EXPLORING COMMUNITY PARTICIPATION IN COMMUNITY-BASED HEALTH PLANNING AND SERVICES IN THE ASUTIFI SOUTH DISTRICT OF GHANA.

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Mini-thesis submitted in partial fulfilment of the requirements for the degree of

Master of Public Health in the School of Community and Health Sciences,

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KEYWORDS

Ghana Health Service

Community-based Health Planning and Services

Asutifi South District

Community

Participation

Community members

Community Health Management Committee

ABSTRACT

Disparity in health service delivery between Ghana's urban and rural areas has been noted to have contributed significantly to the huge gap that exists in health status between the rural and urban areas in the country. Consequently, since the Alma Ata Conference in 1979, Ghana has had a policy of making community-based services available to all, through community-based care and has adopted the Community-based Health Planning and Services (CHPS) Initiative as a national health reforms strategy to mobilize volunteerism, resources and cultural institutions for supporting community-based primary health care. The successful implementation of the CHPS initiative rests heavily on the participation and involvement of the communities.

Aim: The study was an explorative descriptive study that aimed to explore the perceptions, opinions and experiences of stakeholders involved in the CHPS implementation in the Asutifi South District of the Ahafo region of Ghana.

Method: The study employed a qualitative research approach. 17 participants were recruited from two groups of stakeholders, namely: 7 Frontline health workers and 10 community members. All participants were purposively sampled based on their knowledge and/or involvement in CHPS operations. The study was conducted in June 2020 and employed two focus group discussions and a community conversation to collect data. The descriptive data was coded and categorised according to the themes recommended in Rifkin's Spidergram and other themes that emerged during analysis.

Results: The study found that the extent of participation of the community in CHPS was not as wide and deep as it ought to be and that community members were practically not involved at the needs assessment, planning and design stages of the CHPS programme. The community members

were however deeply involved in resource mobilization and management of the clinic. It was also observed through the study that women were not involved in the Community Health Management Committees which are responsible for managing the CHPS programme.

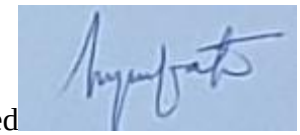
Conclusions: The study concludes that communities participate in CHPS in several ways and that there will always be some form of participation irrespective of how narrow or wide that participation is. The non-involvement of the communities at the needs assessment, planning and design stages of the CHPS programme is worrisome and that the lack of female representation indecision making presents a major challenge to the communities' participation in CHPS.

Recommendations: The study recommends that all efforts must be made to ensure that the communities are involved in CHPS programme early so that the local people can fully own the programme and that to ensure that females are involved in decision making, they should be given quota on all health committees.

DECLARATION

I declare that **Exploring Community Participation in Community-based Health Planning and Services in the Asutifi South District of Ghana** is my own work. It has not been submitted for any degree or examination in any university. All the sources that I have used or quoted have been indicated and acknowledged by complete references.

Kwasi Tutu Ali February 2022

Signed 

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LIST OF ABBREVIATIONS

ANC Antenatal Clinic

CHMC Community Health Management Committee

CHO Community Health Officer

CPHC Comprehensive Primary Health Care

CHPS Community-Based health Planning and Services

CHV Community Health Volunteer

CIA Central Intelligence Agency

DA District Assembly

DFID Department for International Development

DHMT District Health Management Team

FDG Focus Group Discussion

GDP Gross Domestic Product

GEHIP Ghana Essential Health Intervention Programme

GHS Ghana Health Service

GSS Ghana Statistical Service

HMT Health Management Team

MOH Ministry of Health

MTHS Medium Term Health Strategy

NHIS National Health Insurance

PHC Primary Health Care

RCC Regional Coordinating Council

SDG Sustainable Development Goal

UHC Universal Health Coverage

UN United Nations

USAID United States Agency for International Development

WHO World Health Organization

DEFINITION OF TERMS

Assembly member: The District Assembly serves as the highest political authority in the District. The majority of the members are elected to represent designated electoral areas within the district. Some members, are however appointed and others serve in an ex-officio capacity.

CHPS Community: A town, part of a town or a group of villages or settlements grouped together and designated as such by the district assembly as sub-units of a CHPS Zone. These are mapped for ease of planning of itinerant services and assignment of CHOs and CHVs. A CHPS Community in a densely populated area shall be approximately 1500 persons or 250 households.

CHPS Compound: An approved structure consisting of a service delivery point and accommodation complex both of which must be present.

Community Health Management Committees: Community leaders drawn from the CHPS Community with different competencies and responsibilities who volunteer to provide community level guidance and mobilisation for the planning and delivery of health activities and see to the welfare of CHOs in their community.

Community Health Officer (CHO): A trained and oriented Community Health Nurse working in a CHPS zone and may be assigned to a community within the zone

Community Health Volunteers (CHVs): Non-salaried community members identified and trained persons supporting CHOs in a community within the CHPS zone

CHPS Zone: Refers to a demarcated geographical area of a 4 kilometre radius and between 4500-5000 persons or 750 households in densely populated areas and may be conterminous with electoral areas where feasible.

Durbar: Gathering of community members which serves as a platform for communities to discuss and implement developmental projects.

Health Centres provide basic preventive and curative services (mainly OPD). They may have the capacity for basic tests (e.g., Malaria, Haemoglobin, etc). They are managed by Physician Assistants

Primary Health Care System: Organization of people, institutions, and resources that deliver essential health care services to meet the health needs of targeted people at the community level.

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CHAPTER ONE: INTRODUCTION

This chapter introduces and orientates the reader to the study. It includes the background to the study, the problem statement, the purpose of the study, setting of the study, an overview of the research design and methodology, and an outline of this report.

1.1 Background

Geographic access to healthcare remains a major barrier to quality healthcare. Indeed, the high childhood mortality that is witnessed in Ghana is partly due to service inaccessibility (Nettey et al, 2010). In 2014, the CIA fact book on Ghana indicated that nearly 54 percent of Ghanaians lived in rural areas (USAID, 2014). However, women in these rural areas of Ghana travel 4km more than their counterparts in urban areas to get to hospital (Dotse-Gborgbortsi et al, 2020). The disparity in access to health care has been noted as a factor that has contributed to a gap in health status between urban and rural areas (Ghana Health Service, 2005). This disparity has been considered to be one of the significant contributors to child deaths in rural communities – with these being 75 per 1,000 live births in the rural areas compared to 64 deaths per 1,000 live births in urban areas (Ghana Statistical Service, 2014). Indeed, Ghana Statistical Service (2011) and Gething, et al (2012) identified difficulty in accessing a health facility, involving patients travelling long and expensive distances, as a major factor that affects women's decision to access healthcare during pregnancy.

Since independence from colonial rule in 1957, Ghana has, through various developmental strategies, consistently been looking for ways to make health care service more accessible and equitable. For example, the Health Sector Reform initiative launched in 1996 focused on health system development especially at the district level (Ministry of Health, Ghana, 1995). The Medium

Term Health Strategy, 1996-2000 (Ministry of Health, Ghana, 1996a) which formed the basis of the health sector reform initiative came up with a series of Five Year Programme of Work and Common Management Arrangement plans (Ministry of Health, Ghana, 1996a) and produced a conceptual framework which has guided the Ghanaian health sector up to date. This is shown in the figure below:

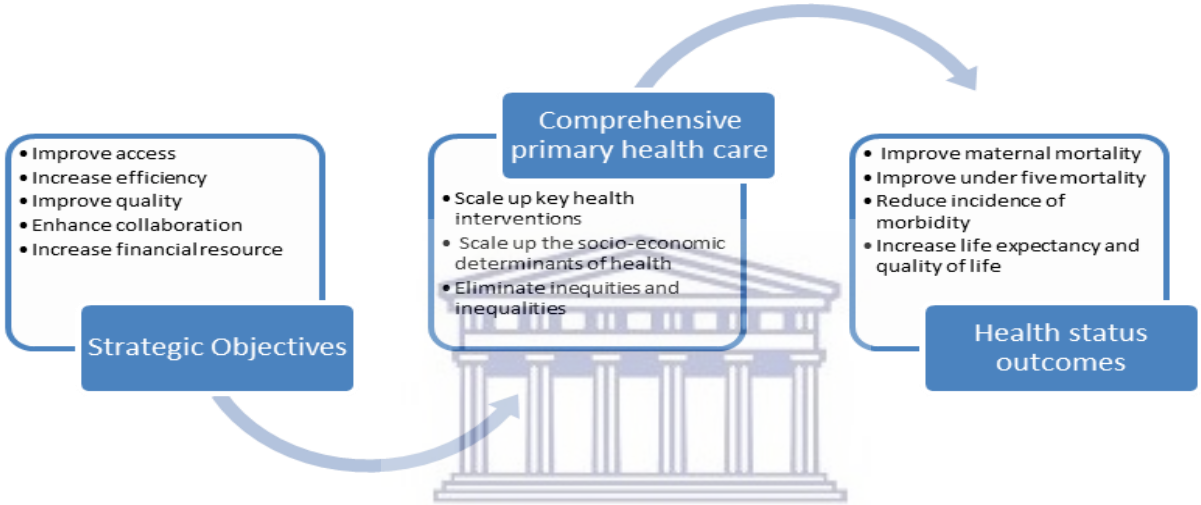

Figure 1: *Conceptual Framework for the five year medium term plans towards 2020*
Source: *Adapted from Ministry of Health, Ghana (2016)*

Primary Health Care (PHC) was seen as the bedrock of this reforms as depicted in the central part of the conceptual framework in Figure 1. This was demonstrated by the fact that about 40% of the annual discretionary budget expenditure in the health sector was channeled to the district and the sub-district levels where nearly all primary health care activities take place (Ministry of Health, Ghana, 2014b).

Subsequent strategies within the Ghanaian health sector have all been geared towards making health care easily accessible and equitable. These strategies have included the Medium Term Health Strategy (Ministry of Health, Ghana, 1996a), the establishment of the Ghana Health Service (Act 525) which led to the adoption of a sector wide approach, the Human Resources for Health

Policy and Strategy in 1997 which was revised in 2002 and again in 2007 (Ministry of Health, Ghana, 2007), the establishment of the National Health Insurance Scheme in 2004 (Act 650), the Health sector Medium-Term Health Development Plan, 2010- 2013 (Ministry of Health, Ghana, 2010), Reproductive Health Strategic Plan 2007- 2011 (Ghana Health Service, 2007), and the Community-based Health Planning and Services. National initiatives like the *Ghana Shared Growth and Development Agenda* (Government of Ghana, 2010) - a national development strategy running between 2010 and 2013 - have also highlighted the principle of health equity in the five policy objectives relevant to the Ministry of Health.

The Community-based Health Planning and Services

In 2005, in order to make PHC more meaningful and as a way of bridging this gap in health status between the urban and rural areas the Government of Ghana, the Ministry of Health (MOH), embarked on a process of health system decentralization which aimed at expanding basic and primary health care services to all Ghanaians, with the active and full participation of the community members (Ghana Health Service, 2005; Ministry of Health, Ghana, 2007; Ministry of Health, Ghana, 2016). Known as the Community-based Health Planning and Services (CHPS), this decentralization initiative was introduced so as to reduce the geographical barriers to health care access, particularly for rural communities (GHS, 2005) by providing health care at the doorstep of clients. The Ghana Health Service (2005:5) defines CHPS as:

> *"mobilization of community leadership, decision making system and resources in a defined catchment area called CHPS zones, the placement of reoriented frontline health staff, the Community Health Officer, with logistics support and community volunteer systems to provide services according to the principles of PHC".*

The introduction of CHPS into districts therefore aimed at facilitating greater participation of communities in the local health services.

According to the Ghana Health Service, CHPS was aimed at achieving three objectives: firstly, improving equity in access to basic health services; secondly, improving efficiency and responsiveness to client needs; and thirdly, developing effective inter-sectoral collaboration between the health sector and the other sectors of the state whose activities impact on health, such as local government, agriculture, education, communication, public works as well as with traditional authorities (GHS, 2005).

The CHPS initiative is also aimed to bring into fruition the ideals of the Comprehensive Primary Health Care (CPHC) approach. It therefore embraced the key principles of the CPHC approach which are equity, community participation, multi-sectoral action, appropriate technology and an emphasis on a health promotive and prevention approach (Ministry of Health- Ghana, 2016). According to the Ministry of Health (2016), CHPS is guided by the following five principles:

- Community participation, empowerment, ownership and volunteerism
- A focus on community health needs to determine the package of CHPS services within the CHPS community
- Task shifting through participation of volunteers as auxiliary staff who deliver services such as ordinary obstetrics and family planning as traditional birth attendants (TBAs) and community based volunteers to help achieve universal access
- The recognition of communities as sources of social and human capital for health system development and delivery, and

- The delivery of health services using a systems approach and thus acknowledging the importance of decentralization of the Ghanaian Health System.

As can be seen from the above principles, CHPS relies quite significantly on having the full participation and engagement of the communities in its planning, implementation and monitoring (GHS, 2005). It therefore attempts to empower communities and give them voice and choice in important health decisions that impact on their local community (Russel, 2008).

1.2 Problem Statement

Nyanator et al (2005) note that a key pre-requisite for the introduction of CHPS in any community is extensive planning, discussions and dialogue between the health service and the community. Understandably, there needs to be a willingness on the part of the community leaders to approve and support the CHPS initiative otherwise it will very likely be unsuccessful. Community participation is therefore the fulcrum around which the CHPS initiative revolves (Nyanator et al, 2005) and is considered as one of the critical elements for the successful implementation of CHPS across the country.

The extent of participation of communities in activities in the public health sector in Ghana is generally broad and includes the facilitation of community entry, dissemination of information and health education, the mobilization of resources, and engagement in planning and implementation (Galaa, 2008). However, the reality is not as inclusive as intended: for instance, in a study conducted in the three northern regions of Ghana between 2000 and 2002, Galaa (2008) found that communities were generally excluded from participating in needs assessments and their involvement in project planning and design was limited. Additionally, a more recent nationwide evaluation of the CHPS programme painted a picture of inadequate community engagement and

participation (Ntsua et al, 2012). Such findings provided the researcher with the necessary motivation to explore such issues in this study – and particularly in the geographical areas in which he was based.

Whilst some studies have been conducted to assess community participation in CHPS in Wa Municipality in the Upper West Region of Ghana (Baatiema et al, 2013 and in Nkwanta District in the Volta Region of Ghana, where CHPS was piloted (Azongo, 2002), no studies on community participation in CHPS have been conducted in Asutifi South District in the Ahafo Region, despite the fact that CHPS was introduced into this region a more than a decade ago. It is also important to note, as observed by Rifkin (1996), that community participation is dependent on local factors such as traditional structures, norms and practices, and in the case of CHPS, its successful community-based implementation hinges on the successful engagement with the existing traditional and social organization and leadership within communities (GHS, 2005). However, little is known about the extent to which communities within the Ahafo Region are participating in the CHPS programme and what aspects of its operations – if any – they are a part of.

Moreover, the CHPS operation has also traditionally relied heavily on funding from international donors such as the Global Fund, USAID and DFID. However, after Ghana was declared a lower middle income country in 2009, and increasingly in more recent years, foreign donor support has been dwindling (Arhin et al, 2018). The cessation of donor support for CHPS implementation has raised some concern amongst health managers in the region. Could the community participation initiatives of the CHPS be maintained and sustained without such donor support? Do community members actually have a sense of ownership of CHPS operations – whether donor support is available or not? Are there alternative ways of implementing the community participation activities more effectively within the region? (K. Issah, Personal Communication, 22nd March,

2018). These – and others – are the type of questions the health managers in the region and the district, as well as other stakeholders, expressed an interest in finding answers to.

1.3 Purpose

The study aims to contribute to the understanding that health managers and community leaders within the Asutifi South District and the Ahafo Region in Ghana have about the perceptions and experiences local community members have about their role within the CHPS operations, their sense of ownership of CHPS, and how they believe their participation in CHPS can be strengthened. These issues have pre-occupied health managers in the Ahafo Region and the Asutifi South District, as well as other stakeholders working within the regional health system in their quest to make the health system at the periphery more robust and make CHPS the focus of primary health care services in the region.

1.4 Study Setting

This study was conducted in three communities in the Asutifi South District (Apenamadi, Apotoyowa and Nkrankrom) in the Ahafo Region of Ghana. The Asutifi South district is one of the six districts in the Ahafo Region and was carved from the Asutifi district in 2012. The Asutifi South district has Hwidiem as the district capital and shares boundaries with Asutifi North District in the north, Asunafo south District in the south, Asunafo North District in the east, and in the west with Ahafo Ano North District. It is the district in which the researcher was based when the study was conducted in 2020.

Figure 2*: Map of Asutifi South District, Ahafo Region, Ghana*
Source: *Asutifi South District Assembly (n.d.)*

All the communities in the district may be classified as rural with the exception of Hwidiem, the district capital. According to the National Population and Housing Census of 2010, Asutifi South district has an estimated total population of 67,198 with a growth rate of 2.5% per annum. The male: female ratio is 1.03:1 (Ghana Statistical Service, 2011).

The people are predominantly farmers with little or no education and are engaged mainly in subsistence farming. The district is poorly served with health facilities. It has one district hospital

which is operated by the Catholic Church, three health centres and five CHPS compounds. Table 1 below shows the distribution of health facilities within the district.

Table 1: Health facilities and ownership in Asutifi South District

NO.	FACILITY	LOCATION	OWNERSHIP
1.	St. Elizabeth (District) Hospital	Hwidiem	Christian Health Association of Ghana (CHAG)
2.	Acherensua Health Centre [1]	Acherensua	GHS
3.	Dadiesoaba Health Centre	Dadiesoaba	GHS
4.	Sienchem Family Planning Centre	Sienchem	GHS
5.	Nkaseim Health Centre	Nkaseim	GHS
6.	Apenimadi CHPS compound[2]	Apenimadi	GHS
7.	Blessed Family Health Centre	Dadiesoaba	Private
8.	Community Clinic	Nkaseim	Private-Community
9.	Akotosu CHPS Compound	Akotosu	GHS
10.	Adolescent/Family Planning Centre	Hwidiem	GHS
11.	Apotoyowa CHPS Compound	Apotoyowa	GHS
12.	Nkrankrom CHPS Compound	Nkrankrom	GHS
13.	Woramumuso CHPS Compound	Woramumuso	GHS
14	Family Care Clinic	Acherensua	Private

Source: *Asutifi South District Health Directorate*

The three highlighted communities (Apenamadi, Apotoyowa and Nkrankrom) were chosen as the study sites because data from the District Health Directorate indicated that improvement on health indicators such as the ante-natal attendance, family planning acceptor rate, and supervised delivery over the past five years in these three communities were at different rates (Asutifi South District

Health Directorate, ASDHD, 2018). The choice of these communities was also to provide different accounts and perspectives to give the researcher a broader picture.

The Asutifi South District is also an interesting case study site because a number of Assembly members in the District have been expressing concerns about the operations of the CHPS – both on the local radio and at various stakeholder meetings convened by the District Health Directorate and the District Health Insurance Scheme. In 2010, one particular community (Apenamadi) even resisted the construction of a CHPS compound in the community because they felt they were not consulted and that the CHPS compound was not a priority need for them. They felt they needed a larger health facility which could provide more services (in other words, a Health Centre where they could have access to the services of physician assistant, general nurses and midwives as well as basic laboratory services). Exploring the nature and extent of the involvement and engagement of communities in the operation of CHPS in this district could thus help to shed some light on some of the emerging dynamics that appear to exist between CHPS and local stakeholders and beneficiaries.

1.5 Introduction to Research Design and Methodology of the Study

This study is an exploratory descriptive study which has used a qualitative research approach. A qualitative approach was selected since it allows for deep exploration and documentation of complex perceptions and experiences, and also allows participants to freely express themselves without being limited by a pre-determined set of questions as may be employed in quantitative approach (Pope and Mays, 1995). This makes the qualitative research approach particularly suitable for this study because it offers the researcher the opportunity to explore a contextual understanding of stakeholders' perceptions, opinions and experiences on the engagement and participation of the community in the operations of the CHPS in a way that cannot be elucidated

with a quantitative survey or set of interviews. The methodological aspects of the study have been described in further detail in Chapter 3.

1.6 An Outline of the Report

The report of this study is comprised of six chapters as follows:

Chapter 1 introduces the study. Chapter 2 reviews the literature for information that is relevant to the aims and objectives of the study. It also provides details from literature on the characteristics of the Ghanaian health system, community-based health planning and services and well as community participation in health. Chapter 3 describes the research design and methodology that was used for data collection and data analysis procedures, the attention that was paid to rigour, along with the ethical considerations and the study limitations. Chapter 4 presents the results of the study and Chapter 5 discusses these findings in the context of existing information from the literature and from the perspective of existing theory. Lastly, Chapter 6 concludes with a summary of the key findings of the study and provides a set of recommendations related to the study findings for future practice and research.

CHAPTER TWO: LITERATURE REVIEW

This chapter is comprised of two main sections: the first introduces the basic architecture of the Ghana Health System so as to contextualize the study and reviews literature on Community-based Health Planning and Services, and the second half describes some of the basic concepts in relation to community participation in health.

2.1 The Health Care System in Ghana

2.1.1 Overview

Ghana is a lower middle-income country in West Africa with a population of 30.8million (Ghana Statistical Service, 2021), an area of 238,537 square kilometres, and a per capita gross domestic product (GDP) of US$ 2,328.50 per year (World Bank, 2020). Life expectancy at birth was 63 years in 2015, and the total fertility rate was 4.2. Under-5 child mortality has steadily reduced from 155 to 60 per 1000 live births and the maternal mortality ratio has also reduced, from 634 to 319 deaths per 100,000 live births in 1990 and 2015 respectively (World Bank, 2016). Ghana is changing epidemiologically, demographically and economically and this change has influence on the already high burden of diseases, both communicable and non-communicable- as well as the growing number of trauma cases from increasing road traffic accidents (Institute for Health Metrics and Evaluation, 2010; Ghana Statistical service, 2021). This therefore requires not just a robust health care system, but one that also offers financial risk protection for the poor and marginalized. The National Health Insurance Scheme (NHIS), was therefore established by law in 2003, and became operational in 2004, to provide access to quality health services, financial protection against catastrophic illness and universal health coverage (Ministry of Health, 2004).

Ghana, since independence in 1957, has embarked upon a series of measures to provide health care to its citizenry. The post-independence period, from 1957 until the overthrow of the Nkrumah regime in 1966, was characterized by rapid expansion of health facilities across the country with the aim of providing basic medical care to the people. This period was followed by several key events intended to shape the design of Ghana's Primary Care strategy which was adopted in 1979 (WHO, 2017), and the associated district health system model that followed. Such key events included, for instance, the government partnering with religious organizations in the 1970s to provide health services in rural and underserved areas through mobile clinics and training and placing village health workers at a local community level (Ministry of Health, Ghana (1996b).

In the 1990s the Ministry of Health established district health management teams and started training public health practitioners and other cadres to provide needed leadership for the district health system and Primary Health Care system (WHO, 2017). Figure 3 below is an illustration of the key times and interventions in the establishment of primary health care system in Ghana. It details chronologically the various health intervention strategies that were undertaken by the Ghana government and its agencies which were aimed at making the Ghanaian Health System more efficient and readily accessible. As can be seen from the timeline, various strategies and reforms since independence were aimed at making the ideals of Primary Health Care realistic. It was not until 1994 that the CHPS concept was conceived and subsequently piloted in Navrongo. It was formally adopted by the government of Ghana in 2000, as a national strategy to improve access of care especially in the rural communities.

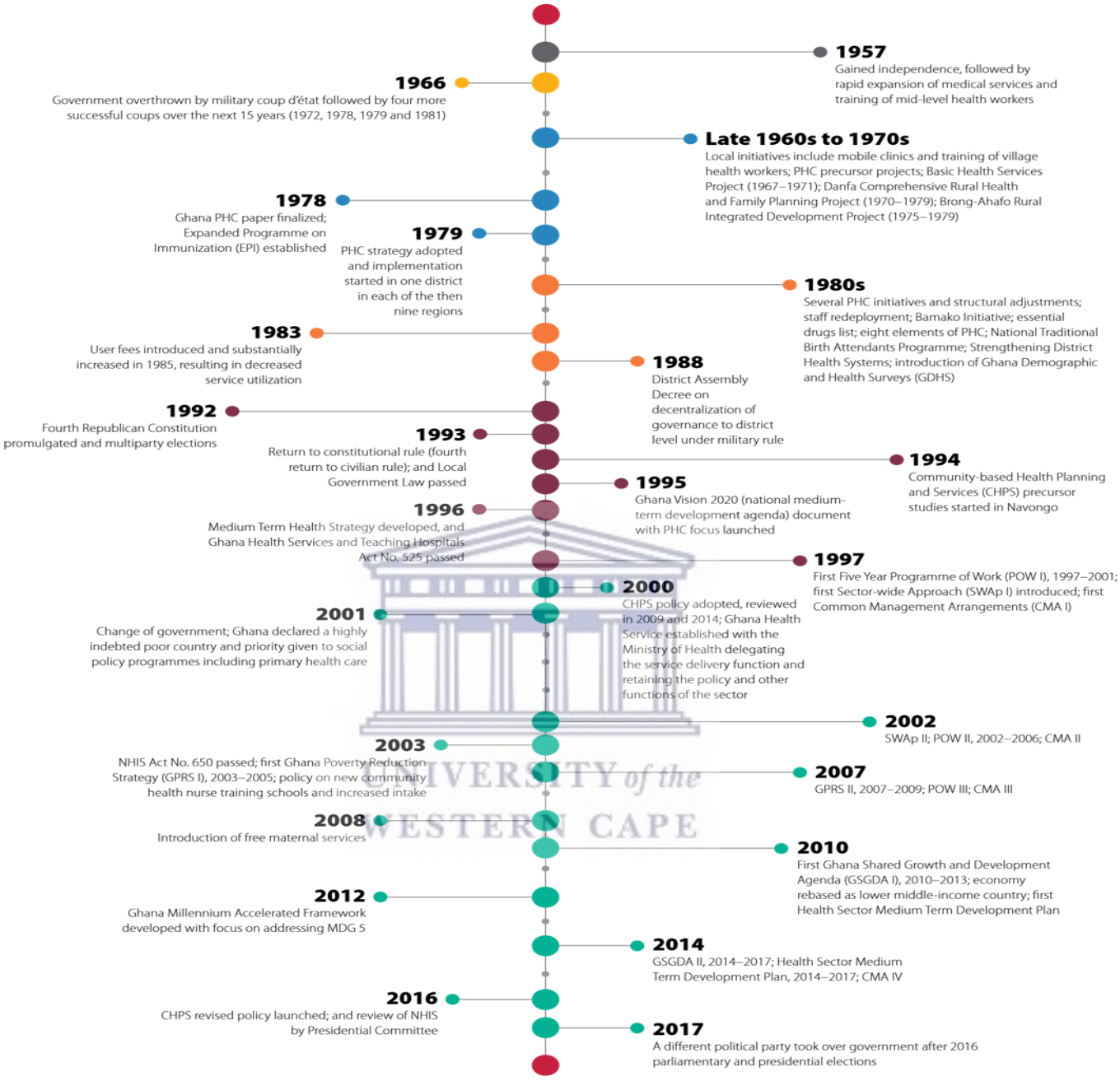

Figure 3: *Timeline of key developments relevant to the Ghana PHC system*

Source: *WHO, 2017:6*

2.1.2 The Governance Structure of the Ghana Health System

Ghana is a democratic government and has a decentralized local government system consisting of 216 District Assemblies (DA), with 16 Regional Coordinating Councils (RCC) performing a coordinating role.

As can be seen in Figure 4 (below), the Ministry of Health provides overall policy direction in the health sector. The Ghana Health Service is an agency under the Ministry of Health, which is responsible for providing direction and implementation of primary and secondary level health services in the country. It therefore works with all service providers at all levels to ensure access to quality primary care services, including tertiary (which is provided by the Teaching Hospitals in Ghana), faith-based, private, traditional and alternative service providers (Government of Ghana, 1996). PHC system governance at the national level is through Common Management Arrangements (Ministry of Health, Ghana, 1996a; Ministry of Health, Ghana, 2002; Ministry of Health, Ghana, 2014b) agreed among the sector stakeholders through various meetings, such as sector working groups, interagency technical group meetings, business meetings and health sector reviews and summits. At the Primary Care level, there are various technical management teams and corresponding committees, with representation from key stakeholders constituting the governance structures for the Primary Health Care system. The two key bodies are the corresponding Health Management Teams (HMT) and the Health Committees. The Ghana Health Service provides leadership at the regional and district levels through the respective Health Management Teams (HMT) to coordinate and provide technical support to the lower levels, and report administratively to the appropriate local government bodies such as the Regional Coordinating Councils and the District Assemblies. (Government of Ghana, 1996) through the corresponding Health Committees.

The Regional and District Health Committees have various sectors such as the corresponding local government, religious and traditional authorities to represent the voice of communities and other relevant stakeholders in health (Government of Ghana, 1996). In CHPS zones (community level), community health teams, comprising health workers and community volunteers, deliver integrated primary care services with Community Health Management Committees (CHMC) or Village Health Management Committees (VHMC) playing an oversight and supportive role (Government of Ghana, 1996).

As discussed above, the structure of the management of the Ghana's Primary Care System places significant emphasis on the participation of the stakeholders and gives them an important role. The health committees at the regional, district and the community level, according to their composition by law (Act 525), are dominated by the local people who represent the voices of the people. The health committees are supervisory, supportive and advisory bodies that work with the health workers to deliver the appropriate and tailored primary health care services to the communities (Government of Ghana, 1996)

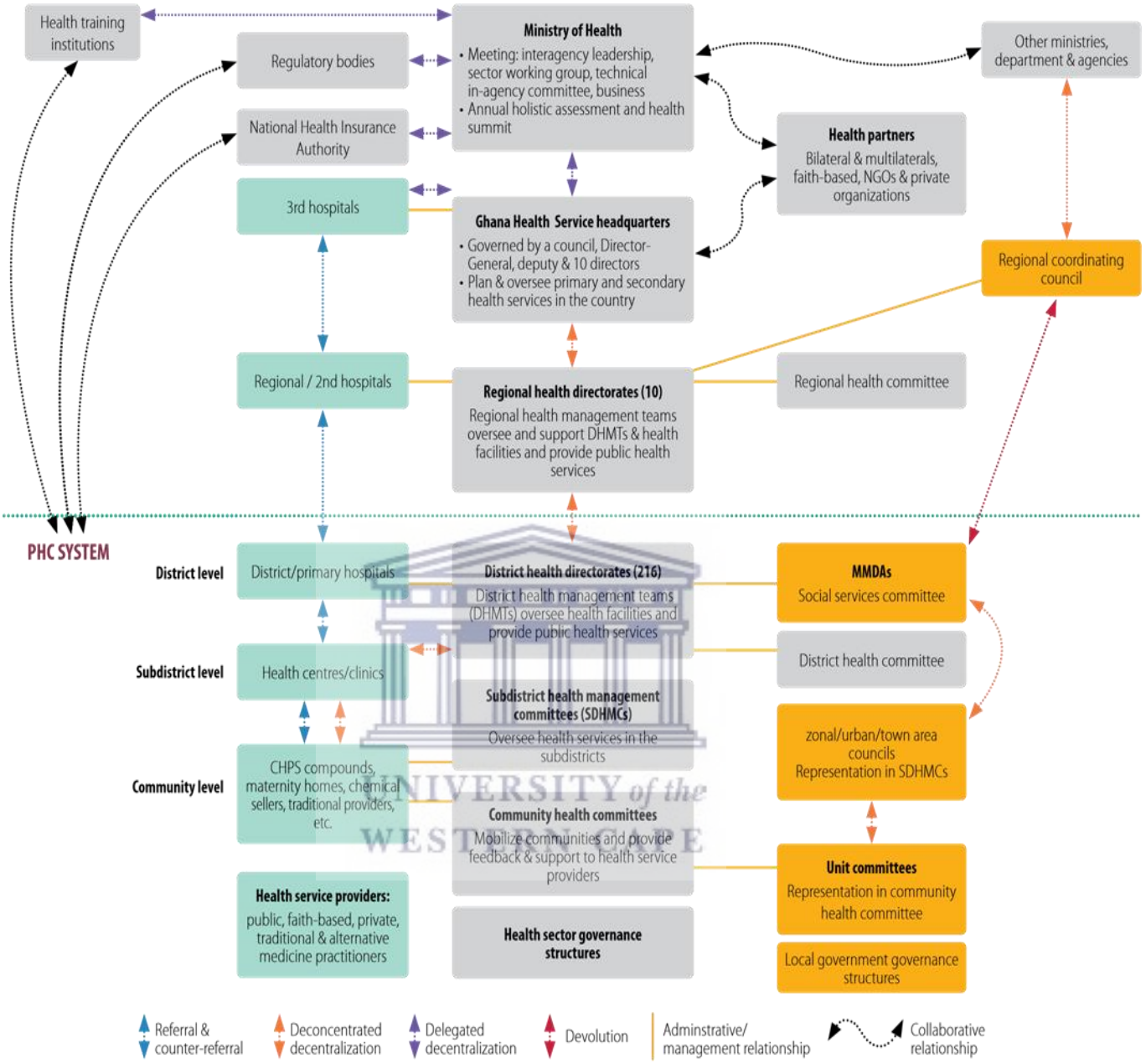

***Figure 4**: The governance structure of the Ghana Health System*
***Source**: WHO (2017:7)*

2.2 Community Based Health Planning and Services in Ghana

The desire on the part of policy makers in Ghana to make healthcare more equitable required the removal of all bottlenecks to accessibility of healthcare. The adoption of the PHC concept in the

1970s was the first real step taken by Ghana towards attaining that objective. The establishment of the NHIS and the CHPS were to demonstrate the countries commitment towards making healthcare equitable. In this section, community based health planning and services is described in more detail, while attempt is made to relate it to other policies especially the health insurance scheme which was also intended to make healthcare accessible and equitable.

2.2.1 Overview

Building on aspects of the Alma Ata Declaration, which declared health to be a fundamental human right and set the Health for All agenda in 1978 (WHO, 1978), UHC is described as a global initiative through which:

> "*all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship"* (WHO, 2015:7).

In the above description the WHO highlights that the aim of UHC is to ensure that every person (no matter where they live in the world) should have appropriate access to quality health services and that accessing health services ought not to put a person at risk of financial harm. Supporting the principles of UHC, the health-related Sustainable Development Goals (SDGs) recognize the importance of UHC and bring hope of better health and protection for the world's poorest (United Nations, 2015).

In the late 1970s, following the Alma Ata Conference, Ghana adopted the PHC principles and philosophy and enacted policies that were geared towards achieving community based health services (Awoonor-Williams et al. 2013). However, the very challenging economic conditions in

the 1980s and the 1990s made its attainment a mirage for Ghana. Access to healthcare services were hampered by not just geographical accessibility, but also by the high cost of services (Oppong, 2018). Fee for service (often referred to, within the Ghanaian health sector, as "cash and carry") was introduced as part of the Structural Adjustment Programme which limited access to health services for many people, especially the poor (Oppong, 2018).

To remedy this the National Health Insurance Scheme (NHIS) was introduced in 2003 by an Act of Parliament (Act 650) (Government of Ghana, 2003). The policy objectives of the Ghana National Health Insurance Scheme were stated as:

> "… *to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential healthcare"* (MOH, 2004: 6).

The implementation of the NHIS essentially aimed to remove any financial barriers so that its citizens could access such quality of health care. Besides the financial barrier to accessibility of healthcare that NHIS was introduced to solve, there was also a huge barrier to geographic accessibility to healthcare. Most of the health facilities were found in the cities while the rural areas, where majority of Ghanaians live, remained poorly served and therefore people had to travel long distances to access health care (GSS, 2003). The government of Ghana, through the Ghana Health Service therefore adopted the Community based Health Planning and Services (CHPS) as a way of bridging the gap in geographic accessibility to health service.

In 1994, prior to the implementation of the NHIS, a community-based health planning and services initiative was started in Navrongo, the Upper East regional capital of Ghana, as part of an operational research project which was then called the Community Health and Family Planning (CHFP) project (MOH, 2014d). Conducted by Ghana Health Service (GHS) and the Navrongo

Health Research Centre, it was based on lessons learnt from Bangladesh (Phillips et al, 2018). CHFP was conducted in three sub-districts and the experiment involved four different models for delivering services for the management of common illnesses such as malaria, acute respiratory infections, diarrhea diseases and other childhood illnesses, as well as for delivering family planning and immunization services (MOH, 2014d). The model that proved most successful had the following components:

- A compound where the Community Health Officers (CHO) lived and could be easily reached in an emergency – along with a courtyard for delivering Ante Natal Care (ANC) and other basic services;
- A volunteer assisted outreach programme that encouraged case tracing and referral, health education and confidential counselling, and
- A Community Health Management Committee (CHMC) which supervises the operation of the CHPS at a local level and sees to the welfare of the staff of the facility, particularly the Community Health Officer and the volunteers. (MOH, 2014d)

This model was successful in that child mortality was reduced by 38% and total fertility was reduced one between 1993 and 2000 (Pence et al., 2001). Additionally, there was an eightfold increase in case load, immunization and family planning coverage improved and fertility and deaths reported within the communities also decreased over the same period (Debpuur et al., 2002).

2.2.2 Scaling up CHPS in Ghana

These positive research results culminated in the replication of this model throughout the country. Starting in 1999, the model was replicated as a national strategy to improve access, efficiency and

quality of health care throughout Ghana (Ghana Health Service, 2002). The replication of the model therefore became another key national health policy to:

> "*re-orient primary health care services from sub-district health centers to convenient community locations. Its goal is to transform the dynamics of rural health care service delivery from community health care providers who passively wait for patients into outreach workers who actively seek patients in communities and their homes, also known as doorstep services"(*Awoonor -Williams et al, 2013: 118).

An important aspect of the preparation towards the national scale up of the CHPS system included the development of a guide to shepherd the implementation process – something which came to be known as the fifteen steps of the CHPS implementation process (Ministry of Health, 2014d). This included the training and designation of Community Health Officers (CHOs) as resident health care professional who will provide health service in a CHPS zone. CHPS zones were geographical coverage areas for community services. The CHOs were trained to provide reproductive, maternal and child health services, manage diarrhoea, treat malaria, acute respiratory infections and childhood illnesses and provide comprehensive family planning and childhood immunization outreach. Community volunteers were also trained to offer services by educating the community on basic health issues and served mainly as agents of referral services and community social mobilization to support the CHOs. The services offered by the CHOs were mainly delivered through home visits but treatment could be provided for those who come to the CHOs at their residence.

The success of the implementation of CHPS thus rested heavily on the local community for support. Along with other stakeholders in a community, the local community was also expected to

provide financial or in-kind resources for the construction of the CHPS compound and to provide oversight for service delivery and ensure the welfare of the CHOs through the Community Health Management Committee (Awoonor-Williams et al, 2013).

The Government of Ghana, through various pronouncements, proclaimed CHPS as a signature policy of the Ghana Health Service (GHS), to provide primary health services to all who need those services (Awoonor-Williams et al, 2013). The initial CHPS scale-up was meant to achieve complete national coverage by 2015 through the establishment of 6,000 CHPS zones. By 2008, it was realized that this target was unachievable since only 3,000 CHPS zones (half of the targeted 6,000) had been established (Awoonor-Williams et al, 2013). In 2010, Ghana then re-launched the CHPS policy by elevating Primary Health Care System as a priority on the national agenda and continued to strengthen and scale up the CHPS model to parts of the country that were not yet covered (Kweku et al, 2020a). This was called the Ghana Essential Health Intervention Programme (GEHIP). The re-launch was also used to develop, implement, and evaluate a programme of CHPS implementation reform, restructuring, and organizational change (Philips et al, 2018).

As part of this re-launch, the Ghana Health Service compiled a detailed implementation guide consisting of performance guidelines, implementation checklists and case studies to guide local health officials through the critical steps needed to establish new CHPS zones and strengthen existing zones to improve the quality of care (Ministry of Health, 2016).

Conceptualized as a fifteen-step process, there are a number of steps that focus specifically on community involvement and participation. These include consultation and raising awareness about CHPS (Step 2), dialogue with the community on the establishment of the CHPS and on the dates and venue of community information durbar (steps 3 & 4), the selection of community

members to serve on the community health committees (step 5) and the selection of Community Health Volunteers. The fifteen steps are listed below:

1. Plan
2. Consult and raise awareness of CHPS
3. Dialogue with community leadership
4. Community Information Durbar
5. Select and train CHOs
6. Select, approve and orient Community health management committee (CHMC)
7. Compile Community Profile
8. Compound Construction / Operationalize Compound
9. Provide CHPS Logistics
10. Durbar to launch activities of the CHPS zone
11. Select Community Health Volunteers (CHVS)
12. Approve CHV Selection
13. Train CHVs
14. Procure Logistics, Equipment and Volunteers supplies
15. Launch the CHPS zone (Ministry of Health, 2014d)

The GEHIP success and lessons learned from it provided a platform for accelerating CHPs scale-up throughout Ghana through an initiative known as the Programme for Strengthening the Implementation of the Community-based Health Planning and Services Initiative in Ghana (CHPS+). CHPS+ was launched in 2016 as a five year project which aimed to strengthen the capacity of District Health Management Teams (DHMT) to oversee improvements in the quality of primary health care, focusing in particular on family planning and maternal, newborn and child

health care delivery (Philips et al, 2018). CHPS+ was designed with the intention of decentralizing reform of CHPS implementation activities with lessons learned from GIHEP providing a guide to strategic planning and action involving team problem solving, peer mentoring, incentivizing financing for improving basic equipment requirements, and technical training (Philips et al, 2018).

2.3 Community Participation

2.3.1 Overview

Community participation is an important component of the CHPS initiative (Ministry of Health, Ghana, 2016). It so important to the success of the CHPS programme that it has been described as a fulcrum around which the CHPS concept revolves (Nyonator et al, 2005). Indeed, the importance of community participation has been well appreciated to all WHO member countries who accepted the Alma Ata declaration (WHO, 1978). In accepting Primary Health Care as government policy, all members of WHO recognised the importance of involving people, living in communities where services and programmes are taking place, in the design and implementation of those programmes and services (Rifkin,1990).

Whilst promoting community participation, the WHO (1978) advanced the following arguments:

- Health services argument: indicating that the services provided are under-utilised and misused, because the people for whom they are designed are not involved in their development.
- Economic argument: that there exist in all communities, financial, material and human resources that could and should be mobilised to improve local health and environmental conditions.

- Health promotion argument: that the greatest improvement in peoples' health is a result of what they do to and for themselves. It is not the result of medical interventions.
- Social justice: that all people, especially the poor and disadvantaged, have both the right and duty to be involved in decisions that affect their daily lives (Rifkin, 1990)

For advocates of community participation, it is not only means of getting things done but it also brings many lasting benefits to people. According to Alexander (1975) participation is inherently good and brings people together in creating and making decisions about their environment which helps promote sense of ownership and control among the people in the community. For Arnstein (1969), appropriate community participation gives power to the citizens who hitherto had no power or control and are excluded from the political and economic processes, and allows them to be deliberately included. Indeed, Mansuri and Rao (2012) note that over the past decade, the World Bank has spent huge sums of money to induce local participatory development because of the underlying belief that:

> *"involving communities in at least some aspects of project design and implementation creates a closer connection between development aid and its intended beneficiaries" and that "local participation is proposed as a method to achieve a variety of goals, including sharpening poverty targeting, improving service delivery, expanding livelihood opportunities, and strengthening demand for good governance"* (Mansuri and Rao 2012: 1).

WHO (2002) sees the benefits of community participation in health programme beyond what has been explained above. Firstly, WHO (2002) indicates that the local people always have an insight into what interventions work and what do not. Involving them in choosing the intervention is more

likely to lead to successful outcome of the project because the decision making process is enriched and resources are utilised in a more efficient and effective manner (WHO, 2002). Edgecombe (2002) buttresses this point by indicating that because communities have different needs, problems, beliefs, practices, assets and resources, a one fits-all approach might not work in health interventions, therefore getting the local people involved in design, planning and implementation of programmes ensures that the most appropriate and acceptable strategies for the communities are chosen to ensure sustainability. Therefore, involvement of the communities ensures that projects are not only successful but are sustained. Secondly, the local people are most likely to be committed to and help make resources available for the successful implementation of programmes they are involved at the planning stage because they feel they own the project thus making them more responsive and more likely to use the services (WHO, 2002). Thirdly, community participation leads to development of partnership between the locals and professionals because they learn from each other. Community participation therefore not only offers an opportunity for innovation and creative thinking (WHO, 2002) but also leads to a situation where there is transfer of skills from professionals to the locals. It therefore helps in building the capacity and competencies of the local people and makes them more employable (WHO, 2002). Finally, community participation also enhances the democratic process and addresses unequal power structure that exists, by giving voice to the voiceless. Community participation has therefore become an important way of addressing the inequities and social exclusion (WHO, 2002).

The WHO (2002) summarizes the above by indicating that Community Participation has the advantage of increasing coverage, effectiveness and efficiency of health interventions and promotes equity and self-reliance among local communities' members. Rifkin (2014) cites

Marston et al (2013) and Prost et al (2013) in a systematic review of literature to confirm the link between community participation and better outcomes of health programmes.

2.3.2 Community Participation in Health in Ghana

The Ministry of Health of Ghana has made several efforts to get communities to participate in health programmes in their communities in a more formal setting in fulfilment of the Alma Ata declaration in 1976 (Galaa, 2008). According to Galaa (2008) the Government of Ghana and the Health Authorities in Ghana have used three main programmes or strategies to get communities to participate actively in their healthcare in Ghana. These are: Primary Health Care (PHC), the Medium Term Health Strategy (MTHS) and the Community based Health Planning and Services (CHPS).

In Ghana, the Ministry of Health considers community participation as a process of engaging and dialoging with members in a community in a manner that makes them equal partners in a programme of activities. The aim is to build a team, comprised of programme managers and community members, who jointly diagnose and find solutions to health problems within the community - with the active involvement of local people providing human and material resources (Ministry of Health, Ghana, 1999).

The extent of participation of communities in activities in the public health sector, in Ghana, is generally broad and includes the facilitation of community entry, dissemination of information and health education, the mobilization of resources, and engagement in planning and implementation (Galaa, 2008).

2.3.3 The Concept of Community Participation

The Alma Ata Conference in 1978 emphasized the need for greater community participation in health (WHO, 1978). Major health policies have since then included the concept of community participation within them (Morgan, 2001) and this has therefore generated a lot of debate as to what constitutes community participation. This is a question that is somewhat difficult to answer because the term community is understood differently by different groups of people. The lack of consensus in *defining* a community has consequences for the reality of the practice of community involvement in health (United Nations Centre for Human Settlements, 1991). For instance, politicians might see community as political constituents; the urban planners might see a community as defined by geographic boundaries; public health practitioners might see community in terms of risk groups whilst the general public might see the community as a group they really feel part of (United Nations Centre for Human Settlements, 1991). Webster's dictionary defines community as "a social group of any size whose members reside in a specific locality, and share a common cultural and historical heritage" (Merriam-Webster Online Dictionary, 2020). The concept is also defined variously in the academic literature. Agudelo (1983) sees community as a group of people living in a particular area and having shared values, cultural patterns and social problems. Rifkin et al (1988: 933), on the other hand, see a community "*as specific group of people with shared needs living in a defined geographic area"*. Kenny et al (2013: 2) also believe that community "*is a group of people bounded by geographic location"*.

Similarly, participation is viewed differently by different stakeholders. WHO Study Group on Community Involvement in Health development : challenging health services (WHO, 1991) in their 11th-18th December, 1989 report suggested that participation could be viewed from three different angles: as a contribution, as an organization, and as empowerment. They indicate that

participation of communities in development can take the form of contributions from local people (e.g. material or labour). The contribution of the local people is critical and fundamental to the success of a project. They also advocate for appropriate organizational structures which represent the communities' interest and which also allow the local people to participate. The group further throw their support behind a form of participation that empowers the local people to have the needed skills to be able to effectively take charge of their affairs (WHO, 1991)

Thus, when the two words 'community' and 'participation' are combined, the various interpretations and perspectives of the concept of 'community participation' is just as complex a concept with a variety of descriptions – essentially driven by ideological and political values. For example, Morgan (2001) suggests that the concept of community participation is either framed as:

(a) Utilitarian effort (from the utilitarian model) in which communities are required by governments or donors to use community resources (such as labour, land or money) to compensate for what is being provided to the community, or

(b) A pathway to empowerment (from the empowerment model) in which communities are assisted with the necessary skills and tools for them to take responsibility for diagnosing their problems and finding ways to solve them (Morgan, 2001).

Bamberger (1988) as cited in Waweru, (2015:17), however, considers community participation as an:

> "*Evolutionary process whereby beneficiaries influence the direction and execution of developmental projects as active participants and not just mere recipients".*

Rifkin, an authority on community participation, has offered a definition which is frequently cited in literature, suggesting that community participation is a:

"*social process whereby specific groups with shared needs living in a defined geographical area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs"* (Rifkin et al, 1988: 933).

Similarly, the WHO (1978:50), defines community participation as:

"*a process by which people are enabled to become actively involved in defining the issues that concern them in making decisions about the factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking actions to achieve change."*

For the purposes of this study, community participation is conceptualized as the deliberate engagement of the CHPS initiative with members of the community through, amongst other things, developing opportunities for engagement that harness the socio-cultural values, beliefs and customs of a particular community, thereby enabling community members to participate in the implementation of local projects that promote their health.

2.3.4 Typology of Community Participation

In order to differentiate the various levels of community participation, a number of typologies have been developed by different authors. According to Cornwall (2008), these typologies represent a good way of differentiating the various forms and degrees of community participation.

Arnstein (1969) presented one of the earliest and best known typologies of participation in the form of a ladder which she called the 'Ladder of Participation' as shown in Figure 5 below:

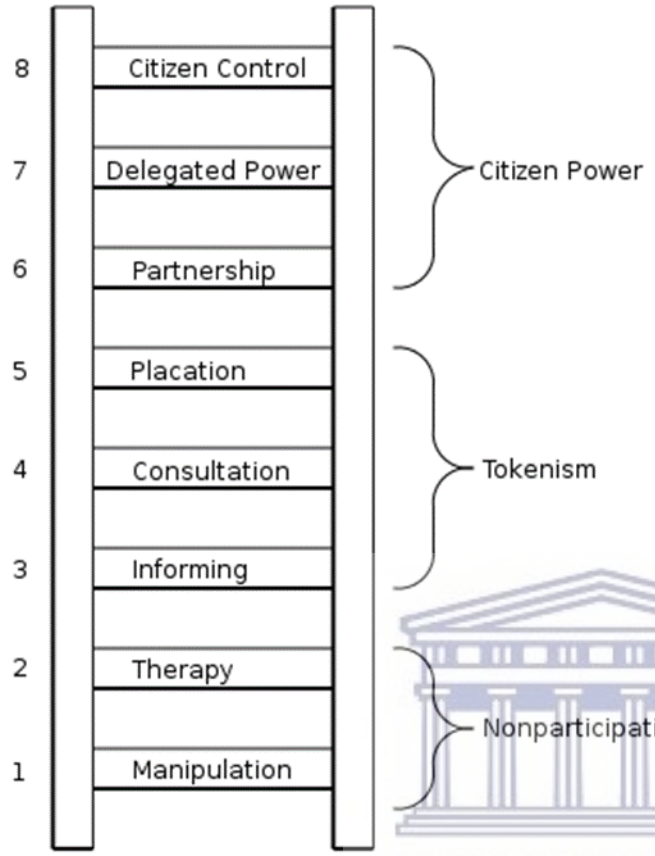

Figure 5: *Eight rungs on the ladder of citizen participation*

Source: *Adapted from Arnstein (1969:217)*

As can be seen from the illustration above, the two bottom rungs of the ladder are Manipulation (1) and Therapy (2). These two rungs describe levels of 'non-participation' that have been misconstrued by some as genuine participation. Arnstein (1969) suggested that the real objective at this level is not to enable people to participate in planning or conducting programmes, but to enable power holders to 'educate' or 'cure' the participants.

Rungs 3 (information), 4 (consultation) and 5 (placation) progress to levels of 'tokenism' that allows the marginalized to be heard and to have some form of 'voice'. Arnstein (1969) suggests

that at this level community members may indeed be heard but do not have the power to ensure that their views will be taken into consideration by those in with authority and/or power. There is, therefore, no change and the status quo remains. Placation (Level 5) allows the marginalized to advise, but the decision making rights are retained by those in power.

Further up the ladder are levels of citizen power which have increasing degrees of decision-making clout. For example, citizens can enter into a Partnership (6) that enables them to negotiate and engage in trade-offs with traditional power holders. At the top rungs, Delegated Power (7) and Citizen Control (8), citizens obtain the majority of the decision-making authority and/or have full managerial power.

Cornwall (2008: 270) notes that Arnstein's typology is 'normative' in that it ranges participation in a linear fashion from 'bad' to 'better (more genuine)' forms of participation. Important to note is that this framework places emphasis on participation from the users (or community) viewpoint rather than those who promote participation (Cornwall 2008).

In order to account for participation of children and young adults, Hart (1992) modified Arnstein's typology as shown below as annexure 1. In this typology, Hart continues to use eight levels of participation as Arnstein did, but has divided the upper five rungs into examples of different degrees of participation, and the lower three rungs as examples of non-participation.

Pretty (1995) also described seven forms of participation similar to Arnstein's typology in that it is also normative and moves from 'bad' to 'better' forms of participation (Cornwall, 2008). The typology of Pretty (1995) differs from that of Arnstein (1969) because it highlights user participatory approaches and emphasizes the motivations of those who use participatory approaches in shaping interventions instead of emphasizing power and control as Arnstein did

(Cornwall, 2008). Moreover, while Arnstein's typology sees participation from the viewpoint of the community, Pretty's typology considers the viewpoint of the community and that of external players or stakeholders (Cornwall, 2008). The details of Pretty's typology is given in a table as annexure 2.White (1996) also offered another type of typology that describes the interests of the various stakeholders involved in participation. Her typology defines how and why people make use of participation at any particular stage in a process. White's typology is presented a table below as annexure 3 and is useful for this research as it confirms the reasons for which the local people feel the need to participate in CHPS and the health authorities' motivation in involving the local people. For instance, while the community members use their participation in CHPS to prove to the political authorities and donor agencies that they are doing something to help solve their health needs (nominal display), health authorities and political leaders engage the local people in CHPS as the best way to sustain and maintain the CHPS programme (representative).

While some authors (Arnstein, 1969; Pretty, 1995; White, 1996) have used their typologies to describe the levels of community participation (as described above), these typologies mainly describe the forms/extent/ degree/ levels of participation of the local people. However, the manner in which these participatory activities are carried out are very significant. The next section outlines the various approaches to community participation that have been described.

2.3.5 Approaches to Community Participation in Health

The fact that there is a general belief that community participation is useful in the development of programmes and health activities (Filho et al., 2002), has made it very crucial for programme designers and implementers to identify the various approaches that have been conceptualized to describe how communities are involved in health activities before such programmes are undertaken. Rifkin (1986) identified three different types of approach while analyzing experiments

in community participation in health planning in South East Asia. These are: the medical approach (based on the view that health is essentially the absence of disease); the health planning approach (based on the view that health is essentially the result of the appropriate delivery of health services); and the community development approach which views health improvements as a means of making community members take control and responsibility for their own health care through education (Rifkin, 1986: 157). Indeed the CHPS policy emphasizes the need for the community members to assume control of their lives (Ministry of Health, Ghana, 2016) and therefore is very much based on the community development approach as described by Rifkin (1986). Rifkin (1986) further describes five ways in which local people can participate in a programme. She indicates that the community can participate in just one way or in multiple of the following ways: planning, implementation, monitoring and evaluation of the project, carrying out activities of the programme and/or enjoying the benefits of the project. Firstly, she indicates that communities can participation in benefits. She opines that all that is required at this level of participation, is for the people in the community to be present to enjoy the services being rendered by the programme. For instance they may be required to be present and enjoy the services in a health facility. Secondly, the community can also participate in the activities of the programme. She stressed that local people contribute in diverse ways to the programme, which may include contribution of land, labour, money and other resources to the programme, but they do not take part in any decision making. Rifkin further states that a third way that communities can participate in the project is to be involved in implementation of the project. At this level, the community assumes some responsibility (Rifkin, 1986). They may be involved in key decision making such as the site of the project or may be involved in running some aspects of the programme. At this level, the community takes decisions on how activities are run, but they leave decisions about what activities are to be

undertaken to the programme planners, and are subject to the control and supervision of the project planners (Rifkin, 1986). Another way communities can participate in the project, according to Rifkin (1986), is to participate in monitoring and evaluation of the project. At this level, the local people are involved in taking decisions as to how the programme outcome meets its' objectives and how this outcome will be measured and monitored. At this level, they are still left out in the planning of the project. Finally, Rifkin (1986) suggests that the ultimate and ideal participation is when communities are involved in the planning of the project. She stresses that in this instance, leaders and key members of the community choose what health programmes they wish to undertake and ask for expertise and/or resources from the government or health authorities and health staff to enable the activities to be pursued. She presented this in a form of a triangle in which level of participation is the broadest in terms of range and depth as shown in Figure 7 below:

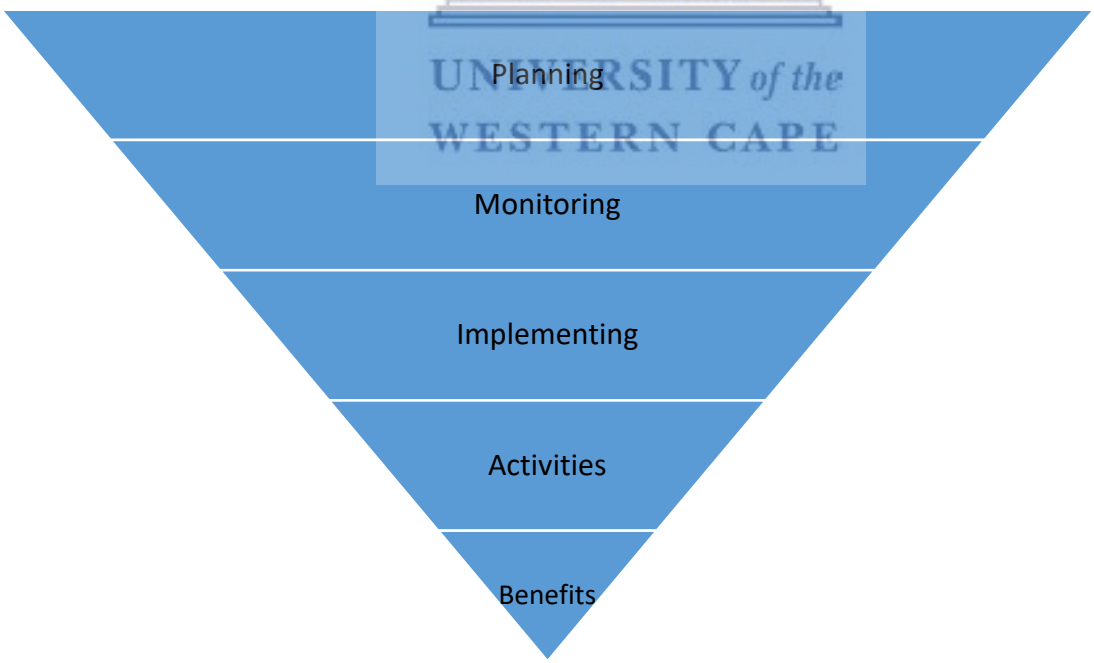

***Figure 7**: How community people participate in health programmes*

***Source:** Rifkin (1986: 247)*

The CHPS policy manual (Ministry of Health, 2016) envisages that communities participate fully at every stage of the project and that the range and depth of participation of the community will be very broad at each of these stages.

However, as has been shown in Figure 7 above, participation in the benefits of the project is the narrowest in terms of range and depth. This type of participation is described as passive (Rifkin, 1986), yet it is this type of participation that the majority of community members are involved in. In the CHPS programme the majority of community members participate at this level by presenting at the health facility for treatment (Baatiema et al, 2013). At the opposite end of the scale, participation in planning and design of the project is the broadest in terms of range and depth and it is the articulated ideals for which many programmes strive to achieve (Rifkin, 1986). Unfortunately, in the CHPS programme, only few, if any, of the community members participate at this level (Baatiema et al, 2013).

Publications from some authors (Filho et al 2002; Moser, 1989) however, merge these three approaches as described by Rifkin (1986) and translate them into two frames of reference that reflect the thinking of health professionals about health improvements and have guided the actions of these professionals (Filho et al 2002; Moser, 1989). These are: 'target-oriented frame' and 'empowerment frame'. The target-oriented which is also called the 'top-down' approach by some authors, follows a line of reasoning based on the logic of traditional western science and on the biomedical determination model of the health/disease process. According to Filho et al (2002), if problems are confronted in this manner:

> "…*improvements in the health status of the population will occur in keeping with advances in science, as discoveries are made, and communities accept and incorporate these*

innovations into their reality. In this frame of reference decision-making is always in the hands of the professionals, the outcomes of the programmes are quantified as products and the community participation is an instrument for achieving an objective" (Filho et al., 2002: 94).

All decisions are therefore taken by the government or agencies without the input of the local people. On the other hand, the empowerment frame also referred to as the 'bottom-up' approach, is based on the assumption that the unfair distribution of wealth and unequal access to health services is responsible for poverty and its attendant differences in health status (Filho et al., 2002). This approach hinges on the principle that:

"*the communities, through gradual access to education and information, assume power and control of the system and are subjects of the social changes most suitable to their interests"*. (Filho et al., 2002: 94).

Thus in the empowerment model, the local people make the decisions and seek the support of government or other agencies. The CHPS concept embraces the empowerment model because it encourages the local people to take charge of the CHPS - in its management and operations - in various capacities such as volunteers and members of the Community Health Management Committee (Ministry of Health, Ghana, 2016). However, the top-down approach has also occurred in CHPS implementation in certain areas. For instance, Baatiema et al (2013) in their study of CHPS in the Wa Municipality observed that the planning stage was 'top-down' as community members were virtually not involved in the needs assessment.

2.3.6 *Assessing Community Participation in Health*

Overview

Definition of Community participation has been difficult and many authors have defined it differently with no consensus being reached. However, there is very little disagreement on the fact that community participation should best be regarded as a process but not an outcome of an intervention (Rifkin and Kangee, 2002). Assessing community participation as a process is, however, very challenging (Rifkin and Kangee, 2002). One of the earliest attempts to offer an analytical framework for assessing community participation was made by Sherry Arnstein in 1969. She offered an analytical visualisation called, 'ladder of participation' as discussed above.

The Spidergram

A more recent visualisation that stresses the similar points as done by Sherry Arnstein in 1969, is that of the spidergram which was developed by Rifkin et al (1988) to enable us to describe the extent of community participation in primary health care programmes. The spidergram is a measurement tool or analytical framework that can be used by stakeholders to visually represent the extent of community participation in 5 key areas that were identified by the authors as influencing the participatory contribution of communities in health programmes (i.e. needs assessment, leadership, organization, resource mobilization and management). The spidergram can be used in a multiple ways, for example, to compare differences in participation over time or between different assessors or different participant groups who are involved in a health programme (Rifkin et al, 1998). Iyandi and Akinyemi (2017) described the spidergram as "simple, practical and powerful way of illustrating the extent of community participation in important areas in a visual way". The spidergram has been widely used to assess community participation in health in

several countries including Ghana (Baatiema et al, 2012), and Nigeria (Iyandi and Akinyemi, 2017). In the spidergram these 5 factors (indicators) are plotted on a continuum as illustrated below in Figure 8.

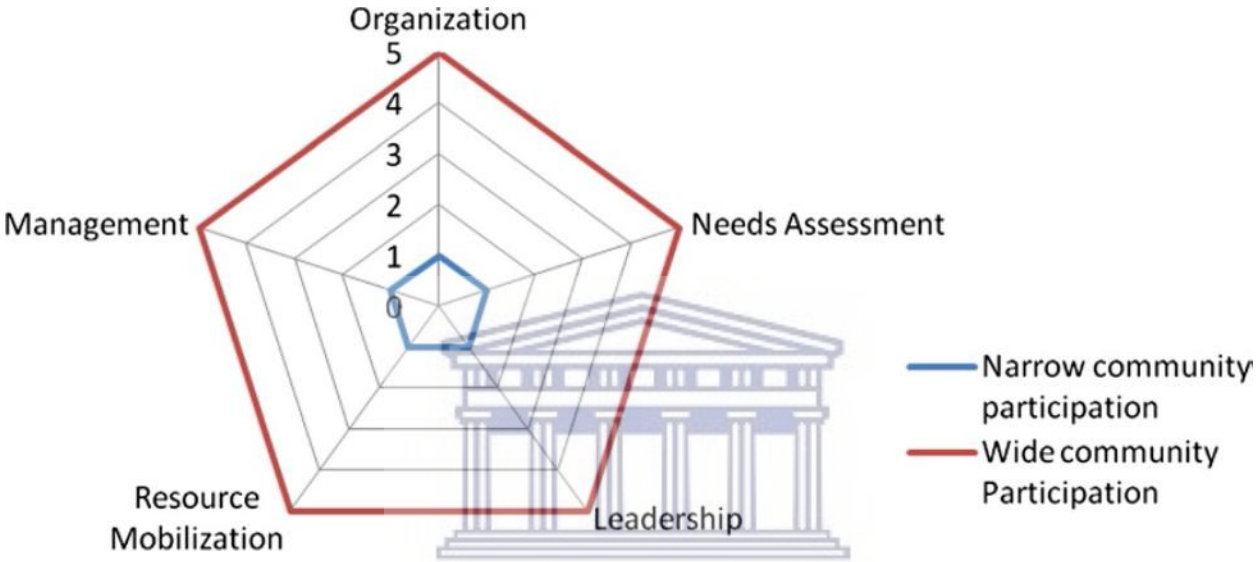

***Figure 8**: Rifkin's Spider-gram*

***Source:** Baatiema et al, 2013*

According to Baatiema et al (2013) ***Needs assessment*** refers to the roles played by local people who are the intended beneficiaries of a programme in identifying their health needs and in designing the community intervention while ***Leadership,*** as described by Rifkin, emphasises the "inclusiveness and representativeness of all community interests groups". Baatiema et al, (2013) described ***Organisation*** as the extent to which new programme "integrates or collaborates with pre-existing community structures or networks". ***Resource mobilization*** however, describes to communities' ability to mobilise and contribute resources such as labour, land and money towards a community–based intervention while ***Management*** refers to community's capacity to take decisions about the programmes direction and development.

The extent of participation across each of these 5 factors can then be visualized along a continuum ranging from narrow or low levels of participation (at the center) to wide or significant levels of participation (at the outside or end of the spokes). Draper and his colleagues in 2010 modified Rifkin's spidergram to place mobilization at one end and empowerment at the other. In the middle is placed a circle which is marked 0 to indicate that in every project there some kind of community participation (Baatiema et al, 2013). This study however, used the original continuum as proposed by Rifkin et al (1988). Each continuum is used to grade how wide or narrow community participation in the health intervention has been.

Indicators for Assessing Community Participation in CHPS Using the Spidergram

In assessing community participation in CHPS Baatiema et al (2013) developed a set of indicators which was a modification of that developed by Rifkin et al (1988). Baatiema et al (2013) used this set of indicators during a community conversation to assess the extent of community participation with participants. The set of indicators for assessing the level of community participation in CHPS developed by Baatiema et al (2013) is detailed in Table 2 below.

Table 2: Indicators for assessing community participation in CPHS

Indicators	**Narrow, nothing 1**	**Restricted, small 2**	**Mean, Fair 3**	**Open, very good 4**	**Wide, excellent 5**
Needs Assessment	Identified or imposed by health experts without community involvement or consultation	CHPS services designed by health experts with limited community involvement	Community was consulted and involved in assessing their needs	Community involvement in needs assessment, and few services resonating with their assessed needs	Full community involvement in needs assessment with service package in resonance with their health needs
Leadership	Dominant-imposing CHPS	Limited committee role in	Few community consultation, involvement in	Good committee leadership role consults	CHPS committee fully represents diverse interests,

	committee chairman represents only committee or few elite or rich community members	leadership, few representation of women or few interest groups	decision-making and represent community interest	community, leadership constitute women representation and all interest groups	Selfless leadership roles, full community involvement in decision-making
Organisation	Parallel operation or no collaboration of CHPS with pre-existing community units or local structures	Limited collaboration of CHPS with pre-existing community units or structures	CHPS cooperates with few community structures	Integration and collaboration of CHPS with other community bodies	CHPS well and fully integrated and works collaboratively with other community units
Resource Mobilization	No community support or resource contribution. Community not involved or consulted in resource allocation	Limited amount of resources raised by the community. No community control over mobilised resources utilisation	Community raised resources and fully support CHPS with limited role in controlling expenditure	Community are resourceful and supports CHPS with mobilised resources. Community involved in resource allocation	Full and active community contributions to support CHPS. community fully consulted in resource allocation
Management	Managed or induced by service providers (GHS). No community consultation in management decision making	CHPS operation overseen by GHS with	CHPS committee role CHPS operation overseen solely by the health committee	CHPS committee self-managed and involved community and other interest groups (women) in decision making	Committee independently managed CHPS with full community consultation

Source: *Adapted from Baatiema et al (2013)*

Community members are asked to grade, from 1 to 5, the level of participation they felt was involved in the programme, with 1 reflecting a low level of participation and 5 reflecting the highest level of participation (Rifkin et al, 1998).

The researcher was guided by this set of indicators which formed the basis of a set of questions that were posed to both stakeholder groups (health workers and community members) about the extent to which they believed the community was involved in the CHPS programme in the district during the community conversation.

2.3.7 Challenges of Community Participation

Despite the fact that community participation was deemed to be the underlying principle of successful PHC and has been hailed worldwide, its practice has been difficult (Kweku et al, 2020b). Several factors influence community participation. Indeed the problems of community participation are basically participatory activities that do not take local structures of power and local people into consideration especially in decision making, planning, budgeting and distribution of resources (World Vision, n.d.). This results in friction, not only between the local government and community but also between community members themselves (World Vision, n.d.).

Enhassi et al. (2016), identified shortage of skills, lack of interest, lack of participatory mechanisms, lack of trust and respect, poor communication channels and cultural constraints, among others, as factors affecting meaningful community participation. Meaningful participatory process requires that the local people have the required skills. However, oftentimes, the local community members have inadequate knowledge, skills and a sense of empowerment as a result weak training that focuses on participatory processes such as budgeting and planning (Enhassi et

al, 2016). Moreover, lack of transparency which results from inadequate involvement of the community members, poor communication and lack of trust and respect, gradually leads to lack of interest in the project (Enhassi et al, 2016).

Takyi et al (2014) also found that low knowledge level and poor information flow account for low involvement and participation of stakeholders. They further indicate that government officials and staff of agencies resist attempts to empower the local people because these officials feel threatened by an empowered local people through their committees, for political reasons.

Adamson (2010) identified the following as major barriers to the achievement of community empowerment:

- low level of community capacity,
- lack of capacity of local authorities to work in community sensitive ways,
- inability of government official to attend partnership meetings regularly as a result of human resource difficulties,
- institutionalized resistance in relation to community empowerment,
- perception gap between community members and statutory service providers in the partnership context
- authoritarianism of the local government members.

CHAPTER THREE: METHODOLOGY

This chapter describes the methodological approaches to the study and describes the research design and strategies in detail.

3.1 Aims and Objectives

The aim of the study was to explore the perceptions, opinions and experiences of key stakeholders on the extent and nature of community participation in key aspects of the planning and delivery of the CHPS programme in Asutifi South District, Ghana.

The specific objectives of the study were to:

- Explore how community members and frontline health workers perceived the current extent of community participation within key aspects of the planning and delivery of health activities related to the CHPS programme.
- Explore what community members and frontline health workers considered to be the key factors hindering the engagement and participation of the community in CHPS activities within the district.
- Explore what community members and frontline health workers considered to be the most feasible approaches, mechanisms and processes that could be put in place to strengthen the level of community participation within the CHPS programme in the district.

3.2 Study Design

The study was an exploratory, descriptive qualitative study whose main aim was to explore the perceptions, opinions and experiences of community members and frontline health workers about community participation within the implementation of the CHPS programme at a district level. This exploratory research was situated in the qualitative paradigm, and it was used to gain an

understanding of underlying reasons, perceptions and opinions of the stakeholders on the participation of community members in the CHPS programme. The qualitative research approach was particularly suitable for this study because it offered the researcher the opportunity to explore a contextual understanding of stakeholders' perceptions, opinions and experiences on the engagement and participation of the community in the operations of the CHPS in a way that could not have been elucidated with a quantitative study.

This study also used focus group discussion (FGD) as its main data collection technique. Barrett & Twycross (2018) note that focus group discussion is a qualitative methods data collection technique "in which a moderator speaks with a group of 6-12 participants on issues that are related to the research question" (Barrett & Twycross, 2018: 63) using a discussion guide.

The application of focus group discussions (FGD) provided the participants space to freely express their thoughts and beliefs on community participation and engagement in CHPS implementation process. The value of using FGD as a data gathering technique in this study was that it allowed the researcher to gather views of many participants at the same time, thus making efficient use of time and resources (Barrett & Twycross, 2018). This was a distinct advantage in this study as the researcher was then able to work across the three communities of Apenamadi, Apotoyowa and Nkrankrom. Using FGD, the researcher provided a more relaxed environment for the participants that enhanced the level of debate and free flow of discussions, and also allowed participants "to bounce ideas off each other resulting in the emergence of different perspectives from the discussions" (Barrett & Twycross, 2018: 63).

FDG, as a number of authors have suggested, also provided the researcher with an opportunity to gather rich and in-depth information and solicit both participant's shared narratives as well as their

differences in terms of experiences, opinions and views on community participation in CHPS (Barrett & Twycross, 2018; van Eeuwijk & Angehrn, 2017).

Community conversation at the end of the FGDs brought the participants together to use the spidergram (Rifkin, 1988) to assess the participation of the community in CHPS. Community conversations are ways to authentically engage members of a community to generate public knowledge that can be used to inform policy (American Library Association, n.d.). It enabled the researcher to understand how the participants think and talk about CHPS in an informal setting (American Library Association, n.d.).

Information obtained during the focal group discussions and the community conversations was supplemented by participant observation. Participant observation is defined as "observation in which the researcher also occupies a role or part in the setting in addition to observing" wherein observation itself is defined as "systematic watching of behaviour and talk in naturally occurring settings" (Pope and Mays, 1995:43). This was considered important in this study because it allowed the researcher to form subjective opinions on the participants, community leaders and health workers through their appearance, body language, facial expressions, voice tone and many other peculiar characteristics of the participants that would influence their particiption in the discussions and/or CHPS activities (Tulsyan, 2008).

3.3 Population and Sampling

The study population comprised all frontline health workers working in the district health service in the Asutifi South District in Ahafo Region of Ghana and all community members residing in this same district (including community leaders and representatives, community health volunteers and nurses and Community Health Officers.).

From this study population, the researcher purposively selected a sample of participants. Purposive sampling, as described by Creswell & Plano Clark (2011), helped the researcher to identify and select individuals who were potentially knowledgeable about the issue under investigation: in this case the operations of CHPS within the district. In this study, with the assistance of the community leaders, especially the village chiefs and their elders, the researcher was able to identify people in the community who have some knowledge about CHPS to be included in the study as participants. All the health workers who were present at the time of the study and working in any of the three communities that were studied, were asked to join the study provided they were willing to participate.

The study sample included 17 participants from the two key stakeholder groups, namely: frontline health workers and community members.

The frontline health workers were made up of 6 staff members of the District Health Service, all of whom are professional health workers and assume a clinical (as opposed to managerial) role within the district, as well as the District Public Health Nurse from the district health directorate. This included three enrolled nurses (2 from Apotoyowa and 1 from Nkrankrom) and 2 Community Health Officers (1 from Apenamadi and 1 from Nkrankrom) 1 Public Health Nurse from the public health unit of the district hospital (St. Elizabeth Catholic Hospital).

Ten community members living in the three villages (Apenamadi, Apotoyowa and Nkrankrom) within which the study took place were included. Three community members from each of these 3 areas were selected to participate in the study including a community leader (i.e. a chief or elder, Assembly Member, Unit Committee Member and/or a Community health management committee member); a community-based health worker (such as a community health volunteer, and

Traditional Birth Attendant). An additional participant, a female community based volunteer was selected from Apenamadi to increase the number of females.

3.4 Data Collection Methods

In January, 2020, prior to the commencement of the data collection, all relevant persons at the Regional Health Directorate, the District Health Directorate and the communities where the research took place were informed about the proposed study, its purpose and objectives. Permission to carry out the research was obtained from the Regional Director of Ghana Health Service (Annexure 11). The researcher was assisted by the Assembly member and the District Public Health Nurse, a representative of the district health directorate, to identify and/or make contact with health workers and/or community members who participated in the study. The researcher first visited the three communities where the study took place to sensitize the communities, and met with the opinion leaders to discuss the study and formally sought their consent and approval. The researcher also used the opportunity to discuss issues of venue for the focus group discussions and time period for the focus group discussions with the community. The researcher also used the initial contact with the community to establish a rapport with the community leaders and to answer any questions they had about the study.

Once the initial introductions had been made, the researcher then contacted the potential study participants individually to find out whether they were willing to participate in the study, and to set up a suitable appointment date, time and venue for the discussions. The researcher also arranged for transport and provided stipend for lunch for all the participants for the group discussions.

A total of two FGDs and a community conversation were held in June, 2020 in the Hwidiem, the district capital with 10 community members and with 7 health workers. Community members were

separated from the health workers to enable each group to freely express themselves even when they are to criticize the other. The FGDs were held in the forecourt of Debab Hotel which provided a safe and spacious environment for the discussions- in the context of Covid 19 pandemic. The researcher also ensured proper adherence to the Covid 19 protocols during the FGDs and the community conversation. The FGD involving health workers (FGD 2) took place first and was followed by that involving the community members (FGD 1). At the start of each FGD, the researcher read the information sheet (Annexure 4 and 5) and consent forms (Annexure 6).

The researcher went through the information sheet with the participants assuring them that they were free to exit from the study anytime without hindrance and without any consequences. After this, they were then requested to give their consent for participation by signing or thumb printing an Informed Consent Form (Annexure 4) after they had agreed to participate. They were also assured that information obtained from the study would be used only for the purpose of the research. Given the nature of the research, no harm to participants was anticipated. However, the researcher took all measures to prevent any harm and a staff from the chaplaincy unit of St. Elizabeth Hospital, the local district hospital, was placed on standby to cater for participants who would have needed any psychological support.

Whilst a different FGD guide was used for each of the two stakeholder groups (Annexure 8 and 9), the two guides essentially focused on exploring the key study themes, namely: needs assessment, leadership, management, organization, resource mobilization and challenges with the implementation of CHPS.

The FGDs were facilitated by the researcher and were facilitated in Twi, the local language, for the community FGD and in English for the health workers FGD. The community conversation was

however conducted in Twi so that everybody (community members and health workers) could contribute. The researcher was accompanied by a colleague who is experienced in research, during the two FDGs and the community conversations. He took notes during the discussions and also noted all non-verbal cues. He also provided the researcher with important feedback on the researcher's interpretation of the interview process and the data that was collected in both FGDs.

At the end of the two FDG sessions, all the participants of the two FGDs were brought together at the same venue to assess community participation through a community conversation using the spidergram (Rifkin, 1988) to reflect their consensus on the level of community participation that characterizes the CHPS in Asutifi South District. The community conversation took place immediately after the FGD of the community (FGD1) to save cost and time. Both the health workers and the community members participated in this community conversation. The two groups- health workers and community members were brought together to enable them debate and consensually agree on the assessment. At this meeting a summary of findings of both FDGs was presented by the researcher to the participants before they were asked to assess by consensus what they perceived to be the level of the communities participation. The spidergram and a set of indicators developed by Baatiema et al (2013) were used to assess the participation of communities in CHPS based on the five thematic areas outlined by Rifkin (1988) in the Spidergram.

Both FGDs and community conversation were audiotaped and transcribed and then translated into English by the researcher.

3.5 Data Analysis

As with all qualitative studies, data analysis starts with data collection, and the researcher recording his experiences and perceptions of the research process in a field diary. Employing

deductive thematic coding analysis, the researcher reviewed the transcripts and field notes and identified recurring themes (Braun and Clarke, 2006; Pope et al, 2000) - using, as a starting point, the 5 key areas that have been suggested by Rifkin et al (1988) as a way of assessing the level of community participation. As illustrated in figure 8 above, the 5 levels included needs assessment, leadership, management, organization and resource mobilization. Through a process of coding and categorization, the researcher was able to make meaning of the responses of the participants (Braun and Clarke, 2006; Pope et al, 2000). Following this initial categorization of the data, the researcher then proceeded to make a more detailed thematic analysis of the data *within* each of the 5 key themes. The researcher also added any additional key themes that emerged from the FGDs e.g. challenges of CHPS implementation.

3.6 Rigour

Rigour (or trustworthiness in the case of qualitative research) is the level of confidence that one can have in a study, from its conceptualization to the data collection and its interpretation (Polit & Beck, 2014). Attention to trustworthiness strengthens the quality of a qualitative study (Polit & Beck, 2014). In this study, trustworthiness was achieved through the processes of member-checking, triangulation and peer debriefing in the following manner:

The researcher ensured that the study's findings were credible by presenting a detailed account of the communities' involvement in the operations of the CHPS in Asutifi South District of Ghana. Firstly, the researcher employed a process of member-checking to determine the accuracy of the interpretations he had made of what participants were sharing in the FGDs. The researcher intermittently summarized some of the key points from the FGDs and asked the participants whether they reflected the sentiments that had been expressed (Lincoln & Guba, 1985). Secondly, triangulation of data sources was used to corroborate the accounts made by the two different

stakeholder groups (i.e. the health workers and the community members). Thirdly, the researcher employed peer debriefing as described by Lincoln & Guba (1985) and Korstjens & Moser (2018) by discussing the research process and findings with his supervisor as well as with his colleague who had participated in the FGDs with him. This ensured that perspectives on the data and research process (other than the researcher's) were incorporated into the findings and thus, through regular feedback and discussion with others, the researcher was able to strengthen the credibility of the study (Korstjens & Moser, 2018; Lincoln & Guba, 1985).

Confirmability, according to Shenton (2004), is the researcher's way of ensuring that his findings reflect the ideas and experiences of the study participants and not those of the researcher. In this study, the researcher ensured confirmability by developing a comprehensive audit trail through the collection of raw data obtained from the FDGs, community conversation, observation notes, and records from the field, which were reviewed by a colleague who is a faculty member of the Department of Public Health, Catholic University of Ghana (Lincoln & Guba, 1985). Confirmability, was also achieved through triangulation (Shenton, 2004) of data sources as described above.

In order to ensure that other researchers can consider in which contexts the findings are transferable, the researcher provided a thick (i.e. detailed) description of the study setting and described the details of all aspects of the research processes undertaken (Lincoln & Guba, 1985). A description like this enables other researchers to replicate the study with similar conditions and in other settings and helps readers of the final account of the study to assess its integrity (Shenton, 2004).

3.7 Research Ethics

Research ethics, according to Saunders, Lewis, and Thornhill (2009), refers to the appropriateness of the researcher's behaviour in relation to the right of those who are being researched. Bryman and Bell (2011) similarly suggested that ethical issues are concerned with how we treat the respondents who are the focus of the research. This researcher adhered to a set of ethical research principles to ensure that the rights of the research participants were honored (Orb et al., 2004). This was done in the following ways:

Before the study commenced ethical clearance was obtained from the University of Western Cape Bio-Medical Research Ethics Committee in September, 2019 (Annexure 12) and the permission from Ghana Health Service was also be obtained from the Ahafo Regional Director of Ghana Health Service in May, 2020 (Annexure 11).

Participation in the study was entirely voluntary and supported the principle that participation in the study was based on informed consent. The researcher used an information sheet (Annexures 4 and 3) to provide participants with adequate information about the study and detailed what their involvement in the study would entail should they decide to participate. The participant information sheet was used to explain the study in detail, the benefits and possible risks of participating in the study and provided the contact phone number of the researcher's supervisor and a relevant contact name and telephone number for UWC should any participants have further questions or concerns about the study. The participants where then asked for their informed consent (Annexure 6) before the research process was initiated.

As noted previously in this chapter, counselling support from the local district hospital was arranged should anyone of the participants feel that they needed to de-briefed or be supported as a result of participating in the study.

The researcher also ensured that identity of participants and that of the CHPS compounds and communities where the study took place would be protected at all times, and especially in relation to reporting the findings of the study. This was done by removing any obvious identifiers associated with the study setting and by giving pseudo names to participants in the write up and reporting of the study. In this regard, the identity of all participants was protected by ensuring that their contributions, such as quotes and accounts or references to incidents, were documented in a way that allowed them to remain anonymous.

CHAPTER FOUR: RESULTS

This chapter analyses and presents the views and perceptions of study participants on the extent, obstacles and future ideas about ways to strengthen community participation in CHPS within the study district.

4.1 Profile of Study Participants

The study involved two groups of participants, namely, health workers and community members, who were interviewed separately in two different FGDs. The FGDs were followed by a community conversation which involved all the participants.

In all, 17 people participated in the two focus group discussions. Focus Group Discussions 1 (FDG 1) involved ten community members while Focus Group Discussions 2 (FDG 2) involved seven health workers. The community members were selected from three different local villages based on their knowledge of and involvement in CHPS activities. Eight out of the ten community members who participated in the study were males with only two being females. However, all but one of the seven health workers were females. The characteristics of the study participants are shown in the tables 3 and 4 below:

Table 3: Characteristics of participants of FDG 1 (Community members)

Study participant	Age/yrs	Gender	Community	Occupation	Nature of involvement in CHPS
CM 1	72	Male	3	Retired teacher/ farmer	Chairperson of Community Health Management Committee
CM 2	74	Male	2	Farmer	Community volunteer/ traditional birth attendant
CM 3	48	Male	3	Farmer	CHMC member/ community bases volunteer
CM 4	45	Male	2	Farmer	Assembly member (community leader)
CM 5	51	Female	1	Farmer	Community based volunteer
CM 6	51	Male	3	Farmer	Fmr. Assembly member (Community leader)
CM7	41	Male	2	Farmer	Traditional leader (Sub chief)
CM 8	35	Male	1	Farmer	Traditional leader (Chief's linquist)/ CHMC member
CM 9	38	Male	1	Farmer	Assembly member (community leader)
CM10	32	Female	3	Farmer	Community based volunteer

As can be seen from the Table 3 above, all the participants from the community were farmers and were predominantly males. The predominance of males only highlights their dominant involvement in CHPS. The researcher made attempt to get more females to participate but was unsuccessful as they were unwilling to participate.

Table 4: Characteristics of participants of FDG 2 (Health workers)

Study participant	Age	Gender	Occupation	Rank
HW 1	34	Female	Nurse	District Public Health nurse
HW 2	27	Female	CHO	Community Health Officer (CHO)
HW 3	25	Female	Enrolled Nurse (Nurse assistant Clinical)	Nurse Assistant-clinical
HW 4	26	Female	Enrolled Nurse (Nurse assistant Clinical)	Nurse Assistant-clinical
HW 5	25	Female	Nurse Assistant Enrolled Nurse (Nurse assistant Clinical)	Nurse Assistant-clinical
HW 6	30	Male	Nurse	Public Health Nurse
HW 7	29	Male	CHO	Community Health Officer

As can be noted from the Table 4 above, health workers were young and inexperienced and those in the three villages were relatively newly trained and at their first duty post since graduation. The CHPS implementation policy envisages every CHPS compound to have at least one CHO but only two of the three villages had any.

During the community conversation to assess the extent of community participation with participants (community members and health workers), the researcher was guided by the set of indicators for assessing the level of community participation in CHPS developed by Baatiema et al (2013) that has been discussed in chapter 2 and detailed in Table 2 above. Using the framework discussed above as a guide, and based of set of questions on the FGD guide (Annexure 8 and 9), the participants made observations and assessments about these 5 indicators of community participation in relation to the CHPS programme in their village. These are described in the following sections.

4.2 Perceptions on Community Involvement in Needs Assessment of the CHPS Intervention

Through the focus group discussions, almost all the community members shared the view that their communities were not involved in identification of their health needs or in designing the CHPS. It was strongly held that the programme was designed by health experts in the district with politicians, specifically the Member of Parliament, the District Chief Executive and political party operatives without much input or participation from community members being included. Below is a reflection of one of the study participants – a community member. It tells the story of how the community members had identified the need for a health center, but the health officials and the politicians had decided that a smaller health facility (referred to as a CHPS compound) was more of a priority:

> *"When the CHPS programme was being started in our community, we were not involved in the planning. In truth, we had made a request to the health authorities in the district and the District Assembly, through our leaders, that we needed a Health Centre because our community had grown big and the roads to the next health facility is so bad and it takes a long time to get to the hospital. We didn't hear anything again until a certain man came to*

the village [and said] that he has been awarded a contract to construct a CHPS compound in the community so we should give him a land for that purpose… The youth in the community got angry because CHPS was not what we needed or requested for. We wanted a Health Centre which could meet most of our health needs." (Male, Traditional leader, Village # 3)

The fact that the communities were not involved in the needs assessment and in the planning stages was also highlighted by another participant from a different community who had this to say:

"In our community, it was exactly as my brother said. We were there when the contractor came with his workers to construct a CHPS compound for us. …There wasn't any discussion within the community about it at the planning stage." (Male, Traditional leader/CHMC Member, Village # 2)

Similarly, a participant from the third community brought into sharp focus the interference of politics in the initial stages of the project and the lack of consultation with community members. He said:

"The whole project was planned and initiated by the health authorities with the politicians. In our case, the Member of Parliament had a huge interest. He used his portion of the Common Fund to build the CHPS compound. He, therefore, planned and executed the project with his party foot soldiers rather than the community leaders." (Male, CHMC member, Village #2).

Another participant from this same community added that:

"What [Name] is saying is very true. As the Assembly Member of the community the MP did not bother to discuss anything with me when he decided to put up the facility in my

electoral area so that I could [then] make any input or pass it [the news] on to the community. In fact, he ignored me because he thinks I belong to a different political party. His political party members chose the site for the CHPS compound… they planted it in an area where he (the MP) gets most of his votes from." (Male, Former Assembly member, Village #2)

Despite the obvious non-involvement of the community during the needs assessment phase of the project in all the three communities the community members interviewed gladly accepted and supported the CHPS programme in their communities. Members of the community especially the leaders disclosed that they supported the project and mobilized the community to support it in diverse ways. The community members presented their sentiments this way:

"*Despite the fact that we were not involved from the beginning, we needed it because our roads can be very dangerous to travel on during the raining season which made it very difficult for us to reach the nearest health facility so we didn't take offense. We embraced it and I singlehanded gave my land to them for the purpose."* (Male, Traditional Birth Attendant/ volunteer, Village #2).

Another participant from a different community added:

"When the youth of [village # 3] become angry and wanted to demonstrate against the District Chief Executive because CHPS was not what we requested for, the chief called the youth to his palace and pleaded with them to support the project. In fact he asked all the people in the community to support the project. He even donated the land that was used for the project" (Former assembly member, Village # 3)

The FGD with the 7 health workers working within the district revealed that whilst none of them had been present in the district when the projects that were referred to by community members were being planned and implemented, they indicated that since they have been in their current posts they have involved the community in the planning of all things they have done related to CHPS. One of the health workers had this to say to illustrate the point:

> "*I have been here since the middle of last year. The community has been involved in the conception and planning of activities we have embarked on since I have been here*." (Female, Health worker, Village # 1).

To support this point, another participant, a health worker in a different community, added:

> *"When I was posted here, I came to meet [Name] who was the midwife in charge but she left as soon as I arrived. Since I have been here, we have collaborated with the CHMC and the community in all our programmes*."(Female, Health worker, Village # 3).

The health workers did however agree in the FGD that most initiatives (including those directly related to CHPS) are decided on at the District Health Directorate and transmitted to them through their supervisor at the Sub-District level. During the community conversation, both sets of participants recognized that there were opportunities for deepening the extent of community participation – something which had been absent during the period of needs assessment – and thus reached consensus that the level of participation the community in needs assessment of the CHPS intervention was at a low point, namely at level 1 on the spidergram (Figure 8).

4.3 Perceptions on the Community's in Leadership of the CHPS Programme

Assessment of leadership of the community in the CHPS programme is an area that produced varying degree of responses from participants in both FGDs and at the community conversation

because of the fact that CHPS is premised on the mobilization of community leadership and decision making systems of the community . The community's leadership of the CHPS as stated here refers to their involvement in Community Health Committees; how members were selected, inclusiveness and effectiveness of the committee leadership and the committee itself. In fact, leadership, as used here, emphasises the inclusiveness and representativeness of all community interests groups.

4.3.1 Criteria for selecting members of the Community Health Committee

There was near consensus among the participants during the FGDs and at the community conversation that the community is responsible for the leadership of the CHPS. They were in agreement that the community exerts this leadership through the Community Health Committees – the participatory structures that are established in each village.

The majority of community members who participated believed that the communities had a free hand in choosing people for the Community Health Committees without any interference from the health workers or health authorities. A participant shared his reflections on how the committee members are selected in his village as follows:

> "*Leadership of the CHPS is exercised by the community through the Community Health Management Committee but the committee members liaise with the chief, elders and the assembly members … The members of the health committee are selected by us. Nobody outside the community interferes with the selection. In fact, we select those who we think can do the work"* (Male, Chairperson of CHMC, Village # 3).

This assertion was further emphasized by the District Public Health Nurse when she stated that:

"The communities are solely responsible for selecting the members of the Community Health Committee. We, at District Health Directorate have no hand in it" (Female, District Public Health Nurse)

The community members indicated that an important criterion for selecting people is to get those "who are willing and able to serve" besides ensuring that the various segments and ethnic groupings within the communities are represented.

4.3.2 Representation of women within the Community Health Committees

It was also clear that all the communities felt that the role and participation of females on the committee is lower that they expect, resulting in a situation where the committees were heavily male dominated. Nevertheless some of the participants assert that the choice of leadership is intended to represent the various segments of the communities. Segments include female groups, religious groupings, and minority ethnic groups. However, a major reason given by the participants for the male dominance of the Community Health Committees is "the lack of willingness and availability to serve on the part of the females".

With regards to inclusion of females in serving on the CHMC, a male participant has this to say:

*"Initially, the committee included two women but one of them is unable to attend meetings because of old age. The other woman never attends meetings. In fact, women don't have commitment. If you appoint them unto the committee, they accept the position but will not do the work" (*Male, Chairperson of CHMC, Village #3).

Similarly, a participant from another community added:

"W*e also included two women but I haven't heard anything from them since then"* (Male, Traditional leader/CHMC member, Village #1)

The apparent lack of interest or participation of females on the committees was also explained by one of the health workers. She believed the women, at times, become too quiet. She explained that:

> "*When we meet with the women groups in the villages (even as women ourselves), getting them to express their views is so difficult"* (Female, CHO, Village #2).

Whilst there are deliberate efforts made to include major segments of the community in a leadership role of the health facilities, and their inclusion in the formation of health committees and in community meeting is encouraged, their lack of engagement might be linked to the reality of their lives. As another male participant, who is also an Assembly Member pointed out:

> "*We know that women are more than men in our communities and when we are sick they take care of us and our children. Their views are therefore very critical to us. Probably they are unable to come for the meetings because they become so busy."* (Male, CHMC member/Community based volunteer, Village #3).

Some of the participants claimed that in selecting members to serve on the health committees in their villages, there was a deliberate attempt to include representatives from the various ethnic groups and villages which are served by the CHPS compound. They believed that was a way to make the committee all- inclusive and get all segments of the community to be represented. A participant commented that:

> *"We selected people from different villages to be [members of the CHMC]. We did this for easy dissemination of information and easy feedback"* (Male, Assembly member, Village#1)

4.3.3 Perceived Effectiveness and Attitude of the Leaders of Community Health Committees

The manner in which the affairs of the Community Health Management Committees was handled and how the leadership of the Community Health Management Committee has been able to work with the community and the health workers to meet the health needs of the people was heavily debated by the participants of both FGDs. Some of the participants (community members) from village #1 claimed that they do not even meet as a Health Management Committee to take decisions and so the activities of the committee were left in the hands of only a few. According to some of the participants, the chairperson and only a handful are left to take decisions. This situation was reported as common in all the communities investigated in this study. One of the health workers had this to say:

> "*It is only three people we see all the time: [name] and the two people who came for the programme yesterday. Once a while, the chief also visits us. As for the other CHMC members we don't hear about them at all.*" (Female, CHO, Village #3).

The assertion that the CHMCs are not functioning properly did not go down well with some of the participants. A participant who chairs one of the CHMCs was quick to admit that while it is true that some members of the committee have not been working, the committee as a whole has been very effective and have been consulting with the community to have their views on board. He emphasized that:

> *"Yes, it is true. Some members don't come for meetings - one of the women he was talking about doesn't come for meetings at all but we have been meeting with the nurses to find solutions to problems that confront them in their work. We have had several meetings with [Name], their supervisor from [town name]."* (Male, CHMC chairman, Village #3).

Another participant from a different community was furious with the assertion that his committee has not been effective and has not been meeting. He indicated as a committee they have been meeting and that they also meet with other stakeholders to solicit their views. He furiously retorted:

> "*I don't remember the last time they called us for a meeting we did not honour. We have been meeting. Our last meeting was not too long ago. We met with the nurses. I was there with two ladies from [Village name] and the Assembly member"* (Male, CHMC member, Village #1).

Given the level of disagreement about the extent of community participation within leadership activities of the CHPS, it was an area where assessment was very difficult. Finally, there was consensus that given the limited role females play within community leadership structures, the level of participation of the community was at level 3 on the Spidergram (Figure 8).

4.4 Perceptions on the Integration of the CHPS into Pre-existing Community Organizational Structures

Organization as used here refers to the extent to which CHPS as a new community intervention integrated or collaborated with pre-existing community structures or networks

In this section, participants discussed their perceptions of how the CHPS operations have been incorporated into the community leadership structures, the decision making systems, other preexisting cultural /traditional practices and most importantly how CHPS has been able to link with programmes and activities that predated it in the community.

Most of the community members believed that the CHPS programme has been very successful in integrating itself into the traditional systems and structures that predated it. Some of the pre-existing structures that CHPS has been able to integrate itself into are the Traditional governance

system (Chieftaincy), District Assembly, Unit Committee, Traditional Birth Attendants, Community Based Volunteers and to some extent the traditional healers including herbalists.

It was the observation of most of the participants that the ultimate leadership of the community's input into the CHPS operations was exercised by the chiefs and their elders and that the CHMC members were deemed to be working on their behalf. All important discussions about the CHPS in the communities take place in the chief's palace. On the role of the traditional authorities in CHPS, one participant had the following comments:

> "*The people in this community are answerable to the chief. Nothing important about the community goes on without their approval. In fact, the ultimate decisions on implementation of the CHPS [as far as the community is concerned] rest with the chiefs and their elders because they are deemed the owners of the land. We, as CHMC members, act on their mandate and we report to them on regular basis. If the chief hasn't heard from our Chairman in a couple of weeks he summons him to his palace"* (Male, Traditional leader, Village #2).

Similarly, Assembly members, who are the elected representatives of the people at the District Assembly have a leadership role within the community which was known well before the inception of the CHPS. The Assembly members have however been given a special roles in CHPS. In all the three communities, the Assembly members have been coopted as members of the CHMC. With their ability to mobilize their supporters, the Assembly members can easily influence support for CHPS activities. Healthcare is a major political and campaign issue. The Assembly members therefore take their role in CHPS very seriously. This was certainly obvious from the study as two

Assembly members of the two of the communities were present as participants. An Assembly member who was also a participant had the following reflections:

> *"For me the success of the CHPS is so critical, if it fails under my tenure as the elected representative of the people, I have also failed as an Assembly member of the community. It is therefore a priority for me to ensure its success. I have therefore followed all their activities"* (Male, Assembly member, Village #1).

The activities of Traditional Birth Attendants, who have been conducting deliveries within the communities from time predating CHPS programme, have been integrated into CHPS operations such that they now act as intermediaries between health facilities and the pregnant women in the communities. A participant who is a Traditional Birth Attendant remarked:

> *"I was a volunteer when people from [Name of town] came to us and told us to come for training. So we were trained as TBAs and they supported us with some things we may need to perform delivery. However, as part of our training, we are to send all women who come to us to the health facility for delivery. Since the CHPS started, we have been asked to send all women who come to us to the health facility. The nurses visit me regularly to encourage me to send the pregnant women who come to me to the CHPS compound* (Male, Community based volunteer/ Traditional Birth Attendant, Village #2)".

Therefore, the TBAs are to report with their clients to the CHPS compound for the health workers to attend to them. The TBAs are to perform deliveries only in emergency cases such as when in transit to a health facility. However, in recent times, the activities of some of the Traditional Birth Attendants have been a source of concern for health authorities. The District Public Health Nurse opined that:

"We trained the TBAs so that they will ***not*** *perform deliveries at home but rather bring them to the CHPS or other health facilities for delivery. However, we have noted that the TBAs are not following the protocol given them but are now actively conducting deliveries because of the token gifts they receive from their clients."* (Female, District Public Health Nurse)

It was the view of many of the discussants in the FGDs that the existence of the Community Based Volunteers (CBV) before the inception of CHPS made it easier for the CHPS programme to get volunteers because the Community Based Volunteers (CBV) within the community required just a little training to become volunteers for the CHPS.

The intense discussions that occurred in both FGDs and the community conversation about reaching consensus regarding the level of participation as far as organization is concerned resulted in the choice of this indicator being at level 5 for CHPS in the 3 villages which this study was focusing on. This is because the majority of the participant in the two FGDs (i.e. health workers and community members) believed that the pre-existing structures that predate CHPS have been fully integrated into CHPS operations.

4.5 Perceptions on Management of the CHPS Programme

Management refers to community's capacity to take decisions about the direction and development the CHPS. Participants were asked to share their thoughts and perceptions about their community's involvement in the management of the CHPS. The majority of the participants in the two FGDs were of the view that the community, through the CHMC, is responsible for key aspects of decision making with regards to the CHPS operations. Examples given include the fact that CHMCs in the 3 villages oversee the work of the health workers and are responsible for maintenance of the facility

as well as for the welfare of the health workers in the community. The majority of the participants agreed that the CHMCs have been very effective at managing the facilities with only minimal interference from the GHS staff. When the Ghana Health Services' assistance is required, the supervisor at the sub-district is informed and called by the CHMC chairman to meet with the community leaders for them to agree on the solution. The CHMC Members indicated that the health workers do not take any major decisions without contacting the community.

A participant reflected:

> "*We have been working closely with the health workers as a committee. They present their plan to us for discussions and approval before they start implementation."* (Male, CHMC chairperson)

The health workers also reiterated that they have been working closely with the CHMC and that the community through the CHMC has been very supportive and provided them with the basic things they need for their work. One health worker pointed out that:

> "*Any time we have any problem we inform our supervisor at [Name of town], who will then call for a meeting with the CHMC and get the problem resolved"* (Female, CHO, Village #2).

In all, the participants (community members and health workers) were of the view that though the CHMCs are left in the hands of few who take most of the decisions, they have been very effective at mobilizing the communities to support the CHPS operations and supervising its operations effectively. They therefore came to the agreement that the participation on the community in management should be placed at level 4.

4.6 Perceptions on Resource Mobilization by the Community to Support CHPS Operations

Resource mobilization refers to communities' ability to mobilise and contribute resources towards CHPS. Discussions in FGD 1 (with the community members) made it abundantly clear that all the communities were not involved during needs assessment and design of the CHPS Programme in the communities. However, several non-monetary contributions were made by the members of the community in all the 3 villages. For instance, the land used for the construction of the CHPS compounds were donated by individuals within the communities. Because the buildings have been given out on contracts by the political leaders in the district (i.e. the District Chief Executive and the Member of Parliament), no communal contributions and activities were made or undertaken during the construction of the CHPS compound. However, the furnishing (furniture, curtains and beds, etc.) was done by the communities through contributions and donations. Several other contributions in kind and in cash had been made by all the community for the maintenance of CHPS activities since the construction of the respective health facilities (CHPS compounds).

Some of the participants gave examples of how communities in villages #1 and #2 had mobilized resources and contributed to the local health services provided by CHPS by stating the following:

> "*We employed a security and a cleaner for the CHPS compound. The villages within the community contributed to pay their salaries. So people in [village name] are paying the security officer's salary while those in [village name] are paying for the cleaner. Since we have sub-chiefs they divide the contributions amongst themselves and each sub- chief will pay with his people*." (Male, Assembly member, Village #2)

A participant from a different community also said this:

"*Initially we had no midwife. We decided we needed one, but accommodation for the midwife was a challenge. The community decided to build a bungalow for the midwife. The community mobilized resources and made all kinds of contributions both monetary and non-monetary such as labour, water, stones and sand etc. towards the project which we later named [service name] after the first midwife to be stationed there"*(Male, Former Assembly member, Village #3)

In all, the participants of FGD 1 believed that their contribution in relation to the CHPS operations is and has been very significant. Nonetheless their non-involvement at the initial stages (Needs Assessment of the CHPS) led them to consensually agree that the level of their participation in resource mobilization should be placed at level 3 in the Spidergram.

Figure 8 below shows the level of community participation in CHPS in the three communities. It shows that participants (both community members and health workers) at the community conversation came to the consensus that the level of participation of the community in the CHPS was lowest in relation to the initial needs assessment (level 1), but was average (level 3) for the communities' leadership of CHPS and for the mobilization of resources by the community to support CHPS. They however, assert that the participation of the community was high for the communities' management of CHPS (level 4) and highest for organization (level5)

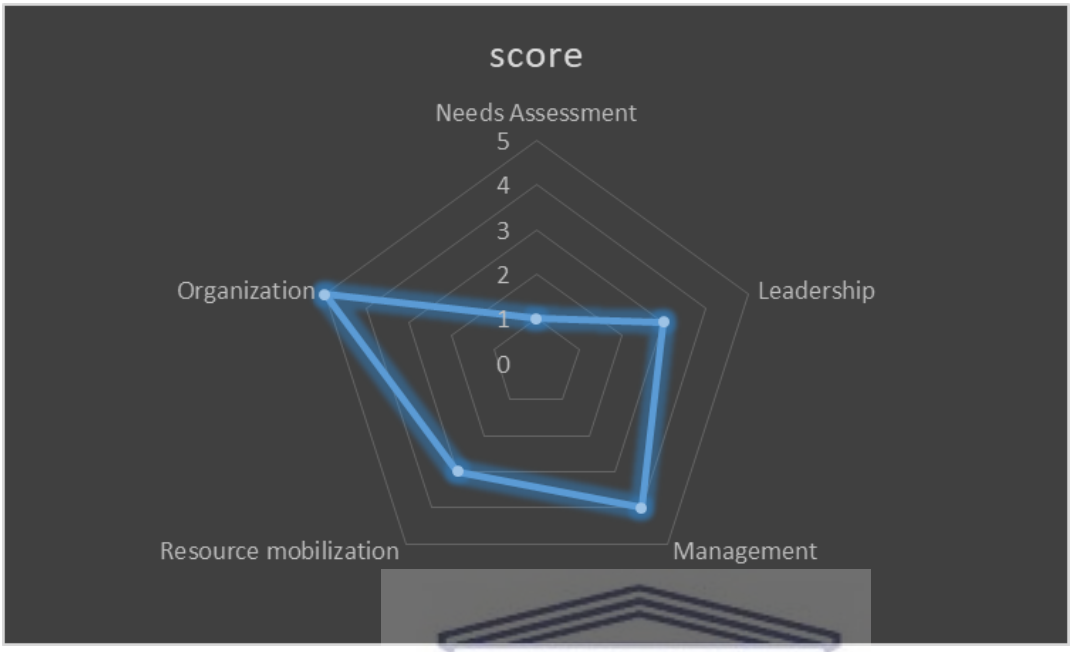

***Figure 8**: Spidergram showing community member's assessment of the level of community participation in CHPS in the 3 villages*

4.7 Barriers that are perceived to be hindering community member's in CHPS programme

Almost all the participants who took part in the study were of the view that their full and total participation is sometimes hindered by certain obstacles or barriers. The 5 factors that they highlighted as hindering their involvement are described below:

Poverty within the communities: The majority of the participants agreed that poverty within the community sometimes prevent them from fully participating. This, they say, becomes more apparent when there is the need to make contributions to support CHPS operations. This was amply depicted when a participant said the following:

> *"As you can see, our communities rely mainly on the 'small, small' farming we do. There are times when money is very difficult to come by especially during lean seasons when we*

don't have enough to eat let alone get some to sell and get money. When there is bumper harvest too, the market women take our farm produce for peanuts. We can't earn enough during such periods and therefore majority of the people in our communities cannot fulfil their obligations when we have to make any contributions" (Male, Assembly member, Village #2).

A few of the participants from the community also believed that their inability as community members to fulfil their contribution does not give them the moral right to comment on the operations of CHPS in their communities. A participant shared an insight on this by saying:

"*Our elders say: 'He who pays the piper calls the tune', therefore most people are of the view that because they are unable to contribute funds to support CHPS operations, they have lost their rights to comment on their activity."* (Male, CHMC member/Community based Volunteer, Village # 3).

When alerted that contributions can be in cash or kind and that contributing labour and other things is as good as contributing cash, another participant responded that:

"Any one of us is capable of contributing labour. Besides, in most cases, what we need to support the operations of CHPS is cash." (Male, Traditional leader (sub-chief), Village #2)

Their lack of capacity: Some of the participants especially those who were members of the CHMC also shared that they sometimes feel that they are not adequately prepared to fully participate in CHPS. This, according to the community members, leads to a situation where only a few individuals hijack the project. One of the CHMC members among the participants highlighted how the lack of capacity adversely affects their output on the committee by saying the following:

"*We were put on the committee without training. So from the onset we did not know our roles even though we were told that we are to help manage the programme."* (Male, Traditional leader/CHMC, Village#1)

The seemingly lack of interest of women to perform their roles in CHPS as members of the CHMC was partially attributed to lack of capacity. It became evident that the women do not have full appreciation of their roles. A female participant from the community had this to say:

"*They will tell you that women don't participate fully in CHPS operations but you see, we sometimes do not have full appreciation of the issues pertaining to the CHPS"* (Female, Community- based volunteer, Village #1)

High Staff Attrition Rate within the CHPS facilities in the Asunafo South District: Most of the participants from the community were of the view that the health workers posted by the Ghana Health Service to their community do not stay long enough for them to get fully acquainted with the people and the way things are done in these communities. The participants averred that some of the health workers spend only about a year and they are transferred out of the community. This, according to the participants, makes it difficult to establish rapport and get things done. This frustration on the part of the community members was expressed by one participant this way:

"They (Ghana Health Service) bring health workers here and they take them away just when we have come to know them and they (health workers) are beginning to understand us" (Male, CHMC Chairman, Village #3)

Another participant (community member) thus highlighted the frustrations of the community with the frequent changes of health workers that has bedeviled CHPS implementation by adding the following:

" They brought a guy who was so helpful and everybody liked him he left only about two years and he said he was going back to school so they took him away and brought a new person"(Male, Former Assembly member, Village #3)

Language barriers between community members and health workers: The majority of the community members who participated in the FGD claimed that while most health workers posted to the communities can speak Twi, the local dialect, there have been some instances when the health workers posted could not speak Twi. The community members averred that when the health workers cannot speak Twi they are unable to work together effectively. One community member highlighted their frustrations by saying the following:

"About five years ago the health worker posted to us could not speak Twi. Most of the people here cannot speak English so she could not work with us. We complained and she was taken away to be replaced by a new person." (Male, CHMC Chairman, Village #3)

Inadequate female involvement in CHPS: Almost all the participants agreed that the role of women in meeting the health needs of the community is very crucial and that the women in the community take care of the sick people within the communities. The participants were however unanimous in admitting that women participation was far below expectation. A male participant emphasized this by saying:

"The mothers in our communities take care of our health needs by caring for us when we are sick especially the children in the community but when we ask them to join us to take decision about our health facility, we don't get them to come" (Male, CHMC member/ traditional leader, Village #1)

A health worker also added that:

"*Almost everybody who comes to the CHPS compound is accompanied by a woman"*. (Female, Enrolled Nurse, Village #1)

Some of the participants from the community were of the view that women don't participate actively, as expected of them, because they are overwhelmed and overburdened by their daily activities which including household chores and farming. A female participant from the community expressed this sentiment in the following manner:

"Sometimes I get worried if it is thrown out there as if as women do not care about things that go on around us. It is just that we get so tired from the numerous work we do (from the farm and the chores at home)." (Female, Community based Volunteer, Village #3)

4.8 General challenges that were raised regarding CHPS implementation

During the course of the two FGDs the participants highlighted some difficulties that they had identified following the implementation of the CHPS programme in their communities. They noted that despite its various successes, there were some challenges which need to be addressed. These included:

Challenges with Health workers: The majority of participants in the two FGDs (both health workers and community members) were of the view that challenges with health workers present the most serious challenge in the implementation of the CHPS programme within their communities. These challenges include inadequate numbers of the health workers, inappropriate cadres mix of health workers, high staff attrition and poor staff attitude.

The District Public Health Nurse said this when she was talking about the health worker situation with CHPS in the district:

"*As you can see we don't have enough Midwives and Community Health Nurses. That's why you don't have these cadre of health care workers here today. We simply do not have them. At least each of the three communities you invited should have at least one midwife and one CHO. There is only one midwife in Apenamadi who couldn't come. The rest do not have a midwife. There is only two of the three CHO at Nkrankrom. The rest do not have CHOs. We are currently using Enrolled Nurses to fill the gap".* (Female, District Public Nurse Officer,)

A few community members also bemoaned the attitude of the health workers. Some community members claim some of the health workers disrespect them and look down on them. Some of the community based volunteers also believe that some of the nurses look down on them with some of the staff referring to them in derogatory manner as 'those villagers". One of the participants shared her experience this way:

"Some of the health workers who have stayed in the cities all their life, find it difficult adjusting to the life here. Some don't fit into our society. They are so disrespectful. There was one who was posted here five years ago. She disrespected everyone in our community including the chief. Can you believe she always referred to us as villagers and backward people?" (Female, Community based volunteer, Village #1)

Accommodation for staff: most of the participants were aware of the fact that the original plan for CHPS compound included a living quarters for the CHO who will stay in the community. They however complained that, though all the CHPS compounds in the 3 communities have at least a room to accommodate one staff, that is most inadequate and the rest of the health workers have to stay elsewhere. This, according to the participants, creates a problem because finding a decent

accommodation for the staff in these communities is very difficult. A participant expressed his sentiments by saying the following:

> *"I have been a member of the committee responsible for finding accommodation for government workers such as teachers and health workers. It is really difficult getting a decent accommodation. The few decent ones are also occupied. ... In our communities people don't build houses for rent. They built to house their families."* (Male, Assembly member, Village #1).

A health worker added that she nearly rejected her appointment because she was not getting any decent accommodation. She shared her experience this way:

> "*When I got here the first time, I rejected the posting and requested to be re-posted to different place because I was not getting accommodation."* (Female, Enrolled Nurse Village #3)

Logistics: Almost all the participants (both health workers and community members) decried the lack of logistics for use by the health workers and the volunteers in the performance of their duties which they say affects the CHPS operations significantly. These logistics that are lacking include but are not limited to motor vehicles to aid in transportation and home visiting, drugs and other consumables. One of the health worker who was a participant had the following to say:

> *"The work here is very difficult. We don't have any means of transport, and we serve several villages. Walking to these villages we are therefore not able to follow up all cases through home visits."*(Female, CHO, Village #2)

Another health worker from a different community added that:

"There are days when we in our facility are faced with shortages of basic consumables such as gloves. In such situations we become demoralized and our work as health workers is seriously hampered."

Health Insurance Claims: The participants believed that the National Health Insurance is a good policy that has been able to expand access to health care by removing upfront payment. However, participants lamented the delay in payment of claims that are submitted to the National Health Authority for payment. This delay in payment is partly responsible for the logistical challenges that are witnessed in the CHPS facilities. A participant shared her thoughts by lamenting that:

"*The NHIS is a very good policy. However, the delay in payment of claims is affecting our operations. We are owing the Regional Medical Stores huge sums of money which we are unable to pay. So if we make requisitions they reduce it by half"*. (Female, Enrolled Nurse, Village #2)

A community member also added that:

"*Because there are no drugs they end up buying the drugs we need from a chemical seller and most of the people within our communities cannot afford to purchase these drugs out of pocket"* (Female, Community-based Volunteer, Village #2)

4.9 Ways of Improving Community Participation

During the discussions, the participants expressed ways in which they would want to be involved in programmes such as CHPS. They were not happy about their non-involvement at the initial stages of the programme. They were of the view that even where it has been given on contract and fully paid for, the communities should be involved in the design and planning of the programme, as it will enhance supervision and make them feel that they own the project. One participant

expressed his disappointment at the fact that buildings that were given out on contracts were poorly supervised:

> *"We were not brought on board at the initial stages of the project. Therefore, we didn't really feel part of it let alone own the project. You see in my community, the building for weighing is collapsing because the contractor did not use the required amount of cement and the right caliber of building materials. The supervision was poor but we couldn't say anything while construction was ongoing because we (community members) were afraid the contractor will rebuke us and tell us we had not given him any contract. If the community had been involved when the contract was being awarded we would have been able to monitor the contractor."* (Male, Former Assembly member, Village #3).

They also believe that if they are made part of the process of posting of health workers to their communities they will be able to identify staff who will likely fit into their communities and hence will be more likely to stay longer and reduce the high attrition among the staff. A CHMC member said the following to emphasize his point:

> *"The Ghana Health Service does its posting without any input from us. Some of the staff posted to our communities can never fit into our society. Imagine posting someone who can't speak Twi to this area. He cannot fit."* (Male, CHMC chairperson, Village #3)

It was also suggested that in order to improve the supervisory role of the community health committees, members should be taken through some training for them to learn the basics of management. This was explained by one participant in this way:

> *"A little training will help build our capacity and give us the confidence to manage the facilities better"* (Male, Traditional leader/CHMC member, Village #1).

Again, the participants averred that government should help the communities to construct accommodation for staff in the villages where decent accommodation for rent is non-existent, to motivate for people to accept postings to those places.

> "*We want to get decent accommodation for all workers posted to us but that is difficult for us. We don't have money to buy all the things needed for the construction of bungalows. We want the government, benevolent organizations and individuals to help us get accommodation for all government workers particularly the nurses and teachers. We are prepared to work with anybody who can help us."* (Male, Assembly member, Village #2).

The participants believe that if they are able to provide good accommodation for the health workers, it will mark the beginning of a healthy relationship between the health workers and the community. A participant added that:

> *"How can you have a good relationship with someone you visited but could not provide you with a place to lay your head? If we want them to be our friends then we should be able to give them good accommodation."* (Male, Traditional leader [sub-chief], Village #2)

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This chapter discusses the major findings of the study and relates the findings to those in literature and policies. The purpose of this study was to explore the level of community participation in CHPS in the three communities that were studied.

While authors have not come to consensus on the definition of community participation, there is very little disagreement on the fact that community participation should best be regarded as a process, not an outcome of an intervention (Rifkin et al, 1988; Rifkin and Kangere, 2001). In this study, community participation in CHPS was considered as a process and the Spidergram was employed to assess the extent to which the community participated.

5.2 The Spidergram

Using Rifkin's Spidergram as a methodological tool, this study obtained views and perceptions of participants in five major areas of participation of the community in CHPS (i.e. needs assessment, leadership, management, organization and resource mobilization). The participants assessed the communities' participation in CHPS with the aid of an assessment tool for assessment of CHPS by Baatiema et al (2013) which was modified from Rifkin et al (1988).

The Spidergram constructed from the study shows that the overall community participation is not as wide as it ought to be in order to fully empower the community and allow them to assume ownership and control of the project. Several authors (Baatiema et al, 2013; Makaula et al, 2012; Rappaport, 1987; Laverack, 2004) have, however, argued that programmes or interventions that seek to empower people to take control of their lives are most likely to be successful if the extent of participation of the beneficiaries is wide enough to ensure that there is adequate transfer of

knowledge and skills to them. There is thus the need to make significant improvements in needs assessment, leadership and resource mobilization as indicated by the results of the study.

It was observed through the study that some factors that enhanced community participation include the following: Firstly, there was a successful integration of CHPS into the existing structures (i.e. Traditional leaders, Assembly members, traditional birth attendants, community based health volunteers etc. were all given roles in the CHPS. Secondly, resources were mobilized from local sources to support CHPS operations. Finally, also inherent in the CHPS operation in the three communities was the representation of community interest through leadership and management of the CHPS with individuals who were independently selected by the community. Factors that are inimical to successful community participation in CHPS, as observed in the study, included inadequate representation of marginalized groups such as women in decision making, and limited involvement of the community in the design and planning of the programme.

The discussion of the results will therefore be based mainly on the five key areas of assessment of community participation as detailed by Rifkin et al. (1988) i.e. needs assessment, leadership, organization, management and resource mobilization.

5.3 Needs Assessment

The results of the study showed that the programme was planned and designed by external players without the involvement of the members of the community. This was similar to observations made in CHPS programmes in Upper West and Volta Regions of Ghana (Galaa, 2002; Baatiema et al, 2013) and in PHC programmes in Nigeria (Iyanda and Akinyemi, 2017). The fact that the CHPS programme in all the studied communities was not self-formed, made the communities unable to assume ownership of the CHPS programme as witnessed by the fact that they looked on

unconcerned as the buildings were being constructed with substandard building materials. This corroborates the assertion of Addae-Boahene (2007), that the best results of community participation is achieved only when the local people are involved in decision making at all stages of the project cycle. Similarly, full participation leading to empowerment of members of the community is better achieved through self-formed and self-run projects because the community assume ownership of the programmes (Heck, 2003).

The initial rejection of CHPS programme by some residents in some of the studied communities, because it did not meet their health needs, emphasizes what McCoy et al (2012) postulated in a systematic review of the literature for evidence on health facility committees in low- and middle-income countries. During needs assessment of CHPS programmes, it has to be known that needs are community specific and therefore the participation of the community ought to be regarded as situation specific.

The results of the study also indicate that some decisions were made based on political considerations during the needs assessment stages of the project as observed in the siting of some of the CHPS facilities. However, political partisanship and political affiliations often present a major challenge to community participation because when committees are used for political gains, it leads to erosion of trust and confidence in the process (Enshassi et al, 2016).

It was also revealed through the study that some of the community leaders were sidelined during the needs assessment stage of the CHPS programme because they were perceived to belong to political parties different from that of certain politicians in the district. This corroborates the arguments of Takyi et al (2014), Addae-Boahene (2007) and Wilcox (2002) that government officials feel threatened by the empowerment of some local people who are often perceived as

agents of opposing political parties – a situation that is inimical to the full commitment and participation from the local people. In fact, this could explain the reluctance of the people to comment on the inadequacies of the construction of the building for the CHPS programme in the communities because they did not want to be tagged as 'opposition members'.

The limited role the community played during the needs assessment reduces their participation to what was described by Arnstein (1969) as tokenism, and by Pretty (1995) as passive participation. It made them passive recipients who were only informed of what was being done, and not asked for their views on what has to be done or how it should be done. This situation does not augur well for effective and empowering community participation because for that to be achieved the external health experts need to engage the local people about the programme, and take their views on board. Although the external health experts may have specific technical knowledge, such expertise needs to be spiced with local knowledge especially on gender issues, resources, culture and power relationships (Baatiema et al, 2013). The interaction of the local people and the experts leads to a situation where they learn from each other thus leading to transfer of knowledge and skills to the local people.

5.4 Leadership

The results of the study observed that the community was fully aware that they are responsible for providing leadership for the CHPS programme within their communities and that this leadership is exercised through the Community Health Management Committees. It was also revealed that the CHMC members were selected independently by the community without any external influence. This finding however contradicts what Baatiema et al (2013) observed (i.e. that the CHMC members were imposed on the local people) when they studied the CHPS programme in the Northern Ghana.

Interestingly, the CHMC is male dominated as corroborated by Baatiema et al (2013) and Iyanda and Akinyemi (2017). There is, however, evidence from the study that some efforts were made to include women in decision making thus following the recommendation of Cornwall (2008) that all efforts must be made to include the marginalized, or else the participatory process itself will further deepen the exclusion of these groups – in this case women. In reality, however, decision making was almost completely left in the hands of men. One of the reasons why Female involvement in decision making was low because the women were not willing or able to participate in the activities of the CHMC. The unwillingness of the women to take part in the CHMCs is partly because they think that they will be wasting their time on the committees since what they say is not taken on board. This corroborates the assertion of United Nations Center for Human Settlement and Development (1991) and Howard-Grabman et al (2017) who argue that women in many cases have low status in the society, and when some segments in the society have been downtrodden for too long, they resist attempts and pressures to participate in projects, thus further deepening their isolation. Women not taking part in leadership of CHPS in their communities of their own accord has been described as "self-exclusion" by Cornwall (2008:279) and further corroborates the observations of Rifkin (1990) and Goodman et al (1998) that culturally, community leadership has been set to exclude marginalized groups such as women. This also concurs with the argument of Cornwall (2008) that participatory process realistically can never be so ideal to involve all stakeholders, as some may be unwilling to participate despite all urgings.

5.5 Organization

The results of the study observed that the CHPS programme successfully integrated itself into the existing community structures including, but not limited to, chieftaincy, elected representatives, traditional birth attendants and community based volunteers. The integration of CHPS into

community structures that predated it ensured that there were no conflicts between CHPS and the existing community structures (Baatiema et al, 2013). It is also pertinent to note that building on existing structures is an important principle of community participation in CHPS because logistical demand on scarce resources is reduced when it is based on what is already existing(Oakley, 1989). For instance, the use of community based volunteers who had been trained to participate in health intervention programmes that predated CHPS reduced the resources required for training entirely new volunteers.

Similarly, Traditional Birth Attendants (TBAs) have traditionally been an important source of provision of antenatal, delivery and postnatal services to pregnant women in several Ghanaian communities (Aryeetey et al, 2015). Therefore, bringing the TBAs on board in the operations of CHPS made it easier for the CHPS programme to get access to the pregnant women and provide them with these services.

Furthermore, integration of health programmes, including CHPS, into existing community structures ensures that there is a holistic view on health just as Oakley (1989) posited. Indeed as Oakley (1989) argued further, effective local intersectoral cooperation is needed to support community participation in health programmes such as CHPS since that will result in a holistic view of health in the communities. Traditional leaders (chiefs) and elected leaders (assembly members) constitute the local structures of power and authority. These two group of leaders (traditional and elected) are responsible for all the other sectors within the communities. Therefore giving them special roles in CHPS ensures that CHPS cooperates with other sectors so as to provide holistic health service. Moreover, involvement of local leaders and other influential community members in the CHPS programme attracts their invaluable support which is essential for building

and maintaining support for the CHPS programme in the communities as corroborated by Management Sciences for Health (2002).

5.6 Management

The results of the study noted that the CHPS programme in the three communities is managed or supervised by the Community Health Management Committees (CHMCs) which have some decision making powers. The Ghana Health Service staff working on CHPS in the three communities however report directly to the District Health Director through a supervisor. There is, however, some collaboration between the Ghana Health Service staff and the CHMC, which represents the community. This finding is in consonance with the CHPS policy which puts the District Director of Health in charge of all health activities in the various districts (MOH, 2014d).

The results also indicated that, there were only few active members on the CHMCs, who take decisions without consulting widely with the general members of the communities. This finding confirms the assertion by Baatiema et al (2013) that the CHMC which manages the CHPS programme for the community had undemocratic leadership styles and took vertical decisions without input from the larger population. The fact that there were so many inactive members of the CHMC is not surprising. Indeed, the Ministry of Health indicated that across the country about 65% of communities have CHMCs which are inactive (MOH, 2013; MOH, 2014c). A major reason for the inactivity of members of the CHMC is the fact that the community members had little knowledge about the project thus hindering their efficient and effective participation in the work of the committees. This finding is corroborated by MOH (2013) and MOH (2014c) who found that in most places where the CHMC was not active, members of the committee had not been trained. It also confirms the assertion of Howard-Grabman et al. (2017) that stakeholder committees are more functional and effective when members are clear about the purpose of the committee and the

roles and responsibilities of the individual members. Unlike Iyanda and Akinyemi (2017), who found that the community members were made responsible for certain activities of PHC such as immunization, in this study we found that community members were given only supportive roles to play in care provision activities of CHPS such as health education.

5.7 Resource Mobilization

The study found that although the communities were not involved at the beginning of the project, especially in the needs assessment stages, community members became very much engaged in all the stages because they wanted the project and believed that they would be the ultimate beneficiaries. They were particularly engaged in mobilization of resources for the project by donating land, making contributions to furnish the CHPS compounds, conducting communal activities to clean and clear bushes at the facilities, and volunteering for the CHPS operations.

It was also found in the study that the community members do not feel that they own the project because they believe that their contribution towards the project which were mainly non-monetary, such as labour, donation of sand and stones or volunteering, were of insignificant value. Indeed several authors (Management Sciences for Health, 2002; Kweku et al, 2020b Rifkin et al 1988) have indicated that a major way communities can feel part and take ownership of any project is when they are actively involved in resource mobilization for the project. While many studies have found in-kind contributions as an essential and important source of community resource mobilization (Baatiema et al, 2013; Iyanda and Akinyemi, 2017; Kweku et al, 2020b), this study however found that most people within the community consider financial contributions as the most important and did not value in-kind contributions made by the community members. This affirms the assertion of Management Sciences for Health (2002) that because the value of non-monetary contributions are not calculated in many projects, such in-kind contributions are often overlooked

and are, consequently, not added to many project reports, thus undervaluing and underestimating contributions made by the local people (Management Sciences for Health, 2002).

5.8 Barriers to Community Participation in CHPS

The results of the study found that factors that hinder full participation of the community members in CHPS operation within the communities include poverty, lack of capacity on the part of community members, high staff attrition and language barriers.

The results of the study also indicate that participation in CHPS is particularly difficult for the community members because what is demanded of them involves cash payments and because they don't have money they are unable to fulfil their obligations. A similar finding was made by Chifamba (2013) in a study in Zambia, which found poverty to be a major challenge/barrier to community participation in projects in Zambia especially when it involved cash payments. Poverty is thus a very important obstacle to full participation of community members in the CHPS programme as has been observed by several studies (Kweku et al, 2020b; Chifamba, 2013; United Nations Center for Human Settlement and Development, 1991). Poverty makes it difficult for the community members to participate fully in CHPS because they neither have the time, the energy nor the inclination to attend meetings about CHPS. This is because they exert all their energies and time working on their farms, which afford them meagre earnings which are not able to sustain them. As a result, they are unable to participate in activities that will give them critical information about the CHPS programme. Most of the community members are therefore poorly informed about CHPS and hence are unable to participating in the CHPS programme, and benefiting from it.

Lack of capacity was observed in the study as a limitation to the involvement of the community members in decision-making processes which in turn affects the extent of their participation in

CHPS. This finding is in line with that of Ministry of Health's study in 2014c which found that lack of training of CHMC members resulted in weak community leadership of CHPS (MOH, 2014c). The lack of capacity of the community members to manage and participate in CHPS made them incapable to plan and monitor CHPS activities. They are therefore unable to demand accountability from health workers and from other members of the community participating in CHPS in the community. This finding corroborates that of Howard-Grabman et al. (2017) when they conducted a systematic literature review of two community participation interventions: quality improvement of maternity care services and maternal and newborn health programme planning and implementation. This was perhaps the reason why the health workers always reported to the Ghana Health Service chain of command instead of discussing issues first with the CHMC.

An important hindrance to full community participation observed in the study was the frequent changes in the health care workers stationed in the various communities. For the people in the community to fully participate in CHPS, there is the need for them to have a cordial relationship with the frontline health workers. However, the health workers do not stay in the community long enough for them to be fully acquainted with the people. This situation makes it difficult for the community to build trust in the frontline health workers so as to fully cooperate with them.

5.9 Limitations

A major limitation of the study is that although the issues raised in the study are similar in all the three studied communities, there were subtle differences which were not reported in the study. While the study is reported as representing the district, the district has several other communities whose experiences may be very different from these three communities.

Since the study is a mini-thesis, it is constrained by time and resources. Only two focus group discussions were held, therefore the observations were based on views and experiences of few individuals. It is therefore difficult to generalize about CHPS in the region.

Another limitation of the study is reporting bias on the part of both health workers and the community members. The community members who served on the CHMCs and the health workers seemed to be defending their work by putting a positive spin on the CHPS programme. For example, during the community conversation, the community members vigorously defended the work of the CHMCs though there were indications that only a few members were active.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study was designed to explore community members' and frontline health workers' perceptions about the current extent of community participation within key aspects of the planning and delivery of health activities related to the CHPS programme. It also aimed to show the implementation challenges to strengthening the level of community participation in the CHPS programme in the Asutifi South District.

Findings from this exploratory qualitative research provide evidence that community participation is still an important principle in health care delivery through CHPS in Ghana and that communities' participation in health programmes come in several forms including, but not limited to, programme designing, planning, needs assessment, advocacy, management and resource mobilization. This study has also shown that there is usually some form of community participation irrespective of how narrow or wide it is.

Communities' non-involvement to any significant extent in the project planning, design and in the needs assessment stages of the project is worrisome because it leads to a situation where the needs and preferences of community members are not given priority in the CHPS operations. This thus defeats the basic tenet of the CHPS concept, which places the community at the centre of its operations.

Lack of female representation in decision making as far as the CHPS is concerned is a major challenge to full and proper community participation in the CHPS programme in Ghana. The absence of women at the table when decisions are being taken about their health negatively affects utilization of the services being provided through CHPS. This is so because women are caregivers

in the community and therefore their not being involved when decisions are being taken about CHPS means that their preferences will be ignored and not taken into account.

Several health-worker, community, and health systems-based challenges militate against the smooth implementation of CHPS in Ghana. Government through the Ministry of Health and the Ghana Health Service can work together with the communities to find avenues that can assuage these challenges and lead to improved implementation of the CHPS programme.

6.2 Recommendations

The findings from this and other studies suggest that the CHPS implementation requires proper participation of the communities and that efforts must be made to deepen and widen the participation of the community in the operations of CHPS. In that regard, the following recommendations are made:

1. The Ministry of Health and the Ghana Health Service should take a critical look at the CHPS implementation and ensure that community participation is encouraged at all stages of CHPS implementation especially at the planning and design stages. This will possibly lead to the desired positive changes in the uptake and utilization and ensure sustainability of the CHPS programme as it will lead to a sense of community ownership.
2. Community participation should be strengthened and made the corner stone of CHPS implementation as has been well articulated in the CHPS policy manuals.
3. The Ministry of Health and the Ghana Health Service should continuously monitor and evaluate the participation of communities in CHPS through various means such as research, regular monitoring visits, etc.

4. Community members and their representatives should continually support the health workers providing care at the CHPS compound especially with respect to community mobilization and advocacy for the CHPS programmes.
5. Deliberate and conscious efforts should be made to engage women in leadership of the CHPS and other health programmes. All efforts should be made to get them to participate. Females must be given a quota on all Health committees from the national level to the community level and such quota system must have legislative backing.
6. Government of Ghana should have special incentives for staff of the Ghana Health Service who stay for longer period (five or more years) in the hinterlands and work at the CHPS level. This special incentive may include scholarships for further education.
7. The Ghana Health Service should devise means of training all community members who have been selected to represent them on the Community Health Management Committee as a way of building their capacity.
8. Frontline health workers who are posted to the communities should be given special training on how to engage communities and work with them.
9. The Government of Ghana should find means of ensuring that the National Health Insurance Authority reimburses the health facilities early.

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LIST OF ANNEXURES

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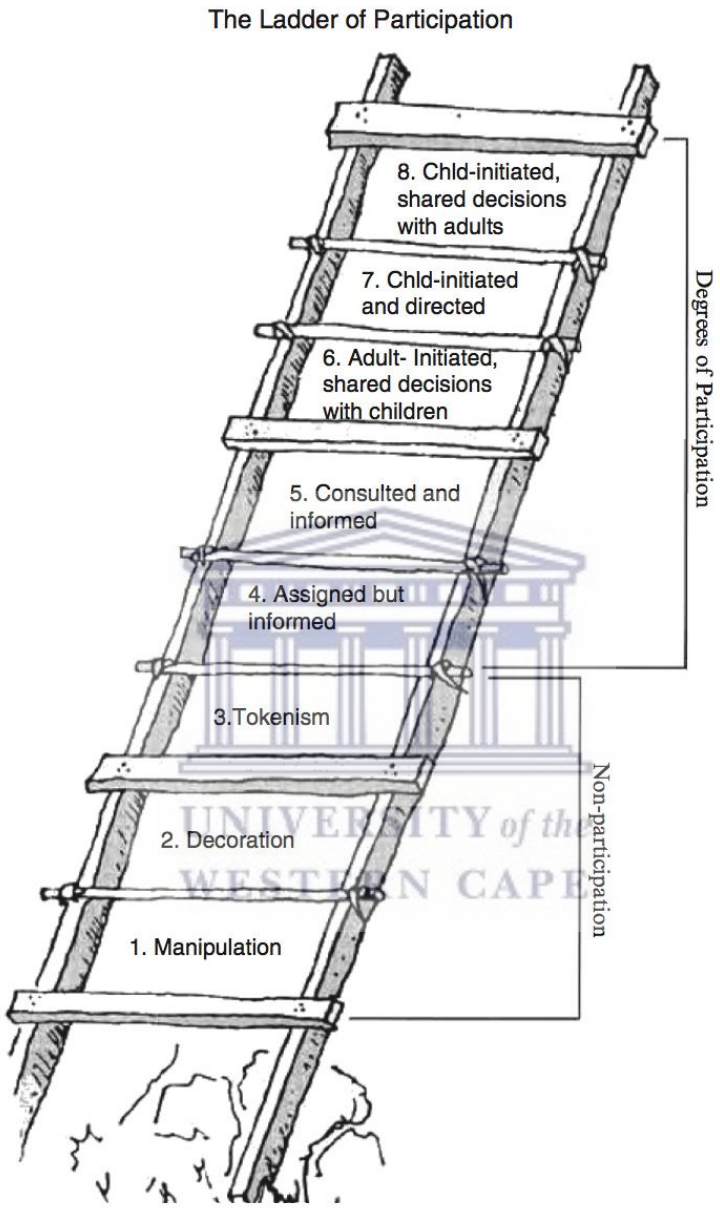
Annexure 12	Ethics clearance UWC

Please note:

The translation of Annexures 5, 7 and 8 (highlighted in yellow) have been translated into Twi. However, given Twi is a language that is *spoken* more than it is written in contemporary Ghana (with English being the official language in Ghana), a computer with a Twi keyboard is not something that is commonly available within the District. The researcher has, however, obtained assistance from a commercial printing company and with their assistance had the above 3 Annexures translated into Twi (using the Twi keyboard). The translations are thus contained in a

separate PDF document (given the keyboard is different and does not convert accurately and easily into a Word document). The translations of these three documents have also not been placed on the official UWC letterhead (again, because the keyboard is different and the translations are within a PDF document), but prior to field work, the researcher – made a copy of each of the translated documents for each of the community participants in the study and stapled a cover page that contains the UWC letterhead on to the translated information sheet, consent form and confidentiality form.

Annexure 1: HART'S LADDER OF CHILDREN PARTICIPATION



Source: Hart (1992:8)

Annexure 2: PRETTY'S TYPOLOGY OF COMMUNITY PARTICIPATION

Level of participation	Characteristics of level
1. Manipulative Participation	In this type of Community participation, representation is a façade in which the local people are given representation on boards and committee. These representatives are unelected and have no power.
2. Passive Participation	In this type of community participation, external professionals make decisions without any input from the locals and those decisions are fostered on the communities. The communities are informed through unilateral announcements
3.Participation by Consultation	People participate by being consulted, and external people listen to views. These external professionals define both problems and solutions, and may modify these in the light of people's responses. Such a consultative process does not concede any share in decision making, and professionals are under no obligation to take on board people's views.
4. Participation for Material Incentives	Communities participate by contributing resources such as labour, in return for material incentives (e.g. food, cash). It is very common to see this called participation, yet people have no stake in prolonging practices when the incentives end.
5. Functional Participation	People participate by forming groups to meet predetermined objectives related to the project, which can involve the development or promotion of externally initiated social organisation. Such involvement does not tend to be at early stages of project cycles or planning, but rather after major decisions have been made. These institutions tend to be dependent on external initiators and facilitators, but may become self-dependent.
6. Interactive Participation	People participate in joint analysis, which leads to action plans and formation of new local institutions or the strengthening of existing ones. It tends to involve interdisciplinary methodologies that seek multiple perspectives and make use of systematic and structured learning processes. These groups take control over local decisions, and so people have a stake in maintaining structures or practices.
7. Self Mobilisation	People participate by taking initiatives independently of external institutions to change systems. They develop contacts with external institutions for resources and technical advice they need, but retain control over how resources are used. Such self-initiated mobilisation and collective action may or may not challenge existing inequitable distribution of wealth and power.

Source: *Adapted from Pretty (1995)*

Annexure 3: WHITE'S TYPOLOGY OF PARTICIPATION

Form of Participation	What 'participation' means to the implementing agency	What 'participation' means for those on the receiving end	What 'participation' is actually meant to achieve
Nominal Display	Legitimation- to show they are doing something	Inclusion – to retain some access to potential benefits	Display
Instrumental	Efficiency – to limit funders' input, draw on community contributions and make projects more cost-effective	Cost – of time spent on project-related labour and other activities	As a means to achieving cost-effectiveness and local facilities
Representative	Sustainability – to avoid creating dependency	Leverage – to influence the shape the project takes and its management	To give people a voice in determining their own development
Transformative	Empowerment – to enable people to make their own decisions, work out what to do and take action	Empowerment – to be able to decide and act for themselves	Both as a means and an end, a continuing dynamic

Source: *Adapted from White (1996)*

Annexure 4: INFORMATION SHEET (Community Representatives)

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21 959 2809 Fax: 27 21 959 2872
E-mail: soph-comm@uwc.ac.za

INFORMATION SHEET

Project Title: Exploring Community Participation in Community-based Health Planning and Services in the Asutifi South District of Ghana

What is this study about?

This is a research project being conducted by myself, Dr Kwasi Tutu Ali, in partial fulfilment of a Master in Public Health Degree I am pursuing at University of Western Cape, South Africa. I am inviting you to participate in this research project because you are a community member who has a role to play in the success of CHPS operations.

The purpose of this research project is to contribute to increasing the understanding of district and regional health managers about the experiences and opinions that you, as local community

members, have about your role within the CHPS operations, how you feel about the ownership of the CHPS, and how you believe your participation in CHPS can be strengthened in the future.

What will I be asked to do if I agree to participate?

You will be asked to participate in a group discussion with other people who, like you, will represent one of these three communities: Nkrankrom, Apenamadi, and Akotosu. The discussions will focus on your perceptions and experiences of how community members are engaged or involved in CHPS and how you and other community member's participation can be improved. The discussions will take place at the Conference Hall of St. Elizabeth Hospital in Hwidiem, the District capital. The group discussion is not expected to exceed one and half hours.

Would my participation in this study be kept confidential?

As the researcher I will undertake to protect your identity and the nature of your contribution. To ensure your anonymity, I will also ensure that the identity of CHPS compounds and communities where the study will take place and the identity of you as study participants will be kept confidential at all times during the course of the study and during the dissemination of the findings of the study.

I will do this by removing anything that will associate you with the study such as your village's name. You will also be given a pseudo name both in the write up of the study and when I report back on the findings to the district and regional health authorities and the communities that have been involved in the study. Your identity will be protected by ensuring that your contributions, such as quotes and accounts or references to incidents, will be made anonymous.

To ensure your confidentiality, your participation which will be recorded in the form of written notes and by audiotape and in all the signed consent form(s) will be well protected on a password-protected computer which can only be accessed by myself. All the paper-versions of your participation will be stored in a locked filing cabinet.

This study will use a group discussion format therefore the extent to which your identity will remain confidential is dependent on participants' in the group maintaining confidentiality. In order to ensure confidentiality during discussions, all participants will be asked to sign confidentiality binding form. This will ensure that what you say during the discussions will be very confidential even among participants.

What are the risks of this research?

All human interactions and talking about one's self or others carry some amount of risks. I will nevertheless try to minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, health workers of St. Elizabeth Hospital are on standby to offer suitable care to you.

What are the benefits of this research?

This research is not designed to benefit you directly. However, the results may help us learn more about how best we can engage communities in the district health programmes. We hope that, in the future, other people might benefit from this study through improved understanding of community participation and engagement.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Dr Kwasi Tutu Ali, as part of the fulfilment of his MPH programmeme at the University of the Western Cape, South Africa.

Should you have any questions please do not hesitate to reach him at the address and contacts below:

Dr Kwasi Tutu Ali

Diocesan Health Service
Catholic Secretariat
Goaso. Ghana
Email: kalimfa@gmail.com
Tel +2335031988

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann
Head of Department: School of Public Health
University of the Western Cape
Private Bag X17
Bellville 7535

ulehmann@uwc.ac.za

Prof Anthea Rhoda
Dean: Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Biomedical Research

Ethics Committee.

Biomedical Research Ethics Committee

University of the Western Cape
Private Bag X17
Bellville
7535

Tel: 021 959 4111

e-mail: research-ethics@uwc.ac.za

REFERENCE NUMBER: BM 19/8/2

Annexure 5: INFORMATION SHEET (Health Workers)

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21 959 2809 Fax: 27 21 959 2872
E-mail: soph-comm@uwc.ac.za

INFORMATION SHEET

Project Title: Exploring Community Participation in Community-based Health Planning and Services in the Asutifi South District of Ghana

What is this study about?

This is a research project being conducted by myself, Dr Kwasi Tutu Ali, in partial fulfilment of a Master in Public Health Degree I am pursuing at University of Western Cape, South Africa. I am inviting you to participate in this research project because you work within the district health service and have a key role to play in the success of CHPS operations.

The purpose of this research project is to contribute to increasing the understanding that various stakeholders within the district have about the extent of community participation within aspects of the planning and delivery of health activities related to the CHPS.

What will I be asked to do if I agree to participate?

You will be asked to participate in a group discussion with approximately 8 other health workers including three staff of St. Elizabeth Hospital. The discussions will focus on your perceptions and experiences of how community members are engaged or involved in CHPS and how you and other health workers believe the community member's participation can be improved. The discussions will take place at the Conference Hall of St. Elizabeth Hospital in Hwidiem, the district capital. The group discussion is not expected to exceed one and a half hours.

Would my participation in this study be kept confidential?

As the researcher I will undertake to protect your identity and the nature of your contribution. To ensure your anonymity, I will also ensure that the identity of CHPS compounds and communities where the study will take place and the identity of you as study participants will be kept confidential at all times during the course of the study and during the dissemination of the findings of the study.

I will do this by removing anything that will associate you with the study such as the facility you work within and the district in which this study is taking place. You will also be given a pseudo name both in the write up of the study and when I report back on the findings to the district and regional health authorities and the communities that have been involved in the study. Your identity will be protected by ensuring that your contributions, such as quotes and accounts or references to incidents, will be made anonymous.

To ensure your confidentiality, your participation which will be recorded in the form of written notes and by audiotape and in all the signed consent form(s) will be well protected on a password-

protected computer which can only be accessed by myself. All the paper-versions of your participation will be stored in a locked filing cabinet.

This study will use a group discussion format therefore the extent to which your identity will remain confidential is dependent on participants' in the group maintaining confidentiality. In order to ensure confidentiality during discussions, all participants will be asked to sign confidentiality binding form. This will ensure that what you say during the discussions will be very confidential even among participants.

What are the risks of this research?

All human interactions and talking about one's self or others carry some amount of risks. I will nevertheless try to minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, health workers of St. Elizabeth Hospital are on standby to offer suitable care to you.

What are the benefits of this research?

This research is not designed to benefit you directly. However, the results may help us learn more about how best we can engage communities in the district health programmes. We hope that, in the future, other people might benefit from this study through improved understanding of community participation and engagement.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you

decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Dr Kwasi Tutu Ali, as part of the fulfilment of his MPH programmeme at the University of the Western Cape, South Africa.

Should you have any questions please do not hesitate to reach him at the address and contacts below:

Dr Kwasi Tutu Ali
Diocesan Health Service
Catholic Secretariat
Goaso. Ghana

Email: kalimfa@gmail.com

Tel +2335031988

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann
Head of Department: School of Public Health
University of the Western Cape
Private Bag X17
Bellville 7535
ulehmann@uwc.ac.za

Prof Anthea Rhoda
Dean: Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee.

Biomedical Research Ethics Committee
University of the Western Cape
Private Bag X17
Bellville
7535
Tel: 021 959 4111
e-mail: research-ethics@uwc.ac.za

REFERENCE NUMBER: BM 19/8/2

Annexure 6: CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21 959 2809 Fax: 27 21 959 2872
E-mail: soph-comm@uwc.ac.za

CONSENT FORM

Title of Research Project: Exploring Community Participation in Community-based Health Planning and Services in the Asutifi South District of Ghana

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

Participant's name……..

Participant's signature…….

Date……

Biomedical Research Ethics Committee
University of the Western Cape
Private Bag X17
Bellville, 7535
South Africa
Tel: 021 959 4111
E-mail: research-ethics@uwc.ac.za

Annexure 7: FOCUS GROUP CONFIDENTIALITY BINDING FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21 959 2809 Fax: 27 21 959 2872
E-mail: soph-comm@uwc.ac.za

Title of Research Project: Exploring Community Participation in Community-based Health Planning and Services in the Asutifi South District of Ghana.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name……..

Participant's signature……..

Date……

Annexure 8: FOCUS GROUP DISCUSSION GUIDE (HEALTH WORKERS)

The researcher will give them the general overview of the project and explain the purpose of the FGD and orientate the group to the process and the ground rules for the discussion - if they are comfortable with that.

As part of the introductory process the researcher will request that each participant provide him with some basic biographical information (for example, years of working within the GHS and within the local district; their current portfolio and their highest professional qualification eg. professional nurse). The observer that will accompany the researcher will record (as they introduce themselves) basic information such as their sex.

The researcher will briefly summarize the Ghana Health Service policy on CHPS (specifically in relation to the community engagement in health aspect). The researcher will then introduce Rifkin's spidergram to the participants and ask the participants to assess community participation based on the 5 areas outlined in the spidergram. He will then ask participants to justify their scoring. The researcher will then guide the discussion with the following questions:

In your experience how have community members and/or community representatives been involved in the needs assessments that have been conducted as part of CHPS in the Asutifi South District?

Probes:

Who conceived of the needs assessments?

How was the needs assessment project communicated to the members of the community?

In which ways did the community actually get involved in the planning and design of the needs assessment?

What specific roles did the community members play in conducting the needs assessment?

Which community members were involved in the design and planning of the project? i.e. was it a particular group or a range of different representatives?

In relation to the future, in which ways do you think the community can best be involved in such needs assessments for CHPS?

In your experience how have community members and/or community representatives been involved in aspects of leadership with respect to the CHPS operations?

After reminding participants what the guidelines/policy is in terms of community participation around leadership, the following could be asked:

How are the community members involved in decision making of CHPS operations (for example, in siting the CHPS compound or selecting which community member becomes a volunteer?)

Have you observed that it is specific members of the community (eg. community leaders) who get involved in leadership or decision making aspects of the CHPS operation – or do various sectors of the community get involved in this (e.g. "ordinary" or "regular" citizens)?

In your opinion, how do you think local community perceive their representation in aspects of CHPS leadership or in key decision making processes related to the operation of CHPS?

In your experience how have community members and/or community representatives been involved in the management of the CHPS?

What specific role(s) do community members play in the management of CHPS?

Are community members ever specifically involved in monitoring and evaluation of the CHPS operations? If they are, what aspects do they get involved in with respect to monitoring CPHS and evaluating it?

In your opinion how has CHPS been integrated into pre-existing community structures, for example?

Has CHPS operations been able to integrate your traditional leadership and customs in any way to enhance service delivery? If this has been possible, could you share some examples? If not could you share some of the challenges you have faced in trying to do that?

How has the CHPS integrated the operations of traditional care providers such as Traditional Birth Attendance, herbalists and drug sellers?

In which ways has the CHPS initiative mobilized existing community member groups such as men groups to enhance health delivery e.g. family planning?

What, in your opinion, are the barriers to effective integration of CHPS into the pre-existing structures?

In which ways can properly integrated to the pre-existing social structures?

In which ways have the members of the community and/or representatives on resource mobilization within the community?

What has been the contribution of the community in putting up of the CHPS compound?

How was community contributions mobilized?

In which ways do you think the community can help in maintaining the CHPS facility?

In which ways do think the community can support the CHPS operations?

What are the barriers to effective resource mobilization at the community level to support CHPS?

In which ways do you think we can effectively mobilized community resources to support CHPS operations?

Potentially, other questions might be asked such as:

How community members (who have been involved in any of the five areas listed above) have been selected? by who? and for how long have they have remained in this position as a 'representative' or participant in the operations of CHPS?

Are there any guidelines that the HWs use to support community involvement in CHPS?

Have they have received any training with respect to supporting the process of community participation within CHPS? And what the nature of that training was (when, length, topics, facilitator)

Annexure 9: FOCUS GROUP DISCUSSION GUIDE (COMMUNITY MEMBERS)

The researcher will give them the general overview of the project and explain the purpose of the FGD and orientate the group to the process and the ground rules for the discussion- if they are comfortable with that.

As part of the introductory process the researcher will request that each participant provide him with some basic biographical information (for example, the number of years they have lived within the local district; which particular village they live in; their current link or association with community based organizations (that they might be representing in the discussion) and with CHPS. The observer that will accompany the researcher will record (as they introduce themselves) basic information such as their sex.

The researcher will briefly summarize the Ghana Health Service policy on CHPS (specifically in relation to the community engagement in health aspect). The researcher will then introduce Rifkin's spidergram to the participants and ask the participants to assess community participation based on the 5 areas outlined in the spidergram. He will then ask participants to justify their scoring. The researcher will then guide the discussion with the following questions:

In your experience how have members and/or representatives of your community been involved in the needs assessments that have been conducted as part of CHPS in the Asutifi South District?

Probes:

Who conceived of the needs assessments?

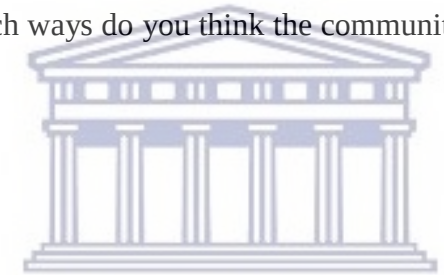
How was the needs assessment project communicated to the members of the community?

In which ways did the community actually get involved in the planning and design of the needs assessment?

What specific roles did the community members play in conducting the needs assessment?

Which community members were involved in the design and planning of the project? ie. was it a particular group or a range of different representatives?

In relation to the future, in which ways do you think the community can best be involved in such needs assessments for CHPS?



In your experience how have members and/or representatives of your community been involved in aspects of leadership with respect to the CHPS operations?

After reminding participants what the guidelines/policy is in terms of community participation around leadership, the following could be asked:

How are your community members involved in decision making of CHPS operations (for example, in siting the CHPS compound or selecting which community member becomes a volunteer)

Have you observed that it is specific members of your community (eg. community leaders) who get involved in leadership or decision making aspects of the CHPS operation – or do various sectors of the community get involved in this (e.g. “ordinary” or “regular” citizens)?

In your opinion, how do you think local community perceive their representation in aspects of CHPS leadership or in key decision making processes related to the operation of CHPS?

In your experience how have community members and/or community representatives been involved in the management of the CHPS?

What specific role(s) do community members play in the management of CHPS?

Are community members ever specifically involved in monitoring and evaluation of the CHPS operations? If they are, what aspects do they get involved in with respect to monitoring CPHS and evaluating it?

In your opinion how has CHPS been integrated into pre-existing structures of your community?

Has CHPS operations been able to integrate your traditional leadership and customs in any way to enhance service delivery? If this has been possible, could you share some examples? If not could you share some of the challenges you have faced in trying to do that?

How has the CHPS integrated the operations of traditional care providers such as Traditional Birth Attendance, herbalists and drug sellers in your community?

In which ways has the CHPS initiative mobilized existing community member groups such as men groups to enhance health delivery e.g. family planning?

What, in your opinion, are the barriers to effective integration of CHPS into the pre-existing structures?

In which ways can properly integrated to the pre-existing social structures?

In which ways have the members of your community and/or your representatives been involved in resource mobilization within the community?

What has been the contribution of the community in putting up of the CHPS compound?

How was community contributions mobilized?

In which ways do you think the community can help in maintaining the CHPS facility?

In which ways do think your community/ members of your community can support the CHPS operations?

What are the barriers to effective resource mobilization at the community level to support CHPS?

In which ways do you think we can effectively mobilized community resources to support CHPS operations?

Annexure 10: LETTER OF REQUEST TO THE REGIONAL HEALTH DIRECTORATE, GHANA HEALTH SERVICE FOR PERMISSION TO CONDUCT THE STUDY

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21 959 2809 Fax: 27 21 959 2872
E-mail: soph-comm@uwc.ac.za

The Director,
Regional Health Directorate
Sunyani. B/A
Ghana.
Dear Sir/Madam

Request for permission to carry out a Masters research

My name is Dr Kwasi Tutu Ali. I am currently studying for my MPH from the University of the Western Cape, Cape Town, South Africa. As part of the requirements of the MPH I am required to conduct a small research project. My research project aims to explore the understanding, experiences and perceptions of the health workers, health managers and community members about community participation in CHPS in Asutifi South District.

Please find the protocol attached to this request that describes the background and motivation for the study and what is proposed in terms of process.

I would like to request permission to conduct my research *"Exploring community participation in Community-based Health Planning and Services in the Asutifi South District"*. Ethical approval for this research has been granted by the University of the Western Cape's Research Ethics Committee. (REFERENCE NUMBER: BM 19/8/2).

I would welcome any questions or concerns you have about this research and can be reached on my mobile (0503198892) or through email (kalimfa@gmail.com).

Should you have any questions regarding this study and the rights of the research participants, or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann
School of Public Health
Head of Department
University of the Western Cape
Private Bag X17
Bellville 7535
soph-comm@uwc.ac.za

Prof Anthea Rhoda
Acting Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

Yours faithfully

Signed:

Dr. Kwasi Tutu Ali

Director- DHS
Diocesan Health Directorate
Catholic Diocese of Goaso
Goaso. B/A
Ghana

Annexure 11: Permission letter from Regional Director of Health

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

- *People Centeredness*
- *Professionalism*
- *Team work*
- *Innovation & Excellence*
- *Discipline*
- *Integrity*

My Ref No: GHS/BAR/HRM/RHD/HRS
Your Ref. No.....

GHANA HEALTH SERVICE
Your Health - Our Concern

Regional Health Directorate
Ghana Health Services
P. O. Box 22
Ahafo Region, Hwidiem
28 th May, 2020.
Tel: 0593567990
E-mail ghsahaforhd@gmail.com

Dr. Kwasi Tutu Ali
Diocesan Health Service Directorate
Catholic Diocese of Sunyani
Sunyani-Bono Region

PERMISSION TO CARRY OUT A MASTERS RESEARCH

With reference to your letter dated 20th May, 2020 requesting for permission to carry out a Masters research in Asutifi South District in the Ahafo Region, I write to inform you of the approval of my office.

However, the Ahafo Regional Health Directorate reserves the right to terminate this approval if you go contrary to the conditions of your ethical clearance. You are also being reminded to adhere to the various Covid-19 protocols as directed by the Ministry of Health and Ghana Health Service.

You are also requested to give a copy of your research finding to the Ahafo Regional Health Directorate for further studies and necessary actions.

Counting on your co-operation.

Thank you.

Dr. K. Boateng Boakye
Regional Director of Health Services
Ahafo Region

Annexure 12: Ethics Clearance UWC

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 4111/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

28 October 2019

Dr KT Ali
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM19/8/2

Project Title: Exploring Community Participation in Community-based Health Planning and Services in the Asutifi South District of Ghana.

Approval Period: 27 September 2019 – 27 September 2020

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

BMREC REGISTRATION NUMBER -130416-050