

**THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) AND
ACCESS TO HEALTH CARE IN THE ASHANTI REGION, GHANA**

BY

VICTORIA YELEDUOR

KNUST

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DECLARATION

I, Victoria Yeleduor, hereby declare that, this work has been my own original research, under the close supervision of Professor S. E. Owusu, Senior lecturer at the Department of Planning College of Architecture and Planning.

All references to other peoples' works have been duly acknowledged.

VICTORIA YELEDUOR

(Candidate Name& ID PG3003609)

Signature

Date

CERTIFIED BY:

PROF. E. S. OWUSU

(Supervisor)

Signature

Date

CERTIFIED BY:

DR. IMORO BRAIMAH

(Head of Department)

Signature

Date

ABSTRACT

Globalization is putting the social cohesion of many countries under stress and health systems as key constituents of the architecture of contemporary societies are clearly not performing as they should. People are increasingly impatient with the inability of health services to deliver at levels of national coverage that meet stated demands and changing needs, and with their failure to provide services in ways that correspond to their expectations.

Since Ghana's Independence, there has been concentration on improving health services delivery at the Hospital and Health Centers by investing in the construction of health facilities, hoping that the presence of these facilities will lead to an increase in uptake of health services. The Health status of Ghanaians has been improving since independence, however, the rate of change has been slow and current health service indicators are still far from desirable.

Good health is one of the most important contributors to individual welfare and ability to perform effectively in all aspects of life. The glaring reality of rural dwellers' is poor access to health facilities and other social amenities. To improve health conditions in Ghana, the Ministry of Health strategic policy adopted by the Ghana Health Service aims at bringing health care to the door step of people, especially those in the rural and deprived areas. To promote access, quality and equitable health care services to all Ghanaians, particularly those in rural and deprived settlements, the Ghana Health Service adopted the Community-based Health Planning and Services (CHPS) as a national programme to achieve its objective.

It is in the light of this that this study focused on access to health service delivery under the Community Health Planning and Services programme and the role of the programme in improving access to health services to the poor and deprived communities in the Ashanti Region. The objective of the study was to examine the role of CHPS and access to health care delivery. The Simple random and purposive sampling procedure was used and 15% of the districts implementing CHPS was the sample size for the study.

The study used both secondary and primary data. The secondary information was sourced from Ministry of Health annual reports, internet, journals, unpublished thesis reports and CHPS policy document. The primary data was collected using questionnaires.

It was evident that, the Ashanti Region is endowed with health facilities including a teaching hospital. However, these health facilities are not evenly distributed across the region. The study revealed that communities with CHPS compounds had easy access to health care as frequency of visits to the CHPS facility was averaging four times within a year and communities without CHPS; frequency of visits was just once a year. This was attributed to long distance travels, bad road conditions and high cost of transportation. Also, the introduction of NHIS has taken care of the financial burden in accessing health care.

Secondly, the CHPS compounds serve as the first point of call in the structure of the health system but the health personnel requirement at the CHPS compounds were inadequate in terms of numbers and technical expertise.

Some of the findings of the study include the following: The CHPS activities is to involve local participation in health decisions making but it was unearth that there was low participation in CHPS's activities. The CHPS serves as the first point of call in health care delivery at the community level. Human resource is inadequate in terms of technical expertise. Affordability of health care services by the local people is through the use of NHIS cards. The location of CHPS compounds using the Zone systems do not effectively serve all communities under the catchment area.

It is recommended that GHS in collaboration with the District Assemblies should train more health professional of the various categories and bond them to service the districts and communities within the region in order to fill the gap of professional inadequacy. Also, the current system where a CHPS compound serve about six communities or based on zones should be looked at again because distance, condition of road and cost of transportation hinder access to health facilities. Therefore more health facilities should be built.

DEDICATION

This work is dedicated to my parents Mr. and Mrs. Paschal Yeleduor, and Siblings Vera, Vitalis and Vincent for their love and prayer support.

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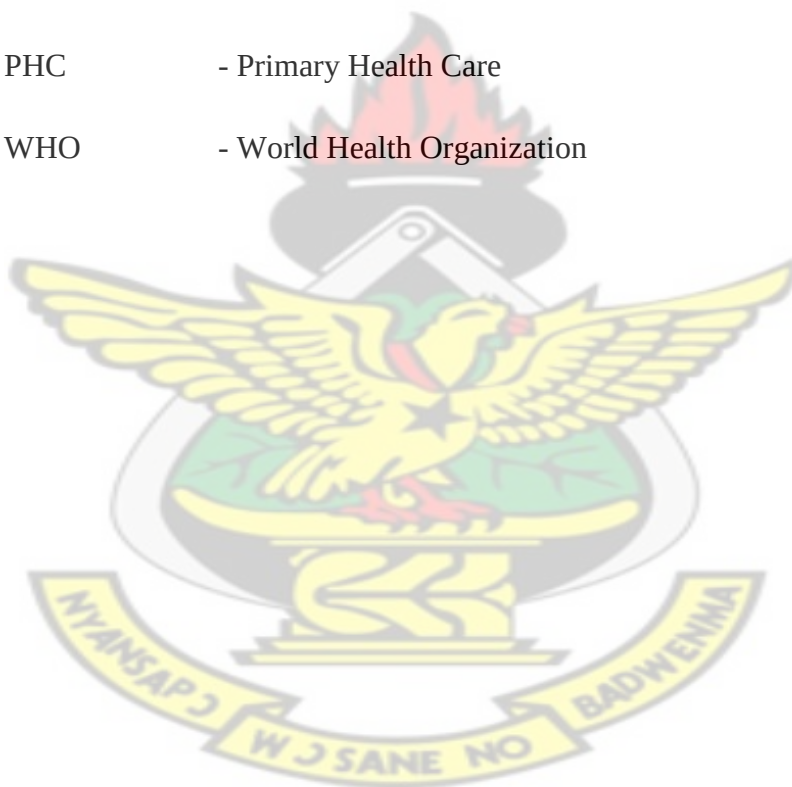
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LIST OF ABBREVIATIONS

CHPS	- Community-based Health Planning and Services
CHO	- Community Health Officer
CHFP	- Community Health and Family Planning
DHMT	- District Health Management Team
GHS	-Ghana Health Service
IGF	- Internally Generated Fund
NHIS	- National Health Insurance Scheme
PHC	- Primary Health Care
WHO	- World Health Organization



CHAPTER ONE

BACKGROUND OF THE STUDY

1.0 Introduction

Good health is one of the most important contributors to individual ability to perform effectively in all aspects of life, the economic sector inclusive. It is an essential prerequisite to the enjoyment of almost any other aspect of life. A high income or a good education will yield much less satisfaction to someone chronically sick. At the limit, poor health which leads to death will make all other sources of satisfaction irrelevant (Grand and Robinson, 1976).

To improve health conditions in Ghana, the Ministry of Health emphasized the conduct of health services research in the 1970s out of which a number of policies were formulated. Ghana adopted a number of programmes to ensure an improved health sector for the delivery of quality health care services and wider access to the poor in rural and deprived areas. These included the introduction of minimum fees paid by patients to augment state funding for health services and a national insurance plan introduced in 1989. Also in 1989, the construction of additional health centers was intensified to expand primary health care to about 60 percent of the rural community. Hitherto, less than 40 percent of the rural population had access to primary health care, and less than half of Ghanaian children were immunized against various childhood diseases. The training of village health workers, community health workers, and traditional birth attendants was also intensified in the mid-1980s in order to create a pool of personnel to educate the population about preventive measures necessary for a healthy community (GHS, 2005).

Health services are the most visible part of any health system, both to users and the general public. Health services, be they promotion, prevention, treatment or rehabilitation, may be delivered in the home, the community, the workplace, or in health facilities. Effective health service delivery depends on having key resources, which include: motivated staff, equipment, information, finance, and adequate drugs. Improving access, coverage and quality of health services also depends on the ways that the services are organized and managed, and on the incentives influencing providers and users. In any health system, provision of good health care services were the facilities which deliver effective, safe,

good quality, personal and non-personal care to those that need it, when needed, and with minimal waste.

However, there are many approaches to improving the organization and management of health services delivery so as to achieve better and more equitable coverage and quality health care.

As a result of decentralization and health sector reform, services are integrated as one goes down the hierarchy of the health structure from the national to the sub-district level. Administratively, the Ghana Health Service (GHS) is organized at 3 levels; National, Regional and District levels. Practically, GHS is organised at five Levels: National, Regional, District, Sub-district and Community levels (GHS, 2005).

At the regional level, curative services are delivered at the regional hospitals and public health services by the District Health Management Team (DHMT) as well as the Public Health Division of the regional hospital. At the district level, curative services are provided by district hospitals, many of which are mission or faith based. Public health services are provided by the DHMT and the Public Health Unit of the district hospitals. At the sub-district level, both preventive and curative services are provided by the health centers as well as out-reach services to the communities within their catchment areas. Basic preventive and curative services for minor ailments are handled at the community and household level with the introduction of the Community-based Health Planning and Services (CHPS) (GHS, 2005).

Currently, the strategic policy adopted by the Ghana Health Service to bring health care to the door step of the people, especially those in the rural and deprived areas, is a three-tier level of service provision within the district: the District (hospital) level, the sub-district (health centre) level and community-based level (GHS, 2005). Community-Based Health and Planning Services (CHPS) compound serve as the first point of call for basic treatment of minor ailment, family planning, antenatal care, delivery and postnatal care, child welfare clinic, and immunization, among others. The CHPS compound is manned by a resident Community Health Officer (CHO) and assisted by volunteers and community members (GHS, 2005).

1.1 Statement of the Problem

Health of the population is one of the important factors which need to be considered in plans for economic and infrastructural development in an area. The provision of health facilities and their location have a correlation with accessibility and utilization of the services. There is also a positive relationship between cost of accessibility and utilization of health care (NHIA, 2008).

In Ghana about 60% of the population is engaged in Agriculture and they form the bulk of the informal sector and majority of these people live in the rural areas (GPRS II, 2007). Unfortunately, most of these people do not have access to basic services/facilities like health care, potable water and good sanitation, schools among others. The focus of this study is on community-based health planning and services which is a component of health facilities.

However, in communities where some Health facilities are located access to them is hindered by long distances, finances and/or poor road conditions. Whenever rural communities are 'lucky' to have a health facility located close to them, they are confronted with lack of or inadequate personnel, logistics and basic equipment at the health facility. The glaring reality of rural dwellers' poor access to health facilities and to reduce barriers to geographical access to health care prompted the Ghana Health Services to adopt the Community-based Health Planning and Services (CHPS) as a national programme to promote access, quality and equitable services to all Ghanaians, particularly those in rural and deprived settlements (GHS,2005).

The relationship between health of the population and the process of development has been identified by various governments of this country. As a result, a number of steps have been taken to provide health services and facilities to all sections of the population and communities. Affordability of health care services has also been considered through the introduction of CHPS compounds as well as the National Health Insurance Scheme (NHIS). Extending the coverage of basic and primary health care services to all Ghanaians has been the major objective of the Ministry of Health since the Alma Ata conference which took place in the then Union of Soviet Socialist Republics on "Health for All" in 1977 (Nyonator, et al, 2003). To be able to achieve the objective of the Ministry, community-based health service delivery has been viewed as an effective strategy for

making basic health services accessible to all Ghanaians. The appropriate means of implementing this goal has been the subject of considerable discussion and debate. In the light of this, it seems imperative to assess the contribution of the CHPS in achieving the objectives that Government of Ghana through the Ministry of Health has set for itself. Has the piloting of community-based service delivery in the Kassena-Nankana district in the Upper East Region demonstrated the feasibility and usefulness of reorienting health care at the periphery? Has it answered the fundamental question of whether health services can be moved out of the clinical setting and whether this actually has the desired impact on the local communities?

In the light of the above, the investigation focused on the assessment of the effectiveness of the health services delivery at the community level. The study therefore focused on access to health service delivery through the Community Health Planning and Services program (CHPS). The role of the CHPS programme in improving physical, social and economic access to health services for the poor and deprived communities in the Ashanti Region.

1.2 Research Questions

The questions that this research intends to answer include the following:

1. Has health care delivery improved since the implementation of CHPS in Ashanti Region?
2. What are the human resource needs at CHPS facilities?
3. Are the locations of CHPS facilities physically accessible?
4. How are the CHPS facilities resourced financially?
5. What are the services rendered by CHPS?
6. Are the services affordable?
7. What are the challenges in the implementation of CHPS programme in the Ashanti Region?
8. What is the role of communities in CHPS?

1.3 Objectives of the Study

The general objective of the study was to examine the role of CHPS and access to health care delivery. Specifically, the study sought to:

- Assess basic health care service delivery in Ashanti Region;
- Examine the physical, social and economic access to health care services under the CHPS program;
- Assess the capacity of the CHPS in health care delivery;
- Examine the challenges with the implementation of CHPS;
- Recommend a way forward for the future of the CHPS program.

1.4 The Scope of the Study

Geographically, the study was limited to Ashanti Region. Contextually, the study focused on examining the physical, social and economic access of rural dwellers to the CHPS compounds. The study also examined common diseases reported at the CHPS compound and the role of CHPS in health service delivery in Ashanti Region.

1.5 Justification of the Study

The thrust of the research was to assess the Community Health Planning and Services (CHPS) and their contribution to accessibility, relevance, effectiveness and utilization in health service delivery in the Ashanti Region of Ghana.

Considering the fact that about 60% of Ghana's population is engaged in Agriculture and are in the rural areas and most health facilities are located in towns and cities, access to these health facilities by rural dwellers has been a major challenge due to unmotorable roads, long distances, income levels etc. The decision by Ministry of Health therefore to bridge the access gap is laudable. After a decade of piloting the CHPS and subsequent rollout to most rural areas in Ghana, has the CHPS programme achieved the objectives of the strategy, that is, easy access to health facilities by rural dwellers.

The selection of Ashanti Region for the study was based on the grounds that the region is an example of a resource endowed region with population that is experiencing relatively high incomes as well as many health facilities including a teaching hospital concentrated in the heart of the regional capital, Kumasi. What then is the situation in the peri-urban and rural communities in terms of health facilities and access to them? Furthermore, the researcher has an in-depth knowledge about communities that have initiated the CHPS in the Ashanti Region.

The study also assessed the results which led to the establishment of the CHPS, and how it conforms to emerging international best practices of health delivery in rural areas. The result of the study is expected to help shape policy and the future of the CHPS program as well as other initiatives of the Ghana Health Service.

1.6 Organisation of the Report

The output of the study is organized into five chapters. The chapters are preceded by an abstract, which is a summary of issues and conclusions from the study.

Chapter one introduces the problem and its context. This includes the background and the objectives of the study. It also presents the statement of problem, the scope, and justification for the study. Also included in this chapter is the general outline of the report.

Chapter two provides a detailed review of related literature on the health care delivery systems. This involved the review of existing literature on Health Services delivery in general and primary health care concept in particular in the international arena and Ghana as a whole. Lessons from the literature were used to fill the gaps.

Chapter three present detailed Methodology and Conceptual Framework used to undertake the study.

Chapter four presents the profiles of the study areas. Also in this chapter, the result of the research is discussed. This is to provide an understanding of the study variables.

Chapter five presents the major findings, recommendations for policy planning and future research, and conclusions of the study.

CHAPTER TWO

AN OVERVIEW OF ACCESS TO HEALTH CARE IN DEVELOPING COUNTRIES

2.0 Introduction

This chapter is the review of various literatures on health care delivery and access to health. This will provide an explanation to the conceptual framework and relevant definitions of terms.

2.1 The Concept of Health Care

According to Schieber and Maeda, (1999) developing countries account for 84% of the world's population and 93% of the worldwide burden of disease. However, they account for only 18 % of global income and 11 % of global health spending. Limited resources and administrative capacity coupled with strong underlying needs for services pose serious challenges to governments in the developing world.

According to the World Health Organization (1981), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The concept of health in this study can be viewed as the human state devoid of physical, mental, and emotional sickness/illness. It encompasses all factors that put human being in a better condition to contribute to development.

It is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of all sectors. Kunfaa (1996) stated that good health is thus the first basic prerequisite for man to spend his life on earth in happiness and maximize the utility of his talents and creative abilities. The attainment of this goal is the ultimate desire of governments, national and international organizations in the health and health related sectors the world over. Health is determined by a number of factors. These factors include the structure of health care delivery systems, health financial arrangements, health personnel's availability and health facilities.

Health care today accounts for about nine percent of global production. Global spending on health totaled about \$ 2.3 trillion in 1994; high income countries (those with per capita income above \$8,500 in 1994) spent over \$2 trillion, amounting to 89% of total health expenditure while their populations accounted for 16 % of global population. Developing countries, with 84% of the world's population, accounted for only 11% of all health spending (Schieber and Maeda, 1999).

This disparity underscores the enormous differences between developed and developing countries in terms of capacities and types of health services that can be provided. This also translates into large differences in health infrastructures and outcomes (Schieber and Maeda, 1999).

2.2 Dimensions of Healthcare

- *Effectiveness*

A key performance dimension of healthcare is effectiveness which is the degree of achieving desirable health outcomes, given the correct provision of evidence-based healthcare services to all who could benefit, but not to those who would not benefit (Arah, et al. 2005; WHO, 2000). Donabedian (2003) stresses that effectiveness in healthcare delivery is the extent to which improvements in healthcare are attained. Juran and other authors cite effectiveness as the degree to which processes result in desired outcomes, free from error (Juran and Godfrey, 2000).

- *Affordability*

The ability and power of an individual or group of persons to pay for health care services at the point of receiving/delivery services without any financial difficulty no matter the cost of services.

- *Relevance*

The degree of importance of health care services to an individual or community

- *Accessibility*

Access according to the Ghana Health Services, implies either the ability to reach a health facility within one hour of travel time or location of facility within 8km distance. Access to healthcare is of fundamental importance to governments globally, since the health service was founded on the principle of equity of access for equal need. Furthermore, as society changes, the public increasingly expects to receive not just fairness in access to healthcare

but prompt and convenient services (Rosen et al, 2001). Improving access to health services ranks among the strategic health policy goals across the globe.

Access is a multi-dimensional concept. According to McIntyre and Thiede (2006), access is in three dimensions namely; availability, affordability, and acceptability. The availability of health care captures all factors that relate to the actual existence of a specific service within reach of the client as well as aspects of user-friendliness with distance as the main indicator. Affordability refers to the direct and indirect costs of care relative to the client's ability to pay. Lastly, acceptability covers many of the subjective, social, and cultural factors, such as the degree to which a particular service is culturally secure (Wilkes et al, 2002).

For the purpose of this study, access is categorized into three: thus, Physical, Economic and Socio-cultural access to health care.

I. Physical Access to Health Care

Access is a complex concept. However, physical access in this context can be defined as the location of health facilities within reach of people; and freedom to use the facility within a well defined geographical setting like a community. The location should take into consideration distance, road network and condition and availability of transportation.

II. Economic Access to Health Care

Economic access refers to the direct and indirect costs of health care relative to the client's ability to pay. Therefore, availability of economic opportunities to people will earn them income to make health care services affordable.

III. Socio-Cultural Factors

Social scientists have made significant strides in shedding light on the basic social and cultural structures and processes that influence health. Social and cultural factors influence health by affecting exposure and vulnerability to disease, risk-taking behaviors, the effectiveness of health promotion efforts, and access to, availability of, and quality of health care. Social and cultural factors also play a role in shaping perceptions of and responses to health problems and the impact of poor health on individuals' lives and well-being (Malaria Journal 2009).

Society is guided by beliefs, norms, customs and other cultural practices that influence individual decisions making. Socio-Cultural factors refer to the degree to which a health care service is culturally accepted and conforms to societal standards. It becomes clear that the level of access to health care is determined by the “degree of fitness” between individuals or communities and the health system (Penchansky and Thomas, 1981).

Based on the multi-dimensional nature of access, the concept of primary health care was introduced to promote world health. In pursuing health sector reform, developing countries face many of the same problems regarding access, efficiency, and quality that developed countries face, although these problems are more severe in developing countries. Developing countries also face greater challenges in providing basic public health services especially in rural areas. Developing countries as a group face serious constraints in financing basic health services and providing physical access to care. (Schieber and Maeda, 1999)

2.3 The Origin and Concept of Primary Health Care

The concept of primary health care has had a significant influence on health workers and policy makers in many less-developed countries over the past few decades, (Marcos 1970). The Alma Ata conference in 1978 formally launched Primary Health Care (PHC) as the main thrust and focus for the promotion of world health. Primary health care was defined as: ‘ essential health care based on practical, scientifically sound and socially acceptable method and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process’ (WHO, 1981).

2.3.1 Basic Principle of Primary Health Care

World Health Organization (WHO) outlined seven principles to guide the successful implementation of Primary Health Care. These principles are:

1. Primary health care should be shaped around the life patterns of the population it is to serve and should meet the needs of the community.
2. Primary health care should be an integral part of the national health systems, and other echelons of service should be designed in support of the needs of the peripheral level, especially with regard to technical supply, supervisory and referral support.
3. Primary health care activities should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, housing etc).
4. The local population should be actively involved in the formation and implementation of health care activities, so that health care can be brought in line with local needs and priorities. Decisions as to the community's needs should be based on a continuing dialogue between the people and the service.
5. Health care offered should place maximum reliance on available community resources, especially those that have hitherto remained untapped, and should remain within the strictest cost limitations.
6. Primary health care should use an integrated approach of preventive, curative and rehabilitative services for the individuals, family, and community. The balance between these services should vary according to community needs and may change in the course of time.
7. The majority of health interventions should be undertaken at the most peripheral level possible of the health services by those workers most suitably trained to perform these activities (WHO 1981).

The main issues coming out of the above principles which need to be taken note of include;

- a. Primary Health Care should be human centred or community based. This means that in providing health care, the focus should be satisfying the community health needs or solving the health problems of the community.
- b. There should be dialogue and effective community participation in health care delivery. This implies that, the community and other stakeholders should come to a consensus on the kind of health care delivery system that should be adopted. The community should actively take part in this dialogue

- c. Health Care should be provided at a reduced cost. Local resources should be mobilized to provide health care at the least cost. These local resources could include labour and land
- d. Service should target deprived areas. This means that in providing health care emphasis should be on targeting the hinterlands which do not have access to health care
- e. Integrated approach to health care. Health should not be treated in isolation from the other sectors of the economy. There should be inter-sectoral collaboration with other sectors like water, sanitation and agriculture which have influence on health.
- f. Preventive rather than curative health care. Attention should be on avoiding the occurrence of preventable diseases through basic personal hygiene.

In implementing Primary Health Care, all governments are required in the formulation of national policies, strategies and plans to integrate primary health care as part of a comprehensive national health system and in coordination with other sectors. Health problems cannot be treated in isolation. This needs an inter-sectoral collaboration. These sectors of the economy influence health greatly, especially water and sanitation.

Examples of health care systems in other countries

A health care system is a set of activities with actors whose principal goal is to improve health through the provision of public and personal medical services (Arah, et al, 2005). Healthcare systems comprise all the institutions, organizations and resources that are dedicated to generating health action (WHO, 2000 in Belcon, et al, vol.13). Operationally, healthcare systems are the organization and method by which healthcare is provided. As with many other systems, healthcare systems are characterized by interrelated components of inputs (human, technology, finances and equipments), structure (organization of public health infrastructure, hospitals, clinics and extended care facilities), processes (operations, services to patients in all settings by providers including Managed Care Organizations) and outputs (outcomes, quality, access and costs) (Busse and Wismar, 2002 in Belcon, et al, Vol.3.).

All healthcare systems share certain common features including components of financing, service delivery and insurer/payer features.

In UK, the health system is organized on a National Health Service system. The government raises 80% of the fund needed through tax revenues and 15% from National Insurance contributions (HM Treasury, Budget 2004). It also directly or indirectly pays providers (physicians and hospitals). The government also coordinates all functions (National Health Service Act, 1946). This system shares some similarity to that of Trinidad and Tobago but additionally in the UK there is a National Health Service (NHS) system in which primary and community health care is emphasized. Hospital based providers are paid salaries and work in facilities that are state owned. Private or general practitioners are a central part in the system of primary care groups that function with other health care professionals in geographically defined umbrella units under a local NHS administrative authority.

Cuba has a unique healthcare system in the Caribbean region. The system is planned, publicly funded, managed and controlled centrally with universal access to all services (Lewis, 2004). Efforts are being made towards decentralization of the operations of the healthcare system so as to promote and develop participatory decision-making through popular councils complementing the legislative arm of government, the National Assembly and its commissions.

The Cuba Ministry of Public Health serves as the lead agency and carries out methodological, regulatory, coordination, and control functions at the national level. In addition to its own advisory commissions at the Provincial and Municipal levels, there are provincial public health offices, under the direct financial and administrative authority of the provincial administrative councils. Municipal public health offices exercise their function through the financial and administrative control of the municipal administrative councils.

The Cuba system currently emphasizes the importance of hospital care, high-technology program and research institutions, and the re-examination of the role of natural and traditional medicine approaches. Maternal and child health, chronic non-communicable diseases, communicable diseases, and care of the elderly are set as government priorities. The polyclinics are gatekeepers that serve as the point-of-entry for most patients in the region with a prevention mandate that includes educating patients on-site and identifying health risks early. Since the end of financial support from the Soviet Union and with U.S

embargo, Cuba focused more on prevention and locally available resources and created the Cuba's Family Doctor Program in 1984 (Nayeri, 1995). The WHO confirms that Cuba has made significant improvements in healthcare services across board (WHO, 2006),

However, in a developing country like Nigeria, the health situation is different. Nigeria is the most populous country in sub-Saharan Africa, with a population of almost 150 million people. The Nigerian health system includes orthodox, alternative and traditional systems of healthcare delivery (World Health Organization, 2006). There are three levels of orthodox healthcare delivery: primary, secondary and tertiary. Government of Nigeria covers 25.5% of the total health expenditure, while private expenditure comprise the remaining 74.5 %; furthermore, 91% of private expenditures are out-of-pocket (World Health Organization, 2006). Nigeria has no national health insurance.

The constitution of Ghana provides that “the state shall safeguard the health, safety and welfare of all persons in employment, and shall establish the basis for the full deployment of the creative potential of all Ghanaians” (Republic of Ghana, 1992, Article 36/10). In Ghana, the healthcare system is organized under four main categories of health delivery: public, private-for-profit, private-not-for-profit and traditional systems. Though the former three are mostly associated with healthcare delivery, efforts are being made since 1995 to integrate traditional medicine into the orthodox mainstream (Abor, et al, 2008).

Health Administration in Ghana is divided into three administrative levels: the national (Ministry of Health/Ghana Health Service), regional (Regional Health Directorate) and districts (District Health Directorate) levels. The Administration is further divided into five functional levels of national (Ministry of Health/Ghana Health Service), regional (Regional Health Directorate) district (District Health Directorate), sub district and community levels. All the levels of administration are organized as Budget and Management Centers (BMCs) or cost centers for the purpose of administering funds by the Government and other stakeholders.

The Ministry of Health is responsible for policy planning processes and information management, particularly concerning the areas of financing, human resources and infrastructure (MOH, 2008, p. 2-3). The public health care system of Ghana is operated through the National Health Insurance Scheme (NHIS), which permits the operation of

three types of insurance schemes; this includes District-Wide (Public) Mutual Health Insurance schemes in all of the country's 145 districts, the private mutual insurance schemes and private commercial insurance schemes. However, only the District-Wide (Public) Mutual Health Insurance schemes are financially supported by the NHIS (Hepnet, 2007).

Currently, the largest provider of health care services in Ghana is the government, “followed by the mission and then the private practitioners” (van den Boom et al., 2004, p. 4). The government “healthcare facilities can be distinguished in four layers depending on the services offered at the facility: village or community health posts, district clinics, regional hospitals and the teaching hospitals” (van den Boom et al., 2004, p.4). The community health posts predominantly provide preventive and primary health care services; however, their curative treatment is limited due to the fact that they are mostly not staffed by doctors.

Similarities drawn from the discussion above indicate that, UK, Cuba and Ghana health systems are largely controlled and funded by the government. However, UK and Ghana have national health insurance systems in place, though the management of the systems are different.

Besides, Nigeria’s health system is mainly privately funded by out-of-pocket payment for health care by citizens. In Cuba, the gatekeeper system is enforced at the polyclinics to serve as the first entry point for most patients. This is a good practice for other countries to adopt to streamline health delivery.

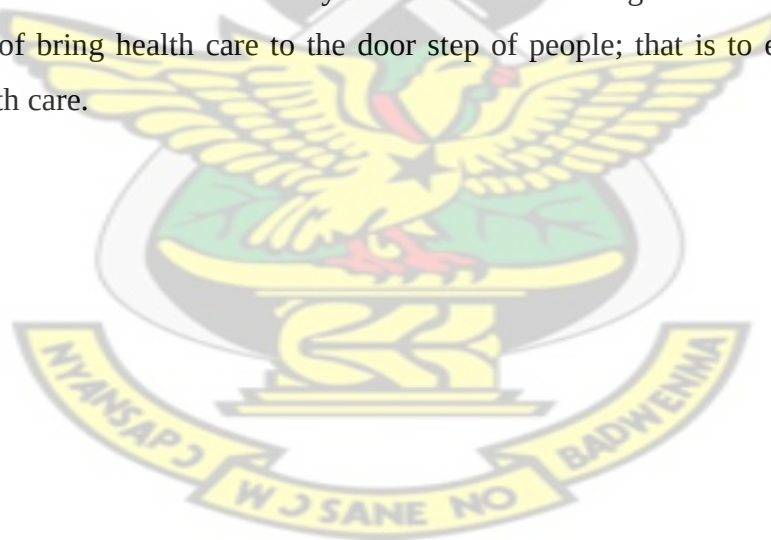
2.4 Summary

To conclude, investment in primary healthcare reforms by governments and international agencies such as the World Bank and the WHO has been substantial, particularly in countries with health care systems in transition. Joint investment program between governments and non-governmental organizations have also been established (Kringos et al, 2008).It is evident that policymakers are concerned about improving the development of primary healthcare systems with the most recent example being Resolution WHA62.12 which was accepted in May 2009 at the 62nd World Health Assembly, which urges WHO

member states to strengthen their health care systems through the values and principles of primary healthcare (Kringos et al, 2010).

So far little attention has been paid to systematically monitor primary care development and this hinders identification and sharing of experiences. Creating an effective primary healthcare system is not a question of implementing one recipe since systems are context dependent. Their development is to a large part shaped by a country's historical background, welfare state, health problems, characteristics of the health care system, and societal values and beliefs. Therefore, the strength of a country's primary healthcare system is determined by the degree of development of a combination of core primary healthcare dimensions in the context of its health care system.

Ghana has implemented and undergone a number of health care reforms. These reforms were targeted to ensuring easy access to primary healthcare services. However, the issue of inaccessibility of health care facilities especially in rural Ghana remains unimproved. Health care delivery in Ghana has therefore not been made accessible to all those who need it. The introduction of Community-Based Health Planning and Services is to achieve the objective of bring health care to the door step of people; that is to enhance physical access to health care.



CHAPTER THREE

RESEARCH METHODOLOGY AND CONCEPTUAL FRAMEWORK

3.0 Introduction

This chapter focuses on the research methodology and the conceptual framework for the study. The chapter contains the research design, sampling procedure, data required and sources and data collection instruments.

3.1 Research Design

The research method used for the study was the experimental design. The aim of the experimental research was to investigate communities with CHPS and communities without CHPS in the Ashanti Region to establish effect of the CHPS program on access to Health Facilities.

3.2 Sampling Procedure

The simple random and purposive sampling procedure was used for the research. Information was obtained on all the districts in the region. The region had 27 administrative districts with 12 districts implementing the CHPS program. (*Appendix 2*)

Due to constraints such as time, money and human resources, the researcher selected 15% of the districts implementing CHPS. In all, eighty household heads were interviewed in the four communities within the two districts. The table of random numbers was used to select Ahafo Ano South and Bosomtwi. *Appendix 4* Morris, (2003).

Ahafo Ano South district had CHPS compounds in four different communities. For this study, one community with CHPS and one without CHPS was needed. The purposive sampling was used to select Esienkyem CHPS compound at Ahafo Ano South district. The reason for Esienkyem community was because the researcher had an in-depth knowledge about the community.

The other community without CHPS which was selected was Betinko. The community was selected using table of random numbers. Bosomtwi being the second district had only

one community with CHPS so the researcher had no other choice than to select the community (Piase). The other community without CHPS which was selected was Worakese. The community was selected using table of random numbers. (*Appendix 3*)

3.3 Mode of Data Collection and Sources

The data used for this research were from both secondary and primary sources. The secondary information were sourced from articles, Ministry of Health annual reports, newsletters, journals, publish and non-published materials and other research works relating to CHPS. The primary information was sourced using household and institutional questionnaires. The institutional questionnaires were used to solicit information from the Regional Health Directorate, District Health Directorates and the CHPS compounds.

Household questionnaires were used to solicit the views of people concerning the impact of the Community based Health Planning and Services with regard to access to health care services. This was employed primarily to collect information from the selected communities with and without CHPS in the two districts.

3.3.1 Data Processing and Analysis

Processing of data was through editing and coding. The editing process helped in the elimination of errors during the data collection.

Both qualitative and quantitative approaches were used in the analysis of the data.

3.4 Conceptual Framework

According to Kakutani (2009), a conceptual framework is used in research to outline possible courses of action to present a preferred approach to an idea or thought. To attain acceptable level of economic development, access to health care services is key to promote healthy lives. To achieve this goal, Governments and communities have a role to play in attaining the goal. Government policies and investments must be geared towards poverty reduction and creation of economic opportunities for communities. This will empower people to access social services such as health care. Besides, development of health facilities should also be paramount in government policies and investments. The location

of these health facilities should take into consideration the World Health Organizations (WHO) standard of 5km radius range of health facility. In addition Population ranges between 2500-4500 also need to be taken into consideration in locating health facilities to facilitate access.

The Ministry of Health and Ghana Health Services adopted the CHPS programme to increase equity and geographical access to basic health services to rural dwellers in Ghana to improve health status and the falling levels of maternal and child health, family planning among others. Achievement in access to basic health care services would lead to improvement in health status, human development and national development. The framework below demonstrate the input needed to achieve improved access to Health care.



Community Health Planning and Services (CHPS) and Access to Health care

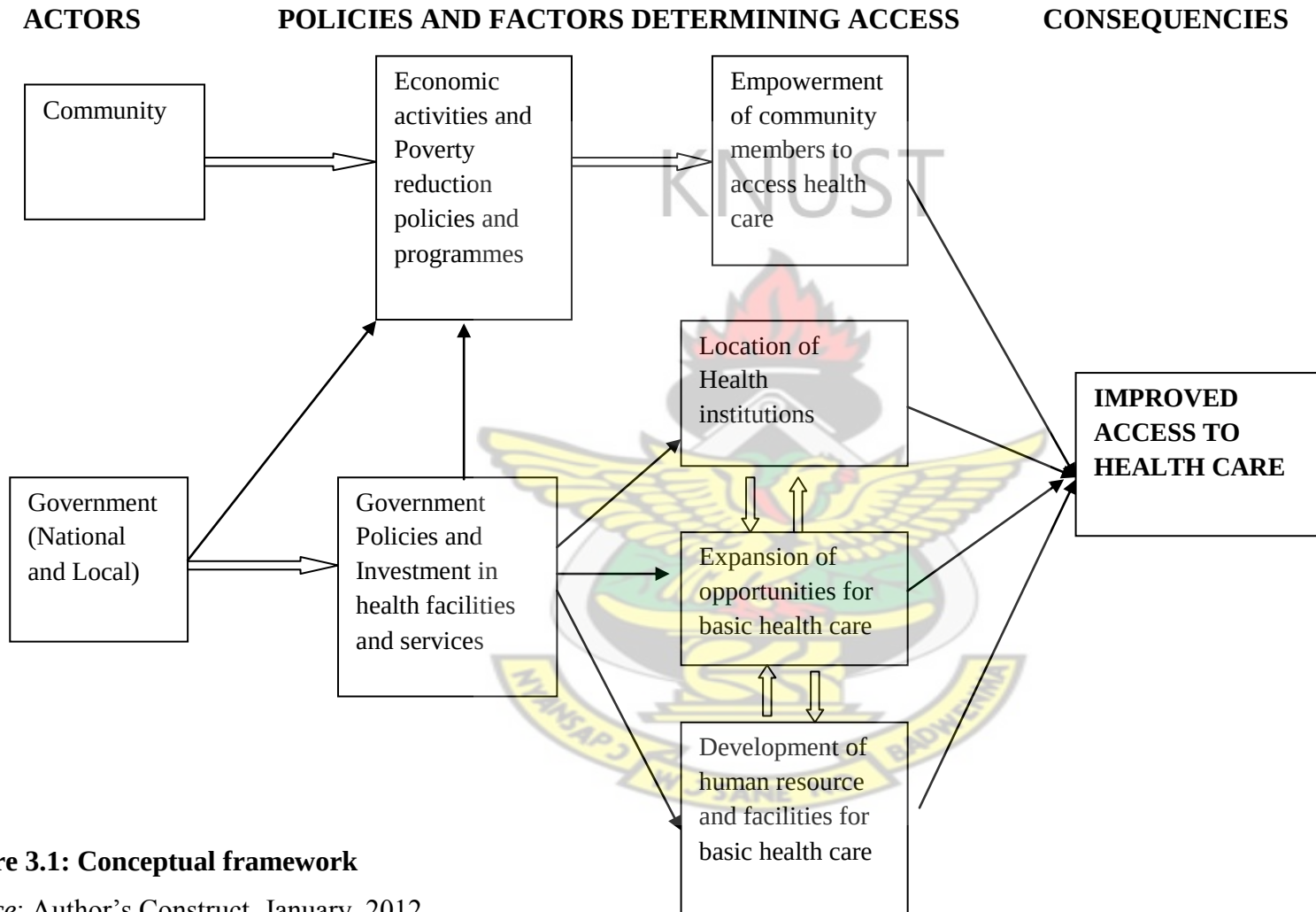


Figure 3.1: Conceptual framework

Source: Author's Construct, January, 2012

CHAPTER FOUR

COMMUNITY HEALTH PLANNING AND SERVICE AND ACCESS TO HEALTH CARE

4.0 Introduction

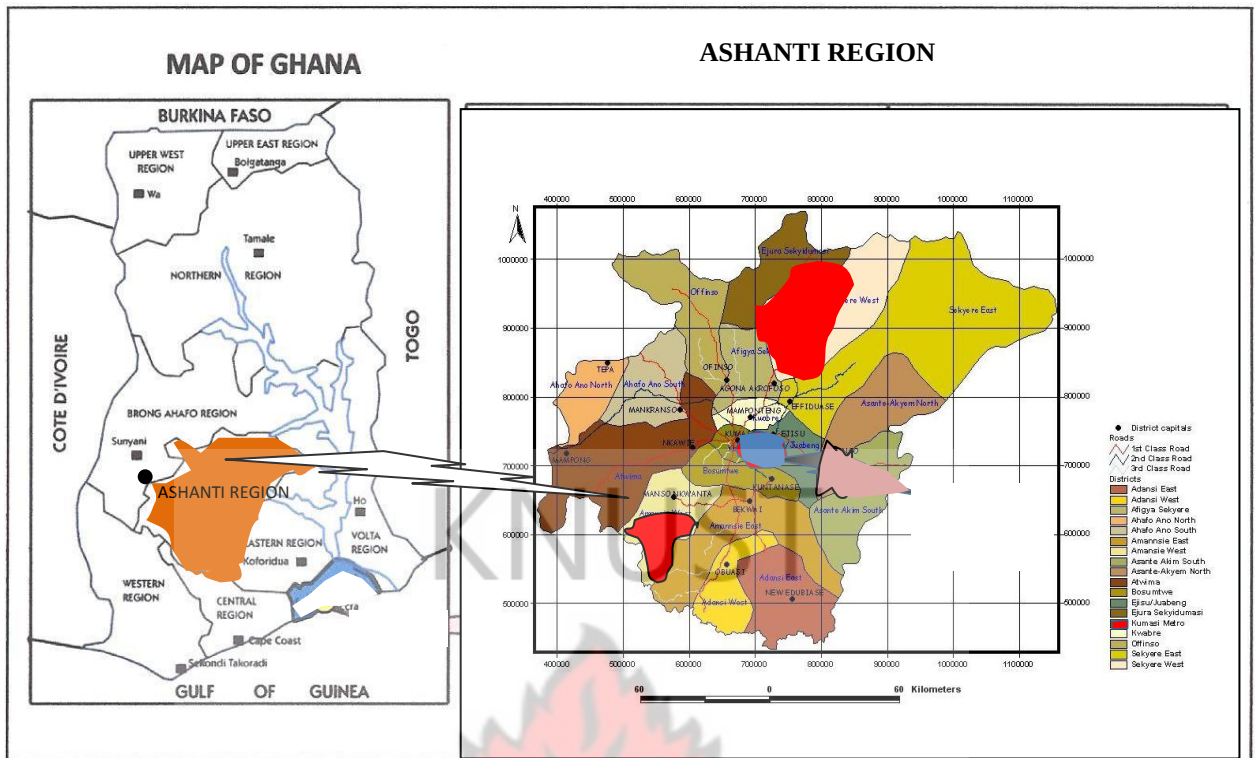
Having established the theoretical and conceptual framework of the study, this chapter discusses data from the field. It starts with a profile of the study area considering its physical and socio-economic characteristics. This is followed by discussions of the primary data, with emphasis on the operations of CHPS compound in the study districts.

4.1 Profile of Ashanti Region

The Ashanti Region is centrally located in the middle belt of Ghana. It lies between longitudes 0.15W and 2.25W, and latitudes 5.50N and 7.46N. The region shares boundaries with four of the ten political regions namely; Brong-Ahafo Region to the north, Eastern Region to the east, Central Region to the south and Western Region to the south west. Figure 4.1 depicts the region in the national context.

The region occupies a total land area of 24,389 square kilometers representing 10.2 per cent of the total land area of Ghana. It is the third largest region after Northern (70,384 sq. km) and Brong-Ahafo (39,557 sq. km) regions. The region has a population density of 148.1 persons per square kilometre, the third after Greater Accra and Central regions. More than half of the region lies within the wet, semi-equatorial forest zone (Ashanti Regional Coordinating Council, 2009).

The Region is subdivided into twenty-seven (27) administrative districts, including the Ahafo Ano South and Bosomtwi districts where this study was carried out.



Source: RCC, 2009

The vegetation is broadly classified into two: Semi deciduous forest and Guinea Savanna woodland. The average annual rainfall is about 166.7cm (66 inches) and the temperature is generally high. The humidity is relatively high, averaging about 85% in the forest area and 65% for the savanna belt. The type of vegetation found in the region relates to the commonly reported diseases at the various health centers in the region. Malaria ranks high among the sickness reported in the region. The vegetation makes it conducive for the plasmodium carrier, female anopheles mosquitoes to thrive.

The region is the most populous and one of the most rapidly growing regions in the country. The region's population as at the 2000 census was 3,612,950, representing 19.1 per cent of the country's population. The provisional 2010 census report indicates that, the region's population is 4,725,046. The region's share of the national population increased steadily from 16.5 per cent in 1960 to 17.3 per cent in 1970 but remained almost the same (17.0%) in 1984 before increasing to (19.1%) in 2000 (Ashanti Regional Coordinating Council, 2009).

The region's population growth rate was 2.9 per cent per annum in 1970, dropped to 2.5 per cent per annum in 1984 and increased to 3.4 per cent in 2000. The population growth rate of the region in 2000 was the second highest in the country, after the Greater Accra Region (4.4%). The region is the most populous in Ghana with a density of (148.1/sq km) only lower than those of the Greater Accra (895.5/sq. km) and the Central (162.2/sq. km) Regions (Ashanti Regional Coordinating Council, 2009). The high density nature of the population increases the pressure on the existing facilities resulting in rapid deterioration of facilities, less access to health workers and poor service delivery to the many people who visit these few facilities.

The economically active population in the region is engaged mainly in agriculture (excluding fishing). The next highest proportion of the economically active population is employed in wholesale and Retail Trade, followed by Manufacturing and Community, Social and Personal Services etc. These four major economic activities employ a total of 85.0 per cent of the economically active population. The proportion of the economically active population engaged in other economic activities is less than 5.0 per cent in each case. Water and Transport, Storage and Communications, Electricity, Gas and all the other activities increased their proportions of the economically active population employed in 2000 compared with 1984, except agriculture, hunting and forestry (Ashanti Regional Coordinating Council, 2009). This presents a good outlook for fiscal access, which at times limits a lot of people from accessing health facilities, where they are provided.

Information on the levels of educational attainment and literacy in the region show that between 40.0 and 50.0 per cent of the population in the districts, particularly, females either have no formal education or have only primary school education. The proportions of the population with basic education vary from 67.7 per cent in the Kumasi metropolis to 86.9 per cent in the Amansie West District. The proportions in JHS are low, ranging from 16.1 per cent to 22.4 percent, tapering down further to lower proportions at higher levels of education.

Illiteracy levels are high in the districts and higher for females than the males; the level is also higher in rural areas than in urban areas. Illiteracy rates vary from 26.0 per cent in Kumasi metropolis to 64.7 per cent in the Ejura Sekyedumase District. Only three Districts, Kumasi metropolis, Adansi North and Ejisu-Juaben, have illiteracy levels lower

than the regional average of 40.4 percent (Ashanti Regional Coordinating Council, 2009). Literacy has a bearing on people's ability to effectively understand and accept outreach activities by health personnel.

There are five hundred and thirty health facilities in the Ashanti Region. The Ghana Health Service operates about 32% of all health facilities in the Region. Kumasi being the regional capital has 38% of all health facilities. Medical establishments in the region comprise hospitals that provide both in-patient and outpatient care; clinics that provide out-patient care exclusively, and health centers. Health facilities in the region are unequally distributed with most of the facilities being in the Kumasi metropolis and few of them in the district capitals (Ashanti Regional Coordinating Council, 2009).

The predominant disease in the region, like all other regions in Ghana, is malaria. Malaria is the leading cause of illness and constitutes 55% of illness recorded in the Region. This can be attributed to the poor sanitary conditions in most part of the region and the humid climatic conditions that makes it conducive for mosquitoes to thrive. Other diseases according to the regional health report are diarrhea, tuberculosis, measles malnutrition and HIV/AIDs.

4.1.1 Ahafo Ano South and Bosomtwi Districts in Perspective

According to the 2000 Population and Housing Census, Bosomtwi and Ahafo Ano South district's population were 146,028 and 133,632 respectively. The two districts have an average household size of seven people. A household consists of a person or a group of persons, who live together in the same house or compound, share the same housekeeping arrangements and are catered for as one unit. This figure is higher than the national average of five people. Marital status of communities was explored as it has health implications such as reproductive health, sexually transmitted diseases among others. Seventy-six and above percent of the sampled population were married and this has influence on decision and ability to access health care. Though the other unmarried group had smaller percentages, access to health care is not the prerogative of one person.

The ability to understand and accept modern health care has a direct relationship with level of education of communities. In all communities in the two districts, people without any

form of education were 5% of the sampled population. However, 61.3% of people had completed middle/JHS, with 3.8% of them obtaining tertiary education. The ability to understand health care issues and the need to access health care when necessary is not an issue with the study communities

It was realized that around 86.3% of people were permanent residents in the two districts. Permanent used here represent an all year round residency. The percentage of people who were seasonal residents was 13.8%. Seasonal here refers to a three or more months of absence from the community in a year. The presence of more permanent residents can partially be explained by the kind of occupation the people are engaged in (Agriculture). In evaluating or assessing the operations of any facility, it is important to examine not only the physical accessibility to the facility, but the economic accessibility as well. Economic accessibility refers to the ability of prospective users of a facility to afford or patronise it. It was against this backdrop that the economic characteristics of communities were assessed to ascertain people's, employment status, the type of economic activities engaged in, as well as their income levels, which will inform their ability to access a facility.

The study Communities were engaged in various economic activities from which they got their income. In Essienkyem in Ahafo Ano South, all respondents were employed. This was shared between agriculture and commerce In Betinko also in Ahafo Ano South District, 95% of respondents were employed, which is shared among agriculture, service, industry and commerce in descending order.

In Piase in the Bosomtwi District, 90% of respondents were employed. The occupational distribution among the sectors is as follows: agriculture, service, industry and commerce being the least. In Woarakose, also in Bosomtwi District, total employment is 95% distributed among agriculture, service and commerce.

The age distribution was high for those in the 20-49 year brackets which is considered to be part of those in the productive age bracket used by the Ghana Statistical Service in their population census classification. The region's population is youthful to engage in economic ventures which will yield income for the people to enable them access health care. In the two districts, households are headed by men

4.2 Historical Perspective of Community Health Planning and Services (CHPS)

In the effort to provide the Community-based level or ‘close-to-client’ doorstep health delivery with household and community involvement, the Ministry of Health through the Ghana Health Service pioneered the implementation of a national programme to replicate the results of Navrongo Community Health and Family Planning Project (CHFP) known as the Community-based Health Planning and Services (CHPS) initiative in key pilot Districts of Nkwanta, Birim North and Asebu-Abura-Kwamankese. The CHPS initiative is therefore the national strategy for implementing the community-based service delivery by reorienting and relocating primary health care from sub-district health centers to convenient community locations.

The strategic policy of the Ghana Health Service is to have a three tier level of service within a District. These will be the District (Hospital) level, the sub-district (Health Center) level and Community-based level. All sub-districts are to be divided into zones with a catchment population of 3000 to 4500, where primary health care services will be provided to the population by a resident Community Health Officer, assisted by the community structures and volunteer systems.

Research in the CHPS program has proceeded by stages. The first phase, launched in 1994, involved convening a Ghana Health Service (GHS) task force to guide a Navrongo pilot for clarifying the appropriate elements of a community health-care programme. The pilot approach was adapted from various initiatives that apply techniques of social learning to operational planning Korten (1980); Simmons et al (2002). Focus-group discussions with adult men, women, community leaders, and health workers were convened to assess participants’ perceptions of service needs. The project’s pilot services were implemented to adapt operational strategies to the climate of opinion expressed in the focus-group sessions.

In 1996, results of the pilot phase were used to guide the operational design of the Navrongo Community Health and Family Planning Project (CHFP), a district wide factorial experiment designed to test the relative impact of two general sets of existing underused resources for primary health care that had been identified. It was evident from the Navrongo design that traditional and social institutions like chieftaincy, lineage and

Social-network system which structure community leadership and social relation play a powerful role in organizing village life.

Although political leaders instinctively turn to this traditional and social system to mobilize votes, Ghana Health Service operations were organized without links to these institutions. The Navrongo experiment coordinated health-service delivery with traditional leaders, enabling health professionals to recruit, train and deploy community-accountable volunteers, and enabling traditional leaders to monitor and support all community health-service operations. The Navrongo experiment was based on the hypothesis that mobilizing the traditional system of leadership, communication and governance can develop health-care service accessibility and accountability and reduce mortality.

Failure of volunteer schemes in the past led some policy makers to be skeptical of any volunteer scheme and supported the view that only paid GHS paramedical staff could be effective workers in the community. In the early 1990s, community health nurses were trained for eighteen (18) months and assigned to sub-district health centers throughout Ghana to provide malaria treatment and other child-health therapies, as well as childhood immunization, family-planning and health-education services Nyonator et al (2003).

Although the nurses were hired to improve service accessibility, program coverage was limited to logistical problems, supervisory lapses and resource constraints. The nurses were confined to Ghana Health Service sub-district centers. The Navrongo experiment tested means of ending the social isolation of the nurses by retraining, renaming and recertifying them as “community health officers” to serve as resident health-care providers.

According to Debpuur et al (2002) by 1997, evidence suggested that the Navrongo experiment was having an impact. A single nurse equipped with a motorbike and relocated to a village health center, performed better than an entire sub-district health center (second level). This increased health care delivery and improved immunization and family planning coverage in Navrongo, Fertility and mortality also began to decline Nyonator et al (2003).

In response to the preliminary evidence, the Ghana Health Service convened a national managers’ conference in 1998 to deliberate on the implications of the Navrongo model for

national policy and action and to review a draft statement declaring the Navrongo system as the national model for community-based health care. This gave birth to the Community-based Health Planning and Services in 2000 Nyonator et al, (2005)

4.2.1 Objectives of CHPS

Within the context of the Growth and Poverty Reduction Strategy (GPRS II), community based health service delivery using the CHPS approach provides a unique opportunity for achieving improved health care delivery. The focus of the CHPS approach is to achieve three important objectives;

- I. **Improve equity in access to basic health services;** the mal-distribution and problems associated with geographical and financial access means that new ways of working are required to deal with the basic ailments that plague the poor. The CHPS strategic response takes into consideration working with households and communities to ensure that all barriers to access at the local levels are removed.
- II. **Improve efficiency and responsiveness to client needs;** community-based service provision can only be effective if services are efficiently delivered and are responsive to client needs. This can be ensured through increasing accountability and performance of health providers on quality, responsiveness and efficiency to the communities.
- III. **Improve inter-sectoral collaboration and partnership in service delivery;** this will require strengthening the role of the community, civil society and community-based organization to support strategy implementation, client access to services and protect client right to quality health services.

4.2.2 Organizational Context for CHPS

In implementing the CHPS process, reorienting and restructuring the health delivery system of Ministry of Health is crucial. This requires clear definition and acceptance of the roles and responsibilities of the District Health Management Team (DHMT) and the Sub-District Health Teams. The organizational layout of CHPS is a five tier system:

- a) **National level;** at the national level, the MOH and GHS have the main function of defining policy direction, facilitating policy implementation and ensuring that the appropriate resources are channeled to support policy implementation

- b) **The Regional level;** at the regional level, the Regional Health Directorate provides a coordination, support and supervision oversight for Districts, Sub-districts and CHPS zones. The regional hospitals also provides specialist referral services to these levels
- c) **The District level;** the District is the major unit of primary health care organization and management of service in Ghana. The District Health Management Team serves as the decision making, programme development and co-ordination for CHPS. It also oversees the identification, orientation, training and posting of the Community Health Officers (CHOs) to the sub-districts and communities
- d) **Sub-district level;** the sub-district health team supervises CHOs and Community Health Volunteers and provides a liaison to District level offices. They manage the flow of essential medicines supply between the DHMT and the Community Health Committee who distribute them to the volunteers to complete actual delivery.
- e) **The Community level;** the CHPS zone has a maximum of two trained CHO to provide services to households within the communities. The services should focus on outreach and house to house services, establishing community decision making systems and using community registers to trace defaulters and people with special conditions like pregnant women and children at risk. At the community level, the CHO ensures that the service delivery package is adhered to and includes treatment of minor ailments, family planning, antenatal care, delivery and postnatal care, child welfare clinics, immunizations, counseling, school health, home visits, supervision of Traditional Birth Attendants and volunteers. The community level also provides support for CHOs, and community volunteers. Within a CHPS zone, the CHO is expected, for the purpose of comprehensive health service delivery and promote activities, develop close links with the chief, health volunteers, assemblyman, traditional birth attendants (TBAs), private midwives, traditional healers, religious groups, DHMT and the District Assembly. These people are the stakeholders to ensure successful implementation of CHPS at the community level GHS (2005)

4.2.3 Organizational and Managerial Context for CHPS

The District Level

The District is the major unit of primary health care organization and management for service delivery in Ghana. Within the district, health services are organized in a three tiered hierarchy with the District level (level C) at the top, the sub-district level (level B) next and the community level (level A) at the bottom.

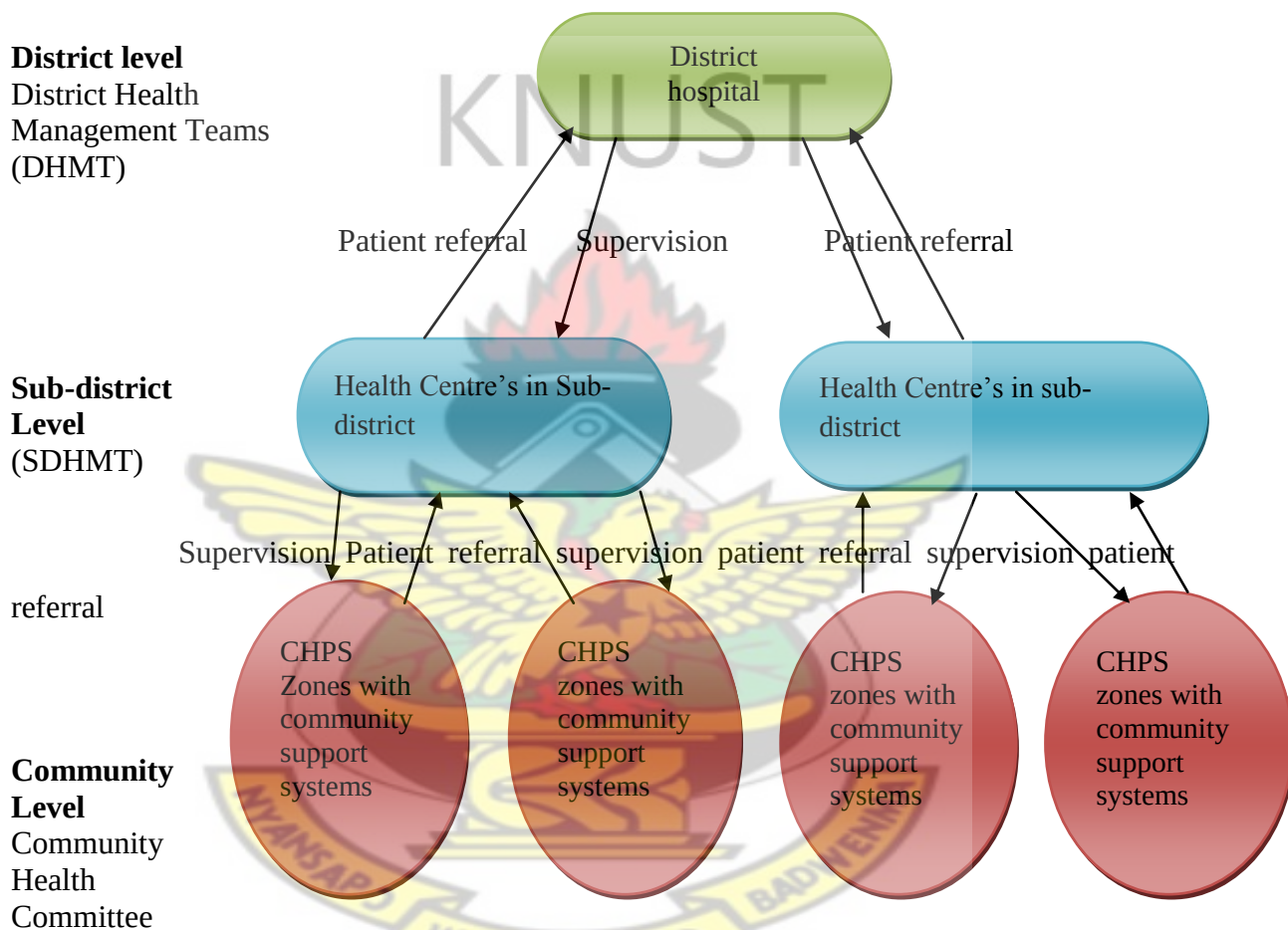


Figure 4.2: Health sector organizational and managerial contexts

Source: GHS May, 2005

The District Health Management Team serves as the decision making, programme development and co-ordination for CHPS. (GHS, 2005)

The Sub-district level

Each District is zoned into four or more sub-districts depending on its size. A sub-district has a population of about 20,000-30,000. Sub-districts in the health sector administrative classification generally correspond to area councils in the local government classification;

the difference being that sometimes the health sector may put two or three area councils together as one sub-district. The Sub District Health Team (SDHT) supervises Community Health Officers (CHOs) and Community Health Volunteers and provides a liaison to District level offices. The SDHTs manage the flow of essential medicines and family planning supplies between the DHMT and community health committees who distribute them to the volunteers to complete actual delivery. (GHS, 2005)

The Community Level

In rural areas, a community usually corresponds to a village or cluster of hamlets but it is not always easy to concisely define a community in terms of population alone. The definition of a community for purposes of service delivery has to take into account geographic location as well as population. Some rural communities may have as few as 100 or less people, but are so far from everybody else it is difficult to group them with another community. On the other hand, a large town with several thousand or more population may not be easy to classify or deliver service to as a single community even though the people are fairly closely clustered in the same geographic location. (GHS, 2005)

4.3 Operations of CHPS Compound in the Study Districts

Adopted in 1999, CHPS is a national health programme initiative that aims to reduce barriers to geographical access to health care. With an initial focus on deprived and remote areas of rural districts, CHPS endeavors to transform the primary health care system by shifting to a programme of mobile community-based care provided by a resident nurse, as opposed to conventional facility-based and 'outreach' services. Regarded as the primary strategy for reaching the unreached, CHPS has, thus, become an integral part of the current Ghana Health Service Five Year Programme of Work and represents one of the health sector components of the national poverty reduction strategy (Nyonator et al, 2005). The Piase and Essienkyem CHPS compound in the Bosomtwi and Ahafo Ano South districts were among the first compounds to be established in 2003 and 2004 respectively in the Ashanti Region. The two CHPS compounds serve a population of 5,466 and 6,237 respectively. The catchment area of Essienkyem CHPS compound covers six communities and that of Piase is five communities.

The success of every CHPS compound is largely dependent on the willingness of health professionals to accept postings to these health posts, in areas considered deprived in terms of infrastructure (Nyonator, 2005). The CHPS Initiative is accepted by most communities. The reason being that travelling long distances for services, convenience of having '24 hour service' available locally and ownership makes the CHPS a first point of call for basic health services.

It was evident from the information obtained that the two communities (Piase and Essienkyem) with CHPS had average household size of four people which is lower than the national average of five people. This is attributed to health education and child welfare clinics services rendered by CHPS.

Health facilities in the region are unequally distributed with few of them in the district capitals. In most of the localities in the districts, the nearest facility is located more than 10 kilometers away. In some localities, Traditional treatment is the only option available to many who are ill (field survey, 2011) In the Ahafo Ano South District, there are two health centers at Mpasaso and Sabronum, Clinics at Domiabra, Pokukrom, Dwenewoho, Anitemfe, CHPS compounds at Essienkyem, Adugyama, Mpasaso-Dotiamu and one Maternity home at Assibey-Nkwanta, an orthopedic centre at Kunsu and a district hospital at Mankranso. Apart from these all the other communities including Betinko will have to travel to other communities with health facility to access health care. Health facilities in these communities are in fairly good conditions.

In the Bosomtwi District, health facilities are located in few communities. There is a district hospital at Kuntanase, a mission hospital at Pramso, two private hospitals at Esereso and Feyiase, health centers at Jachie and Tetrefu, a CHPS compound in Piase, mission clinics at Nyameani, Brodekwano, Amakom, Konkoma, Apinkra and an Eye Clinic at Jachie. The rest of the communities within the district do not have health facilities, hence will have to travel an hour or more distance before accessing health care.

It was revealed that people in Betinko and Woarakose in Ahafo Ano South and Bosomtwi respectively, are not located close to health care providers and therefore have to access health services in the nearby communities when the need arises.

Generally, all communities in the two districts prefer orthodox medicine to traditional medicine. In communities without any orthodox health facility, the people preferred to travel to other communities with such facilities.

4.4 Access to Health Facilities

The health facilities are inadequate for effective health delivery in the districts as facilities are concentrated in Kumasi. Before the introduction of the CHPS compounds, the situation was worse, as all six communities were access health care at Mankranso the district capital (field survey, 2011). Accessibility affects the frequency of visit to health facilities as the longer the distance, the less the frequency. Also owing to bad road network, transportation has become disincentive for people to travel to access health care.

It was revealed from the information obtained from the field that, frequency of visit to health facilities depended on the facility availability within communities. The average number of visits to a health facility in communities with CHPS compound was four times in a year; while communities without the CHPS compound had an average of one visit in a year. This means that for communities that have CHPS compounds, there is the frequency of visit, which greatly helps improve the health of community members. For communities without health facilities, they are tempted to wait till the condition worsens before being taken to a health facility. Often, because their conditions have already deteriorated, there is the need to refer cases to a higher level of care field survey, (2011).

4.4.1 Distance to Health Facility

Distance travelled by patients in communities with the CHPS compound in the two districts averages between 100 metres and 500 metres. In Essienkyem in the Ahafo Ano South District, the average distance covered by patients is less than 200 metres, but the other catchment communities travel an hour average distance thereby increasing patronage and easing access to the facility. In Piase, the average distance is less than 500 metres and an average travel of 35 minutes for other catchment communities. The above is well within range using the standard of an hour travel time or eight kilometers away from the facility.

In communities without the CHPS compound or any health facility, average distance is over 500 metres with an average travel time of two hours and 34 minutes to the nearest facility.. The minimum time taken was an hour and 26 minutes for a vehicle and a maximum of four hours for those on foot. In communities where the CHPS compounds are located, the preferred mode is walking as the facility is within reach (Essienkyem and Piase in Ahafo Ano South and Bosomtwi districts respectfully) Medical conditions are however detected and treated early and prevented from becoming complicated. Also, where higher health care is required, referral is made. In communities where CHPS compound is absent and community members or patients have to walk for about four hours, certainly medical conditions are not detected early for treatment. This situation has the tendency to worsen cases before they are brought to the attention of health workers. Emergencies may result in deaths, with the lack of first aid. Therefore, communities such as Betinko and Woarakose are disadvantaged and may not effectively deal with small emergencies and cases.

4.4.2 Cost of Transportation to Health Facilities

The current economic profile of the region is typical of a developing country: low per capita income, which translates into low spending on health. In cases where transportation cost is high, it is detrimental to access health facilities. For communities that have the CHPS compounds, transportation cost is negligible. For serious cases or where the patient cannot walk (i.e. women in labour), average transport cost is less than GH¢0.30p. In communities without the CHPS compound (Betinko and Woarakose) or any health facility, transport cost can be as high as GH¢5.00, which may not be affordable to some patients. Field survey, (2011)

Unavailability of vehicles, bad roads and weather condition tend to exacerbate the situation leaving those in need of serious medical attention helpless. On a good day, the average waiting time for a vehicle in Betinko and Woarakose in the Ahafo Ana South and Bosomtwi is 30 minutes. However, in the raining season when rains have eroded some parts of the roads, patients may have to wait for over 30 minutes before getting vehicles to take them to the nearest health facility field survey, (2011).

Financial sustainability and cost of health services at CHPS

According to the GHS (2011), Ashanti Region is part of the best five regions in the country in terms of access to health care. This was attributed to the introduction of CHPS. However, CHPS compounds are not budgeted for by the Regional Health Directorate. They depend on internally generated funds (IGF) and also from the district health directorate. For example, the Essiemyem CHPS in 2011 was given only GH¢100.00 by the Ahafo Ano south health directorate.

It is interesting however to note that community preference for orthodox medical care over traditional medicine is not limited by affordability.. With the introduction of the National Health Insurance Schemes people are able to access health care without money being an issue at all at the point of service delivery. Where some people pay for basic services, as confirmed by some respondents, reasons assigned for paying basic health care include: field survey, (2011)

- The expiry of health insurance membership or non-renewal of membership; or
- Not registered with the scheme at all.

However, without NHIS valid ID card, cost of treatment of various illnesses is represented on the table below. 4.1

Table 4.1: Health condition and service charges

Health condition	Charge/Rates
Spontaneous vaginal Delivery	GH¢12.10
Dressing and minor suturing	GH¢2.37
Change of dressing	GH¢2.37
Antenatal/postnatal	GH¢5.34
General OPD	GH¢2.38
Consultation only	GH¢1.02
Detention for Observation and Treatment-Adult	GH¢3.66
Detention for Observation and Treatment-Child	GH¢ 3.27

NHIA, 2008

Income of the local people is erratic due to the fact that the main occupation is farming and is also seasonal.

4.5 Human Resource at CHPS Compounds

In the study areas in Essienkyem and Piase, the CHPS compounds are managed by nurses, who serve as first point of call for medical cases. They attend to minor cases, responsible for medical outreach and public health education. Most CHPS compounds are managed by Community Health Officers (CHOs) or midwife with some supporting staff like security, health extension workers etc. However, the CHOs or midwives are oriented in community entry skills and mobilisation in order to manage the compounds well. Without these health workers manning the compounds, the communities would not have access to quality health service. Table 4.2 summarizes the staff situation in the districts.

Table 4.2: Staff requirement at CHPS

Communities	Category of Staff	Number Available	Standard number required
Essienkyem	Midwife or CHO	One CHO, one enrolled nurse and two support staff	One midwife, CHO, enrolled nurse with supporting staff
Piase	Midwife or CHO	One CHO and one support staff	One midwife, CHO, enrolled nurse with supporting staff

Field Survey, 2011

Table 4.2 presents the inadequacy of health professional in the two Communities. Supporting staff here refers to a security man, auxiliary nurses, health extension workers etc. Delivery is one of the major services that is rendered by CHPS and this requires a qualified midwife yet the two CHPS compounds do not have a midwife. The CHO at Essienkyem confirmed that she does delivery because of the distance from the community to Mankranso though she is not a midwife and that if there are complications she refers to Mankranso Government Hospital.

4.6 Contribution of CHPS to Health Delivery

From the discussions so far, communities with CHPS compounds benefit in terms of the following services;

- Door-to-door health service delivery for those that cannot come to the facility,
- Provision of preventive health education,
- Quick delivery of pregnant women, Antenatal, postnatal and child welfare clinics,
- Treatment of minor ailments before they get complicated,

Before the introduction of the CHPS compounds in Essienkyem and Piase in Ahafo Ano South and Bosomtwi especially the above health care services stated were not available to community members (field survey, 2011). Now, they consider it as health care in comfort. In Betinko and Woarakose, also in Ahafo Ano South and Bosomtwi districts respectively, the services mentioned above are absent and every case has to be treated as emergency because of the distance to the nearest facility and the uncertainty of seeing a health worker upon arrival. In other words, they do not have the comfort of waiting for cases to be 'emergency' before taken the patient to the nearest facility.

Though health care has improved considerably in the region and the communities in the two districts, communities with the CHPS compound are better off in terms of access to the facility than their counterparts, who have to travel not less than 500 metres to access a health facility.

4.7 Challenges of CHPS in Ahafo Ano South and Bosomtwi Districts

Despite the immense contribution of the compounds to the health care of community members in the two communities in the two districts, there are some challenges that confront service delivery. Funds allocated to the CHPS compounds are woefully inadequate. The following basic facilities/equipment need to be available in all CHPS compounds; accommodation for staff, delivery set, beds, dressing set, weighing scales, motor bikes, fridges, vaccine carriers, stationeries, thermometers, medicines etc. However, beds, motorbikes, medicines, lamps, stationeries, and accommodation for staff are woefully inadequate. Eg at Essienkyem, the only motorbike was very old and breaks down frequently making it difficult for health personnel to carry out outreach programs.

Power outages or no power at all and no standby generators hamper activities at these compounds, making '24 hours' service not possible. In events where medicines are prescribed, they may not be available and patients will have to purchase them outside the communities. Health professionals are also inadequate at the CHPS compounds especially midwives to deliver mothers and contribute to attaining the MDG 4 &5.

4.8 Summary

Discussions so far have proven the immense benefit of CHPS compound in remote areas where access to health service is difficult. In communities without the CHPS compounds such as Betinko and Woarakose, accessing health services was difficult because people have to travel to other communities before accessing health care. Additionally, bad road network, high transport cost and distance create delays, or exacerbate medical conditions which can worsen or cause premature deaths. However, it has been clearly demonstrated that areas with a health facility such as the CHPS compounds in Essienkyem and Piase in Ahafo Ano South and Bosomtwi districts respectively have compelling evidence of improved access to health service and improved healthcare as well.



CHAPTER FIVE

FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.0 Introduction

This chapter summaries the findings in relation to the set objectives for which this study was undertaken. This chapter also contains general conclusion of the work and recommendations which have been put forth in response to the findings.

5.1 Summary of Findings

This segment of the report focuses on the summary of findings in relationship to the set objectives of this study. The goal is to ascertain whether the objectives set out in the study have been met, thus;

- To examine the CHPS programme and access to health care delivery in Ashanti Region, using selected communities in Ahafo Ano South and Bosomtwi Districts as test cases.

It was evident that the Ashanti Region was well endowed with health facilities including a teaching hospital. However, there was unequal distribution of these facilities across the region.

Establishment of CHPS and Government policy

In the effort to provide the Community-based level or ‘close-to-client’ doorstep health delivery with household and community involvement, the Ministry of Health through the Ghana Health Service pioneered the implementation of a national programme to replicate the results of Navrongo Community Health and Family Planning Project (CHFP) known as the Community-based Health Planning and Services (CHPS). The CHPS initiative is therefore the national strategy for implementing the community-based service delivery by reorienting and relocating primary health care from sub-district health centers to convenient community locations. The Piase and Essienkyem CHPS compound in the Bosomtwi and Ahafo Ano South districts were among the first compounds to be established in 2003 and 2004 respectively in the Ashanti Region.

Position of CHPS in the Structure of Health sector

The District is the major unit of primary health care organization and management for service delivery in Ghana. Within the district, health services are organized in a three tiered hierarchy with the District level (level C) at the top and the community level (level A) at the bottom. The CHPS compounds are manned by a resident CHO, security man and health extension workers.

Management and participation of local people in CHPS activities

The only community participation in CHPS activities is to provide communal labour to weed around the compound as and when necessary.

Facilities at CHPS compounds

The following equipments are found in a CHPS compound; motorbikes, delivery set, weighing scales, fridges, beds, vaccine carriers, thermometers, and dressing set.

Human Resources at CHPS

The two CHPS compounds had at least a CHO manning the facility with a help of either enroll nurse or health extension worker. The CHPS compounds are managed by CHOs, who serve as first point of call for medical cases. At Essienkyem and Piase, it was evident that health professionals were inadequate because the two Compounds lacked a midwife.

Services offered by CHPS

They attend to minor cases such as simple malaria, cutlass cuts, snakebites, ANC, emergency delivery, dressing and minor suturing, change of wound dressing, post-natal care, family planning services, child welfare clinics etc, responsible for medical outreach and public health education. Where the ailment is above the CHPS level, the case is referred to a higher level of care.

Cost of Health Services at CHPS

Cost of health services at CHPS compounds ranges between GH¢1.02-GH¢12.10. Affordability of health care services by the local people is through the use of NHIS cards all respondents had a card.. The introduction of NHIS has empowered people to access health care without directly paying money at the point of service delivery.

It was also established that, in communities where CHPS compounds are located, people had easy access to health care. This was the reverse for communities without any health facility.

Population served by CHPS

The two CHPS compounds serve a population of 5,466 and 6,237 respectively. The catchment area of Essienkyem CHPS compound was six communities and that of Piase is five communities.

5.2 Recommendations

The following are suggested way forward for the smooth implementation of CHPS to address access to health care delivery.

Location of CHPS

It is recommended that government of Ghana and Ministry of Health should build more health facilities, especially CHPS compounds and locate them in the rural and peri-urban communities in the region to improve access to health care. The current system where a CHPS compound serve about six communities or based on zones should be looked at again because the other Communities where the CHPS compound is not located yet it is suppose to serve people there as well, access is hindered by distance, condition of road and high cost of transportation. CHPS compounds should be well equipped by Ghana Health Service and District Assemblies to facilitate effective health delivery.

Human Resources at CHPS

The human resource situation should be improved to reflect the standard requirement of a midwife, CHO and other supporting staff in every CHPS compound. GHS in collaboration with the District Assemblies should train more health professional of the various categories and be bonded to service the districts and communities within the region in order to fill the gap.

Cost of services and income of peoples

More economic opportunities should be created, for example subsidy for fertilizer, ready market for farm produce, loan facilities to farmers etc to increase people's incomes levels to afford the cost of health services and subscribe to NHIS.

5.3 Conclusions

CHPS compounds represent one of the few attempts made in Africa to draw upon findings from a research initiative to reform a national health-care programme. The health delivery system of Ghana has been focused on the facility based (curative) system which is inaccessible to a large proportion of the population especially, for those in the rural areas. The introduction of the CHPS is seen as a way of making health care equitable, accessible, and affordable to the poor in society. The Ashanti Region has made a lot of strides as far as the implementation of CHPS is concern.

The objectives of the study were to assess basic health care service delivery in Ashanti Region, analyze the physical, social and economic access to health care services under the CHPS program, assess the capacity of the CHPS in health care delivery, examine the challenges with the implementation of CHPS and make recommendations based on findings that may influence national policy on health care delivery in the region and country as a whole. At the end of the study, it was found out that, CHPS have helped improved physical access to health care in communities with CHPS but communities without CHPS have a challenge with access. With the introduction of NHIS, people do not pay out of pocket at the point of service delivery. The standard required health professionals (midwife, CHO, enroll nurse, etc) are not available in the CHPS compounds. The CHPS compounds are sustained using IGF.

It can be concluded that, communities with CHPS, have easy access to health care and communities without the CHPS, access to health care is a major problem. The effective implementation of these recommendations would go a long way to improve access, and quality of health care for rural dwellers in particular and Ghana as a whole.

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APPENDICES

Appendix 1: Data Requirement and Mode of Collection

Objectives	Research question	Data requirement	Sources	Mode of collection
To Assess basic health care service delivery in Ashanti Region	Has health care delivery improved since the implementation of CHPS in Ashanti Region?	Number of Health facilities in Ashanti Region Type of health care services offered	Regional Health directorate District health directorates Communities with CHPS Community Health Officer	Institutional questionnaire
To Analyze the physical, social and economic access to health care services under the CHPS programme	Has accessibility to health facilities improved due to the implementation of CHPS?	Distance, road network and transport availability and cost to CHPS facility. Cost of services provided Attitude of Health workers	Community members District health directorate Community health officer	Household and institutional questionnaire
To Examine disease patterns/conditions reported at the CHPS compounds.	Has the CHPS programme improved the health status of the populace in Ashanti region?	Health conditions that are reported at the CHPS compounds	Community members District health directorate Community health officer	Household and institutional questionnaire
To Assess the capacity of the CHPS in health care delivery.	Has the CHPS programme improved the health status of the populace in Ashanti region?	Capacity of the CHPS compounds in terms of personnel, office space, equipment, logistics and funds for effective operation	Regional Health directorate District health directorate Community health officer	Institutional questionnaire
Examine the challenges with the implementation of CHPS	What are the constraints in the implementation of CHPS programme in the Ashanti Region?	Challenges and constraints of CHPS implementation	Regional Health directorate District health directorate Community health officer	Institutional questionnaire
To Recommend a way forward for the future of the CHPS programme	What is the way forward for the implementation of CHPS programme in Ashanti region?	Suggestion and recommendation to improve CHPS	Regional Health directorate District health directorate Community health officer	Institutional questionnaire

Data Requirements

Data Required	Sources	Tool for collection	Mode of collection
Number of Health facilities in Ashanti region Type of health care services offered	Regional Health directorate District health directorates Communities with CHPS Community Health Officer	Interview guides	Direct interviews
Implementation of CHPS in Ashanti region Challenges and constraints of CHPS implementation	Regional Health directorate District health directorate Communities with CHPS District Assembly	Questionnaires and interview guides	Direct interviews
Diseases reported at CHPS	Community Health Officer's reports Community members District health directorate reports	Questionnaires and interview guides	Direct interviews
Physical access to CHPS facility	Community members District health directorate Community health officer	Questionnaires and interview guides	Direct interviews
Financial access to health care delivery	Community members Community health officer District health directorate	Questionnaires and interview guides	Direct interviews
Capacity of the CHPS compounds in terms of personnel, office space, equipment, logistics and funds for effective operation.	Community health officer Community members District health directorate Regional health directorate	Questionnaires and Interview guides	Direct interviews.
Suggestion and recommendation to improve CHPS	Community health officer Community members District health directorate Regional health directorate	Questionnaires and interview guides	Direct interviews

Appendix 2: Districts with CHPS where the Researcher selected the Two Study Areas using the table of random numbers.

1. Adansi South
2. Ahafo Ano South
3. Amansie Central
4. Amansie West
5. Atwima Kwanwoma
6. Bekwai Municipal
7. Bosome Freho
8. Bosomtwe
9. Ejura Sekyeredumase
10. Mampong Municipal
11. Sekyere Central
12. Offinso Municipal



Appendix 3: Communities without CHPS Compounds in the Study Districts

DISTRICTS	COMMUNITIES
BOSOMTWI	1. Abono
	2.Abountem
	3.Beposo
	4.Dedesua
	5.Gyekye
	6.Homabenase
	7.New Adwampong
	8.Oyoko
	9.Sawua
	10.Woarakose
AHAFO ANO SOUTH	1.Amakom
	2.Asempanaye
	3.Attakrom
	4.Betinko
	5.Bronikrom
	6.Dwenewoho
	7.Gyawukrom
	8.Hwibaa
	9.Nsuta
	10.Ogyambedibi

Appendix 4: Random sampling numbers

78 41	11 62	72 18	66 69	58 71	31 90	51 36	78 09	41 00
70 50	58 19	68 26	75 69	04 00	25 29	16 72	35 73	55 85
32 78	14 47	01 55	10 91	83 21	13 32	59 53	03 38	79 32
71 60	20 53	86 78	50 57	42 30	73 48	68 09	16 35	21 87
35 30	15 57	99 96	33 25	56 43	65 67	51 45	37 99	54 89
09 08	05 41	66 54	01 49	97 34	38 85	85 23	34 62	60 58
02 59	34 51	98 71	31 54	28 85	23 84	49 07	33 71	17 88
20 13	44 15	22 95	98 97	60 02	85 07	17 57	20 51	01 67
36 26	70 11	63 81	27 31	79 71	08 11	87 74	85 53	86 78
00 30	62 19	81 68	86 10	65 61	62 22	17 22	96 83	56 37
38 41	14 59	53 03	52 86	21 88	55 87	85 59	14 90	74 87
18 89	40 84	71 04	09 82	54 44	94 23	83 89	04 59	38 29
34 38	85 56	80 74	22 31	26 39	65 63	12 38	45 75	30 35
55 90	21 71	17 88	20 08	57 64	17 93	22 34	00 55	09 78
81 43	53 96	96 88	36 86	04 33	31 40	18 71	06 00	51 45
59 69	13 03	38 31	77 08	71 20	23 28	92 43	92 63	21 74
60 24	47 44	73 93	64 37	64 97	19 82	27 59	24 20	00 04
17 04	93 46	05 70	20 95	42 25	33 95	78 80	07 57	86 58
09 55	42 30	27 05	27 93	78 10	69 11	29 56	29 79	28 66
46 69	28 64	81 02	41 89	12 03	31 20	25 16	79 93	28 22
28 94	00 91	16 15	35 12	68 93	23 71	11 55	64 56	76 95
59 10	06 29	83 84	03 68	97 65	59 21	58 54	61 59	30 54
41 04	70 71	05 56	76 66	57 86	29 30	11 31	56 76	24 13
09 81	81 80	73 10	10 23	26 29	61 15	50 00	76 37	60 16
91 55	76 68	06 82	05 33	06 75	92 35	82 21	78 15	19 43
82 69	36 73	58 69	10 92	31 14	21 08	13 78	56 53	97 77
03 59	65 34	32 06	63 43	38 04	65 30	32 82	57 05	33 95
03 96	30 87	81 54	69 39	95 69	95 69	89 33	78 90	30 07
39 91	27 38	20 90	41 10	10 80	59 68	93 10	85 25	59 25
89 93	92 10	59 40	26 14	27 47	39 51	46 70	86 85	76 02
99 16	73 21	39 05	03 36	87 58	18 52	61 61	02 92	07 24
93 13	20 70	42 59	77 69	35 59	71 80	61 95	82 96	48 84
47 32	87 68	97 86	28 51	61 21	33 02	79 65	59 49	89 93
09 75	58 00	72 49	36 58	19 45	30 61	87 74	43 01	93 91
63 24	15 65	02 05	32 92	45 61	35 43	67 64	94 45	95 66
33 58	69 42	25 71	74 31	88 80	04 50	22 60	72 01	27 88
23 25	22 78	24 88	68 48	83 60	53 59	73 73	82 43	82 66
07 17	77 20	79 37	50 08	29 79	55 13	51 90	36 77	68 69
16 07	31 84	57 22	29 54	35 14	22 22	22 60	72 15	40 90
67 90	79 28	62 83	44 96	87 70	40 64	27 22	60 19	52 54
79 52	74 68	69 74	31 75	80 59	29 28	21 69	15 97	35 88
69 44	31 09	16 38	92 82	12 25	10 57	81 32	76 71	31 61
09 47	57 04	54 00	78 75	91 99	26 20	36 19	53 29	11 55
74 78	09 25	95 80	25 72	88 85	76 02	29 89	70 78	93 84

Source: From Morris, C. (2003) *Quantitative Approaches in Business Studies*, 6th edn. Reproduced by permission of Pearson Education Ltd.

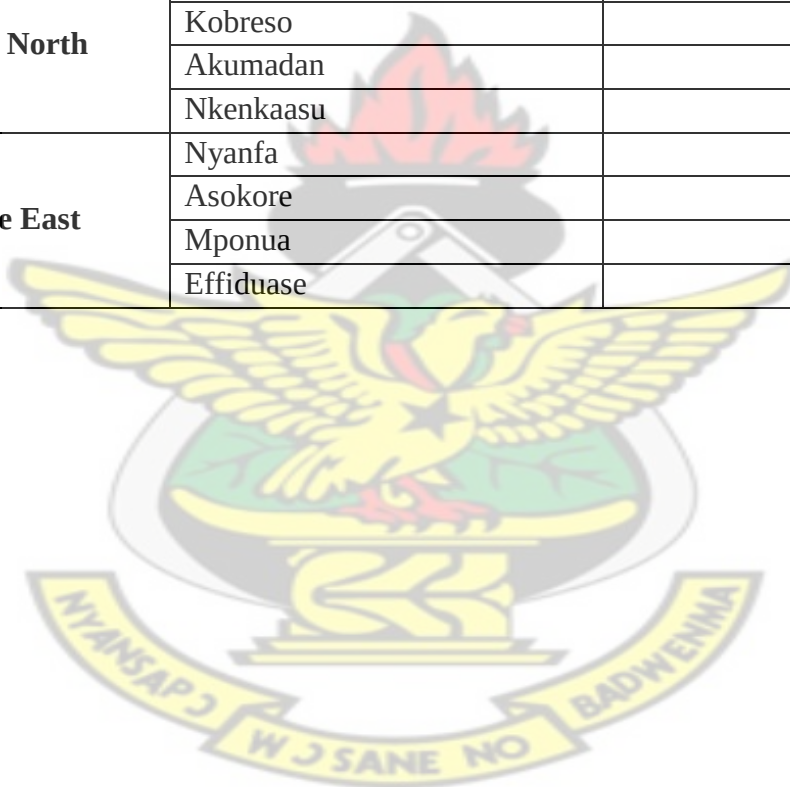
Appendix 5: Districts / Sub-districts with CHPS Compounds in Ashanti Region as at 2010

District	Sub-District	CHPS Compounds
Adansi North	Aboabo	
	Akrokerri	
	Asokwa	
	Fomena	
	Fumso	
	Anhwiaso	
Adansi South	Ataase	Atwere
	Amponyase	Obonsu
	New Edubiase	Grumesa
	Akutreso	
	Akrofuom	
Afigya Kwabre	Ankaase	
	Kyekyewere	
	Aboabogya	
	Brofoyedru	
	Boamang-Kwamang-Ahenkro	
	Afrancho	
Sekyere South	Kona	
	Agona	
	Wiampoase	
	Jamasi	
Ahafo Ano North	Manfo	
	Betiako	
	Anyinasuso	
	Tepa	
	Subriso	
Ahafo Ano South	Mpasaaso	Mpasaaso Dotem
	Mankranso	Effienkyem
	Pokukrom	Kunsu Dotem
	Sabronum	Anitemfe
	Wioso	
	Biemso	
Amansie Central	Fena Hia	Tweapease
	Tweapease	Numereso
	Numereso	Fenaso
	Jacobu	Mile 14
	Fiankoma	Abuakwaa

Amansie West	Keniago	Keniago
	Manso Nkwanta	Asamang
	Essuowin	Adimposo
	Tontokrom	Mpraniase
	Agroyesum	Manso Nkran
	Antoakrom	Akyekyerekrom
	Edubia	Datano
		Aboaboso
		Nnipankyeremia
Asante Akim North	Konongo-Odumase	
	Amantenaman	
	Juansa	
	Agogo	
	Dwease-Praaso	
Asante Akim South	Bompata	
	Ofoase	
	Obogu	
	Komeso	
	Juaso	
	Banka	
Atwima Kwanwoma	Foase	Kwanwoma
	Trabuom	Yabi
	Ahenema Kokobeng	Nwereso
	Trede	
Atwima Mponua	Gyereso	
	Nyinahin	
	Bayerebon	
	Sreso	
	Ntobroso	
	Saakrom	
Atwima Nwabiagya	Abuakwa	
	Barekese	
	Nkawie	
	Akropong	
	Asuofua	
Bekwai Municipal	Kortwia	Gyasikrom
	Kokofu	Subriso
	Bekwai	
	Dominase	

Bosome Freho	Dunkura	Nsuta
	Tebeso	Nsuaem
	Asiwa	Tebeso
	Nsuaem	
	Nsuta	
Bosomtwe	Pramso	Piase
	Kuntanase	
	Jachie	
	Amakom	
Ejisu Juaben	Kwaso	
	Bomfa	
	Ejisu	
	Juaben	
	Achiase	
Ejura Sekyedumase	Anyinasu	Honako
	Nyamebekyere	Nokwareasa
	Nkwanta	
	Kyenkyenkura	
	Sekyedumase	
	Ejura	
	Babaso	
Kumasi Metro	Subin	
	Manhyia North	
	Bantama	
	Asokwa	
	Manhyia South	
Sekyere Afram Plains	Funsua	
	Anyinofi	
	Bira Onwam	
	Dawia	
	Kumawu	
	Drobonso	
Kwabre	Mamponteng	
	Aboaso	
	Asonomaso	
	Kenyase	
Mampong Municipal	Mampong Sub Municipal	Yonso
	Kofiase Sub Municipal	
	Krobo Sub Municipal	
	Adidwan Sub Municipal	
	Yonso Sub Municipal	

	Oku	Gyeduako
Sekyere Central	Asubuasu	
	Birem	
	Nsuta	
	Kwamang	
	Kwabrafoso	
Obuasi Municipal	Gauso	
	New Nsuta	
	Brahabehome	
	Tutuka	
	Offinso Central	Kwaagyekrom
Offinso Municipal	Abofour	
	Bonsua	
	Nsenoa	
Offinso North	Kobreso	
	Akumadan	
	Nkenkaasu	
	Nyanfa	
Sekyere East	Asokore	
	Mponua	
	Effiduase	



Appendix 6: CHPS Status, Ashanti Region 2011

District	Sub-districts	Demarcated zones	Functional CHPS zones	CHPS Compounds
Adansi North	6	18	0	0
Adansi South	5	31	6	6
Afigya Kwabre	6	2	1	1
Ahafo Ano North	5	15	3	3
Ahafo Ano South	6	19	4	4
Amansie Central	5	29	5	5
Amansie West	7	15	9	9
Asante Akim North	5	17	1	1
Asante Akim South	6	22	3	3
Mampong Municipal	5	3	1	1
Atwima Mponua	7	22	8	1
Atwima Nwabiagya	5	19	0	0
Atwima Kwanwoma	4	6	3	3
Bekwai Municipal	4	15	2	2
Bosome Freho	5	11	5	5
Bosomtwe	3	14	1	1
Ejisu-Juaben	5	18	1	1
Ejura-Seko	7	14	3	3
Kumasi	5	35	0	0
Kwabre	4	30	0	0
Obuasi Municipal	5	6	0	0
Offinso Municipal	3	11	1	1
Offinso North	2	7	1	1
Sekyerere Afram Plains	6	30	3	3
Sekyerere Central	5	18	2	1
Sekyerere East	4	8	0	0
Sekyerere South	4	3	0	0
Total	134	438	63	55

Sub-district: The second level in the health structure of GHS

Demarcated zones: Areas earmarked to establish CHPS compounds

Appendix 7: Questionnaires

DEPARTMENT OF PLANNING

COLLEGE OF ARCHITECTURE AND PLANNING

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND
TECHNOLOGY, KUMASI



TOPIC:

Community-Based Health Planning and Services (CHPS) and Access to Health Care in the
Ashanti Region, Ghana

REGIONAL HEALTH DIRECTORATE (RHD)

I am a graduate student of KNUST and I am conducting a research on the subject Community Health and Planning Services and Access to Health Care. This is to enable me to prepare a thesis report in order to satisfy a requirement for MSc Development Policy and planning degree. To enable me prepare the report; I would be grateful if you could kindly respond to the following questionnaire. Your responses will be used for examination purposes only and they will be treated confidentially. Thank you.

VICTORIA YELEDUOR

Position of Respondent:

Date of Interview:

Background of RHA

1. When was the Regional Health Administration established?

2. What are the functions of the RHA?

.....
.....
.....
.....

3. What are the sources of funds to run the RHA?

.....
.....
.....

4. How much do you receive?
5. What is your budget for a year?
6. How many staff do RHA have?
.....
.....
.....
7. What are the categories?
.....
.....
.....
8. What policies/legislations support the establishment of CHPS in the Region?
.....
9. Are these policies/ legislations effective in enhancing the activities of CHPS in the Region?
.....
10. What is CHPS about?
.....
11. What are the functions of CHPS?
.....
12. How are the CHPS compounds in the Region managed?
.....

Institutional Role in Healthcare

1. What are the roles of the Regional Health Directorate in improving the health status of residents in the region?
.....
2. What roles does your Directorate play in promoting CHPS in the region?
.....

CHPS Coverage

1. How many districts in the region have CHPS?
2. Where are CHPS Compounds located?
.....
3. How many CHPS compounds are available and operational in the Region?
.....
.....

4. What are the rates charged at CHPS and for which health condition?

Health condition	Rates

5. How has CHPS improved access to health care delivery in the region?

.....

Human Resource Requirement and Facilities of CHPS

1. What is the total number of health staff required to manage CHPS?

.....

2. How many staffs are available at CHPS Compounds?

.....

3. What are the categories of staff required?

.....

4. How many of the categories are available and at post?

.....

5. What are the facilities/equipments available in each of the CHPS compounds?

.....

6. What is the number required?

.....

How many of these facilities/equipments are available?

.....

7. What services are rendered by the CHPS compounds?

.....

.....

Stakeholders in Healthcare and CHPS

8. Who are the stakeholders involved in the activities of CHPS in the Region?#
.....
9. What is their role in promoting CHPS?
.....
10. What challenges does your Administration face in collaborating with the other stakeholders?
.....

Funding for CHPS

11. What are the sources of funds for CHPS?
A. Central Government []
B. Donor partners []
C. NGOs []
D. Internally Generated Funds of CHPS compounds []
E. Others (specify)
12. How much funds are allocated to each of the CHPS compounds annually?
.....
13. How much do you receive annually?
14. What is your budget?
.....

Effects and Challenges of CHPS

15. What have been the effects of CHPS on healthcare delivery in the Region?
.....
.....
16. What are the benefits/importance of CHPS to healthcare delivery in the Region?
.....
17. What factors impede the operations of CHPS?
.....
.....
18. What efforts are being made by your Directorate to improve CHPS?
.....
.....

Way Forward

19. Are there plans to establish new CHPS in the Region?

A. Yes []

B. No []

20. If No in Question 20, why?

.....
.....

21. If yes in Question 20, where?

.....

22. What can be done to improve the activities of CHPS?

.....





Topic:

Community-Based Health Planning and Services (CHPS) and Access to Health Care in the
Ashanti Region, Ghana

DISTRICT HEALTH ADMINISTRATION (DHA)

I am a graduate student of KNUST and I am conducting a research on the subject Community Health and Planning Services and Access to Health Care. This is to enable me to prepare a thesis report in order to satisfy a requirement for MSc Development Policy and planning degree. To enable me prepare the report; I would be grateful if you could kindly respond to the following questionnaire. Your responses will be used for examination purposes only and they will be treated confidentially. Thank you.

VICTORIA YELEDUOR

Name of DHA:

Position of Respondent:

Date of Interview:

Background of DHA

1. When was the District Health Administration established?
2. What are the functions of the DHA?
.....
3. What are the sources of funds to run the DHA?
.....
4. How much do you receive?
5. What is your budget for a year?
6. How many staff do DHA have?
.....

7. What are the categories?

.....

8. What policies/legislations support the activities of CHPS in the district?

.....

9. Are these policies/ legislations effective in enhancing the activities of CHPS in the district?

.....

10. What is CHPS about?

.....

11. What are the functions of CHPS?

.....

12. How are the CHPS compounds in the district managed?

.....

Institutional Role in Healthcare

13. What are the roles of the DHA in improving the health status of residents in the district?

.....

14. What roles does your Administration play in promoting CHPS activities in the district?

.....

CHPS Coverage

23. Where are CHPS Compounds located?

.....

24. How many CHPS compounds are available and operational in the district?

.....

25. How many communities in the district have access to CHPS facilities?

.....

.....

26. What are the activities of CHPS?

.....

.....

27. What are the rates charged at CHPS and for which health condition?

Health condition	Rates

28. How has CHPS improved access to health care delivery in the district?

.....

Human Resource Requirement and Facilities at CHPS

29. What is the total number of health staff required to manage CHPS in the district?

.....

30. How many staff s are available in managing CHPS in the district?

.....

31. What are the categories of staff required?

.....

32. How many of the categories are available and at post?

.....

33. What are the facilities/equipments available in each of the CHPS compounds?

.....

34. What is the number required?

.....

35. How many of these facilities/equipments are available?

.....

36. What services are rendered by the CHPS compounds in the district?

.....

.....

Stakeholders in Healthcare and CHPS

37. Who are the stakeholders involved in the activities of CHPS in the district?

.....

38. What is their role in promoting CHPS?

.....

39. What challenges does your Administration face in collaborating with the other stakeholders?

.....

Funding for CHPS

40. What are the sources of funds for CHPS activities in the district?

A. Central Government []

B. Donor partners []

C. NGOs []

D. Internally Generated Funds of CHPS compounds []

E .Others (specify)

41. How much funds are allocated to each of the CHPS compounds in the district annually?

.....

42. How much do you receive annually?

43. What is your budget?

.....

Effects and Challenges of CHPS

44. What have been the effects of CHPS on healthcare delivery in the district?

.....

45. What are the benefits/importance of CHPS to healthcare delivery in the district?

.....

46. What factors impede the operations of CHPS in the district?

.....

47. What efforts are being made by your Directorate to improve CHPS in the district?

.....

.....

Way Forward

48. Are there plans to establish new CHPS in the district?

A. Yes []

B. No []

49. If No in Question 26, why?

.....

50. If yes in Question 26, where?

.....

51. What can be done to improve the activities of CHPS in the district?

.....

KNUST





Topic:

Community-Based Health Planning and Services (CHPS) and Access to Health Care in the
Ashanti Region, Ghana

CHPS COMPOUNDS QUESTIONNAIRE

I am a graduate student of KNUST and I am conducting a research on the subject Community Health and Planning Services and Access to Health Care. This is to enable me to prepare a thesis report in order to satisfy a requirement for MSc Development Policy and planning degree. To enable me prepare the report; I would be grateful if you could kindly respond to the following questionnaire. Your responses will be used for examination purposes only and they will be treated confidentially. Thank you.

VICTORIA YELEDUOR

Name of the CHPS Compound:

Position of Respondent:

Date of Interview:

1. When was the CHPS Compound established?

2. What policies/legislations support CHPS?

.....

3. What are the facilities/equipments available at the CHPS?

.....

4. What is the number required?

.....

5. How many of these facilities/equipments are available?

.....

6. How many staffs are available in managing CHPS?

.....

.....

7. What are the categories of staff required?

.....

8. How many of the categories are available and at post?

.....

Role in Healthcare Delivery

3. What are the roles of the CHPS Compound in improving the health status of residents in the Community?

.....

4. What roles does the community play in promoting CHPS?

.....

5. Does your institution receive external support in the implementation of CHPS?

A. Yes []

B. No []

6. If yes to Question 3, what type of support?

.....

CHPS Coverage

7. How many CHPS compounds are available and operational in the Community?

.....

Do you charge people who visit the facility?

A. Yes []

B. No []

8. What are the rates charged at CHPS and for which health condition?

Health condition	Rates

9. How has CHPS improved access to health care delivery in the Community?

.....

.....

Human Resource Requirement and Facilities at CHPS

10. What is the total number of health staff required to manage CHPS in the Community?

.....

11. How many staffs are available?

.....

12. What are the categories of staff required?

.....
.....
.....

13. How many of the categories are available and at post?

.....

14. What are the services being rendered by the CHPS compounds in the Community?

.....
.....
.....
.....

Stakeholders in Healthcare and CHPS

15. Who are the stakeholders involved in promoting CHPS in the Community?

.....

16. What challenges does your institution face in collaborating with the other stakeholders?

.....

Funding for CHPS

17. What are the sources of funds for CHPS?

- A. Central Government []
- B. Donor partners []
- C. NGOs []
- D. Internally Generated Funds of CHPS compounds []
- E. Others (specify)

18. How much funds are allocated to each of the CHPS compounds annually?

.....

19. How much do you receive annually?

20. What is your budget?

.....

Effects and Challenges of CHPS

21. What have been the effects of CHPS on healthcare delivery in the Community?

.....

22. What are the benefits/importance of CHPS to healthcare delivery?

.....

23. What factors impede the activities and operations of CHPS?

.....

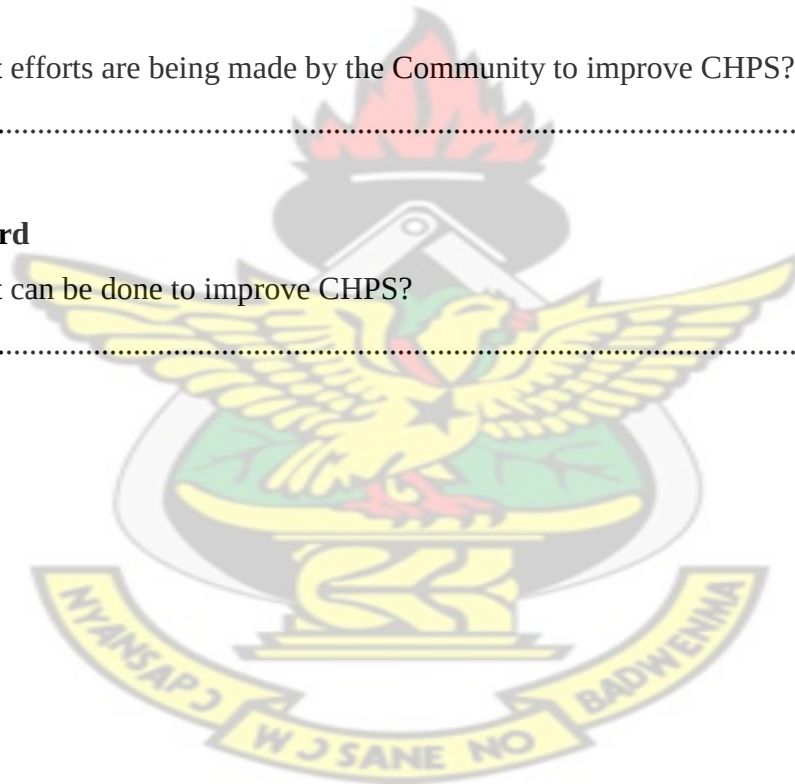
24. What efforts are being made by the Community to improve CHPS?

.....

Way Forward

25. What can be done to improve CHPS?

.....



DEPARTMENT OF PLANNING

COLLEGE OF ARCHITECTURE AND PLANNING

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY, KUMASI

Topic:

Community-Based Health Planning and Services (CHPS) and Access to Health Care in the
Ashanti Region, Ghana

HOUSEHOLD QUESTIONNAIRE

I am a graduate student of KNUST and I am conducting a research on the subject Community Health and Planning Services and Access to Health Care. This is to enable me to prepare a thesis report in order to satisfy a requirement for MSc Development Policy and planning degree. To enable me prepare the report; I would be grateful if you could kindly respond to the following questionnaire. Your responses will be used for examination purposes only and they will be treated confidentially. Thank you.

VICTORIA YELEDUOR

Name of Community:

Date of Interview:

Personal and Household Characteristics

1. How old are you?
2. What is the size of your household?
 - A. 1 []
 - B. 2 []
 - C. 3 []
 - D. 4 and above []
3. What is your marital status?
 - A. Single []
 - B. Consensual Union []
 - C. Married []
 - D. Widowed []
 - E. Never Married []

4. What is your religious background?

- A. Christianity []
- B. Islamic []
- C. Traditional []
- D. Others []

5. What is your level of education?

- A. Primary []
- B. Middle/JHS []
- C. Secondary/Vocational []
- D. Tertiary []
- E. Non-formal []

6. What is your residency status?

- A. Permanent []
- B. Seasonal []
- C. Occasional []
- D. Others (specify)

.....

7. Which ethnic group do you belong?

- A. Akan []
- B. Ga []
- C. Ewe []
- D. Tribes of Northern Origin []
- E. Others (specify)

.....

8. Are you employed?

- A. Yes []
- B. No []

9. If yes to Q 8, which economic activity are you engaged in?

- A. Agriculture []
- B. Service []
- C. Industry []
- D. Commerce []

Health Facilities and Services

1. Do you have a Health Facility in this community?

A. Yes []

B. No []

2. If yes, where is it located?

3. Which health facility do you patronise?

A. Orthodox []

B. Traditional []

C. Others (specify).....

4. How often do you visit a health facility?

A. Weekly []

B. Monthly []

C. Annually []

D. Others (specify).....

5. What is the distance to the nearest healthcare facility?

A. Below 100m []

B. 100-200m []

C. Above 200m []

6. By what means do you use when visiting the facility?

A. Walking []

B. Motor []

C. Vehicle []

7. How much is the Vehicle fare?

.....

.....

8. How many minutes would one take at the station before getting a Vehicle?

A. 10min []

B. 15min []

C. 20min []

D. 30 and above []

9. What type of illness do you go there with?

.....

.....

.....

10. What type of health services do you receive?

.....

.....

.....

11. Are the health facilities physically/geographically accessible?

A. Yes []

B. No []

12. Are the health facilities financially accessible?

A. Yes []

B. No []

13. If questions 11 and 12 responses are No, why?

.....

.....

.....

Attitude of Staff

1. Who attend to you when you visit the facility?

A. Doctor []

B. Nurse []

C. TBA []

D. Volunteer []

2. How many staff are there to provide Health care?

.....

.....

3. What is the attitude of Doctors towards people?

.....

.....

.....

4. What is the attitude of Nurses towards People?

.....

.....

.....

5. What is your advice to the Doctor on their attitude?

.....

.....

.....

6. What is your advice to the Nurses on their attitude?

.....

.....

.....

Service Charges

1. Do you pay money before health services are rendered to you?

A. Yes []

B. No []

2. If yes, how much do you pay for health services?

.....

.....

.....

3. If no why don't you pay money?

.....

.....

.....

CHPS Activities

1. Do you know about CHPS?

A. Yes []

B. No []

2. If yes to Q 1, what do you know about CHPS?

.....

.....

.....

3. How does CHPS enhance access to healthcare delivery?

A. less costly []

B. Located close to the people []

C. Others (specify)

4. Do the activities of CHPS cover the entire community?

A Yes []

B. No []

Effects of CHPS

5. What have been the effects of CHPS in improving your health status?

.....

.....

.....

6. What are the benefits/importance of CHPS to healthcare delivery?

.....

.....

.....

Challenges/ Solutions

1. What are the challenges that you face when accessing health care?

.....

.....

2. What are the challenges at the facility?

.....

.....

3. What are your suggestions to solve the challenges at the facility?

.....

.....

4. What is the community doing to resolve the challenges at the facility?

.....

.....

5. What role does the community play in supporting the CHPS programme?

.....

.....

