Willing but unable? Extending theory to investigate community capacity to participate in Ghana’s community-based health planning and service implementation

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ARTICLE INFO

Keywords:
CHPS
Community capacity
Participation
Primary health care
Voluntarism
Ghana

ABSTRACT

While primary health care programmes based on community participation are widely implemented in low- and middle-income settings, empirical evidence on whether and to what extent local people have the capacity to participate, support and drive such programmes scale up is scant in these countries. This paper assessed the level of community capacity to participate in one such programme – the Community-Based Health Planning and Service (CHPS) in Ghana. The capacity assessments were drawn from Chaskin’s (2001) theorised indicators of community capacity with modifications to include: sense of community; community members commitment; community leadership commitment; problem solving mechanisms; and access to resources. These capacity measures guided the design of an interview guide used to collect data from community informants, frontline health providers (FLP) and district health managers. Key qualitative themes were built into a questionnaire administered to households selected through systematic sampling approach. Findings showed that growing individualism, low trust in neighbours and apathetic behaviours undermined the capacity of mutual support for CHPS. The capacity to support CHPS was high for local leadership and community social mobilisation groups who often dedicated time to working with FLP to promote maternal and reproductive health service use, and in advocating broader support for CHPS. Within the wider community, commitment to voluntarism was low as members perceived CHPS to be owned by, and run on government funds and resources. Poor voluntarism was compounded by poverty that crippled the capacity to provide needed resource support for CHPS. Findings have great implications for building strong capable communities for participation in community oriented health programmes.

1. Introduction

In Low and Middle Income Countries where centrally controlled health programmes often fail to make significant impact, community participation is seen as the way to make health systems results oriented (Rifkin, 2014; Rosato, Laverack, & Grabman, 2008). Community participation although an age-old concept associated with the 1978 Alma Ata proclamation of primary health care, has remained relevant in contemporary global health policy discourse (Draper, Hewitt, & Rifkin, 2010; Rosato et al., 2008). Within the last decade, for example, community participation has been revitalised by a number of international health policy initiatives – the Millennium Development Goals, the Every Newborn Action Plan, the Integrated Management of Childhood Illnesses among others that strongly encourage strong community involvement in promoting health and well-being (Juma, Owuor, & Bennett, 2015; Rosato et al., 2008). Such global initiatives were necessitated by evidence showing primary health care founded on community participation results in quality and cost-effective health service delivery (Morgan, 2001), and that targeted programmes and strategies designed to improve maternal, child and newborn survival and tackle disease burden of the poor triumphed with community involvement (Levin, Lavis, & Oxman, 2008; Rifkin, 2014; Rosato et al., 2008).

Community participation has traditionally been viewed from the lens of utilitarian (participation as a means to and end) and empowerment (participation as an end in itself) in pursuing social change (Morgan, 2001; Pérez, Lefèvre, & Romero, 2009). Central to both traditions of participation is that the community acts as an agent in defining, diagnosing and prioritising solutions to problems confronting...
Community capacity has been given diverse interpretations, creating confusion about its precise meaning. Nonetheless, despite the many definitions proffered (see for example: Goodman, Speers, & McLeroy, 1998; Laverack, 2005; Wendel, Burdine, & McLeroy, 2009), they seem unified in Chaskin’s (2001: 4) definition of community capacity as ‘...a community’s human, organisational and social capital that can be leveraged to solve collective problems, and improve or maintain well-being; it may operate through informal social processes and/or organised efforts by individuals, groups, networks of associations and the broader system of which the community is part’. From this point of view, capacity is seen as the bedrock of a functional community participation as it determines the ability to mobilise, network and collectively solve health problems.

The capacity to participate in health is reported to have profound benefits. Notably, it motivates actions in addressing problems of programmes implementation (Hickey & Mohan, 2004; Mansuri & Rao, 2004), offsets cost of health delivery, increases broad-based support and health service use, thereby improving confidence in the health system (Alfonso, Nickelson, & Hogeboom, 2008; Millar, Robertson, & Allender, 2013). Alfonso et al. (2008) and Goodman et al. (1998) highlighted the importance of capacity; noting it is linked to programme ownership, where community members act as champions to communicate goals, motivate each other, obtain resources and spearhead implementation. Systematic efforts by international bodies including the World Bank, UNICEF and World Health Organisation to devolve some elements of management and delivery of health services to the community (Bhutta, Ahmed, & Black, 2008), means that capacity cannot be ignored in health programmes scale up, and doing so will be problematic as real life implementation decisions and actions are tied to the individual and collective will to participate in providing needed support systems.

While knowledge on the importance of community capacity proliferates, empirical evidence on whether and to what extent local people have the capacity to participate and support community-based health programmes implementation is poorly documented. This has created room for multiplicity of assumptions regarding what a capable community; commitment among community members; mechanisms of problem solving; and access to resources. Sense of community describes the nature and quality of social ties for mutual benefits. It is determined by mutual concern for community issues, shared values as well as norms that propel common actions for participation in, and addressing problems of health programme as a defined group (Wendel et al., 2009). Commitment of community members has to do with the ability of individuals, groups and leaders to invest time and resources in promoting general wellbeing and common good of the community (Chaskin, 2001). Once everyone seeks the common good, individuals will be more responsive to barriers that take away success (Goodman et al., 1998).

Mechanisms of problem solving involve formal and informal channels through which individuals or groups identify and solve problems or

**Fig. 1.** Some of the defined community roles linked to CHPS implementation.
pursue collective goals (Chaskin, 2001). Such channels typically include but not limited to strong social networks, social organisations and coalition groups exhibiting prosocial behaviours to advance a course of action (Laverack, 2006). Social networks somewhat act as a binding force, creating trust within neighbourhoods on community matters (Hollard & Sene, 2016). Access to economic and physical resources internal to the community is a crucial defining feature of community capacity. Prevailing economic opportunities, and access to assets and expertise are important enablers of community capacity to participate in health (Wendel et al., 2009).

Chaskin (2001) indicators of capacity were termed in this study as: 1) sense of community; 2) Community members commitment; 3) Community leadership commitment; 4) problem solving mechanisms; and 5) access to resources. We theorised that these domains of capacity are means to community participation in the CHPS programme. However, they are not mutually exclusive (Chaskin, 2001) and might have interaction effect on the capacity to participate. We define participation in this study as any form of involvement in CHPS activities: delivering health services, providing resource support, engaging in voluntarism, taking part in decisions and plans relating to CHPS or advocating for CHPS health service use.

2.1. Methodology

The data for this paper is drawn from part of of a larger study into how and why community, frontline health provider (FLP) and district health system factors shape CHPS implementation in the areas of service delivery, access and use of health services, and community participation. The larger study was conducted between June and November 2015 in 4 CHPS communities in 2 districts of the Upper West Region (UWR), Ghana using exploratory sequential mixed-methods: qualitative findings informed the design of quantitative methods (Creswell & Clark, 2011). The aim was to maximise the credibility of results from both methods by gathering complementary evidence that take into account subjective and objective views.

2.2. Qualitative methods

Qualitative data were collected from 8 focus group discussions with key community stakeholders of CHPS such as traditional authorities, Assembly Members, Community Health Volunteers (CHVs), and Community Health Management Committee Members (CHMC). In addition, 13 in-depth interviews were held with FLP and district health managers (Directors and CHPS Coordinators). Participants in the qualitative study totalled 74 and were selected purposively because of their defined roles linked to CHPS implementation (Table 1).

Topic guides for the qualitative interviews relevant to this paper included understanding of CHPS, social networks and community mobilisation, local leadership support for CHPS, sense of community and ownership of CHPS, socio-economic context, livelihood activities and commitment to voluntarism. The data was collected through conducting qualitative interviews, recording narratives and behaviour control collected the qualitative data. Interviews were more of discussions, using probes and prompts to clarify issues, elicit details and broaden narratives (Curry, Nemhbard, & Bradley, 2009). All interviews were tape recorded alongside note taking and lasted for an average of 45 min.

Qualitative field notes and audio recordings were transcribed, processed and coded with the aid of Nvivo 11 software (QSR International Pty Ltd, Victoria, Australia). The first author (RAA) and one of the field researchers coded the transcripts deductively – based on a pre-determined coding scheme reflecting dimensions of the conceptual framework, and inductively – nesting new codes emerging into existing codes. Codes were cross-checked after coding every fifth successive transcript to ensure consistency and align codes derived inductively. Upon completion of coding, we examined all data within the various categories and sub-categories further to determine clear-cut relationships. During this process, some codes were combined while others were recoded into different sub-categories.

2.3. Quantitative methods

Themes generated from the qualitative data were built into a structured questionnaire pretested among 40 respondents before being used to collect survey data from community members. The final questionnaire contained 75 statements, of which 27 were related to the five capacity indicators of this paper. Statements about sense of community, community members’ commitment, problem solving mechanisms and access to resources were assessed using a 5-point agreement/disagreement scale; while those pertaining to community leadership commitment were placed on high/low likert type scale. For each capacity indicator, respondents were asked to rate from a scale of 1 (being very low capacity) to 5 (being very high capacity), the overall level of community capacity for that indicator. Examples of such questions are: “overall how will you rate community leadership capacity to support CHPS”; and “overall how will you rate the community’s capacity to offer financial support for CHPS”. A set of open-ended questions were also asked to determine frequency of participation in CHPS activities and how much money respondents contributed to support CHPS within 12 months to the time of the study.

A two-stage sampling procedure was used to select respondents. We first selected households in each community using random systematic sampling technique (Kothari, 2004), based on a self-determined sample fraction of 1/5 since the total number of households were unknown. In each selected household, the head was interviewed, and in his/her absence any adult man or woman aged 18+ was selected by balloting.

Table 1

<table>
<thead>
<tr>
<th>Participants</th>
<th>Defined role linked to CHPS implementation</th>
<th>Number recruited</th>
<th>Number responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional authorities</td>
<td>● Donate land for building the CHPS facility</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>● Harness community support for CHPS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assembly members</td>
<td>● Provide political interface between district authorities and the community on CHPS matters</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>● Consultative persons in implementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHVs</td>
<td>● Provide non-clinical support services</td>
<td>35</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>● Organise people for programmes and disseminates health information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHMC</td>
<td>● Provide local administrative support systems</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>FLP</td>
<td>● Provides routine health services</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>● Act as the interface between the community and district health managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District health Directors</td>
<td>● Key policy decision makers at the bottom of the implementation structure</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>CHPS coordinators</td>
<td>● De facto CHPS managers at the interface between the community, FLP and the District Directors</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Key: CHMC - Community health management committee; CHVs - Community Health Volunteers.
In all, 420 respondents were sampled but 402 of them fully answered the questionnaire.

The SPSS PASW 24 was used to analyse data. During analysis, it was observed that multiple statements measuring each capacity indicator did not yield meaningful variability in the response pattern. To ensure maximum variation, therefore, the statements were narrowed using principal component analysis (PCA) with oblique rotation. This resulted in 17 statements being strongly loaded under the five capacity indicator framework. Cronbach alpha values of the statements produced for each capacity indicator were above the 0.70 threshold (Field, 2009). Data were presented using descriptive statistics. We first summed the statements derived from the PCA for each indicator and computed an overall mean (\( \bar{x} \)) score. Next, the 5 point scales of each statement were collapsed into a binary agree/disagree scale for ease of interpretation of the findings. We calculated mean scores on questions measuring overall level of capacity and illustrated that with a spider diagram developed from Origin2016 Software (Massachusetts, USA). The study obtained ethical approval from the Ghana Health Service Ethics Review Committee (Ethical approval ID No. GHS-ERC: 14/07/15).

3. Results

3.1. Demographic characteristics of participants

Demographic characteristics of participants are shown in Table 2. Participants in the qualitative study were older (\( \bar{x} = 37 \)) than those in the quantitative study (\( \bar{x} = 32 \)). The majority of participants in both studies had no formal education and farming was the main occupation.

3.2. Community capacity to participate in CHPS

This section presents findings of both the qualitative and quantitative data on the capacity to participate in CHPS applying Chaskin (2001) community capacity indicators: sense of community (shared values and social capital and their effect on participation, and perceived ownership of CHPS); community leadership commitment to providing necessary support systems; community members commitment to voluntarism; mechanisms of problem solving and access to resources (the capacity to provide financial support or undertake small scale project linked to CHPS). Salient points are illustrated by verbatim quotes from the focus group discussions (FGD) and in-depth interviews (IDI).

3.3. Sense of community

3.3.1. Shared values and social capital

Participants expressed concern about declining shared values and the fact that individuals tended to enact and place their own values and interest above the common good of the community. This problem was more with the youth who faced social alienation, leaving themselves out of the loop and in critical decision taking as a result of adaption to life in urban environments. As noted by this participant: “some of them have returned from Kumasi, Accra and Obuasi...they feel being enlightened and exclude themselves from community matters”. This adversely affected the capacity to converge, connect and thrust out issues pertaining to the common good of the community. In addition, it was found the capacity of social trust that can be leveraged to foster quality interactions in achieving specific ends in relation to CHPS was problematic.

“You know as a community we talk and greet each other, but I cannot trust that someone is thinking good about me or someone is talking nicely to me with good intentions...if you invite me to attend a function of the clinic [CHPS] and I don’t trust you, I will not go”. (FGD, Male, CHMC)

Perspectives of the qualitative participants somewhat contrasted the quantitative findings where many respondents agreed that shared values among community members was strong (53%; \( \bar{x} = 3.98 \)) and that there is positive social capital among members (52%). However, shared values did not translate into mutual support for CHPS by the majority of respondents (51%; \( \bar{x} = 4.10 \)) and from this participant’s perspective:

“I can say that as a community we share common values, cultures and maybe identity. Because of that we help each other during funerals and traditional events. But that is yet to reflect fully in CHPS which is not something that we grew up with”. (FGD, Male, CHV)

3.3.2. Perceived ownership of CHPS

The low sense of community perhaps shaped perceptions around ownership of CHPS. About 55% (\( \bar{x} = 3.89 \)) and 53% of the respondents respectfully agreed that the community own CHPS, and that CHPS is tied to the community’s identity. To the contrary, most participants in the qualitative data did not feel the community owns CHPS, because its operations were rarely community driven. As for example, “we can’t say it is for us when our people are not in charge of it, when we don’t know what actually goes inside there”. A range of problems were deduced to account for the low perception of ownership. Key among them were poor broad-based sensitisation and consultations in the planning process (“...we were actually not informed that the clinic is our own”) and non-deployment of local labour in building the CHPS facility (“the clinic was built by a contractor”); “I don’t know those who were actually involved in building the clinic”). Additionally, and as demonstrated in the quote below, FLP explained that sense of ownership was weak, as most community members were somewhat distanced from CHPS, because of perceptions that CHPS is government owned and the community is only used as a vehicle of enabling government achieve its objective.

“When you tell them to support CHPS because it’s their own, some of them will reply that it is for the government...stop worrying us, tell the government to help”. (IDI, Female, FLP)

3.4. Community members’ commitment

3.4.1. Commitment to voluntarism

The ability of individuals and all segments of the community to commit to CHPS implementation was somewhat weak. Commitment to voluntarism, such as being part of a voluntary committee or altruistic initiatives to drive CHPS scale up was a challenge. Most respondents (69.2%) considered it needless providing active voluntary services and giving donations (67%); because of perceptions that CHPS already operate with government funds and resources. FLP were also perceived as doctors earning substantial salaries, and therefore in a capacity to better manage CHPS without the community’s support. Consequently, voluntarism for CHPS was drifting towards pecuniary transactions.
“They want money not voluntarism. If you call people to assist do anything for CHPS without giving them money for transport or food, then don’t expect to see them next time.” (IDI, Female, FLP).

All the communities were reportedly endowed with artisans including carpenters and masons, but they were rarely seen voluntarily providing maintenance services for the CHPS facility. It was revealed that parts of the walls, roofing and woodworks of the CHPS facilities were impaired, as for example: “the roof leaks when rain is falling”; “there are cracks all over the fence wall” and “some of the doors have problems”, but local artisans did not commit themselves voluntarily to fix the problems. This persisted despite reported persistent appeals by sections of the community: “we have been pleading with them to help maintain the clinic [CHPS] but the problems are still there”; “we have informed them to help but they keep saying they have so many people work at hand”; and “they may work on it just that we have to keep reminding them”. A FLP explained that community members preferred health authorities taking up maintenance of the facility because of weak community capacity to undertake such responsibilities.

“...instead of mobilising to work on the problems of the facility, they keep telling us to talk to Director [District Health Director] or the Assembly because they are not able to work on it”. (FGD, Female, FLP).

Poor commitment to voluntarism also reflected in the frequency of participation in CHPS activities. Across all the communities, an average of 8 CHPS events in the form of meetings, durbars and health education among others were organised 9 months prior to this study. However, respondents participated in an average of 2.4 out of the 8 events. As shown in Fig. 2 about 26% of the respondents never participated; 29.9% participated twice and only 4% participated in all events. Key reasons that accounted for poor participation were time – people working for long hours in farms and other occupations to feed their families, apathetic behaviours and the feeling that government and not the community can be of significant support to CHPS.

“When you go there for the meeting, they will by all means tell you to do something and support the clinic [CHPS], but government has to help, it is only government that has what it takes to support the clinic”. (FGD, Male, Assembly Member)

3.4.2. Serving in the community health volunteer programme

Not only was there weak broad-based interest to serve in the community health volunteer (CHV) programme (71.2% agreed interest for the CHV programme was low), but also, existing members of the committee expressed low self-interest and commitment to voluntarism. Members lamented about lack of incentives and poor capacity to perform prescribed duties. They were unhappy about lack of transport logistics, a situation that compelled them to travel on foot to deliver information to households. Routine poor capacity to execute their roles was a demotivation to members and potential members of the committee.

“The area is large and we have to go round to give information or family planning to people. Sometimes you return from farm very tired but still have to walk round…people tell some of us that they want to be members but our walking is too much. People who could not stand this have left the committee.” (FGD, Male, CHV).

While obviously trying to cope with the sacrificial and prosocial motivation at CHPS implementation, the CHVs were discouraged by additional distresses they endured from cross sections of community members.

“Whether farming season or not, we leave our personal work and run errands for the good of the clinic [CHPS]. But people don’t see this. Sometimes if you tell a woman to come for ANC you get either insults or nonsense and that is discouraging to us.” (FGD, Male, CHV).

3.5. Mechanisms of problem solving

One area that the communities showed high capacity was mechanisms of problem solving. This demonstrated in the existence of gender-based social mobilisation groups known as Mother-to-Mother-Support (M-MSP) group for women and Father-to-Father Support (F-FSP) group for men, both actively diffusing information, soliciting support and using social events to attract broad-based support for, and participation in CHPS. Below we present detail findings about the social networking groups.

3.5.1. The Mother-to-Mother Support Group

This participant just like others explained that the M-MSG was a platform where women network, share ideas and use meetings and other social events or fora to discuss mechanisms of supporting CHPS.

“They try to get women together to think about how they can support CHPS...they are passionate about CHPS. Because of that they meet every month to discuss the clinic [CHPS] and try to encourage others to join them”. (IDI, Female, FLP)

The group also sought to empower women to gain control over health decisions and to collectively identify and solve maternal and child health problems confronting the communities. Activities of the M-MSG were shown to be reassuring (77% (X = 4.1) of the respondents acknowledged the M-MSG empowered women to gain control over health decisions, and that the group was able to influence ANC use to some extent (72%; X = 4.2). A cross section of the FLP also highlighted how dividends from the M-MSG activities were beginning to accumulate.

“The M-MSG is making our work easy. I can say most women now cooperate with us, they sleep under mosquito nets during pregnancy and they attend the child welfare clinics unlike the past”. (IDI, Female, CHPS Coordinator).

“With their efforts some of the common causes of maternal and child mortalities are reducing because women tend to accept the advice we give them”. (IDI, Female, District Health Director)

Actions of the M-MSG were impeded by a significant number of contextual factors. Most notably, socio-cultural factors including patriarchal cultures compromised the group’s capacity to fully mobilise and implement actionable plans. For example, men were reported to control family decisions and used such decisional powers to prevent their spouses from participation in the group’s activities.

“...everything in this community is the man. If you dress up to go the M-MSG meeting, he can tell you to stop and you have to respect his decision”. (IDI, Female, FLP)

![Fig. 2. Frequency of participation in CHPS 12 months to this study.](image-url)
3.5.2. The Father to Father Support Group

The F-FSP on the other hand aimed to increase men knowledge on health issues and participation in CHPS meetings, durbars and other programmes of scaling up. Its membership targeted adult men, but their approach to enabling broad-based participation differed from the M-MSG.

“They mostly rely on people who gather together for farming to talk to them. They also send people round to houses to talk about CHPS.” (FGD, Male, Chief)

Participants reported that the group members carried out education across to peers on the importance of family planning, use of contraceptives for birth spacing, allowing pregnant women make 4 + ANC visits and male involvement in family health. The group’s activities were reported to be beneficial by a large proportion of the respondents (75%) and from these qualitative participants:

“In fact it is because of what they tell us that some of us now accept family planning. Sometimes we even try to go with our wives to the CHPS facility for the family planning injection.” (FGD, Male, CHV).

“For the F-FSG I can say it is helpful because when I was going to deliver my third baby, my husband was very helpful than previously. He even went with me to the facility and made sure I delivered before. I was very happy by that.” (FGD, Female, CHMC)

3.6. Community leadership commitment

There were mixed views regarding community leadership commitment to CHPS implementation. Over half of the respondents highly rated efforts of the leadership in promoting antenatal care use (56.6%; X = 3.99) and inspiring others to participate in CHPS (52.4%; X = 4.1). A high proportion, however, viewed leadership as putting minimal efforts in promoting use of CHPS family planning services (55.1%). In the qualitative data participants revealed that community leadership demonstrated the capacity to support CHPS by openly advocating use of antenatal care (ANC) and child health services, but not family planning. Two of the Chiefs were credited for being able to work with FLP in designing sanctions against women who delivered at home, an action which participants said positively influenced ANC use and facility based deliveries to some extent.

“One thing I can say about the Chief is that he is doing his best for CHPS. He sometimes educates men not to allow their wives deliver at home and that people should use FP. Because of that some women are becoming conscious about delivering in the facility.” (FGD, Male, Assembly Member)

The qualitative data showed that sections of the community leadership, led by the Chiefs were able to establish clear problem solving channels to deal with matters arising in relation to CHPS. This also came to light in the larger sample as 60.1% of the respondents rated leadership, led by the Chiefs were able to establish clear problem solving, consensus building and decision making solutons to meet evolving situations of CHPS.

“Whenever there is problem with the nurses or anybody concerning the clinic (CHPS), we report to the Committee after which the matter is taken to the Chief. The chief normally takes his time to solve the problem, creates friendship and tries to ensure that the problem does not reoccur”. (FGD, Male, CHMC)

3.7. Access to resources

3.7.1. Capacity of material resource donation to CHPS

Poverty appeared to have had crippling effect on the communities’ capacity to invest resources, especially finances to support CHPS. Small scale farming and pito (local beer) brewing constituted the primary local economic activities, which according to participants brought in adequate income to adequately support livelihood. As a result, the majority of respondents (54%) said community members lacked capacity to offer financial support for CHPS implementation.

When respondents were asked to state how much money they contributed to CHPS activities within the past 12 months preceding this study, only 67 (16.7%) out of the 402 provided figures (mean: GH¢ 7.73; range 1–65; exchange rate: GH¢3.7 to US$1 as of July 2015) (Table 3). In principle, security personnel in the CHPS facility provide voluntary service, but in practice they are supposed to be remunerated monthly from community donations. Participants were however concerned that poverty accounted for meagre and irregular wages for security personnel. As can be seen in Table 3, annual community contributions for security personnel averaged GH¢ 8.76 (std. dev. 6.96).

At the time of the study, the security personnel in one of the CHPS facilities vacated post, while some of them were irregular at work either because wages were irregularly paid them or they were dissatisfied with the monthly wages. A FLP complained about cases of theft and pilfering due to such actions of the security personnel.

“…because the pay is not much, he will report to work today, and the next day you don’t see him again. Thieves will come at night and anything they see they pick. I have told the community that if they don’t do something about the security, I will not sleep here again”. (IDI, Female, FLP).

Limited economic power also prevented the communities from implementing their own CHPS related action plans. The M-MSG and F-FSG, for example, complained about lack of funds to implement action plans agreed upon by members. This reflected in the statement: “we have good plans for CHPS but we have nothing to put them to work, I mean no money”. Prior to the time of this study, both groups agreed to contribute money and excavate a waste pit, pay security personnel timely and support the CHVs. However, such plans never materialised due to poverty.

3.8. Overall community capacity assessment

To determine the overall level of community capacity to participate in CHPS, respondents were asked to rate each indicator on a scale from 1 to 5. The average rating for all the capacity indicators was 3, which is an indication that overall capacity was fairly high. Ratings ranged between 2 and 5 – low and very high capacity respectively. Capacity rating was low for community members’ commitment to CHPS (rated 2) and access to resources (rated 2), but moderate for sense of community (rated 3) and community leadership commitment (rated 3). Only mechanisms of problem solving was rated very high (5), which is understandable giving the commitment and synergy with which the social mobilisation groups demonstrated towards CHPS. Fig. 3 is a spider diagram illustrating the ratings for each capacity indicator.

4. Discussion

CHPS is more than just a medium of health service delivery. It
encompasses community participation, mobilisation and social support systems in reducing cost of care delivery and promoting social accountability mechanisms in health governance at the micro level (Nyonator et al., 2005). As participation is paramount to sustainable CHPS implementation in achieving target objectives, this study sought to determine whether and how local people have the capacity to participate in it, with the ultimate aim of identifying gaps to be used as target points for strengthening scale up. Since capacity as a concept has not been explicitly theorised and widely applied with differential meanings in health programmes context, we situated our analytical approaches within Chaskin’s (2001) theory of community capacity.

Our quantitative findings of the level of capacity to participate as illustrated in Fig. 3 demonstrates how the communities were fairly weak in all the capacity dimensions except problem solving mechanisms grounded in the formation of gender-based social network groups. Consistent with earlier studies (Agongo, 2014; Ministry of Health, 2009), social structures of the communities that could be leveraged to support implementation were weakened by growing sense of individualism, apathetic behaviours and weak communal ties. More fundamentally, a more intense close-knit culture which according to Woolcock (2001) is an essential fibre and can be deployed to get by and promote social discourse within and across community members was challenged by the spread of urbanisation and the experience of it. The youth who represent a more promising force and whose synergies can be harnessed to support CHPS implementation, were loosely bonded with the community, owing to cognitive and perhaps, socio-psychological responses to city life. Such orientations posed great barriers to inclusive participation and socio-affective behaviours to CHPS.

In spite of the low sense of community, the quantitative findings showing the communities’ claim to ownership of CHPS symbolises the readiness to control and challenge risk factors of implementation (Mathbor, 2008). Studies show that when community members identify with, and claim ownership for community health programmes, participation increases, such that members more likely see themselves working together for a common good, in order to maximise implementation outcomes (Pérez et al., 2009; Rifkin, 2014). The reverse, not accepting ownership has been detrimental in taking primary care interventions to scale (Draper et al., 2010), emphasising the need to exploit the tools of community ownership to bring about social change and inclusive participation in CHPS.

Findings demonstrated that individuals acted in low voluntary capacity for CHPS implementation. The communities had differential conception of CHPS, mostly viewing it as an entity run on government resources, logistics, supplies and support. This fuelled demands for, and expectations of monetary rewards in return for services rendered, contrary to the CHPS policy prescription – community members must demonstrate capacity to provide voluntary labour and social support systems for implementation (Awoonor-Williams et al., 2013). Weak voluntary behaviours were also apparent in the CHV programme that encountered poor membership. Findings suggest CHV members saw themselves as mere ‘do-gooders’ as their efforts often went unrecognised by community members and health authorities. Other lived experiences of the volunteers – tediousness of voluntarism and the absence of economic rewards, and the particular challenges and dilemmas they generate resonates with Topp, Price, and Nanyangwe-Moyo (2015), who also found that lack of economic rewards or material support, coupled with other unpleasant experiences reduced social aspirations of rendering voluntarism and commitment to future voluntarism among HIV caregivers in Zambia.

The capacity of problem solving mechanisms was high, as demonstrated in the social activism of the gender-based social organisations dedication to strengthening implementation. In line with Simmons, Reynolds, and Swinburn (2011), a key strength of the social organisations was their ability to command social resources and leverage minds for implementation. Moreover, the perceived increased awareness of using treated bed nets, reproductive and maternal health services demonstrated their collective efficacy to a large extent. This echo a recent analogous evidence linking the roles of community social networking groups to increased use of primary health services (Hollard & Sene, 2016). One other notable crucial role of the social organisations in the scale up process was their commitment to idea sharing, and the use of advocacy initiatives to empower members to prioritise maternal and child health. Such initiatives have long-term prospects of enabling the powerless and underprivileged to challenge societal normative norms that pose as risks factors to maternal care seeking (Rifkin & Pridmore, 2001).

The considerable leadership exhortations on use of maternal and facility-based delivery services upheld first, the CHPS policy requirements – capacity of supportive traditional leadership and their involvement in governance and management structures is key to promoting the delivery, access and use of health services (Nyonator et al., 2005) and second, a similar study in Nepal showing improved maternal care seeking was the result of community leadership leading the way in a community-based health programme implementation (Morrison, Tamang, & Mesko, 2005). Consistent with Rifkin (2009), initiatives by the community leadership were shown to be reassuring, as well as providing direction and motivators for broad-based support. In addition, the leadership’s demonstration of capacity to manage CHPS related social conflicts and competing interest by instituting hierarchical problem solving channels has been recommended for scaling up community-based programmes (Rifkin, 2009), which are vulnerable to failure when implementation processes encounter hostility and disagreements (Pérez et al., 2009).

As expected, the communities lacked the economic muscle to support CHPS implementation. Recent reports classify the three regions north of the country as poor (Ghana Statistical Service, 2014). High
poverty incidence measured by income levels (people earning 1 US$ or less a day) is especially high in the UWR where there are limited economic and employment opportunities. This suggests that the primary local economy based on pito brewing and small scale agrarian practices is to be expected. The challenge is that these livelihood ventures do not only bring inadequate returns, but also they are unreliable (Hudu, 2009). Thus, community members are better off by not investing the meagre livelihood returns on CHPS – because any such move potentially results in disturbance to household subsistence. This finding resonates with earlier studies linking poor participation in CHPS to limited economic power to donate resources, attend programmes and provide financial assistance (Awoonor-Williams et al., 2013; Ministry of Health, 2009).

5. Conclusion

Policy makers seeking strategies to strengthen CHPS implementation can benefit from the study’s findings in a number of ways. First, since social capital is important for building and sustaining community values towards mutual beneficial relationship (Woolcock, 2001), we suggest the initiation of strong community networking programmes that will allow for formal and informal meetings and promotion of horizontal collective action. Brune and Bossert (2009) noted how such networks helped build trust and social capital leading to restoration of strong ties among community members in post-conflict communities. The scale of social networking held by the social organisations can be leveraged to harness social cohesion and diversity for CHPS scale up. For example, when they are encouraged to strengthen vertical and horizontal membership, or inclusion of people from a range of professions and backgrounds, diversity increases so that individuals are more likely to see themselves as working together to promote CHPS. State and non-state institutions can intervene and craft appropriate strategies within which to maximise support for CHPS from the social organisation, while at the same time challenging them to go higher. Findings about declining voluntarism, generally within the larger population, and specifically within the volunteer cohorts, suggest exploiting strategies internal and external to the community. Internally, local leadership taking up frontline roles in voluntarism, or encouraging hearts, and in acknowledging volunteers’ efforts, critical roles, initiatives and routine sacrifices to a large extent can stimulate broad-based altruistic behaviours. Externally, minimal compensations in the form of allowances for upkeep, as well as for field and transportation can be introduced by government to spur up voluntarism among the CHVs.

Conflict of interest

None.

Funding

This study received support from the African Doctoral Dissertation Research Fellowship by the African Population and Health Research Centre, Nairobi Kenya (Grant number: 2014-2016 ADF 001) for the first author’s doctoral thesis work. The Centre played no role in the development and writing of this manuscript.

Acknowledgements

We are deeply grateful to all the field assistants for their immense efforts during the data collection process. We would also like to thank the District Health Directors and all the participants for making time to participate and provide invaluable information for the study.

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