't say that physical accessibility to CHPS is adequate. Yes, I wouldn't say that” (Key Informant, DHMT).

Finally, on physical accessibility, there emerged a marked difference in perceptions about waiting time for CWC/ANC services between the participants in the Konkomba Cultural Area and those in the Bimoba Cultural Area. Whereas the frequency of quotes about long waiting time was high among participants from the Bimoba Area, the same issue rarely emerged from participants from the Konkomba Area. In addition, considerable number of codes from the Konkomba Area indicated that the time clients spent at service delivery points before receiving

services was not an issue as clients readily receive services when they reported at these contact points.

The quote below indicates how long waiting time was considered as a barrier to the utilization of CHPS in the Bimoba Area:

“When we come for weighing (CWC/ANC) and there are a lot of children, we have to wait for long, and because of that some people when they come and it’s like that, next time they become reluctant to come (for ANC/CWC)”(FGD, pregnant women, Bimoba).

On the other hand, participants in the Konkomba Area perceived services were readily provided at the service delivery points as contained in the following quote:

“They do it (CWC/ANC) fast. If they don’t do fast it is from us. When we come early, they do it fast. It is when we delay in the house and come late, that is when we don’t leave early” (pregnant woman, FGD, Konkomba).

4.3 Economic and Financial factors on Utilization of CHPS

The accounts by participants suggested that economic factors including poverty; cost of transportation; poor availability of health insurance services; high cost of treatment; and unofficial charges for health services by nurses (‘CHOs’) affected the utilization of CHPS by the community members. These subthemes are presented below:

4.3.1 Poverty and lack of regular access to health insurance services

Issues of poverty and cost of using health services were the commonest across the FGDs and the IDIs. The discussants in the study revealed that poverty was a major factor that undermined their use of CHPS. The financial burden of pregnant women and caregivers of new-borns and young children was exacerbated by poor availability of health insurance subscription services. Participants, mostly from the more rural Konkomba Area revealed that they had no regular

access to NHIS registration within their reach, and the cost of acquiring membership elsewhere was prohibitively expensive to them. Participants indicated that as a result of the difficulties involved in acquiring NHIS subscription, a lot of people in the area had no active membership of the scheme. Participants also mentioned that the NHIA registration outlet in the area whenever it was operational, always demanded that spouses of pregnant women must have active NHIS membership before they could be registered for the free maternal health insurance cover, and that excluded some pregnant women from benefiting from the policy. The quotes below illustrate the above issue:

“You know somebody may have money to take care of the wives and children, but other people are there, when he wakes up in the morning, he has woken up, he has nothing, and he doesn't even think about his wife or child”. (IDI, CHV, Konkomba).

A pregnant woman also indicated how poverty together with poor accessibility to Free Maternal Care Policy (FMCP) resulting from unofficial policy by NHIA officers obstructed her utilization of ANC:

“The reason (for the delay or non-registration for ANC) is that you the pregnant woman will register free but your husband will pay for himself. If your husband doesn't have active membership, they won't allow you to register for free. And when you tell your husband to go with you to register and he says, he does not have money, you can't go for ANC because, they said “without health insurance, you have to pay money when you come for antenatal care”. So, to come and pay every time there is weighing is difficult for us and that is why we come to register late sometimes. Now, where we go to register (for health insurance) is far: sometimes we go to places like Garu, Gambaga or Bunkpurugu, and there are always plenty people waiting to register. And if you don't have any relative there you can't stay for many days to wait for your turn to register (FGD, pregnant woman, Konkomba).

4.3.2 Transportation cost

Participants reported that many community members often travelled by foot over several kilometres to access CHPS and healthcare in higher facilities. This study revealed that commercial transport was rarely available and unreliable in many communities in study area. Participants also reported that although there was an NGO in the area that provided Tricycle Motors for emergency cases, the coverage and timeliness of the services of the Motor Tricycle Ambulance (MTA) was poor. Therefore, community members mostly relied on the generosity of households that owned motorbikes to seek emergency care in health facilities, which they perceived as helpful but expensive because of the cost of fuel, sometimes, no ready availability of fuel in the communities complicated issues for them. The following quote illustrate this finding:

“For the (ANC) services we want it. But the room that is used to check the pregnant women is our problem. And the motor king too: the motor king (MTA) is very important, but in this community, we don’t get it. When your labour is not prolonged, before they can get a motor to send you, you may give birth at home. When you are in labour you cannot sit on a bicycle too, and some of us our husbands have no motors and you cannot also foot to Yunyoo (Health Centre). They (household members) have to go round the community, and before they get a motorbike, by that time you have suffered. That is the most difficult thing” (FGD, Mother, Konkomba).

Another Mother reported as follows:

“When I was pregnant for three months, I felt some pains. Pains that don’t end, and it was also not labour pain. I asked him (my husband) to look for a motor so that we could go for check-up in Nakpanduri (about 18 km away). When I told him, he was just quiet. So, the next day

which was Nasuan market, I woke up and looked for money and footed until one boy met me on my way, and picked me up with a motor” (FGD, Mother, Konkomba).

4.3.3 Unofficial Charges

One of the recurrent issues among participants from the more rural Konkomba Area was unofficial charges for health services by nurses (CHOs).

Respondents, mostly in the Konkomba Area, reported that the cost of Maternal Health Record Booklet and the Child Health Record Booklet was a determinant of their use of ANC and CWC respectively. However, by government policy these booklets were supposed to be provided for free to clients of ANC and CWC. The following quote from an FGD participant illustrates how Community Health Nurses charge registrants for the ANC clients and CWC clients for services they were supposed to receive for free:

“For collecting the card early, day may break and you don’t have even 50 peswas in your hand. It is money problem. Because there is no money, that is why we delay in taking the (ANC) card. We own the pregnancies, so why should we refuse to go early for the (ANC) card? But because we don’t have money, that is why (we don’t register for ANC early). We are not telling lies. We are saying the truth. If the men (our husbands) will not give us the money what can we do? Or are we going to cut parts of our bodies for money, no. So, because you won’t get the money you won’t go for the card, and they (the Community Health Nurses) will be saying (that) we refuse intentionally to come for ANC. When one woman gave birth here and went for the card (CHR booklet) did she get it? She didn’t get it because she was holding GH¢5.00 and she returned with it. If she was having GH¢10.00, She would have gotten the card. If the man (the CHN) had given it to her, she would have collected it” (FGD, Mothers, Konkomba Area).

A volunteer corroborated the claims by the FGD participants:

“Some of the pregnant women they don’t have money. They say that they are paying Ghc10 , and because of the GHc10, a woman will stay in the house and eventually deliver without attending ANC.” (IDI, CHV, Konkomba).

Another portion of an interview with the same CHV from the Konkomba Area reveals illegal charges by CHOs:

“There is another thing too I want to say, a woman will deliver in the house, and if she comes to collect the weighing card (CHR booklet), she is paying GHc 10.00 for the card. First, they (the nurses) were collecting ten cedis (GHc10.00), but now, they have reduced it to five cedis (GHc5), for the weighing card..... Sometimes, there is one problem too, a man will carry his wife to Nasuan clinic (Health centre) to deliver, and when she delivers in Nasuan, you (the man) will bring her to the CHPS Compound for weighing, they will say that you have to pay and collect the card. You see another problem? The woman delivered in a clinic (Health Centre), meanwhile, we are told that when a woman delivers in a clinic, they will give her everything, but they don’t get all the things, and they will have to go and pay money before they collect it (the CHR booklet)” (IDI,CHV, Konkomba).

Participants also perceived that charges for motivation of CHV impeded weighing of children, especially, those above two years. They reported that charges per child receiving CWC services limited the number of children some caregivers sought CWC services for. Payment for volunteer motivation ranged from 10 peswas to 50 peswas per CWC child client:

“Because of money. As for the children aged between 1 and 5 years, we just don’t send them (for weighing). Sometimes we don’t get informed early enough before the weighing date. So, when they just tell you that tomorrow is weighing, and you may not be having 10peswas at hand, so when you manage to get (money) to pay for the baby’s weighing; you forget (ignore weighing) the older child. You wished to have sent both of them (for weighing) but the money

is not there. On weighing day, you see us fumbling. it is not that we don't care (about the weighing the older children). If we could be allowed to bring them and pay for one and weigh (both), and then pay for the other one later, we will send both of them"(FGD, Mother, Konkomba).

4.3.4 Treatment costs

In addition, the financial cost of transportation to seek health services as well as the cost of treatment (if uninsured) was perceived as a hindrance to the use of health services by communities. A participant of FGD who was unable to renew her NHIS membership and had to go for out-of-pocket payment for healthcare narrated her experience as follows:

"when you go twice or thrice and you don't get (access to renew your Health Insurance subscription), you stop because you cannot be buying fuel for motors to be sending you for than two or three times. Our husbands too are not supportive. When you want to go and register for insurance and you tell your husband, he may tell you that, "if you want to go and register, go on your own". When I was sick and they sent me to Yunyoo, I paid GH¢ 50 on my own. The fare for the motor was also GH¢12 from my hands (pocket)" (FGD, mothers, Konkomba Area).

4.4 CHO Availability

Participants across the various participating subgroups and Cultural Areas reported that CHO unavailability hindered service delivery and consequently affected the utilization of CHPS adversely. This finding is evident in the following quotes from the respondents:

"sometimes the complaint they (community members) give to us is that, sometimes, somebody may go there and will not meet anybody, sometimes they do complain of this. Sometimes they(the nurses) may not be around. It happens sometimes, that all of them (the nurses) are not there, but not so often. At times, all of them may be attending a workshop (outside the CHPS zone). So, these are some of the challenges" (IDI, CHMC member, Konkomba Area).

The above account by the community members was corroborated by a Key Informant from the District Health Management Team in the quote below:

“The challenging area is actually the number of staff we have to provide the preventive services. As we speak now, not all the CHPS zones have Community Health Nurses, not all the CHPS zones. And we have some CHNs providing services in more than one CHPS zone, and with that they are actually unable to provide the services the way we really want it to be.

It looks like the community aspect, going to the houses, visiting the families at home and what not, that aspect is actually not being taken care of properly, and to some extent it’s actually not entirely the fault of the staff (CHOs). One, their numbers! The number of people who can do that work is not enough. So, it becomes difficult for them. Even the home visits that they do it’s not effective because of inadequacy of numbers of CHOs we have. Imagine Sumaila, a Community Health Nurse in Yunyoo, presently taking care of Yunyoo catchment area, Bunbuna catchment area, and Sambik catchment area, he cannot be effective. So, what he does is just outreach, he will just go to the community and immunize children and go back” (Key Informant, DHMT).

4.5 Availability of Infrastructure, Medicines and Equipment and transport

4.5.1 Infrastructure

The views of stakeholders in this study suggested that the availability and nature of CHPs infrastructure were poor. A key informant from the DHMT reported that most of structures put up as CHPS compounds in the district could not allow for the provision of delivery services. He indicated that, although at present the district did not have enough number of midwives to be posted to all the CHPS compounds, even if it got more midwives, assigning them to conduct deliveries in the CHPS compounds would come with serious challenges with

regard to space for labour room. The DHMT key informant's views are captured in the quote below:

“for us to have midwives at the various CHPS compounds, it means that some of structures that we have now will have to be either redesigned or expanded. Because, the structures that were put up, you know, especially here, there was no standard design, so anybody gets up and then put up anything and calls it a CHPS compound, and if you want to add on any services it becomes difficult. I think that getting midwives in the CHPS compound is part of the policy. It is something that is catered for in the policy, but what we need to do is to work on the infrastructure so that we can have midwives posted there, so that they can conduct deliveries there” (KII, DHMT).

4.5.2 Equipment, medicines and vaccines

Participants in this study conceived that, sometimes, the CHPS facilities experienced stock out of health commodities that denied community members access to services anytime such situation prevailed. The shortages of health commodities predisposed some community members to resort to self-medication. The quotes below illustrate this point:

“when we even go to the facility with insurance, they won't give us drugs. They will write (the name of the drug) for you to go and buy from the drugs store. As for the insurance, they will take it but you will not get drugs unless they write for you to go and buy from a drugs store. And as they keep writing to us to go and buy drugs from the stores, we now know the drugs ourselves, so we go and buy from the market without going to the CHPS Compound. Last month I bought 2 syrups they are still in my room. Today too, when the Dagomba boy (a drug peddler) came around, I bought drugs for about five cedis (GHc 5) from him. Anybody that complains of headache they say "aunty give me medicine" and I will give them and the pain ceases. That saves us from going to Tema to buy drugs especially when the children fall sick. I buy the

drugs and keep and when anybody complains of pains, I give them” (FGD, older women, Konkomba).

In the only CHPS compound in the district conducting delivery, the midwife reported about some logistical challenges as follows:

“For instance, when it comes to wound dressing, we don’t have equipment for wound dressing; it is recently we remove some equipment from the labour ward for those (CHOs) in the dressing cubicle to be managing with. Also, where to dispose off those things: there are no dust bins around. Even inside the labour ward, there should have been a dust bin, but there is none. Then liquid soap, savlon, those things, they are not there, and as at now, when you go (to the District Health Directorate) and ask, they will tell you it is not there. Right now, I have my personal items that I work with if a client comes, because I need to protect myself from infections” (IDI, midwife, Bimoba).

A DHMT key informant’s comment below validated the reports of the community focus group discussants:

“We also have challenges with health commodities; drug and non-drug consumables, we have had challenges with vaccines, the logistics to go with vaccines, like solo shots and what have you. We have had challenges in that we ran short of them and when we go to the medical stores, and we are not able to get our requirements. The things that you want to go work with, they are not there; you don’t have enough vaccines, you don’t have enough that. When it comes to the clinical aspect too, it is the same: the drugs are not there. We are supposed to get reimbursement from Health Insurance, and Health Insurance payments too have not been the best” (Key Informant, DHMT).

4.5.3 Transport for Service Delivery

A Key Informant from the DHMT also reported that the inadequate number of functional

motorbikes in district retarded the work of CHOs:

“We have had challenges with transport, motorbikes. You can’t run CHPS successfully without motorbikes in our setting here. Last year, it got a point where four (4) of our CHPS compounds did not motorbikes to run outreach, so the motorbikes that were available in the district, we were then alternating them between CHPS zones (Key Informant, DHMT).

A volunteer (CHV) also suggested that the motorbike used by the CHO for his community should be replaced or properly repaired because frequent breakdown of the motorbike led to postponement of CWC/ANC days:

“The health workers they are having a weak motorbike; you are coming and, on your way, your motor spoils, you will have to go back. It’s not their (CHOs) fault, because you can’t walk to the community (IDI, CHV, Konkomba).

4.6 Service Availability

CHPS stakeholders who participated in this study were of the view that the range of health services provided under the CHPS strategy was inadequate to meet the health needs of community members, and that was said to have impeded community members’ use of CHPS. Participants of FDGs, IDIs and the KII reported that community members sometimes bypassed CHPS compounds in their areas to Health Centres or hospitals elsewhere for health care or depended on other sources of healthcare. Across the various participating subgroups and also commonplace in the two ethnic areas, majority of respondents stated that they were mostly referred to higher facilities when they attended CHPS, especially for curative services, even for minor illnesses as indicated in the following quotes:

“sometimes somebody may come there (CHPS compound) and maybe, the person is supposed to take amoxicillin and then, they (the CHOs) are not supposed to prescribe it, so they will refer them, and sometimes they (clients) will not go, they will rather go to a drug store and just

buy their drugs and go home. And the midwives too, wherever there is a CHPS compound, they should have posted a midwife there so that it will help women in labour, because, our women here are suffering, do you know Gbeduri? Gbeduri is about 14 km from here, and if a woman is in labour, unless they send her to Nasuan (a distance of about 17 km from Gbeduri). Many communities in here are far away from Nasuan Health Centre, so when a woman is in labour, and then they will pick the person on a motorbike up to Nasuan, before they get there, the woman is already tired. So, there is the need we get a midwife around this area”(IDI, CHMC member, Konkomba).

A CHO made the following comment about how the limited range of services under the CHPS strategy affected utilization of CHPS:

“There are certain treatments we don’t give. Antibiotics like this, we don’t give antibiotics. So, when they come, you have to write for them to go and buy, so the next time the person will prefer to go to Binde (Hospital) or Nakpanduri (where there is a hospital and a health centre) instead of coming here” (IDI, In-Charge of a CHPS compound, Bimoba).

A key informant from the DHMT also noted this:

“if we also want to tackle maternal health properly, we have to actually ensure that we have midwives at the various CHPS compounds” (Key Informant, DHMT)

The key Informant also suggested an expansion of the clinical/curative services in the CHPS package, because based on his observation; community members undermined the status of facilities that did not offer adequate curative services. His observation is contained in the following quote:

“so, if they have a facility in their community, no matter the orientation that you take them through, if they don’t see the clinical aspect, then [shaking his head], they don’t really want to

consider it as a health facility. So, my suggestion is that for us to actually succeed in getting our community members to patronise CHPS, we need to probably think of a hybrid system where we have staff (CHOs) in the CHPS facilities who will take care of the clinical aspect as well as the preventive aspect, we have to look at a hybrid. But if we want to actually concentrate on the preventive alone, I don't think we can succeed" (Key Informant, DHMT)

Also, the perception of inadequacy of services under the CHPS strategy and how that influenced the utilization CHPS was noted in the comments of Community Health Volunteer (CHV):

"If any person gets sick, they tell me and I send the person to hospital. Even this month, I sent Wuche's wife to the hospital. I sent her to Nasuan (health Centre). Because if she goes to Temaa (CHPS), they will tell her she should go to Nasuan (Health Centre). So, I just sent her straightaway to Nasuan" (IDI, CHV, Konkomba).

4.7 Demand Creation for CHPS

Another dimension of accessibility to CHPS mentioned by participants was demand creation for CHPS by CHOs. Knowledge about services provided under the CHPS strategy was high among participants in both Cultural Areas and also across the various subgroups. The participants also perceived that community sensitisation activities carried out by CHOs had considerable influenced the utilization their (CHOs) services by households. Below are some quotes from participants that relates to health promotion and education activities to utilization of CHPS services:

"somewhere around the 24th day of every month they used to organize a meeting and teach us a lot about our pregnancy (the participant made reference to the pregnant school component of a maternal health project was piloted by Navrongo Health Research Centre in the CHPS zone) and I can boldly say that those of us who have delivered safely, and for most of them,

their husbands helped them to go to Binde to deliver, so we believe the teaching that we receive from the nurses helps us a lot. When any of us fell sick they will treat the person and still come to our house and pay visit to us” (FGD, pregnant women, Bimoba).

Another participant also observed as follows:

“I heard about it (family planning) at outreach point when the nurse came to do weighing here. She educated us family planning, and I saw that it was good. If I do family planning to stop giving birth, it’s better, because giving birth to five children is better than having 10 children and they (will all) become my burden. If I tell my husband about it(family planning) and he refuses, I have to hide and do it” (FGD, mother, Bimoba).

4.8 Quality of CHPS Services

Analysis of the statements in the transcripts of the FGDs, IDIs and KI revealed that service quality issues had influence on community members’ usage of CHPS. Aspects of CHPS quality that were reported in discussions and interviews were categorised into three dimensions namely, effectiveness of CHPS service delivery; responsiveness of CHPS to community needs; and safety in the delivery of CHPS.

There were also perceptions of substandard treatment by CHOs to clients. This was captured in an FGD with older women as shown below:

“Sometimes when you go (to the CHPS Compound) and they are to give you medicine, they won't give you the bottle of full syrup, they will ask you to bring empty bottles and then they will pour small, small for you and leave the remaining with them there. If you don't have empty bottles, you will have to go round the community until you get them and they will then put some of it for you(in your own bottles)” (FGD, older women, Konkomba).

Perception of undesirable side-effects of contraceptive use was also reported in an FGD with mothers in which majority of the participants agreed to the existence of the perception among community members, especially among men. This has been captured in the following quote from the FGD:

“According to them (the men), that when you (the woman) do the family planning and later on they want you to conceive, it becomes very difficult for them and they will end up roaming with you to hospital and other places.”

A young male adult also recounted a scene he witnessed when he sent an expectant mother to deliver at the only CHPS compound that provided supervised delivery services, and to which all participants in that FGD agreed was not a good practice and could deter more women from seeking birthing services there. Below are excerpts of the discussion that support this point:

“What I want to add is that, I once took a certain woman in labour to CHPS to deliver but what I noticed was that, in front of the delivery room, some nurses were also there weighing children and also attending some women in the same yard, and that was actually not good. They also need to build a toilet at the CHPS compound, and partition the delivery room from the other side so that whatever is happening in the delivery room will not be seen by those outside” (FGD, Young Male Adults, Bimoba).

A section of participants from the Bimoba Area conceived that CHOs did not consistently enter CWC information into the Child Health Record Booklets of children that received services from them (CHOs). The participants also reported that caregivers of the children were not provided with counselling on the health status of their children when they received services from CHOs. These issues are illustrated in the following quote:

“....Andin those days it was helping us, and it even got to a time I knew when my (child’s)next weighing was coming, but now I don’t know. And sometimes I give my card out for people to

help me know when my (child's) next weighing is coming. And it is like, nowadays the nurses do not tell us (about the weighing dates), and they do not also write it (in the Child Health Record booklet). Sometime ago, I asked someone to look at my child's weighing card and tell me what the nurses had written there, but I was told that the nurse didn't write the date in it" (FGD, mother, Bimoba).

Perceptions of ineffectiveness in the continuity of care across the levels of care also emerged from FGDs:

"I was pregnant and bleeding, although the pregnancy was not up to even six months. I came here (to the CHPS compound) and they looked at it and just said, I should go to Nasuan (health centre -about 3km away from her community), and when I got to Nasuan, they checked me and asked me to return in 3 days' time, but on my way home I had miscarriage, I could not get home, I was lying by the roadside, it was motorbike rider who saw me and took me to the health centre" (pregnant woman, FGD, Konkomba).

There were also issues of postponement of CWC/ANC sessions, and how that had the potential of disrupting the contraceptive-use schedules of some clients:

".... last month they didn't bring the weighing ..., so they couldn't weigh us. They collect our weighing books and they didn't come back for the weighing again.... they told some of people to come to Tema (CHPS Compound) for the injection, but they didn't come back. They give us days and they will not come back. Some of us will become pregnant, as they keep long and will not come" (FGD, older women, Konkomba).

Another service delivery quality issue that came up in the FGDs was acceptability of how certain ANC services were provided. Two separate FGDs with pregnant women and mothers of children under-five in two different communities indicated that the spaces in which palpation for pregnant women was done were inappropriate. However, this issue was only mentioned in

the two participating CHPS zones in the Konkomba Area. The following quotes attest to the above observation:

“if they can get a separate room for we the pregnant women. It is not good for the patients and pregnant women to be taking their services in the same room at the same time..... We need beds too, sometimes we lie down on benches for them to check us” (pregnant woman, FGD, Konkomba)

In another FGD in a different CHPS zone, the following issue came up:

“For the services we want it. But the room that is used to check the pregnant women, is our problem” (mother, FGD, Konkomba).

4.9 Leadership and Governance

The study explored leadership and coordination mechanisms adopted at the community (zonal) level, subdistrict and district levels in the operation of CHPS. The subthemes that emerged from the transcripts as far as leadership and governance in CHPS was concerned were community mobilization and participation in CHPS; training of CHPS providers; and monitoring and supervision.

On community mobilization and involvement in CHPS, the study found that several initiatives were put in place to engender community ownership and participation in CHPS among community members. These initiatives included the formation of Community Health Management Committee for every CHPS; Community Emergency Transport Committee for every CHPS facility; and orientation of TBAs to serve as link agents in their communities to encourage expectant mothers to seek skilled delivery in health facilities.

“in some areas we have formed the health committees and they (CHOs) meet with them. But as to whether they (community members) have been properly sensitized on the role that they are supposed to play, that is also another issue that I am not too sure whether we are doing

what is expected of us. There has also been issues where we formed these Community Emergency Transport Committees that was an attempt to get community involvement when we talk about the Community Emergency Transport Committees. Then, another attempt has been training of TBAs to serve as link providers; where the TBAs no longer deliver women when they are in labour but rather encourage them and also accompany them to the health facility. So, these are bits and attempts to involve the community, but we have not been able to structure it properly as the CHPS concept outlines” (Key Informant, DHMT).

A key informant interview revealed that despite the existence of those initiatives, the levels of ownership and involvement of community members in the CHPS strategy were still low. Low effectiveness of the initiatives was attributed to poor initial implementation of CHPS in the district. It emerged from the interviews that CHPS was poorly adapted in the district as so many of the steps in the national CHPS implementation guidelines were not undertaken. Therefore, there was a long-standing perception among community members that the CHPS Compounds were to operate like the traditional clinics, and as a result the subsequent attempts to re-orient the communities about CHPS to have sense of ownership of it and participate actively in the provision of health and related services did not yield the expected results.

“the concept that they are having is that they are having this clinic concept, so, a CHPS facility has been put up in their community, but what they see it to be is different, I mean, they see it as a mini-hospital in their community and should provide the services of a hospital, yeah. But the concept of CHPS as I know it, I don’t think it is actually going on now in most parts of the country” the concept places more premium on preventive than clinical (care) but what I have noticed is that, the setting that we have, for the community members, the mirror through which they look at health service is clinical care. Without clinical (care) they don’t see it as health service. Those of us in the preventive aspect, we know what preventive health does, but for those in the community they see health (service) as clinical care, so, if they have a facility,

and then no matter the orientation that you take them through, if they don't see the clinical aspect, then [shaking his head] they don't really want to consider it as a health facility. (Key Informant, DHMT).

It was revealed that some community members who played key service provision roles such as CHVs or CHMC members expected compensation for services they provided in CHPS and when such demands were not met, they tend to show disinterest in the programme. The following quotes are examples of the above observations:

"Sometimes convening the (Community Health Management Committee, CHMC) meeting is a problem. You may schedule it and before you realise, only 2 or 3 people will be present, the rest are not. So, we normally face challenges sometimes in holding the meeting" (male community member, CHMC, Konkomba).

Another issue about poor commitment from community members is contained in the following quote:

"Because they are supposed to know that if you say you are a volunteer, you should not expect to be paid anything because you are helping your community. But now, it's like they try to demand for little little things. So, if there is refresher training, they can get to know that there is nothing attached to (their work) it" (Female CHO, Bimoba).

Closely related to poor community mobilization/ownership is capacity building for CHPS providers. The study revealed that CHPS providers including CHMC members, CHVs and CHOs did not receive a structured training course on CHPS prior to the implementation of the programme. Participants in the study reported that providers of CHPS in the communities, including CHOs, CHVs and CHMC did not have enough skills to do effective community

mobilization. The following are examples of quotes that suggest the training needs in the programme:

“You know, the CHPS concept is a bit different from the traditional way that we were providing preventive services. So, for somebody to be able to provide the CHPS services according to the implementation guidelines, or even the policy, the person needs to undergo some training. And to be honest with you, in the district here, I think they are just 2 or 3 people who were trained by Systems for Health in Walewale. So, yeah, they are providing the services, but they are not doing it to the level we really wish it should have been done” (Key Informant, DHMT).

The following excerpts from an interview with CHMC member further validates the fact that CHPS providers had not been trained:

“Training? No. I haven’t seen anything like that.training! it will be good! Some of us, we don’t know much about health, so if they can be a training once in a while to educate us on how to keep ourselves healthy” (IDI, CHMC member, Konkomba).

Another dimension of CHPS leadership and governance that emerged from the discussions and interviews was monitoring and supervision. Study revealed that supportive of supervision for CHOs and CHVs was regular as indicated in the following interview:

“We usually meet with them (volunteers) when we go to the community, mostly, once in a month. When you go, you ask them what they have done so far. After that you ask them, “do they have challenges”? Then when they bring their challenges out, then you try to help them”(IDI, CHO, Bimoba).

A CHO also reported frequent supervision visits by the DHMT:

“...almost every two or three months they come here to see what we are doing. Have they been here in the last 6 months? They come for monitoring, to see how work goes on they looked at our reports and other things” (IDI,CHO, Bimoba).

Supervision and monitoring as explored was frequent at the various functional levels of the health delivery system.

4.10 Sociocultural Factors

Analysis of discussion and interview transcripts revealed the societal and cultural perspectives about the CHPS strategy influenced the use of its services by community members. Social and cultural issues such as awareness about CHPS among community members; attitudes of staff towards CHPS and cultural norms and values about health and illness emerged as the sociocultural factors affecting utilization of CHPS in the district.

Awareness about CHPS among the various population subgroups involved in this study was very high. Across all FGDs with the subgroups in the two ethnic areas, participants demonstrated their awareness of CHPS in their localities by mentioning the kind of activities carried out by CHOs and CHVs that they directly observed or heard from other community members. The Following statements provide evidence of awareness of CHPS among community members:

“As we are living here, if there is any problem relating to health you have to go to the CHPS before you can proceed to other facility, if only they cannot handle your sickness. If they can handle it they give you drugs, children, women in labour can also be brought here” (Young male adults, FGD, Bimoba).

Participants indicated that health education at ANC/CWC sessions and during community durbars by CHOs were their main sources of information about CHPS. They revealed that CHOs organize community durbars from time to time to educate them about CHPS and health

issues in general, especially family planning, malaria prevention, skilled delivery, ANC and CWC. The following quote illustrates how community members get aware of CHPS:

“In the time past, few people understood the benefit of CHPS service but now many people do go for the service to durbars been organize all the time” (older male, FGD, Bimoba).

Below is another evidence of the sources of information about CHPS among participants:

“We met at the market place. Yunyoo old men and women came on “Gbanbik” market day and we gathered there. And the one helping us to give birth (the midwife in Yunyoo Health Centre) came. They asked all men and women to meet there. They talked to us about Family Planning, that we should not be delivering every year. And that if you are pregnant and labour sets in you should rush to Yunyoo. They brought pito and when they finished we drunk and they prayed to God for all of us and returned”(FGD, mothers, Konkomba).

The high frequency of quotes about awareness of CHPS across the communities, subgroups and ethnic was an indication of high level of awareness of CHPS in the district.

The study revealed that, generally, community members had positive attitudes about the CHPS strategy. However, there were differences in attitudes about CHPS by gender. In the study, statements that depicted positive attitude about CHPS were more frequent in the FGDs involving the individual female subgroups than was observed among male subgroups. Whereas the remarks of the female groups indicated that they regarded CHPS as useful and had made use of a wide range of its services (including durbars on health promotion, ANC, CWC, Family Planning and clinical services), the males views about CHPS centred on the relief they get from no longer having to travel far away to treat malaria either for themselves or family members. The following conversation in an FGD of Mothers of children under five years old illustrates the difference between the attitudes of men and that of women towards CHPS:

“We asked them to go with us (to ANC/CWC centre), several times, but they won’t even mind you. If you are pregnant, and you tell them they don’t care about what you do about it. As you were coming, if you had made it to be a meeting for men only, they would have come and sat for the meeting but when you leave, they will turn a deaf ear to your matter. We must tell you. They are not good. When we were asked to build a room for the weighing, what did they do about it? We the women brought logs and they mounted them, but it couldn’t stand, and that was all” (FGD, Mother, Konkomba).

Below are some of the statements from the FGDs that indicate positive attitude of community members about CHPS:

“The durbar we attend has opened our eyes. We know that the children who are injected don’t fall sick like those who are not injected. So we see benefit of injection. Weighing makes the children look well, because the sickness will be seen and treated. There was a sickness call “Kinaajak” (a bull) that was killing many children, but because of the needle injections that they have been given to the children that sickness is no more there”(FGD, Male, older adults, Konkomba).

“The women used to travel long distance for outreach services (CWC and ANC) but now, the CHPS come to our community for the services. We are satisfied with the kind service they provide to us” (FGD, married young male adult, Bimoba).

In addition the quote below illustrates how women are supportive of efforts to improve CHPS by recommending stronger community involvement:

“When the nurses are organizing durbars they should make sure that the chief and his elders and all the men and women take part so that after the durbars the men will also know everything that is being discussed, but Jacob should talk about the FP without our husbands” (Pregnant women, FGD, Bimoba).

The following extracts about home-visits by CHOs shared in a FGD of pregnant women illustrate an attitude of men towards CHPS activities:

As for the nurses, they come (to our homes), not just once. They tell us we should attend ANC all the time. But the problem is our husbands; they will not give you money or send you to renew your insurance. When they see the CHPS workers holding white papers sitting in the house and he realizes it is about health issues he will hide and leave you alone. Once I came here and I was asked to renew the insurance and I got home and told him but he said he had no money so I asked him “how will I attend the ANC”? And he said anytime he gets money, and that was all, that’s why when they see them (CHOs) coming they will be hiding”(FGD, pregnant women, Konkomba).

This study also revealed that the attitude of community members towards CHPS was in a way influenced by the range of services they get from CHPS. The head of CHPS facility indicated that because her facility was not accredited to dispense certain drugs for treatment of minor illnesses, community members tend to stop using their services especially the clinical services. She indicated because her facility could dispense a basic antibiotic like amoxicillin, when a client came his/her condition requires treatment with amoxicillin, they prescribe for them to go and buy from a drug store, which in her view discouraged client from seeking the services of the CHPS. She narrated that initially they used to prescribe some drugs but that about three years ago when they brought the medicines list, they were restricted to just a few drugs for treatment of minor ailments.

“Sometimes it’s to save the client because if you refer them to go the next level they don’t go. They prefer going back to the community and buying even paracetamol from the drug store to take than going to suffer to go the next level. So we prescribe for them so that they can go and buy the right medicine” (Female CHO, IDI).

It also emerged from a KII that the attitude of community members give little recognition to CHPS due to the limited clinical services in the programme:

“...the CHPS concept actually places premium on preventive aspect and that is the reason why community health nurses were initially used for manning the, so the concept places more premium on preventive than clinical but what I have noticed is that the setting that we have, the community members, the mirror through which they look at health service is clinical care. Without clinical they don't see it as health service. Those of us in the preventive aspect, we know what preventive health does, but for those in the community they see health as clinical care, so, if they have a facility and then no matter the orientation that you take them through, if they don't see the clinical aspect, then [shaking his head] they don't really want to consider it as a health facility” (KII, Male, DHMT)

The above observation from the KII was corroborated in an IDI with CHMC member CHP as follows:

“initially when the CHPS was opened, initially those perceptions were there, because of some of the drugs are not to be prescribed at the CHPS compound, or are not to be administered there, so, when they go and they refer them, sometimes, they say, “this is not a serious this facility, if you go there, they will just refer you”. As time go on, we start educating them and we explain that some of the drugs are not to be administered there. So, if you are sick and your condition is supposed to be taken this thing, then they have to refer you, so they understand” (Male CHMC member, IDI, Konkomba)

It is worth stating that most of the above issues mentioned were spontaneously mentioned by the respondents without probing.

It emerged from the FGDs and IDIs that utilization of CHPS was linked to certain community norms and beliefs about health and illness among community members. Study revealed that

cultural norms and beliefs had varying influence on the utilization of specific CHPS services. Whereas participants' accounts of their experiences of issues of family planning in their communities revealed strong cultural barriers to contraceptive usage, their opinions about utilization of ANC, skilled delivery, CWC, and seeking treatment for illnesses for themselves or family members showed that cultural norms/beliefs were not immediate determinants for use of those services. Majority of participants agreed that husbands and other family members were mostly indifferent towards ANC and CWC services. The study revealed that the impact of culture on utilization health services was not a direct one but was mediated through the control of household resources. The study revealed that women could freely use ANC and CWC services so far as they could afford the cost of services and had a means of transport. Below are examples of quotes that demonstrate the influence of cultural norms on the use of specific health services:

“When the men sit together they say that, if your wife receives family planning injection, she cannot give birth again. That, left on to only dry vagina, he won't let you do it. So you hide and go and do it and when your time is up, you go and they will remove it... ..But when they noticed that you have done it, they will send you back to your parents” (Mothers, FGD, Konkomba).

The influence of cultural values about health and illness on CHPS utilization can be observed from the following statements by a participant of an FGD of pregnant women:

“If you are pregnant, and may be some part of body is paining, and you inform them (other household members), nobody will mind you. They will even say you are lazy, and you don't want to work that is why you are complaining. Even your husband will not mind you. When you talk of going for check-up, he won't listen. He will ask you whether when their mothers were pregnant they attended weighing (ANC) before giving birth to them. If you couldn't sleep well in the night and day breaks the household will not even ask of your condition and if it

rains he (your husband) will tell you that he is taking the lead (to the farm) to do so so and so work, and that if you don't follow him there and he comes back what will be there you for will be there for you (there will be punishment awaiting you) (FGD, pregnant women, Konkomba).

The text below indicates how cultural norms well as unapproved charges by CHOs and CHVs negatively affect CWC attendance. It also illustrates an unintended effect of lack of support from husbands and illegal charges by CHPS workers on adoption of Family Planning.

As for the injections is good for us. When you give birth, on the third month, you will begin to menstruate. When you don't get injected you may get pregnant shortly. You see that, your children that are due for weighing will be more and you can't get money to send them including your own antenatal care. The men will say his mother never went for weighing and for that matter you should stop worrying him. He will even say that "look at me, I am very strong, but look at your children! upon the injections and weighing, they are weak and not strong even." You will only cry alone and finally enter into your room with your many children (because you don't have money to weigh them). You won't get soap to wash their clothes and can't go for weighing too. As for the injection, it's helping us, so they should continue to inject us. For me, my husband is not complaining about it. If a person is absent, but his god is present here. I won't tell lies. My husband does not complain. When I started giving birth successively and the children were not walking he saw it so he does not complain" (Mothers, FGD, Konkomba).

The following statement shows an unintended positive outcome of a cultural norm on family planning:

"For some of the men, when you are pregnant they have it in their mind that it's your own burden, it is you and your child, they don't care, so if I tell him and he refuses I will hide and do and keep the card. Where he will not see it, if not, if he finds it or someone tells him, that will be another problem" (mother, FGD, Bimoba).

Another observation was made as follows:

“sometimes those who get married but do not get pregnant, they used to go for the traditional medicine, and over there they may tell her not to take the medicine that we receive from the health centre”(FGD, pregnant woman, Bimoba).

Respondents revealed that registering or renewing their membership of the National Health Insurance Scheme was very expensive due to high cost of travel and loss of productivity associated with unduly long waiting time as a result of congestion at the centres. The quotes below illustrate the poor accessibility to health Insurance:

“Some time ago they were doing it (NHIS registration) at Nasuan (the capital for subdistrict within which the CHPS is located), but whenever they came, within just one or two weeks, they will say the machine has broken down. Sometimes, people will go to snap their insurance (register for the NHIS) or renew their membership at Nasuan, and they will go there and sleep more than two weeks, there will not get access. When they go to Bunkpurugu, the same thing, and Bunkpurugu is far. So, one of the challenges that is facing us is to renew; that was around September last year (about nine months to date since the registration centre in Nasuan got closed down). So, now they go to Bunkpurugu (the district capital which is about 35km away), some people will go to Garu (a the capital of town of a district in another region, the Upper East Region), and Gambaga (a town in a neighbouring district) to register Health Insurance. When you go there you may sleep there for (spend) so many days ...so this is a very serious challenge” (IDI, CHMC member).

CHAPTER FIVE

DISCUSSION

5.0 Introduction

5.1 Physical Accessibility to CHPS

This study explored health service delivery factors that affect community members' utilization of CHPS in the study area. The findings of this study indicate that participants generally perceived that the vast majority of persons within Functional CHPS zones had reasonably good physical access to CHPS, even considering the bad roads and slow travel times as well as the dispersed nature of the communities within CHPS zones. Participants perceived that CHPS services were within reasonably physical reach of majority of communities could be due to the strategic location of outreach sites for clusters of communities as well as home-visits by CHOs to complement facility-based CHPS services. This finding supports the results of a study in rural Guatemala that indicated that even under the circumstances of dispersed settlements and physical separation of rural communities from health centres, strategic location of services in congruence with specific community circumstances can improve accessibility to health services (Annis, 1981). This finding also reinforces a global health principle that implores providers of “preventive, follow-up, ongoing, and other care”, to endeavour to bring the health facility to the client in order to address healthcare accessibility challenges related to distance and rugged topography (also known as the problem of the last mile). It is worth mentioning that the CHPS strategy by policy, offers more effective ways of overcoming challenges related to physical accessibility to health services as it does not just seek to remove physical barriers to health care, but also focuses on rigorous community mobilization and involvement to break sociocultural barriers to healthcare-seeking.

However, the findings of this study showed that CHOs were challenged with transportation issues in sending health care to the doorsteps of communities and households. Inadequate number of functional motorbikes for health service delivery presented a threat to effective community-based service delivery in the study area. This finding concurs with that of the MOH in its holistic assessment, in which it found out that inadequate means of transport for service delivery was a challenge in the Northern Region as almost all the Nanfang motorbikes distributed to facilities were not roadworthy (MOH, 2014). It is therefore important for primary health care managers to focus on overcoming the last mile challenge to utilization of essential health services by remote community members. This can effectively be done by providing effective transportation means and ensuring the constant availability of health commodities, as well as effective supportive supervision to CHOs.

5.2 Availability of CHOs

Findings in this study showed that, though community members had reasonable physical access to CHPS compounds and outreach sites, inadequate number of CHOs was major factor that affected the availability of certain services such as counselling through home-visits and during CWC/ANC services. CHPS Stakeholders who participated in this study revealed that inadequate availability of services in individual communities in CHPS zones posed a barrier to the use of CHPS by community members who had the need for healthcare. Under the CHPS strategy, CHOs are supposed to visit households on daily basis to engage in health promotion activities with families; however, due to inadequate number of CHOs serving in the CHPS zones, home-visits were not frequently undertaken. This was because there was a mismatch between the number of CHOs and the number of communities that they had to cover to provide monthly CWC and ANC services. Inadequate number of CHOs as an identified challenge reinforces the observation in an earlier study that the number of health professionals in remote rural areas has been a serious challenge for public health organizations of many countries (Lori

et al, 2012). Rejections of posting to rural settings among young and newly qualified health professionals which is commonplace in developing countries is mostly accountable for the inadequate number of health professionals in those settings. The basis for these rejections often includes rural conditions such as “unacceptable housing accommodations, no access to potable water, impassable roads, no access to entertainment, no transportation, poor or non-existent schools for future children, insufficient lighting and local people who are ignorant and, therefore, do not make ideal patients” and would not make suitable marriage partners (Lori et al, 2012). In addition, the results of a systematic review indicated that the preferences of the location of health professionals’ practice may depend on the kind of living conditions health personnel are used to (Lehmann et al., 2008). The study revealed that rural upbringing increases chances of health workers returning to practice in rural communities (Lehmann et al., 2008). The remoteness of the study area with features of repulsive social conditions coupled with recurrent tribal and chieftaincy conflicts, could be responsible for the low numbers of health professionals in the district. Inadequacy of the number of various health professionals in the district created a severe disproportion between the number of CHOs and the size of the CHPS zones in terms the population and number/distribution of communities. This finding therefore, underscore the need for stakeholders in CHPS to continuously identify qualified high school leavers from the district and enter into a memorandum of understanding with them in order to sponsor their training in the colleges of health, and subsequently recruit them to serve in their own district. This will not only minimize rejection of postings or turnover, but also, can “effectively link services to local cultural conditions, languages, and health needs”(Awoonor-Williams et al, 2013).

Furthermore, a preliminary study data on health facilities and health professionals obtained from the District Health Directorate revealed a severe deficit in the number of Community Health Nurses (CHNs) who were mainly responsible for providing preventive services (which

is the main focus of CHPS) in the district (see Appendix 1). Although the national CHPS policy stipulates that there “shall be up to 3 CHOs of appropriate mix”(Ghana Health Service, 2016) serving in a Functional CHPS Compound, this study revealed that the combination of CHOs in Functional CHPS in the district was inconsistent with the principal objectives of CHPS as the CHOs that provided preventive services (CHNs) were less in number than those (Enrolled Nurses, ENs) that provided clinical services. This study found, for instance, that a one of the Functional CHPS compound had two ENs with no CHN, and also, majority of the Functional CHPS compounds had at least two ENs with only one CHN. This resulted in a situation whereby overall CHO to population ratios within the CHPS zones appeared quite sufficient, but in reality, it was low because the ENs mainly provided severely limited clinical services within the compounds whereas the CHNs had a wide range of services to provide to a consistently high number of clients. Though a cost analysis (on indirect cost of time for providing each of the two categories of services at the CHPS level) is needed to arrive at a conclusion on the work burden on CHNs and ENs, the wide range of services that CHNs provided both at the facilities and in communities quite far away from the CHPS compound presupposed that there was excessive work overload on them as compared to their counterparts in the clinical service provision (ENs) who mainly provided limited facility-based services only. As a stopgap measure, there is the need for task shifting (which originally, is one of the principles of the CHPS concept (Ghana Health Service, 2016) while in putting in place mechanisms to train more CHNs to meet the demand for preventive services. This could result in a fair division of labour in the CHPS compounds which can in turn contribute to achieving a balance between service supply and demand (Manzi et al., 2012) which is a key determinant of utilization of health services.

Moreover, a modification of the CHPS strategy that allows demarcated CHPS zones to be made operational even without a Compound and /or CHOs staying within the zone further hampered

CHO availability to potential clients. This practice led to a rapid increase in the number of Functional CHPS zones in the district without a corresponding increase in number of CHO. The new practice introduced additional responsibilities to CHOs in CHPS zones with compounds to man one or two more new category of CHPS only known as “Functional CHPS zone”, and that resulted in limited availability of CHOs in individual communities within CHPS zones. Before the introduction of the new category of CHPS, mostly rural communities in the country that were not covered by CHPS were provided the traditional outreach-based services by subdistrict health centres or hospitals, whereas CHOs and CHVs concentrated on providing services holistic family and population health services in their respective catchment areas with emphasis on community mobilization and participation. The new practice accounted for the clustering of communities for outreach sessions. Combining communities together for CHPS services could have accounted for the overcrowding at service delivery points as reported by some participants in this study. Overcrowding at service delivery points could be a recipe for ineffective counselling services as well as neglect of home-visits, which are all avenues for promoting the utilization of CHPS. Obviously, the new practice created a situation in the district that was not different from the traditional outreach-based service delivery by health centres and hospitals. This study found that CHNs who were responsible for providing preventive services mostly administer vaccines, family planning and weighed children at the outreach sites with virtually no counselling or home-visits, due to large number of communities they had cover in a month.

Other engagements of CHOs, including participation in workshops outside their CHPS zones, maternity and annual leaves, study leave, as well as absenteeism due to travel to receive salaries contributed to poor availability of services to community members. This study found that, for several months, CWC/ANC services were not organized in certain communities because the CHO that was responsible for conducting those services in that area had gone on maternity

leave. This finding re-echoes the results of a previous study, in which it was found that high incidence of absenteeism among health professionals in rural Tanzania resulted in clients bypassing primary level facilities to seek care directly from higher level facilities leading to loss in functionality of referral system that facilitates a two-way utilization of health services across the levels as observed in this study (Manzi et al., 2012). Poor availability of CHOs could erode the confidence of community members in the CHPS strategy and could have negative consequences on the utilization of CHPS.

5.3 Economic and Financial Factors

There is strong empirical support for the proposition that the poor are more price sensitive than the better off in terms of utilization of health services (O' Donnell, 2007). It has been well recognized that economic constraints may suppress utilization of health services even if the benefits of the services are recognized by the target population (O'Donnell, 2007). User fees often effectively exclude the poor from essential services.

In the light of this, coupled with evidence of poor health status indicators, increasing cost of care and limited accessibility of health services in Ghana, a twin track strategy was considered by the government to remove both the financial and geographical barrier to access to care. The National Health Insurance Scheme (NHIS) was seen as a social intervention to address the financial challenge and CHPS was to make basic services available and "close to client" (Ghana Health Service, 2016).

Aside the universal NHIS, the government also instituted a Free Maternal Care Policy (FMCP) in the form of a "subsidised health insurance to pregnant women, with the existing NHIS benefits that include comprehensive maternity care with some notable exceptions such as ambulance service and post-partum family planning counselling"(HERA and Health Partners, 2013). Under the FMCP in the study district, the only official requirement for a pregnant

woman to secure NHIS membership was a proof of evidence of registration for ANC services by providing her Maternal Health Record (MHR) booklet, no peswa was supposed to be charged for her subscription. In addition, all CWC services including immunization and nutrition interventions such as vitamin A supplementation, Growth monitoring and promotion, Community-based Management of Acute Malnutrition (CMAM) were also provided free of charge free to the public through the sponsorship by the government of Ghana and development partners. The NHIS benefits also covered the cost of all medical services provided at the CHPS level.

Despite the existence of financial risk protection policies by government that took away the direct cost of healthcare to clients at the point of use at the CHPS level, other costs (both financial and economic) related to use of health services limited CHPS utilization by community members. First, effectiveness of the financial protection under NHIS in particular, was perceived to have been reduced by the cost involved in acquiring membership in distant and overcrowded centres due to the limited number of membership registration/renewal centres. The results of this study showed that high cost of transportation (direct cost) and indirect cost of feeding as well as the opportunity cost related to camping in the district capital or other neighbouring districts to acquire NHIS membership adversely affected the capability of some community members enrol in the NHIS, hence limited their ability to use CHPS, especially for antenatal care and treatment of illnesses. This study revealed that community members were willing to utilize CHPS services in the absences of any financial barriers. This finding parallels the finding of a study in rural Uganda that observed that the poor had high motivations to utilize public health services that were provided free of charge (Bakeera et al., 2009). In addition, the unofficial policy by NHIA officers in the Konkomba area, as revealed in this study that required the spouses of pregnant women to have active membership of the scheme before they could benefit from the free subscription under the maternal health policy

by government further limited the use of ANC services by many poor households. As reported in this study, pregnant women whose husbands did not have NHIS membership were unable to acquire NHIS (under the free maternal health policy) and hence not able to utilize ANC services due to the cost of routine ANC drugs. The fact that some husbands could not afford to acquire NHIS membership in order to qualify their pregnant spouses to benefit from the FMCP (as unofficially required by NHIA officers) support the outcome of a systematic review that stated that even nominal private prepayment for health insurance can lead to immense exclusion of deprived households who otherwise could benefit from essential health services (Sachs, 2012). For the objective of the free maternal policy to be fulfilled within the district, the NHIS subscription services should be made readily available in the various subdistricts, and without restriction to any pregnant woman.

Furthermore, illegal charges by CHOs for maternal and child health record booklets as well as contributions charged on clients for CHVs' incentives limited the use of CHPS by community members. This finding exemplifies the finding of O'Donnell in his systematic review study on access to healthcare in developing countries, in which he observed that unofficial payments were substantial in many public health care systems, and that they may exist even when official charges had been abolished. This study found that though pregnant women were exempted from paying NHIS premium and also from maternal health care services, they were required to make informal or under-the-table payments for Maternal Health Record booklet, and this was reported as big financial hurdle that led to underuse of ANC by many pregnant women (Whitehead, Whitehead, Dahlgren, & Evans, 2001).

Unofficial charges on Maternal Health Record booklet was found to be so detrimental to maternal health initiatives in that it was reported to have created a double barrier to the ability of pregnant women to access antenatal care services. First, the unofficial charges increased the financial burden of antenatal care for pregnant women and their households, which could

prevent those from poor households in particular from registering early for ANC or completing forgoing ANC especially as it was reported that delays by pregnant women in paying for and collecting the MHR booklet attracted further penalty charges. The other barrier created by the informal charges was the fact that needed to submit her MHR booklet as a proof of pregnancy and ANC registration before she could benefit from the free NHIS subscription under the FMCP. Obviously, the barriers created by these illegal charges could have negative consequences on the performances of several maternal and child health interventions that are delivered through CWC and ANC including IFA supplementation for pregnant women, EPI, growth monitoring and promotion, malaria prevention (IPT), deworming for children, vitamin A supplementation, FP, postnatal care, PMTCT as well as health and nutrition counselling.

For the free maternal care policy to achieve the purpose of improving maternal and new born health outcomes and reducing maternal and infant mortality rates, it will be important that the NHIS registration process is made available at the doorstep of community members and illegal charges on MHR and CHR booklets are abolished.

Moreover, poor transportation system within the district was also perceived to have imposed economic challenges to community members, either in using CHPS and/or to undertake referral to a higher facility for further treatment of illnesses, for delivery or for postpartum complications arising from unsupervised delivery. Excessively poor availability of means of transportation and the bad nature of roads linking communities to CHPS and higher care level facilities as well as the cost involved were major causes of home or unsupervised deliveries. The association between poor transportation system and low adherence by clients to referrals has been well documented in the literature. For example, a study conducted in the Upper West Region of Ghana indicated that delay in undertaking referral is influenced by the nature of the road and availability of means of transport (Atuoye et al., 2015). Although Most CHPS in the district were not supposed to conduct deliveries, CHPS is considered as the point of entry into

the health system and community members in need of any health service were required to first visit the CHPS for care, including referral services. This study found that poor transportation services hampered clients' adherence to referrals, especially for birthing services, and unsupervised deliveries remained the norm in the communities. The long distance travelled before locating a health centre indicates inadequate number and/or unequal distribution of health facilities conducting delivery (Philip & Paul, 2017). Considering the magnitude of resources needed to solve the transportation challenges in the district as far as accessing skilled delivery services is concerned, it will be more cost-effective to deploy midwives to at least clusters of Functional CHPS Compounds or orientate CHOs to able conduct to deliveries for uncomplicated labour cases, while putting in place an enhanced referral system.

5.6 Demand Creation for CHPS

In a review of the development of the CHPS initiative and processes for its implementation and scale up in Ghana, it was recommended that CHO training workshops are needed in order to introduce to them the techniques of community diplomacy and counselling methods among other skills. Contrary to this recommendation, most of CHOs and all the volunteers and CHMC members in the study area were not given any training on the CHPS concept, and the term 'CHO', which applies to a health professional trained to provide CHPS services was only being loosely misapplied to the nurses working the CHPS facilities. Lack of training of CHPS workforce prior to their deployment to man CHPS, as identified in this study can be likened to the findings made about a rural health programme in Sierra Leone in which health workers posted to rural health facilities took up leadership roles but were not supported or trained with the required skills to enable them work effectively in their managerial roles in order engender community participation in the programme (Wurie et al., 2016). Generation of demand for health services is central to the success of the CHPS strategy, and it is important that the workforce of CHPS possess much soft skills to be able deliver services in a manner that is

sensitive to the socio-cultural norms of community members. This task may require adequate understanding of the prevailing norms and beliefs in the communities. In this study it came up that, sometimes misunderstanding between community members and CHOs could be as a result of poor understanding of the values of the former by the latter. A solution to this challenge could be the adoption of the strategy implemented in the Upper East Region whereby indigenes of various districts were assisted to pursue nursing programmes and upon completing their programmes, they were posted back to their respective districts to serve in the CHPS zones (Awoonor-Williams et al., 2013). This strategy was aimed at removing language and cultural distances between CHOs and their clientele, and also to reduce CHO absenteeism due to travels outside the district to visit their families elsewhere. This approach may also be useful in the study area to deal with challenges similar to those in the Upper East Region.

A key component of the initial CHPS strategy was effective provision of family planning information and services and other promotional services that were targeted at the needs of men especially, and organized mainly by male volunteers by adopting a doorstep approach (Awoonor-Williams et al., 2013). In a similitude to the emphasis on the use of community members to provide doorstep services, this study revealed that CHVs conducted door-to-door services on malaria prevention and referral of malaria cases for management. This practise is useful to the success of the CHPS strategy in that the use of community members to provide health services because community volunteers themselves are often touted to be agents for facilitating community agency and provoking social change (Kok et al., 2017).

Although active participation of CHVs in CHPS was found in this study, results of the study also points to a decline in the number of active CHVs over incentives issues. CHVs who agreed to participate in CHPS delivery often demanded compensation from CHOs when they were engaged to carry out certain tasks. Lack of or inadequate involvement of CHVs in demand creation activities could result in low effectiveness of BCC activities in the Functional CHPS

Compounds, particularly considering the workload on CHOs and in some cases, cultural and linguistic barrier between CHOs and community members. The effects of this issue about language barrier between CHOs and community members could be less if there are active CHVs to act as intermediaries between community members and the health delivery system. Poor participation of CHVs in the CHPS programme could be an obstacle to community mobilization and general service delivery, considering the role they play in community acceptance of innovations.

5.7 Availability of Infrastructure, Medicines, Equipment and Transport

Making sure that health facilities have adequate supplies, equipment and drugs is essential if people are to have confidence in health services and health workers (Mangit and Sarah, 2001). Among several other issues Kwesigabo et al. (2017) indicated that common concerns in primary health care facilities was frequent unavailability of necessary equipment and consumables. The results of this study concurs with the aforementioned finding by Kwesigabo and his colleagues as shortages of tracer items for ANC, CWC, FP and drugs for treatment of minor illnesses recurred in the discussions and interviews with the various stakeholders that participated in this study. The findings of this study indicate that CHPS compounds were unreliable in terms of addressing the health needs of community members especially for curative for services. Therefore, people living in the CHPS zones bypassed the CHPS Compounds to seek care directly from health centres and hospitals, sometimes, even for health conditions that could be handled at the CHPS level. This issue does not only lead to a loss in the functionality of the referral system, but could also push poor households deeper into poverty (Manzi et al., 2012) due high cost of transport in the district.

In this study, unavailability of medicines was perceived to have influenced community members to resort to self-medication, which was not only detrimental to their health and

economic status (as drugs bought from peddlers were not covered by NHIS), but also had consequences for global healthcare cost related to the fight against antimicrobial resistance.

Furthermore, this study revealed infrastructural challenges in CHPS delivery. The study uncovered community members' discontent about lack of privacy in the spaces in which ANC, FP and delivery (for in the only CHPS with a midwife) services were conducted. The use of spaces such as classrooms, bedrooms in houses close to outreach points or shared space for patients and ANC and FP clients were deemed inappropriate by community members, and could adversely affect their use of services of CHPS. This study therefore found an account by a key informant that a the MOH had developed and disseminated a prototype of standard CHPS compound to provide appropriate space and WASH facilities very imperative to the utilization of CHPS by community members. In order to improve the utilization of CHPS, stakeholders in CHPS should ensure that acceptable infrastructures are provided at the various service delivery points. Based on perceptions of inappropriate space for outreach ANC and FP services, it is important that health service managers engage with community leaders in planning and resource mobilization for the construction (Nyonator et al, 2005) of at least one room at every outreach point for services that require strict privacy.

This study revealed that there were many new CHPS compounds constructed in the study area by different stakeholders that were not operationalized over lack of equipment and additional health personnel to man them. Due to a government's directive to District Assemblies to construct 2 CHPS compounds every year, as well as the growing interest of MPs in CHPS construction, 6 new CHPS compounds were constructed within the last 2 years in the study area, but none was equipped, hence had remained unused for the purpose for which they were constructed. The huge difference between the number of CHPS compounds and that of operational CHPS compounds highlights a lack of harmonization of efforts of different stakeholders in CHPS. There is therefore the need for the DHMT to use simple-to-implement

communication strategies that facilitated exchanges between local government authorities, politicians, and health leadership about CHPS (Awoonor-Williams et al, 2013).

5.8 Range of Services Available in the CHPS strategy

The results of this study showed that the package of CHPS services was inadequate. The complete unavailability of skilled delivery services in the Functional CHPS Compounds (except one) as well as the severely limited curative services in the CHPS programme was perceived as not being responsive enough to the health needs of community members.

The current national CHPS policy states that deliveries may not be performed by CHOs (Ghana Health Service, 2016). According to the policy, CHOs are expected to refer all delivery cases to a higher level of care. It also stipulates that based on need, the District Director of Health Services may include midwifery services in the package of services for specific Functional CHPS Compounds and post a qualified resident midwife to the zone. Going by the CHPS policy, the sparse distribution of the communities in the district resulting in the distant nature of sub-district health centres from most communities substantially justifies the need to expand a few Compounds and post midwives there to improve access to and uptake of skilled delivery in the district. Reducing the combined distance and transportation barrier to supervised delivery services could increase the proportion of skilled deliveries in the district. This statement is based on a study in Ghana that showed that the uptake of skilled birth care was significantly higher in communities where CHPS have become functional in combination with the existence of facilities conducting deliveries (health centres or hospitals) when compared to communities with access to CHPS alone, or no access to both health facilities (conducting deliveries) and CHPS (Johnson et al., 2015). The negative relationship between utilization of supervised delivery services and distance to a facility providing skilled birthing services in the findings of Johnson and his colleagues can be explained by the finding in this study that indicated that

transportation challenges associated with seeking delivery services in distant sub-district facilities compelled expectant mothers and their households to resort to home delivery. Many participants in this study perceived that delays in obtaining means of transport, bumpy roads and distant nature of health centres and hospitals from many communities increases the risk of an expectant mother delivering during the course of the journey, and the psychosocial, cultural and medical consequences associated with it restrains many community members from seeking skilled delivery service. Obviously, this finding can serve as evidence to the claim made by Johnson and his colleagues regarding the association between utilization of skilled delivery services and the accessibility to a facility providing delivery services. The Ministry of Health of Ghana noted that in its holistic assessment of the performance of the health sector that, a rapid increase in the number of CHPS coupled with the posting of midwives to CHPS facilities to perform deliveries and the substantial provision of OPD services by these CHPS facilities significantly improved health outcome indicators in the Upper East Region (MOH, 2014). It is in the light of this that it is imperative for CHPS compounds to be adequately resourced in terms of health workforce and health commodities, and also given the accreditation to provide a wide range of preventive and basic clinical services. In this way, the utilization of CHPS can greatly be enhanced, and ultimately its contribution to health and wellbeing of community members may increase tremendously.

Furthermore, this study revealed that frequent referrals from CHPS facilities to distant higher facilities for 'minor' illnesses eroded the confidence of community members in CHPS. As a result of that many community members stopped to seek care from CHPS and either sought services directly at the sub-district facilities or resorted to use the services of chemical sellers. This findings may be explained by the fact that the variety of services offered within a primary healthcare programme is positively associated with client perceived quality of care (Schäfer et al., 2018). The revelation in this study that community members reported their ailments to a

CHV and he led them to bypass CHPS to a sub-district facility was an indication that even the CHPs link agents in the communities were dissatisfied with the services available in the CHPS and also did not value the referral procedures offered by CHPS.

5.9 Quality of CHPS

There is often a gap between the intended role of primary health care services and actual care delivered to the population mainly due to lack of resources and management capacity (Bamford, 1997). This study revealed high perceptions of wrong insertion of long term FP devices, which deterred many women from receiving those specific family planning methods which they otherwise wished to adopt. This finding provides a supporting evidence to the assertion that low utilization of public health facilities could be a reflection poor quality of care and not physical access nor socio-cultural barriers (Annis, 1981), as clients are noted to be willing to return only to facilities that have the best treatment track record offering them inexpensive and socially dignified services.

In addition, service quality issues such as postponement of CWC/ANC sessions; frequent stock outs of medicines and vaccines; lack of basic equipment; lack of constant availability of CHOs; inadequate privacy during palpation for pregnant women; substandard and unsafe treatment (use of unsterilized used bottles to prepare medicines for clients); as well as lack of WASH facilities such as toilet in some Compounds affected the utilization of CHPS in the study area. This findings lends support to an earlier study in Ghana that noted that a decline in quality of public health care was associated with 40% fall in utilization within only five years (1979-1983)(O'Donnell, 2007). He further noted that low quality of public primary health care can result in patients forgoing (“bypassing”) care at the nearest facility and seeking care at a higher level public facility or in the private sector (Donnell, 2007). The findings in this study concurs with that of O'Donnell as in the above since participants in this study reported that many

community members tend to depend on chemical sellers (both licensed and unlicensed) or sought care directly from the sub-district health centre or hospital.

The results of this study also highlights the assertion drawn from previous studies, that, the range of services provided within primary care is positively associated with patient perceived quality of care (Starfield, Shi, and Macinko 2005; Wilhelmsson and Lindberg 2007; Kringos et al., 2013). The results of this study indicate that recognition for CHPS as formal healthcare facility among community members was low, and hence low demand for its services. The results therefore points to the need to expand clinical care services in CHPS if recognition and demand for it were to be ensured.

5.10 Leadership and governance

This study revealed that community ownership and involvement in CHPS in the study area was weak despite the existence of community mobilization initiatives such as formation of CHMCs, partnership with TBAs to be Link Providers for skilled delivery utilization, and establishment of Community Emergency Transport Committees (CETCs). Weak community ownership and involvement was attributed to poor initial introduction of CHPS in the communities. By the design of the CHPS initiative, adoption of the initiative in any community should be done through extensive planning and community dialogue on the part of health service and the community (Nyonator et al, 2005). Based on the fact that CHPS relies on participation and mobilization of the traditional community structure for service delivery (Nyonator et al, 2005), a neglect or ineffective initial community entry and diffusion of CHPS to community leadership could establish a weak foundation for the implementation of the initiative as identified in this study. This study identified that CHPS was implemented in demarcated zones without any structured orientation of community leadership and members on the initiative. This finding finds similarity with the observation that, in the initial scaling up of the CHPS initiative nationwide in Ghana, Community Health Compound construction was more widespread than

community entry, despite the fact that financial resources required for construction were far greater than resources required for community diplomacy (Nyonator, et al, 2005). Community participation innovations of the Navrongo experiment were neglected (Nyonator et al, 2005) in the implementation of CHPS in the study area. The omission of community-entry activities by DHMT suggests that the concept of CHPS was not well understood, since community participation, mobilization and ownership is central to the system reform process (Nyonator et al, 2005).

This study revealed that aside the CHVs that CHPS inherited from other health programmes, the DHMT did not have much focus and recognition of community leadership involvement in CHPS until the implementation of the World Bank funded MCHNP project in 2015. The CHMCs, Link Providers, and CETCs all came into being during the implementation of MCHNP.

This study has also revealed that individuals serving in the CHMCs had no prior orientation on CHPS. Likewise, the majority of CHOs that facilitated the formation and operations of these committees themselves had no training on CHPS, and hence, there was a high likelihood of incoherence and miseducation on the role of CHMCs. The selection of the CHMC members in the district was not representative of the communities in a Functional CHPS Compounds. The study revealed that the CHMC memberships of CHPS Compounds in the study area were comprised of inhabitants of the community that hosted the CHPS compound only, and their activities were largely based in their own communities without much interaction with volunteers from outreach communities within the CHPS zone. The results of this study therefore indicates that the CHMCs in study area were largely unrepresentative of all the communities within the CHPS zones, and as a result of that they were ineffective in their role of mobilizing community members for CHPS across communities in the CHPS zones. This study found that CHMC activities in the CHPS zones hardly go beyond the MCHNP

funded quarterly meetings, calling into question, the sustainability of the committees post-MCHNP.

Furthermore, findings of study indicate that human resource capacity building in CHPS delivery was inadequate and ineffective. For instance, the study found that although about 67% of (4) technical DHMT members were trained on CHPS, that did not trickle down to the subdistrict and CHPS levels as less than 10% (9.5%) representing 2 CHOs were trained on CHPS. Volunteer and CHMC members did not also receive CHPS orientation or training. The neglect of empowerment of CHOs, CHMCs and CHVs in skills on the CHPS concept could have repressive effects on community mobilization and participation which are key determinants of the social behaviour change, and a vital precursor for utilization of CHPS. This is because human resources are among the most important components of a health system's inputs (Rao & Pilot, 2014). The performance of a primary health care centre depends ultimately on adequate staffing levels and on the knowledge, skills and motivation of the team responsible for delivering services (Rao & Pilot, 2014). To ensure effectiveness community mobilization and social change for uptake of CHPS services, a joint training of CHVs with CHOs (a hardware element) could contribute to enhance their understanding about each other's roles and competencies, and ultimately could help to improve the working relationships between them (part of health system software) (Maryse et al, 2017). In addition, more field practical training than didactic conference room training is recommended for the training CHPS providers at the various levels. In the initial national scale up of the CHPS strategy, Counterpart Training was adopted, whereby districts intending to start CHPS implementation visit CHPS advanced districts to understudy the programme. In the 2 weeks counterpart training approach the visiting team were comprises of the District Director of Health Services, the District Public Health Nurse, one sub-district supervisor and one or two CHOs (Nyonator et al, 2005; Awoonor et al, 2013). Each visitor is teamed up with a counterpart for 2 weeks of practical on-

the-job demonstration of CHPS. These demonstrations transfer the system to members of a team who can actually implement the new programme as a pilot in their home district (Nyonator et al, 2005; Awoonor et al, 2013). When counterpart training works well, visiting teams establish pilot demonstration zones for fostering diffusion and scaling up of the initiative among the remainder of the workforce in their home district (Nyonator et al, 2005; Awoonor et al, 2013).

Problem solving, feedback, clinical supervision and involvement with the community were less commonly part of the supervision. Therefore, it is important to reflect about how the supervision is conducted, which components are included (for example, it has only check lists or includes problem solving) and how to make it more cost effective (for example, considering integrated visits).

5.11 Socio-cultural factors influencing CHPS utilization

A community is defined as a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings (Ronald, 2001). "Sharing common interests and perspectives" is part of belonging to a community. Therefore, members of a community share values, norms, religion, interests, worries, needs, happiness, and suffering with the other members of the community (fhi, 2004).

The acceptability of a given health service relates to cultural and social factors determining the possibility for people to accept the aspects of the service (for example the sex or social group of providers, the beliefs associated to systems of medicine) and the judged appropriateness for the persons to seek care (O'Donnell, 2007).

Key socio-cultural factors identified in this study included: awareness about CHPS among community members; attitudes of community members towards CHPS and cultural norms and values about health and illness.

Knowledge about available health interventions among a target population is a pre-requisite for the use of the interventions. It has well been established that individuals' ability to recognise their health needs as well as the potential benefits of relevant interventions are prerequisites for demand for the interventions (O' Donnell, 2007). In a setting where a large proportion of the population is in poor health, the poor health condition is regarded as the norm, and is not easily recognized as a concern (O'Donnell, 2007). If the coverage of available intervention is low, there is less opportunity to learn of its benefit. The unfortunate outcome can be the continued toleration of the health condition or disease (O'Donnell, 2007). In the light of this, it is imperative that sensitisation creation on any health intervention should be considered a key component of health programmes. This study explored the level knowledge about CHPS services among community members. The results of this study show that majority of participants (in both Cultural Areas) displayed high knowledge about "CHPS Compound" and what services were provided in the CHPS compounds and in the communities almost all participants. Community durbars, home-visits and health education at ANC/CWC sessions were identified as the main sources of CHPS information for participants of FGDs. However, it was identified that although both males and female possessed good knowledge about CHPS services, men's attitudes towards CHPS services such as family planning, support for their pregnant wives, and ANC/PMTCT services was not favourable to the use of these services. Poor male involvement in ANC is a barrier to the use of maternal health services in general. This is because, in patriarchal societies such as in the study area, a household head, is usually the husband, and he greatly influences the woman's ability to seek health care, and implement health practices and interventions (Osei et al., 2016). The dominance of men over their wives in most African societies transcend all spheres of life including maternal and reproductive health decisions (Adongo et al., 2013). As in the findings of Osei et al (2016), this study revealed that "care for pregnancy was seen as the duty of women", with little or

no support from their husbands for important pregnancy care issues in the area such as transportation to acquire NHIS, ANC, seeking supervised delivery, good nutrition practices, and occupational duties and household chores. As explained by participants, that frequent complaints of pain was seen sign of laziness and an excuse to escape from farming activities.

However, similar to the observation made by Osei et al (2016), men in the study area could not fathom why a man would go and sandwiched himself among nursing mothers and pregnant women just for the purpose of weighing and immunizations. They thought that it will appear so weird for a man to be seen accompanying his wife to a CWC/ANC delivery point, as it will amount to lowering his status as a man (Osei et al., 2016) and for this reason he will be reluctant to visit a health facility with his pregnant wife. There is therefore the need to target men with innovate BCC approaches that can translate their knowledge on CHPS services in to adoption.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents a summary of the major findings regarding the objectives of the study.

Conclusion drawn from the results of this study has also been presented in this chapter.

Recommendations to improve utilization of the CHPS strategy in the context of the study area have also been outlined in this chapter.

6.1 Conclusion

The findings of this study suggest that the CHPS strategy lapses in the supply of health services to community members, including inadequate number of and skills of CHOs in community mobilization; ineffective transportation for service delivery; stock outs of medicines and

vaccines; poor access to health insurance, financial burden imposed on clients as a result illegal charges by CHOs; and limited range of CHPS services hindered the utilization of CHPS by community members. In addition, although the CHPS strategy has, on overall, increased physical access to primary healthcare services including high health knowledge among community members that has not translated into a corresponding increase in a general utilization of the programme. Nonetheless, the results of this study suggest that health promotion on family planning by CHOs has empowered women to utilize family planning services with or without the knowledge and consent, and /or approval of their partners.

Furthermore, sociocultural norms and values that prescribe gender roles for community members inhibited the use of antenatal care, referral by CHPS for supervised delivery services, postnatal care and family health services. Sociocultural norms in the area favour husband's dominance over their spouses in the control of household resources and decision making, as well demoralizes male involvement in maternal health and childcare roles. These norms had repercussions for women's ability to benefit from services available in the CHPS programme.

Finally, the CHPS strategy has the potential to improve the utilization of health services in settings with similar characteristics as the study area. Areas for immediate improvement in the programme include strengthening of the CHPS workforce, a review of the package of services under programme to reflect community needs and aspirations as clearly stated in the national CHPS policy.

6.2 Recommendations

- Training and recruitment of more community health nurses to meet the demand for preventive services in the CHPS compounds. Indigenes from various district who qualify as CHNs should be recruited and given six weeks pre-service training and then

posted to areas within their home districts but outside their communities (Awoonor et al., 2013).

- The ministry of health, Ghana Health Services and development partners should make efforts to provide motorbikes to CHOs so that they can effectively carry health services to the doorsteps of communities.
- The district health management team should put in measures to stop unofficial community members on free services provided by Ghana Health Services and encourage them to report any extortion by CHOs to the District Director of Health Services for appropriate disciplinary actions to be taken.
- The management of National Health Insurance in the district needs to make available, the necessary logistics for the registration and renewal of membership of its potential clients and existing clients respectively in the various subdistricts on regular basis. Abolishment of the criterion that requires the spouse of a pregnant woman to have active membership of the scheme before she can acquire membership of the scheme can significantly contribute to improve utilization of maternal health services across the various levels of care.
- The DHMT and the District Assembly should mobilize Assembly Members and the various traditional leaders in the district to champion the involvement and ownership of CHPS in their respective communities. To ensure high commitment in CHPS by community members, Ghana Health services should explore the possibility of every community having a health management committee to coordinate activities of CHPS. As indicated in this study, the eight (8) member CHMC in one of the CHPS studied were all drawn from the community hosting the CHPS and their activities were mostly limited to their community. This practice does not encourage community mobilization and ownership in CHPS.

- For essential maternal health services to be well utilized by community members, male involvement in maternal health programmes is very crucial. Organizations that operate or plan to operate in the area in the area of maternal health should place so much emphasis on male involvement in their programmes.
- CHPS workforce in the study area should be equipped with innovative Information, Communication and Education materials and techniques and well supervised to used them to improve the knowledge and practices of community members regarding objectives of CHPS.

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APPENDICES

APPENDIX 1: Distribution of Health Facilities in the Study Area.

	Facility name and type	Compound available	Coverage	No. of trained as CHO	No. of CHN	No. of EN	No. of MW	No. Staff Nurses /Nursing Officers/Psy. Nurses	No. of physician Assistants	No. Medical Officers	Total No. of staff
Bimoba Area	KAMB ATIAK CHPS	Yes	5,255	0	1	2	0	N/A	N/A	N/A	3
	KUNK WAADAN CHPS	Yes	3,353	0	1	1	0	0	N/A	N/A	2
CHPS served by only one CHN in the District Hospital	NAJONG 1&2 CHPS ^β	No	1,987	0	0	0	0	0	0	0	0
	Binde Hospital	N/A	6,836	N/A	1	11	3	15	1	2	33
	NGAMAK GBERUK CHPS	1530	1,110	0	1	1	0	N/A	N/A	N/A	4
	KAMBAGU CHPS	Yes, N/U	3,411	0	1	2	0	N/A	N/A	N/A	3
	KINKANGU CHPS*	Yes, N/U	4,067	0	0	0	0	0	0	0	0
	PAGNATIC CHPS ^β	No	4,083	0	0	0	0	0	0	0	0
	TOJING CHPS ^β	No	1,598	0	0	0	0	0	0	0	0
	Bunkpurugu Health Centre	N/A	20,115	N/A	3	6	3	3	1	0	12
	Rabito Clinic	N/A	0	N/A	0	3	0	0	1	0	3
	Served by the	NAPON TBAUK CHPS ^β	No	3,530	0	0	0	0	0	0	0

same CHOs	BIMBA GU CHPS	Yes	9,451	0	1	5	1	N/A	N/A	N/A	7	
same by the only CHN , Field a Techni cian, and a Award Assista nt from the subdist rict Health Centre	BOATE RIGU CHPS*	Yes, N/U	3,587	0	0	0	0	0	0	0	0	
	TUSUK CHPS*	Yes, N/U	2324	0	0	0	0	0	0	0	0	
	Nakpan duri Health Centre	N/A	16,81 4	N/A	1	10	3	3	1	0	18	
	Faith Commu nity Hospital	N/A	0	N/A	1	7	1	3	3	2	17	
SUBTOTAL			89,65 3		11	48	11				102	
Konk omba Area	NAMO NGO CHPS	Yes	3,602	0	1	1	0	N/A	N/A	N/A	2	
	Served by the same CHOs	Yes	2,723	1	1	2	0	N/A	N/A	N/A	3	
	TEMA A CHPS											
	MONT ANA CHPS*	in progr ess	7,371	0	0	0	0	0	0	0	0	
	Nasuan Health Centre	N/A	7,796	0	1	4	1	1	0	0	7	
	TUNA CHPS	Yes	4,642	0	0	2	0	N/A	N/A	N/A	2	
	Served by CHOs from Bimba gu CHPS	GBING BANC HET CHPS ^β	No	1,882	0	0	0	0	0	0	0	0
		MOZIO CHPS	Yes	2,898	0	1	1	0	N/A	N/A	N/A	2
3 Functi onal	BUNB UNA CHPS ^β	No	4,099	1	1	0	0	0	0	0	0	

CHPS zones served by 2 staff from the subdistrict health centre in addition to the Health Centre Catchment area	JIMBA LE CHPS*	Yes, N/U	3,362	0	0	0	0	0	0	0	0
	SAMBI K CHPS*	Yes, N/U	4,752	0	0	0	0	0	0	0	0
	Yunyoo Health Centre	N/A	3,517	0	1	2	1	1	0	0	5
A Functional CHPS zone Served by health centre staff	GBAN KURU GU CHPS*	Yes, N/U	6,205	0	0	0	0	0	0	0	0
	Gbingbani Health Centre	N/A	4,155	0	1	1	1	0	0	0	3
Subtotal			56,912								
Total			146,565		29	109	25	26	8	4	127

Appendix 2: Informed Consent Authorisation To Participate In A Research Project

Focus Group Participant

STUDY TITLE: FACTORS INFLUENCING THE UTILIZATION OF COMMUNITY-BASED PLANNING AND SERVICES IN BUNKPURUGU/YUNYOO DISTRICT IN NORTHERN REGION OF GHANA

PRINCIPAL RESEACHER: ABDUL-RAHAMAN YAKUBU

RESEACH SUPERVISOR: DR. SETH AFADADZE

INSTITUTION: DEPARTMENT OF HEALTH POLICY PLANNING AND MANAGEMENT, SCHOOL OF PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON.

Sturdy Purpose:

The purpose of this study is to learn how community members use Community-Based Health Planning and Services (CHPS) for their health needs and how satisfied they are with services provided by CHPS. We hope to learn things that the stakeholders in health can use to improve CHPS so that it can better cater for the health needs of community members . We are, therefore, very interested to hear your valuable opinion on what and how stakeholders can do to improve the use of CHPS by the members of this community. This study is purely for academic purpose (that is, in a partial fulfillment of the requirements for the award of a Master of Public Health degree). Nonetheless, its findings will be disseminated to the District Health Management Team, and that may be useful in its planning and implementation of CHPS-related programmes. The findings may also be published by the Principal Investigator, through which it will be widely available to various stakeholders in CHPS.

Study Procedure:

You are being invited to participate in this research that uses focus groups to obtain information regarding issues that enables or hampers the use of CHPS by the members of this community.

If you agree to participate in the focus group discussion, you will be asked to complete a demographic form that includes your age, sex, marital status, ethnicity, religion, occupation and years of stay in this community.

The focus group discussion will last approximately one and half to two hours and will be led by two Facilitators. They will ask open-ended questions about barriers and enablers of CHPS utilization in this community. The discussion in the focus group will be audiotape recorded and transcribed following the session, but you will not be identified individually on the transcripts.

Risks Or Discomforts of the Study

There are no anticipated risks of physical harm to your involvement in this study. However, there may be a potential minimal risk of emotional discomfort resulting from the attitudes, actions or inactions of other participants, such as heckling or psychological risk such as fear, confusion, guilt, loss of self-esteem, depression, or triggering of past emotional experiences. The study team will try as much as possible to enforce agreed ground rules to ensure that every participant expresses his/her views freely devoid of intimidation from the other participants. The team may not be able to prevent certain discomforts you may experience as a result of you being reminded of a past negative experience, however, it will do well to manage such incidents when they come up. That notwithstanding, you may choose not to answer any question that you think might discomfort you.

You may also choose to withdraw from this study at any time without having to suffer any negative consequence. That is, if you choose not to participate in this study, all the services you receive at the CHPS will continue and nothing will change or your relationship with the study team will not be negatively affected if you decide to leave the focus group). You do not have to give any reason for not responding to any question, or for refusing to take part in the research.

Possible Benefits

You will not receive direct benefit from participating in this study except to state that you will be provided with a snack of one 0.5L of soft drink and biscuit for refreshment at the end of the discussion.

This study in itself is purely for academic purposes, without an objective of implementing any follow up intervention programme. Your voluntary participation in the study may assist the research team have a better understanding of the issues that affect utilization of CHPS in this district, which ultimately may result in the execution of better strategies to improve CHPS through dissemination of the study findings to key stakeholders in CHPS (Ghana Health Service and its partners in CHPS implementation).

Additional Costs And Compensation

The research team has not set aside any funds for financial compensation for your participation in this study or for any liability that you incur as a result of your participation in this study. However, if you incur any liability as a result of your involvement in this study, for which you believe justifies pursuing a legal remedy, you have the right to do so. Therefore, by signing this form, you are neither waiving any of your legal rights against or releasing the Principal Investigator or any of his assistants of any from liability for negligence with respect to this study.

Nonetheless, all participants will be given snack of one 0.5L of soft drink and 125g of biscuit at the end of the discussion.

Confidentiality

Due recognition will be given to the fact that your statements or actions, if become known to other individuals in this community, will cause you some embarrassment, so, adequate measures will be taken to protect your confidentiality. These measures include: first, any of your identifying information will not be on the transcripts, hence any information cannot be traced to you by anybody. Only the research team (the PI, the two RAs and three language experts, and the Research Supervisor) will have access to the data collected. Any tapes and transcripts of the focus group will be destroyed at the end of the study to prevent any possible leakage of the recordings. Also, all questionnaires will be strictly accessible to the research team only to prevent any possible use of information on them by a third party to identify you. In effect, data will be stored in an encrypted folder on my password protected laptop. This will ensure that only the research team will have access to the study data.

In addition, because the focus groups include discussion of personal experiences and opinions, extra measures will be taken to protect each participant's privacy. Every participant of the focus group is required to agree to keep information discussed in the group confidential. Signing to the certificate means that you have consented to keep information of other participants confidential and the researcher will not be liable for any breach of confidentiality.

Sharing Of Results

The findings of this study will be submitted as a dissertation to the Graduate School of the University of Ghana for academic purposes. It will also be shared with the District Director of Health Service so that the District Health Management Team may use it to plan on how to improve CHPS in the district. In addition, it may also be made available to any other organizations or stakeholders who make request for it.. I may publish the results so that it will be widely available to various individuals and organizations. However, when presenting the findings, your names and other identifying information will not appear in the final document, hence no comment can be traced to you by any person.

Contacts For Additional Information

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following: Abdul-Rahaman Yakubu, Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon on the following numbers 0249581584/0207526936, or email rahamana82@yahoo.com or Dr Seth Afagbedzi, School of Public Health, University of Ghana, Legon on , or email EMaya@ug.edu.gh or Hannah Frimpong, Ghana Health Service Ethics Review Committee on 0243235225, email hanna.frimpong@ghsmail.org

PART II: CERTIFICATE OF CONSENT

I have been invited to participate in a study about CHPS utilization. The document describing the benefits, risks and nature and purpose of the study has been read and explained to me. I have been given an opportunity to have any questions about the study answered to my satisfaction. I agree voluntarily to participate in this study.



Full name of participant

Signature or

Thumb print

Date

Declaration by witness (if participant cannot read the form herself)

I was present while the benefits, risks and nature and purpose of the study were read to the participant. All questions were answered and the participant has agreed voluntarily to take part in the study

Full name of witness

Signature of witness or Thumb print

Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this study have been explained to the above individual to the best of my ability.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the consent has been given freely and voluntarily

Name of researcher

Signature

Date

**Appendix 3: Informed Consent Authorisation To Participate In A Research Project
In-Depth Interviewees/Key Informant**

STUDY TITLE: FACTORS INFLUENCING THE UTILIZATION OF COMMUNITY-BASED PLANNING AND SERVICES IN BUNKPURUGU/YUNYOO DISTRICT IN NORTHERN REGION OF GHANA

PRINCIPAL RESEACHER: ABDUL-RAHAMAN, YAKUBU

RESEACH SUPERVISOR: DR. SETH AFADADZE

INSTITUTION: DEPARTMENT OF HEALTH POLICY PLANNING AND MANAGEMENT, SCHOOL OF PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON.

Sturdy Purpose:

The purpose of this study is to learn how community members use CHPS for their health needs and how satisfied they are with services provided by CHPS. We hope to learn things that the Ghana Health Service and the Ministry of Health can use to improve CHPS so that your health needs will be better catered for by CHPS. We are, therefore, very interested to hear your valuable opinion on how the Ghana Health Service can do to improve the use of CHPS by the members of this community. This study purely for academic purpose (that is, in a partial fulfillment of the requirements for the award of a Master of Public Health degree). Nonetheless, its findings will be disseminated to the District Health Management Team, and that may be useful in its planning implementation of CHPS-related programme. The findings may also be published by the Principal Investigator, through which it will be widely available to various stakeholders in CHPS.

Study Procedure:

You are being invited to participate in this research that uses In-Depth Interview to obtain information regarding issues that enables or hampers the use of CHPS by the members of this community.

If you agree to participate in the study, you will be asked questions on your demographic characteristics such as your age, sex, marital status, ethnicity, religion, occupation and years of stay in this community.

My interview with you will last for about 15 to 20 minutes. I ask you open-ended questions about barriers and enablers of CHPS utilization in this community. The interview will be audiotape recorded and transcribed following the session, but your identifying information will not be in the transcripts. I will also like to take down some notes during the interview.

Risks Or Discomforts of the Study

There are no anticipated risks of physical harm to your involvement in this study. However, there may be a potential risk of emotional discomfort fear, stress, confusion, guilt, loss of self-esteem, depression, triggering of past emotional experiences resulting from you responding to the questions that will be posed to you. However, I wish to assure that my main aim in this interview is to obtain your experiences and views about CHPS and not to find fault or judge you. Therefore, you should feel comfortable to express your views without any fear of being ridiculed. Not only I have I been trained in the ethics of conducting study interview, but I have also been educated well on the general values of people in this area so as to able to gather information from participants in a manner that is culturally acceptable. That notwithstanding, you may choose to withdraw from this study at any time without penalty (*If you choose not to participate all the services you receive at the CHPS will continue and nothing will change*). Also, your relationship with the study team will not be negatively

affected if you decide to leave the focus group). You do not have to give any reason for not responding to any question, or for refusing to take part in the research.

Possible Benefits

You will not receive direct benefit from participating in this study. This study in itself is purely for academic purposes. Nonetheless, the study findings will be disseminated to the District Health Management Team, and hence the study findings may provide a useful input into the planning and execution of CHPS activities in this district. Therefore, your voluntary participation in this study may assist the research team have a better understanding of the issues that affect utilization of CHPS in this district, which ultimately may result in the execution of better strategies to improve CHPS .

Additional Costs and Compensation

The research team has not set aside any funds for financial compensation for your participation in this study or for any liability that you incur as a result of your participation in this study. However, if you incur any liability as result of your involvement in this study, for which you believe justifies pursuing a legal remedy, you have the right to do so. Therefore, by signing this form, you are neither waiving any of your legal rights against or releasing the Principal Investigator or any of his assistants of any from liability for negligence with respect to this study.

Confidentiality

Due recognition will be given to the fact that your statements or actions, if become known to other individuals in this community, will cause you some embarrassment, so, adequate measures will be taken to protect your confidentiality. These measures include: first, any of your identifying information will not be on the transcripts, hence any information cannot be traced to you by anybody. Only the research team (the PI, the two RAs and three language

experts, and the Research Supervisor) will have access to the data collected. Any tapes and transcripts of the interview will be destroyed at the end of the study to prevent any possible leakage of the recordings. Also, all questionnaires will be strictly accessible to the research team only to prevent any possible use of information on them by a third party to identify you. In effect, data will be stored in an encrypted folder on my password protected laptop. This will ensure that only the research team will have access to the study data.

Sharing Of Results


Nothing that you tell the study team will be shared with anybody outside the team, and nothing will be attributed to you by name. The knowledge that will be obtained from this study will be shared with the District Director of Health Service so that they will see what to do to improve CHPS in your community. I may publish the results so that other interested people may learn from the study.

Contacts For Additional Information

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following: Abdul-Rahaman Yakubu, Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon on the following numbers 0249581584/0207526936, or email rahamana82@yahoo.com or DrSethAfadadze, School of Public Health, University of Ghana, Legon on , or email asafagbedzi@gmail.com or Hannah Frimpong, Ghana Health Service Ethics Review Committee on 0243235225, email hanna.frimpong@ghsmail.org

PART II: CERTIFICATE OF CONSENT

I have been invited to participate in a study about CHPS utilization. The document describing the benefits, risks and nature and purpose of the study has been read and explained to me. I have been given an opportunity to have any questions about the study answered to my satisfaction. I agree voluntarily to participate in this study.

_____ _____  _____
Full name of participant Signature or Thumb print Date

Declaration by witness (if participant cannot read the form herself)

I was present while the benefits, risks and nature and purpose of the study were read to the participant. All questions were answered and the participant has agreed voluntarily to take part in the study

_____ _____ _____
Full name of witness Signature of witness or Thumb print Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this study have been explained to the above individual to the best of my ability.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the consent has been given freely and voluntarily

_____ _____ _____
Name of researcher Signature Date

Appendix 4: Focus Group Discussion Guide

1. Welcome

Introduce yourself and the notetaker, and send the Sign-In Sheet with a few quick demographic questions (age, gender, cadre, years lived in this community) around to the group while you are introducing the focus group.

Review the following:

- Who we are and what we're trying to do
- What will be done with this information
- Why we asked you to participate

The review of the above can be as follows:

Thank you for agreeing to participate. We are very interested to hear your valuable opinion on how the Ghana Health Service can do to improve the use of CHPS

- *The purpose of this study is to learn how community members use CHPS for their health needs how satisfied they are with services provided by CHPS. We hope to learn things that the Ghana Health Service can use to improve CHPS so that your health needs will be better catered for by CHPS.*
- *The information you give us is completely confidential, and we will not associate your name with anything you say in the focus group.*
- *We would like to tape the focus groups so that we can make sure to capture the thoughts, opinions, and ideas we hear from the group. No names will be attached to the focus groups and the tapes will be destroyed as soon as they are transcribed.*
- *You may refuse to answer any question or withdraw from the study at anytime.*
- *We understand how important it is that this information is kept private and confidential. We will ask participants to respect each other's confidentiality.*

- *If you have any questions now or after you have completed the questionnaire, you can always contact a study team member like me, or you can call the study team on the phone numbers provided on this form.*

2. Explanation of the process

Ask the group if anyone has participated in a focus group before. Explain that focus groups are being used more and more often in health and human services research.

About focus groups

- We learn from you (positive and negative)
- Not trying to achieve consensus, we're gathering information
- No virtue in long lists: we're looking for priorities
- In this study, we are doing both questionnaires and focus group discussions. The reason for using both of these tools is that we can get more in-depth information from a smaller group of people in focus groups. This allows us to understand the context behind the answers given in the written survey and helps us explore topics in more detail than we can do in a written survey.

Logistics

- Focus group will last about one hour
- Feel free to move around
- Help yourself to refreshments

3. Ground Rules

Ask the group to suggest some ground rules. After they brainstorm some, make sure the following are on the list.

- Everyone should participate.
- Information provided in the focus group must be kept confidential
- Stay with the group and please don't have side conversations
- Turn off cell phones if possible
- Have fun(N Chaudhury & Hammer, 2003)

3. Turn on Tape Recorder

Ask the group if there are any questions before we get started, and address those questions.

4. Introductions

- Go around table: position in community, where you were born

Discussion begins, make sure to give people time to think before answering the questions and don't move too quickly. Use the probes to make sure that all issues are addressed, but move on when you feel you are starting to hear repetitive information.

Questions:

1. Let's start the discussion by talking about what the health workers at the CHPS do in this community. What are the activities that the health workers in the CHPS do (both at facility and in the entire community)?

Probes for Discussion:

- *Weighing children*
 - *Immunizing children*
 - *Treating sick persons*
 - *Home visits*
 - *Durbars*
 - *Family Planning*
 - *Delivery*
 - *Checking pregnant women*
2. Do you participate in the activities that the CHPS health workers carry out in this community or use any of the services they provide?
 3. If you have been using the services of the CHPS, how do you find the services that the health workers there provide (satisfactory or not satisfactory)?
 4. What kind of health services do you seek from the CHPS compound?
 5. If you have never been involved in CHPS or use its services, what is/are your reasons?

Where do you then seek healthcare from? Why do prefer that to CHPS?

6. Have you considered stopping to seek healthcare from the CHPS? If so, why? What factors have contributed to your decision to want to stop seeking healthcare from the CHPS?
7. What are the factors that encourage you to keep using CHPS?
8. Would you recommend other community members to use CHPS?

9. What do you think the health people should do improve CHPS so that you would want to use its services?

10. Recap the main issues that came up

That concludes our focus group. Thank you so much for coming and sharing your thoughts and opinions with us. If you have additional information that you did not get to say in the focus group, please feel free to write it on this evaluation form.

Materials and supplies for focus groups

- Sign-in sheet
- Consent forms (one copy for participants, one copy for the team)
- Pads & Pencils for each participant
- Focus Group Discussion Guide for Facilitator
- 1 recording device
- Batteries for recording device
- Extra tapes for recording device
- Permanent marker for marking tapes with FGD name, facility, and date
- Notebook for note-taking
- Refreshments

Appendix 5: In-Depth Interview Guide -Chmc

In-Depth Interview Guide -CHMC

We are conducting a study on the Utilization CHPS in this district. Your input will help us identify the factors responsible for utilization of CHPS in this district. Participation is voluntary: that is you may decide to participate or not. If you agree to participate then you will answer a few questions that I will ask you, and this will last for about 15 minutes. Any information you give will highly be kept confidential and used only for the study. For Verification or Additional Information about this study you may contact:

**The chairman, Ghana Health Service Ethical review committee, P. O. Box MB 190
Accra, Ghana .Tel : +233-302-681109 email: *Hannah.Frimpong@ghsmai.org***

A1. Name of sub-district:

A2 Name of interviewer.....

A3 Date of interview.....

A4 Start (time).....

End (time).....

Name of CHPS zone:

A3. Questionnaire Number:

A6 . ID of Respondent:

Designation.....

A7. Age:

A8. Sex:

A7. Level of formal education:

A8. Occupation.....

Section B: CHPS Zone Profile

B1. Do you have sketch map of this CHPS zone?

B2. How many communities are in this CHPS zone?

B3. What is the population of CHPS zone?

Section C: Community Involvement

C1 What activities does the CHMC undertake in this CHPS zone?

C2 How many are the CHMC members? {Give the breakdown by sex and by community}.....

How often does the committee meet?.....

Where does the meeting take place.....

How is the meeting convened?

C3. When was the last time a CHMC meeting was held?.....

C4 What challenges do you encounter in the holding the meeting?.....

Are you able to implement the decisions you take at CHMC meetings?

What are the challenges in implementing those decisions?.....

How are these challenges handled?

Has the CHMC being able to help the CHPS carry out any activity within the zone in the last three months? Give details

How regularly do you meet with the health workers in the CHPS compound??

What is the relationship between you and they (CHPS officers)?

Are you aware of the existence of a plan of health activities for the CHPS for this year?

Do CHPS health workers engage you in the planning and carrying out health activities in the zone? Yes No

ii. If yes, explain.....

iii. If no, how do they operate in this Zone?

C13. i. Do communities in this zone contribute to the maintenance of the Compound? Yes No

ii. If yes, how do they contribute?.....

iii. If No, why do they not contribute

C14.Can you mention the trainings you have received within the last two years and where and when was the training done?

Title of training	Venue	Month/Year

C15.i. Do you receive any incentives for the work you do? Yes No

ii. If yes, explain?.....

iii. If no, what motivates you to keep working?.....

C16. What do think should be done to facilitate you to work better? { probe for additional training, provision of resource materials}

Section D: Service Availability, Quality and usage

D1.i. Do community members use the services provided by the health workers from the CHPS?
Yes No

ii.If yes, is it as you expect? {Is it encouraging}.....

iii. If it is encouraging, what accounts for that {probe about the quality of service}:.....

iv.If it is not, what are the causes of poor usage?.....

D2.Are a particular group of people in this zone who have any difficulties reaching the CHPS compound or the nearest outreach site for health services?.....

D3. Do people who seek services at the outreach site or at the CHPS compound complain about long delays in receiving services?.....

D4. Are there traditional/cultural practices in the communities that restrict community members from seeking certain kind of health services from the CHPS?

D5. Apart from the CHPS compound, are there other places within this CHPS zone that people in this community seek health care from {e.g herbalists, over-the-counter chemical sellers, TBAs, spiritual healers)?

Give details.....

D6. i.Do community members travel out of this CHPS zone to seek healthcare in facilities elsewhere? . ii. If yes, which facilities to they go to,..... and with what conditions?.....

D7.i. Do you know the number of active Health Insurance Subscribers in this community? Yes No

ii. If Yes, how many are they?..... and what proportion of the population is that?...

D8.i. Do community members have an easy access to the NHIA registration centre? Yes No

ii. If Yes, explain....

iii. If No, explain.....

D9.i.Are there additional services that community members expect from CHPS? Yes No

ii.If yes, what are they?

D10. What do think about the attitude of health workers at the CHPS towards community members?

D11. What are the perceptions that community members have about the CHPS compound and the health workers who work there? {the bad and the good}.....

D12. What do you think should be done to improve the use of the CHPS by community members?

.....

Are any other issues relating to CHPS that you wish to share with me?

Thank you, the information provided.

APPENDIX 6: In-Depth Interview Guide-CHO

We are conducting a study on the Utilization CHPS in this district. Your input will help us identify the factors responsible for utilization of CHPS in this district. Participation is voluntary: that is you may decide to participate or not. If you agree to participate then you will answer a few questions that I will ask you, and this will last for about 15 minutes. Any information you give will highly be kept confidential and used only for the study. For Verification or Additional Information about this study you may contact:

**The chairman, Ghana Health Service Ethical review committee, P. O. Box MB 190
Accra, Ghana .Tel : +233-302-681109 email: *Hannah.Frimpong@ghsmail.org***

Name of Subdistrict	Name of CHPS	Year established
Number of communities in CHPS zone	Total population	
ID of Contact	Designation	Telephone number
Number of years served in CHPS		

Section A: Human Resource Availability

1. How many staff does this facility have?
 - a. Give the breakdown of the various categories of staff (e.g CHN, EN, SN, FT etc)
 - b. Are the numbers adequate? Yes No

Can you please, give reasons for your answer in (1b) above?

2. How many of the staff are indigenes of this district?

.....

Do all staff stay within this CHPS zone? Yes No

If no, why are some staying outside the zone?

3. Have all the staff in this facility been formally trained on CHPS? Yes No

If yes, when, and by which organization ?.....

If no, how many staff have not been trained, and why have they not been trained?

Community Involvement in CHPS

4. Does this facility ever have a CHMC?

How many are they?

How were the members selected?

What is the composition of the CHMC (e.g in terms of sex or position in community(pastor, Imam, Chief, TBA etc)

Were CHMC members given a structured orientation on their role in CHPS? Yes No

If yes, by whom.....

If no, why?.....

Does is it still exist? Yes No

If yes, how often does the committee meet?

Do all CHMC members attend meetings regularly? Yes No

Give details, please {or can we confirm from the minutes of the last three meetings)

.....

Can you briefly describe what CHMC's role is in CHPS?

Are these roles carried out by the CHMC?

What activities have the CHMCs supported you (CHPS staff) to undertake within this Quarter?

5. Does this facility have CHVs?

How many are they?

How were they selected?

Can provide the breakdown of the number of CHVs by sex?

Have the CHVs been trained on their role in CHPS? Yes No

If yes, how many..... and when

Can I see a copy of the training report?.....

If no, why.....

6. Can you briefly describe the roles of CHVs in the CHPS?

Are these activities being carried out by the CHVs of this CHPS? Yes No

If yes, explain the specific activities that they do.....

If no, why?.....

Does this facility work with TBAs in the zone? Yes No

If yes, explain {include details of the number of TBAs and you collaborate with them}.....

If no, why?.....

Does the Facility hold meetings with social groups within the zone? Yes No

If yes, give details

7. Does the Assembly Member for this Electoral area contribute to the running of the CHPS?

Give details for your answer.....

8. Does the your facility collaborate with religious leaders in the zone?

Give details for your answer [*probe to know whether they are in support or against CHPS*]....

9. Is there a CHAP for the CHPS zone for this year? Yes No

If Yes, how was it developed? {did every community in the zone have a representation in the process?}

How is the CHAP implemented?

10. What proportion of CHVs have carried out such activities at least once within the last three months?

11. Do CHVs receive incentives from the CHPS or the DHMT? Yes No

If yes, what form of incentive and how often?

12. How do you identify and handle issues arising from the community to the facility and vice versa?

Availability of Medicines and Equipment

13. Does this facility frequently experience stock out of essential commodities (such as drugs, vaccines, contraceptives, RDT for Malaria, etc)?. Explain.....?

14. Has the facility faced any such stock –out within the last six months? Yes No

If yes, mention the particular commodities for which the was stock out.....

What was the cause of the stock-out?.....

15. Does this facility have the minimum equipment required for CHPS? Yes No

If yes, do they function accurately?

Did you receive training on the use of those equipment?. {explain}

If no, give details {which ones are lacking}.....

Service Availability

16. What services do you provide in this facility?

{probes: ANC, PMTCT, treatment of illnesses, family planning)

17. a. Do you conduct community outreach services

b. How many outreach sites are there in this CHPS zone?

c. How many times do you hold outreach sessions in each of the sites?

What are the specific services you routinely provide at outreach sites.....

18. Is the patronage of the services of this facility by community members good? Yes

No

If yes, how many clients do see in a day for clinical services?

Has the facility met its targets for all the immunizations continuously in the last 3 months?

If no, what accounts for that?.....

19. Does this facility undertake home-visits to households? Yes No

If yes, on average how many households does the facility cover in a month?

If no, why?.....

How are home-visits planned and carried out?

What services are provided during home-visits?

20. Does the facility conduct community durbars?

How often are community durbars conducted?

Does this facility refer clients to other health facilities?

[probe for details about the conditions being referred, if the response is yes]

Is there a system in place to follow up on clients referred from this facility?[ask for detail explanation of how it done]

Challenges in Service Provision

- 21. What are the main challenges that this facility is faced with ?
- 22. What are the causes of these challenges?
- 23. What has been done about these challenges so far {what measures have put place}?
- 24. What is the result of the action taken?

Quality of Service

25. Do clients spend long times in this facility or at outreach site before receiving services? Yes No

If Yes, how why?

26. What are the operational hours of this facility?

Day	Open	Break for lunch	Open after lunch	Close for the day
Weekdays				
Saturday				
Sunday				

26 Do staff attend to emergency cases during periods outside the usual operational hours? Yes No

If no, why?

27. Briefly describe how you attend to OPD clients?

28..Do you provide counselling services to clients? What category of clients do you counsel?

29..Does the facility staff hold meetings to discuss how to improve services? Yes No

If yes, how often.....

Do you implement the decisions that you take at such meetings?

If No, why.....

30. Are there any specific socio-cultural beliefs and practices in this zone that negatively affect the use of CHPS among community members?

If Yes, describe.....

31. Is every staff of this facility involved in outreaches, community durbars and home-visits?

Yes No

If No, why?.....

32. Which of the services are highly utilized by community members?

33. Which of the services are poorly utilized by community members?

34. Are there services that you think are highly demanded for by community members but are not available in the CHPS?

If, yes what are they? And why don't you provide that service

Type of service on demand	Reason for not offering services
1	
2	

Affordability of Services

35. Does the facility accept health insurance? Yes No

If, no why?.....

36. Does the facility charge insured clients additional charges for services covered by the insurance? Yes No

If yes, why.....

37. Have there ever been reports from community members about some health staff charging illegal fees? Yes No

If yes, how was the matter investigated and what was the outcome?

Monitoring and Supervision

38. How often are you supervised by the DHMT or the Medical Superintendent of the District Hospital?

Is the supervision helpful to you? Yes No

If yes, how?.....

If No why?.....

39. How often do you supervise CHVs and how?

40. Do you get data from CHVs?

41. What do you do with those reports?

42. Do you have any form of feedback with CHVs regarding the reports?

If yes, what kind of feedback?

43. What challenges do you encounter during the supervision?

44. In which areas do you require training/updates?

45. What can be done to improve your performance?

We have come to the end of the interview, thank you so much for your time.

However, if wish to share with me, any other information relating to CHPS, that is highly welcome.

APPENDIX 7: In-Depth Interview Guide-Volunteer

We are conducting a study on the Utilization CHPS in this district. Your input will help us identify the factors responsible for utilization of CHPS in this district. Participation is voluntary: that is you may decide to participate or not. If you agree to participate then you will answer a few questions that I will ask you, and this will last for about 15 minutes. Any information you give will highly be kept confidential and used only for the study. For Verification or Additional Information about this study you may contact:

**The chairman, Ghana Health Service Ethical review committee, P. O. Box MB 190
Accra, Ghana .Tel : +233-302-681109 email: Hannah.Frimpong@ghsmail.org**

A1. Name of sub-district:

A2 Name of interviewer.....

A3 Date of interview.....

A4 Start (time).....

End (time).....

A5. Community Name:

A3.Questionnaire Number:

A6 . ID of Respondent:

A7. Age:

A8. Sex:

A7. Level of formal education:

A8. Occupation.....

Section B: Community Profile

B1. Do you have map of this community?

B2. How many Households are in this community?

B3. What is the population of this community?

B4. Do you have a register of pregnant women in this community?

B5. Do you have a register of all children under five in this community?

B6. Do you have register of the social groups in this community?

B7. What is the main source of drinking water for people in this community?

Section C: Community Involvement

C1 What services do you offer in the community? {probe for what they do, home visits reporting cases of diseases to CHPS staff etc }

C2. What services do you provide at the CHPS compound?

C3. When was the last time you undertook any of those services?

C4 What challenges do you encounter in the process of doing your work?

C5.i. Are there additional services that community members expect you to provide? Yes No

ii. If yes, explain.....

C6. i. Do members of this community show interest in the services you provide? Yes No

ii. If yes explain.....

iii. If no, why?.....

C7.i. Do you meet with the leadership of this community regarding health issues in the community? Yes No

ii.If yes, how often? on what specific issues?.....

iii. If no, why?.....

C8. i. Do you meet with CHMC for the CHPS?.....

ii.If yes, how often? on what specific issues?.....

iii. If no, why?.....

C9.How regularly do you meet with the health workers in the CHPS compound??

C10.What is the relationship between you and they (CHPS officers)?

C11. How often do you get site supervision visits by the health workers at the CHPS compound?

C12. i. Do CHPS health workers engage you in the planning and carrying out health activities in the community? Yes No

ii. If yes, explain.....

iii. If no, how do they operate in this community?

C13. i. Do community members contribute to the maintenance of the Compound? Yes No

ii.If yes, how do they contribute?.....

iii. If No, why do they not contribute

C14.Can you mention the trainings you have received within the last two years and where and when was the training done?

Title of training	Venue	Month/Year

C15.i. Do you receive any incentives for the work you do? Yes No

ii. If yes, explain?.....

iii. If no, what motivates you to keep working?.....

C16. What do think should be done to facilitate you to work better? { probe for additional training, provision of resource materials}

Section D: Service Availability, Quality and usage

D1.i. Do community members use the services provided by the health workers from the CHPS?

Yes No

ii.If yes, is it as you expect? {Is it encouraging}.....

iii. If it is encouraging, what accounts for that {probe about the quality of service}:.....

iv.If it is not, what are the causes of poor usage?.....

D2. Do members of this community have any difficulties reaching the CHPS compound or the nearest outreach site for health services?.....

D3. Do people who seek services at the outreach site or at the CHPS compound complain about long delays in receiving services?.....

D4. Are there traditional/cultural practices in this community that restrict community members from seeking certain kind of health services from the CHPS?

D5. Apart from the CHPS compound, are there other places within this CHPS zone that people in this community seek health care from {e.g herbalists, over-the-counter chemical sellers, TBAs, spiritual healers)?

Give details.....

D6. i.Do community members travel out of this CHPS zone to seek healthcare in facilities elsewhere? . ii. If yes, which facilities to they go to,..... and with what conditions?.....

D7.i. Do you know the number of active Health Insurance Subscribers in this community? Yes No

ii. If Yes, how many are they?..... and what proportion of the population is that?...

D8.i. Do community members have an easy access to the NHIA registration centre? Yes No

ii. If Yes, explain....

iii. If No, explain.....

D9.i. Are there additional services that community members expect from CHPS? Yes No

ii. If yes, what are they?

D10. What do you think about the attitude of health workers at the CHPS towards community members?

D11. What are the perceptions that community members have about the CHPS compound and the health workers who work there? {the bad and the good}.....

D12. What do think should be done to improve the use of the CHPS by members of this community?.....

Are any other issues relating to CHPS that you wish to share with me?

Thank you, the information provided.

Appendix 8: Key Informant Interview Guide

Interviewer's Initials: _____

Date: _____ Start time: _____

End time: _____

Name: _____ Title: _____

ID No, of Interviewee _____ Designation.....

Number of years in this district: _____ Number of years in current
position: _____

1. In general, how do you rate the utilization of CHPS by community members in this district?
2. In your opinion, has the utilization of CHPS (improved, stayed the same or declined over the past few years?)
 - a. i.If it has improved why do you think it has improved?
 - ii .What other factors have contributed to the improved use of CHPS by community members?
 - b. i.If you think there has been a decline or stagnation what do you think is reason for that?
 - ii. What other factors have contributed to the stagnated or decline in the use of CHPS by community members?
- 7.a. In your opinion, what are the most critical service delivery issues that affect the use of CHPS by community members? (both enablers and barriers)
 - b. what needs to be done to sustain or improve upon the enabling factors?
 - c. What needs to be done to address the barriers?
8. a.What are the community-related issues that affect the use of CHPS by community members? (*both enablers and barriers*)
 - b. what needs to be done to sustain or improve upon the enabling factors?
 - c. What needs to be done to address the barriers?
9. In your opinion, what else will improve the use of CHPS in this district?

Close: Thanks so much for sharing your concerns and perspectives on these issues. The information you have provided will contribute a lot to this study.

Before we conclude the interview, is there anything you would like to add? Thanks once more for your time. It's been a pleasure to meet you!