

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH



**ASSESSMENT OF THE INFLUENCE OF COMMUNITY-BASED HEALTH
PLANNING AND SERVICES (CHPS) ON MATERNAL HEALTH IN JIRAPA
DISTRICT, UPPER WEST REGION OF GHANA**

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**A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH,
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FOR THE AWARD OF A DEGREE OF MASTER OF SCIENCE IN
POPULATION AND REPRODUCTIVE HEALTH.**

MARCH, 2014

DECLARATION

I, Noella Anglaaere, hereby declare that this study is my own work towards the MSc. Degree in Population and Reproductive Health and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made.

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DEDICATION

I dedicate this piece of work to the Almighty God who guided me throughout this programme.

To my Husband, children and my siblings who have made me come this far through their immense support, I have the pleasure dedicating this research work to you.

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DEFINITION OF ACRONYMS

CHPS - Community-based Health Planning and Services.

CHOs - Community Health Officers.

DHMT - District Health Management Team.

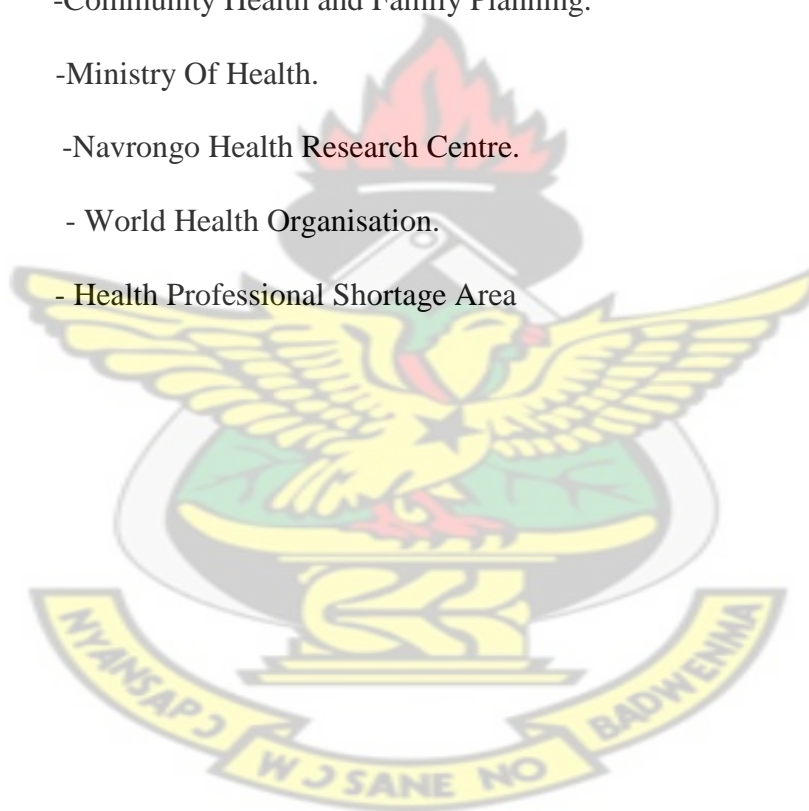
CHFP -Community Health and Family Planning.

MOH -Ministry Of Health.

NHRC -Navrongo Health Research Centre.

WHO - World Health Organisation.

HPSA - Health Professional Shortage Area



ABSTRACT

Background: The Community-based Health Planning and Services (CHPS) programme is an initiative to improve access to healthcare especially maternal health services in rural communities in Ghana. This is done through providing simple compounds in rural communities and providing key staff such as midwives, community health officers, with participation of community members and the use of local resources to provide healthcare services. With the challenges of staffing and logistics in Community-based Health Planning and Services facilities, this research seeks to investigate how Community-based Health Planning and Services facilities have influence access to quality maternal health care in the Jirapa District.

Method: The study design was a descriptive cross-sectional study carried out in the Jirapa District involving 420 respondents using both probability and non-probability sampling methods. Exit interviews were used for patients and staff responded to both open and close questionnaire while focus group discussion and key informant interviews were held with various community members and facility managers respectively.

Results: The study discovered that financial access to maternal healthcare has improved tremendously but spatial factors such as poor roads, transportation to health facilities were still big barriers to maternal healthcare access. Quality of care was generally good but lack of midwives in some Community-based Health Planning and Services compound, sporadic shortage of some family planning devices negatively affected quality of care. Except needs assessment, community participation was very good with community members mobilizing resources for maternal healthcare and taking decisions through the community health committee.

Conclusion: In conclusion the Community-based Health Planning and Services has chalked great success in improving access to quality maternal healthcare in the Jirapa District but more midwives and logistics are needed to improve maternal healthcare quality.

CHAPTER ONE

GENERAL INTRODUCTION

1.1 Introduction

Chapter one contains the background information of the research, followed by the problem statement, the significance of the study, conceptual frame work, research questions and the objectives of the study. It also presents the definition of terms and organization of the work.

1.2 Background of the Study

In Ghana, Community-based Health Planning and Services (CHPS) initiative is a programme designed to translate innovations through an experimental research study at the Navrongo Health Research Centre (NHRC) into national programme for improving the accessibility, efficiency and quality of health and family planning services (Binka et. al. 1995; Pence et. al. 2001; Debpuur et. al.2002). With the advent of the CHPS initiative, the Navrongo experiment became the operational model for health-care development in Ghana. This was originally launched by the Ministry of Health (MOH) in 1994. The Navrongo Community Health and Family Planning Project addressed a long-standing commitment to improve access to primary health care. The Community-based Health and Planning Services (CHPS) system is to increase access to and use of health services in remote communities. This revolutionary system brings trained health care workers directly into the communities and rallies community support behind them to ensure the system's acceptability and sustainability. CHPS offers the best opportunity for more effective and efficient health care in rural communities in Ghana.

Despite the “health for all” policies launched over two decades ago in 1990, more than 70 percent of Ghanaians still cannot get access to quality health care services as they stay about eight kilometers away from the nearest service provider, leading to rural infant mortality rates being 50 percent higher than corresponding urban rates (GDHS/MOH 2008). Improving access to health-care delivery, therefore, remained a primary goal of health-sector reform since the early 1990s.

In 1999, the CHPS initiative was introduced by the Ministry of Health in collaboration with the Ghana Health Service as a national policy for improving rural health care delivery. Improving access to health care is a critical aspect of poverty alleviation, especially in the severely under-developed areas of the country; CHPS represents the contribution of the health sector to national poverty-alleviation policies. This initiative has its origin in an experimental research programme known as Community Health and Family Planning (CHFP) project, which was developed and tested at Navrongo Health Research Centre. Evidence from this experimental research at Navrongo demonstrated the need for re-orienting and redeploying Community Health Nurses to stay in the community setting, while mobilizing the traditional structures and resources inherent in the community, to dramatically enhance service delivery and maternal child health. CHPS is recognized as one of the most strategic measures for increasing geographical and financial access to health care and is promoted as the principal means of providing health care services to deprived rural communities. Its five strategic pillars are improved quality, access, efficiency, partnerships and financing, which is apply to the delivery of an essential package of health services and improved equity and access for the poor.

Attention is given to improving health worker performance and responsiveness to client needs, improving financial, geographical and socio-cultural access to care, and improving partnerships with households and communities, between private and public sector providers, and with other ministries, departments and agencies.

In Ghana, when the Navrongo Health Research Centre (NHRC) experiment demonstrated that community-based health services could reduce child mortality and fertility in impoverished communities, the Government of Ghana launched the Community-based Health Planning and Services (CHPS) Initiative to scale up results. Navrongo presented an approach to evidence-based policy development, which aimed to bridge the gap between research and programme implementation (Nyonator et al. 2005a). The CHPS Initiative scaled up innovations from NNHRC's experimental study into a programme of national community health care reform that sought to improve the accessibility, efficiency and quality of health family planning care. Over a two year period, 104 out of the 110 districts in Ghana started CHPS (Nyonator et al 2005b). Regarded as the primary strategy for reaching the unreached, CHPS became an integral part of the Ghana Health Service Five Year Programme of Work and represented one of the health sector components of the national poverty reduction strategy (Nyonator et. al., 2005a).

The CHPS model is seen as a key element of the MOH/GHS strategy to achieve these results, as it is establishing the regulatory and policy environment for health insurance and developing exemption policies and practices that favors the poor. To further address

the inequities of the past, attention is given to deploying health resources to currently under-served regions of the country.

1.3 Problem Statement

Majority of people in Ghana have no access to quality basic healthcare. This is especially so in deprived communities among the vulnerable population such as women and children who need such services most (MOH Policy Document, 1977). In areas where health services are available, lack of Community involvement in the planning and delivery of healthcare can prevent people from accessing such services.

The CHPS initiative was instituted to provide quality, Community-based level, or “close-to-client” doorstep health delivery with household and community involvement and ensure efficiency in resource utilization. A Programme that tries to engage communities to improve their own health status. Even though the initiatives have been implemented some ten years ago, there still exist among others high infant, child and maternal mortality rate in the Jirapa district. Infant mortality in 2012 was 5254 per 10,000 live births while maternal mortality in 2012 stood at 299 per 100,000 live births. This study seeks to investigate the quality of healthcare, access to services and the level of community participation among communities with CHPS facilities in the district.

1.4 Justification of the Study

Despite the high increase contribution to the research towards provision/supply of quality of standard health services to enhance development in developing countries, a lot

is still expected on the importance of rendering quality maternal health care to enhance the effect on reducing maternal mortality/ improving standard of living. This present study therefore seeks to assess and provide empirical evidence with regards to easy accessibility to health care services which the CHPS concept aimed to achieve. In this regards, the findings would be of immense benefits to policy makers, especially, in the field of primary health care services. Also, this study would provide evidence on the success or otherwise of the CHPS concept to policy makers and stakeholders. Conducting this study will equally result in getting relevant information for improving pragmatic healthcare programmes and promoting culturally acceptable policies to enhance the quality of CHPs zones operations, especially on maternal health issues and some recommendations will be made to the District Health Directorate.

1.5 Conceptual Framework

The conceptual framework describes the independent variables such as waiting time, provider client interaction, geographical, acceptability, perception, etc., in relationship to the dependent variables such as quality of care, accessibility and community participation at the CHPS zones of the study area.

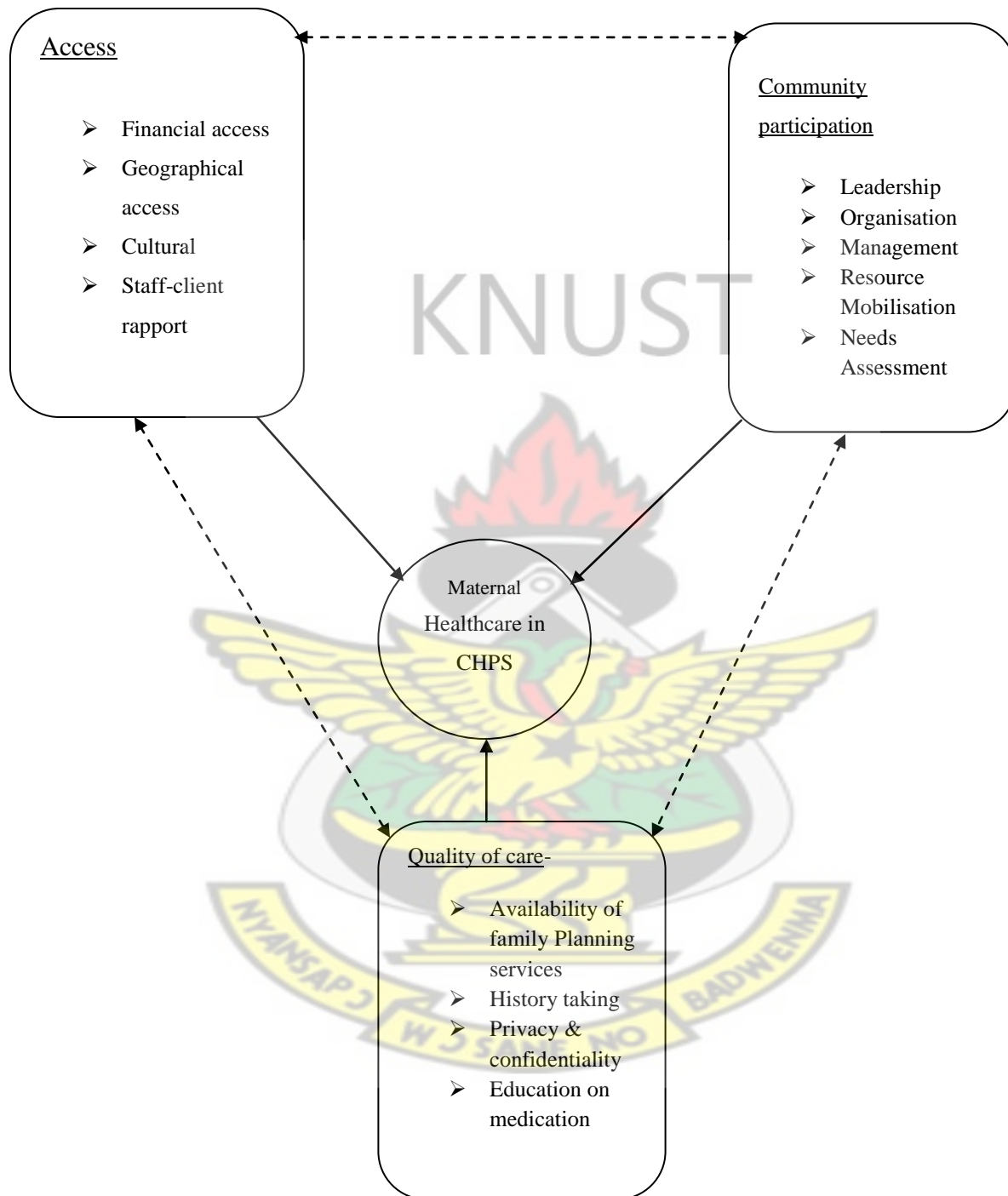
When people have financial access, geographical access and friendly health personnel providing culturally acceptable maternal health services with the participation of community members, maternal health is influenced positively because utilization of health services will be enhanced. In the same way, if people have to travel several hours on unmotorable roads to health facilities and will have to wait several hours to receive

healthcare services from uncaring health staff, patronage of services will reduce and maternal health will be compromised. Community involvement in all areas of the CHPS activities will lead to community ownership and enhance the use of the services by the community members thereby improving maternal health services. Fig 1.1 depicts this relationship between the independent and dependent variables.

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Fig. 1.1 Conceptual Framework



Source; Author's Own Construct 2012

1.6 Research Questions

1. What is the quality of maternal health care in the CHPS facilities within the Jirapa district?
2. How does the CHPS influence access to maternal healthcare in the Jirapa district?
3. What is the level of community participation in CHPS activity in the Jirapa district?

1.7 General Objectives of the study

The main objective of the study is to assess the influence of CHPS on maternal health care services with regards to quality, access to care, community participation and its associated challenges.

1.7.1 Specific Objectives

The specific objectives of this study are:

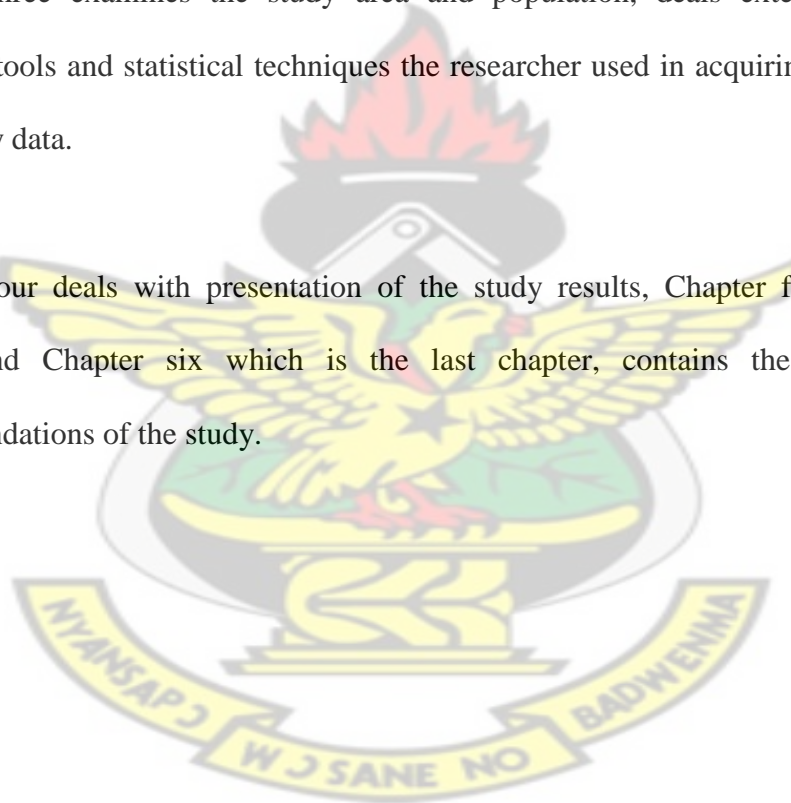
- 1) To assess the quality of maternal health services in the CHPS within the Jirapa district
- 2) To investigate the effect of CHPs on access to maternal health care services in the Jirapa district
- 3) To describe the community participation in CHPS services in the Jirapa district

1.8 Organization of the work

This research is organized in six chapters. Chapter one which is the introductory chapter comprises of the background information, the problem statement, objectives of the study, significance of the study, organization of the work, definition of terms and conceptual framework. Chapter two reviews various literature on the topic of study. It starts with an introduction which highlights the themes to be discussed in the review and goes on further to thoroughly discuss these themes.

Chapter three examines the study area and population, deals extensively with the methods, tools and statistical techniques the researcher used in acquiring and processing of primary data.

Chapter four deals with presentation of the study results, Chapter five discusses the results and Chapter six which is the last chapter, contains the conclusion and recommendations of the study.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The CHPS initiative is aimed at improving access to quality maternal healthcare in remote locations in Ghana in order to reduce child and maternal morbidity and mortality. This chapter will review both empirical and theoretical literature on the CHPS programme relating its influence on access to quality maternal healthcare, and community participation in the CHPS activities.

2.2 Influence of CHPS on Quality Maternal Healthcare

The CHPS system is one of the first of its kind, but the need for community-based health action is not unique to Ghana. Many developing countries face the same daunting maternal and child mortality rates, high fertility rates, low immunization coverage, and generally poor health outcomes. The Navrongo experiment has attracted international attention as a useful way to combat these issues by bringing health to the doorstep of the least fortunate. Navrongo has hosted delegations from Nigeria and Burkina Faso in 2002 and 2004, respectively, which have come to learn from CHPS. Other countries in West Africa and beyond are realizing the gains to be made from mobilizing community momentum to drive health. The Navrongo experiment serves as a guide for countries throughout the developing world to realize health for all

A minority of the population also seek care from traditional healers such as spiritual healers, bone setters, and herbalists. Barriers to solving these problems include poverty, low education and literacy rates, lack of organization in the health

system, poor infrastructure, inequitable health financing, and dearth of skilled health personnel. Most of Ghana's most impoverished individuals live in remote villages, where it is particularly difficult for Ghanaians to receive proper and timely medical attention. About 60% of Ghanaian's participate in subsistence farming and an astounding 80% work in the informal sector as farmers, fishermen, or roadside vendors. Ghana has adopted the Community-based Health and Planning Services (CHPS) system to increase access to and use of health services in remote communities. This revolutionary system brings trained health care workers directly into the communities and rallies community support behind them to ensure the system's acceptability and sustainability. CHPS offers the best opportunity for more effective and efficient health care in rural communities in Ghana.

Donabedian (1990) defines quality of care as the set of activities carried out for the patient that meets the requirements of the best evidence at the time in the particular setting or location. The Quality Management Handbook (2006) on the other hand defines quality of care as the ability to meet customer (user) expectation and provider satisfaction, at a minimum possible cost. Yeboah (2003) defines quality of care as everything the health care organization undertakes to fulfill the expectation and ultimate satisfaction of the user, the payer, the service provider and the employer at the minimum possible cost.

The concept of quality of care has several meanings or implications depending on who is using it. To the health service manager, it is the availability of the right amount of essential inputs, needed to deliver uninterrupted services, for instance, personnel,

buildings, plants, equipment, transport, drugs, information and funds. To the clinician, it is more of the application of modern technology, correct diagnoses, and efficacy of the treatment given. Quality of care as perceived by the user has varied dimensions as Table 2.3 illustrates.

Table 2.1 Quality of Care as Perceived by the User

Quality factor	Its meaning to the user
Working Hours	Convenient opening and closing hours
Human Relations	Mutual respect and treating the user in a humane manner
Direction	Good directions making it easy to locate service points
Hygiene and Sanitation	Good hygiene and sanitation to prevent new infections whilst receiving care
Diagnosis	<ul style="list-style-type: none"> - Health personnel should appear to have time for diagnoses. - Can the user know the result of the diagnosis?

Drugs	Does the facility have the drugs prescribed? Is the dosage well explained to the user?
Time	Are queues respected? Is the total amount of time spent at the facility reasonable and acceptable?
Confidentiality	Are the medical records of the user kept confidential?
Cost	Is cost of the total package of the service (including transport) affordable or reasonable?

Source: Yao Yeboah (2003)

The use or disuse of health facilities will depend on how favorable the above factors are. Any one of these dimensions has the potential to inhibit the user especially the most vulnerable in society; the poor, women and children from enjoying healthcare.

According to Yeboah, the infant mortality rate varies from less than 57 per 1000 live births in southern Ghana to over 100 per 1000 live births in northern Ghana. This may be a clear case of the role of poverty in accessing health care.

The World Health Organisation (WHO) has recommended four key assessment areas for determining quality of healthcare in the provider's perspective. These are:

- Proper history taking of all patients.
- Adequate diagnosis before treatment.
- Good prescription habits (not more than four drugs at the same time).
- Availability of tracer/essential drugs.

In the view of WHO, failure on the part of providers to adhere to any of the above will lead to poor quality of care provided to consumers.

Issah in 2008 observed that even though the National Health Insurance Scheme's (NHIS) ultimate goal is to make people healthy, it is not a panacea for the promotion of quality healthcare delivery in the country (Issah, 2008). He said the NHIS only helped to remove the financial barriers of clients, but this needs to be complemented with the provision of improved equipment, efficient transport system, quality training of health personnel, and good management of health facilities as well as attitudinal change of health personnel towards patients to ensure quality health care.

The package of treatments and drugs available to communities through the volunteers and nurses is comprehensive. The volunteers carry medicines that are easy to prescribe and use: paracetamol for pain, oral rehydration salts for diarrhea, multivitamins, condoms, other contraceptives, and first line malaria drugs. Since free drugs are unfeasible, communities decide a reasonable price for the drugs, and the system is sustainable. Community health nurses come to the field armed in with advanced medicines, immunizations, and modern contraceptives. These nurses also need a motorbike for

transportation, a radio, pens and paper, and other necessities for the community health compound. Armed with these necessities, the nurses and volunteers are prepared to deal with a myriad of problem at the community level, and are able to make necessary referrals to district hospitals or nearby health centers.

The public health facilities under normal situation are expected to provide services to all people without discrimination and at affordable charges. The quality of health services delivered in public, private for profit (PFP), and private not-for-profit (PNFP) facilities has been affected by several factors including the distance to health facilities, availability of drugs, equipment, and training of health workers. Some attempts have been made by the Ministry of Health (MOH) to improve the quality of services. These include among others, building more health facilities, providing more drugs, recruiting more health workers and training health workers through continuing medical education.

The dimensions of quality that relate to client satisfaction affect the health and wellbeing of the community. Patient satisfaction is one of the factors that influence whether a person seeks medical advice, complies with treatments and maintains a relationship with the provider and health facility. The CHPS experiment showed conclusively that the best intervention at the community level combines the MOH dimension and the Zurulegu effect. They learned that community volunteers, no matter how dedicated, were no substitute for a trained nurse. Nurses allow for greater coverage of immunizations, ambulatory services, and referrals. In areas where the Zurulegu dimension was implemented without the MOH dimension, total fertility rates actually increased. This

highlights the importance of skilled health care workers in a community, and relegates the community volunteers to disease prevention, health promotion, and some types of primary care. The Zurulegu dimension greatly supported the MOH dimension and made CHPS more feasible.

The CHPS experiment in Navrongo achieved some success but was plagued by uncertainty and uneven results. Specifically within family planning, however, results were strongly encouraging. Within the first year of both the MOH dimension and Zurulegu dimension, the total fertility rate dropped by about one half of a child; this number continued to drop in subsequent years but not by a consistent amount. This translates to a 15% drop in the fertility rate in only 4 years. Also, women who were in contact with community health nurses were 2.6 times more likely to continue with modern contraceptive use. It was found that 59% of women in 1999 expressed a desire to space out their births, up from 42% in 1993. This statistic suggests that fertility rates will most likely continue decreasing. These statistics illustrate the usefulness of including family planning as a key element in a CHPS system (Stephen, 2008).

Similar progress was made in reducing child mortality, although some statistics point of the lack of breadth in the CHPS programme offerings. Children exposed to the MOH and Zurulegu dimensions had a 12% lower mortality, and children between the age of 24-59 months who had contact with communities health care workers for two years had a 60% decrease in mortality. Infant mortality, as well, dropped from 141 to 96 per 100,000 live births. While these numbers are encouraging, there was no change found in neo-natal mortality, illustrating a need for emergency obstetric care and more births attended by a

trained health care worker. Another worrisome statistic is that, during the CHPS program, HIV infection rates grew from 2.4% to 5.1% in the period of only 12 months. This highlights the potential for widespread transmission of HIV/AIDS and could present a major hindrance not only to the CHPS system, but also the entire Ghana health system (Nyonator, 2003).

Health quality experts have defined quality in various ways. Donabedian, one of the most widely recognized experts on quality of health care research defined quality care as “that kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts.” According to Brawley, for the client the most important dimensions of quality are technical competence, interpersonal relations, accessibility, and amenities. Technical competence refers to the skills and actual performance of the health providers in regard to examinations, consultations and other technical procedures. The interaction between the providers and the client comprises the category of interpersonal relations.

A baseline survey conducted by Socioserve-Ghana (2013), revealed that many Community-Based Health Planning and Services (CHPS) compounds in the Asuogyaman and the Lower ManyaKrobo districts operated under very poor conditions. It was realized that due to the poor conditions, almost all patients, most of who were pregnant women, shun the CHPS compounds at their respective areas and travelled longer distances to visit bigger health facilities even on emergencies. The report showed that most of the CHPS in

Asuogyaman lacked certain basic logistics and equipment as delivery sets, delivery beds and weighing scales among others. Almost all the facilities did not have electricity and water, and also more community health nurses sent to those facilities did not have accommodation and so were forced to commute from outside their respective areas to work there.

2.3. Influence of CHPS on Access to Maternal Healthcare

The objective of the CHPS initiative in Ghana is to ensure access to quality healthcare for all especially mothers and children who form the vulnerable part of many rural communities. To access means the ability to make use of the services rendered by the health facilities in times of need. The question that comes to mind is whether maternal and child health services are access to all mothers after the introduction of the CHPS in Ghana. Those who need health services most that is, women and children tend, to be the least able to gain the benefits and are frequently more harmed or ignored by the actual operations of the CHPS services as they are delivered (Penchansky, 1981).

Access to healthcare varies across space because of lack of healthcare providers and consumers (spatial factors); it also varies among population groups because of their different socio-economic and demographic characteristics (non-spatial factors). Accordingly, spatial access emphasizes the importance of geographic barriers (distance or time) between consumer and provider, whereas non-spatial access stresses non-geographic barriers or facilitators such as social class, income, ethnicity, age, sex, among others (Joseph & Phillips, 1984).

Since the 1960s, health policy makers have attempted to improve maternal healthcare by considering aspects of both spatial and non-spatial factors (Meade and Erickson, 2000). Such efforts are exemplified in designations of Health Professional Shortage Areas (HPSA) and Medically Underserved Areas or Populations (MUA/P) by the US Department of Health and Human Services (DHHS). In Ghana, these medically underserved areas are the places where CHPS facilities are located to help improve the access and quality of maternal healthcare.

2.3.1. Geographical Accessibility and Transportation Issues

Although distance to a healthcare facility/provider is becoming less of a problem in Ghana with increasing urbanization, there are still some parts of the country where people must travel relatively long distances to access health care. This factor is a significant problem in rural areas where public transportation systems do not exist. Even in urban areas, the timeliness and convenience of public transportation and other available forms of transportation affect access to healthcare (Yeboah, 2003). According to Socioserve-Ghana (2013), poor road network and lack of means of transport was major barrier to maternal healthcare in the Asuogyeman district.

An area can be designated as underserved for maternal healthcare if the nearest source of health care facility is greater than 30 minutes travel time from a primary care facility and greater than 40 minutes away for specialist health services such as dental and mental health services (Meade and Erickson, 2000). Availability is a factor that influences healthcare services. A mother or child's access to transportation may limit his or her access to some better healthcare services or treatments at locations not close to his/her

home. Availability of more skilled midwives and other health workers may be limited if a person lives in a rural geographical location.

2.3.2. Availability of Health Care Providers

Maternal Healthcare professionals are not available everywhere and for everyone. Another barrier to healthcare is primary care provider availability and distribution. In the Upper West Region, more than 2 million people live in areas with insufficient maternal healthcare providers, a phenomenon referred to as health professional shortage areas or medically underserved areas (Issah, 2008). Rural communities are the hardest hit communities when it comes to lack of healthcare providers. Some areas, “geographically designated health professional shortage areas”, do not have midwives and community health nurses to take care of their health needs. In many communities, these health professionals are available but not enough to serve the health needs of the whole population especially mothers and children.

2.3.3. Financial Access

Even though maternal healthcare services are free in all parts of Ghana, low-income mothers still lack access to healthcare because they do not have money to transport themselves and their children to health facilities especially during referral. According to a report issued by the Kaiser Commission on Medicaid and the Uninsured (2000), low-income Americans (who earn less than 200 percent of the federal poverty level (\$26,580 for a family of three in 1999) run the highest risk of being uninsured. Nearly 40 percent of the poor (those with incomes under 100 percent of the federal poverty level) and 30 percent of the near-poor (those with incomes between 100 and 200 percent of the federal poverty level) lack maternal health coverage.

Like their counterparts in other nations, low income Ghanaian mothers may lack access to healthcare because they are more likely to be staying far from health facilities and have no access to transportation facilities. Low income women and minority residents of Florida are twice as likely to be uninsured. According to the Florida Health Insurance Study completed for the Agency for Health Care Administration in 1999, 39.9% of families earning between \$5,000 and \$9,999 per year are uninsured compared to 13.4% of families earning between \$35,000 and \$44,999 per year. As income goes up, the percentage of families without maternal healthcare access goes down. Only 52% of those women leaving welfare under the WAGES Program that began in 1996 were estimated to have health care coverage in 1999, according to the Florida Health Insurance Study.

The association between socioeconomic status and health status of adults women may be explained in part by reduced access to healthcare among those with lower socioeconomic status (Centers for Disease Control and Prevention, October 2000).

According to SEND-GHANA (2010), indigents represented 2.3% of the total membership of the scheme in the Upper West Region in 2008. Considering the fact that the Upper West Region has the highest incidence of poverty, the percentage of indigents in the region should have been the highest. Ironically, the Upper West Region has the lowest proportion of indigents (2.3%). One cannot understand the reason for the inability of some schemes to cover indigents.

Even if all indigents were identified and exempted from paying premium, their ability to make other related payments such as identification cards and administrative expenses is

another mile stone to ensuring that the access of the poor and vulnerable groups to basic quality health care is obtained and maintained.

According to Yeboah (2003), it is estimated that out of eighty percent of the population who require healthcare at any given time, only twenty percent of them are able to access it. That is, about eighty percent of people living in Ghana, majority of who were women and children who need healthcare cannot afford to pay out-of-pocket at the point of service use. This has resulted in delays in seeking healthcare, non-compliance to treatment, and consequently premature death.

The work of Awoonor (2012), shows that the CHPS is working, promoting access for maternal healthcare and mobilizing local resources for the provision of healthcare. Utilisation of health care services had increased under the CHPS initiative from 37% in 2004 to 70% in 2008 in Ghana (Ayizem, 2012). Similarly, the Ministry of Health (Ghana) in 2008 reported that the use of out-patient under the CHPS initiative almost doubled between 2005 and September 2007. A recent study in the Volta Region of Ghana, also found CHPS to have positively affected health seeking behaviour and the consumption of healthcare services (Gobah 2011). Elsewhere in Burkina Faso, Gnawali and others (2009), reported higher utilization rates (about 40% higher) for out-patient services under the Community-based Health Facility programme similar to the CHPS in Ghana.

Table 2.2 Dimensions of Access in Healthcare

Dimension	Details
Geographical	<ul style="list-style-type: none">• All- weather motorable roads• Availability of transport• Distance of health facility from home• Travel time
Physical	<ul style="list-style-type: none">• User- friendly layout of the health facility• Effective directions to service points-using photos and local languages where possible
Organizational	<ul style="list-style-type: none">• Convenient service hours for users• Waiting time
Linguistic & Cultural	<ul style="list-style-type: none">• Language (effective communication)• Mutual respect for cultural differences
Financial	<ul style="list-style-type: none">• Ability of users to pay for services (e.g. transport, diagnosis and drugs)

Source: Yao Yeboah, (2003)

CHPS is the Ministry of Health's plan to shorten the gap between health access for the increasingly urbanized south and the agrarian north. Even within districts, there is often a spectrum between urbanized areas and remote communities. The CHPS system decentralizes Ghana's health system by locating more resources directly into communities and involving communities in important health decisions. This empowers communities with choices about their health care and gives individuals the opportunity to receive quality and prompt treatment from the health system. The CHPS system is the system of the present and the future for Ghana, and it represents an opportunity for the country to provide quality health care for all citizens, a goal which has long been sought by the government and a crucial step for Ghana's development.

Accessibility of health for the client means that the health care services are unrestricted by barriers such as geography, cost, language, and times when the facilities are open. Also, access refers to a client's perception of the physical healthcare facility, as well as supplies and equipment within the facility. At the community level, great strides have been made in recent years, with the government committing itself, to moving health care from established facilities of which there are woefully few, directly to communities as CHPS (MOH, Ghana 2006). This concerted effort was outlined in the country's Programme of Work (POW) for 2002-2006, which has been the backbone of MOH and GHS activities for more than the past ten years and will continue to be influential in its plan of work to increase access especially in the rural areas of Ghana.

2.4 Community Participation in Maternal Healthcare Services

Community Participation is a structured process whereby consumer, career, and community views are integrated into the health service's operational planning and policy development process. This includes active partnerships between the community and health service facilitated by advice from the Community Advisory Committee to the Board (Alfred Health, 2012).

Global health systems continue to be championed by biomedical scientists and health experts whose technocratic solutions to ill health provide community members with few opportunities to appropriate these solutions to local realities (Campbel, 2012). According to Draper and others (2010), this tendency was challenged by the 1978 Alma Ata Declaration which established community participation as a core principle of primary health care. Despite the revolutionary significance of the Alma Ata Declaration in viewing primary health care through the lenses of equity, social justice, and participation, shifts favoring community participation in international health policy and for that matter Ghana had been slow and saw a decline in the late 1980s and 1990s (Campbel, 2012). More recent efforts however, spearheaded by the 2008 Lancet special edition to celebrate the 30 year anniversary of Alma Ata and the 2008 WHO report on Social Determinants of Health, have revitalised the message that community participation is key to the delivery of health care (Lawn, 2008; WHO, 2008). Lysack and Zakus however believe that many countries, including Ghana through its Community-based Health Planning and Services (CHPS) Programme, have since taken active steps to involve community

members in addressing health problems at the community-level (Zakus and Lysack, 1998).

Much of the literature on community participation is driven by ideological and political commitments to participation, contested and framed either as a basic human right, a pragmatic strategy to utilise services or as pathway to empowerment (Morgan, 2001). In this paper attention is drawn on the theoretical insights of a social psychology of participation, which leans towards the model of empowerment. The social psychology of community participation was promulgated by Campbel and Jovchelovitch (2000), as a conceptual framework for action research seeking to explore the pathways between community participation, health and social development. The starting point of this framework is that the poor and marginalised often lack a sense of control over their health and well-being, leading to a sense of fatalism, and a tendency to wait for outside actors and agencies to take control of local health problems.

Against this background, the framework seeks to draw attention to ways in which communities can be 'empowered' to exercise greater agency over their health, by changing health-damaging behaviours where possible, and making optimal use of available health services. Drawing on Habermas' idealised notion of the public sphere, the framework advocates that for participation to offer community empowerment, it should take place in a social space (public sphere) where all participants (in this case health service providers and users) have the right to participate fully in the design, implementation and evaluation of health programmes, with programmes being driven by a synthesis of 'local' and 'expert' knowledge, with both knowledge systems being

accorded equal respect (Habermas, 1974). Freire (1973) suggests participation is most likely to empower marginalised communities to exercise greater control of their lives (and more specifically their health) if it is framed within a dialogical and facilitative approach through knowledge negotiation and power transfer from health professional to communities.

Petesich and others, health-enabling community participation should involve genuine sharing of power amongst health experts and decision makers on the one hand, and marginalised groups on the other (Petesich, 2007). Such an approach is said to build a sense of community ownership of local problems (as opposed to a sense that such problems can only be solved by outside professionals), and to encourage communities to contribute to the development of concrete strategies through which they can improve their health. This approach resonates with the views of Robert Chambers who argues that poor communities can be empowered by taking responsibility and action in cases where experts are ready to share power and control over programs (Chambers, 1997).

Table 2.3 Criteria on Needs Assessment

Indicator	Definition
Needs Assessment	<ol style="list-style-type: none"> 1. How were needs identified? 2. Who identified them? 3. Why was it decided to carry out the programme?
Leadership	<ol style="list-style-type: none"> 1. Which groups are represented in the leadership? 2. Which type of leadership is it? (democratic, inherited, authoritative) 3. How are decisions made? 4. How did the leaders obtain their post? 5. What the attitude of the leaders towards the

	<p>interventions?</p> <ol style="list-style-type: none"> 6. How does the leadership mobilise support? 7. Which groups have profited from leadership?
Organisation	<ol style="list-style-type: none"> 1. Which groups are involved in the organization? 2. Are the goals shared by the organization? 3. What is the relationship of health professionals to the organization? 4. Who make up the organization staff?
Resource Mobilisation	<ol style="list-style-type: none"> 1. What are beneficiaries' contributions? 2. What resources are being into play? 3. How are resources mobilized? 4. What interest are serves by resources mobilization and allocation?
Management	<ol style="list-style-type: none"> 1. What are the roles of beneficiaries in managing the programme? 2. On whom does the ultimate responsibility lie? 3. Who decides on activities and allocation of resources?

Source; Rifkin, 1989

According to the Uganda Participatory Poverty Assessment Programme (UPPAP), Ugandans draw a distinction between individual and community-level poverty. At the personal level, poverty in Uganda is defined as inability to meet the basic necessities of life, poor access and quality of social services, and inadequate infrastructure. Thus a person or household is considered to be poor when she/he is unable to meet basic needs, such as clothing, soap, health care, school tuition, decent housing, and paraffin fuel for light.

CHPS is a dynamic framework that requires dedication and hard work from the Ghana Health System at all levels, as well as in communities advocating for themselves. CHPS

creates a working micro health system in communities that is flexible and able to grow horizontally to include more interventions. Once CHPS programme gets off the ground they should be sustainable; if this is the case than Ghana's prospects look bright. Monitoring results of healthcare services attest to the need to build policies that tap CHPS' greatest resource. The most enthusiastic promoters of CHPS are communities that have benefited from CHPS services and workers who have developed a sense of pride in their capacity to serve the rural poor. CHPS, once it is implemented, is sustained by society and political support.

Observing the present healthcare system, researchers identified the dual problem of underutilized nurses at healthcare facilities and individuals in rural communities unable or unwilling to go to healthcare facilities. The communities were simply too far and the people too poor to travel to healthcare facilities. Also, the harm caused by carrying or carting a sick child might kill them before ever reaching care. The Navrongo researchers especially, thought it possible to address the issue of limited access to orthodox healthcare in rural communities by moving nurses directly into community settings. Another problem was the continued importance of traditional healers and other sources of unorthodox healthcare.

Rather than making the long and costly trip to orthodox health care, community member thought it just as effective to go through traditional avenues to deal with health issues. The Navrongo researchers proposed that, some sort of social intervention was necessary to ensure that communities would accept orthodox health care. They identified limited

access to health care and lack of social involvement in health decisions as barriers to creating a better system of providing healthcare at the community level.

To initiate community participation, a healthcare team appeals to the chief of the community or the elders and presents the program. If the chief or elders accept the proposal, then a meeting is planned and the community is informed, either by the chief or by the Dodowa research team using a car with a loudspeaker attached to it. The loudspeaker invites all members of the community to the meeting. At the meeting, the community selects their community-based agent, someone whom they trust to provide quality care. The Dodowa research team then trains the individual on characteristics of malaria and pneumonia and how to recognize and treat fevers; later, the community-based agent is reintroduced to the community as a health contact (Dodowa Health Research Centre, 2007). The re-introduction of the Community-based Agents (CBA) coincides with a video presentation by the Dodowa research team showing early signs of fever and encouraging them to seek the CBA for medical attention and possible referral.

This program mirrors the lessons learned from the Navrongo experiment and, although it is not an exact replica of CHPS, it uses the same type of community-based intervention to improve healthcare at the community level. By convening the community together, asking them questions, and showing them the video of proper behavior the Malaria/Pneumonia study replicates the idea of “social diffusion” popularized by the Navrongo experiment. The belief is that behavioral change occurs through social interaction. The Malaria and Pneumonia video emphasizes the importance of orthodox health centers in treatment of fevers. It also schools men on their vital role of managing

the house and family when the wife has taken the child to the CBA or the clinic. Another section of the video shows one mother telling another mother about the great job that the CBA did in caring for their kid; she encourages the mother to take her ill child to see the CBA. These types of social interactions encourage social diffusion and will hopefully encourage communities to use orthodox health avenues.

It is an encouraging sign that, while CHPS may not be implemented completely in every district, centers such as Dodowa are finding ways to deliver necessary health interventions at the community level with the CHPS example. Like the Navrongo experiment, Dodowa's Malaria and Pneumonia program initiates community action, involves the community in decision making for the program, and uses community based agents to provide close care. CHPS can be initiated in districts by building on just one or two programs like the Malaria and Pneumonia program before district teams have the ability and confidence to scale up CHPS operations. The Malaria Pneumonia program is safe, efficient, and acceptable to the community, but as the study is in progress it is yet to be seen how effective the intervention is in reducing under 5 mortality

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methodology used in conducting the study; the study type and design, study area, study population, sample size and sampling method, data management and analysis, the ethical considerations and concluded with the limitations encountered in the course of the study.

3.2 Study Type and Research Design

The study was a descriptive one with a cross-sectional design to assess the quality and access to maternal healthcare services and community participation in the CHPS activities in the Jirapa District. Quantitative data were collected from 260 community members and 100 health staff using questionnaire. Qualitative data were obtained from 10 facility managers in a Key Informant Interview using an interview guide. In addition, focus group discussions were held for 48 community members (eight members in a group). The cross-sectional design enabled the researcher to obtain the views of all the major stakeholders in the CHPS concept to make a better judgment on the quality of services, access to services and the challenges faced by CHPS.

3.3 Profile of the Study Area

The Jirapa District is one of the fast developing districts among the ten Districts in the Upper West Region of Ghana. The total area of the district is 1,667 square kilometers

with a projected population based on the 2010 population and housing census as 64,629 (GSS, 2000). The district shares boundaries to the South with Nadowli District, to the East with Sissala District, to the West with Lawra District and to the North with LambussieKarni.

Health Facilities

The district has one hospital (St. Joseph's Hospital), which serves as the district Hospital, 7 health centres and ten CHPS compounds. The biomedical health facilities in the Jirapa district include; Jirapa Hospital, Duori Health Centre, Hain Health Centre, Tuggo Health Centre, Ullo Health Centre, Sabuli Health Centre, Yagha Health Centre.

Economic Activities: The major economic activities in the district include subsistence agriculture, animal rearing and fishing.

Transport and Communication: Bicycles, motorcycles, urvans, and metro mass transport and mummy trucks are the main means of transport. Access to transportation especially for the critically ill is a challenge in the district because the road network connecting most villages to the health facilities is very poor with most of the road not tarred. This coupled with the fact that commercial vehicles do not plough these roads could limit access to health services especially the critically ill in receiving timely intervention.

One-Touch, Tigo, and MTN network services are available in about 90% of the total land area.

3.4 Study Population.

The study population consisted of pregnant women and breast feeding mothers, staying in the six CHPS communities at the time of the data collection. Health staff and community leaders in the CHPS communities also took part in the study. Some workers at the Jirapa District Health Directorate with oversight responsibility in the CHPS activities were also interviewed.

3.4.1 Inclusion Criteria

Pregnant and breast feeding women who had stayed in the CHPS communities for at least six months qualified to be respondents. Opinion leaders and health staff in the sampled communities were also eligible to participate.

3.4.2 Exclusion Criteria

Pregnant and Breast feeding women who had not stayed in the CHPS communities for up to six month and non-pregnant women were excluded from the study. Men who were not health workers or opinion leaders in these communities were also excluded from the study.

3.5 Study Variables

Table 3.1 Study Variables

OBJECTIVE	Dependent Variable.	Independent Variable.	Conceptual Definition of dependent variable.	Scale of measurement	Indicators	Data collection method	Type of statistical analyses
To assess quality of maternal health care.	Quality of health care.	Waiting time, provider-client interaction, skills of provider.	Attendances rate of pregnant/feeding mothers per year.	Nominal: High, Low.	Proportions, frequencies.	Questionnaire, records	Descriptive.
To investigate access to maternal health care.	Access to maternal health care.	Geographical, availability, financial and acceptability	Temporal and permanent, degree of exposure to pregnant/postnatal women.	Nominal	Odds ratio, CI, Chi-squares, correlation coefficient, etc,	Questionnaire.	Descriptive.
To assess the level of community participation at CHPS.	Level of community participation .	Perception, expectation, attitude.	Sources of seeking healthcare and basis of preference	Nominal and ordinal.	Proportions, frequencies	Questionnaire, interview guide.	Descriptive.

3.6 Sampling

3.6.1 Sample Size Estimation

The sample size was determined using Cochran's formula for large populations. This formula ensures good precision and prevents bias from too small a sample size.

$$n = \frac{z^2 \cdot pq}{e^2}$$

Where n is the sample size, Z^2 is the abscissa of the normal curve that cuts off an area α at the tails ($1 - \alpha$ equals the desired confidence level, e.g., 95%), e is the desired level of precision, p is the estimated proportion of an attribute that is present in the population, and q is 1-p. The value for Z^2 is found in statistical tables which contain the area under the normal curve.

Given that the proportion of people who had access to quality maternal healthcare services in CHPS located in the Jirapa District was 50%, and estimating the true proportion to within ± 5 percentage points with 95% confidence level, The formula is given as:.

$$n = \frac{z^2 \cdot pq}{e^2} = \frac{(1.96)^2 (0.5)(0.5)}{(0.05)^2} = 384.16$$

Taking a 10% non-response rate, the minimum sample size for good precision is 420 participants.

Therefore the estimated sample size for the study was 420.

3.7 Sampling Technique

The study employed both probability and non-probability sampling methods. Purposive sampling was used to select workers from the District Health Directorate for Key Informant Interviews and community members for Focus Group Discussion. The number of pregnant and breast feeding women was obtained from each CHPS zone and a proportionate sample size calculated for each community. The postnatal and antenatal days for all CHPS facilities were taken for the whole of the data collection period. This was divided by the sample size for that community to get the number of questionnaire to be administered per day. A systematic sampling was then applied to get the quota of each community's sample. Using Deriyiri CHPS zone for example, their share of the proportionate sample was 66 and six antenatal and postnatal days in a month, thus $\frac{66}{6} = 11$. So 11 questionnaires were administered per clinic day. To select the sample units, the average daily attendants at the facility 48 was divided by the number of questionnaire to be administer per day, 11 to get the interval, thus $\frac{48}{11} = 4$. Papers with numbers one to four written on them were then balloted and selected at random to get the starting point. The paper with number two written on it was selected, thus the second patient to exit the facility was interviewed followed by the 6th patient and in that order till the days sample size of 11 was obtained. This procedure was used for all the other communities for the purpose of selecting respondents for the study. Table 3.2 shows that proportionate sample size, number of antenatal and postnatal days and the number of questionnaire administered per clinic day for the various CHPS compounds in the Jirapa District.

Table 3.2 Results of Sampling

CHPS ZONE	PROPORTIONATE SAMPLE SIZE	TOTAL ANTENATAL & POSTNATAL DAYS	QUESTIONNAIRRE TO BE ADMINISTER PER CLINIC DAY
PING	55	4	13
GUOPUO/PIIFAAAYIRI	66	6	11
SAAWIE	70	6	12
KUNCHENI	27	4	7
NANBEG	6	2	3
DERIYIR	36	4	9
TOTAL	260	26	55

Source: Researcher's own construct, 2013

3.8 Data Collection Methods

Quantitative and qualitative methods were used to collect data from clients seeking healthcare, health providers and DHA staff who oversee the activities of the CHPS and therefore have expert knowledge on the quality of care and challenges facing the facilities with regards to service delivery. Key informant interviews (KII) and FGDs were used to collect qualitative data from DHA staff and opinion leaders from the sampled communities. Closed questionnaire designed by the researcher was used to collect data from women (and clients who attended the sampled facilities during the period of the data collection) and health service providers at the CHPS.

3.9 Data Analysis

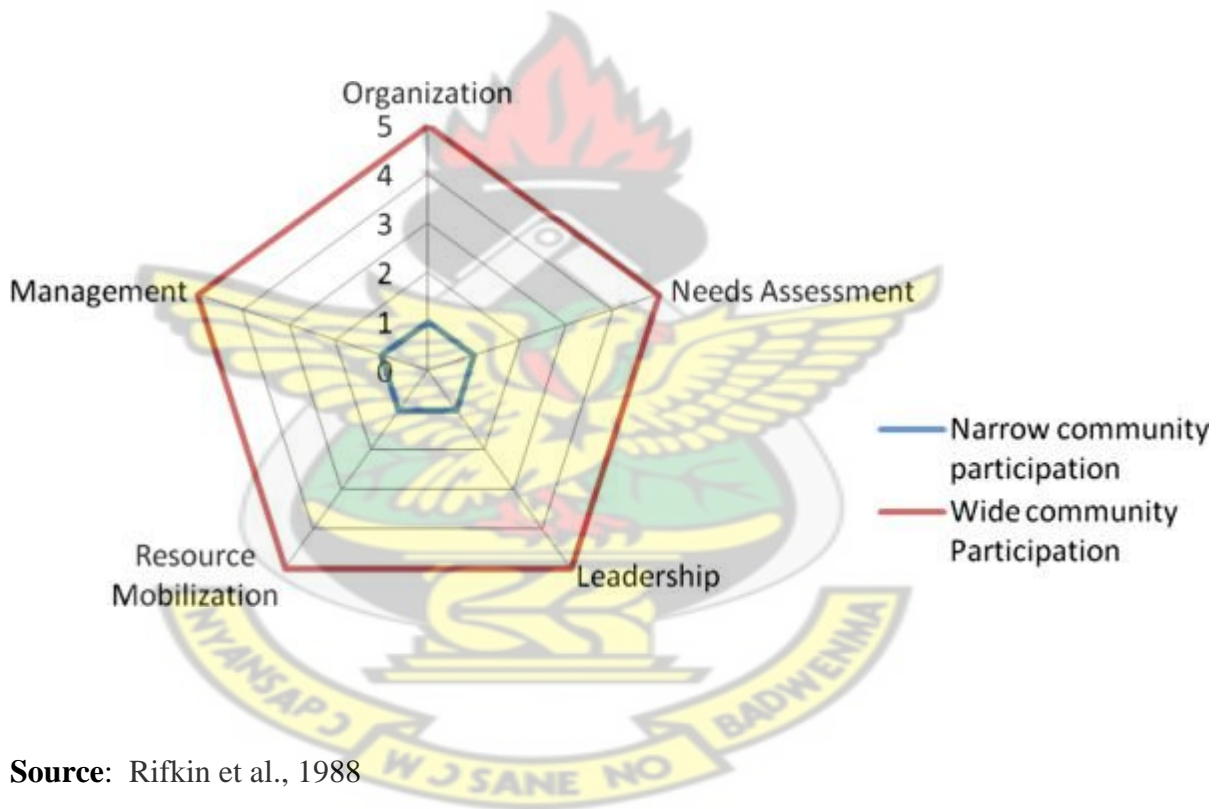
The quantitative data resulting from the questionnaire will be analysed using Stata version 16. The results were presented in frequency distribution tables and charts. The taped interviews from the KII and FGD were transcribed verbatim and the resulting texts analysed by using thematic analysis. Maynard and Purvis (1994) state that repeated listening to tapes of interviews with participants is an essential, yet often neglected area of analysis. Broad themes were from the transcripts and then progress to identify coded themes. In establishing themes, consideration was given to statements of meaning that were present in most of the relevant data. In an attempt to ensure the credibility of the findings, independent coders were used to verify/corroborate the themes extracted from the data. The data was analysed simultaneously with data collection. This allowed the researcher to progressively focus the interviews and observations, and to decide how to test the emerging conclusions.

The data on community participation was analysed using a Spider-gram. The Spider-gram methodology was developed by Rifkin and co (1988), to measure, visualise and locate levels of community participation in health programmes on a continuum.

Each indicator is located on a continuum. The original spider-gram plotted these indicators on a continuum that at one end marked narrow participation and at the other marked wide participation. This continuum was modified by Draper (2010), to place mobilization at one end and empowerment at the other. For this research the original continuum was used. The continua are linked together at the narrow end to form a pentagram. Each continuum is used to grade how wide or narrow community

participation is. Community members were asked to grade, from 1 to 5, the level of participation they felt was involved in the programme, with 1 reflecting a low level of participation and 5 reflecting the highest level of participation. To illustrate this, as well as to operationalize these indicators in relation to a continuum of participation, Fig. 2 applied the principles of spider-grams to the CHPS programme.

Fig 3.1: Spider-gram for measuring community participation



Source: Rifkin et al., 1988

3.10 Ethical Consideration

Ethical clearance was sought from the Ethics Committee-KNUST/KATH. Also writing permission was obtained from the regional and district health administration and at the various health facilities before data was collected. At the time of data collection,

participation in the study was based on the willingness of the respondents. Informed/ verbal consent was obtained from the participants. Privacy, confidentiality were maintained by reporting findings in groups and not mentioning respondents identity in the report.

3.11 Study Assumptions

This study was conducted with the following key assumptions:

- 1) That the sample size selected was a true representation of the study population
- 2) That all the data collectors applied the rules adapted and were therefore consistent in asking questions.
- 3) That all the methods applied in collecting and analyzing the data were suitable
- 4) That the research participants gave accurate responses to the best of their knowledge.

Based on the above assumptions, the investigator is 95% confident that the findings are true about the influence of community-based health planning and services (CHPs) on maternal healthcare in the Jirapa district.

3.12 Limitation of the Study

The major limitation of this study was that, it covered only those communities with operational CHPS compounds as compared to the total population of all the pregnant women and breastfeeding mothers within the study area. Another limitation was the high number of mother's inability to read the questionnaires.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter outlines the results of the study. Frequency distribution tables, charts and spider-grams were used to analyse the data obtained from the field. The study was aimed at assessing the influence of Community-based Health Planning and Services (CHPs) on Maternal Healthcare in Jirapa District, Upper West Region of Ghana. The findings and related interpretations are presented in tables, charts and figures below.

4.2 Background Information of Respondents

Table 4.1: Demographic and Personal Characteristics of Patients

Variables	Response	Frequency	Percentage
Sex	Female	260	100.0
	Total	260	100.0
Age	<18yrs	65	25.0
	18 - 25 yrs	84	32.3
	26 - 33yrs	87	33.5
	34 - 41yrs	24	9.2
	Total	260	100.0
Educational Background	No Formal Education	111	42.7
	Primary/JHS/Middle School	117	45.0
	SSS/Vocational/ Technical	29	11.2
	Tertiary	3	1.2
	Total	260	100.0
Occupation of Respondents	Unemployed	24	9.2
	Farmer	178	68.5
	Trader	40	15.4
	Government worker	3	1.2
	Otherse.g private security man.	15	5.8
	Total	260	100.0

Marital Status	Single	49	18.8
	Married	196	75.4
	Divorced	15	5.8
	Total	260	100.0
Number of children	None	49	18.8
	1-3	102	39.2
	4-6	93	35.2
	Above 6	16	6.2
	Total	260	100.0
Number of respondents per community.	Ping	55	21.2
	Deriyiri	66	25.4
	GuopuoPiifaayir	70	26.9
	Saawie	27	10.4
	Kuncheni	6	2.3
	Nambeg	36	13.8
	Total	260	100.0

Source: Field Data, 2013

The study was basically made up of females. This is to say that the respondents who formed part of this study were all females with a representation of 260 indicating 100% of total respondents. For the age of respondents, majority 33.5% were aged 26-33yrs, 32.3% (n=84) aged 18-25yrs, 25% (n=65) aged below 18 years, 6.9% (n=18) aged 34-41yrs and a minimum of 2.3% (n=6) falling within the age range. For the educational background of respondents, 45% (n=117) indicating majority, were Primary/JHS/Middle Sch. leavers. 42.7% (n=111) have had no formal education, 11.2% were SHS/Vocational/Technical school leavers and a minority of 1.2% represented by 3 respondents were tertiary school leavers. With respondents occupation, 68.5% were farmers, 15.4% (n=40) traders, 9.2% (n=24) were unemployed, 5.8% (n=15) were workers not indicated on the questionnaire, such as private security personnel and house girls. A minimum number of 3 representing 1.2% were Government workers.

For the marital status of respondents, 196 representing 75.4% of the respondents were married. 18.8% (n=49) were single and 5.8% (n=15) were divorced. Considering respondents' number of children, the results showed that majority (39.2%) of the respondents had 1-3 children. 34.6% (n=90) had 4-6 children, 18.8% (n=49) had no child and 6.2% (n=16) had more than six children. For community of respondents, 26.9% were lived at Guopuo Piifaayir, 25.4% (n=66) were from Deriyiri, 21.2% (n=55) came from Ping, 31.8% (n=36) from Nambeg, 10.4% (n=27) lived at Sawaali and 2.3% (n=6) were residence of Kuncheni.

Table 4.2: Demographic and Personal Characteristics of Health Personnel

Variables	Response	Frequency	Percentage
Sex	male	34	34.0
	Female	66	66.0
	Total	100	100.0
Professional Status	Community Health nurse (CHN)	56	56.0
	Health Assistant	44	44.0
	Total	100	100.0
Number of Years	1-5 years	68	68.0
	6-10 years	20	20.0
	11 years and above	12	12.0
	Total	100	100.0

Source: Field Data, 2013

In relation to the gender of health personnel respondents, 66% (66) were females, 34% (34) were males. In terms of the profession of respondents, 56% (56) were community

health nurses and 44% (44) were health assistants. In relation to the number of years of service, 68% (68) had worked between 1-5 years, 20% (20) had worked between 6-10 years, and 12% (12) had worked for 11 years and above.

Table 4.3: Quality of Maternal Healthcare as Perceived by Patients

Variables	Responses	Frequency	Percentage
Convenient Opening and Closing Hours	Morning up to Evening	153	58.8
	Throughout Day and Night	107	41.2
	Total	260	100.0
Mutual Respect and Treating clients in a human manner	Agree	260	100.0
Good hygiene and sanitation to prevent new infection whilst receiving care	Yes	260	100.0
Adequate time for diagnosis	Yes	258	99.2
	No	2	.8
	Total	260	100.0
Whether Personal Tell Clients Results	Yes	249	95.8
	No	11	4.3
	Total	260	100.0
Whether facility has the Prescribed medicines	Yes	245	94.2
	No	15	5.8
	Total	260	100.0
Dosage of medicines usually we explained to patients	yes	258	99.2
	No	2	.8
	Total	260	100.0
Clients Record Kept Confidential	Yes	258	99.2
	No	2	.8
	Total	260	100.0

Source: Field Data, 2013

Considering the time of operation of the facility, 58.8% (n=153) said the most convenient opening and closing hours were from morning up to evening while 41.2% (n=107) said the convenient opening and closing hours were throughout day and night. From the results, all (100%) respondents agreed that health personnel in the CHPS facilities had mutual respect for patients and as such treated them in a humane manner. According to the study, all the respondents attested to the fact that there was good hygiene and

sanitation to prevent new infections whilst receiving care. As to whether health personnel had time for diagnosis, majority (99.2%) said yes whilst 0.8% (n=2) said no. From table 4.5, 95.8% (n=249) indicating majority said “yes” health personnel told patients their results. 3.1% (n=8) said no and 1.2% (n=3) provided no response.

According to the results shown in the table 4.5, 94.2% (n=245) said “yes” the facility had the medicines prescribed whilst 5.8% (n=15) said “no” the facility sometimes did not have the prescribed drug. Majority, 99.2% (n=258) said dosages were usually explained to patients whilst 0.8% (n=2) on the contrary, said no. The results of the study showed that patient’s records were kept confidential. This was affirmed by majority (99.2%) of the respondents. 0.8% (n=2) however, said patients records were not kept confidential.

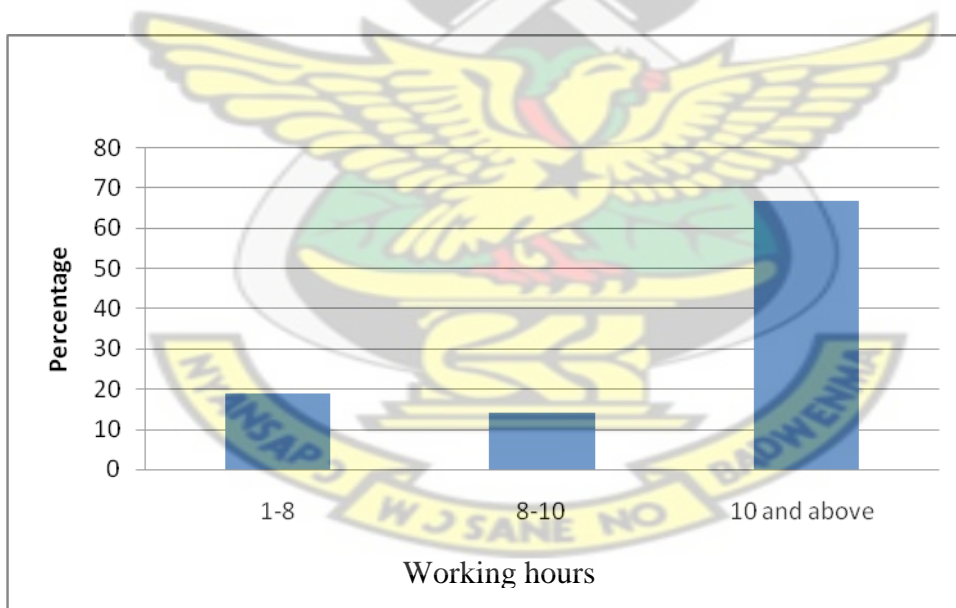


Figure 4.1: Number of Working Hours

Source: Field Data, 2013

In terms of working hours of respondent in a day, 67% (67) said 10 hours and above, 19% (19) said 1-8 hours, and 14% (14) said 8-10 hours. In terms of reasons why respondents worked more than 8 hours, 40% (40) said increase attendance because of free maternal health care, 37% (37) said few staff, 18% (18) gave no response and 5% (5) said others.

In relation to whether the CHPS programme had increased health personnel work load, 89% (89) said yes, 9% (9) said no and 2% (2) gave no response. On how the CHPS programme has affected quality of maternal healthcare services, 60% (60) said CHPS programme has resulted in decrease quality of maternal healthcare services, 28% (28) said it has increase quality, 12% (12) said it had no effect on quality of maternal healthcare services. In relation to whether patient's was taken properly when they visited the CHPS, 96% (96) said yes, 2% (2) said no and 2% (2) said sometimes.

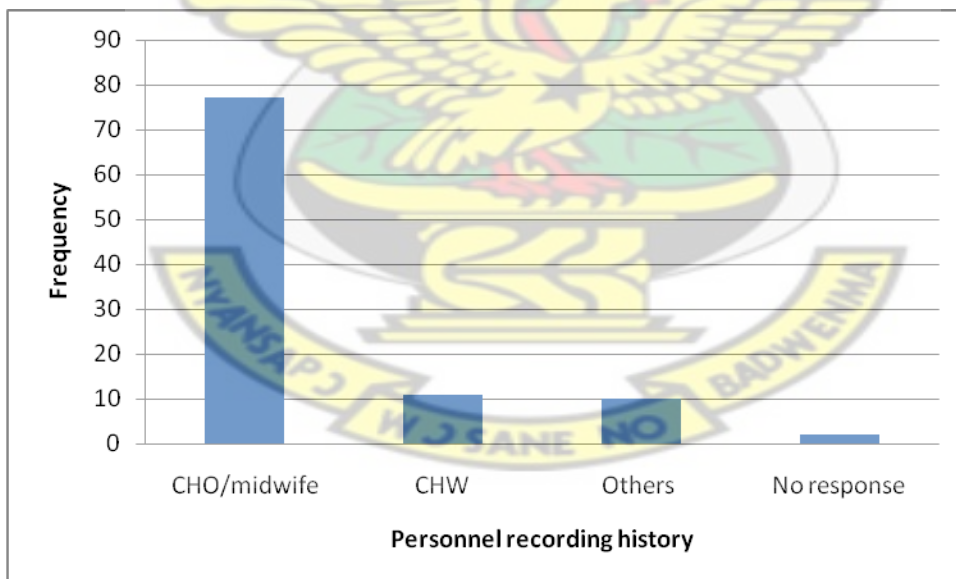


Figure 4.2: Who takes Patients History at CHPS Facility

Source: Field Data, 2013

When respondents were asked of persons who took patient's history, 77% (77) said CHO/Midwife, 11% (11) said CHW, 10% (10) said others, and 2% (2) gave no response.

In terms of whether all patients were given preliminary diagnosis before treatment or management, 98% (98) said yes and 2% (2) said sometimes. In terms of whether patients were told their diagnosis, 79% (79) said yes and 21% (21) said sometimes.

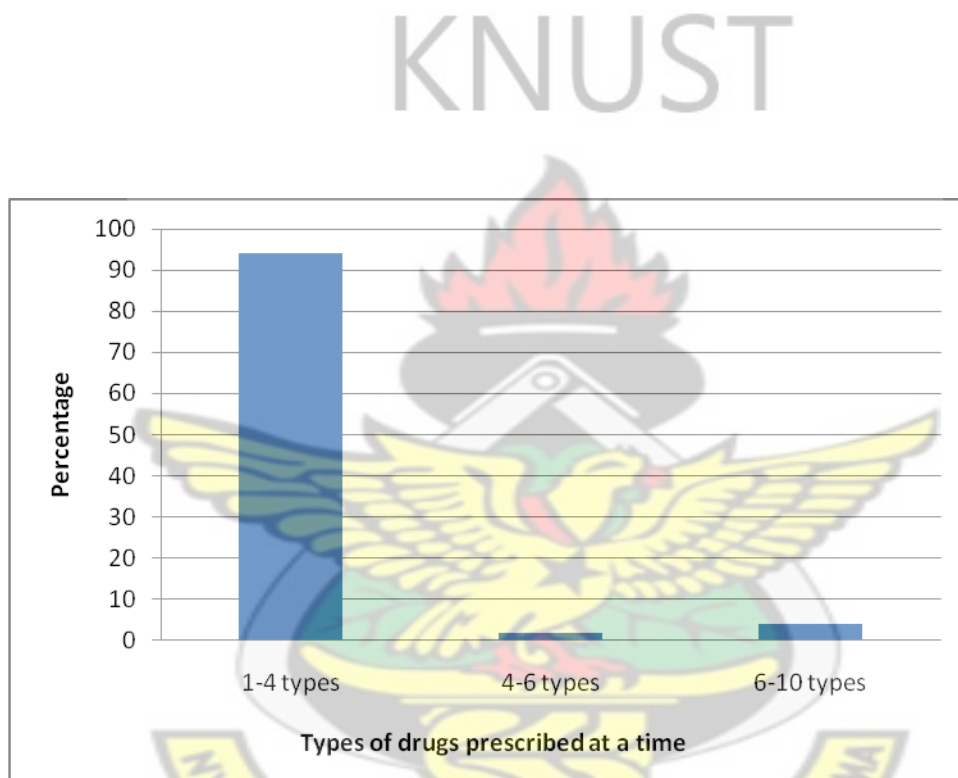


Figure 4.3: Average number of types of drugs prescribed to patients at a time

Source: Field Data, 2013

On prescription habits of health personnel in terms of average number of types of drugs prescribed to patients at a time, 94% (94) said 1-4, 2% (2) said 4-6 and 4% (4) said 6-10.

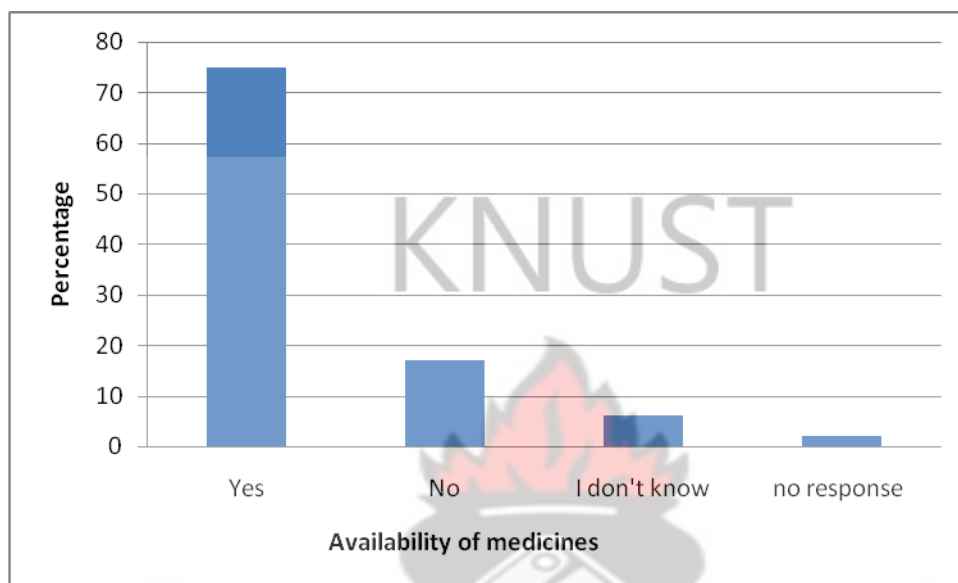


Figure 4.4: Availability of Medicines in CHPS Facility

Source: Field Data, 2013

In relation to whether medicines were available in the CHPS facilities all the times as shown in Fig.4.4, 75% (75) said yes, 17% (17) said no, 6% (6) did not know and 2% (2) gave no response.

In terms of whether respondents thought the advent of the CHPS had improved maternal healthcare, 98% (98) said yes, and 2% (2) said no. In relation to whether family planning services were provided to clients, 95% (95) said yes, 4% (4) said no, 1% (1) gave no response.

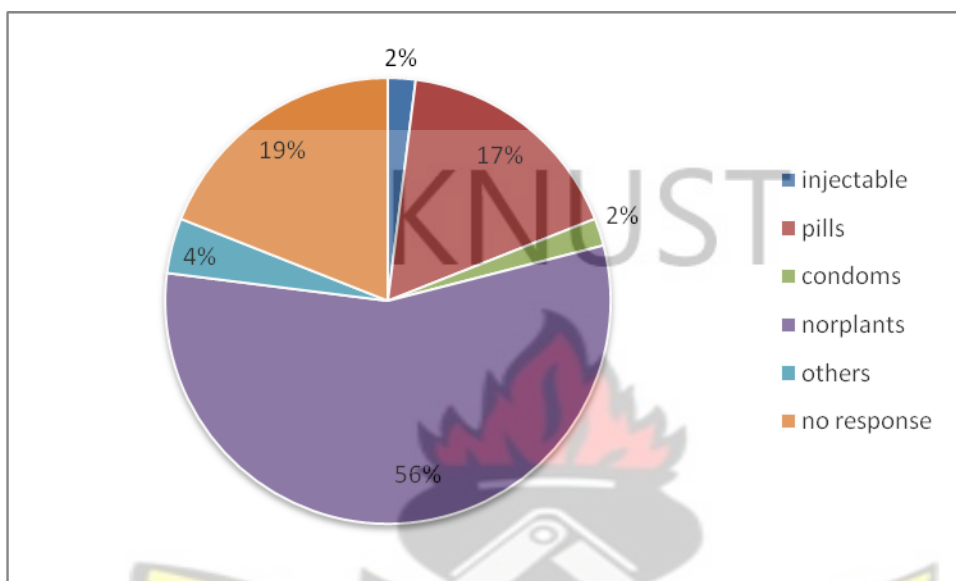


Figure 4.5: Availability of Family Planning Commodities in CHPS facility

Source: Field Data, 2013

Considering the family planning commodities not availability at the CHPS facilities, 56% (56) said norplants, 17% (17) said pills, 19% (19) gave no response, 4% (4) said others without specifying, 2% (2) said injectable, 2% (2) said condoms were not access at the CHPS facilities in the Jirapa District.

In terms of whether respondents had had any training in basic emergency obstetric care, 56% (56) said yes, 42% (42) said no and 2% (2) gave no response. In relation to whether respondents needed further training in order to provide quality maternal health care to patients, 92% (92) said yes, 4% (4) said no and 4% (4) gave no response. In terms of

whether there were adequate vaccines in the facility, 59% (59) said yes, 41% (41) said no among others.

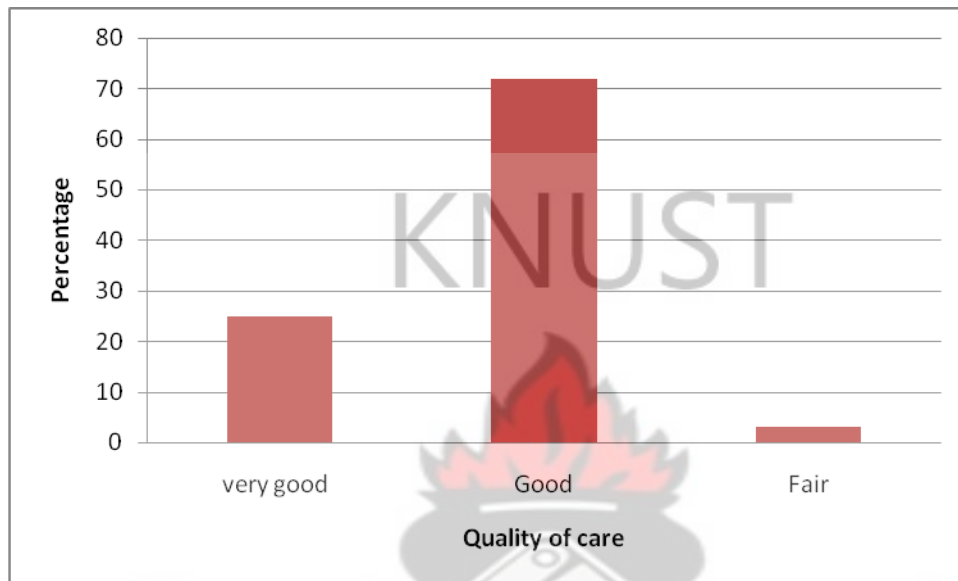


Figure 4.6: Description of the Quality of Care in the Facility

Source: Field Data, 2013

In describing the quality of maternal healthcare services in the CHPS facilities, respondents were asked to indicate on a likert scale of 1 to 3. 1 represented fair, 2 indicated good and a tick on 3 meant very good quality maternal healthcare services. In the view of the respondents, 3% (3) said quality was fair, 72% (72) indicated quality was good, 25% (25) rated it as very good.

Table 4.4: Access to Maternal Healthcare services

Variables	Response	Frequency	Percentage
No motorable roads to CHPS facilities	Strongly Agree	130	50.0
	Agree	95	36.5
	Disagree	29	11.2
	Strongly Disagree	6	2.3
	Total	260	100.0
Transport available to CHPS facility	Strongly Agree	40	15.4
	Agree	48	18.5
	Disagree	96	36.9
	Strongly Disagree	76	29.2
	Total	260	100.0
Service Provider Regular at post	Strongly Agree	30	11.5
	Agree	82	31.5
	Unknown	11	4.2
	Disagree	91	35.0
	Strongly Disagree	46	17.7
	Total	260	100.0
Health Services are Always Available	Strongly Agree	92	35.4
	Agree	74	28.5
	Unknown	2	.8
	Disagree	92	35.4
	Total	260	100.0
Hard to Pay for Healthcare Services	Strongly Agree	33	12.7
	Agree	30	11.5

	Unknown	9	3.5
	Disagree	113	43.5
	Strongly Disagree	75	28.8
	Total	260	100.0
Health Services Cheaper at CHPS Zone	Strongly Agree	159	61.2
	Agree	73	28.1
	Unknown	6	2.3
	Disagree	22	8.5
	Total	260	100.0
Services are Culturally Acceptable	Strongly Agree	133	51.2
	Agree	104	40.0
	Unknown	12	4.6
	Disagree	11	4.2
	Total	260	100.0
Easier Now to get Health Services at CHPS Facility	Strongly Agree	139	53.5
	Agree	108	41.5
	Unknown	2	.8
	Disagree	11	4.2
	Total	260	100.0
CHPS zone is user friendly health facility	Strongly Agree	116	44.6
	Agree	136	52.3
	Disagree	8	3.1
	Total	260	100.0

Source: Field Data, 2013

With respect to the nature of roads leading to the CHPS facility, 50% (n=130) said they strongly disagreed that the roads were motorable. 36.5% said they also disagreed, 11.2% (n=29) said they agreed whereas 2.3% (n=6) said they strongly agreed. According to the results, 36.9% (n=96) said they agreed to the fact that getting transportation to the CHPS facility is difficult. 29.2% (n=76) strongly agreed, 18.5% (n=48) on the other hand said they disagreed to the fact that getting transportation to the facility is difficult. A fewer representation of 40 also said they strongly disagreed to this fact. As to the notion that service providers were not regular at post, 35% (n=91) said they disagreed, 31.5% (n=82) said they agreed, 17.7% (n=46) said they strongly disagreed, 11.5% on the other hand said they also strongly agreed. 4.2% (n=11) provided no response.

For the availability of health services, 35.4% said they strongly agreed that health services are always available. Another representation of 92 respondents representing 35.4% also said they disagreed. 28.5% (n=74) said they agreed and 0.8% (n=2) provided no response. From the results gathered, 43.5% (n=113) said they disagreed to the fact that payment for health care services was difficult. 28.8% (n=75) said they strongly disagreed, 12.7% (n=33) said they rather strongly agreed to the fact that payment of health care services is hard. 11.5% also said they agreed and 3.5% (n=9) provided no response.

From the views of 159 respondents, they strongly agreed that healthcare services at the CHPS facilities were cheaper. 28.1% (n=73) also said the services at CHPS were cheaper to them. On the other hand, 8.5% (n=22) said they disagreed and 2.3% (n=6) provided no response. For the services rendered at the CHPS facility, 51.2% (n=133) said they strongly agreed that the services were culturally acceptable. 104 respondents also said

they agreed that the services were culturally acceptable. 4.2% (n=11) on the contrary disagreed whereas 4.6% (n=12) provided no response.

As to whether it was easier to access health services at the CHPS facility, the results indicated that 139 respondents strongly agreed. 41.5% (n=108) said they agreed, 4.2% (n=11) said they disagreed and 0.8% (n=2) provided no response. The results from the study again showed that 52.3% (n=136) agreed that the CHPS facilities were user friendly health facility. 116 respondents also said they strongly agreed, 3.1% (n=8) on the contrary said they disagreed.

In relation to whether healthcare in the CHPS facilities had become more affordable to the community members, 98% (98) said yes, and 2% (2) said no. In terms of whether some clients still patronized delivery outside the CHPS facilities, 82% (82) said yes, 18% (18) said no.

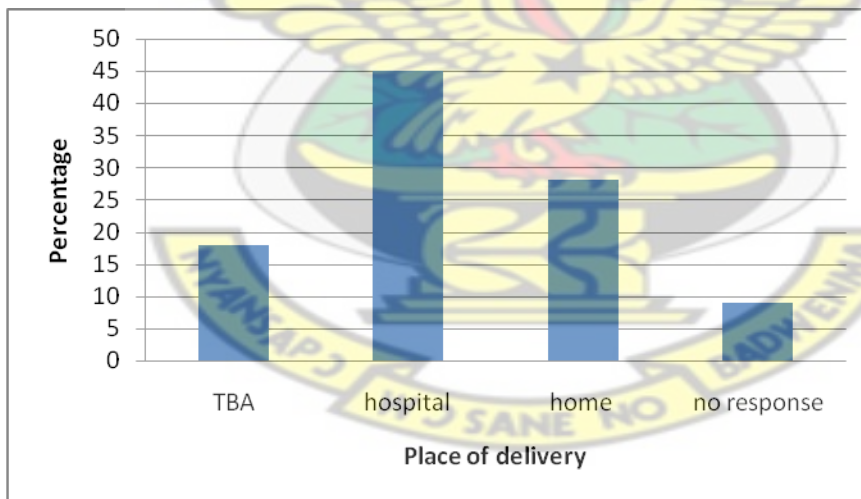


Figure 4.7: Places of Delivery for Clients Who Still Patronize Delivery outside the CHPS facility. (Source: Field Data, 2013)

In terms of places of delivery for clients who still patronized delivery services outside the CHPS facilities in their communities, 45% (45) said they went to the hospital, 28% (28) said home delivery, 18% (18) were delivered by TBAs and 9% (9) gave no response .

In terms of whether the introduction of the CHPS had improved client's access to orthodox healthcare especially maternal health, 100% (100) said yes. In terms of whether there were enough instruments/ equipment in the facility to provide quality health care to all patients attending the facility, 55% (55) said yes and 45% (45) said no.

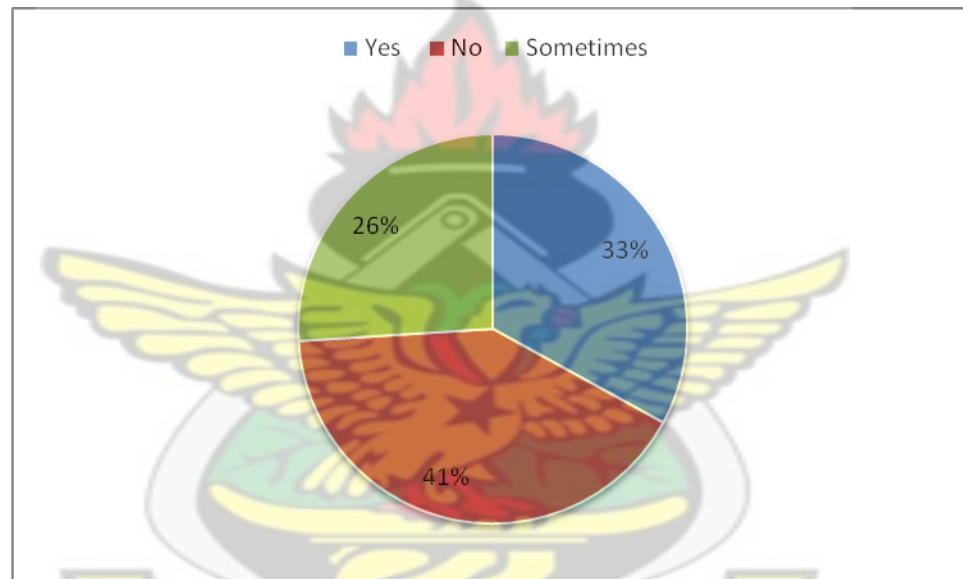


Figure 4.8: Availability of resources to provide quality healthcare in CHPS facility. (Source: Field Data, 2013)

In terms of whether respondents thought there were enough resources to provide quality healthcare in the CHPS facilities, 41% (41) said no, 33% (33) said yes and 26% (26) said sometimes.

4.2 Community Participation in CHPS Operations

Table 4.5: Community Involvement in CHPS as Perceived by Patients

Variable	Response	Frequency	Percentage
Community Members are not involved in CHPS activities	Strongly Agree	19	7.3
	Agree	24	9.2
	Average	15	5.8
	Disagree	125	48.1
	Strongly Disagree	77	29.6
	Total	260	100.0
There is no Community Health Nurse at Post	Strongly Agree	12	4.6
	Agree	11	4.2
	Average	9	3.5
	Disagree	113	43.5
	Strongly Disagree	115	44.2
	Total	260	100.0
Community Members are Usually Involved in decision making	Strongly Agree	128	49.2
	Agree	120	46.2
	Average	3	1.2
	Disagree	9	3.5
	Total	260	100.0
Community Members are mobilized in healthcare delivery	Strongly Agree	100	38.5
	Agree	158	60.8
	Average	0	0
	Disagree	2	.8
	Strongly Disagree	0	0
	Total	260	100.0

Source: Field Data, 2013

As to whether community members were not involved in CHPS activities, a likert scale of 1 to 5 was used to assess community involvement. A tick on 1 is strongly agreed, 2 agreed, 3 indicated average community involvement, 4 showed disagreed and 5 stood for strongly disagreed. 48.1% (n=125) said they disagreed. 29.6% (n=77) said they strongly disagreed, 9.2% (n=24) said they Agreed, 7.3% (n=19) also said they strongly agreed and a fewer number of 15 representing 5.8% of respondents said average community are involvement in CHPS activities.

The results from the study further showed that 44.2% (n=115) of respondents strongly disagreed that there was no community health officer in the facility. 43.5% (n=113) said they disagreed to this notion, 4.6% (n=12) also strongly agreed that there is no community Health Officer in the facility, 4.2% (n=11) on the other hand said they agreed and a minimum of 9 respondents representing 3.5% provided no response. For the involvement of community members in decision making, 49.2% (n=128) indicating majority said they strongly Agreed. 46.2% (n=120) said they Agreed, 3.5% (n=9) also said they disagreed and 1.2% (n=3) indicating minority provided no response. As to whether community resources are mobilised in Healthcare delivery, the results showed that 60.8% (n=158) indicating majority of respondents said they Agreed. 38.5% (n=100) said they strongly disagreed and 0.8% (n=2) also said they disagreed.

Table 4.6: Community Involvement in CHPS as Perceived by Health staff

Variable	Response	Frequency	Percentage
Community Members are not involved in CHPS activities	strongly agree	1	1.0
	agrees	5	5.0
	disagree	39	39.0
	strongly disagree	55	55.0
	Total	100	100.0
There is no Community Health Nurse at Post	Agree	3	3.0
	Disagree	28	28.0
	Strongly disagree	69	69.0
	Total	100	100.0
Community Members are Usually Involved in decision making	strongly agree	46	46.0
	agree	52	52.0
	strongly disagree	2	2.0
	Total	100	100.0
Community Members are mobilized in healthcare delivery	strongly agree	40	40.0
	agree	55	55.0
	disagree	1	1.0
	strongly disagree	4	4.0
	Total	100	100.0

Source: Field Data, 2013

From the health personnel viewpoint on whether community members were not involved in CHPS activities, 55% (55) strongly disagreed, 39% (39) disagreed, 5% (5) agreed, 1% (1) strongly agreed among others. In terms of whether there was no community health officer in the facility, 69% (69) strongly disagreed, 28% (28) disagreed, 3% (3) agreed. In terms of whether community members were usually involved in decision making, 52% (52) agreed, 46% (46) strongly agreed, 2% (2) strongly disagreed. In relation to whether community resources are mobilised for healthcare delivery, 55% (55) agreed, 40% (40) strongly agreed, 4% (4) strongly disagreed and 1% (1) disagreed.

Community Participation in Maternal Healthcare

Assessment of Community Participation at the CHPS on Maternal Healthcare was done by holding Focus Group Discussions in all the six communities that took part in the research. After participants discussed their views on the level of participation, they were led to draw a spider-gram using the indicators for assessing community participation as outline by Riftkin in 1988 (Needs assessment, Leadership, Management, Resource Mobilization and Organization).

This section presents the views and perspectives of our informants, representing six groups of programme stakeholders: Each group consisted of eight people; four community health committee members (two males and two females), two people interested in maternal health issues, who were appointed by the local chiefs and other

community opinion leaders, without consultation with the wider community and two maternal health service users from the communities.

During the FGD on community participation in Maternal Healthcare at the CHPS, different views and perspectives were raised by participants regarding the level of participation. However, the six groups of informants (FGD) eventually came to a collective consensus on the degree of participation on all the five indicators on community participation. The results indicated narrow, restricted and broad community participation as illustrated by the scores in the table and the spider-grams.

Needs assessment

From the FGD, the view shared by all participants was that the community did not play any role in identifying their health needs or designing CHPS. From their accounts, the programme was designed by health experts from Wa without their inputs or participation. Despite this pattern, the study revealed community members welcomed and supported the program because it had improved their health especially maternal and child health in the communities.

Below is a male participant's reflection on this.

'....No! We don't have any idea how this was done. The team didn't even ask us what we needed or wanted, but they brought us CHPS and this is good. We wanted a health centre and not CHPS but it is good that we have been given this because it serves our health needs but not everything' (Male service user in FGD)

Contrary to the dominant view that their needs had been pre-defined by the service providers, a minority of participants indicated there were indeed community consultations and meetings about the CHPS program before it was brought to them. This was echoed further by interviews from the service providers namely the District CHPS coordinator and the District Director of Health Services (DDHS). The DDHS reported they held meetings with community members on issues of implementation and these were discussed and agreed by all during the community meetings before they started the CHPS implementation. He maintained the meetings were organised for community members to reach a consensus on how the programme could well be implemented.

Below is the DDHS explanation in this regard.

'Well! The community was involved in the whole process from the very beginning. The communities met to plan and discuss how CHPS implementation will be executed – this happened immediately the health team informed community members about the CHPS programme and the roles members were required to play. Community members' attendance in the meetings was not encouraging at the initial planning stages but subsequently the numbers increased and the support base for community implementation of CHPS increased and this explains why CHPS is been successfully implemented here' (District Director of Health Services, Jirapa District).

However, in reaching a consensus on their level of participation, respondents rated their participation in needs assessment at point-2 on the spider-gram indicating restricted level of participation, except Sawaali community that rated it at one, minimal participation.

Leadership

Under leadership, different views were expressed by both community members and managers of CHPS regarding the leadership style and composition of the community health committee. Key Informant Interviews from managers revealed that the leadership style and composition of the community health committee represented all interested groups and that its activities and decisions served their interests and not that of the committee or any individual. Few community members held contrary views to this. Affirming the trust community members had of the community health committee's leadership role, a participant said:

'...No! I know anything they decide or undertake is best for us. They know our situation. The committee works selflessly for the interest of everybody and I have no reason to doubt the agenda behind their work' (Male service user in individual interview)

However, all informants were unanimous that programme leadership was completely male dominated.

'We don't take part in community meetings about CHPS, our husbands do. When it has to do with contributions to support CHPS, then our services are needed. This is the case in this community like any other community around here but there is nothing we can do because that is how life is structured in this setting and it has always been so'. (Female service user in focus group discussion)

Resource Mobilisation

Findings from the FGDs and interviews revealed the communities had made significant 'in kind' and 'cash' contributions to support the program. Contributions in kind took the

form of Land, water, sand, and purchase of stones, among others for the construction and maintenance of CHPS, as well as the labour to build and sustain the buildings. Contributions were also made in cash to support the building and maintenance of the CHPS program.

'We fetched water, carried sand, we really did a lot. Will there be such a project without payment? We are even fed up with the contribution to maintain this compound. We did a lot of contribution from the very start until the end and even now, we still occasionally contribute to repair broken parts. Go and have a look around and you will be marveled at what these small and poor communities like ours have been able to achieve. The building alone speaks of what contribution we did.' (Female service user in individual interview)

Our findings suggested that contributions to labour and materials were made by a wide range of community members irrespective of their economic status or gender. However, inputs were gender differentiated, with men and women. The men contributions were in the form of labour, cash, digging of sand, etc. whilst the women carried water, sand, cleaning the surroundings of CHPS.

Madam Fati! You know everybody's situation in these communities. We are all poor. Once you are living in a community like this, you are considered poor or else you would be living around Jirapa town. We all share the same problems and so no one is higher, lower or expected to be given any preferential treatment. But contribution was segregated by gender. You know we can't contribute equally, we have our share to contribute and our male counterparts have theirs. But for us, we all contribute equally; if

you don't, your fellow women will discount you'. (Female service user in focus group discussion)

Also, community members said that decisions on contributions were exclusively discharged by the community health committee, that is, decisions were vertically made. The community health committee had absolute and unquestionable decision making powers over what needed to be contributed. However, community members shared the view that their support of the programme had empowered them. Corroborating with data elicited from the Key Informants Interviews, the six focus groups affirmed that their contributions and support to implement CHPS had been tremendous and as a result they firmly rated the community's contribution on the spider-gram at point 4 in most cases and even 5 in other places.

Management

The findings showed that CHPS was independently managed by the local community health committee without any outside influence. Some service users in the interviews also spoke and expressed confidence in how the community health committee was managing and overseeing the CHPS programme implementation. A participant highlighted this point in the following extract:

'...Certainly! The committee is managing the programme very well without external or outside (GHS) influence. We might be small at the moment and not representing all but this is a view widely held in the community if you want to enquire further to establish the fact'. (Female service user in focus group discussion)

Also, the study indicated that management and decision making structures were vested under the authority of the community health committee who made decisions vertically without full community members' engagement. Community members (service users) were only at the receiving end of decisions unilaterally made by the community health committee.

'Hmmm...what can we say since we are not them? I mean the committee. Ok. From outside point of view, I think everything is working alright without external interference. We would have been made aware if there were such issues'. (Male service user in individual interview)

Again, female representation in the management structures was silent as findings indicated a male-dominated management style. The service users when prompted about their views on such an arrangement did not have any reservation about it. They appeared to be satisfied with what they regarded as the good management roles and decision making structures coordinated by the committee. Regarding opportunities for management capacity building, the committee chairman indicated that they had no access to capacity and skills training programmes to enhance their capability to manage the programme. On the whole, in rating their participation in managing the CHPS on the spider-gram, majority of the communities solidly agreed on point-4 as the extent to which they participated in the programme although this did not fully reflect the positions held by all, as some few respondents held contrary views regarding their level of participation in managing CHPS.

Organization

Findings from the study revealed that the CHPS programme successfully integrated itself into pre-existing community structures that predated the establishment of the CHPS. Some of these structures that had existed in the community prior to the advent of the CHPS programme the study revealed included a unit committee, health volunteers and traditional birth attendants. The study gathered that all these community structures were all absorbed and fully integrated into the CHPS programme in order to avert any confrontation or conflict between CHPS and the community structures. In highlighting on the degree of CHPS integration with the community structures, a health committee member gave the following commentary:

'The unit committee and the volunteers are still very active and working to support the CHPS as I said. Some of the unit committee members are playing dual roles as unit committee members and community health committee members. I was a member of the unit community when the programme started and from experience I know although they are parallel structures, they work collaboratively'. (Male service provider in individual interview)

Following this, participants deliberated on where to rate their level of community participation on the spider-gram. Subsequently, participants unanimously agreed that pre-existing community structures were fully integrated into the CHPS programme and so they rated it at point 5.

The table 4.7 shows an aggregate of the scores from the six communities where FGDS took place. From the table, only needs assessment scored an average of 2 out of the five maximum point which indicated restricted community participation. Some of the criteria

also scored three indicating mean or fair community participation while most had four and five which shows broad or maximum participation by community members in this direction as shown in table.....

Table 4.7: Scores (Rating) of Community Participation by Community Members

community	Leadership	Organisation	Needs Assessment	Management	Resource Mobilisation
Ping	4	3	3	3	4
Deriyiri	3	4	2	5	5
Guopuo/Piifaa yir	4	4	2	3	4
Saawie	3	4	1	4	5
Kuncheni	4	3	2	4	5
Nambeg	4	4	2	5	5
Average scores	4	4	2	4	5

The spider-gram in Fig 9 is a visual indication of how community members in the CHPs zones participated in the CHPS activities using Leadership, Organisation, Needs Assessment, Management and Resource Mobilisation as indicators.

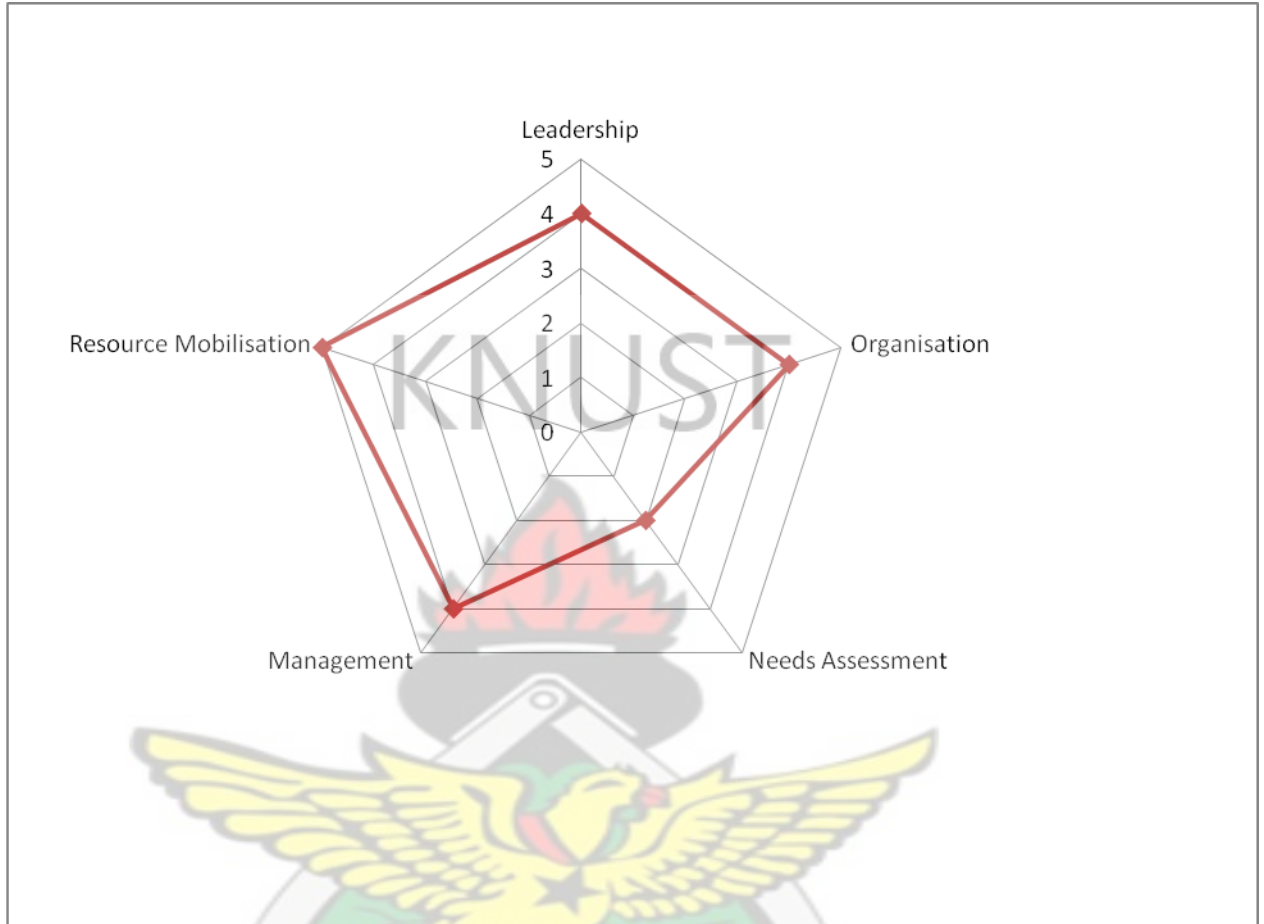


Figure 4.9: Spider-gram showing community participation in CHPS in Jirapa District

Source; Field Data, 2013.

The red line that joins the various indicators to make the spider-gram shows how wide or narrow the community participation in the CHPS zone is. The closer the line to the core or center, the narrower the community participation but the furthest away, the broader the participation. From fig. 9, community participation is generally broad in the CHPs zones in the Jirapa District with regards to Resource Mobilization, Management and

Organization. It is fair or average when it comes to Leadership and Restricted at Needs Assessment.

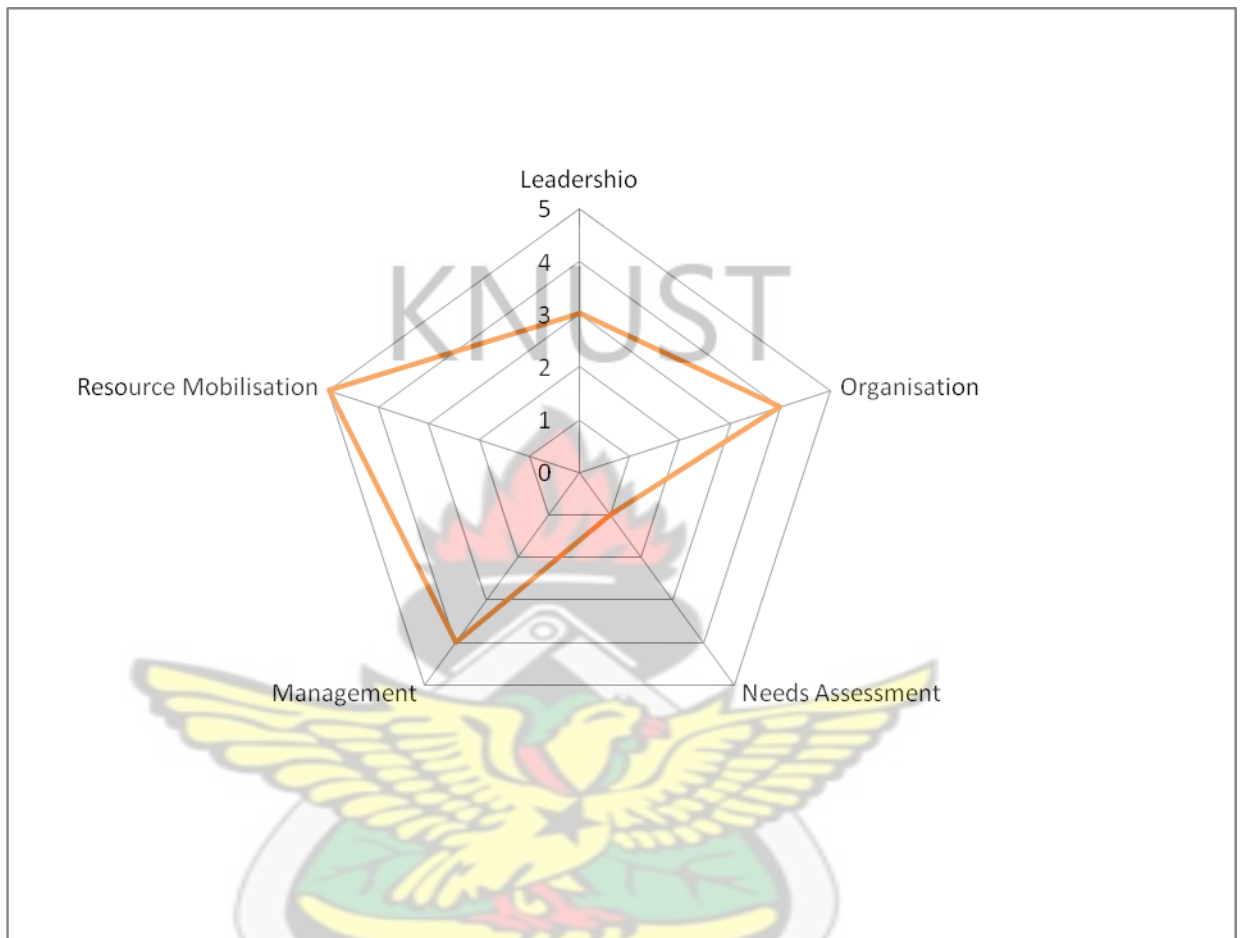


Figure 4.10: Spider-gram Showing Community Participation at Saawie.

Source; Field Data, 2013.

However, it is observed in Fig 10 that Needs Assessment in the Saawie community was Minimal or narrow as it is much closed to the core of the spider-gram with a score of just one.

CHAPTER FIVE

DISCUSSIONS

5.1 Introduction

This chapter discusses the analysed field data in comparison with existing literature as reviewed by the researcher on the influence of Community-based Health Planning and Services (CHPs) on maternal healthcare. The discussions relate to the analysed data and existing literature in the areas of quality of healthcare, access to orthodox healthcare, community participation and the challenges in the smooth implementation of the CHPs programme in delivery maternal healthcare.

5.2 Personal Information

By the research design, all the client respondents were females in their reproductive years. Sixty-five (25%) of the client respondents were less than eighteen years old and were either pregnant or had already delivered at the time of data collection. This shows a high rate of teenage pregnancy in the Jirapa District and may be an indicator of the practice of early marriage among the people in these communities. Binka and others (1995), in their research found how lack of access to modern family planning methods precipitated by culture and discrimination among healthcare givers in rural communities could lead to pregnancies among young girls. The Jirapa District which is a rural District in Northern Ghana has inadequate access to Family planning services especially among young girls as revealed by this study and this might be responsible for the high number of pregnancies among girls under eighteen years.

Educational status among the research participants indicated that, one hundred and eleven (42.7%) had no formal education while one hundred and seventeen (45%) were either junior high school or middle school leavers. Only three people representing 1.2% of the respondents had tertiary education. This is not good for maternal health because there is a strong association between level of education and knowledge on maternal health practices and indeed behavior and decisions that improve maternal and child health according to Mariachiara in 2013. This very low level of education among the women could also mean mothers would not be gainfully employed to take care of their health and financial needs. This is amply demonstrated in their occupation as 77.7% of the respondents were either unemployed or peasant farmers. The data also show that 196 of the respondents representing 75.4% were married with 18.8% being single mothers. The number of single mothers was too high because among the people of Jirapa, child bearing in a stable marriage is a pride as they frown on child bearing outside marriage and devoice.

Majority of the staff respondents (64%) were females. This is not surprising as nursing and ward assistant jobs are skewed towards female gender worldwide. Most of the staff were community health nurses (56%), followed by health assistants who represented 43%. This staff-mix could be problematic for maternal health as midwives who are trained to deliver maternal health services such antenatal, delivery, postnatal and other related services like family planning services were absent. Quality of maternal health services might also be a problem in the District as 60% of the staff had between one to

five years working experience. Only 12% of the staff had working experience above ten years.

5.3 Quality of maternal Healthcare Services.

Generally, quality of maternal health services in the CHPS facilities within the Jirapa District was good as both staff and client respondents scored high marks in favour of quality. One hundred and fifty three representing 58.8% of client respondents said working hours were convenient for them to access maternal healthcare because services were available from morning till evening, but one hundred and seven representing 41% said maternal healthcare services were available to them both day and night, a situation they described helpful to their health and that of their children. All client participants also indicated that maternal health services were provided in a hygienic environment with mutual respect between staff and clients. They said most of the drugs prescribed for them were available at the facility. Staff participants also indicated that average number of drugs prescribed to a client per time was four as indicated by 94% of staff respondents. This is in line with WHO best practice as it states that no patient should be given more than four drugs at a time (WHO, 2000). On the availability of family planning medicines, majority of the clients and staff said they experience frequent shortage of products especially Norplant. 56% said norplant was not available at the CHPs most of the times they visited the facility. This periodic shortage of modern family planning commodities could explain why about 18.8% of client respondents who were either pregnant or breast feeding at the time of data collection were less than eighteen years of age.

One of the main set back on quality was the fact that 52.7% of client respondents said healthcare providers were not regularly present at their duty post. During the Key Informant Interview however, participants said it could be on few occasions when key staff were invited for training or when staff left the CHPS facility for outreach services in other parts of the community at the time of the study.

CHPS facilities in the Jirapa District also lacked midwife to provide good maternal healthcare to community members. The highest qualified professionals were community health nurses who were usually not trained to proficiency level to provide maternal and child health services. SEND-GHANA in their 2012 health report indicated lack of professional midwives and logistics in CHPS in the Greater Accra and Northern Regions of Ghana. SEND-GHANA enumerated some of the challenges to quality healthcare as: lack of storage facilities for drugs; lack of properly and scientifically trained birth attendants (midwives) in some areas; low patronage of the CHPS facilities in some parts; attitudes of some CHOs; lack of accommodation; uncooperative attitude of some district and regional assembly workers and duty bearers.

5.4 Access to maternal Healthcare Services at the CHPs.

CHPS is a process for changing health service delivery by increasing geographic and financial access to health care (a major strategic pillar in Ghana's HSR and currently the GPRS). Its coverage plan seeks to address inequalities to access in healthcare especially in deprived regions, districts and communities by providing Community-based level, or "close-to-client" doorstep health services with household and community involvement.

The introduction of CHPS in the Jirapa District has improved Access to Maternal Health services. Financial access has improved as some 232 (89.3%) of client respondents said services at the CHPS compounds were cheap and generally affordable. They said they could now access maternal health services easily at the CHPS compounds compared to travelling to the District hospital at Jirapa; 91.2% of clients respondents also described the services provided in the CHPS facilities as culturally acceptable and user friendly. Debpuur and others, however found out that, the CHPS in the Upper East Region had helped improved access to family planning drastically with an associated decrease in total fertility rate the Region (Debpuur et. al., 2001).

Despite the above description of access by respondents, the situation was different when it came to spatial factors as 86.5% of clients indicated there were no motorable roads from their residence/location to the CHPS facilities, they said the lack of transportation to the CHPS facilities and to the District Hospital in Jirapa had worsened the plight of patients especially in emergencies. During the FGDS some community members could not hide their frustrations on the very poor nature of their roads, which made it very difficult to transport pregnant women to the CHPS compounds for delivery and other services. They said even though they did communal labour to repair the roads, the roads became very deplorable within a short time especially during the rainy seasons. These findings are similar to that of Yeboah, who noticed that, there are still some parts of Ghana where people must travel relatively long distances to access health care. This factor is a significant problem in rural areas where public transportation systems do not

exist. Even in urban areas, the timeliness and convenience of public transportation and other available forms of transportation affect access to healthcare (Yeboah, 2003).

Meade and Earickson (2000) also realized that a person's access to transportation may limit his or her access to some better healthcare services or treatments at locations not close to his/her home. Availability of more skilled nurses or doctors may be limited if a person lives in a rural geographical area with poor roads and lack of means of transportation. These findings however contradicts that of Debpuur and others (2002), who showed that the CHPS programme guaranteed geographical access to health with tremendous improvement in maternal and child mortality in the Upper East Region of Ghana.

5.5 Community Participation to Maternal Healthcare in CHPS.

Community Participation in delivery maternal healthcare services in CHPS is very important in health programmes especially in developing countries. The assumption is that, the wider the range of activities, the greater the participation and the greater the participation, the better the effects in the community health programme on maternal health.

Community Participation in maternal healthcare services in the CHPS facilities/compounds within the Jirapa district is generally very good as both community members and health staff indicated during data collection. 202 (77.7%) of client respondents said community members actively participated in CHPS activities in their various communities. Majority of them, 258 (99.3%) said community members were mobilised to undertake various activities in the CHPS compound to improve maternal

health. During FGDS, members recalled how community members mobilized transport for emergency patients to be taken to hospital and also contributed monies to buy delivery beds and some other items for CHPS in their communities. Awoonor (2010) in his research on access to healthcare services in the Volta Region of Ghana, a rural Region like the Upper West Region, also indicated how community members provided support to transport pregnant women and sick children especially during referral. This finding gives the CHPS programme a good future as community members are willing to take decisions and actions to improve their own health by using locally available resources.

Community members however bemoaned their lack of involvement during needs assessment in the initial stages of CHPS. This is clearly demonstrated on the spider-gram drawn by the community members during the FGDS. Needs Assessment had the lowest score of two, meaning restricted community participation. Health staff at the District Health Directorate however disagreed with the community's assertion on Needs Assessment. The District Director of Health Services and the District CHPS Coordinator indicated that there were wide consultations and general meetings with all the communities before starting the programme. These findings are consistent with Batiema and others (2012) when they sought to find out the level of community participation in CHPS in the Wa Municipality. The spider-grams drawn by the community members during the Focus Group Discussions generally showed a broad community participation in maternal healthcare services in the various CHPS facilities within the District except Needs Assessment which was restricted as shown on the spider-grams.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This part of the study draws conclusions for the study based on the discussion of the data analyzed. This is done primarily in alignment with the objectives. The study also offers some recommendations on how to remedy some of the challenges that were identified during the study.

6.2 CONCLUSIONS

CHPS is a viable concept in increasing access to quality Maternal Healthcare Services in rural locations and for that matter the Jirapa District. This will ensure that Ghana improves and maintain the health of the vulnerable segment of society, women and children.

6.2.1 Access to Maternal healthcare Services

Access to Maternal Healthcare Services was good in CHPS facilities within the Jirapa District. Services were cheap for community members who described the facilities as culturally acceptable and user friendly, a situation which would encourage community members to patronise services. Distance to health facility had also been reduced for a lot of the community members.

Geographical barriers however still existed as unmotorable roads and lack of means of transportation especially during emergencies was a daily affair.

6.2.2 Quality of maternal Health Services in CHPS

Quality of Maternal Healthcare in the CHPS facilities within the Jirapa District was good according to both staff and community members. On the WHO criteria on assessing quality healthcare and other indicators such as environmental hygiene, staff attitude and convenience working hours, scored very high. However, if maternal healthcare services are supposed to meet scientific standards, the lack of midwives in most of the CHPS facilities in the District must be addressed.

Other equally disturbing issues bordering on quality of Maternal Healthcare Services is where the frequent stock out of some family planning product, especially Norplant. This sporadic shortage in combination with cultural barriers to family planning services among the youth could probably have led to the over 18% teenage pregnancies in the District at the time of the study.

6.2.3 Community Participation in Maternal Health in CHPS

The community members actively participated in four of the five indicators recommended by Rifken to measure community participation in a health programme. Leadership, Organisation, Management and resource mobilisation were areas community participation was very broad, the fifth indicator which performed badly was initial Needs Assessment of the communities before CHPS was established. Community members complained in the FGD that they were not involved.

6.3 RECOMMENDATIONS

From the data analyses and the discussions, the following recommendations are made.

Health Staff

- Improve availability of family planning products by doing proper budgeting and tracking minimum stock levels in order to detect low stock of products and re-order to prevent shortage of family planning products.
- Health workers in CHPS facilities should use social marketing techniques to create more outlets and sale points for family planning products while working on cultural, religious and social factors that make family planning products inaccessible to the youth. This is important because, even though family planning products may be physically present in health facilities in the community other factors still make them inaccessible to vulnerable groups.
- Mobile phones should be bought and credit provided always for all CHPS facility to facilitate communication during transfer of patients. Also, a directorate of telephone numbers of all the ambulance drivers in the District should be made available to all CHPS facilities to facilitate transport arrangement for emergency patients from the various CHPS facilities to the District hospital in Jirapa.

Community Members

- Community members should contribute monies into a fund that takes care of ambulance fees in case of emergency transfer of patients to health facilities. This risk-pooling mechanism relieves individuals and family members of the financial burden in terms transportation at the time of ill health. This could improve

timeliness with which emergency patients are transported to health facilities to access emergency healthcare.

- The assembly men and other stakeholders in the various communities could also liaise with the district assembly to construct roads to the various communities for ease of transport of emergency patients.

District Health Administration

- The District Health Administration could lobby with the District Assembly to train more midwives and post them to the CHPS facilities to facilitate quality maternal healthcare delivery within the CHPS facilities. More experienced midwives should also be posted to the CHPS facilities because the current situation where most of the staff had only 1-5 years working experience could affect quality of maternal healthcare.
- The District CHPS Coordinator and the District Health Management Team must improve supervision and monitoring of medicines and logistics to prevent the situation where CHPS facilities run out of stock of essential products such as the family planning medicines.

Concluding Remarks:

The CHPS in the Jirapa district has improved to a larger extent, access to maternal health services in the district with majority of community members enjoying culturally acceptable and friendly services that are affordable. Community participation has been generally good with community members in decision making and mobilizing resource for

maternal healthcare contributing to good quality maternal services. Barrier to accessing quality maternal healthcare services in CHPS facilities within the district include; poor road network and lack of means of transporting emergency patients, sporadic shortage of some family planning commodities and lack of trained midwives to man the facilities.

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REFERENCES

Alfred Health., (2010). *Incorporating the Cultural Responsiveness Plan and Disability Action Plan*.Community Participation Plan 2010 – 2013.<http://www.alfredhealth.org.au>.
12/02/14

Ayizem,P., Joseph,J., (1984). *Accessibility and Utilization, Geographical Perspectives on Health Care Delivery*.Happer& Row Publishers, New York.

Awoonor, W., (2010).*Transporting and Referral for Maternal Health within CHPS systems in Ghana*, No woman should die given life.

Batiema, B., Skovdal, M., Rifkin, S., Campbell, C., (2013).*Assessing participation in a community-based health planning and services programme in Ghana*.<http://www.biomedcentral.com/1472-6963/13/233> 20-11-13.

Bertrand, J., Marine. C., (2001). Operations research: *Measuring its impact on service delivery and policy*. (unpublished manuscript).

Binka F, Nazzar A, Phillips J. (1995). The Navrongo Community Health and Family Planning Project.Studies in Family Planning.

Brawley M. (2000).The client perspective: What is quality health care service? A literature review. Kampala, Uganda: Delivery

Center for Disease Control and Prevention, National Center for Health Statistics, (2000).*Comparing with Socioeconomic Status & Health Chart book*.Health, United States of Improved Services for Health.

Chambers, R., (1997).*Whose reality counts ?putting the first last*. London: Intermediate Technology.

Campbell, C., Cornish, F., Skovdal, M., (2012).*Using Scale to think about HIV/AIDS interventions: local and global dimensions*.*Health Place* 2012, **18**(3)

Cole-King S, Gordon G, Lovel H. (1979). Evaluation of primary health care - A case study of Ghana's rural health care system.*Journal of Tropical Medicine and Hygiene*.

Draper, A., Hewitt, G., Rifkin, S., (2010).*Chasing the dragon: developing indicators for the assessment of community participation in health programmes*. *SocSci Med* 2010, **71**(6):1102-PubMed AbstractPublisher Full Text

Debpuur C, Phillips JF, Jackson E., (2002). The impact of the Navrongo Project on contraceptive knowledge and use, reproductive preferences, and fertility.*Studies in Family Planning*.

Dodowa Health Research Centre (2007), *Malaria Pneumonia Study: Home and Community Management of fevers in children under five in Dangme West district.*” *Powerpoint Presentation. August 2007.*

Donabedian, A., (1988). *The Quality of Care and How it can be Assessed. Quality Assessment and Monitoring, vol. 1*]; Ann Arbor: Health Administration Press

Freire, P., (1973). *Education for critical consciousness.* New York: Seabury press.
xiii, 146 p

Gnawali, D. P., Pokhrel, S., Sié, A., (2009): *The effect of community-based health insurance on the utilization of modern health care services: Evidence from Burkina Faso.*

Gobah, F. K., Liang, Z.,(2011). *The national health insurance scheme in Ghana: prospects and challenges: a cross-sectional evidence.* Global Journal of Health Science.

Habermas, J., (1974). *The Public Sphere: An Encyclopedia Article.* New German Critique 1974, 3:49-55.

Issah, K., (2008). *The National Health Insurance Scheme is not a Panacea to Quality Healthcare Delivery.* Retrieved February 8, 2011. [www.ghanaweb.com/GhanaHomePageNews Archive/ arkiel.php](http://www.ghanaweb.com/GhanaHomePageNewsArchive/arkiel.php).

Joseph, A.E., Phillips, D.R., (1984). *Accessibility and Utilization, Geographical Perspectives on Health Care Delivery*. Happer& Row Publishers, New York.

Kaiser Commission on Medicaid and the Uninsured, (2000). Analysis by the Urban Institute based on the March 1999 CPS Data, Washington, DC. *National Survey of America's Families*.

Lawn, J., (2008). *Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise*. *Lancet* 2008, **372**(9642):917-927. PubMed Abstract | Publisher Full Text

Mariachiara, D., Sabates, R., Keiith, M., (2013). A double prevention: How maternal education can affect maternal mental health, child health and child cognitive development. <http://dx.doi.org/10.14301/llcs.v4i3.233>. 22/02/14.

Maynard, M. & Purvis, J. (1994). *Researching women's lives from a feminist perspective*. London and Bristol, PA: Taylor & Francis Ltd.

Meade, S.M., Erickson, R.J., (2000). *Medical Geography*. 2nd Edition. The Guilford Press, New York.

Ministry of Health, Government of the Republic of Ghana, "The Second Health Sector Five Year Programme of Work: (2002-2006). Nov. 2001. Pg. 1-56.

<http://www.ghanahealthservice.org/includes/upload/publications/2004%20PROGRAMME%20OF%20WORK.pdf>.

Morgan, L., (2001). *Community participation in health: perpetual allure, persistent challenge*.

Health Policy Plan 2001, **16**(3):221-230. PubMed Abstract | Publisher Full Text

Navrongo Health Research Centre., (2003). “What Works, What Fails: Chapt. 1 Project Design” Vol. 3, 2003: 1-9. <http://www.ghana-chps.org/pdfs/ww/WHATWORKS.CHAP4.pdf>.

Navrongo Health Research Centre., (2001). “What Works, What Fails: Chapt 2 Planning the Initiative” Vol. 1, 2001: 11-35. <http://www.ghana-chps.org/pdfs/ww/WHATWORKS.CHAP2.pdf>

Petes, P., Smulovitz, A., Walton, M., (2007). *Evaluating empowerment: a framework with cases from Latin America. In Measuring empowerment: cross-disciplinary perspectives*. Edited by Narayan D. Washington, DC: The World Bank; 2005::39-67.

Johns Hopkins University., (2006). Ghana: Community-based Health Planning and Services (CHPS).” http://www.jhuccp.org/africa/com_mob/ghana_chps.shtml#5.

Nyonator, Frank K. et. al.,(2003). “The Ghana Community-based Health Planning and Services Initiative: Fostering Evidence-based Organizational Change and Development in a Resource-constrained Setting.” Population Council: Policy Research Division.

<http://heapol.oxfordjournals.org/cgi/reprint/20/1/25>.

Nyonator, F., (2005). *The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation*. Health Policy Plan 2005, **20**(1):25-34. PubMed Abstract | Publisher Full Text

Pence, Brian, Philomena Nyarko, Fred N. Binka, James F. Phillips, and Cornelius Debpuur.(2001). “*The impact of the Navrongo Community Health and Family Planning Project on child mortality, 1993–2000.*” Paper presented at the Global Conference of the International Union for the Scientific Study of Population.

Pence, B., Nyarko, P., Binka, FN., Phillips, JF, Debpuur C. 2001. The impact of the Navrongo Community Health and Family Planning Project on child mortality, 1993–2000. Paper presented at the Global Conference of the International Union for the Scientific Study of Population, Salvador, Brazil (August).

Penchansky, R., Thomas, J.M., (1981) “*the Concept of Access: Definition and Relationship to consumer Satisfaction*”. Medical Care, Vol.7.

Rifkin, S., (1988). Primary Healthcare, On Measuring Community Participation in Social Science and Medicine, 26, 931- 940

SEND-GHANA, (2010), *Balancing Access with Quality Healthcare: An Assessment of NHIS in Ghana*.<http://gh.sendwestafrica.org>. 10/12/14.

Stephen, R., (2008), *Community-based Health and Planning Services: Decentralizing Ghana's Health System*. **GUJHS.2008 Apr; Vol. 5, No. 1. 01/01/14**

Socioserve-Ghana, (2013), *Mobilizing Community Action towards Maternal Health Improvement (MOCAMI)*.www.ghanaweb.com. 12/02/2014.

WHO,. (2008).*Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva.

Yeboah, Y., (2003). *Partnership in Health Service Planning and Provision*. Prospects and challenges in Ghana . Spring Center, University of Dortmund

Zakus, J., Lysack, C.,(1998).*Revisiting Community Participation. Health Policy Plan* 1998, **13**(1):1-12. PubMed Abstract | Publisher Full Text

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APPENDIX A

INFORMED CONSENT FORM

Project Title:

Influence of the Community-based Health Planning and Services on Maternal Healthcare Services in the Jirapa District, Upper West Region of Ghana.

Institutional affiliation

Department of Community Health, Kwame Nkrumah University of Science and Technology

Background

The principal investigator is Noalla Anglaaere, a student of the School of Medical Sciences, Department of Community Health, Kwame Nkrumah University of Science and Technology. She is conducting this research on the Influence of the Community-based Health Planning and services on maternal healthcare services in the Jirapa District, Upper West Region of Ghana and the results of the study will help improve on the access and quality of Maternal Healthcare Services in the Jirapa District. It is also in partial fulfilment for the award of Master of Public Health (MPH) degree.

Procedure

It will involve asking some few questions from you about various social and health issues. I will very much appreciate your participation in this study.

Risk and Benefits.

The outcome of this study will help advice policy makers and programme managers as to the way forward in the improvement of access and quality Healthcare Services in the District. This will help improve the Maternal Health situation in the District. No risk is anticipated to respondents as privacy and confidentiality were ensured

Right to refuse

Participation in this research is voluntary, and if I should come to any question you don't want to answer, just let me know and I will go on to the next question; or you can stop the interview at any time. However, I hope that you will participate in this study since your participation and that of your ward are important.

Anonymity and confidentiality

The questionnaire usually takes about 20 minutes to complete. Whatever information you provide will be kept confidential and will not be shown to anyone other than members of the research team.

Before taking consent

At this time, do you want to ask me anything about the study? May I begin the interview now?

Thank You.

Consent

I.....declare
that the purpose, procedures as well as risks and benefits of the study have been
thoroughly explained to me in English/Dagaare languages and I have understood. I
hereby agree or disagree to participate in the study.

Signature/Thumbprint of Parent/ Guardian

Date.....

Interviewer statement

I.....the
undersigned, have explained this consent form to the subject in the language she
understands. The subject understands the purpose of the study, procedures to be followed
as well as the risks and benefits involved. The subject has freely agreed to participate
with the ward in the study.

Signature of interviewer.....

Date.....

APPENDIX B

Health Staff Questionnaire

Introduction

Good morning/afternoon. I am a student at School of Medical Sciences, KNUST. I will be conducting several meetings with people like you in Jirapa district to find out your views and ideas about “the influence of CHPs on maternal healthcare”. Your opinions are highly essential at the same time vital as they will help us to improve the kind of service we provide. Whatever you say will be treated confidential, so feel at ease to express your candid opinion. Be assured that your responses will not in any way be linked to your identity. You are kindly requested to answer the questions below by indicating a tick or writing the appropriate answer when needed.

THANK YOU.

Date of Interview:

Health staff Questionnaire

Demographic Data (Background Information)

1. Age:
2. Sex: ---male () female ()
3. Profession:
 - (a) Community health nurse (CHPs)
 - (b) Community nurse midwife/ midwife
 - (c) Health Assistant

(d) Others (specify).....

4 .Number of years of service

(a) 1-5 years

(b) 6-10 years

(c) 11 years and above

5. Current post/facility

Instruction: Please tick the appropriate response as defined below,

AS =Strongly agrees, A =Agrees, U = Unknown, DA = Disagrees, SDA = Strongly disagrees .

S/no	Item	AS	A	Unknown	Disagree	Strongly disagree
7.	Community members are not involved in CHPS activities					
8.	There is no community health officer in this facility					
9.	Community members are usually involved in decision making.					
10	Community resources are mobilised for healthcare delivery					

Effect of CHPS Activity on Service Providers

6. How many hours do you work in a day?

- (a) 1-8hours
- (b) 8-10 hours
- (c) Above 10 hours

7. If you work more than 8hours, why?

- (a) Few staff.
- (b) Increase attendance because of free maternal health care.
- (c) Others

(specify).....

.....

8. Do you think the CHPs initiative has increased your work load?

- (a) Yes
- (b) No

9. What has your answer to question (8) got to do with the quality of care you provide to the patients?

- (a) Decrease it.
- (b) Increase it.
- (c) No effect.

10. Do you take history on all patients?

- (a) Yes
- (b) No
- (c) Some times

11. Who takes patient's /client's history?
- (a) CHO /Midwife.
 - (b) CHW
 - (c) HEWs
 - (d) Others (specify)
12. Are all patients given preliminary diagnoses before treatment/management?
- (a) Yes.
 - (b) No.
 - (c) Some times.
- 13 .Are patients told their diagnoses?
- (a) Yes.
 - (b) No.
 - (c) Some times.
14. On the average, how many drugs are prescribed per patient at a time?
- (a) 1-4.
 - (b) 4-6.
 - (c) 6-10.
 - (d) Above 10
15. Are tracer medicines available in the CHPs all the times?
- (a) Yes.
 - (b) No.
 - (c) don`t know.

16. With the advent of the CHPS, do you think maternal health has improved in this community?

(a) Yes.

(b) No

17. Explain your answer in question (16) above

.....

.....

18. Do you provide family planning services to clients?

(a) Yes.

(b) No

19. Which of these family planning methods are not available in this facility?

(a) Injectables

(b) Pills

(c) Condoms

(d) Norplant

(e) Others (specify).....

20. Have you had any training in basic emergency obstetric care?

(a) Yes

(b) No

21. Do you think you need further training to provide quality maternal healthcare to your patients?

(a) Yes

(b) No

22. Are there adequate vaccines in this facility?

(a) Yes

(b) No

23. Do you think you have enough resources to provide quality healthcare in this facility?

(a) Yes.

(b) No

(c) Some times.

24. If NO to question (23) above, what resources are you lacking?

.....

.....

25. How can you describe the quality of care in the facility?

(a) Very good.

(b) Good.

(c) Fair

(d) Poor.

(e) Very poor.

26. Do you think health care in the CHPs zone has become more affordable to the community members?

(a) Yes.

(b) No.

27. Give a reason for your answer in question (26) above.

.....

.....

28. Do some clients still patronized delivery outside the CHPs zone?

(a) Yes. { }

(b) No. { }

29. If yes to question (28) where do they deliver?

(a) TBA

(b) Hospital

(c) Home

30. Do you think the introduction of the CHPs has improved client's access to orthodox health care especially maternal health?

(a) yes

(b) No

29. Give reason(s) for your answer in question 28

above.....

.....

.....

30. Are there enough instruments/equipment in the facility to provide quality health care to all patients attending the facility?

(a) Yes

(b) No

.....

THANK YOU FOR YOUR TIME

APPENDIX C

Patients' Questionnaire

Introduction

Good morning/afternoon. I am a student at School of Medical Sciences, KNUST. I will be conducting several meetings with people like you in Jirapa district to find out your views and ideas about “the influence of CHPs on maternal healthcare”. Your opinions are highly essential at the same time vital as they will help us to improve the kind of service we provide. Whatever you say will be treated confidential, so feel at ease to express your candid opinion. Be assured that your responses will not in any way be linked to your identity. You are kindly requested to answer the questions below by indicating a tick or writing the appropriate answer when needed.

THANK YOU.

Date of Interview:

Client Questionnaire

QUESTIONNAIRE NUMBER: 001 DEMOGRAPHIC DATA.

S/no.	Item
1.	Sex 1.Male [] 2.Female []
2.	Age.....
3.	Educational background 1.No formal education [] 2.Primary/JSS/Middle school [] 3.SSS/Vocational/Technical [] 4.Tertiary [] 5. Others (specify).....
4	Occupation. 1.Unemployed [] 2. Farmer [] 3.Trader [] 4. Government worker [] 5.Others (specify).....
5.	Marital status. 1.single [] 2.Married [] 3.Divorced [] 4.Widowed [] 5. Others (specify).....
6.	Number of children.....
7	Community/location

SECTION B: ASSESS THE QUALITY OF MATERNAL HEALTH CARE.

SECTION C: THE ACCESSIBILITY OF HEALTH CARE SERVICES AT THE CHPS ZONE.

Instruction: Please tick the appropriate response as defined below,

AS =Strongly agrees, A =Agrees, U = Unknown, DA = Disagrees, SDA = Strongly disagrees .

S/no	Item	AS	A	U	Disagree	Strongly disagree
10.	All roads leading to the CHPS facility are motorable.					
11.	It is hard to get transport to the CHPS facility.					
12.	The service provider is not regular at post.					
13.	Health services are always available.					
14.	It is hard to pay for the health care services.					
15	Health care services at CHPS zone is cheaper for me.					
16	The services rendered at the CHP facility are culturally					

	acceptable.					
17	It is easier now to get health services at the CHPS facility					
18	The CHPs zone is a User friendly health facility					

Instruction: Please tick the appropriate response as defined below,

AS =Strongly agrees, A =Agrees, U = Unknown, DA = Disagrees, SDA = Strongly disagrees .

S/no	Item	AS	A	Unknown	Disagree	Strongly disagree
7.	Community members are not involved in CHPS activities					
8.	There is no community health officer in this facility					
9.	Community members are usually involved in decision aking.					
10	Community resources are mobilised for healthcare delivery					

Table 2.3; Quality of maternal health Care as Perceived by the User

Quality factor	Its meaning to the user
19. Working Hours in the CHPs zone.	Convenient opening and closing hours are: 1. Morning up to evening. { } 2. Throughout day and night. { }
20. Human Relations of service provider.	Mutual respect and treating clients in a humane manner. 1. Agree { } 2. Disagree { }
21. Hygiene and Sanitation at CHPs zone.	Good hygiene and sanitation to prevent new infections whilst receiving care. 1. Yes { } 2. No { }
23. Any diagnosis at the CHPs zone	Do the health personnel have time for diagnoses? 1. Yes { } 2. No { } Do they tell their clients the results of the diagnosis? 1. Yes { } 2. No { }
24. Regular drugs at the CHPs zone.	Does the facility have the drugs prescribed? 1. Yes { } 2. No { } Is the dosage usually well explained to client? 1. Yes { } 2. No { }
25. Confidentiality at CHPs zone.	Are client records kept confidential? 1. Yes { } 2. No { }

THANK YOU FOR YOUR TIME