

Improving the Effectiveness of Mass Long-Lasting Insecticide-Treated Net Distribution Campaigns through Community-Based Health Planning and Services Programme in Ghana (MY-CAMP Project)

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Abstract

Background: Mass long-lasting insecticide net (LLIN) distribution campaigns apply comprehensive stakeholder engagement approaches; however, this approach has not systematically been transitioned into the primary healthcare structures within Ghana Health Services (Community-based Health Planning and Services, CHPS). The aim of this study was to co-create a stakeholder and community-based intervention to transition the mass LLIN distribution campaigns within the CHPS programme in Ghana.

Methods: A concurrent triangulation mixed methods approach across six districts in the Eastern and Volta regions, Ghana, was used. A desk review, baseline and end-line surveys (n=800), key informant interviews (KII, n=10), 6 community health officers focus group discussions (FGD, n=37), 6 household heads focus group discussions (FGD, n=60), 8 caregivers of children under 5 focus group discussions (FGD, n= 69), and 6 community stakeholders participatory workshops (16-17 participants per workshop) were used to collect data.

Results: Results of the desk review showed that even though most households receive LLINs for free, continuous social and behavioural change communication (SBCC) activities are needed to promote use among beneficiaries. Community FGDs revealed that some community members (i.e., traditional authorities, volunteers, etc.) are engaged to support the campaign, yet, there are negative perceptions and misunderstandings surrounding LLIN campaign processes within these communities. Through participatory workshops, considering formative findings, an intervention (Community Health Advocacy Team – CHAT) was co-created by community, district and regional stakeholders alongside project investigators. The CHAT is a nine-member team that comprises community actors, with the community health officer as the co-convenor to provide support for LLIN distribution campaigns, as well as plan and lead SBCC activities on regular LLIN use within communities. After successful implementation of the CHAT intervention for four months, 90% of community members in all six districts perceived the intervention to be an acceptable, appropriate and feasible approach to transition the LLIN campaign into CHPS.

Conclusion: The CHAT intervention was accepted by community members in the six study districts and deemed as an appropriate approach to transition the mass LLIN distribution campaigns into the CHPS programme.

Introduction and Background

The use of long-lasting insecticide-treated net (LLIN) has been identified by the World Health Organization (WHO) as an effective approach for malaria prevention [1]. In line with the Ghana Malaria Strategic plan (2021-2025), the mass LLIN distribution campaign seeks to protect at least 80% of the population at risk with effective malaria prevention interventions, through household registration (90%) and distribution (90%) in target regions, by adopting WHO's universal coverage policy [2]. The National Malaria Control Programme (NMCP) is solely responsible for the implementation of the LLIN distribution campaign in Ghana [3]. Over the years, the NMCP, together with its partners, continues to scale up LLIN

ownership. From 2010 to 2012, there was nationwide LLIN door-to-door mass distribution with a hang-up campaign. This was followed by another point mass distribution (PMD) campaign in 2018, which used technology in the capture and management of registration and distribution data via a mobile application software (i.e., NetApp) and was repeated every three years. (Point mass distribution (PMD) of LLINs is one of the strategies adopted by Ghana to make nets available to households throughout the country, as part of efforts to achieve universal coverage of LLINs.) Apart from the PMD, there is the continuous distribution to pregnant women during antenatal, children under five during postnatal and students via the School Health Education Programme. Despite the progress made in overall LLIN ownership over the years, the challenge remains to reach the target of 80% utilisation amongst pregnant women and children under 5 years as outlined in the National Malaria Control Programme (NMCP) Strategic Plan [3,4]. Also, the 2019 Ghana Malaria Indicator Survey shows that 67% of household residents in Ghana indicated they had at least one LLIN, however, only 43% slept under a LLIN the night before the survey [4]. Though these campaigns reach high proportions of the Ghanaian community with LLINs, they hardly lead to desired health-related behaviours regarding use (i.e., 43% of the household population, 54% of children under age 5 and 49% of pregnant women slept under an ITN the night before the survey)[4].

Ghana adopted the Community-based Health Planning and Services Program (CHPS) as a primary healthcare system in 2005 to ensure accessible, equitable, efficient and good quality health care services [5,6]. The CHPS concept involves the provision of door-to-door primary health care services to community members by trained nurses known as community health officers (CHOs) and has proven to be successful in providing maternal, reproductive and child health services in communities where they are much-needed [5-8]. The main source of funding for the CHPS is the Ministry of Health In Ghana and according to the 2022 budget and economic policy of the Government of Ghana, the budget allocation for education and health service delivery was GHS 808.61 million [9]. Despite its established structures in enhancing community involvement and ownership of primary health care in Ghana, the PMD and continuous distribution of LLINs is not well integrated into the CHPS structures. To ensure sustainability and continuous community engagement through SBCC activities on regular use of LLINs, there is the need to transition the mass distribution campaign into the CHPS programme. This would help reduce the overall gap between access and use of LLINs and achieve the desired health-related behaviours. This study, therefore, assessed the real-life implementation of the 2021 point mass LLIN distribution campaign to prioritize contextual factors and co-create innovative implementation strategies through a reiterative refinement process, to ensure effective transitioning into the CHPS programme.

Study Objectives

1. Assess the LLINs campaign implementation processes at the community level to identify stages involved in the delivery of LLINs by end of August 2021.
2. Identify potential enablers and barriers within the CHPS programme to determine institutional structures that can be leveraged/addressed to support the implementation of mass LLIN distribution campaigns to improve the use of LLINs by end of August 2021.

3. Prioritize contextual factors and implementation processes to transition the LLIN campaign into CHPS to increase household use of LLINs through stakeholder engagement, by end of September 2021.
4. Co-create interventions (i.e., capacity building for community health officers (CHOs), community mobilization) to strengthen the mass LLIN distribution campaign, by the end of October 2021, to increase the use of LLINs within households.
5. Assess the acceptability and appropriateness of co-created campaign interventions (i.e., capacity building for CHOs, community mobilization) through the conduct of community surveys and interviews by end of February 2022.
6. Assess the feasibility of transitioning the co-created interventions (i.e., capacity building for CHOs, community mobilization) into primary health care delivery through the conduct of key informant interviews among healthcare workers by end of May 2022.

Methods

Study design

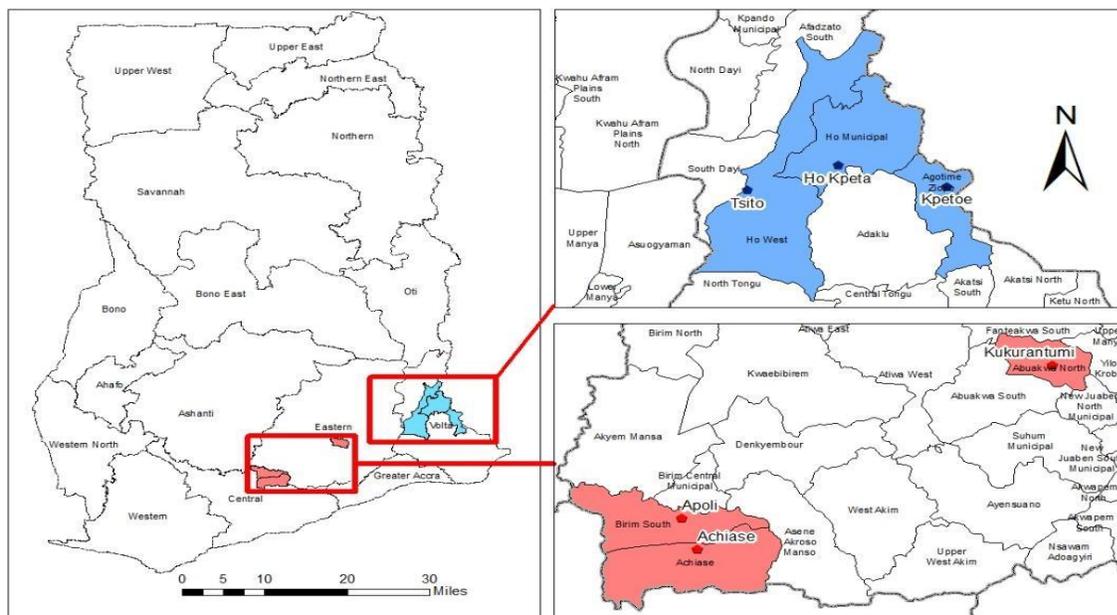
The study employed a concurrent triangulation mixed methods research design, involving participatory approaches within an implementation research framework. A desk review, survey, in-depth Interviews (IDIs), key informant interviews (KIIs), focus group discussions (FGDs), and participatory workshops (PWs) approaches were used to collect data. Ethical clearance was obtained from the Ghana Health Service Ethics Review Committee (GHS-ERC: 002/06/21). All participants involved in the study provided written informed consent before participating in the study.

Study site

The study sites included six communities, across two regions (Eastern and Volta) in southern Ghana. These were communities in districts where (1) the 2021 point mass distribution (PMD) campaigns of LLINs were ongoing and (2) had recorded the highest prevalence of malaria as reported in the District Health Information Management System (DHIMS2): Ho West (Tsito-90%), Ho (Takla Hokpeta-75%) and Agortime Ziope (Kpetoe-100%) in the Volta Region; and Birim South (Apoli-94%), Achiase (Achiase-94%) and Abuakwa North (Kukurantumi-93%) in the Eastern Region [NB: Percentages represents malaria prevalence]

See the next page for a map of the six study sites.

Figure 1: Location of the six study sites in the Eastern and Volta Regions of Ghana.



Sample Size, Sampling Method and Data Collection

The sample size for the survey was 800 (i.e., 400 per region) respondents across the six districts. The sample size for the qualitative component of the study was 176 participants. This comprised of ten KIIs (n=10) and twenty FGDs (n=166) from six communities in the Volta and Eastern Regions.

The data collection methods included:

- A desk review which included a comprehensive literature search and review to identify relevant published and grey literature on potential barriers, enablers, lessons learnt and recommendations from similar interventions.
- A baseline survey (800 participants) conducted across the six districts to identify baseline parameters to be used for assessing the effectiveness of our co-created intervention.
- An end-line survey (800 participants) to measure the effectiveness of the intervention.

The survey data were collected using REDCap software on Android tablets. In addition, key informant interviews were conducted with respondents who were purposely selected. These included NMCP and Ghana Health Service focal persons at the regional and district levels of the study regions to assess LLIN campaign delivery processes. In addition, FGDs were organized to contextualize and explore the barriers to, and enablers of mass LLIN distribution campaigns in the context of community mobilization, capacity building and SBCC. FGDs involved purposely selected household heads (6), caregivers of children under 5 (8), and community health officers (6).

Findings from the desk review, FGDs, KIIs, and baseline surveys were synthesized, grouped and further distilled to guide the participatory co-creation workshops. Co-creation involved participatory workshops

(PW) including various stakeholders (i.e., investigators, NGO representatives, School Health Education Programme Coordinators, ANC nurses, Disease Control Officers, District Health Management Teams (DHMTs), CHOs, community leaders and opinion leaders). Six participatory workshops (16-17 participants per workshop) were conducted in the six study communities (i.e., one PW per community) employing the participatory learning-in-action technique which is a practical, adaptive research strategy which enables diverse groups and individuals to learn, work and act together cooperatively.

Findings from the participatory workshop suggested that the establishment of a Community Health Advocacy Team (CHAT) was necessary for facilitating LLIN distribution campaigns within communities in Ghana. CHAT is made up of significant actors whose influences are recognised within communities. They include CHOs, religious leaders, school health education programme coordinators, assemblymen/women, community information officers, representatives from any of the security services, CBOs and traditional authorities. The CHAT received capacity training in identified areas relevant for supporting National Malaria Control Programme (NMCP) agenda in areas of community/social mobilisation, capacity building and SBCC which will lead to improved use of LLINs.

Data Processing and Analysis

Both quantitative and qualitative data collected were managed, cleaned and stored by the University of Ghana, School of Public Health (UG-SPH) MY-CAMP project team in Ghana. The data was stored on the University of Ghana OneDrive business account and password-protected with access to only the MY-CAMP project team (i.e., Project PI, Co-PIs and Project manager). Data analysis was conducted by the Project PI, Co-PIs and Project manager. The quantitative data was analyzed statistically (chi-square analysis) using the SPSS 22 software. All audio recordings of the qualitative data were transcribed verbatim, coded with the aid of a codebook and analyzed thematically, and managed using the NVivo software version 13.

Results

Objective 1: LLIN Campaign implementation processes: stages involved in the delivery of LLINs

From the desk review, sources of LLINs from recent nationally representative data sets such as the Demographic and Health Survey, Multiple Indicator Cluster Surveys and Malaria Indicator Survey indicate that majority of households receive LLINs for free from the public sector which includes the mass campaign and continuous distribution channels. Very few households purchase LLINs from various sale points. Continuous distribution of LLINs to the population most vulnerable to malaria done through ANC, CWC and schools complements the mass distribution campaign and ensures an uninterrupted supply of LLINs. The desk review also revealed that LLINs distribution without LLIN hang-up activities make beneficiaries less likely to use LLINs. Hang-up activities implemented by community health officers during home visits provide opportunities for effective interaction with community members to increase malaria knowledge or emphasise specific behaviours.

Furthermore, desk review findings show that there are SBCC activities that are rolled out during the net distribution campaign in Ghana and other parts of the world. Continuous education and reminders strengthen community members' capacity to lead sustainable and effective measures, which can reduce and eventually eliminate malaria transmission.

Results from the community FGDs revealed that LLINs campaign implementation at the community level is driven by social and behaviour change communication strategies which use multiple channels (e.g., community information centre, radio) to support household registration and distribution. The campaign adopts pedagogical approaches (e.g., outreach) to promote awareness and knowledge of LLINs, as well as use among community members. Although some community members (i.e., traditional authorities, volunteers, etc.) are engaged to support the campaign processes, there are negative perceptions and misunderstandings surrounding LLINs campaign processes within these communities. For instance, the rushed implementation of the campaign creates the negative perception of nets being dumped at the community level. Relatedly, there are misunderstandings about the criteria (2:1) used to determine the number of LLINs per household, since some community members expect a 1:1 criterion for distribution. Also, some male community members mentioned the campaign's heavy attention on women, as against men.

Objective 2: Potential enablers and barriers within the CHPS programme that can be leveraged/addressed to support the implementation of mass LLIN distribution campaigns to improve the use of LLINs

Table 1: Potential enablers and barriers within the CHPS programme

No.	Enablers	Barriers
1.	Community receptiveness to the CHPS concept.	Some communities are hard to reach, making it difficult to effectively carry out health-related activities in these communities.
2.	Community presence of the community health officers.	Inadequate staff capacity.
3.	Community health officers who provide services at the CHPS compound have competency in the language spoken in their communities.	Lack of accommodation for community health officers within the communities.
4.	Community health officers in their various communities are able to facilitate interactions with the people in the community.	The Community Information Centers (CICs) require payment of fees for the facility to be used.
5.	Awareness creation on health-related activities including the mass LLIN distribution campaign by community health officers.	

6.	Continuous distribution of LLINs through ANC, CWC and schools complements the mass distribution campaign and ensures uninterrupted supply for the population most vulnerable to malaria.	
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Socio-demographic characteristics of study participants can be found in the appendix (Tables 2-5)

- Table 2: Sociodemographic Characteristics of Household Heads (HH) and Caregivers of Children under 5 Years (appendix)
- Table 3: Sociodemographic Characteristics of Community Health Officers (CHOs) (appendix)
- Table 4: Sociodemographic Characteristics of Participants for Key Informant Interviews (appendix)
- Table 5: Sociodemographic Characteristics of Survey Respondents (appendix)

Objective 3: Prioritise contextual factors and implementation processes

Table 6: Priority Matrix (see appendix)

The result showed the need to develop a community-based intervention to support the distribution of the bed nets through continuous SBCC on regular use by community members.

Objective 4: Co-created intervention and the mass LLIN distribution campaign

The role of the CHAT includes community/social mobilisation, capacity building, social and behaviour change communication, focusing on LLIN use, and malaria education and prevention. Furthermore, the CHAT is required to convene quarterly meetings, led preferably by a community health officer. Also, by consensus, it was agreed that CHAT members work voluntarily. However, CHAT members could be motivated tangibly (e.g., receiving branded souvenirs such as T-shirts and caps, citations or awards as a form of appreciation, etc.) or intangibly (e.g., acknowledgement/words of affirmation or praise/moral support) from community leaders, including the District Health Directorate. The ultimate aim of the CHAT is to support the National Malaria Control Programme to transition LLINs distribution campaign to CHPS and continue with SBCC activities at the community level post point mass distribution campaigns. This would help reduce the gap between access and use of LLINs in the communities. Detailed information about the CHAT has been published elsewhere [10].

Objectives 5 & 6: The acceptability and appropriateness of the co-created campaign intervention (CHAT) and the feasibility of transitioning into CHPS

After implementing the intervention (CHAT) for four months, Chi-square analysis of the endline survey data showed that, about 90% (i.e., 89.8 % for acceptability, 89.5% for appropriateness and 90% for feasibility) of community members thought that the intervention was acceptable, appropriate and feasible (**see Table 7 in the appendix**). When disaggregated by district, the same findings ran through for the majority of community members in all six districts (Table 8 attached as an appendix).

Communities that recorded higher frequency of acceptability, appropriateness and feasibility had more

community members aware of, participating, and engaging in SBCC activities organized by the CHAT compared to communities where the community members had not heard much about the CHAT or participating and engaging in CHAT SBCC activities. Notwithstanding these successes, the CHAT intervention needs to be assessed for its effectiveness, costs, and cost effectiveness in a rigorous type 2 hybrid trial across Ghana in order to provide convincing evidence for its adoption into policy.

Promising Practices

1. This community-based advocacy team (CHAT) is able to plan and carry out social and behavioural change communication activities to increase bed net use and reduce repurposing of nets received.
2. High participation in the activities of CHAT by community members can sustain a positive attitude towards bed net use.
3. The team can be used to champion other community-based health interventions.
4. The CHAT team can be integrated into the existing Community Health Committees.

Lessons Learned

1. Continuously engage community members to properly educate, promote, and monitor the use of nets, whilst deterring misuse of LLINs in the communities.
2. Maximise the use of the Community Information Centres for the mass LLIN distribution campaigns.
3. When community stakeholders are systematically constituted within the Community Health Management Team (CHMT), it can sustain LLINs use in the communities.

Implications for Policy, Practice and Future Research

1. Integrate the Community Health Advocacy Team (CHAT) to strengthen the Community-based Health Planning and Services (CHPS)- CHAT will focus on LLINs use/malaria prevention, and their capacity regularly strengthened .
2. Consider reconstituting the Community Health Committee (CHC) to include the CHAT. This could be re-aligned so that the CHAT will be a sub-committee or team focusing on malaria control.
3. Determine how to mobilise funds to sustain the activities of CHAT.
4. Determine the effectiveness, cost, and cost-effectiveness of the CHAT across Ghana.
5. Matching of baseline and end-line survey data should be considered in evaluating the long-term impact of CHAT.

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and Abuakwa North districts, CHAT members, as well as community members who committed time to share experiences and provide data for this study. We are also grateful to the field staff for their meticulous work during data collection.

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Note: The appendix of tools/instruments is a separate document.

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Appendix

Socio-Demographic Characteristics of Qualitative Participants (HH & CG)

Caregivers of Children Under 5 Years and Household Heads

A total of sixty-nine (69) caregivers of children under 5years (CG) and sixty (60) household heads (HH) were sampled from six different communities in the Eastern and Volta Regions of Ghana to participate in the focus group discussions for this study.

All participants for caregivers of children under 5years were females (69). Also, many (27) of the participants' age ranged between 30 to 39years. The highest level of education recorded among these participants was secondary level (46), with few (8) attaining tertiary level education. A majority (40) of the participants were married and the highest number of children recorded per participant was 8. Many of the participants were traders/artisans (25) and farmers (19) and the highest length of stay in the community recorded among these participants was 74years with the least being 3years.

For household heads, nineteen (19) of the participants were females with the majority (41) being males. Also, many (32) of the participants' age ranged above 50 years. Thirty-one (31) participants attained secondary level education with few (9) having no formal education. A majority (51) of the participants were married and the highest number of children recorded per participant was 9. Many of the participants were farmers (25) and traders/artisans (24) with a few pensioners (4) and unemployed (2). The highest length of stay in the community recorded among the participants was 81 years with the least being 5years.

Table 2: Socio-Demographic Characteristics of Participants (Caregivers of Children Under 5years and Household Heads)

Characteristics of Participants	Number of Participants		
	CG (FGDs)	HH (FGDs)	Total (CG &HH)
Community of Residence			
<i>Eastern Region</i>			
Kukurantumi	-	20	20
Achiase	16	-	16
Apoli	18	16	34
<i>Volta Region</i>			
HoKpetta-Takla	22	13	35
Tsito	-	11	11
Kpetoe	13	-	13
Total	69	60	129
Sex			
Female	69	19	88
Male	-	41	41
Total	69	60	129
Age			
>20years	7	-	7
20-29years	25	-	25
30-39years	27	13	40
40-49years	6	15	21
50+years	4	32	36
Total	69	60	129
Educational Level			
No formal education	-	9	9
Primary	15	12	27
JHS/Secondary/Middle School	46	31	77
Tertiary	8	8	16
Total	69	60	129

Continued

Marital Status

Single	14	4	18
Cohabiting	10	-	10
Married	40	51	91
Divorced/Widowed/Separated	5	5	10
Total	69	60	129

No. of Children

<5	56	1	57
5-9	13	39	52
10+	-	20	20
Total	69	60	129

Occupation

Unemployed	17	2	19
Petty trading/Artisan	25	24	49
Farming	19	25	44
Formal Employment	7	5	12
Retired	1	4	5
Total	69	60	129

Length of Stay in Community

<5years	3	-	3
5-9years	21	10	31
10+years	45	50	95
Total	69	60	129

Socio-Demographic Characteristics of Qualitative Participants (CHOs)

Community Health Officers (CHOs)

A total of thirty-seven (37) Community Health Officers (CHOs) were sampled to participate in the focus group discussions held in six different communities in the Eastern and Volta Regions of Ghana. Many of these participants were females (30) with a few being males (7). Also, many (18) of the participants' age ranged between 20 to 29years, with a few (2) having an age range between 40 to 58years. All participants in this category attained tertiary level education.

A majority (23) of the participants were single and the highest length of stay in the community recorded among participants was 30years and the least being 6months.

Table 3: Socio-Demographic Characteristics of Participants (Community Health Officers)

Characteristics of Participants	Number of Participants (FGD)
Community of Residence	
<i>Eastern Region</i>	
Kukurantumi	5
Achiase	8
Apoli	8
<i>Volta Region</i>	
HoKpete-Takla	8
Tsito	5
Kpetoe	3
Total	37
Sex	
Female	30
Male	7
Total	37
Age	
20-29years	18
30-39years	17
40-49years	1
50+years	1
Total	37
Educational Level	
Primary	-
JHS/Secondary/Middle School	-
Tertiary	-
Total	37
Marital Status	
Single	23
Married	14
Divorced/Widowed/Separated	-
Total	37

Continued

Length of Stay in Community

<5years	23
>5-10years	8
>10+years	6
Total	37

Socio-Demographic Characteristics of Qualitative Participants (KIIs)

Key Informants

Ten (10) representatives from NMCP and GHS at the regional and district levels were sampled from the Eastern and Volta regions to participate in the key informant interviews for this study.

Six (6) of the participants were females. Many (6) of the participants' age ranged between 30-39 years and all participants have attained tertiary level education.

Six (6) out of the ten (10) participants were married and the highest length of stay in the community recorded among the participants was 11 years with the least being 2 years.

Table 4: Socio-Demographic Characteristics of Participants (NMCP and GHS Representatives)

Characteristics of Participants	Number of Participants (KII)
Community/Region of Residence	
Eastern Region	5
Volta Region	5
Total	10
Sex	
Female	6
Male	4
Total	10
Age	
20-29years	1
30-39years	6
40-49years	3
50+years	-
Total	10
Educational Level	
Primary	-
JHS/Secondary/Middle School	-
Tertiary	10
Total	10
Marital Status	
Single	4
Married	6
Divorced/Widowed/Separated	-
Total	10
Length of Stay in Community	
2-5years	7
6-9years	3
10+years	1
Total	10

Table 5: Participants in baseline and endline survey by district and sex

		Sex					
		Baseline (N = 800)			Endline (N = 800)		
		Male	Female	Total	Male	Female	Total
District/	Ho West (Tsito) ¹	39	94	133	45	91	136
Municipality	Agotime Ziope (Kpetoe) ¹	28	107	135	34	98	132
	Ho (Hokpeta) ¹	43	87	130	41	89	130
	Birim South (Apoli) ²	57	69	126	48	76	124
	Achiase (Achiase) ²	36	100	136	28	109	137
	Abuakwa North (Kukurantumi) ²	36	98	134	36	97	133
Total		239	555	794	232	560	792

¹Volta Region; ²Eastern Region

Table 6: MY-CAMP PROJECT PRIORITY MATRIX

The priority matrix below is based the LLINs campaign processes by the National Malaria Control Programme (NMCP) for the Point Mass Distribution (PMD).

LLINs IMPLEMENTATION PROCESSES IN THE CONTEXT OF CHPS	Current Practices	Impact (0-10) 0 = No Impact 10 = Maximum Impact	Effort (0-10) 0 = No Effort 10 = Maximum Efforts	Total Score	Designation
LLINs IMPLEMENTATION					
Recruiting volunteers		9	9	18	Major project
Training	Training conducted for two days. It may be difficult for new recruits to comprehend the process well. More effort is required but with less impact	4	9		Thankless task
Registration/Household listing	Listing of households to determine number of bednets required. This involves a lot of efforts with high impact in allocation of appropriate numbers to every community	8	10	18	Major project
Logistics and supplies	This are distributed to designated community sites for door-to-door distribution	9	9	18	Major Project
Social and Behavioural Communication	Pre-distribution During distribution Post distribution. Pay for one off activities	6	9	15	Major project
Distribution	Use of volunteers recruited purposely for the distribution	9	9	18	Major Project
Monitoring and evaluation	Conducted by workers from the district, regional and national.	5	10	15	Major Project
Post distribution monitoring for use	Not done	2	0		Thankless Task
COMMUNITY-BASED HEALTH PLANNING AND SERVICES STRUCTURE					
CHPS is community-based	Nurses with aid of health committee and volunteers render all year-round door to door service	10	2	12	Quick win
CHPS is Ghana Primary Health Care System	CHPS has adopted to improve access to basic health care and health promotion activities at community level	10	2	12	Quick win
Routine health education to community (continuous health education)	CHOs provide daily health education to community members using culturally appropriate strategies. Low knowledge on care of net reported as barrier to use	10	2	12	Quick win
Continuous updates of household information by community volunteer	This practice ensure data is available at all times	9	3	13	Quick win
Sustainability	Integrated into already existing CHPS structures makes it sustainable	10	1	11	Quick win
Community Health Management Committee	This has membership drawn from key stakeholders in the community	10	2	12	Quick win
Door to door visit	The door-to-door visits and health education gives opportunity to inspect for use and provide hang up support. Challenges in hanging has reported as barrier to use	10	4	14	Quick win

Legend

Quick Wins (High Impact, Low Effort): Quick wins are the most attractive projects, because they give you a good return for relatively little effort. Focus on these as much as you can.

Major Projects (High Impact, High Effort): Major projects give good returns, but they are time-consuming. This means that one major project can "crowd out" many quick wins.

Fill Ins (Low Impact, Low Effort): Don't worry too much about doing these activities – if you have spare time, do them, but drop them or delegate them if something better comes along.

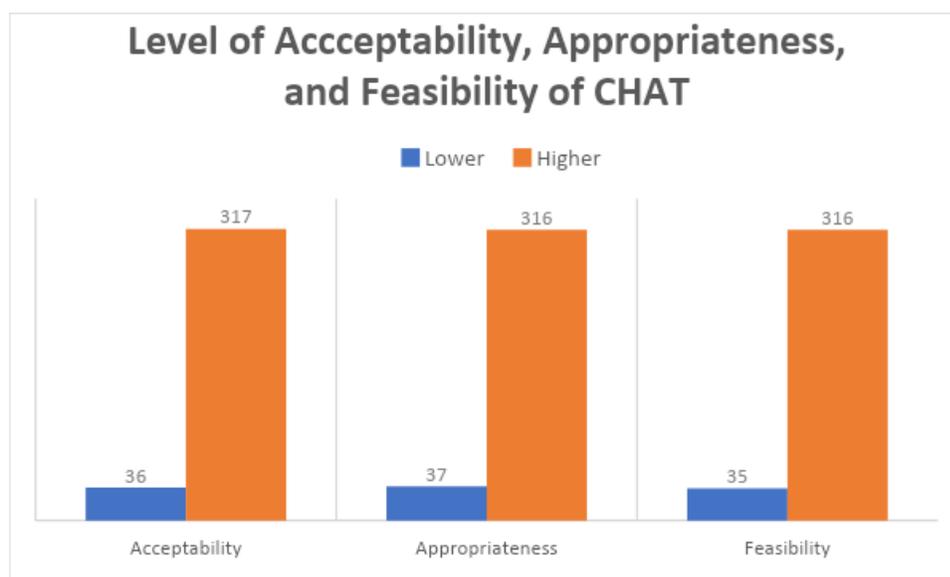
Thankless Tasks (Low Impact, High Effort): Try to avoid these activities. Not only do they give little return, they also soak up time that you

The acceptability and appropriateness of the co-created Campaign intervention (CHAT) and the feasibility of transitioning the co-created interventions into the Primary Health Care Delivery System in Ghana

After implementing the intervention (CHAT) for four months, about 90% of community members thought that the intervention was acceptable and appropriate to them and feasible at the same time (Table 7).

Table 7: Acceptability, Appropriateness and Feasibility of the Community Health Advocacy Team in six Districts

Outcome measures	Level		Total N (%)
	Lower N (%)	Higher N (%)	
Acceptability	36 (10.2)	317 (89.8)	353 (100)
Appropriateness	37 (10.5)	316 (89.5)	353 (100)
Feasibility	35 (10)	316 (90)	351 (100)



When disaggregated by district, majority of community members in all six districts thought that the CHAT intervention was acceptable, appropriate and feasible (Table 8).

Table 8: Chi Square analysis showing Acceptability, Appropriateness and Feasibility of the Community Health Advocacy Team by District

District	Acceptability			Appropriateness			Feasibility		
	Lower	Higher	Total	Lower	Higher	Total	Lower	Higher	Total
Ho West (Tsito)	15	16	31	15	16	31	15	16	31
Agotime Ziope (Kpetoe)	14	33	47*	15	32	47**	14	33	47*
Ho (Hokpeta)	6	51	57***	6	51	57***	5	51	56***
Birim South (Apoli)	1	101	102**	1	101	102***	1	102	103** *
Achiase (Achiase)	0	87	87***	0	87	87***	0	86	86***
Abuakwa North (Kukurantumi)	0	28	28***	0	28	28***	0	28	28***
Total	36	316	352	37	315	352	35	316	351

* p < 0.05; ** p < 0.01; *** p < 0.001

