

A CRITICAL LOOK AT THE COMMUNITY PARTICIPATION STRATEGY FOR HEALTH IN GHANA: THE CASE OF BIRIM NORTH DISTRICT IN THE EASTERN REGION OF GHANA

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53rd Master of Public Health/International Course in Health Development
19 September 2016 – 8 September 2017

KIT (ROYAL TROPICAL INSTITUTE)
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Vrije Universiteit Amsterdam

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A thesis submitted in partial fulfilment of the requirement for the degree of
Master of Public Health

By

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Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis "**A Critical Look at the Community Participation Strategy for Health in Ghana: The Case of Birim North District in the Eastern Region of Ghana**" is my own work.

Signature:-



53rd Master of Public Health/International Course in Health Development (MPH/ICHHD)
19 September 2016 – 8 September 2017
KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam,
Amsterdam, The Netherlands

September 2017

Organised by:

KIT (Royal Tropical Institute), Health Unit
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam/Free University of Amsterdam (VU)
Amsterdam, The Netherlands

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Acknowledgement

I, first of all, express my heartfelt gratitude to the almighty God for His Wisdom, Protection and Provision that has seen me gone through this programme successfully.

I will also like to express my gratitude to the Netherlands Government for granting me the scholarship that enabled me to partake of this Masters programme in the Netherlands.

Mention must be made also about the whole staff of Royal Tropical Institute, both teaching and non-teaching staff who contributed towards achievement of this success. Special appreciation goes to my academic advisor as well as thesis advisor whose constructive guidance, feedback, encouragements, support and pieces of advice has enabled this thesis to see the light of day as well as successful completion of the Masters programme.

I would also like to say a big thank you to the Ministry of Health, Ghana through the Director of the College of Health-Yamfo, who released me from duties to pursue this programme.

I also want to express my profound appreciation to the District Health Directorate of the Birim North District, headed by the District Director of Health Services and other personalities in the district for their unflinching support during my stay in the district for my data collection.

This success will not have been achieved without the support of my family and especially my wife and children whose prayers and encouragement have been my stronghold. Thanks also go the Resident Pastor, leaders and the entire congregation of the HolyLand Temple of the International Central Gospel Church, Sunyani-Abesim for their prayers.

I am also thankful to all my course mates of the 53rd batch of the ICHD. Special thanks go to Priscilla Mary Ntim Babae who has been a source of inspiration and a true friend. God bless you Prissy for your kindness. Bash, Adwoa, Jumy, Mike, Tan and Jamal, it was good meeting you guys.

Pastor Dagoë, my coming to KIT and going through this programme would not have been successful without you. Your pep talks and guidance has been very helpful.

I am also grateful to the Head Pastors and members of Pentecost Revival Church and Christian Faith Church in Amsterdam for your support spiritually and physically during my stay in Amsterdam.

To any other person who supported me in any way, God bless you.

Finally, this thesis is dedicated to the memory of my late brother, Samuel Atta-Nyarko.

Abstract

Community participation gained popularity in the health sector after the Alma Alta Conference. The Ghana government has adopted the CHPS strategy of health delivery, which has its main principles on community participation. Few studies exist to explain how the community participation processes have been done in CHPS communities in Ghana. This study sought to explore how communities in the Birim North District of the Eastern Region experienced their involvement in CHPS so as to inform policy makers on how community participation in the CHPS concept must be conducted towards community ownership and sustainability. Sherry Arnstein's ladder of participation was used as a framework to judge how the communities experienced various elements of the CHPS programme design, using a qualitative study design where 22 key informants and 4 focus groups were interviewed within a period of two weeks. The study revealed that there was a high degree of non-participation in deciding on CHPS as a preferred facility by the communities. There were some forms of participation in Leadership, planning resource mobilization and the management of the CHPS concept. Politics is gaining root in the current CHPS implementation paradigm. The study concludes that generally the level of community participation was not encouraging and that more needs to be done to ensure the active involvement of the community. It is recommended that political leadership should collaborate with the District Health Management Team (DHMT) to actively engage the community for them to own the CHPS programme. Conscious efforts must be made to include women in leadership positions to contribute to decision making.

Name of Author: Daniel Atta-Nyarko

Nationality: Ghanaian

Keywords: community participation; community involvement; empowerment; leadership; planning

Word count: 13,174

List of abbreviations

CHPS	COMMUNITY-BASED HEALTH PLANNING AND SERVICES
CHC	COMMUNITY HEALTH COMMITTEES
CHO	COMMUNITY HEALTH OFFICERS
CHV	COMMUNITY HEALTH VOLUNTEERS
DHD	DISTRICT HEALTH DIRECTORATE
DHMT	DISTRICT HEALTH MANAGEMENT TEAM
DCE	DISTRICT CHIEF EXECUTIVE
DCC	DISTRICT CHPS COORDINATOR
DDHS	DISTRICT DIRECTOR OF HEALTH SERVICES
DHIO	DISTRICT HEALTH INFORMATION OFFICER
DNO	DISTRICT NUTRITION OFFICER
FGD	FOCUS GROUP DISCUSSION
GHS	GHANA HEALTH SERVICE
ICHD	INTERNATIONAL COURSE FOR HEALTH DEVELOPMENT
KII	KEY INFORMANT INTERVIEWS
KIT	ROYAL TROPICAL INSTITUTE
MOH	MINISTRY OF HEALTH
MPH	MASTER OF PUBLIC HEALTH
MTN	MOBILE TELECOMMUNICATION NETWORK
PHC	PRIMARY HEALTH CARE
PI	PRINCIPAL INVESTIGATOR
REC	RESEARCH ETHICS COMMITTEE
RHD	REGIONAL HEALTH DIRECTORATE
TBA	TRADITIONAL BIRTH ATTENDANTS
VU	VRIJE UNIVERSITEIT

Glossary

Community Health Planning and Services (CHPS): "The mobilization of community leadership, decision making systems and resources in a defined catchment area known as a zone, and placing a reoriented frontline health worker, who is a trained community health nurse, a midwife or any other cadre of nurse (known as Community Health Officer) with logistic support and community volunteer system to provide services according to the PHC close to client service delivery system".

Elements of Arnstein's Ladder of Participation

Manipulation and Therapy. Both are non-participative. The aim is to cure or educate the community. The proposed plan is best and the job of participation is to achieve public support through public relations.

Informing. A most important first step to legitimate participation. But too frequently the emphasis is on a one way flow of information. No channel for feedback.

Consultation. Again a legitimate step attitude surveys, neighbourhood meetings and public enquiries. But Arnstein still feels this is just a window dressing ritual.

Placation. For example, co-option of hand-picked 'worthies' onto committees. It allows citizens to advice or plan ad infinitum but retains for power holders the right to judge the legitimacy or feasibility of the advice.

Partnership. Power is in fact redistributed through negotiation between citizens and power holders. Planning and decision-making responsibilities are shared e.g. through joint committees.

Delegation. Citizens holding a clear majority of seats on committees with delegated powers to make decisions. The Public now has the power to assure accountability of the programme to them.

Citizen Control. Have-nots handle the entire job of planning, policy making and managing a programme e.g. neighbourhood corporation with no intermediaries between it and the source of funds.

Introduction

My thesis is about exploring how the communities are engaged in the CHPS strategy that will eventually lead to active community participation for sustainability of the concept. This is because if the communities are not properly engaged for them to own the concept, a time will come where there will be a lot of CHPS compounds without health workers or where there are health workers, they will become mini-hospitals managers where the communities have little or no voice in their health decisions. I hope to explore how communities experienced their involvement in CHPS to establish whether we can say for a certainty that there was real citizen control in the process or just tokenism or complete non-participation so as to inform policy makers in what to do to get the communities to own and sustain the programme. This has become necessary especially at a time in our country where the government is seeking to scale up the CHPS compounds.

If care is not taken, the goodwill of government will end up creating white elephants in communities where the government's effort of reducing poverty through making quality health service accessible and affordable to the doorstep of the rural poor will only be a mirage, further deepening the inequalities in health between the rich and the poor, rural and urban.

My name is Daniel Atta – Nyarko, a technical officer in health information management as my professional background. I worked as the district health information officer for about four years and during this period, had the privilege of experiencing how the communities were involved in health delivery using the CHPS concept.

The thesis is organised under five main chapters. The first chapter talks briefly about the background of the study area. A detailed information regarding how health services is organised in Ghana is attached in the appendix. Chapter two explains the concept community participation as well as the methods that were employed in conducting the study. The findings of the study are described in the chapter three. Chapter four combines the discussion of the study and the major conclusions emerging from the various themes under discussion. The final chapter outlines the recommendations emerging from the study.

CHAPTER ONE

1.0 BACKGROUND INFORMATION OF THE BIRIM NORTH DISTRICT

1.1 Location

Birim North District is among the twenty-six districts in the Eastern Region with New Abirem as its capital. The district shares borders with Kwahu West District, Akyemansa District, Asante Akyem South District and Adansi South District. The district assembly is the highest political and administrative body.

1.2 Surface Accessibility

There are three major trunk roads from the district capital New Abirem to Akim Oda, New Abirem to Kade and New Abirem to Nkawkaw capital of Kwahu West District. Roads connecting these major trunk roads to outreach communities are mainly laterite. Transportation is mostly by public buses, there are few private minibuses and taxis that ply the route.

1.3 Telecommunication

The district is privileged to have four communication networks out of the six throughout the nation, namely MTN, Airtel, Tigo and Vodafone.

1.4 Energy

The district is on the national electricity grid however not all the communities benefit from it.

1.5 Education

The district has several public and private basic schools some with boarding facilities and two-second cycle institutions.

1.6 Health Infrastructure

The district has in totality twenty-four health facilities which are fairly distributed. See Table 1 in the appendix. The district hospital and other hospitals at Atobie and Nkawkaw serve as the main referral points from the Health centres and CHPS centres. The high number of Community-based Health Planning and Services (CHPS) compounds and its role has contributed to the popularity of the district in areas of CHPS. Students from training health institutions visit the district to acquire knowledge and skills in the CHPS concept. The map of Birim North and Ghana, as well as organization of health service delivery in Ghana are indicated in appendix 1, 2 and 4 respectively

CHAPTER TWO

2.1 The issue

The Government of Ghana adopted the Community – based Health Planning and Services (CHPS) approach as the health component of its national poverty reduction strategy, and in line with it, the Ministry of Health adopted this policy as a strategy of health delivery in Ghana in the year 2000. (GHS, 2002, GHS, 2007, MOH, 2002, Debpuur, et. al., 2002, Awoonor-Williams, et. al., 2004, Awoonor-Williams, et. al., 2010, Bawah et. al., 2006, GHS, 2011). CHPS is supposed to strengthen the Primary Health Care (PHC) concept by reorienting health professionals and community leadership to bring quality health care to the door steps of the rural community. The approach has six main milestones that need to be achieved for successful implementation. In these milestones, the involvement and participation of the community are essentially required during the community entry, construction of the compound and the recruitment and selection of the community health volunteers (CHVs) and community health committees (CHCs). The CHCs are a recognized body in the community to oversee all health activities in the community. The successful collaboration between CHPS and the community to a larger extent depends on the vibrancy of the CHCs. The successful involvement of the community in the areas of community entry, construction of CHPS compound volunteer recruitment and CHC formation culminates into community ownership and eventual sustainability of the CHPS strategy. In a recent study by Gibbs et. al. (2014) on sustainability by local communities, it emerged that many factors exist in communities and outside the community's domain that contribute to undermine the sustainability of community programmes and reaffirmed that, the assumption of local sustainability may be a 'wishful thinking'. In as much as a lot of studies have been done with the purposes of explaining what is meant by community participation, little has been done in analysing the processes involved in community participation (Preston, et. al., 2010). Milton et. al. (2011) reiterate that there are only a few studies that measure the effectiveness of community participation on the people who are involved in such engagement. CHPS has three main components that rest on the involvement of the community which presupposes community ownership and eventual sustainability.

Based on the premise about the dynamics of community participation according to literature, it is increasingly relevant to question how community participation with respect to CHPS implementation has been done. According to Draper et. al. (2010) in programmes or interventions that hinge on community participation, there is always a complexity of issues precisely because, there may be a myriad of specific components and key to these components is usually participation itself, therefore participation need to be looked at critically instead of the usual romanticism around community involvement. This is the intention of this study for the context of CHPS program in Ghana. The study is relevant as it seeks to critically analyse how the community involvement processes under CHPS have been implemented thus far – it is particularly relevant at this juncture as Ghana is in the process of revisiting the CHPS strategy with a view to make it more effective going forward. The insight derived from this study will be used to inform policy decisions on how the community involvement processes within the CHPS program could be improved to ensure community ownership of the strategy, and thereby to achieve long term sustainability.

2.2 Mapping the concept of community participation in health and its evolution over the last few decades

2.2.1 Community participation concept

The concept of community participation and the role it plays in community directed interventions and programmes have gained significant recognition over the years. Specifically, the concept has gained prominence in the public health field. Even though some health professionals continue to be wary of the idea that the community should play a critical role in health improvements, they appreciate the principles upon which community participation becomes integral in PHC. The reasons include communities have

resources that can be adequately utilized, they have the capacity to take decisions to deal with their own health needs and also have the ability to effectively partner with health professionals. (Rifkin, et. al., 2007).

Over the years, there is substantial evidence to suggest that the design and implementation of health programmes and interventions appear to falter without the communities' participation. On the contrary, few evidence also exists to clearly point out the outcomes of health interventions as due largely to community participation (Pritchett & Woolcock, 2004, Wallerstein & Duran, 2008, Rifkin, 2014). A key reason, as put up by Rifkin et. al. (2007) and Draper et. al. (2010) for these difficulties is the varied range of the definition of community participation. It has become increasingly challenging to draw the link between community participation and positive health outcomes and sustainability (Popay, et. al., 2007). Rifkin (2003) suggests that community participation is gradually being replaced with community empowerment based on the fact that empowerment recognises the capacity building of individuals and again currently, empowerment is on the agenda of socioeconomic and political policies.

For almost every intervention or programme that is population based, much emphasis has been placed on perceived success by the involvement of the communities involved. The impression is created to suggest that once the community 'participates' desired outcomes are sure to observe. Interventions or programmes concerned with prevention or curative, high risk or general, women or men, children or adults all seem to point to success once the 'community participates'. More so, not only do governmental interventions rely on this glory of community participation but also non-governmental organization and international organization all place significant emphasis on community participation whenever they want to implement any intervention being social, economic or health. (Cornwall, 2008, Eversole, 2010).

To be able to better understand the concept of community participation and its subsequent relationship to health outcomes, Draper et. al. (2010) suggest that, the definition of community participation should be contextual and be able to "incorporate the definition into an evaluation framework that allows relationship between the participation process and defined outcomes. Morgan (2001) views community participation from two perspectives. He argues that, donors or governments may use community resources such as land, labour and money to offset the cost of service provision or programme design and implementation. He referred to this as Utilitarian. In the other perspective which he referred to as the empowerment tool, he describes it as when local communities take responsibility for diagnosing and working to solve their own health and development problems. These perspectives are usually applied in the health domain when it comes to community participation. Rifkin (1985), as cited by Draper et.al. (2010) also suggest that, communities participate in health programmes in one of three ways, namely the medical approach, the health service approach and finally, the community development approach. These approaches can be termed as community mobilization, collaboration and empowerment respectively and are not mutually exclusive.

To further contribute to understanding the relationship between Community participation and health outcomes, it is important to understand that there is no gold standard for the replication and evaluation of community participation but community participation should be viewed as a process that is contextual and specific to situations, not forgetting that community participation may take many forms because communities are not homogenous but heterogeneous and complex and for that reason, "their participation should be viewed as a social process" (Rifkin, et. al., 2000, Draper, et. al., 2010). Proponents of community participation are to consider who takes part in the participation, why they take part in the participation, how they take part in participation and what benefit they stand to gain by participating (Cornwall, 2008). In that regard, community participation should also be about shaping and creating knowledge (Rifkin, et. al., 2000) Community participation with

regards to power control is depicted in the Arnstein's ladder of participation where citizen control appears at the top with non-participation at the bottom of the ladder. According to Arnstein, power of participation is invested in citizens and is depicted in a ladder where therapy and manipulation at the lowest are considered as non-participation, placation, informing and consultation are termed as degree of tokenism whilst citizen power comprises partnership, delegated power and citizen control (Cornwall, 2008, Cummings, 2001). By community participation, health professionals will have to one way or the other, relinquish some of their power and control for community members to execute and this has been one of the areas health professionals are unable to explicitly address (Taylor, 2004). Just like the Arnstein's ladder, it has been suggested elsewhere that participation has traditionally assumed the practice whereby decision-making can be viewed as a ladder that ranges from coercion to full control (Rifkin, 2000).

2.2.2 Community participation in practice

Despite its current popularity, the concept of Community Participation has received mixed responses with some scholars promoting it as a "gold standard" while others criticise it. In as much as it sounds appealing that community mobilization or participation enhances ownership and subsequent sustainability, it is equally imperative that this is critically analysed in context because there are pertinent issues that may undermine community participation for instance if there is limited 'supportive material, symbolic and relational context (Campbell and Cornish, 2010). According to Bruni et. al. (2008), community interventions cannot exclude the beneficiary communities because it is the community that will eventually fund and use the intervention, involving the community deepens democracy, thereby building their trust and support for the intervention and finally, it provides crucial perspective about what the communities' value as priorities.

This is more so with respect to the dynamics of communities as communities evolve with time and practitioners who take this into consideration in designing and implementing interventions are expected to account for unforeseen bottlenecks and so get the full participation of the communities (Checkoway, 2011, Smets, 2011). Practitioners therefore, are encouraged to redesign how community participation is organised to meet the need of communities (Eversole, 2010). In further interrogating the concept of community participation, the degree of participation and the quality of the participation are key components that should not be overlooked as they inevitably influence the outcome of the intervention. Community participation has contributed to successful implementation of interventions in some context.

Campbell and Cornish (2012) analysed how community involvement led to sustainability in India but same could not be achieved in South Africa and highlighted the strategies that were employed in these context for the observed outcomes. This further draws reasoning as to why community participation needs to be looked at contextually and question how the processes were carried out so that policy makers and professionals are not carried away that community participation is all it takes to sustain community interventions. In a study by Gooden et. al. (2014), they suggest that if the local community is engaged in ways that address patient safety through awareness creation, it results in healthy engagement and outcome with health care providers. Research suggests that the active involvement of communities in the design, governance and implementation of interventions contribute to positive health outcomes as well as enhancing the sustainability of policy initiatives (Rifkin, Lewando-Hundt and Draper, 2000; Wallerstein, 2006).

Community participation does not always lead to improved or desired outcomes. Yang (2016) in revisiting South Korean rural modernization of the 1970s indicated that community participation did not in itself improve performance in terms of sustainability but rather the nature of the participation and governance that existed. One could then not lose sight of these risks entailed in the process of community involvement and participation

especially when politics play a significant role in initiating or facilitating the process of community participation (Marks & Erwin, 2016).

2.3 Objectives of the study

2.3.1 General objective

To interrogate the nature of community participation in CHPS programme design in the Birim North District of the Eastern Region of Ghana so as to inform policy makers on how to engage communities for a successful CHPS implementation.

2.3.2 Specific objectives

- To analyse how community members experience the process of their involvement in CHPS.
- To investigate the views of health workers and managers regarding how they see the communities' involvement in CHPS.
- To critically analyse the functioning of community health committees with a view to understanding the forms and nature of their involvement in CHPS.
- To recommend measures to improve the community participation processes in the CHPS implementation.

2.4. Methodology

2.4.1 Study type

An explorative qualitative research design was considered appropriate given the objectives of the study. This was considered so because it would allow one to gain in-depth insight into the phenomenon of community participation and of the processes involved in implementing the community facet of the CHPS program in Ghana.

2.4.2 Study population

The primary study population were community members in purposefully selected communities under CHPS zones. The participants had to be permanent residents of the communities and had to be willing to be part of the study. The study focused on permanent residents because they would be in a better position to contribute meaningfully to the discussions, not least, be able to locate their experiences in a historical and longer term perspective. Secondary respondents who also provided in-depth information and served as key informants included the CHVs, CHC, Community Health Officers (CHOs) in the CHPS zones, Opinion leaders and Core members of the District Health Directorate (DHD)

2.4.3 Sampling and recruitment

The study employed the purposive sampling technique to select all primary respondents. Two sub-districts were selected. One with urban characteristics and another from the periphery with rural characteristics. One CHPS zone from each of the sub-districts was also selected. A community from each CHPS zone was then selected for the study. The DHD was contacted for their support and permission to use CHOs and CHVs, who liaised with the community leadership to recruit the community members who were willing to participate in the study. Recruitment was conducted by the Principal Investigator (PI). As an initial step, to ensure access, the PI made appointments with the community leaders (men and women) to explain to them the purpose of the study. Participants included only members of the community who are permanent residents and had been in the community at least six months prior to the study. Potential participants who fulfilled the inclusion criteria were approached by the PI; the purpose of study explained to them and those who were willing to participate were recruited. Key members of the District Health Directorate who were able to provide required information were purposely selected.

2.4.4 Data collection

Semi-structured interviews and Focus Group Discussions (FGDs) were the main means by which data were collected. Two main groups were used in each community, one male and

one female. The different sex groups were used to enable them to express themselves freely with their equals. Each FG comprised eight (8) participants. Participants above age 18 years were considered for the study. The semi-structured interviews were used to collect data from the key informants. Table 2 in appendix 3 shows the distribution of respondents. Issues addressed during the interviews included the history of CHPS, community entry procedures, land acquisition and construction of CHPS compounds, constitution of CHCs, selection of CHVs, community involvement in CHPS activities, collaboration between communities and the health sectors etc.

2.4.5 Data processing and analysis

The Principal Investigator (PI) conducted all interviews. Tape recorders tested and assured of quality were used to record proceedings. Data were transcribed in MS excel worksheet. The items on the topic guides were coded for FGDs and Key Informant Interviews (KIIs). Themes that arose during interviews were captured accordingly. Analysis was done concurrently with transcription according to themes based on the topic guide and other themes that emerged during data collection.

2.4.6 Ethical consideration

Ethical clearance was sought from the Research Ethics Committee (REC) of KIT and the Institutional Review Board, Dodowa Health Research Centre before commencement of the study. The proposal together with all required documents was presented to these ethics committees to assess the feasibility and safety of the study. After the approval from the ethics committees, permission was also sought from the local authorities of the study site thus, the Regional Health Directorate (RHD), the DHD and the community leadership. The participants approved their participation by signing a consent form which was explained to them. Participants who travelled to the interview site were reimbursed their transportation cost. Right to participate or not, freedom to answer questions or not, liberty to discontinue with the interview, potential benefits of the study were all explained to the participants. All interviews, (FGD and KII) were conducted in a safe and conducive environment chosen by the respondents at a time they were comfortable with to provide them with privacy.

2.4.7 Quality assurance

The data collection tools were translated into the local dialect and retranslated into English to ensure item consistency. The tools were pre-tested outside the study area to allow familiarization with the questions and how to ask them to improve questioning and probing. There were no issues that demanded modifying the topic guide after the pre-testing. On the actual data collection days, all tape recorders were tested and provided with reserve batteries. Daily summaries were done for improvements.

2.4.8 Analytical framework

The research was conceptualized on the Sherry Arnstein's ladder of citizen participation. The ladder depicts levels of engagement with citizen participation and the degree of power or control participants can exercise to influence an outcome. Figure 1 below shows Arnstein's ladder

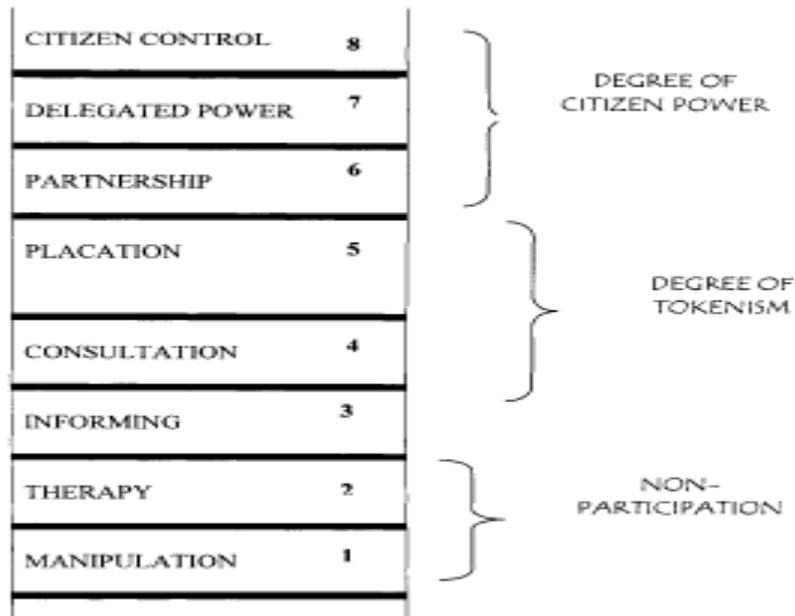


Figure 1: Arnstein's Ladder of participation (Cumming, 2001)

The ladder explains that the community can either be educated in other words referred to as therapy (step 2), informed (step 3), and consulted (step 4) or power can be delegated to them through partnership (step 6) and other means. The effectiveness of community participation in the CHPS process can be explored according to the frame work and as a result, elucidate from community members how their experiences of involvement or participation had been and whether such involvement has contributed to improved outcome in terms of their participation in health related programmes (CHPS activities) in the communities.

CHAPTER THREE FINDINGS

3.1 INTRODUCTION

The findings of the study are organized into five main sections that underpin the CHPS concept. The first section deals with the processes that ought to occur before a consensus is reached between health authorities and the communities, regarding the CHPS programme. Central to such a consensus is the kind of leadership that exists in the communities and how decisions are taken to address the needs of all groups in the community. Leadership determines how the community is involved in the whole planning from beginning to the end of the CHPS programme through meetings and durbars. The involvement of the community from the initial assessment based on the kind of leadership who in turn ensures involvement of the community in the whole planning, will yield to the integration of existing community structures and resources. The last section looks at how health managers view community involvement in health programmes as a result of how the communities have been engaged to participate in the CHPS programme. These are the elements upon which the analysis has been based. Arnstein's ladder of participation was used to make judgements based on how the communities experienced each of these elements that have been explained.

3.2 Involvement in choice of a facility

The research sought to elicit whether the communities were involved in identifying their needs in terms of the CHPS compound construction. It is envisaged under the CHPS strategy that the community plays a leading role in the design of the concept and as such, it is expected that events leading to construction of a CHPS compound and subsequent implementation of the strategy should be the combined initiative of all stakeholders. The community should be actively involved in assessing and deciding what should be brought or implemented in their communities. The primary purpose was to ascertain the level of control that the communities had towards the design of the programme, considering Arnstein's ladder of citizen control. The responses from the participants indicate that, there had been limited to no discussions at all in some instances regarding the construction of the current CHPS compound. Majority of their responses suggest that this was an initiative of the district assembly where political manipulations played a major role and that, they were only informed during the sod-cutting for the commencement of the compound construction. In many instances, respondents were with the view that the discussion might have gone on between a few elders and the political leadership. A literate male opinion leader in one of the communities indicated that the community was grateful to have been built a clinic but his view point out that there was no community involvement in any discussion leading to the construction but the community was approached to provide a land for the compound which they did. This is akin to non-participation according to Arnstein's participation ladder as it seems to suggest that the community was manipulated about the decision. However, consultation was also observed in the discussion by the fact that the community was asked to provide the land but the way and manner in which it was done did not place enough value on community involvement and will still inure to non-participation. Below is the commentary by him.

"Okay as for the clinic, I know a little history of it. And what I know is that, we were here when our "mother" Mavis came to inform the entire community that the government is initiating CHPS in some selected communities in the country and thank God, Kuntanase is one of the selected communities. So all that we should need is the land that they will do the project on and as for the commencement, it will be done by the district".

This notion by the opinion leader was buttressed by a leader in a renowned church from the community who opined that it was the government who had instructed the district to build CHPS compounds and so the community had been added to it. This leader suggested that the community actually needed a clinic but not CHPS compound. He did not indicate whether what has been decided would be liked or not liked by the community. In his view,

as the excerpt below illustrates, the community was totally manipulated as no form of consultation was observed considering Arnstein's concept.

"With this one, we initiated for a clinic. So as for the CHPS compound it was not our request. But rather it was she (District Chief Executive, (DCE),) who said that the government says they should build CHPS centres and because we have requested for a clinic, she will add our proposal to the initiative"

The level of the manipulation was corroborated when a participant in a female FGD reiterated that it seemed there was some kind of a rush in the construction of the CHPS compound. The women suggested that though they heard about the information regarding the construction of the CHPS compound, they cannot completely be certain that what was said to the leaders was the same as they heard. This assertion indicates how deep the community was manipulated and in essence how vast the non-participation of the community in assessing their needs in terms of Arnstein's ladder. The view of the participant is expressed below

"They decided that they are constructing this clinic speedily so when that happened our leaders came and informed us. But an information communicated to you cannot be equally (exactly) communicated to a second person".

However, they welcomed the idea of the CHPS even though they were not involved in the initial discussion because they believed it was going to serve a similar purpose. A male semi-literate volunteer expressed his dissatisfaction about how the community was not actively involved in the initial assessment but at the same time was not in a position to refuse the CHPS compound because the community needed a health facility. His view can be compared to therapy in the domain of non-participation. See the excerpt below

"Okay as for that, I can't remember they told or explain things of that sort but because they said they will bring us clinic and we also thought that the clinic will help us if it was brought. What we know was that the clinic will help the community".

The views of the majority of the community informants were further corroborated by the members of the DHD who felt they were only consulted after the district assembly had finished with their plans. They only had to move along with the district assembly because those communities were already earmarked for CHPS. Indeed the DHD is with the view that proper engagement had not gone on well in the communities to let them know and understand the concept. The views of the DHD are summed by the District Director who felt the political leadership erred in the manner in which the compound was constructed. The views of the DHD are consistent with the views of the community in two instances. First of all, they all felt they were not adequately involved in assessment and secondly they welcomed the construction of the compound because it is a need both for the community and the health directorate. The director, as echoed in the quote below, signalled that it is imperative for the community to participate because he felt the process had not adequately involved the beneficiary communities.

"At the time of the selection, they didn't allow us to visit the communities, sensitize them, do the necessary work; I was here before I realize they have gone to start the whole thing. They have gone to cut their sod and started construction. Given the contract and that sort of thing without any proper community engagement, we selected the community, it is a deprived area you have been there yes it is a good location. But let them understand that it is a community base participatory".

In conclusion, the communities were not involved in the decision to construct a CHPS compound because they had initially requested for a bigger clinic. That notwithstanding, they accepted the project because they believed it would genuinely serve their purpose

and hence their contribution of providing the lands for the construction. According to Arnstein's ladder of participation, the views by both community members and health managers indicate high degree of non-participation in the process of need assessments

3.3 Leadership experiences by community members

CHPS relies largely on community leadership and who constitutes the leadership. The nature and structure of leadership in implementing CHPS is to ensure that all groups in the community are represented. Leadership under CHPS during the initial planning and subsequent implementation is essential to the involvement and participation of all people in the community. Different views were shared by the respondents regarding the nature of leadership in the community and also the CHCs. Some of the participants view the assemblymen and few elders of the communities as leaders. They feel that it is the assemblymen and few elders who usually go to the district assembly and meet with the DCE. As far as the CHPS compounds were concerned, some informants view the CHCs as those who are solely responsible and take decisions regarding the compound. The general observation is that, major decisions are taken by the assemblymen and few elders before such decisions are communicated to the community. A female community member felt that the assemblyman alone takes decisions in their community regarding health issues. Her sentiment seems to even doubt the credibility of the assemblyman when she retorted that they don't even know where he goes. She again suggested that all the community members are experiencing what she is experiencing when she says "we". This view of the community member indicates that the assemblyman only **'informs'** the community about decisions taken from "wherever" he goes since they don't know where he goes. For her, the leadership of the assemblyman falls in the informing domain of the participation ladder. Another female community member shared similar sentiments because according to her too, the assemblyman again **informed** the community about a meeting he attended with the DCE regarding the health of the community. Their views are expressed below.

"Please that one if something of that sort is there it will be the assemblyman because we don't know where he goes, all that he always tell us is that he goes to the assembly. That's my view on it".

"Oh we knew it before the DCE came because the assemblyman announced to the community that there was a meeting between the DCE and himself regarding our health problem which she has accepted to build a clinic for the community".

According to an elite male opinion leader, the leadership of the community is mainly one of a chief and his elders who decide on pertinent issues affecting the community before they come out publicly to announce it. He affirms that it is after conclusions have been made before decisions are communicated to the entire community, leaving the other members of the community with little voice rather than accepting what has been discussed by the leaders. His suggestion questions the representativeness of such leadership criteria as it is traditionally observed that women are underrepresented at such echelon of power. Such leadership styles do mostly inform members what decisions they have taken, which is consistent with what the female community members opined. See his comments below

"Please with that one, if something is important like that and you go to meet the chief and his elders in order to communicate it to them and all is being finalized they don't bring it publicly. Unless we are going to inaugurate it before that issues is being shared".

Other informants revealed that their CHCs are dominated by males and hardly do they involve women in decision-making processes in the communities. The community leadership is also the same with men at the helm of affairs. An educated female volunteer expressed her frustration when it comes to how women have been excluded in decision making in the community. In her view, women must be considered or given voice when it comes to decision making. She seems to suggest that it is as if the men in their communities do not acknowledge the contributions of women when it comes to decision

making. This participant believes it is wrong for women to be discriminated like that. Her view was supported by women in the female group discussion who shared similar sentiments. They seem not to challenge the status quo, whether good or bad. The commentaries below were ran by the volunteer and participants of the FGD.

"That's the problem. In this community they don't involve females when they call for such things. I always ask them to have an arrangement to constitute a committee that will involve the females but they don't do it. It was the Unit Committee that a lady stood for and they voted for her to be part. But I don't know if they included her in this project issue".

"It is the men. The men always lead and they direct the women as the way and means we should do it and we also comply with their decisions"

An illiterate female opinion leader seems to suggest that there is nothing wrong when it comes to males dominating leadership positions in the communities which are not consistent with the views expressed by the other participants. This opinion leader actually laughed it off when she exclaimed the disparity in leadership in the formation of the community health committees as shown below.

"They were appointed from different communities and villages. Males more than females in the CHC. The males always have authority over the females" (laughing).

One interesting issue that is worthy of mentioning is the political dimension that the community views the leadership in the events leading to the construction of the CHPS compound. This development was observed as worrying by the respondents because they believed it could prevent utilization of the facility. An educated male respondent during an FGD had this to say:

"The leadership affair in this community has turned into politics and it is retarding economic development in this community. For instance, this clinic was built during (Former MP for the Birim North Constituency) Mama Esther's term of office and since she is not in power anymore, it is as if no one cares"

A DHD member viewed leadership differently and believed females were actively involved in leadership. The District CHPS Coordinator (DCC) believes that women were involved in leadership because according to him, women have been seen during their meetings with the community leadership. See his commentary below:

"Yeah! Yeah! Sure in all the two communities for example ahaa, there were women and all the areas (the communities) anytime we meet, you see women being part".

To conclude, leadership roles in the CHPS processes were limited to the political figures (assemblymen) and chiefs; even their roles have been to merely **inform** the communities after decisions have been taken and without extensive consultation with community members (degree of tokenism). Again, the study shows dominance of men and exclusion of women when it comes to leadership in CHPS processes.

3.4 Community Involvement in Planning of the CHPS Programme

The CHPS concept also espouses that the community is actively involved in the planning and discussions of the CHPS concept. The planning is expected to happen during meetings between community leadership and health managers which will then be eventually communicated to the entire community through durbars. Selection of volunteers and CHCs are expected to be done transparently during these durbars. The research set out to explore the views of the respondents regarding how they were involved in the planning of the CHPS concept. According to the informants, they experienced some forms of meetings and durbars but these occurred after most of the planning have been done by the

community elders and assemblymen together with the officers of the district. The meetings and durbars they experienced were to communicate to them the decisions that have been reached already but not to solicit their views. In most instances, the meetings and durbars were only organised during the sod-cutting for the commencement of the compound construction or at the inauguration of the compound. The informants mentioned that usually, it is at these inaugurations that the volunteers and health committee members are introduced to them. An educated adult male CHC member was with the view that there was no discussion involving the entire community as to what facility that was to be constructed but then when the leaders had finished with the planning, they then informed the community that they were going to construct the CHPS compound. His assertion was corroborated by a male semi-literate community member who remembered a durbar where even the DCE was in attendance but here too, they were only told what was going to happen and only encouraged to contribute towards the construction. Both informants experienced this as a mere information delivery when this is considered by Arnstein's concept. Their commentaries are illustrated below:

"Ok there was a durbar and they told us what they were going to commence so we should support it in good faith which we did. (oh) the little history I know of, the time they were about to commence that facility, they informed the community that they want to build a compound and that made them contributed effectively".

"Yes there was a durbar for the community which involved all the leaders. Even the DCE came. They said that, they have built the clinic so the community should also contribute in a way to help the clinic such as cleaning and clearing the surroundings of the clinic".

Their views were however contradicted by a minority of the respondents who never experienced any durbar or meeting for them to also contribute to the planning process. A male health volunteer was with the view that, it would have been appropriate even if the contractor of the project had been introduced to the community. His expressions exude a person who felt disrespected and ignored by the community leadership. In his view, it seemed the community had been manipulated after everything had been planned by the elders and managers for them only to be asked to contribute towards the construction. His view was consistent with the views expressed by informants in an FGD who also felt that the planning of the CHPS concept in the communities was only done by a few elders of the community without the involvement of the entire community. See their excerpts below

"Ok, I never heard of any durbar that even a member came to identify himself that he has been awarded a contract, to the extent that if you ask of me the name of the contractor, I can't be specific to you".

"They didn't intentionally call for a durbar for the construction of the clinic. It was just few elders that met just like we have met and discussing here".

The political involvement also affected the planning of the CHPS programme in the communities. Because of politics, some politicians decided to do their own bidding without recourse to the DHD who are responsible for the technical planning and implementation of the programme. In the view of the health managers, failure of political leaders to recognise and plan with the DHD contributed to the non-participatory attitude of the community. The District Director of Health Services (DDHS) did not hide his frustration when he lamented in the commentary below. To him, when political leaders assume such postures, it deprives the community's the opportunity to feel they own the project because they will consider themselves not part and that it is the project of the government.

"They go around, they just give promises to the community we will give you a CHPS compound. Without the people understanding that CHPS is a community base health

planning. You get the point, the person comes as a political leader with promises we will give you a CHPS compound. So at the back of their minds it is being provided for them not that they are to participate or contribute to getting the service or the system running at the community. That is what I mean by the political involvement”.

In conclusion, as far as planning of the CHPS concept was concerned, the durbars and meetings that took place were to just inform the communities about the decisions taken by the leaders but not to solicit for their inputs. This is considered non-participating according to Arnstein’s concept.

3.5 Resource mobilization towards construction of the CHPS compound

CHPS also recognises the importance of how the communities’ resources are identified and maximised. It is believed that when the communities contribute their resources, they become more committed to maintaining or owning such programmes. The resource mobilization in this study looked at the contribution of the community as well as external contribution towards the construction. Resources in this regards could be kind or cash that might have contributed to the construction of the CHPS compound. Findings from the study indicates that the community contributed mainly during the preparation of the land before the commencement of the construction. Their contributions were in the form of weeding and uprooting stumps to make the land ready for construction. The views expressed by the informants as far as contributions were concerned were experienced differently. A male community member suggested that weeding the land for the commencement of the project was the community’s part of contributing towards the project and this can be viewed as partnership by Arnstein’s ladder of participation. His view was consistent with the view expressed by the District Health Information Officer (DHIO) who opined the community supported the construction with some materials aside weeding the area in preparation for the commencement of the construction. Their views are in the excerpts below:

“The community helped in the clearing of the land such as uprooting trees stumps through communal labour before the contractor started work”.

“So they weeded the area, they supported with some materials and then they helped in supervision as well”.

However, a male community member seemed to suggest otherwise. To him, he felt they could have contributed in other ways aside from the weeding because of how he categorised weeding. He thought that even though their strength was used to weed, probably they could have done more. Nevertheless, his view can also be viewed as a form of partnership. See his commentary:

“To tell you the truth we never contributed anything but we only used our strength to support the building of the clinic through weeding”.

These forms of contributions had its gender disparities. The men were mostly involved in the weeding and uprooting stumps, deemed to be the difficult aspect whereas the women did the sweeping and burning. In this study, this status quo was not challenged but rather reinforced just like male dominance in decision making. There was nothing suggestive in the study that differentiates performance of the community contribution between people with different socio-economic status. A male opinion leader, who is well educated tried to even contrast the activities that the various gender offer as their contributions towards the construction of the CHPS compound. As far as the communities were involved in contributing some forms of resources towards the construction, they can be viewed as to have partnered the other stakeholders in this venture. Find below how the male opinion leader experienced the gender disparities in resource contribution.

"Okay, most often the females sweep the weeds weeded by the males. Secondly, when we are moulding bricks, our women do carry the sand that has being dug by us the men. Thirdly, when we are working with sand that involves water, they do the fetching for us to work with. That is the top three works I know they normally do. For the men, we weed, we pull down trees, uproot stumps and carry wooden slabs that's the work of the men in the community".

There was, however, inconsistency in the views expressed by the majority. A male community member believed that the women can also contribute in some of the supposed difficult jobs. In his view, it was not only the men who uprooted stumps but some of the females also did same. He was also certain that the females aside helping the men uproot stumps, also took part in the more traditional roles of sweeping after the land has been cleared by men.

"Okay the males mostly weed. For example the health clinic that was built, initially the land was very bushy so the men weed the plot then the females' help the males in uprooting the trees stumps. The males always do the hard ones moreover the females clean and clear the land such as sweeping".

This study again revealed that much of the constructions were done by a contractor. This prevented the community from using their other resources such as helping in brick moulding or mixing mortar together with other little jobs. In the event that the contractor even used community resources, he paid for such services either in fetching water by females or digging trenches by the males. In this instance, the community cannot be deemed to have partnered the other stakeholders but would rather have been non-participating. An educated female CHC member and an uneducated male opinion leader all noted that construction of the compound was done by a contractor who sometimes hired some of the community members to fetch water or any other job after which they are paid. These are their commentaries:

"They asked us to do a communal labour to weed on the plot so we did it before the work got started. No but as for that one thus the fetching of the water it's the contractor who was in charge of that and he paid us".

"Even the water that they used for the project, the contractor paid the people to fetch it. It is not like the community that fetch the water, it was them that paid people to fetch the water and the project was done within some short period of time".

There were however, contradicting views by a minority of the respondents who said the communities contributed by fetching water, moulding blocks through communal labour during the construction. Perhaps they did not know that those who fetched the water or other jobs were paid for by the contractor. What makes it interesting is that one male opinion leader suggested that the whole community took part in these activities. The male opinion leader's view was supported by one of the uneducated female community members as well as the DCC. It is imperative to mention that there were some contradictions in the views expressed by the same opinion leader who indicated that after digging the trenches for the foundation, the community did not get involved again. The views expressed by these informants are shown below.

"So we supported them with our effort by digging the trench of the foundation and other communal labour done. Relating to the construction, when the contractor came and dug the trench of the foundation with his workers, the community didn't get involved again".

"The men helped the contractor in building the clinic with masonry whiles the females also weed and clean the surrounding of the clinic".

"They supported the contractors by bringing water, fetch mortar for them, carrying blocks, do this and that".

To conclude, there were some forms of partnership between the community and the other stakeholders. The study indicates that in these communities, their main contributions were to weed the site for the compound whilst the greater resources were external.

3.6 Organization and Management of the CHPS Programme

CHPS encourages the integration of existing community structures. Management of the CHPS programme design in this context is who is in charge of affairs with regards to the programme in the communities. Organization also looks at whether the programme made use of existing structures in the communities. There are activities in terms of service delivery ongoing where nurses visit and carry out basic activities in the communities such as Child Welfare Clinics (CWCs) and home visits. It imperative to establish how the programme is currently organized and managed in the communities. The findings of the study show that the CHCs have the responsibility of managing the CHPS programme in the communities and then give feedback to the community. Some of the respondents indicate that the committees serve as links between the communities and the health sector and are responsible for maintaining the newly constructed CHPS compounds. The study revealed that these committees were only constituted during the inauguration of the compounds and were giving the mandate to maintain the facility. No formal training from the DHD has been given to committees. One educated male opinion leader emphasised that he had heard the mandate of the committees from a third party. He was however explicit to say that he knows the committee conveys messages from the officials to the entire community from time to time. This scenario can be viewed as a form of partnership between the health sector and the community even though there seems to be a weakness in the partnership. His commentary is below:

"Their mandate, I have heard that they are to look over the clinic and other materials that will be beneficial to the facility. And also when the nurses from Abirem come here, they meet to discuss issues concerning the clinic then they will deliver the message to the community that this is what the officers from Abirem has talked of or they think the community should do this and that".

A female volunteer affirmed this with the view that they have been told what they were expected to do and her commentary below is consistent with the male opinion leader who suggested that they were to maintain the facility.

"Yes they told us that, we will think about the welfare of the clinic so that if it need something we will see to it that they are provided".

Another CHC member, a male, opined that they realised in communities that had CHPS, there were CHCs and therefore it was relevant that their communities also had their own committees and so together with the health officials, some people volunteered to be part of the community health committees. The view of this member did not give details as to what went on in the discussion of the need for such a committee, whether it was for the whole CHPS programme or for the facility maintenance alone when he mentioned **"Project"**. See below excerpt of this

*"Okay what entails of the formation was that, the entire community had a meeting and we realized that such committees has been formed in various communities that have CHPS compound so it was announced there, they will need volunteers towards the **project** so interested people will be welcome and we volunteered ourselves. We are five in number for now".*

In a female FGD, the women revealed that the committee was only formed after the clinic was inaugurated. They are with the view that even though they have heard about the

committee they don't actually know who forms part. Their experience stipulate that the CHCs have not been properly introduced to the entire community nor was the community totally involved in selecting and approving who becomes part of the CHC in the communities. See their commentary below:

"Since we started working in this clinic and we heard they have brought a group like that but I am not very sure so when you ask me to mention their names, it's only about two of them I can mention but I don't know all of them. We have heard about the group but we don't know their total number".

The organizations of these committees did not make use of existing community structures. For most of the respondents, a completely new committee was formed after the completion of the compounds. A semi-literate community member suggested that it was the health officials who told them of the necessity to have a committee to take care of the facility. In his view, the constitution of the committee was voluntary though the selection was done by the community. The revelation suggests that though the community did not come out with the idea to form a committee, they collaborated with the health officials and selected the members themselves and so it was a kind of partnership. The views expressed by this community member were consistent with another educated male community member. Their commentaries below:

"Okay a nurse from Nkwarteng came to inform the community about it, she said that since they now have a clinic its necessary to form a health committee so that if something is needed at the clinic the committee will take care of it for the community or report to them. If we look at you and see that you can help the committee then we include you if you accept it to work with the committee".

"When the officers came around, they wanted a committee who can stand in for the clinic. So they said this is a volunteer work. Anyone who is willing to help the clinic can send their name and some of them submitted their names and became volunteers for the clinic".

In terms of gender and power relations, the study shows that the committees are dominated by males. This seems to be consistent with other findings of the study that suggest that male dominance in these communities is perverse. A male volunteer showed consistency in how the idea of the formation that was at the door step of health professionals and the agreement by the communities to constitute a health committee to further buttressed the partnership element but at the same time, his opinion brought to bear the gender inequalities in our societies. His assertion was also confirmed by a female opinion leader that committees were dominated by males. Find below these excerpts

"They came from Abirem thus the madam who is now at Nkwarteng made us form the committee. So we now have members which when it becomes urgent for us to meet we do so. We are 3 females 7 males".

"They were appointed from different communities and villages. Males more than females in the HC".

A minority however indicated equality in terms of composition of the CHCs. It is not clear how this particular committee came about. The view of the informant, a male opinion leader, elite, suggest that they were also voluntarily constituted.

"So we appointed three men and three women to do that, this boy here is part of them (errhm) and the rest are at the top there. So when we appointed them they are also on it. They asked for people to come out willingly and three women and three men raised up their hands and we agreed to that so they were appointed to begin their work".

The study also reveals that the communities were aware of the existence of the volunteers and appreciate the contributions they are making. It however emerged that the community leadership do not provide any form of incentives for the volunteers. One of the volunteers (Male) exclaimed that the community does not provide any support for his activities. He seems to suggest that his work is tedious and so expected some kind of motivation from the community. His assertion was corroborated by an elite male opinion leader who, though not too enthused about the fact that the community does not do anything to support the volunteers also believed they don't deserve any incentives. A minority of the respondents suggest that they did not know that the community leadership was to do anything as a form of motivation for these volunteers.

"... No help comes from anywhere, in the community I am the only one who shares the medicines and the community is really huge but am still the only one who shares the medicine. The health facility per say, in case they call us to go and meet at Akoase, apart from our transportation that's all"

"Not a penny, they don't even go and assist them at their various farms, we do nothing for them and that's the reason why they are called volunteers because they have volunteered".

The management and organization of CHPS in this study suggest that there was a partnership between the health sector and the communities in the formation of health committees. However, the health sector did not make use of existing structures.

3.7 Health managers' view of community involvement in CHPS

One of the objectives of the study was also to investigate the views of health managers regarding how they see community involvement in CHPS. The findings of the study indicate that among the DHD members, they were with the view that community involvement for the CHPS programmes has reduced drastically compared to some times past. They were also with the view that, community involvement has gone down to the extent that even weeding around the CHPS compounds even becomes a problem as some communities demand payment from the CHOs before they weed. Again, responses from the health managers show that the community does not demand any accountability from the health workers because they feel they are just doing their work and that it is not the responsibility of the community to demand any accountability. The DCC did not mince words when he expressed that the communities are "struggling" to participate in health programmes. By his view, it could be argued that the communities want to participate in health programmes but lack the capacity to get involved or they are simply not given the opportunity to participate. See his commentary:

"But when it comes to the commitment doing their part, that one I think they are struggling with it. Struggling with it in the sense that sometimes getting them to do their part is a bit difficult um we may have to meet them they will tell you "oh don't worry we will do it the next day. It's like community coming together to do stuff is a bit low nowadays, yeah".

The DHIO believes the communities should provide some basic things like tables and chairs for the health workers to use but these are not provided for. Again, he seems disappointed in the level of community involvement in the CHPS programmes at the moment because according to him, there used to be community involvement some time past. This is his comments

"When you go to some places you realized that some of these things, they are lacking. When it happens like that, it means the communities are not being involved in the health activities. What we have come to hear is that in some time past the community involvement was very high but these days it is like everybody is thinking about him or

herself. *"Uhm the involvement, they see it that if I want to support in community health activities then I have to get something in return, be it in cash or in other kind. That is how it is like now but in time past the volunteerism was there but now we are not seeing that".*

The health managers nevertheless maintain that there is a cordial relationship between the communities and health officers because of their representatives thus the CHOs seem to be working peacefully in the communities. According to the District Nutrition Officer (DNO), the DHD has a very cordial relationship with the communities they serve. Her view was consistent with the views of the other DHD members. One quickly asks then what has happened for the breakdown in community involvement in CHPS? Is it something the DHD and health professionals are not doing well or right? Is there an opportunity or an avenue to explore to rekindle community spirit again? The view of the DNO is shown below

"When we get to the community the way they respond to us (you see) in terms of the relationship I will say it's good. They like us when we visit them. Errhm when they have issues usually they tell their community health nurse or sometimes together with the nurse they come to the district. Sometimes they invite us to the community and we go there we also have situations where we have issues to share, we tell the health staff there to relate but there is sometimes we go down there together with the health staffs to go and meet the opinion leaders and if we need the whole community we go ahead to do so".

The two CHOs interviewed all shared similar views as expressed by the DHD members as far as their relationships with the communities are concerned. This again provides an avenue for the health sector to strengthen the relationships. An excerpt by the CHOs are below

"I don't know how to put it. We are friendly when I see them and I know such person speaks my language, I do speak with them and I can also speak twi. I am friendly with everybody. I have a cordial relationship with them".

"I guess you can attest it for yourself. When we were walking in town you saw me with them when they were calling me as "doctor" in as much as I'm not a doctor, but then you know in this community when they see you a man as the.... they refer to you as a doctor. The relationship is very cordial".

Even though the core members of the DHD view the involvement of the community as low, the CHOs who work in the communities share a different opinion. The CHOs though acknowledged that it is difficult to engage the communities recently, there are many occasions that the community offer their unflinching support to health programmes and even some of them provide foodstuffs for their upkeep. Excerpts below

"With regards to involvement of the community, in the CWC aspect their involvement is really great and they do same with ANC. pertaining to the attendance is really good, they come in their numbers". (Female CHO)

"Let's say if I am rating them in terms of percentage, I will say 70% because when I started earlier I said they are humans and with some things are noted among humans, so you can't take some things out of them but then in a whole I will say if I do inform them, they do partake and its encouraging somehow, encouraging". (Male CHO)

In conclusion, the DHD members believe that the community involvement in CHPS programmes in the district has gone down compared to what they had heard in the time past. They also revealed that there is a very cordial relationship between the two parties (Health Managers and Communities) which could be an opportunity to rekindle community spirit in health programmes.

CHAPTER FOUR

4.0 DISCUSSION AND CONCLUSIONS OF STUDY FINDINGS

Community participation though has received worldwide support for its role in ensuring positive health outcomes, critics have questioned the various forms community participation occurs and subsequent outcome on interventions. This research explored how the communities experienced their involvement in the CHPS programme design in the Birim North district of the Eastern region. Key findings are discussed under four major themes, and each theme is followed by conclusions.

4.1 Community involvement in the decision about choice of facility

The study shows that the communities were not adequately involved in establishing the choice of a facility for the community. Usually, it is expected that the community is engaged to decide on what kind of facility should be built or constructed for them. This will earn the total support of the community as well as foster community ownership and long term sustainability. Not involving the community in deciding the kind of facility seems to suggest imposition by the authorities with the communities accepting it though not their choice. Health is always a pressing need for community members especially those in deprived areas. They, however, wish for a facility that they presume will serve their needs. Authorities also provide facilities based on available resources and according to plans. It is not surprising that there will always be differences between what communities' desire and what the state can provide. In such situations, it is incumbent upon the state to engage the communities for a consensus to be reached before a facility is provided. Many states, however, take advantage of the fact that communities will not refuse a health facility no matter what discourses occur. We must not lose sight of the fact that this programme is community-based and as such the success of it depends largely on community acceptance. This finding was consistent with Baatiema et. al. (2013), whose study in the Upper West region of Ghana showed similar trends. Again, Rappaport (1987) and Wallestein (1992) argue that programmes that seek to empower communities must ensure active participation of the community at all levels of the programme design though Parry and Wright (2003) believe otherwise. Our findings and that of Baatiema et. al. (2013) raise concerns in the CHPS policy guidelines that mandate all DHMTs to demarcate their districts into CHPS zones. Our view is that this limits the communities' ability to negotiate for a bigger facility. Again should communities be coerced into accepting any programme or intervention just because they are in desperate need? In such cases, how willing are the communities to fully participate in such interventions in the long run?

It is thus concluded from the above discussions that the communities were not involved in the decisions that led to the CHPS programmes design. It emerged that the CHPS compound was imposed on the communities who preferred a bigger facility. This amount to non-participation according to Arnstein's concept and therefore puts the sustainability of the CHPS programme in doubt.

4.2 Composition of leadership and community involvement in planning of CHPS

Results from the study also depict male dominance in all aspects of leadership. This seems to reinforce the existing inequalities as far as gender roles are concerned. This assertion seemed to be accepted in most communities and ultimately affect the outcome of programme interventions (Prost, et. al., 2013). When such gender disparities dominate in programmes especially health, it prevents the female voice to be heard and included in decision making that affects the health of especially the vulnerable in society. This was also realised by Baatiema et. al. (2013). It is also worthy of note that gender disparities in governance have the potential to undermine community participation as witnessed in the study which is supported by Macwan'gi & Ngwengwe (2004) as well as Iwami & Petchey (2002) and Parry and Wright (2003). CHPS is health and it is an undeniable fact that as far as health is concerned, the groups that are mostly affected are females and children. When leadership does not make use of the voice of females, decisions are likely to skew

against females and children which will eventually affect the health of the community. It is also important to note that there is a tremendous shift in responsibilities where the females are taking roles in decision making even in cooperate organizations. These all suggest that the era when women were supposed to be left behind have passed and as such, leadership in the communities as well should embrace women. Involving women in decision making will have the tendency of incorporating the needs of the socially excluded as argued by O'Mara-Eves et. al. (2013). The study observed limited opportunities for the communities to be engaged through meetings and durbars towards planning the CHPS programme. This is consistent with D'Ambruoso et. al. (2017) who suggest that it is impractical to involve the community in public health planning from the human rights point of view. Such meetings and durbars depending on its quality have the potential to win the hearts of communities and gain their trust and friendship for successful community participation (Irvin & Stansbury, 2004, Marston, et. al., 2016). The lost opportunity to engage the community according to this study suggests such trust could be lost in these communities. The findings are also consistent with Rifkin et.al (2000) who argue that non-involvement of community undermine the opportunity of the socially marginalised to assume control of their own health and also create and shape knowledge. Baatiema et. al. (2013) shares similar view where community meetings and durbars were limited, depriving a broader consultation with all stakeholders. The study also revealed a very significant finding. The Ghana government has taken interest in expanding the CHPS concept by constructing CHPS compounds. However, the political leadership do not fully understand the community-based concept of CHPS and think merely building a compound is enough. As a result, political leadership tend to build compounds in communities without proper engagement with the DHD. This leadership style by the political figures deprives communities from actively participating in decisions that affect their health. It is important to note that as far as politics is concerned, there are sections of the community who belong to one party or the other and may not contribute meaningfully once a project or programme is viewed through a political lens.

In conclusion, male dominance in leadership is still persistent in the communities. This was apparent at the community level and the health committee levels. This prevented women and other marginalised groups to be adequately represented in decision making in the communities. This amounted to degree of tokenism where little consultation and much of informing was done by community leaders in the CHPS programme design who were dominated by males.

Another conclusion is the involvement of party politics in the CHPS process in the district. The political involvement deprived the DHD of taking full control in engaging the community leadership to mobilise community resources and to supervise the construction of the compound and this has delayed the operationalization of the CHPS programme though the CHPS compound has been inaugurated. The kind of participation as a result of political involvement had two components. In one instance, the community was manipulated into accepting the CHPS compound, leading to non-participation but in another instance, the communities were asked to contribute by providing land and also clearing the land for the commencement of the construction, which is viewed as a form of partnership hence degree of citizen power in Arnstein's concept.

4.3 Resource mobilization

Identification and utilization of community resources in community directed interventions improve community participation that assures ownership and long term sustainability (South, 2015). Programme designers seek to use community resources as a means of galvanising community participation. In this study, it emerged that such community resources were not adequately harmonised. Inability to identify and use community resources deprive them the opportunity to participate effectively as they see the project as foreign. To corroborate the seemingly ineffective partnership, Lane and Tribe (2010) suggest that effective partnership will result in positive outcomes. Political disposition was

overbearing in this circumstance. Politics overshadowed community participation. It limited the community's power to supervise and monitor the construction of the CHPS compound. The community regards it as a government project and not the community's. The involvement and subsequent effect of politics is consistent with what Mark and Erwin (2016) emphasise as the disruption of social cohesion when politics play a leading role in facilitating community participation. The results imply that the authorities did not consider the inherent power and attachment that communities have towards programmes that they contribute towards in cash or kind. In Ghana, it is generally perceived that free things are not of good quality and therefore for communities to value something, they must contribute towards it. Failure to understand and apply this might lead to programme failure. Indeed Rifkin et. al. (2007) reiterate that one of the reasons why community involvement is integral in PHC is the availability of resources in the communities that can be utilized effectively and efficiently to bring positive health outcomes.

In conclusion, we realise that the programme failed to utilize the community resources to the maximum. This will undermine the communities' capacity to contribute towards the monitoring and welfare of the facility since their sense of ownership is limited. The fact that the communities were made to contribute and prepare the land denotes some kind of partnership that amounted to citizen control.

4.4 Organization and management of the CHPS programme

The CHPS programme is designed to be managed by the community leadership through CHCs and volunteers who work in collaboration with the health professionals. We found in our research that the CHCs were limited in their capacity to manage the CHPS programme because they were not given any formal training by the health authorities. Training them ensures proper integration into the planning process and implementation. Srivastava et. al. (2016) as well as Goodman et. al. (2011) share similar finding. Due to the insufficient training and engagement of the CHCs, their existence was somewhat questionable by the community members. This has the potential for them to shift their attention largely on health providers instead of their communities, because no one checks their activities, depriving the communities of active community participation (Falisse, et. al., 2012). The activities of the volunteers and CHC were greatly appreciated by the communities (George, et. al., 2015). It is worthy of note that the CHCs and volunteers are not paid and so the communities are expected to motivate these volunteers in their work. Our study revealed that, the communities were not doing anything to motivate these volunteers probably because they did not know they had to or just refusing to do it. Such attitude from the community has the tendency to serve as a demotivation for these volunteers. The composition of the health committees is male dominated, with its associated consequences as noted by other findings (Lane & Tribe, 2010, Attree, et. al., 2011, George, et. al., 2015). The difficulty in ensuring proper constitution of committees may stem from the fact that authorities may not even be abreast with the roles of these committees as suggested by Meier et. al. (2012).

Communities participate in health programmes if they know the end results will benefit them even though this is sometimes contextual (Farmer & Nimegeer, 2014). It is again suggested that the greatest beneficiaries of community participation are health providers. Community participation facilitates the smooth implementation of the intended interventions as beneficiaries need not be chased or coerced to receive such interventions. Our findings reveal that health managers view the involvement of the communities in health activities as not encouraging. It is not wrong to suggest that the communities are not participating as expected because they have not been properly engaged or involved in health programmes by the health managers. Their comparison of the present situation with the past brings a lot of questions as to whether this is a mere perception or fact as there is no evidence to support this claim. The health providers have designated staff to be resident in the CHPS compound so as to ensure successful implementation of the CHPS programme. This is consistent with the finding of Cawson et. al. (2007). There is a window

of opportunity to revive the eroding community spirit as there still seems to be a cordial relationship between the health sector and the communities.

To conclude, CHCs were formed to manage the CHPS compounds but not the entire CHPS programme. The community members knew these committees but their roles were not adequately communicated to the community. The formation of the CHCs did not take into consideration the presence of existing community structures. The composition of the health committees was also dominated by males. In the selection of committee members, the communities were given the power to choose without any interference from the health authorities. This kind of participation amounted to degree of citizen power due to the delegation, partnership and citizen control elements.

Again, CHVs are not given any form of incentives by the communities they serve though the communities recognise their existence and contribution towards health improvements in the communities.

4.5 Usefulness of the Conceptual framework used for the thesis

The conceptual framework was very useful for the thesis. It shows the level of power available to influence community participation in the CHPS process to address the objectives of the study. No element was missing in the analysis according to the framework used.

CHAPTER FIVE

5.0 RECOMMENDATIONS

5.1 Recommendations

The following recommendations are therefore proposed to these respective stakeholders

5.1.1 Ministry of Health/Ghana Health Service

- ✓ The MoH and the GHS should convene a broader consultation meeting with all stakeholders and revise the CHPS policy document that seeks to demarcate districts into zones without consideration from the communities involved.
- ✓ Such a consultation should also revisit the CHPS strategy, particularly the parts that relate to the involvement of communities, and make revisions to enable genuine participation.

5.1.2 The District Health Directorate

- ✓ It is recommended for the DHD to facilitate broader consultation meetings with the district assembly to explain to the political leadership the concept of the CHPS strategy so that they will all be on the same wave length in the implementation, not to create a situation whereby the construction of a CHPS compound will be viewed by communities as an agenda of a particular political party in order to strengthen community ownership of the CHPS strategy. There should be an agreement of what each sector is to do and what should be expected of the communities for the purpose of CHPS to be achieved.
- ✓ The DHD is to facilitate a dialogue between the communities and the health sector through the community leadership to explain to them the whole concept, what needed to have been done, what should be done and what the community must do to ensure that the implementation of the CHPS programme in the communities become successful
- ✓ The DHD should train all CHC members and volunteers for them to be adequately informed about their roles and responsibilities regarding the CHPS programme.
- ✓ The DHD should sensitize the community leadership to consider involving females in decision making processes in the community by giving women positions and allowing them to operate.
- ✓ The DHD should also encourage community leadership to find ways of motivating the volunteers and CHC members. This could be done through both formal and informal meetings between the community leadership and the DHMT since there is already a cordial relationship between these two stakeholders.

5.1.3 The Communities

- ✓ The community leadership should deliberately, through affirmative action, get women to be included in the decision making processes of the community. Such women should be encouraged and empowered to contribute to discussions whenever the need arises
- ✓ The community leadership should in consultation with the entire communities, devise means to incentivise the volunteers and community health committee members to serve as motivation for them to continue doing their voluntary services to the community.

5.2 Area for further research

A mixed method of both qualitative and quantitative research is needed to establish how community participation in the CHPS programme has contributed to improvement in health outcomes by comparing indicators in communities covered by CHPS and those not covered by CHPS

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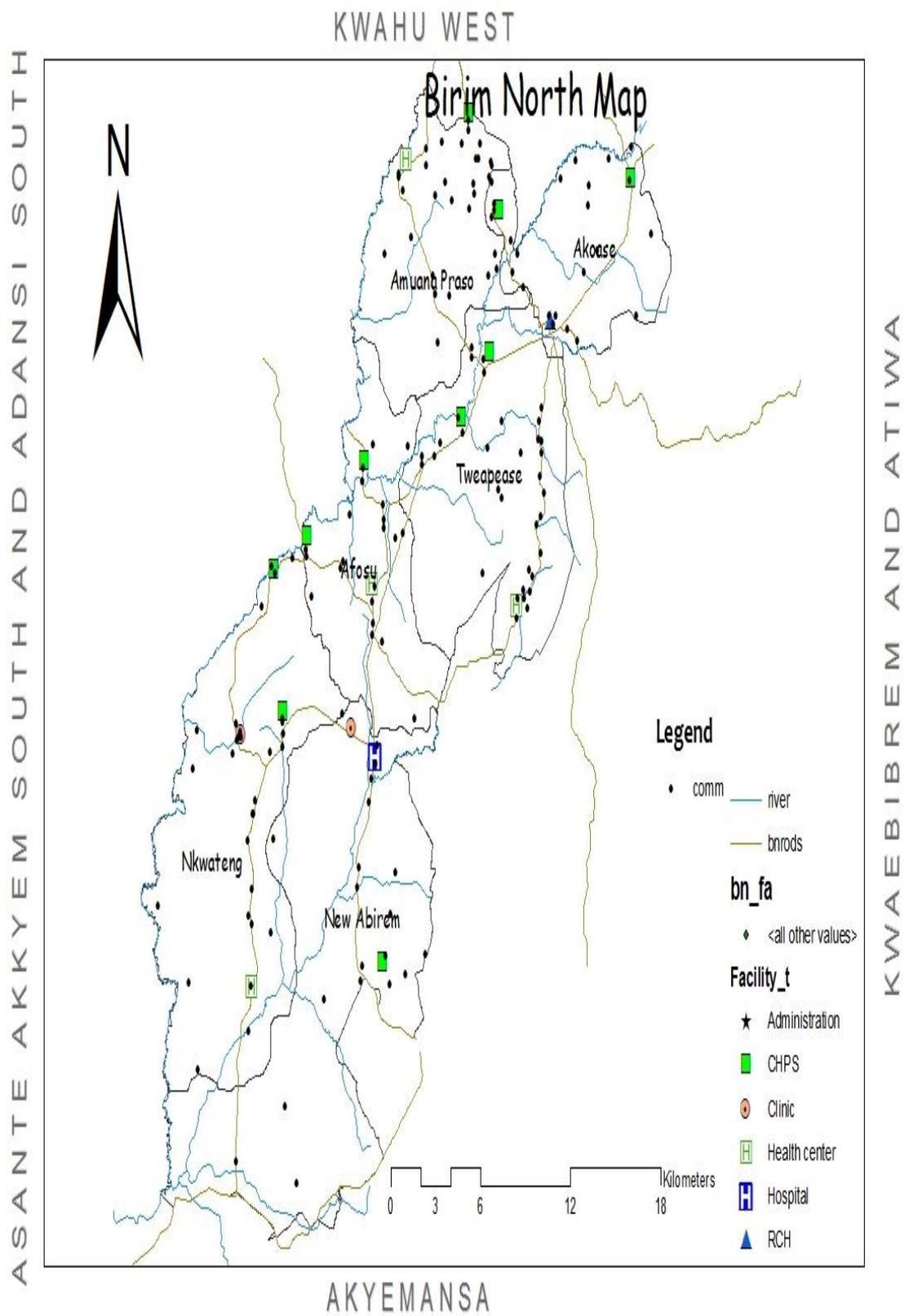
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Appendix 1: Map of the Birim North District



Appendix 2: Map of Ghana



Appendix 3: List of Tables

Table 1: health facilities

Facility type	Number
Hospital (NAGH)	1
Health Center	5
CHAG	1
CHPS Zones	14
Private Clinic	3

Table 2: List of respondents

SR. NO.	CATEGORY OF RESPONDENT	AGE
1	DISTRICT DIRECTOR OF HEALTH SERVICES	58
2	DISTRICT NUTRITION OFFICER	36
3	DISTRICT DISEASE CONTROL OFFICER	36
4	DISTRICT CHPS COORDINATOR	30
5	DISTRICT HEALTH INFORMATION OFFICER	33
6	DISTRICT PUBLIC HEALTH NURSE	36
7	MALE COMMUNITY HEALTH OFFICER	27
8	FEMALE COMMUNITY HEALTH OFFICER	27
9	MALE HEALTH COMMITTEE MEMBER	48
10	FEMALE COMMUNITY MEMBER	43
11	MALE COMMUNITY MEMBER	64
12	MALE OPINION LEADER	59
13	FEMALE HEALTH COMMITTEE MEMBER	32
14	MALE COMMUNITY HEALTH VOLUNTEER	39
15	FEMALE COMMUNITY MEMBER	28
16	MALE COMMUNITY HEALTH VOLUNTEER	44
17	FEMALE COMMUNITY HEALTH VOLUNTEER	59
18	MALE COMMUNITY MEMBER	50
19	MALE COMMUNITY HEALTH COMMITTEE MEMBER	42
20	FEMALE OPINION LEADER	53
21	MALE OPINION LEADER	58
22	MALE OPINION LEADER	51
23	MALE FOCUS GROUP DISCUSSION 1	MEAN=43
24	MALE FOCUS GROUP DISCUSSION 2	MEAN=39.4
25	FEMALE FOCUS GROUP DISCUSSION 1	MEAN=41
26	FEMALE FOCUS GROUP DISCUSSION 2	MEAN=36.3

Appendix 4: Organization of Health Service Delivery in Ghana

Health Services in Ghana are organized in a robust and comprehensive manner. The health delivery system comprises the public and private (profit and non-profit) which may be formal or informal. The system of operation determines the flow of information from the lower level to the higher level and subsequent feedback flow of information. The location of a facility determines the level of operation. Generally, the organization of health services range from the community level to the national level. In the formal public system, the community level facilities are manned by Community Health Nurses, assisted by community health workers (volunteers) in a system known as the community-based health planning and services (CHPS). Other private health providers (formal or informal) also exist, including chemical shops and traditional birth attendants and traditional healers. The next level from the community level is the sub-district level which mainly comprises health centres, health posts and some community clinics. These facilities serve as the referral points for the CHPS compounds from the community level as well as the other private providers of health services. Facilities from the sub-district level report and refer to the next higher level which is the district level. At the district level, district hospitals, polyclinics and faith based facilities like Christian Health Association of Ghana (CHAG) are normally found. These facilities serve as the referral points for the facilities at the sub-district and community levels. From the district level, the next level is the regional level where Regional, teaching Hospitals and other private hospitals serve as the referral points for the district level facilities. The apex of the system of health delivery in Ghana is the National level. The Ministry of Health (MOH), which is headed by the Minister of health assisted by a deputy, is the place where policy guidelines and directives for the whole sector emanate. Also at the national level is the Headquarters of the Ghana Health Service (GHS), headed by the Director General. The Ghana Health Service is the implementing body of the policies, guidelines and directives of the Ministry of Health. The Headquarters of the Ghana Health Service operates through its eleven (11) directorates namely Family Health, Finance, Health Administration and Support services, Human Resources, Institutional Care, Internal Audit, Office of the Director General, Policy, Planning, Monitoring and Evaluation, Public Health, Research and Development, Supplies, Stores and Drugs Management. All the public health facilities in the country are covered by the National Health Insurance Scheme whilst the majority of the private (non-profit and profit) are also accredited to operate under the National Health Insurance Scheme. Reproductive Health Services are covered under the National Health Insurance Scheme under the public sector and private sector facilities that are accredited except contraceptives. Adolescent sexual and reproductive health services are rendered at the health centre, CHPS and hospitals. CHPS activities embraces adolescent sexual reproductive health issues but do not have a designated office for adolescent services as can be seen at the health centres and hospitals.

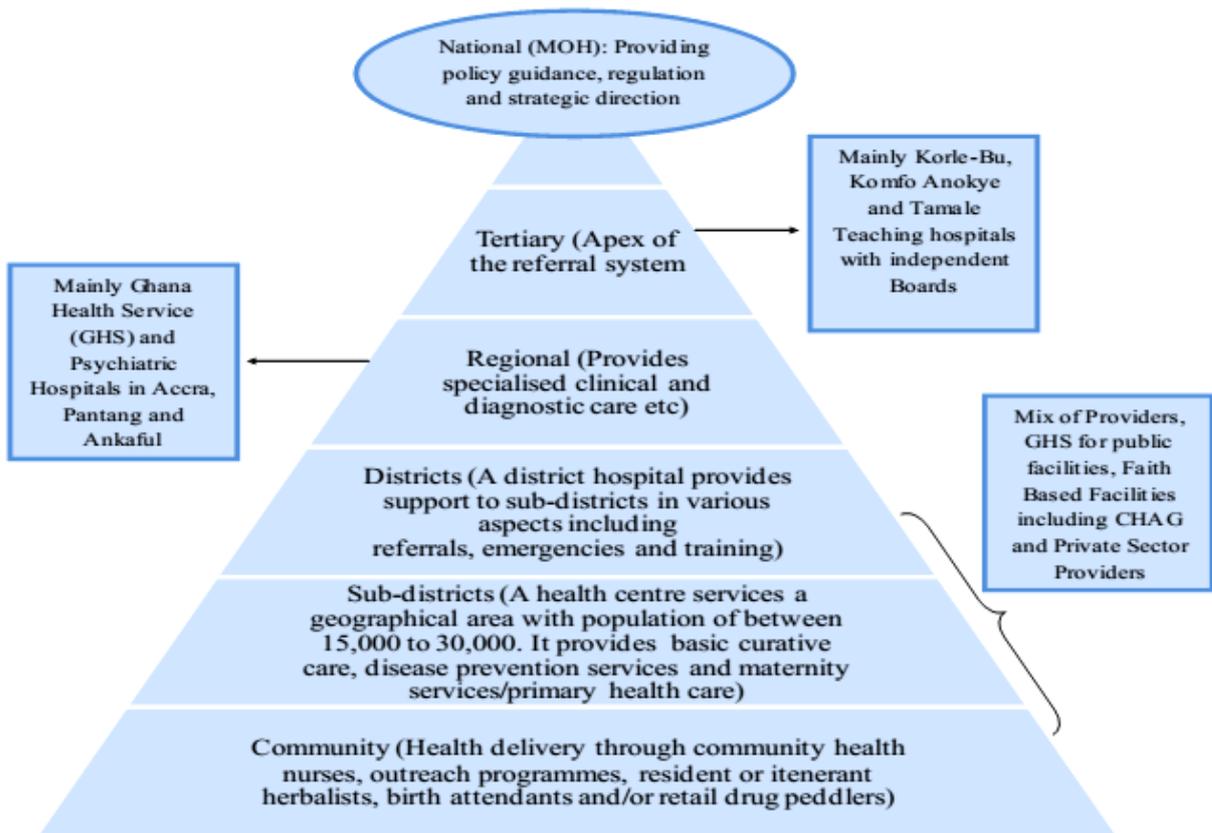


Figure 2: organization of health services in Ghana

Source: DHIMS II, GHS, 2014

Appendix 5: Ethical Approval letter from the Research Ethics Committee, KIT



KIT | Health

Contact

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Our reference KIT Health

Amsterdam, 8 may 2017

Subject Decision Research Ethics Committee on Proposal S79

Dear Daniel,

The Research Ethics Committee of the Royal Tropical Institute (REC) has reviewed the proposal entitled "The Community-based Health Planning and Services (CHPS) as a Strategy of Health Delivery in Ghana: The role of Community Involvement in the Birim North District of the Eastern Region of Ghana"

The decision of the Committee is as follows:

The Committee has reviewed the revised protocol and has taken note of your changes and clarification, and is pleased to see that you have addressed our concerns and questions to our full satisfaction.

The Committee is of the opinion that the proposal meets the required ethical standards for research and herewith grants you ethical approval to implement the study as planned in the afore mentioned protocol.

Kind regards,

P. Baatsen,
Chair Research Ethics Committee, KIT

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Royal Tropical Institute

Appendix 6: Approval letter from Region of studies

In case of the reply the number and the date of this letter should be quoted.

My Ref: ERHD/15/01/17
Your Ref. No.



REGIONAL HEALTH ADMIN,
GHANA HEALTH SERVICE
EASTERN REGION
P.O. BOX 175
KOFORIDUA

Tele: 03420-23341
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12th JUNE, 2017

THE DISTRICT DIRECTOR
GHANA HEALTH
SERVICE
BIRIM NORTH
NEW ABIREM

BIRIM NORTH DHD
RECEIVED
DATE: 15/6/17

RE: PERMISSION TO CONDUCT A STUDY IN THE BIRIM NORTH DISTRICT

Your letter with reference no. GHD/DHA/BN/050/17 dated 2nd June, 2017 on the subject quoted above refers.

You have been granted approval to allow Mr. Daniel Atta-Nyarko to undertake his research work in the Birim North District.

It is hoped that you will offer him the needed support to facilitate his work.

Thank you.

~~ASARE BEDIAKO-MICAH~~
ASARE BEDIAKO-MICAH
DEPUTY DIRECTOR, ADMINISTRATION
AG. REGIONAL DIRECTOR OF HEALTH SERVICES
EASTERN REGION

Min 2

Att. pls for your attention

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Appendix 7: Approval letter from study district

In case of the reply the number and the date of this letter should be quoted.



District Health Directorate
Ghana Health Service
P.o.Box 15
New Abirem E/R
Ghana.

My Ref. No. GHS/DHA/BN/039/17

Your Ref. No.

17th May 2017
Tel. 050613468/ 0243329133
Email: birimnorthhealth@yahoo.com

MR. DANIEL ATTA NYARKO
DEPUTY DIRECTOR ACADEMIC
COLLEGE OF HEALTH – YAMFO
BRONG AHAFO REGION.

RE: PERMISSION TO CONDUCT A STUDY IN THE BIRIM NORTH DISTRICT

Reference to your letter dated 16th May 2017 on the above subject refers:

Permission has been granted you to carry out a Study on the topic “*The Community – Based Health Planning Services (CHPS) as a Strategy of Health Delivery in Ghana*” in the Birim North District from 25th June to 15th July 2017.

Kindly submit to Management a copy of your Ethical Certificate on the intended topic for our perusal.

Thank you,

Mr. Emmanuel Fiebor
Senior Administrative Manager
District Health Directorate
Birim North.