

Assessment of Community Utilization of CHPS Services in Komenda-Edina-Eguafo-Abrem (KEEA) Municipality in the Central Region of Ghana

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Abstract

In response to health care needs, Ghana has adopted the Community-based Health Planning and Services (CHPS) system to increase access to and use of health services in remote communities. The purpose of the study was to assess the utilization of the CHPS facilities in the Komenda-Edina-Eguafo-Abrem Municipality. A total of 175 respondents comprising 50 males and 125 females participated in the study. Four communities with CHPS zones were selected. The study design was a cross sectional descriptive survey. The respondents in each of the selected communities were chosen through systematic random sampling. Collection of data was done through a structured interview using an interview guide. About 59.4% of the respondent mentioned that CHPS system provided immediate and timely healthcare services to the community hence admitting the relevance of the CHPS themselves as well as their respective communities. 65.8% of the respondents said they were satisfied with services at the CHPS zone. Drug unavailability, lack of midwifery services, poor staff attitude and fear of blood by some nurses were challenges in the utilization of CHPS services in the municipality. The study recommends that drug availability rate should be improved in all the CHPS zones especially the basic and very essential drugs; and more community health nurses should be trained in midwifery.

Keywords: CHPS zone, Staff Attitude, Municipality, Health facility, OPD, KEEA

1. Introduction

1.1 Background

Ghana, like many sub-Saharan African countries faces health challenges. Some of these include: high maternal and child mortality, diarrhoea, malnutrition, HIV/AIDS, malaria, and other endemic diseases. Barriers to solving these problems include poverty, low education and illiteracy, inability to organize the health system, poor infrastructure, inequitable health financing and inadequate health workers (Ministry of Health, 2007). Furthermore, about 49% of Ghana's most impoverished individuals live in remote villages (Ghana Poverty Reduction Strategy 2001) where it is particularly difficult for Ghanaians to receive proper and timely medical attention. In response to health care needs, Ghana has adopted the Community-based Health Planning and Services (CHPS) system to increase access to and use of health services in remote communities (Ghana Health Service, 2009).

This system brings trained health care workers directly into the communities and rallies community support to ensure the system's acceptability and sustainability. CHPS offers the best opportunity for more effective and efficient health care in rural communities in Ghana.

1.2 Problem Statement

The Community-based Health Planning and Services (CHPS) system came into being in 1999 as a national policy to provide health care to the doorstep of the people in the community. It is a key strategy for increasing access to basic health care services and improving the health status of the people in the Komenda-Edina-Eguafo-Abrem (KEEA) Municipality. The KEEA Municipality is divided into five (5) sub-district; namely, Elmina, Agona, Komenda, Kissi, and Ankaful sub-districts. Currently there are eight functional CHPS zones in the Municipality. Health services provided at the CHPS zones include home visit, treatment of minor ailments, immunization, family planning, antenatal care, emergency deliveries, postnatal care, school health and health education.

Although the CHPS zones are supposed to serve more clients from the communities, people prefer accessing health care at other health facilities other than the CHPS zones. Out of 30,000 people served by the six functional CHPS zones in the Municipality, only 12.9% accessed health care services at the CHPS zones in 2010 resulting in an Out Patient Department (OPD) per capita of 0.1 (Municipal Health Directorate, 2010). According to the 2011 KEEA Annual Report, only 388 out of a total population of 5,458 in Atonkwa – a community in the

Ankaful sub-district – accessed health care services at a CHPS zone; while in Benyadze – a community in the Agona sub-district – 961 out of a population of 3,988 accessed health care services at a CHPS zone. Similar trend is observed in all the other communities.

Based on the above observations, the study seeks to ascertain the reasons why the communities prefer health facilities other than the CHPS zones, which are closer to them.

1.3 Objectives of the study

1.3.1 General objectives

The general objective of the study is to assess community utilization of CHPS services in the Komenda-Edina-Eguafo-Abrem Municipality.

1.3.2 Specific objectives

The specific objectives of this study are to:

1. Analyze the demographic characteristics of the people.
2. Assess the perception of the community towards CHPS activities.
3. Assess the usage of CHPS services.
4. Identify factors associated with utilization of CHPS services

1.4 Significance of the study

The findings of the study, will inform health providers, policy makers, international development partners and the government on factors that contribute to low utilization of community-based health facilities such as the CHPS. This will help to equip stakeholders in developing effective strategies to encourage members of the communities to patronize health care services at the CHPS zones in their communities.

Furthermore, the findings will help to identify the gaps and weaknesses in the CHPS zones and provide suggestions to strengthen the CHPS system in the KEEA Municipality, and to improve the health status of community members. It is envisaged that the findings of this research will contribute to knowledge and update existing ones in the utilization of CHPS services in the Municipality and elsewhere.

2.0 Literature Review

2.1 Introduction

This research focuses on the review of studies that have been conducted to examine the concept, challenges and utilization of CHPS zones in Ghana. The review is categorized as follows:

- i. Concept of Community-based Health Planning and Services
- ii. Perception of patients of the Community-based Health Planning and Services.

2.2 Concept of Community-Based Health Planning and Services

CHPS is the plan of Ghana Ministry of Health (MOH) to shorten the gap in access to health services between the increasingly urbanized south and the rural north (Nyonator *et.al*, 2003). There is often a discrepancy between urbanized areas and remote communities within districts. Ghana's health systems allocate more resources into CHPS communities and involve community members in important health decisions.

This empowers them and gives individuals the opportunity to receive quality and prompt treatment from the health system. In order to improve Primary Health Care (PHC), CHPS evolved a method of changing focus on clinical care at district and sub-district levels to a new focus on suitable and quality services at community and doorstep levels (Nyonator 2006). Research was observed as a tool to guide health system reform on the basis of lessons learned. During this period, the National policies for healthcare reform were guided by the "Sector-Wide approach" mandated by the World Bank for integrating health-care planning, services and budgets (Adjei *et. al.*, 2002).

The CHPS system signifies an opportunity for the country to give quality health care for all its residents. It involves phases designed to encourage the process of organizational development. With the addition of each phase, activities of earlier phases are necessary and continue. The operational strategy for the nationwide implementation of community-based service delivery has consisted of four interrelated phases.

Phase 1: Spanning the 1998 to 2000 period involved building consensus among the various units of the Ministry that operational components of the Navrongo experiment should be a national health policy. District Directors of Health Service (DDHS), Regional Health Administrators (RHA) and senior staff of the various health directorates were sensitized on the Navrongo system and its impact in routine MOH meetings. Special resources were directed to consensus building event. Consultative meetings and fora held each year at the national level. Also, the process of initiating and managing CHPS was discussed at the regional level.

Phase 2: System demonstration. The Kassena-Nankana District in the Upper East Region and Nkwanta District in the Volta Region served as field demonstration sites. Visiting teams who participated in the programme got guidance from peers and the new knowledge shared on how to solve problems proved to be an effective means of fostering initial CHPS pilot activity in districts throughout Ghana. Many District

Health Management Teams [DHMTs] visited Navrongo, or conducted exchanges with other districts that acquired some exposure to the Navrongo system. Regional Health Management Teams (RHMT) supported pilot programmes that changed service operations that spontaneously arise from these exchanges. By the end of 2001, 70 of the 110 districts in Ghana had started some form of activity designed to develop community-based health care. United States Agency for International Development (USAID) and Collaborating Agencies (CAs) produced a variety of printed, video, and multimedia material to support the CHPS dissemination programme. This dissemination programme has been a continuous operation that fosters diffusion of innovation into routine service delivery operations of the Ministry of Health.

Phase 3: The 'Lead District' initiative. This phase focused on implementation in 'Lead Districts' where CHPS demonstration capabilities were developed. Programme of exchange about the Navrongo model was speeded up. The initial work was to identify at least 10 districts dispersed in the 10 regions of Ghana where commitment and capacity existed to start CHPS work. On-site training and demonstration capabilities were developed on the Navrongo model at Volta Region which served as the 'Lead Region'.

A system of 'learning by doing' in which the Navrongo model would be reviewed, modified and pilot tested in pilot areas of some districts in other regions was the main purpose of the lead district phase. Initial work in all 10 lead districts had begun by the end of 2000 and dissemination to neighbouring district was launched in 2001.

It was expected that by 2001, 20 lead districts would have fully functioning CHPS operating. It was emphasized that two districts in each of the ten 10 regions would have two sub-districts where at least two work zones would be functioning. The formula '2 by 2 by 2' was stressed.

Phase 4: System-wide scaling up. A fourth and final stage in the CHPS process involved utilizing the 20 lead districts as demonstration areas for the remaining districts to be covered by the programme. Community mobilization, programme of exchange and training was developed in the 20 lead districts that facilitated further scaling up activities to all remaining districts. Since implementation in a district consisted of at least a year of training, facilities development and other activities, the entire CHPS initiation process was expected to extend for at least five years from January 2001. During that period, the 2 by 2 by 2 CHPS pilot areas was scaled up. Thus, "learning-by-doing" was encouraged, so that CHPS strategies were adapted to local conditions and needs before district wide services were attempted.

2.3 Perceptions of clients about the Community-based Health Planning and Services

According to a study by Nyonator *et al.*, (2002), in the Hohoe district, a community was confused about CHPS concept. Most of the women thought the outreach nurse who visited them weekly to conduct a community clinic was part of CHPS activity, even though the outreach nurse has not been posted to a Community Health Clinic (CHC) and does not reside in the community. Thus, traditional outreach clinic activities that have been in operation before the CHPS programme are sometimes labelled as "CHPS."

When community members went to the health centre, they reported that they "see their nurse" working there, because she visits their community. In both Hohoe and Keta, indication shows that community leaders knew about the CHPS programme while community male Focus Group Discussion (FGD) participants did not. This situation prompted that more efforts was needed to inform the community by communicating with leaders about CHPS.

The introductory programme extended beyond community entry to include the provision of general community information and educational activities. Informing community leaders was therefore a necessary, but insufficient basis for organizing a CHPS programme.

The community leaders and members constantly responded to the perceptions, attitude and reactions towards the CHPS programme. Even where the programme was not fully implemented, people were pleased with elements of the programme that have been launched, particularly if the service regimen included a resident nurse, and even if the scheme was limited to providing a non-resident visiting nurse on a weekly basis.

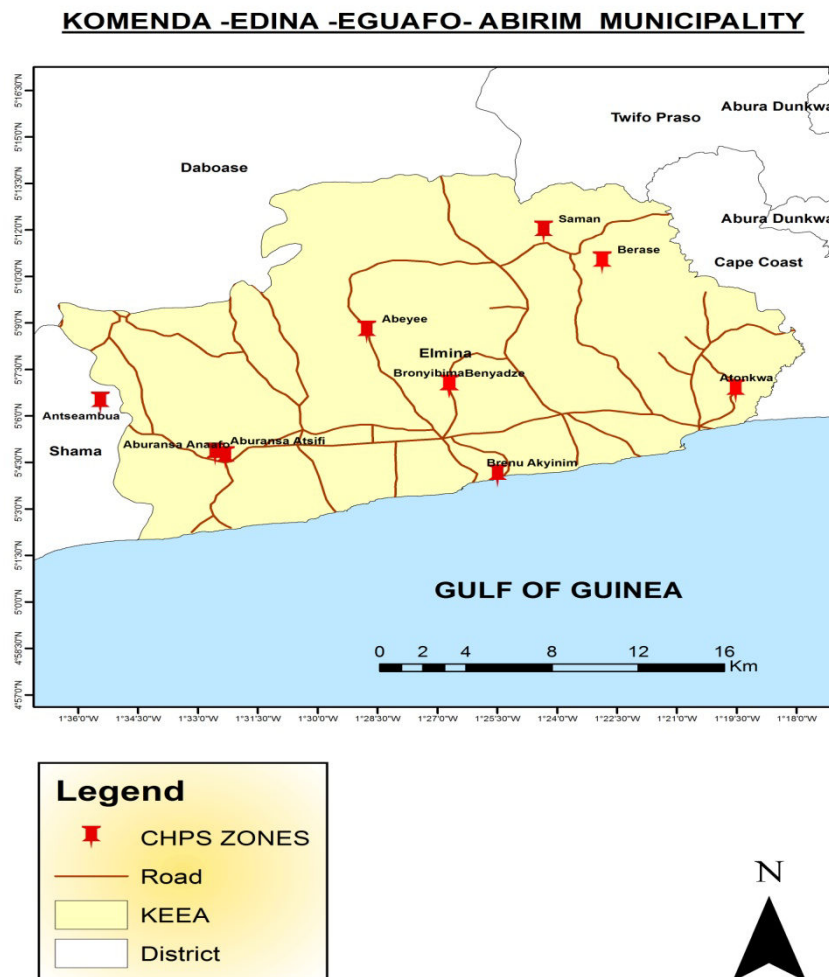
In a study, an opinion leader of a community commented that, they "preferred a nurse who will reside in the community and available on a 24-hour call". Though, the awareness of CHPS elements is unclear, community members were happy about the idea of CHPS and strongly supported and willing to assist to make the Community Health Officer (CHO) useful and comfortable in the community: the excitement of some of such community is captured in the following remarks: "If the CHO is posted here we shall get a house for her.... *If there are problems at her residence and she informs the community we shall assist her...we will provide foodstuff to make her comfortable*" (Community leader, Blemazado). During the FGD, the community participants were so keen about the relocation of nurses from clinics to the community and the perception that this will make curative health services more accessible and affordable by reducing travel costs for first-aid or minor medical treatment.

3.0 Materials and Method

3.1 Study site

The study is the Komenda-Edina-Eguafo-Abrem Municipality in the Central Region (Figure 1). Specifically, the study was conducted in the eight communities that have the CHPS facilities. The Komenda-Edina-Eguafo-Abrem (KEEA) Municipal is one of the decentralized Agency in the Central Region of Ghana. It was formed in the year, 1988 with Elmina as the Municipal Capital. The population is estimated to be about 153,816 with an annual growth rate of 3.1%. It has four traditional areas and each with a paramountcy namely Komenda-Edina-Eguafo-Abrem. It is boarded on the north by Twifo Hemang Lower Denkyira, on the south by Atlantic Ocean (Gulf of Guinea), on the east by Cape Coast Municipality and on the west by Mpohor Wassa District in the Western Region. The district covers an area of 1,372.45 square kilometers. The landscape is generally undulating with lagoons and wetlands along the coastal zone. The vegetation consists of shrubs of about 1.5 m high, grasses and scattered trees in the coastal areas and secondary forest in the interior. The main languages spoken in the district are Fante and English.

The principal religions are Christianity and African Traditional Religion with few people practicing Islam. The predominant occupation of the people is fishing, farming, salt winning and boat building. About 70% of the people have access to drinking. However at certain time of the year, water stops flowing compelling people to use unsafe water from streams, pond and rivers.



MAP SOURCE, RS/GIS LAB, 17TH APRIL 2013.

Figure 1. KEEA municipal map showing the various CHPS zones

Health context

The Municipality is divided in five (5) Sub-municipalities as shown in Table 1. These include Elmina sub municipal, Agona sub- municipal, Kissi sub- municipal, Komenda sub- municipal and Ankaful sub- municipal. Currently, two of the CHPS zones have been closed down and measures are being put in place to re-open soon. The health institutions, types and ownership in the Municipal are presented in Table 2.

Table1. Summary of sub-municipal profile

Sub-municipals	Population	Communities	Outreach points	CHPS compounds
Elmina	50,740	33	16	2
Agona	30,749	22	18	3
Komenda	30,749	13	12	1
Kissi	26,135	22	14	2
Ankaful	15,443	10	14	1
DISTRICT TOTAL	153,816	100	74	9

Table 2: List of Health Institutions in the district

SUB-DISTRICT	INSTITUTION	TYPE	OWNERSHIP	STATUS
ELMINA	Elmina Urban Health Centre	Health Centre	Government	Functional
	BrenuAkyinim	CHPS Zone	Quasi-government	Functional
	Bronyibima	CHPS Zone	Quasi-government	Functional
	Paa Wattenberg	Maternity	Private	Closed
	Good Shepherd	Maternity	Private	Functional
AGONA	Agona Health Centre	Health Centre	Government	Functional
	Benyadze CHPS	CHPS Zone	Quasi-government	Functional
	Berasese CHPS	CHPS Zone	Quasi-government	Functional
	SAP CHPS	CHPS Zone	Quasi-government	Closed
	Bando Han Medical Centre	Clinic	Quasi-government	Functional
KOMENDA	Komenda Health Centre	Health Centre	Government	Functional
	Nyame Tease	Maternity	Private	Functional
	Aburansa CHPS	CHPS Zone	Quasi-government	Functional
KISSI	Kissi Health Centre	Health Centre	Government	Functional
	Antseambua	CHPS Zone	Quasi-government	Functional
	Abeyee	CHPS Zone	Quasi-government	Functional
ANKAFUL	Leprosy /General Hospital	District Hospital	Government	Functional
	Psychiatric Hospital	Tertiary Hospital	Government	Functional
	Contagious Disease Prisons	Prisons	Government	Functional
	Atonkwa CHPS	CHPS Zone	Quasi-government	Closed

Disease burden

Malaria is the leading cause of morbidity, followed by skin diseases and ulcers, Acute Respiratory Infections and Diarrhoeal diseases.

3.2 Study Design

A cross-sectional descriptive survey was used in this study. The design was preferred for its advantage of economy, rapid data collection and the ability to identify attributes of a population from a small group of individuals (Gall, Gall, & Borg, 2003; Gay, 1992). Again, the design was adopted because the researcher aimed at generalizing from the sample to a population so that inferences could be made about some characteristics, attitudes or behaviour of the population (Best & Khan, 1993; Gay, Mills & Airasian, 2009).

The cross-sectional descriptive survey is practical in that it determines and reports the way things are. It focuses on vital facts about people and their beliefs, opinions, attitudes, motives and behaviours, and simply describes and provides understanding of a phenomenon (Creswell, 2005). Furthermore, Ary, Jacobs, and Razavieh (1990) indicated that descriptive survey provides information on which to base sound decisions. It interprets, synthesizes, integrates data, and points to implications and interrelationships. Furthermore, it can be

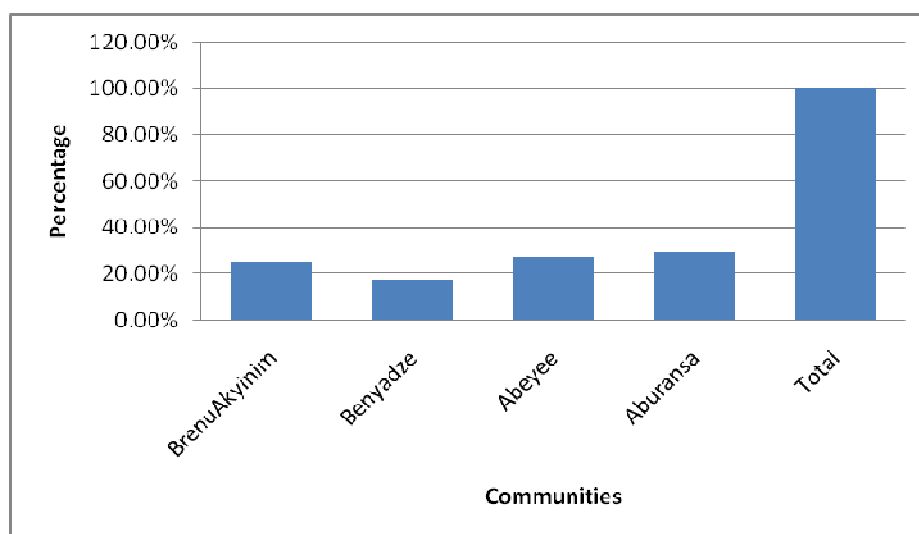
used with greater confidence with regard to particular questions of special interest to the researcher, Babbie, 1990; Wiersma, 1980).

3.3 Study Population

The target population (6483) for the study was made up of all persons living in the KEEA Municipality. Brenu Akyinim in the Elmina sub-municipal, Aburansa in the Komenda sub-municipal, Benyadze in the Abrem-Agona sub-municipal, and Abeyee in the Kissi sub-municipal were the participating communities (Table 3).

Table 3: List of Participating Communities.

BrenuAkyinim	Benyadze	Abeyee	Aburansa	Total
1624	1149	1778	1932	6483
25.05%	17.72%	27.43%	29.80%	100.00%



3.4 Sample size determination

The sample size for the study was 180 individuals as presented in Table 4.

The statistical software, EPI-INFO StatCalc version 7.0.9.1, dated 19th February 2012, was used to estimate the sample size for the study. Thus, with a population size of 6,483 and the frequency of utilization of the CHPS zones of about 13%, the sample size was estimated at 169 using confidence limits of 5% and a confidence level of 95%. The sample size was rounded up to 180 and distributed proportionally among the four selected communities.

According to Glass and Hopkins (1984); Anastasia (1982) and Fraenkal and Wallen (2000), descriptive studies, require a sample with a minimum number of 100 which is essential if the population under study is homogenous. Furthermore, Amedahe (2000) indicated that a sample size of 5% to 20% of a population in most quantitative studies was valid enough to make the conclusions arrived at, barring any serious flaws, sufficient for generalization purposes.

Table 4: Sample Sizes of Participating Communities for the Study.

Community	Population	% of Total Accessible Population	Sample Size
BrenuAkyinim	1,624	25.1	45
Benyadze	1,149	17.7	32
Abeyee	1,778	27.4	49
Aburansa	1,932	29.8	54
Total	6,483	100	180

3.5 Sampling Procedure

Both probability and non-probability methods were used to select the sample for the study. Thus, the four communities where CHPS zones were identified and purposively selected and respondents in each of these communities were chosen through systematic random sampling. This exercise was important because in descriptive research, the most important tasks were to be sure that, the measures being used were reliable and

valid and that the individuals from whom information is received were the true representatives of the population to whom the results are applicable (Amedahe, 2000; Triola, 1989; Razavieh, 1990).

3.6 Data Collection Procedure

Data was collected by interviewing heads of households in the four communities. The researcher and assistants used one week to collect the data from the four communities. Each interview session lasted about 25 minutes. In order to encourage respondents to frankly respond to the items, the researcher re-iterated the fact that the study was purely for academic purposes and, therefore, respondents should feel free to express their feelings. Confidentiality of their responses was also assured.

3.7 Data Gathering Tools

Collection of data was done through a structured interview using an interview schedule. This method was suitable for the researcher because most of the subjects could not read nor write on their own. Besides, the four participating communities were in the Komenda-Edina-Eguafo-Abrem Municipality and were easily accessible.

3.8 Data Analysis

Data were analyzed using Epi info version 3.3.2 and the results presented as tables, frequencies, percentages and discussed.

3.9 Ethical Consideration

Respondents were informed of the purpose of the study and were assured of the confidentiality of their responses. None was compelled to participate and their responses remained anonymous as they were not required to indicate their names.

4.0 Results

4.1 Introduction

This study presents the analysis of findings and discusses the results of the study. The presentation is done in two sections. The first section presents the results of the responses to the questionnaires in tabular form. The second section focuses on the analysis and discussion of the results. The analysis and discussion of the results are based on the responses of 175 individuals from four communities.

4.2 Demographic Characteristics of Respondents

As presented in Table 5, for 175 respondents, 47 (26.9%) were from Abeyee, 54 (30.9%) were from Aburansa while 30 (17.1%) came from Benyadze with Brenu Akyinim accounting for 44 (25.1%).

Table 5: Demographic Characteristics of Respondents

Community	Number of Respondents	%
Abeyee	47	26.9
Aburansa	54	30.9
Benyadze	30	17.1
Brenu Akyinim	44	25.1
Total	175	100

4.3 Gender Characteristics of Respondents for the Study

Results in table 6 shows the gender characteristics of respondents for the study. The male respondents constituted 28.6% of the respondents while 71.4% were female. It is clear that there were more females than males.

Table 6: Gender Characteristics of Respondents for the Study

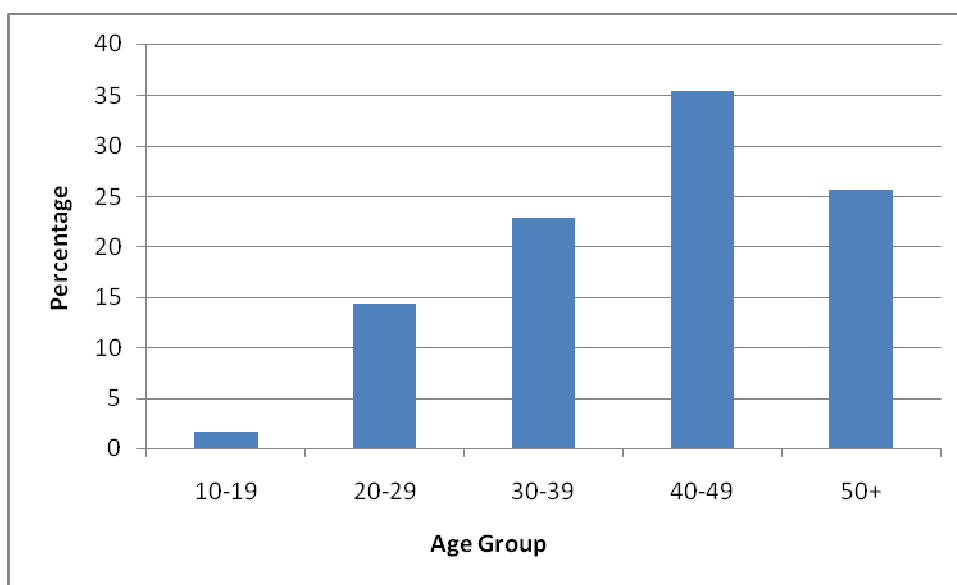
Gender	Number of Respondents	%
Male	50	28.6
Female	125	71.4
Total	175	100

4.4 Age Distribution of Respondents

Table 7 shows the age distribution of respondents. Obviously respondents between the ages 40-49 were in the majority accounting for 35.4%. the least age bracket was between 10-19 years accounting for 1.7% of the total respondents.

Table 7: Age Distribution of Respondents

Age Group	10-19	20-29	30-39	40-49	50+
No. Of Respondents	3	25	40	62	45
Percentage	1.7	14.3	22.9	35.4	25.7



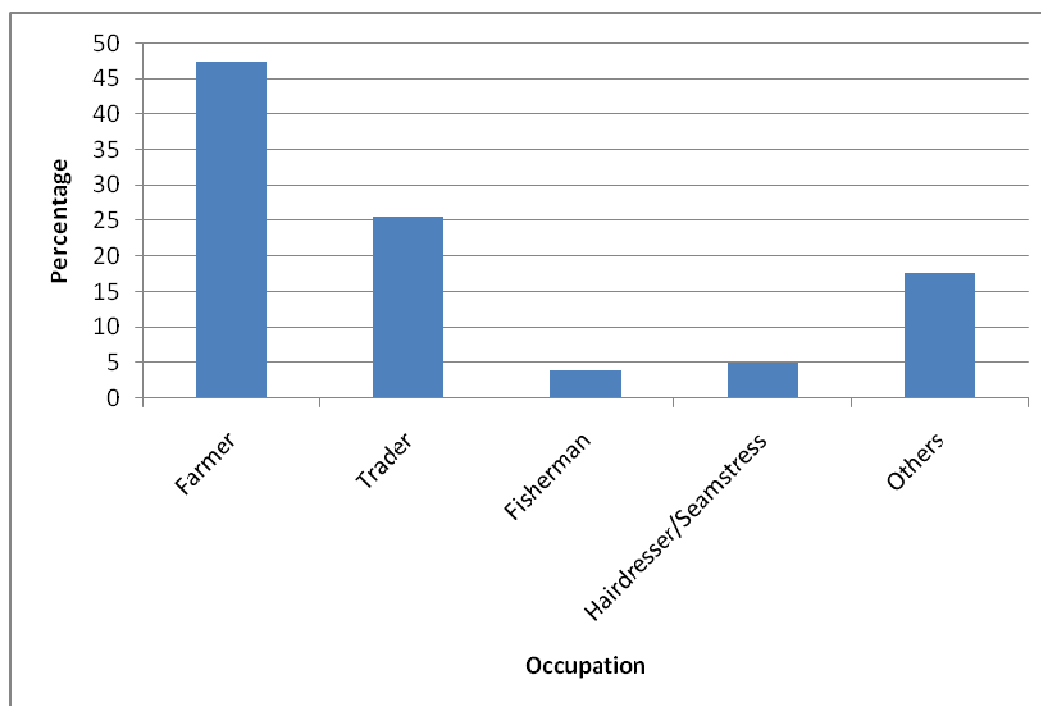
4.5 Occupational Distribution of Respondents

In Table 8, the types of occupation undertaken by respondents are shown. The majority 83 (47.4%) were farmers; traders constituted 45 (25.7%). Only 7 (4.0%) were fishermen.

Table 8: Occupational Distribution of Respondents

Table 8: Occupational Distribution of Respondents

Occupation	Farmer	Trader	Fisherman	Hairdresser/Seamstress	Others
No. Of Respondents	83	45	7	9	31
Percentage	47.4	25.7	4	5.1	17.7

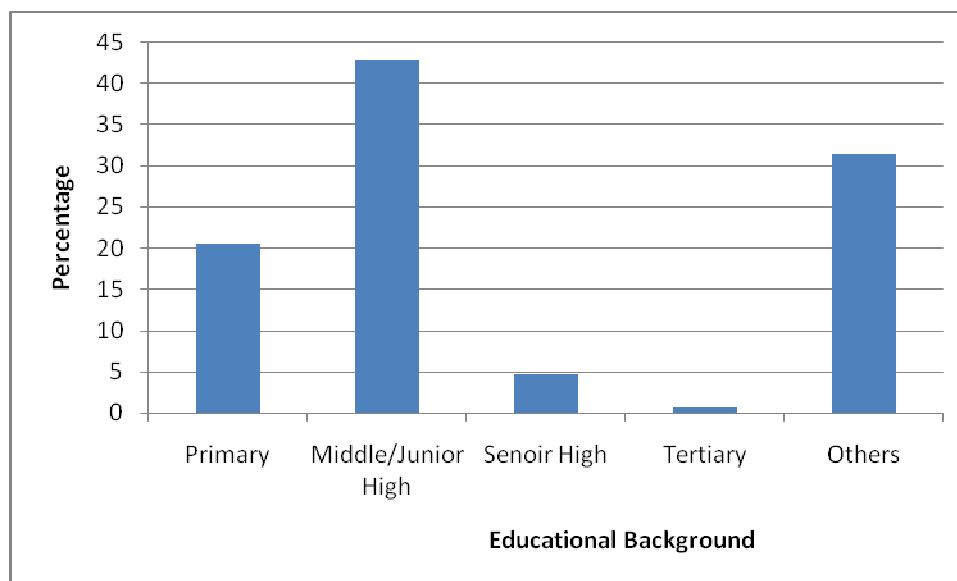


4.6 Educational Backgrounds of Respondents

An examination of the educational backgrounds in Table 9 indicates that only 1 (0.6%) has had tertiary education. Primary and Senior High school levels were 20.6% and 4.6 respectively. Those who have had no formal education were 55 (31.4%).

Table 9: Educational Backgrounds of Respondents

Educational Background	Primary	Middle/Junior High	Senior High	Tertiary	Others
No. Of Respondents	36	75	8	1	55
Percentage	20.6	42.8	4.6	0.6	31.4

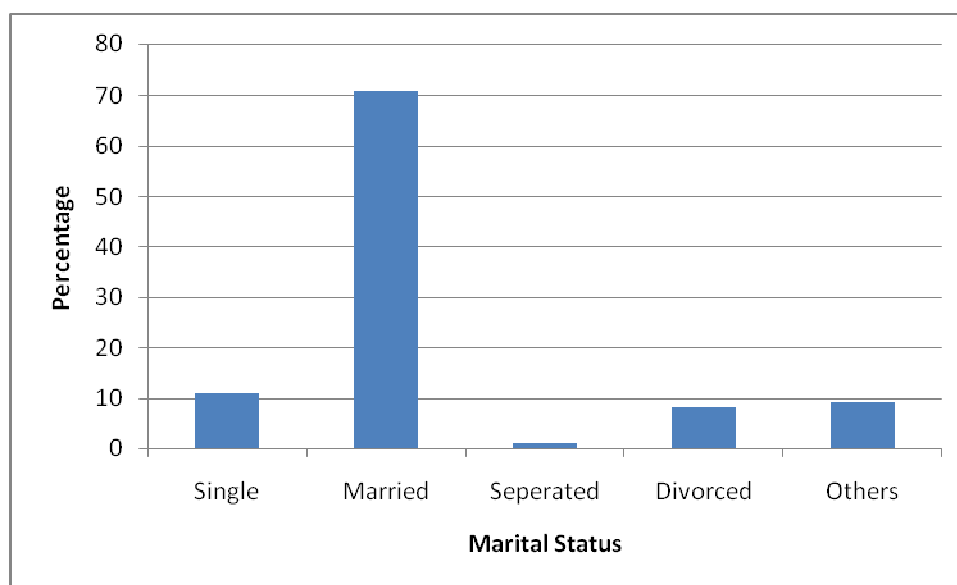


4.7 Marital Status of Respondents

The marital statuses of respondents are shown in Table 10. From the table, it is observed that 124 (70.9%) of them are married, 19 (10.9%) are single while 14 (8.0%) are divorced. The remaining were either separated or of other status not specified.

Table 10: Marital Status of Respondents

Marital Status	Single	Married	Separated	Divorced	Others
No. Of Respondents	19	124	2	14	16
Percentage	10.9	70.9	1.1	8	9.1



4.8 Utilization of CHPS services

Results in Table 11 shows that out of the 175 respondents, 117 (66.9%) indicated that they did not utilize the CHPS services often. Contrarily, 53 (30.3%) utilized the services often with a further 5 (2.9%) saying they utilized the CHPS very often. This information is shown in Table 11.

Table 11: Utilization of CHPS services

Response	Number of Respondents	%
Very Often	5	2.9
Often	53	30.3
Not Often	117	66.9
Total	175	100

4.9 Suitability of location of CHPS Facility

The findings in Table 12 clarifies information on those responding to the suitability or otherwise of the location of the CHPS facility, about 171 (97.7%) respondents said the location of the CHPS facility was suitable to them. Only 4 (2.3%) did not find the location of the facility suitable.

Table 12: Suitability of location of CHPS Facility

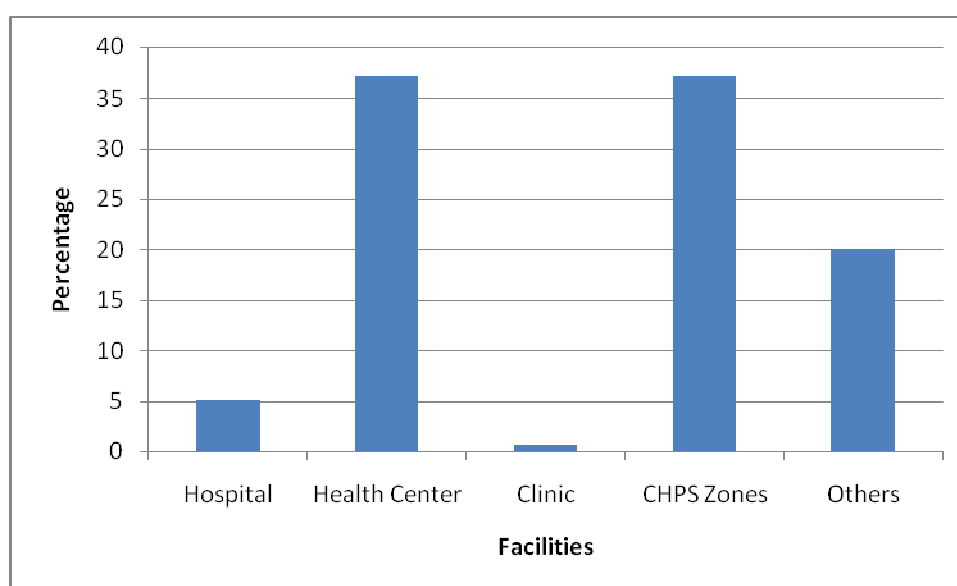
Response	Number of Respondents	%
Suitable	171	97.7
Not Suitable	4	2.3
Total	175	100

4.10 Preference for Types of Health Facility

Table 13 shows the data indicating their preferences for the types of health facilities available, 65 (37.1%) said they preferred health centres. Another 65 (37.1%) said they preferred the CHPS facility. A much smaller number of 9 (5.1) preferred hospital while only 1 (0.6%) preferred clinic. The remaining 35 (20.0%) respondents preferred treated from other sources.

Table 13: Preference for Types of Health Facility

Facility Preference	Hospital	Health Centre	Clinic	CHPS Zones	Others
No. Of Respondents	9	65	1	65	35
Percentage	5.1	37.1	0.6	37.1	20



4.11 Perception of Services Provided at the CHPS Compound

An examination of Table 14 shows the responses to the perception of the services provided by the CHPS. About 70.9% of the respondents rated the human resource situation at the CHPS zones as good. With respect to emergency services, 10.3% said it was excellent, while 20.6% said it was very poor. Drug availability was rated good as indicated by 32.6% of the respondents. The rating for customer relationship described excellent by 10.3% with a further 12.6% describing it as very poor. The availability of staff was rated by 60% of respondents as good though 12.6% said it was poor. In the same vein, facility availability was described as good by 55.4% of respondents. Availability of Equipment and Logistics were very good as indicated by 43.4% of respondents.

Table 14: Perception of Services Provided at the CHPS Compound

Service	Rating				
	Excellent	Very Good	Good	Poor	Very Poor
Human resource	1.1%	10.9%	70.9%	4.0%	13.1%
Emergency Service	10.3%	18.3%	32.6%	18.3%	20.6%
Drug Availability	5.7%	23.4%	32.6%	24.0%	14.3%
Customer relationship	10.3%	47.4%	20.6%	3.4%	12.6%
Staff Availability	2.3%	22.3%	60.0%	2.9%	12.6%
Facility Availability	1.1%	16.0%	55.4%	1.7%	25.7%
Equipment & Logistics	12.6%	43.4%	27.4%	2.3%	14.3%
Total		175		100	

4.12 The calibre of staff available at the CHPS facility

Table 15 shows the Calibre of Staff available at the CHPS facilities. The number of CHOs and CHNs were the highest number of staff at the CHPS facilities. They accounted for 88.5%. There was 1 midwife as well as 1 HEWs/BGMs. Other categories of staff were 18 (10.5%).

Table 15: The calibre of staff available at the CHPS facility

Calibre of Staff	Number of Respondents	%
Midwife	1	0.5
CHOs/CHNs	155	88.5
HEWs/BGMs	1	0.5
Others	18	10.5
Total	175	100

4.13 Level of Satisfaction of Services Rendered at the Facility

Table 16 shows the satisfaction levels of respondents with respect to the services rendered by the CHPS facilities. 65.8% of the respondents said they were satisfied with services rendered at the facility and 34.2% said they were not satisfied.

Table 16: Level of Satisfaction of Services Rendered at the Facility

Calibre of Staff	Number of Respondents	%
Satisfied	115	65.8
Not Satisfied	60	34.2
Total	175	100

4.14 Prescribed Drugs Received at the Facility

Table 17 shows the number of respondents who received all prescribed drugs. 125(71.4%) said they received all prescribed drugs and 50 respondents representing 28.6% did not receive all prescribed drug.

Table 17: Prescribed Drugs Received at the Facility

Prescribed Drugs	Number of Respondents	%
Received all prescribed drugs	125	71.4
Do not receive all prescribed drugs	50	28.6
Total	175	100

4.15 Perception of Staff Attitude towards Clients

The perception of staff attitude towards clients is presented in Table 18. The results show that a significant number of 117 (67.6%) respondents said staff attitude towards clients was good with a further 19.1 % scoring staff attitude as excellent. However 17(8.7%) saw that staff attitude as very poor.

Table 18: Perception of Staff Attitude towards Clients

Perception of Staff attitude towards Clients	Very Good	Good	Poor	Very Poor
No. Of Respondents	33	117	8	17
Percentage	19.1	67.6	4.6	8.7



4.16 Availability of Sign Post with Detailed Information

Table 19 shows the statistic of those responding to the availability or otherwise of signpost with detailed information, 61.7% of the respondents said there was visible sign post to the CHPS zone while 20.6% said there was none. However 17.7% of the respondents said they do not know of any sign post directing people to the CHPS compound.

Table 19: Availability of Sign Post with Detailed Information

Sign Post	Number of Respondents	%
Sign post available	108	61.7
No sign post available	36	20.6
Don't Know	31	17.7

Total	175	100
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4.17 Knowledge of the Operating Hours of the Facility

Table 20 indicates knowledge of operating hours of the facility. Of the total respondents, 92 (52.6%) said they are aware of the opening and closing time of the facility where as 83 (47.4%) of the respondents said they are not aware of the opening and closing time of the facility.

Table 20: Knowledge of the Operating Hours of the Facility

Operating Hours	Frequency	%
Known	92	52.6
Not Known	83	47.4
Total	175	100.0

4.18 Acceptance of Health Insurance at the Facility

Table 21 shows the responses for the acceptance or otherwise of health insurance by the CHPS staff. Of the total respondents, 62.9% indicated that the CHPS zones accepts insurance while 20.6% said the facility do not accept insurance.

Table 21: Acceptance of Health Insurance at the Facility

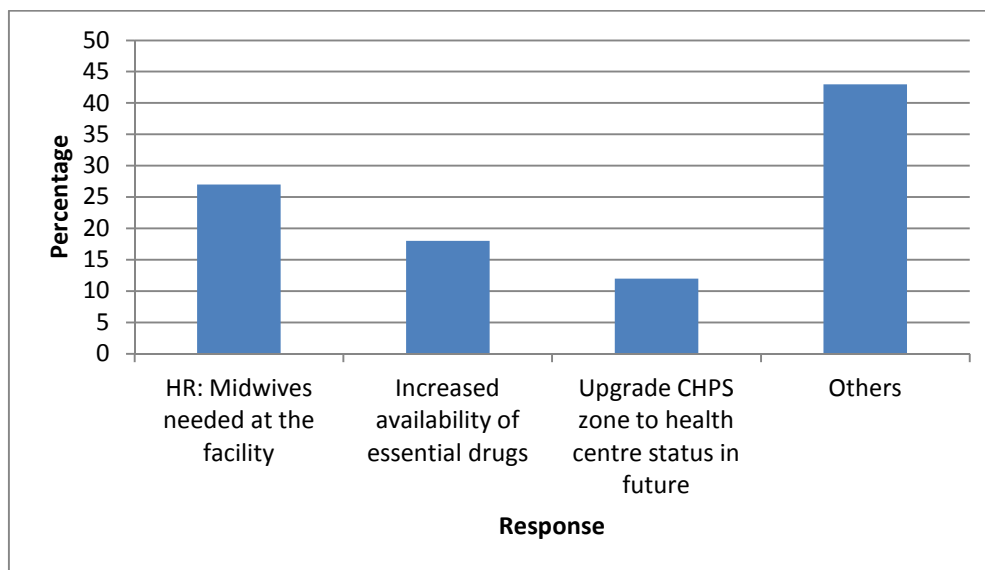
Health Insurance	Frequency	%
Facility accepted Health Insurance	131	74.9
Facility does not accept Health Insurance	44	25.1
Total	175	100.0

4.19 Suggestions to improve the utilization of services at the CHPS zone

The table 22 reveals suggestions made by respondents to improve the utilization of services at the CHPS zone. From the table below, 27% of the respondents suggested a midwife is posted to the CHPS to conduct antenatal and delivery services. Again 18% said drugs availability rates should increased, 12% said the CHPS facilities should be upgraded to health centre status, and others making 43% of the respondents mentioned the provision of generators, the beautification of the CHPS facility, provision of weekend services, provision of services at night, relocation of facility as well as provision of some infusion services at the CHPS zones as measures to enhance the utilization of services at the CHPS zones.

Table 22: Suggestions to improve the utilization of services at the CHPS zone.

Response	HR: Midwives needed at the facility	Increased availability of essential drugs	Upgrade CHPS zone to health centre status in future	Others
No. Of Respondents	47	32	21	75
Percentage	27	18	12	43



5.0 Discussion

Overall, data were collected from 175 respondents made up of 26.9% from Abeyee, 30.9% from Aburansa, 17.1% of respondents from Benyadze, and 25.1% from Brenu Akyinim. Most of the respondents (71.4%) interviewed were females. This was largely due to the fact that most of the men were not found at home during the visit to the data collection sites. It also indicates that because women are the caregivers, they were mostly at home.

More than half (61.1%) of the respondents were between the age group of 40 years and above while those under 40 years were 38.9%. Farmers constituted 47.4% of the respondents while 25.7% were traders. This was expected as most people were predominantly farmers and traders. Those who had no jobs to do were 17.7%.

Others include fishermen, hairdressers and seamstress representing 9.1%. Having more than half of the respondents (68.6%) as having some form of formal education influenced the health seeking behaviour of the people and importantly how to prevent and promote good health. For the utilization of CHPS services however, it was revealed that 92.6% of respondents did not know or have any understanding of CHPS concept. Only 7.4% understood CHPS as Community-based Health Planning and Services.

About 60 respondents representing 34.3% claimed that the CHPS zone provides accessible health care services to the community as confirmed by Nyonator (2003) that the CHPS system was adopted to improve access. Significantly, about 104 (59.4%) respondents mentioned that it provided immediate and timely health care services to the community hence admitting the relevance of CHPS to themselves as well as their respective communities.

With respect to staff attitude toward clients, 67.6% said it was good. However when probed as to why they did not fully utilize the CHPS facility, reasons as non accreditation by NHIS to facility, unavailability of midwives, services being seen mainly as meant for women and children, irregular services, unavailability of drugs at the facility, the fear of blood by some nurses as well as the facility not running hypertension clinic and not having hypertensive drugs were cited. This explanation disputes the fact that CHPS came to change focus on clinical care at district and sub-district levels to a new focus on suitable and quality services at community and doorstep levels as said by (Nyonator, 2006). Though the focus was on home visit, it is seen as a clinically based facility.

A significant number, 171 (97.7%) of the respondents said the CHPS facilities are located at the place of their choice as against only 2.3% who did not like the location of the facility. More so, 37.1% of the respondents preferred the health centre at the same time 37.1% also visited the CHPS zone for their health needs. However, about 20% of the respondents preferred other places such as pharmacy shops, Faith Based Organizations (Camps) and private individuals (retired nurses) in the community for health care.

With respect to the perception of services provided at the CHPS compound, most of the respondents said the CHPS compound is easy to access in time of health need therefore believes that immediate health care services are made available to them. Some respondents indicated also that through the CHPS programme health promotion activities are going on, treatment of minor ailments, but were concerned about delays at the facility. Some respondents were also quick to add that services at the CHPS centre were too limited or few.

Majority (70.9%) of the respondents rated the human resource situation at the CHPS zones as good. Again most of the respondents (61.2%) have rated emergency service as good, very good and even excellent at the CHPS Centre. On the other hand, about 14.3% of the respondents said drug availability was very poor. A

total of 47.4 % of the respondents said the customer relationship at the CHPS centre was very good and 60% of the respondents said staff availability was good and 12.6% said it was very poor.

With respect to facility availability at the time of need, 55.4% said it was good whereas only a few thus 1.7% said it was poor. Again about 43.4% of the respondents said equipments and logistics were very good whereas only 2.3% said it was poor. In the case of the calibre of staff at the centres, 88.5% of the respondents mentioned the CHOs/CHNs as the main calibre of staff available at the CHPS centre whilst the minority thus 0.5% mentioned midwife; 0.5% Health Extension Worker or Better Ghana Management Service worker. Others who did not know the calibre of health staff accounted for 10.5%. This means that the community is very much aware of the type of workers at the facility.

In relation to the factors affecting utilization, it is important to note that whenever clients are satisfied with services they received not only will they come back for your good service but would inform others also to attend the facility to see for themselves. This however was shown in majority thus 65.8% of the respondent saying they were satisfied with services at the CHPS zone and 71.4% of the same respondents admits they receive all prescribed drugs whenever they visit the CHPS facility. It is important to note about 67.6% of the respondent said the attitude of staff was good whereas only a few (4.6%) said the attitude of staff was poor. This was attributed to long waiting time and very poor reception they receive sometimes when they visit the CHPS facility.

About 62.4% of the respondents said there was visible sign post to the CHPS zone whilst 20.8% said there was none. However, 16.8% of the respondents said they do not know of any sign post directing people to the CHPS zones. The results also revealed that 47.7% of the respondents were not aware of the opening and closing time of the facility. With the question of whether the CHPS facility accepts health insurance or not, 74.9% of the respondents answered yes while 25.1% said the facility did not accept health insurance.

27% of the respondents suggested a midwife is posted to the CHPS to conduct antenatal and delivery services. Again 18% said drugs availability rates should increase, 12% said the CHPS facilities should be upgraded to health centre status, and others (43% of the respondents) mentioned the provision of generators, the beautification of the CHPS facility, provision of weekend services, provision of services at night, relocation of facility as well as provision of some infusion services at the CHPS zones as measures to enhance the utilization of services.

6.0 Conclusions and Recommendation

6.1 Conclusion

From the study the following conclusions were drawn.

1. Utilization of CHPS services has been good. However, most of the respondents do not know nor understand the CHPS concept.
2. Drug unavailability, lack of midwifery services, poor staff attitude and the fear of blood by some nurses were challenges in the utilization of CHPS services in the municipality.
3. Non acceptance or use of Health Insurance Card due to lack of accreditation was also of a great concern.
4. Delays in the treatment of minor ailment and eventual referral to hospital were deterrent factors to the use of CHPS facility.

6.2. Recommendation

Considering the findings and conclusions drawn from the study, the following recommendations are made.

1. There is the need for the Municipal Health Directorate to intensify supportive monitoring and supervision visits to all health facilities every quarter especially the CHPS zones.
2. The Municipal Health Directorate should organize a client satisfaction survey to find out the level of satisfaction of the CHPS in the municipality.
3. The Municipal Health Directorate should facilitate the NHIS accreditation process for Brenu Akyinim CHPS zone.
4. Drug availability rate should be improved in all the CHPS zones especially the basic and very essential drugs.
5. The Sub Municipal Health Management Team (SMHMT) should institute regular in service training programme for staff on the code of conduct.
6. The MHD should collaborate with the Municipal Assembly to renovate the CHPS compound at Benyadze.
7. The MHD should ensure the citing of sign post at vantage points to show direction and provide information on the CHPS zones in the Municipality.
9. CHOs should be trained as midwives to improve skilled delivery services.

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QUESTIONNAIRE

Section A: Demographic Characteristics of respondents

1. Community Name
2. Gender
 - a. Male
 - b. Female
3. Age
4. Occupation
 - a. Farmer
 - b. Trader
 - c. Fisherman
 - d. Hairdresser/ Seamstress
 - e. Others specify
5. Education
 - a. Primary
 - b. Middle/JHS
 - c. SHS
 - d. Tertiary
 - e. Others specify
6. Marital Status
 - a. Single
 - b. Married
 - c. Separated
 - d. Divorced
 - e. Widow/Widower
 - f. Other specify

Section B: The usage of CHPS services

7. What is your understanding of CHPs?
 - a. Community Based Health Planning Services
 - b. Community Implementation of Health Planning Services
 - c. Don't Know
 - d. Other specify
8. How relevant is the CHPS centre to you and the community?
 - a. Provides accessible health care services to the community
 - b. Provides immediate and timely health care services to the community
 - c. Don't Know
 - d. Other specify
9. How often do you access this facility?
 - a. Very Often
 - b. Often
 - c. Not Often
10. Give reason (s) if your answer to Q 9 is 'Not often'

11. In your opinion, is the facility located at the place of your choice?
 - a. Yes
 - b. No
12. If NO, state the place (local area) of your choice in your locality where the facility can be located

13. Where do you often go for your health needs?
 - a. Hospital
 - b. Health Centre
 - c. Clinic
 - d. CHPS Centre
 - e. Other specify

Section C: Perception of Community on CHPS Services

14. What is your perception of services provided at the CHPs compound?

15. How do you rate the following items relative to service provision at the CHPs centre?
 Tick appropriately

	Items	Very High	High	Moderate	Poor	Not Applicable
a	Human Resource (Staff)					
b	Emergency service					
c	Drug availability					
d	Staff- Customer relationship					
e	Staff availability					
F	Facility availability (for service provision)					
g	Equipment & logistics (Weighing Scale, BP Apparatus, Thermometer etc.)					

16. How many staffs are there at the CHPs compound?
a. One b. Two c. Three d. Four
e. Others specify.....

17. What cadres of staff are available at the CHPS compound?
a. Midwives b. CHOs/ CHNs c. HEWs d. BGMS Others Specify.....

18. Have you attended the facility in an emergency situation in the last 6 months?
a. Yes b. No

If the response is 'No' to Q18 Skip Q19 to Q24

19. If yes, have you been attended to promptly?
a. Yes b. No

20. If No, give reasons why you were not attended to promptly
.....

21. Then, are you satisfy at this level with the services rendered at the facility?
a. Yes b. No

22. Whenever you attend the facility do you received all prescribed drugs?
a. Yes b. No

23. If No, what was the reason?
.....

24. How would you describe the attitude of staff?
a. Very good b. Good c. Poor d. Not applicable

25. If poor give reasons

26. Is there a visible sign post/ sign board mounted with detailed information on the facility?
a. Yes b. No c. Don't Know/ not aware

Section D: Factors Associated With Utilization of CHPS Services

27. Are you aware of the opening and closing time of the facility?
a. Yes b. No

28. Does your facility accept health insurance?
a. Yes b. No c. Don't Know

29. If no, why?
.....

30. In your estimation, what are (is) your suggestions for improvement on the utilization of services at the CHPS compound?
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