



UNIVERSITY OF GHANA  
THE BALME LIBRARY

BALME LIBRARY THESES

1. Balme Library theses are available for consultation in the Library. They are not normally available for loan, and they are never lent to individuals.
2. All who consult a thesis must not copy or quote from it without the consent of the author and of this University.
3. Any copying or quotation permitted should be duly acknowledged.

**RG966.G3H39**  
**bltc C.1**  
**G355585**

THE BALME LIBRARY



3 0692 1008 6431 1

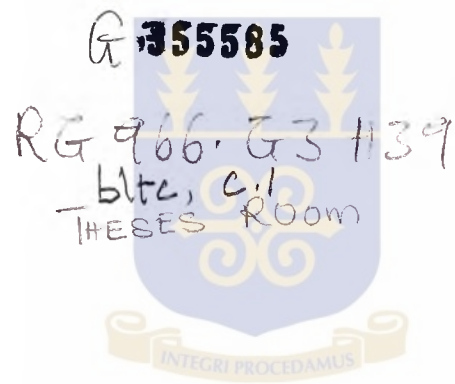
**UNIVERSITY OF GHANA  
SCHOOL OF PUBLIC HEALTH  
GHANA**

**COMMUNITY PARTICIPATION IN MATERNAL  
AND CHILD HEALTH/FAMILY PLANNING  
PROGRAMMES  
AT THE SUBDISTRICT LEVEL**

**BY  
RICHARD KWASI HENNEH**

**A DISSERTATION SUBMITTED TO THE UNIVERSITY OF  
GHANA, SCHOOL OF PUBLIC HEALTH, IN PARTIAL  
FULFILMENT OF THE REQUIREMENTS FOR THE MASTER  
OF PUBLIC HEALTH DEGREE.**

**SEPTEMBER, 1998.**



### DECLARATION

This dissertation is the result of independent investigation. Where my work is indebted to the work of others, I have made acknowledgement.

I declare that, it has not already been accepted in substance for any other degree. nor. is it concurrently being submitted in candidature for any other degree.



*Richard, Kwasi Henneh*

Richard, Kwasi Henneh

Date: September, 1998.

ACADEMIC SUPERVISORS

*S. Ofori-Amuah*  
DR. NANA ENYIMAYEW

Signature

DR. ERIC AMUAH

*Eric Amuah*  
Signature

## DEDICATION

This piece of work is dedicated:

To my father, the Late Kwame Nsiah

To my grandmother, the Late Agnes Amma Darkowaa

To my mother, Grace Akua Ameaa

To my wife, Paulina Yeboah Henneh

And to my children: Bridget, Amanda and Gillian.



# DISTRICT MAP OF GHANA



**TABLE OF CONTENTS**

	PAGE
Abstract .....	I
Acknowledgements .....	ii
List of Abbreviations .....	iv

**CHAPTER ONE****INTRODUCTION**

1.1 Background of the Study .....	1
1.2 Study Location .....	1
1.3 Statement of the Problem .....	3
1.4 Assumption .....	5
1.5 Rationale for the Study .....	7
1.6 Justification for Using MCH/FP Programme to assess extent of CP in Health Programmes .....	7
1.7 Literature Review .....	7
1.8 Operational Definitions .....	15

**CHAPTER TWO****STUDY OBJECTIVES**

2.1 General Objectives .....	16
2.2 Specific Objectives .....	16

**CHAPTER THREE****METHODOLOGY**

3.1 Design of the Study .....	17
3.2 Sampling .....	20
3.3 Data Collection Techniques and Tools .....	25
3.4 Data Processing and Analysis .....	29
3.5 Limitations and Biases of the Study .....	31

**CHAPTER FOUR**

4.1	Description	.....	.....	.....	.....	.....	.....	.....	32
4.2	Leading Responses	.....	.....	.....	.....	.....	.....	.....	34
4.3	Ranking Matrix	.....	.....	.....	.....	.....	.....	.....	41
4.4	Factors Influencing CP in MCH/FP Programmes	.....	.....	.....	.....	.....	.....	.....	45

**CHAPTER FIVE****DISCUSSION AND CONCLUSIONS**

5.1	Extent of CP	.....	.....	.....	.....	.....	.....	.....	48
5.2	Factors Influencing CP	.....	.....	.....	.....	.....	.....	.....	48
5.3	Conclusions	.....	.....	.....	.....	.....	.....	.....	55

**CHAPTER SIX****RECOMMENDATIONS**

6.1.	Director of Medical Services	....	.....	.....	.....	.....	.....	.....	60
6.2	DANIDA-HSSP	.....	.....	.....	.....	.....	.....	.....	60
6.3	RHMT/DHMT	.....	.....	.....	.....	.....	.....	.....	61
6.4	Level B Health Workers	.....	.....	.....	.....	.....	.....	.....	62
6.5	The Communities	.....	.....	.....	.....	.....	.....	.....	63

**REFERENCES****ANNEXES**

ANNEX	1	Rifkin's Ranking Matrix
ANNEX	2	Individual In-depth Interview Guide for Level B. Clinic Workers
ANNEX	3	Key Informant Interview guide for Chiefs, Landlords and Women Leaders
ANNEX	4	In-depth Interview Guide for village Health Volunteers
ANNEX	5	Focus Group Discussion Guide for SDHMT Members/TABs
ANNEX	6	Checklist

## ABSTRACT

Community Participation has been identified as a key factor in the improvement of health care delivery in Ghana. The Wa District Health Administration set up a number of community health structures with the intention to get communities more involved/participating in health programmes in order to improve coverage and utilization.

Despite these community health structures and other efforts aimed at improving coverage / utilization in health services, there has not been any significant improvement. Nevertheless, the Wa District Health Management Team (DHMT) strongly felt that the unsatisfactory coverage/utilization in health programmes might be due to low or narrow community participation. This study assessed the extent of community participation in health programmes using MCH/FP programmes as a proxy. The study also sought to identify factors which influence community participation.

The study was descriptive in design using only qualitative approach. Both primary and secondary data were collected through the use of focus group discussions, in-depth individual/key informant interviews, annual reports, minutes books and log book. Altogether 106 people selected from 38 communities in four subdistricts were involved in the study.

The “Pentagram Model” developed by Susan B. Rifkin and associates in 1988 was used to assess the extent of community participation. This model uses five factors or indicators namely Needs Assessment, Resource Mobilization, Organization, Management, and Leadership to assess the extent of Community participation.

One of the significant findings was that in all the four subdistricts studied the extent of community participation was found to be either restricted (small) or lying between restricted and mean (fair). The most strained areas were Needs Assessment and Management.

Since the extent of community participation was either small (restricted) lied between small and mean it could partly or fully account for the low coverage/utilization of MCH/FP services as well as other health services. However since only subjective and qualitative indicators were used no correlation could be established between small or poor community participation and low coverage/utilization.

Another significant finding was that the health professionals had inadequate knowledge on community participation. They had not been trained on the extent to which they should involve the communities in health programmes.

The study identified some positive features which could improve community participation. They included the existence of community health structures (e.g. subdistrict health management teams [SDHMTs] village health volunteers, etc) , and absence of community conflicts in most communities.

The study also revealed a few negatively reinforcing factors of community participation. These included: unwillingness of the communities to contribute financially towards health programmes and development, poor quality of leadership especially the SDHMT members in some communities, absence of team work at the community level, and the influence of soothsayers and fetish priests in some of the communities.

A standardized framework on the extend and/or level to which the public or communities should participate in health programmes/projects should be developed

especially in areas of planning, implementation, monitoring evaluation, and financial mobilization. The Upper West Regional Health Management Team and Wa District Health Management Team should come out with an incentive package for the community structures. The communities should also support the community health structures financially or otherwise especially the traditional birth attendants (TBAs).

It is also recommended that health professionals should educate the communities on the need to contribute financially or otherwise to support health programmes.

The pentagram model has been found to be very useful. It should be used periodically to assess the extent of community participation in health programmes/projects.

## ACKNOWLEDGMENTS

First and foremost I wish to thank the Almighty God for giving me the opportunity and strength to carry out the study from the beginning to the end.

I am greatly indebted to my academic supervisors Drs. Nana Enyimayew and Eric Amuah for their guidance throughout the period of this study. They had to travel up north for my sake.

I am greatly indebted to my field supervisor Dr. F.D. Sangber-Dery for his yeoman's services. Apart from giving me technical support throughout the study he also made sure my social needs were met.

It is not easy to forget the effort of Dr. Ebenezer Appiah-Denkyira, the outgoing Upper West Regional Director of Health Services who was also my back-up field supervisor. He spent quite a substantial time in coaching and reviewing my work. He also assisted me to get sponsorship from DANIDA-HSSP

Nevertheless this work would not have come up the way it is if not the special financial support I received from DANIDA-HSSP. It is therefore not easy to forget the efforts of DANIDA-HSSP staff especially Mrs. Hanne the Chief Executive, Mrs. Abigail Kyei and once again Dr. Nana Enyimayew who assisted me greatly to get this special support from DANIDA.

The Ministry of Health and the School of Public Health (SPH) also assisted me financially. Their assistance is very much appreciated.

I will be ungrateful if I fail to appreciate or recognise the efforts of my

Biostatistics/Research Methodology lecturers: Drs. Omar Ahmad, Paul Arthur and Eric Amuah. They equipped me with the knowledge and skills used to carry out this study.

Certain key people were of help to me during the development of the research proposal. They included Prof. S. Ofori Amaah, Director - SPH; Dr. (Mrs) Matilda Pappoe, Deputy Director - SPH; Prof (Emeritus) E. Laing of Botany Department, University of Ghana, and Mr. A.A. Obuobi, Lecturer in Management, SPH.

The efforts of the members of the Wa DHMT which contributed in no small measure to the success of this study cannot be overlooked. To Them I say BRAVO.

My work would not be completed without the cooperation of my respondents and/or participants for the study. Some of them including chiefs, landlords and elderly women over 60 years had to travel between 20-60 kilometres to honour my invitation. To all these people including the health workers I say “Barka” (Thank you).

To the team of gallant Research Assistants Mr Jonas Kasagbayele and Mrs. Rosina T. Yenli, both of Wa District Health Administration and the driver Mr. Williams who withstood adverse field conditions to ensure successful data collection I say “Tres bien”.

There have been encouragement and support from the Brong Ahafo Regional Health Administration especially from Dr. I.K. Asare, RDHS and Mr. W.S. Sopiimeh, the Regional Health Education Officer. Thank you very much for using your sixth sense in my interest.

To Wa RHMT I say Thank You for your tremendous assistance in my hour of need.

The comments from some lecturers, and academic and field supervisors whom I

had discussions with during the Annual Review Meeting were valuable in writing my final research proposal. Special thanks should be given to Dr. Arday Acquah (RHA, GAR), Dr. Antwi Agyei (SMO-PH, BAR) and Dr. Kyei Faried (DDHS, Sekyere-West District).

Mrs. Crentsil and Ms Zenabu, the librarians of SPH Library, University of Ghana, and Upper West Regional Health Administration Library respectively supported me tremendously during my literature review. To them I say “cherrio”

Ms Elsie Mante of Brong Ahafo Regional Health Administration typed my Final Research Proposal and her effort is very much appreciated. I would be ungrateful if I fail to appreciate the effort of the typist at Wa DHA Ms Lydia Johnson who gave me secretarial support during my stay in Wa.

This work would not have come up the way it is if not through the efforts of others whose works I used as references. To them I say more grease to your elbow.

I would also like to thank Ms. Adzo Ayissah who patiently typed the manuscript, as well as Ms. Comfort Asantewaa of Brong Ahafo Regional Health Administration who effected the necessary corrections after the script has been marked.

As it is not easy to thank all those who have contributed to this work by names, I take this opportunity to thank them.

Last but not the least, I have to thank my wife Paulina Henneh for her tolerance to lead a lonely marriage life for the sake of my success. It is her tolerance and the warmth she was giving through letters that has done the work for the benefit of many others as well.

**LIST OF ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BAR	Brong Ahafo Region
BARIDEP	Brong Ahafo Rural Integrated Development Programme.
CBD	Community Based Distributor
cf	Compare
CP	Community Participation
DANIDA	Danish Development Agency
DDHS	District Director of Health Services
DHA	District Health Administration
DHMT	District Health Management Team.
DPT	Diphtheria, Pertussis & Tetanus
FGD	Focus Group Discussion
GAR	Greater Accra Region
GOG	Government of Ghana
HSSP	Health Sector Support Programme
IE&C	Information, Education and Communication
IMR	Infant Mortality Rate
KI	Key Informant
MCH/FP	Maternal and Child Health/Family Planning.
MOH	Ministry of Health
NGO	Non-governmental Organisation

PHC	Primary Health Care
PI	Principal Investigator
PNC	Postnatal Care
PNDC	Provisional National Defence Council
SDHMT	Subdistrict Health Management Team
SDHT	Subdistrict Health Team
SMO	Senior Medical Officer
SPH	School of Public Health
TB	Tuberculosis
TBA	Traditional Birth Attendant
TDC	Town Development Committee
TT	Tetanol Toxoid
UNICEF	United Nations Children's Fund.
UWR	Upper West Region
VHC	Village Health Committee
VHV	Village Health Volunteer
WHO	World Health Organisation

## CHAPTER ONE

### 1.0 INTRODUCTION

#### 1.1 Background of the Study

The conceptual gap between communities and health planners or health service providers has always led to the failure of many health development projects or programmes. Adams and Smiths (1989) observed that without community participation (CP) and involvement, “Health for All by the Year 2000 ” will not be realised.

Invariably the success of any health programme depends very much on the extent to which the community participates. Thus knowing how broad or narrow community participation is in programmes is very useful to planners or health managers.

This study was undertaken to assess the extent of community participation in maternal and child health programmes including family planning (MCH/FP) programmes at the subdistricts in Wa District where the level B clinics operates.

#### 1.2 Study Location

##### 1.2.1 History of the Region

The Upper West Region (UWR), the region where this study was undertaken, has unique regional characteristics. Taking its present name from its geographical location, the UWR has existed under different names in the past. Christened The Black Volta Administrative District in 1898, it became known as The North Western Province in 1907, enjoying full provincial autonomy.

Later in 1932, it was merged with Gambaga and Tamale to become The Northern Territories. In 1960, however, the Northern Region was carved out of the Northern Territories and what remained became The Upper Region.

On 14th January, 1983, in pursuance of its decentralization policy, the PNDC Government divided the Upper Region into two, thus creating The Upper West Region.

The region is therefore the youngest and least resourced in the country. This study was conducted in one of the region's five administrative districts namely Wa.

### **1.2.2 Wa District**

Wa District is located between Latitudes  $8^{\circ}30'' - 10^{\circ}N$  and Longitude  $0^{\circ}30'' - 2^{\circ}30'' W$ . The district shares boundaries with Tumu District to the east, Nadowli District to the north, the Northern Region to the south, and the Black Volta River Bordering Burkina Faso to the west. The district occupies a land mass of  $5889.5 \text{ km}^2$  which is about 32% of the total land area of the region. Wa is both the district and the regional capital.

The 1998 population of the district projected from 1984 using a growth rate of 3.1% is about 248,000 giving it a population density of 42 persons per square kilometre. There are 411 communities in 14 subdistricts. The male to female population ratio is 100:108.3.

The major ethnic groups in the district are Dagaaba, Wala, Sissala and Lobi. The main occupation in the district are farming (including livestock production). The vegetation is generally semi-savanna with light undergrowth and scattered shrubs.

There are twenty (20) health facilities (including a regional hospital) in the district. The district has designed structures and activities to revitalise CP. For instance the district has trained 120 traditional birth attendants (TBAs) to assist in maternal care. There are community based distributors (CBDs) who educate the communities on family planning as well as providing some form of family planning services.

There are also myriads of village health volunteers (VHVs) who are primarily supposed to assist the health workers in MCH/FP outreach services as well as other programmes.

Besides in each subdistrict there is a subdistrict health management team (SDHMT) which is a community representative body for advocacy and CP in health delivery. However the extent to which the communities are participating in health activities is not known.

### **1.3 Statement of the Problem**

There have been concerns expressed at the District and Regional Health Services Directorates in the Upper West Region about low MCH/FP coverage/utilization in Wa District. At two successive Districts and Regional Managers Conferences organised at Wa in 1994, it came out clearly as a topic for discussion that the MCH/FP coverage/utilization in Wa and some other districts were low.

In 1994 the Wa District achieved an ANC coverage of 52% compared to target of 80%. Other indicators for the same year were: TT<sub>2</sub> - 21%, DPT<sub>3</sub> - 37%, supervised delivery - 39% PNC - 23% and F/P (acceptors) - 13% (Upper West Regional Annual Report, 1994).

In order to improve MCH/FP coverage/utilization, a number of measures have been put in place such as:

1. Increasing number and quality of staff.
2. Provision of logistics such as transport (e.g. motor bikes), fridges and weighing scales.
3. Increasing MCH/FP outreach centres (There are now 229 outreach centres in the district).
4. Increasing regular health education and IE&C campaign on MCH/FP programmes.
5. Regular monitoring and support visits by DHMT, and
6. Improving structures to promote community participation.

Because of outreach centres and programmes MCH/FP services have now been made available in most communities in the district. Having all these programmes and structures in place the anticipation is that MCH/FP coverage will improve. However, in spite of all these efforts by the DHMT, MCH/FP services coverage have not been satisfactory. Thus coverage were still low as shown by some performance indicators of 1996 and 1997.

Indicator	Target	1996		1997	
		Target	Cov.	Target	Cov.
F/P (acceptors)	15 %	15 %	8.6 %	15 %	12.3 %
TT2	30 %	30 %	13 %	30 %	15 %
Sup.delivery.	60 %	60 %	36 %	60 %	37 %
ANC Visits	4 Visits	4 Visits	1.5 Visits	4 Visits	1.9 Visits

Since all the necessary health service factors have been put in place to improve MCH/FP coverage, there is a strong feeling that the low coverage or utilization might be due to community factors. Nevertheless the Wa DHMT is not sure the extent to which

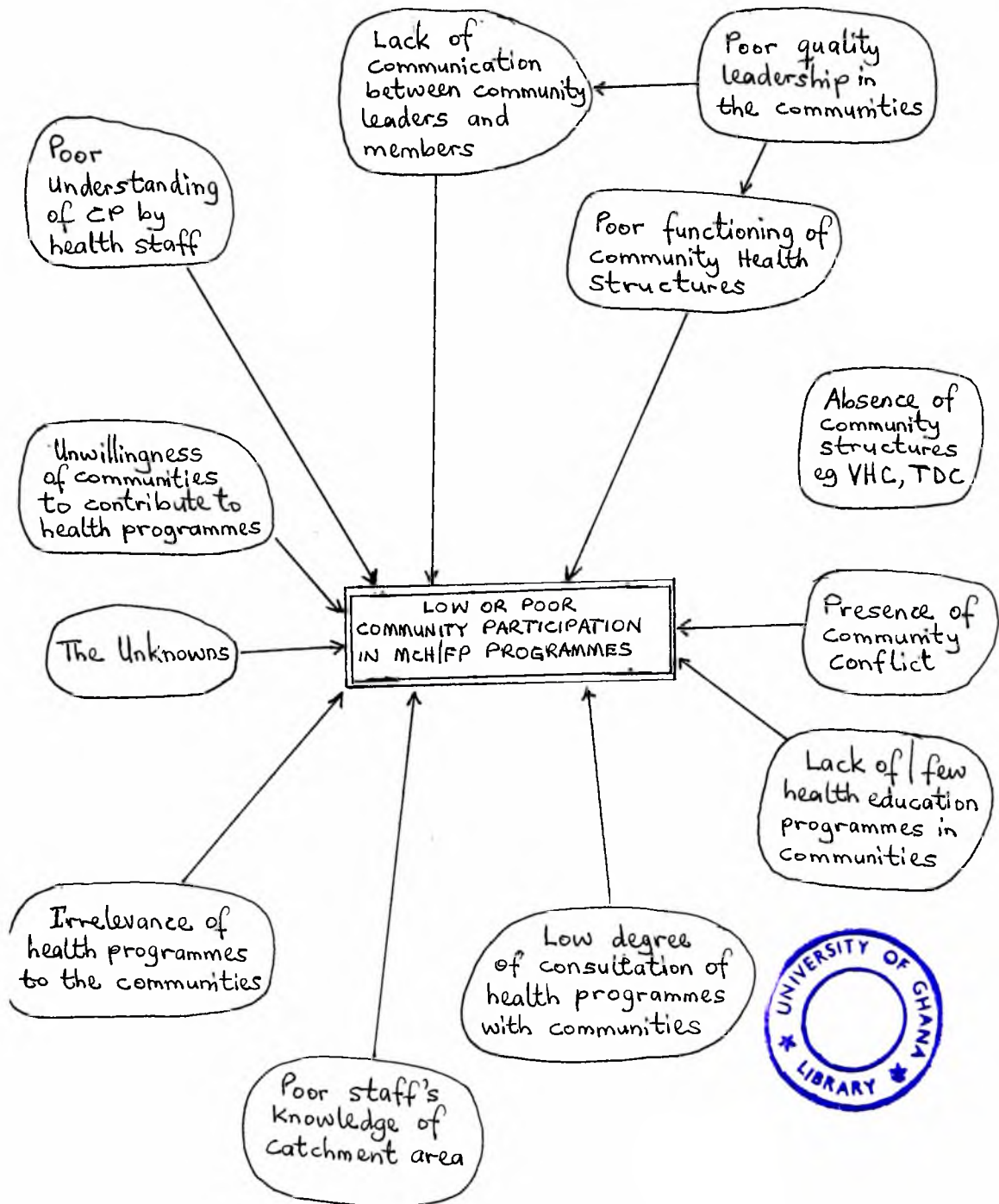
the community is participating in MCH/FP programmes. There have not been any previous study of that nature. There are structures to enhance CP - TBAs, CBDs, VHVs, SDHMT etc - but the DHMT is not sure whether these structures are working. This study was therefore set out to assess the extent of community participation in MCH/FP programmes.

#### **1.4 Assumption**

The basic assumption to guide this study was that the extent of community participation in MCH/FP programmes in Wa District is narrow.

Figure 1.1 below is a problem analysis of how various factors could be influencing community participation in MCH/FP programmes at the subdistrict level.

ANALYSIS OF DIAGRAM  
FACTORS AFFECTING COMMUNITY PARTICIPATION



### 1.5 Rationale for the Study

1. The Wa DHMT has listed CP at the subdistrict as their topmost area of interest for study. The findings will help the district assembly and the DHMT to know the extent of community participation in health care at the subdistricts.
2. There has not been any evaluation of CP to assess its effectiveness since the formation of the SDHMTs, VHVs and CBDs in 1994 to revitalise the participation or involvement of communities in their health care.

### 1.6 Justification for using MCH/FP Programmes to assess extent of CP in Health Programmes.

Health is a broad concept and for that matter assessing the level or extent of community participation in Primary Health Care (PHC) in general will be a difficult task within this short period for the study. Since time is very limited the researcher has decided to use only one component of PHC to assess the level of CP in health care.

At the level B institutions over 80% of the performance indicators come under MCH/FP services. Besides most of the structures put in place to enhance CP are skewed towards MCH/FP activities (e.g. The TBAs, CBDs). Thus using MCH/FP activities/indicators to assess the extent of CP may be proxy for all health activities.

## 1.7 Literature Review

### 1.7.1 Definition of community participation

The concept of CP is the brain-child of the Alma Ata Conference on Primary Health Care (PHC) held in 1978, where participants conceived of CP in health development process as a means to an end and as an end in itself (Pappoe 1993). Since then, there have been development of a variety of definitions, interpretations and approaches to the implementation of CP. These descriptions and interpretations of CP have been derived from operational research in health programmes (Swai, 1993).

CP has been defined as the process by which individuals and families assume for those community, and develop the capacity to contribute to their and their community's development (WHO, 1978). Again, WHO (1984) defined CP or involvement as the active form of social organization and cohesion in planning operation of PHC using local, national and other resources. The term "Involvement" is preferable to "Participation" because it implies a deeper and more personal identification of members of the community PHC (Swai 1993).

Susan B. Rifkin et al (1988) also defined CP as a social process whereby specific groups with shared needs, living in a defined geographical area, actively pursue the identification of needs, take decisions and establish mechanisms to meet these needs'. In this study CP is defined as a process which must necessarily start with mobilization of community resources and eventually to community control of their MCH/FP activities. If the extent of CP is wide the community will plan implement and evaluate the MCH/FP programme using health professionals as resource persons.

If narrow CP it will mean that health professionals take all the decisions and there is no lay participation. In between the two there are various degrees of CP

### **1.7.2 Reasons for Community Participation**

On the conceptual level community participation should make a difference in health status of the majority of the world's people. Indeed in most countries, for example the Phillipines (Laleman and Annys, 1989), Latin America (Winch et al, 1992) and United Kingdom (Adams and Smith, 1989) the basis of many of the major changes in health and public service provision and registration can be traced back to some form of community pressure and/or participation.

A review of literature of MOH, 1996, White, 1982 in Pappoe 1993, Philips 1990 and WHO, 1991 has also indicated the following as reasons for community participation:

With good mobilization, community on its own, has potential resources which can be utilized for the benefit of the majority.

When well sensitized, the needy majority can do a lot more in their own environment than by health services in isolation.

The right of decision on what affects the daily life is in the hands of the community. The phenomenon increases self-confidence.

Increasing access to service. This includes building cultural sensitivity into the packaging and delivery of health services and messages and reaching vulnerable subgroups in the community.

Improving quality of service delivery, flexibility in time, improvisation, staff attitude and client satisfaction are assured.

Improving efficiency and use of resources. This is achieved by involving communities in decision - making including needs assessment, planning and the mobilization and use of local resources as well as the monitoring and evaluation of programmes.

Considering the above, one can say that the success of any health programme depends very much on the extent to which the community participates.



### 1.7.3 Community Participation Concepts

There are different interpretations for community participation (Oakley, 1987).

Two schools of thought will be discussed here.

One school of thought sees participation as synonymous with the use of community health workers, low-cost community health care programmes, or simply health activities that members of the community carry out themselves as distinct from those being provided by the formal professional health services (Askew in Akhtar, 1991). According to this interpretation community participation is seen as a means to a more efficient and effective health care. A review of the literature indicates that it is the conception applied by most national health programmes in the third world, including Ghana (Pappoe, 1993).

A second interpretation sees participation as a way “of achieving greater individual fulfilment, personal development, self awareness and some immediate satisfaction” (Pappoe, 1993). This conception of community participation expects communities to take greater responsibility for their own health and argues that for a health care delivery system to have any appreciable impact on the communities

(people), it must be “demedicalised” and “deprofessionalized” (Sterky 1978, Griffiths 1974, Goldsworthy 1988, Pappoe 1993).

That these alternative interpretations of the concept of community participation have different implications for the implementation of PHC, and for that matter MCH/FP services on the community level is appreciated. Nevertheless, for purposes of this dissertation, no such distinction is made. Participation is seen as a process which must necessarily start with mobilization of community resources eventually to community control of most health and welfare activities (Pappoe, 1993).

#### **1.7.4 Community Participation in Ghana**

In Ghana, attempts have been made at promoting community participation or involvement in Primary Health Care. These include the Brong Ahafo Rural Integrated Development Programme – BARIDEP (Beausoleil, E.G. et al, 1978), Danfa Rural Health Project (DANFA, 1979) and several mission-initiated PHC programmes notably the Ashanti-Akim Rural Health Programme (1979). The conclusions of all these projects indicated that the progressive involvement of the community in the provision of essential health care led to the solution of numerous health problems at the local level (Letsa et al. 1992).

Notwithstanding all these, in Ghana community participation in PHC is yet to have the expected impact. For instance the village health worker (VHW) scheme which was introduced by MOH in the 1970s to provide community based primary health care came to nothing (Amuah et al, 1993; Alirigia, 1997).

Pappoe (1993) observed that there is a yawning gap between policy and the implementation of lay participation in health development activities.

Nevertheless since 1993 different strategies or methods of involving communities in the health care have evolved in many parts of the country. For example the Navrongo Community Health and Family Planning project uses the community in planning, mobilization of resources and service provision (Navrongo Project, 1994).

#### **1.7.5 Community Participation in Wa District**

The Wa District, in Upper West Region has also been running a number of health projects. These include Sanitation campaigns, Adoption of Family Planning (especially by men), the Weaning Food Project, Guinea-worm eradication, Immunization on the preventable diseases, Nutrition Surveillance, MCH/FP, AIDS, TB and Leprosy Control.

It is reported that these programmes initially got on well, but started slowing down in the early 1990s (Swai, 1993). For instance the Sing Community Nutrition Project (under UNICEF) which started in 1990 was closed down in 1991. The slow down in all the above mentioned programmes was attributed to low community participation (DHMT Report, July, 1992).

However to enhance community participation the Wa District Health Services has put up a number of structures in the communities as already discussed (cf 1.2.2 ). Interestingly these community structures such as CBDs, TBAs, VHV's are skewed towards MCH/FP programmes.

### 1.7.6 Maternal and Child Health/Family Planning (MCH/FP)

Maternal and Child Health/Family Planning represents the sum total of the services required to promote and maintain the health of women and children in Ghana.

MCH/FP services therefore incorporate all Safe Motherhood, Child Survival and Family Planning strategies. Components of Safe Motherhood include antenatal care, supervised delivery, postnatal care and treatment of complications of abortion.

Components of child health include growth monitoring, promotion of exclusive breastfeeding for the first six months, immunization against the six antigen preventable diseases (tuberculosis, pertussis, tetanus, diphtheria, poliomyelitis and measles), and school health services (MCH/FP Annual Report, 1994).

The strategy for achieving the MCH/FP objectives and target is based upon the principles of Primary Health Care. This include:

health education

appropriate and affordable technology

inter and intra sectoral co-ordination

community based activities or outreach activities

with full community participation. [source: MCH/FP 1993]

### 1.7.7 Review of indicators for assessing Community Participation (CP)

Whereas some aspects of CP require quantitative indicators, this study used only qualitative indicators. This is because “ The extent of CP” can best be determined by qualitative indicators. Very few qualitative indicators have been developed in the medical field. A review of literature (Laleman G et al, 1989; Bichmann W et al, 1989; Oakley 1988; Rifkin S.B. et al 1988; Rifkin S.B., 1990; and

Rabbow M, 1991.) revealed the following qualitative indicators used to assess community participation in health programmes:

Table 1.1 Indicators for assessing CP

Indicator Score				
Dimension of CP	[+]	[++]	[+++]	[++++]
PAHO	Utilization of services	Co-operation in programmes	Involvement in programmes	
Cohen of Uphoff	Sharing of benefits	Participation in implementation	Participation in decision making	Participation in evaluation
Agudelo C.	Non-management	Co-management	Self-management	
Rifkin	Medical approach	Health service approach	Community develop approach	

**NOTE: 1** The extent of CP broadens as indicator score (number of pluses) increases.

**2.** The first column indicates the individual or group who propounded the model

**3.** PAHO means Pan American Health Organisation

There is also “Pentagram Model” developed by Rifkin S.B, Mulfer F and Bichmann (Rifkin et al 1988, Rifkin S.B. 1990, Swai 1993) which has five factors: needs assessment, leadership, organization, resource mobilization and management.

This study used the Pentagram Model to assess the extent of community participation based on the afore-mentioned five factors. The “Pentagram Model” has been used because it has the ability to describe how broad or narrow community participation is in (Swai 1993). [Refer 3.4.2 for description of the “Pentagram Model”]

**1.8. Operational Definitions**

1. SDHT This is Subdistrict Health Team. It refers to the health workers at the Level B Clinic. In each subdistrict there is one clinic and all the staff are members.
2. SDHMT - This is Subdistrict Health Management Team. It is a community representative body for advocacy and health delivery. The health staff are co-opted members. In this study whenever the term SDHMT is used, it refers to only the community members.
3. Landlord or locally referred to as “Tendaana” is the owner of the land. He gives out pieces of land to people to build their houses. In terms of rank or status he is next to the chief.
4. The arms of the “Pentagram Model (ec fig.1) have been labelled N,R, O, M and L and they mean the following

N = Needs Assessment

R = Resource Mobilisation

O = Organisation

M = Management

L = Leadership

## CHAPTER TWO

### 2.0 STUDY OBJECTIVES

#### 2.1. General Objective

To determine the extent to which the communities in Wa District participate in Maternal and Child Health/Family Planning programmes.

#### 2.2 Specific Objectives

1. To determine the extent of community participation in MCH/FP activities using the following factors:

- a) Needs Assessment
- b) Organisation
- c) Resource Mobilization
- d) Management (planning, implementation, Monitoring/evaluation)
- e) Leadership.

**(refer table 3.1 for variables, indicators/operational definitions for these factors )**

2. To identify health service factors which promote or hinder the extent of community participation.
3. To identify community factors which promote or hinder the extent of community participation.

## CHAPTER THREE



### 3.0 METHODOLOGY

#### 3.1. Design of the Study

##### 3.1.1. Study type

The study was a descriptive cross-sectional one using only qualitative methodologies.

##### 3.1.2 Variables

The dependent variable was narrow or poor community participation in MCH/FP programmes, all other variables were independent variables.

The variables of the study with their indicators/operational definitions are given below under specific factors known to influence community participation.

**Table 3.1. Variables measured in this study**

FACTORS	VARIABLES	INDICATORS/OPERATIONAL DEFINITIONS
I. Needs Assessment	I. Identification of the need for a) SDHMT b) VHVs c) Trained TBA d) CBDs  ii. Selection of SDHMT members  iii. Selection of TBAs for training  iv. Selection of VHVs/CBDs	I. Needs identified by: health professionals community both  ii. Descriptive:- Imposed on communities or not  iii. Same as (ii)  iv. Same as (ii)

FACTORS	VARIABLES	INDICATORS/OPERATIONAL DEFINITIONS
2. Organisation	I. Repeat I ii, iii and iv ii. Presence of TDC/VHV iii. Organization of SDHMT, VHVs, TBA meeting  iv. Functional SDHMT/VHVs	I. Same as I ii ii. Present or Absent. iii. Response to questions on who organises these meetings÷  iv. - Regular meetings - 4 meetings a year - Good attendance (>/75%). - Minutes available
3. Resource Mobilization	I. Mode of financing SDHMT, TBAs, VHV meetings  ii. Community support to TBAs, VHVs, and SDHMT members  iii. Support/Contributions to MCH/FP programmes  iv. Other contribution to health care in general	I. Response to question on who finances the meetings  ii. Descriptive: Time Labour - Money - Kind  iii. Descriptive: Time Labour Money etc.  iv. Descriptive
4. Management	I. Planning MCH/FP Programmes  ii. Implementing MCH/FP Programmes.  iii. Monitoring/Evaluating MCH/FP programmes	I.- iii) Communities involved or not involved.  To describe the extent of involvement.

5. Leadership	<p>i. Mode of selecting community health leaders</p> <p>ii. Composition of SDHMT</p> <ul style="list-style-type: none"> <li>- All communities represented</li> <li>- Women fairly represented?</li> </ul> <p>iii. SDHMTs members/VHVs representative of the subdistricts/Communities</p>	<p>I. Descriptive</p> <p>Imposed on communities or Not Imposed.</p> <p>ii. Yes/No</p> <p>iii. Yes/No descriptive</p> <p>Consulting them before meeting.</p> <p>Providing feedback</p> <p>Supporting MCH/FP activities</p>
<p><u>Other factors</u></p> <p>6. Degree of consultation</p>	I. Frequency of health education contacts/other contacts with communities	Descriptive.
7. Relevance of Health service	I. Relevance of MCH/FP programmes to the community	Descriptive Relevant Not Relevant

### 3.2. Sampling

#### 3.2.1. Study population/target groups

Ideally in qualitative research all views are respected including the vulnerable groups in communities. In this study however, factual information rather than individual opinions or views was required, and therefore some key informants were used to represent the communities. The following target groups were therefore used for the study.

1. Subdistrict Health Teams (SDHTs)
2. Subdistrict Health Management Teams (SDHMTs)
3. Village Health Volunteers (VHVs)
4. Traditional Birth Attendants (TBAs)
5. Chiefs
6. Landlords
7. Women leaders (“Mangazias”)



#### 3.2.2. Justification for the target groups

##### SDHT

At the subdistrict level, there is the Subdistrict Health Team (SDHT) which consists of the health workers in the subdistrict. They see to the day to day delivery of services at static, outreach centres, institutions, and home visits in the communities in health delivery. Hence they should be included in the study of community participation in MCH/FP programmes.

### **SDHMT**

The Subdistrict Health Management Team is a community representative body for advocacy and community participation in health delivery. The SDHT (the health workers) are supposed to involve the SDHMT in the planning, implementation, monitoring and evaluation of all health delivery programmes in the subdistrict. Membership of SDHMT may differ from one subdistrict to another, but generally they include farmers, teachers, priests, assemblymen, village health volunteers, traditional birth attendants, chiefs etc. The composition and functions of the SDHMT makes it a very good target group for the study.

### **TBAs**

There are 120 trained traditional birth attendants (TBAs) who provide maternal health services in the district. They are therefore a good yardstick to measure the extent of community participation in MCH/FP programmes.

### **VHVs**

The village Health Volunteers (VHVs) work closely with the aforementioned groups as well as the rest of the community. They are, among other things, supposed to organise/mobilise the community for MCH/FP activities especially MCH/FP outreach programmes. By their functions the VHVs could not be left out in this study.

### **Chiefs/Landlords**

By their positions the chiefs and landlords (“Tindaanas”) are good key informants for any study on community participation. In this study the researcher wanted to find out from the chiefs and landlords whether decisions taken by the SDHTs, SDHMTs, TBAs groups and VHV groups were passed on to the rest of the community members. The researcher also wanted to determine the extent to which the chiefs and landlords mobilised resources (human and material) for community participation.

### **Women Leaders (the “Mangazias”)**

In the Upper West Region women are grossly marginalised in decision making planning and organisation of communal activities. Nevertheless, there can be no effective community participation in MCH/FP programme without women. In this study because of time and financial constraints the women in the community were represented by the women leaders (the “mangazias”) who may be formal or informal leaders. The researcher believes that if the women in the community who are the vulnerable group are highly involved in MCH/FP programmes then it means the extent of community participation would be broad.

### **3.2.3. Sampling procedure**

A multistage sampling procedure was used. A simple random sampling was used to select 4 out of the 14 subdistricts in the district. These subdistricts were similar in characteristics. The names of the fourteen subdistricts were written on pieces of papers, folded and put in a container.

A school girl was asked to pick four of them randomly without looking in the container.

In the first draft proposal it was stated that seven (50%) of the subdistricts would be selected for the study. However because of the time and financial constraints the number was scaled down by a factor of half, and the results (3.5) was rounded off to 4.

In each subdistrict the community in which the level B station (Health Centre) is located was selected. They were selected because they are the communities where static MCH/FP programmes are organised. The study had questions for communities with static MCH/FP programmes. However since communities that enjoy outreach services were many there was the need to sample some of them. Hence in each subdistrict the names of the communities (apart from the one with static clinic) were written on pieces of papers, folded and put in a container. Nine (9) of these folded papers were picked randomly. Where there were less than 10 communities in a selected subdistrict all the communities were chosen for the study (For instance Holomuni subdistrict had 8 communities).

In each selected community the SDHMT member and the trained TBA were chosen for focus group discussions (FGDs). Where there were more than one SDHMT member or trained TBA one was selected at random. The names of the SDHMT members or TBAs were written on pieces of papers and one of them was picked at random.

By rule of thumb the Level B Clinic in-charge and one other SDHT member who was actively involved in MCH/FP programmes (as mentioned by the in-charge) were selected for individual in-depth interviews.



In each subdistrict two out of the ten (10) selected communities (the community with the static clinic and one other community picked randomly) were once again chosen, and in each of the two communities the chief, the landlord (“Tindaana”), the village health volunteer (VHV) and the women leader (“Mangazia”) were selected for key informant interviews.

Thus in all:

1. Four (4) subdistricts were selected.
2. 38 communities were selected.
3. 8 SDHT members (health workers) were interviewed.
4. There were 8 FGDs (4 for SDHMTs and 4 for TBAs)
5. 16 other opinion leaders (chiefs, landlords, village health volunteers and women leaders) were interviewed.

The selected subdistricts and communities are as follows:

SUBDISTRICTS

COMMUNITIES

a) Poyentanga

- |      |            |      |        |    |        |
|------|------------|------|--------|----|--------|
| * 1. | Poyentanga | * 2. | Tanina | 3. | Naha   |
| 4.   | Nakor      | 5.   | Polee  | 6. | Nyoli  |
| 7.   | Sugibalong | 8.   | Ga     | 9. | Samabo |
| 10.  | Joleyire   |      |        |    |        |

b) Charia

- |     |         |     |          |    |           |
|-----|---------|-----|----------|----|-----------|
| * 1 | Charia  | *2. | Zang     | 3. | Asse      |
| 4.  | Eggu    | 5.  | Kpila    | 6. | Tandaboro |
| 7.  | Bultuo  | 8.  | Cherille | 9. | Kachuu    |
| 10. | Sukpere |     |          |    |           |

- c) Lasia-Tuolu \* 1 Lasia \*2. Buli 3. Janebo  
 4. Vieri 5. Pegbengben 6. Woloyir  
 7. Kaw 8. Kandeu 9. Kungha  
 10. Yeliyir
- d) Holomuni \* 1 Holomuni \* 2. Gbantala \* 3. Kpalwogu  
 4. Babatuyiri 5. Katua 6. Bialebile  
 7. Yayounyiri 8. Dolindauyiri

{\* Communities selected for key informant interviews in addition to Focus Group Discussions}

### 3.3 Data Collection Techniques and Tools

The following data collection techniques were used for the study.

1. Focus group discussions
2. Interviewing (face-to-face)
3. Using available information (eg. Minutes, Log book, Monitoring

Reports etc.)

Interview guides and focus group discussion guide were used as the main tools to conduct key informant interviews and focus group discussions respectively.

#### 3.3.1 Focus group discussion (FGD)

Is a special type of interview with a small group of people (usually between 6-10) where a discussion is carried out freely and spontaneously guided by a facilitator.

The characteristics of such groups include: participants of the same sex, similar social and/or family background, participation is absolutely free and facilitator remains neutral in the discussion (Maier B.R et al 1993).

This methodology has its strengths and weakness as pointed out by Richard A. Krueger (1990) and Annet, H and Rifkin, S.B (1998). The strengths include:

People feel more free to express the reality of their life experiences with the group dynamics.

The moderator (facilitator) stands a better chance to carrying out some probing into the discussion.

It provides a higher validity form of understanding, and the results are presented in a way that is not complicated.

It can offer quick results especially in situations where quick action is required.

Some of the limitations which a researcher is likely to encounter are:

There is a limited control over the group. It could get unwieldy.

It is also highly subject to influence by dominant individual.

Data analysis consumes a lot of time and sometimes difficult.

There are clear cut yardsticks for reference.

It requires facilitators who are well trained in this method.

It could be very subjective.

### **3.3.2. Key informant interviews**

These are interviews (ranging from unstructured to structured ones) carried out with people who have a special position in the community. They are looked upon as representatives of the opinions and experiences of the whole group.

These range from government officials, government and non-government Organisations (NGOs) employees, to community own resource persons and leaders of informal groups (Kruerger R.A. 1990, Maier B et al 1993, Swai, 1993).

Key informant can give a valuable and independent information about the community in a relatively short time without needing a large group in the study. However as Annet and Rifkin pointed out one needs to be a very careful with local leaders and some key informants. They may not represent the views of the vulnerable groups of the society.

### **3.3.3 The research team**

The research team was made up of the Principal Investigator (P.I.), four supervisors (two academic and two field supervisors) who could be described as Co-investigators, and two research assistants recruited in Wa District. One of the research assistants was a Public Health Nurse and the other one was an Ophthalmic Nurse/IE&C Co-ordinator.

The P.I. trained the research assistants for four days on community entry, data collection techniques (FGDs and key informant interviews) use of research instruments (data collection tools), and notetaking. The District Public Health Nurse and the District Disease Control Officer assisted in translating the data collection tools in the local languages: Lobi, Waali and Dagaare.

The researcher (the P.I.) interviewed the SDHT members (that is the health staff) whilst the research assistants interviewed the key informants from the communities, as well as conducting the FGDs.

#### **3.3.4. Pretesting of research instruments**

Presenting of in-depth/key informant interview guides and FGD guides were done after the development of these instruments and after the training of the research assistants, for duration, ease of understanding and translation.

The pretesting was done in Wa Subdistrict which was one of the subdistricts not selected for the study.

After the pretesting the data collection tools were reviewed and finalised.

#### **3.3.5 Ethical consideration**

Verbal and/or written consent for the study was sought from the Regional Director of health Services, the District Chief Executive and the chiefs of the selected communities. Individual consent for the interview and the FGD were also sought.

#### **3.3.6. Fieldwork**

Fieldwork was undertaken over a period of four days. In each subdistrict the participants for the FGDs came to the subdistrict capital where the Level B clinic is located, from their various communities. Some of the participants had to travel a distance of over 60 kilometres. With the key informant interviews the Research Assistants moved into the communities.

#### **3.3.7. Quality checks**

With the key informant interview the P.I. ensured that data collected by Research Assistants were complete and consistent.

With the FGD the P.I. designed an interview guide based on the questions on the FGD guide, and used it to interview either the secretary or chairman of the SDHMT in each subdistrict. The purpose was to check consistencies in responses provided during the individual interviews and those provided during the FGDs. The FGD cassettes were also given to somebody from Ministry of Agriculture to translate the message into English. The purpose was to cross-checked the translations which were done by the Research Assistants.

Lastly two of the cassettes were sampled and given to somebody in Sunyani (Brong Ahafo Region) who is a Dagaaba (Dagarti) to interpret.

### **3.4. Data Processing and Analysis**

#### **3.4.1. Data handling**

Data collected was kept safely in waterproof bags and sorted by tool type. All the in-depth/key informant interview guides coded by name of subdistrict, name of community, and interviewer to facilitate sorting. The FGDs were also transcribed, sorted and coded by type of subdistrict and respondents.

#### **3.4.2. Describing the analytical frame-work [The Pentagram Model]**

With the Pentagram Model, attention is paid to the factors which influence CP. These factors are [1] Needs Assessment (N),[2] Resources Mobilization (R),[3] Organization (O),[4] Management (M) and [5] Leadership (L).

A continuum is developed on each of these factors. This continuum has a wide participation on one end [community carries out the planning, implementation, and evaluation of the programme. Professionals are used as resources].

The other end is described as having a narrow participation [where every decision is made by professionals without involving the people].

Such a two-ended continuum is graduated to give various levels of participation. Using this graduation a mark can be put on/or closer to the point which best describes the nature of participation obtained (broad or narrow; high or low). Using such a made continuum for all the factors, we can form the co-ordinates of a “Pentagram Model” as in figure 1. [Rifkin et al 1989, Laleman, 1989, and Swai 1993].

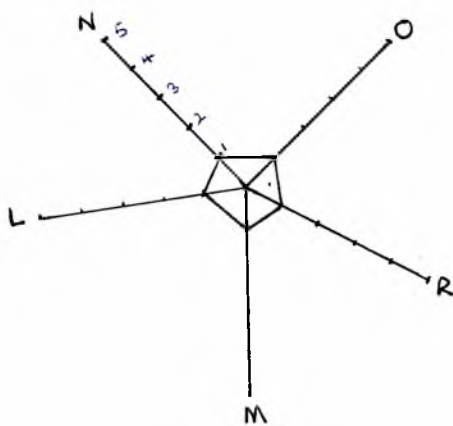


Figure 1

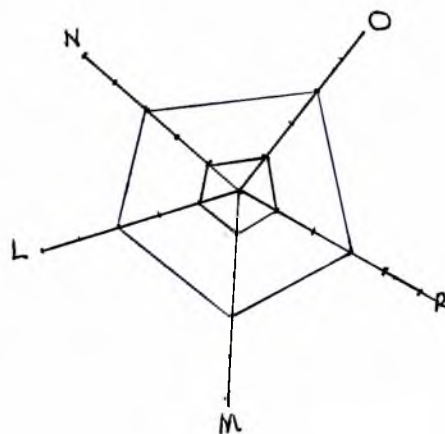


Figure 2.

The factors which influence CP do not stand in isolation. They are always interacting with each other. This forms the basis for linking up the different points on the co-ordinates to form the “Pentagram” (figure 1). The small pentagram so obtained denotes that at any given time there is a form of CP as per definition given in the literature review.

Another observation is that, the co-ordinates are meeting somewhere at the centre. This does not mean that at this point community participation is nil.

It is a turning point where all the factors have a common influence. If say a programme has been started and after some time an assessment is done, another level can be obtained and compared to the initial one to see what could have been the change over the period. [cf figure 2]

### **3.5. Limitations and Biases of the Study**

The limitations and biases presented below are perceived to have had some effects on but which however do not underscore the outcome of the study.

1. Translating the guiding questions into the local dialect was a bit difficult. Translating was done to and from three times before intended meaning could be maintained in some of the questions. An element of this bias could be by hesitance in responding to some of the questions.
2. Some respondents could have answered questions to please the researcher/research assistants (they were strangers to most of them) or exaggerated their feeling instead of telling the truth about the exact situation on the ground. Even the health staff could just have spoken out what they thought was expected to be heard from them or even things which were of their interests. This limitation could have been overcome by validating responses from interviewees over some time. but time was a limited resource.

3. The interpreter bias cannot be completely ruled out in coming up with the transcripts.
  
4. Facilitators skills were limited though she did a nice job (She was trained for only four days, and had no previous experience).

## CHAPTER FOUR

### 4.0. RESULTS

#### 4.1. Description

The data was collected from four subdistricts in Wa District both at the subdistrict and community levels. At the subdistrict level there were FGDs for both SDHMT and TBAs. There were also in-depth interviews with the health staff (SDHT).

At the Community level there were key informant interviews with the VHV, chiefs, landlords (“Tindaanas”), and women leaders (“Mangazias”).

10 (5.6%) of the respondents or participants invited to the subdistrict capitals for the FGDs did not turn up. They included two TBAs from Holomuni Subdistrict, two TBAs from Charia Subdistrict, three TBAs from Lasia-Tuolu Subdistrict, and two TBAs and one SDHMT member from Poyentanga Subdistrict.

#### 4.1.1 Basic characteristics of respondents

All the TBAs invited for the FGDs were females aged between 35 and 77 years. None of them had any formal education. Of the 29 TBAs who took part in the FGDs 27 (93.1%) were farmers, 1 (3.4%) was a Pito\* brewer, and 1 (3.4%) was a petty trader.

---

\*Pito is a local drink brewed from either millet or corn. It may be alcoholic or non-alcoholic.

Of the 37 SDHMT members who came for the FGDs 22 (59.4%) of them had elementary<sup>1</sup> education (M.S.L.C.), and 4 (10.9%) either completed Post-Middle or Post-Secondary Teacher Training College.

32 key informants were interviewed and only 4 (12.5%) of them had elementary education (M.S.L.C.). The key informants were chiefs, landlords (Tindaanas), Village Health Volunteers and women leaders (“Mangazias”). They aged between 22 and 76 years.

**Table 4.1: Categories of Health Staff interviewed**

OCCUPATION	FREQUENCY	PERCENTAGE (%)
General (Nurses (SRN)	1	12.5
Public Health Nurses	2	25.0
Community Nurses	3	37.5
Staff Midwives	1	12.5
Field Technician		12.5
Total	8	100.0

**Note:** The Public Health Nurses and the general nurse were all professional midwives.

## 4.2 Leading Responses

In this study both the key informant (KI) interviews and the FGDs were analysed together without making any clear distinction of which responses came from KI interviews or FGDs. Neither was it specified which particular person made a particular response. As stated earlier in this study, the researcher looked at settings, people and responses holistically.

Typical responses from the participants in all the four subdistricts have been categorized under the five factors of CP as underneath.

### 4.2.1 Needs assessment

In all the four subdistricts majority of the participants had the opinion that the identification of needs for SDHMTs, VHVs, CBDs and trained TBAs were done by health professionals.

Typical responses were:

The idea came from the health staff.

The Nurses in-charge inform us the need for SDHMT, VHVs and trained TBAs.

A letter came from the District Director that we should form these structures.

Health workers were not getting clients. They suggested formation of SDHMT would help them

There were however some participants who did not know who identified the needs. One participant said the needs were identified by Whiteman.

Nevertheless, according to the health staff a letter came from the district

SDHMT, VHVs, CBDs, and trained TBAs.

#### 4.2.2 Organisation

The selection of people to form the afore-mentioned structures were done in diverse ways. In Lasia-Tuolu subdistrict the following were some of the leading responses.

I volunteered to do everything so they (community) chose me.

I was selected by the chief. You give birth to 10 children but you trust one. The chief trusted me so he selected me.

In my house I am the TBA. When they wanted a TBA my son asked me to go, so I went and had the training.

The then Nurse in-charge selected me in my capacity as women organiser.

A meeting was called and I was chosen.

In Charia subdistrict similar responses were observed as stated belows:

I was selected by the chief and elders.

The chief called us (untrained TBAs) and chose me.

The health workers in consultation with the communities selected the TBAs.

We were directed by the health professionals to get a member from each community preferably from the formal sectors such as Education, Agriculture, etc. The chief summoned a meeting and going by the guidelines I was selected.

In Poyentanga subdistrict some typical responses were:

There were already structures called volunteers in our communities so they were converted to VHVs. For the SDHMT, communities were asked to meet and select representatives.

The community selected me ( a TBA) after a meeting.

The Assemblyman informed the chief to select me.

My brother selected me, he is the chief.

The elders of the community selected me.

Leading responses from Holomuni Subdistrict were:

The chief and his elders chose me.

The chief selected me.

In Holomuni Subdistrict the SDHMT meetings were solely organised by the health professionals. However in the other subdistrict SDHMT meetings were organised by both the SDHMT leaders (chairman and secretary) and the health staff.

Meetings have not been regular for the past two years in all the subdistricts. This was because the meetings depend on DANIDA-HSSP/health professionals for funding. Apart from Holomuni the rest of the subdistrict had minutes books. Lasia-Tuolu subdistrict however had not recorded minutes for the last meeting. Majority of the respondents believed the TBAs were doing well. However there were satisfactions and dissatisfaction with regard to the performance of the VHVs and SDHMTs. The leading responses from Holomuni Subdistrict were:

The SDHMT member is dedicated to his work. The VHV is also good. There is team work between the two.

The TBA is good. She is always available to render services.

The VHVs mobilise the community for the workers.

The SDHMT member in my community is not committed to his work. However the TBA is good and is always prepared to assist.

The SDHMT member is not serious, he does not tell us anything. I cannot assess the performance of the VHV because I do not know him. However the TBAs are good, they assist women to deliver safely.

Leading responses from Charia Subdistrict included:

The SDHMT member is good He is performing well. The VHV is not active so the SDHMT member has assumed his (VHV's) role. The TBA is somehow good but seldom attends meetings.

The SDHMT and the VHV are dedicated to their work. The TBA is also good, she is committed to her work.

Leading responses from Lasia-Tuolu Subdistrict also include:

The SDHMT member is good. He mobilizes community for communal labour and also gives health talks. The VHV is hardworking, teams up with the SDHMT member to carry out health activities. The TBA is good. She is always ready to assist.

The VHV and the SDHMT member do not give us feedback. However the TBA is good. She is skillful and hardworking.

Leading responses from Poyentanga:

The SDHMT member and VHV are dedicated to their work.

The TBAs are good. They have been conducting delivery successfully.

#### **4.2.3 Resource mobilization**

Community contribution towards MCH/FP programmes was reflected more in the form of labour and time. Financial contribution towards MCH/FP programmes was nil. Most TBAs are not supported either financially or otherwise. Charia and Poyentanga have started generating communal fund (Village Loan Scheme) to support the needy but its success is yet to be realised. Poyentanga scheme was more advanced in terms of contributions than that of Charia.

The Poyentanga Community Fund was being controlled by the health

professionals. An attempt by Charia and Lasia-Tuolu Subdistricts to contribute €10,000.00 each to pay part of their watchmen salaries have almost proved futile. Some communities did not want to pay.

Leading responses were:

They do not give me anything. Nobody supports me.

My community periodically give me money when I am attending meetings.

They do not give us anything when we assist delivery.

As a VHV I mobilise the people to attend MCH/FP services. Once in every season the community members organise themselves and farm for me.

They help in communal labour.

The people say we are paid by the health workers so they will not support us.

#### **4.2.4 Management**

The study looked at management of MCH/FP programmes under the heading Planning, Implementation, Monitoring and Evaluation. Almost all the responses revealed that planning of MCH/FP activities was done solely by the health professionals. The communities were only informed about the dates of outreach programmes in their communities.

The communities were informed by writing letters to either the chief, the VHV or the SDHMT member through any community member who comes to the health centre. Sometimes the health professionals went to the communities to deliver

the message themselves. It was revealed from the responses that sometimes the letter sent to the communities did not reach the addressee.

At the implementation phase the following were observed.

1. In all the communities the TBAs were actively assisting delivery. They were also giving some form of antenatal care (e.g. palpating the mothers and advising them on diet).
2. At Poyentanga Subdistrict (the only selected subdistricts with CBDs) the CBDs were actively involved in the sale and promotion of contraceptives, mainly the spermicides and condoms. However there were some few CBDs who were inactive. One of the inactive CBDs even remarked: “We don’t need family planning at our area because we are few and we need more people”

Almost all the responses revealed that there was no community involvement during MCH/FP static services. During outreach services too the community members were not technically involved apart from Poyentanga and Charia subdistricts where the VHV’s took part in weighing the children. Most communities however rendered supportive services to facilitate the MCH/FP outreach programmes. These included: [1] Organising the outreach centre (sweeping the venue and arranging for tables and benches) [2] Mobilising the people (clients) to patronised these services [3] Maintaining order at the outreach centre, and [4] sometimes providing drinks (“pitoo”) and food to the health professionals.

There were some communities especially in Lasia-Tuolu and Holomuni

Subdistricts which did not support MCH/FP outreach programmes.

Some leading responses from the health professionals were:

#### CHARIA SUBDISTRICT

The VHVs and the TBAs move from houses to house mobilise the clients some VHVs sometimes translate the health talks in local languages.

The VHV or any educated person can be invited to assist in the weighing and charting of the weights.

#### POYTENTANGA SUBDISTRICT

The VHV and the gong-gong beater call out the people to attend the clinic. The VHV also maintains order at the working place.

The VHV mobilises the people by going from house to house with a community register. The TBAs only come to sit by us.

#### LASIA-TUOLU SUBDISTRICT

They (VHVs and TBAs) organise the people. Some prepare the place: sweeping and arranging of tables and benches. Some communities do not do anything. In some communities you go and they will tell you we have not heard of your coming.

Almost all the responses revealed that the community members were not involved in the monitoring of the TBAs and CBDs. However evaluation of MCH/FP programmes were discussed at the SDHMT, VHVs, TBAs and CBDs meetings. Nevertheless it was observed that these meetings which were quarterly meetings were not regular especially in Holomuni, Lasia-Tuolu and Charia Subdistricts. Besides some of the representatives either sent no feedback to the entire communities or provided feedback to only the chief and sometimes the chief and elders.

#### 4.2.5 Leadership

As already mentioned the selection of SDHMT members and VHVs were done in diverse ways (Refer 4.2.2). Some were democratically selected whilst others were selected by the health workers, the chief, the assemblymen, etc. It was observed that not all the communities were represented on the SDHMTs. For instance at Charia Subdistrict there were 4 communities without SDHMT members, and Poyentanga Subdistrict there were 23 communities. In Lasia-Tuolu Subdistrict out of 32 SDHMT members only two were females an indication that the females were not fairly represented. In Charia Subdistrict out of 24 SDHMT members only four of them were women. And in Poyentanga Subdistrict 5 out of 17 SDHMT members were females. Holomuni Subdistrict health staff did not know the number of SDHMT members or VHVs in the subdistrict, and in some of the communities their representatives did not know whether they were SDHMT members or VHVs. They were used to the term “committee members” so most of them said they were committee members. It was after further investigations that we (the researcher, the health staff and the SDHMT secretary) were able to separate the two groups. All the VHVs from the communities studied were males.

Majority of the responses from the health staff, TBAs Women leaders, Landlords and the chiefs revealed that in the communities the VHVs were more active than the SDHMT members. In Charia Subdistrict the SDHMT chairman was found to be inactive. His position had been taken over by the vice chairman. The SDHMT secretary in Holomuni Subdistrict had not written minutes for the previous meetings.

Some of the SDHMT members and VHVs were found not representing their communities. They neither consult them before meetings nor give them feedback after meetings. At Lasia, the chief did not know who the VHV was.

Some leading responses on leadership were:

As for the SDHMT members they only come to meetings to eat and go away. Whatever you tell them to do in the communities they don't do.

When we go to a community we first contact the VHV. If he is not around we go to the TBA. If the two are not around we see the chief. We go to the SDHMT members for assistance only in places where there are no VHVs.

#### **4.3 Ranking Matrix**

The following ranking matrix is a modified form of the one developed in 1988 by Professor Susan B. Rifkin and her associates. This was used to assess or measure the extent of CP in MCH/FP programmes in the four selected subdistricts. For the original ranking matrix developed by Rifkin et al refer to Annex 1.

RANKING MATRIX FOR MEASURING EXTENT OF CP

FACTOR	NARROW (NOTHING) +1	RESTRICTED (SMALL) +2	MEAN (FAIR) +3	OPEN (MUCHGOOD) +4	WIDE (VERY GOOD) +5
NEEDS ASSESSMENT	Professionally identified Committees/Organizations imposed on community	Dominating professionally views. Community interests considered.	Community leader (eg. Chief, Assemblyman representing community views and assesses needs.	Committees/Opinion leaders representing the community and assesses the needs.	Community members in general involved assessment.
ORGANIZATION	Committee/Organisation members imposed by planners/health professionals and are inactive.	Committees imposed by health professionals but became active.	Only community leader(s) or some few individuals were involved in creating the committees or organizations but are active.	Existing community organizations/entire community involved in creating the committees or organizations. Active but financially dependable.	Entire community involved in creating committees or organizations. Fully active and financial independent.
RESOURCE MOBILIZATION	No or meagre resources raised by community. No support/contribution any form. No community mobilization/organization.	No financial contribution but contribute towards labour and social or community mobilization and organization. Provide food, soap etc to TBAs, VHVs CBDs, etc.	Periodical funds raising by the community (to support meetings, programmes, TBAs, etc) but not controlled the expenditure.	Periodical fund raising by the community. Committees control the use.	Considerable amount resources raised by or otherwise to support health activities/programmes and to support TBA etc. Committees allocate the money collected.

Contd.

FACTOR	NARROW (NOTHING) +1	RESTRICTED (SMALL) +2	MEAN (FAIR) +3	OPEN (MUCHGOOD) +4	WIDE (VERY GOOD) +
MANAGEMENT	No active involvement of communities in planning, implementing and monitoring and evaluating MCH/FP programmes	Health staff manages independently with some involvement of committees in some aspects of management.	Community play active role in Managing MCH/FP programmes but decisions are imposed by health professionals.	Co-management. There is partnership in planning, implementing, monitoring and evaluating MCH/FP programmes	Self-management. Community(ies) are control of planning, implementing, monitoring and evaluating MCH/FP programmes.
LEADERSHIP	Leaders are imposed. Do not represent the community(ies) views	Committees/Organizations not functioning or mildly active. Only few members are active and represent the Committee/Community(ies) views	Committees/Organizations very active but some communities are not represented. There is also gender bias.	Active committees well represented by most communities.	Committees/Organizations fully represent variety of interest in community(ies). All communities represented.

**4.3.2 Data analysis applying the ranking matrix.**

From the above responses, existing reports from the District Health Administration, the observations and applying the ranking matrix [CF 4.3.1.] the following summary has been arrived at.

**4.3.3 Summary table**

Subdistrict	Indicator Score				
	N	R	O	M	L
Charia	1.0	2.5	3.0	2.0	2.5
Holomuni	1.0	1.5	2.5	2.0	2.0
Lasia-Tuolu	1.0	2.0	3.0	2.0	2.5
Poyentanga	1.0	3.0	3.5	2.5	2.5

“Pentagram model” visualization for the extent of CP were as follows:

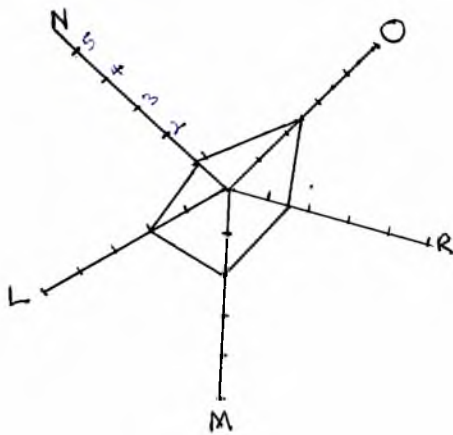


Fig. 3 Holomuni Subdistrict

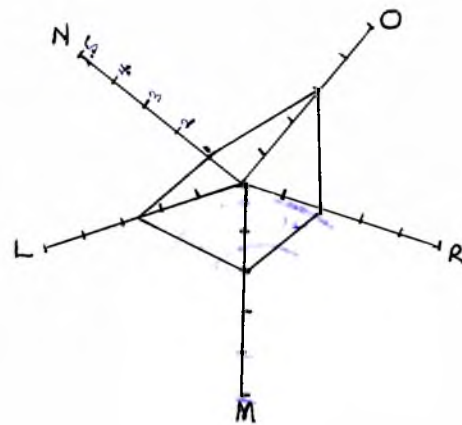


Fig.4 Lasia-Tuolu Subdistrict

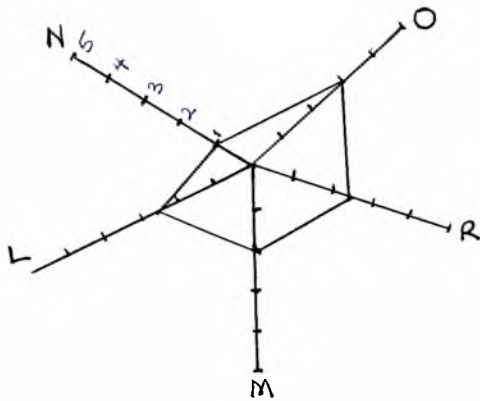


Fig. 5 Charia Subdistrict

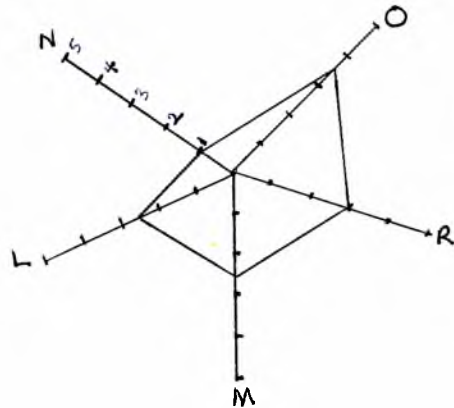


Fig. 6 Poyentanga Subdistrict

#### 4.4 Factors Influencing Community Participation in MCH/FP Programmes

1. The presence of community health structures - SDHMT, VHVs, CBDs, and TBAs. Another important group called the Community Based Rehabilitation group (CBRs) was identified in Poyentanga Subdistrict.
2. Relevance of MCH/FP programme to the communities. Most communities studied saw MCH/FP programmes very relevant. Some leading responses were:

We no longer have measles because of the immunization

- Our women used to have problems with pregnancies but now they don't

3. Absence of community conflict. With the exception of Lasia where there was mild chieftaincy problem all the communities were devoid of conflicts.

4. Willingness to attend meetings. Some community representatives walked over 20 kilometres to attend meeting. Some of these community representatives were TBAs who were over 60 years.
5. Financial support from DANIDA-HSSP especially in financing meetings was seen as a positive feature to enhance CP.
6. Most health professionals had good knowledge of their catchment area.
7. There was good relationship between the health professional and the communities.

#### 4.4.2 Factors which hinder CP.

##### A HEALTH SERVICE FACTORS

1. Health education contacts with communities was found to be inadequate. It was observed that a maximum of 30 minutes was used for Health Education.
2. Poor understanding of CP by health professionals. It was revealed that most of the health professionals did not understand CP as well as the extent to which they should involve the communities in their health care.

Leading responses were:

CP is community coming out to do something in common or together eg. Coming together to do communal labour.

We didn't know that we should plan with them (that is the community members)

3. Low degree of consultation of health programmes with the communities. That is when the health professionals identify any health problem (actual or potential), they rarely go to the communities to discuss with them.

4. There was an element of negative attitude of the health professionals towards the communities. Remarks such as “They (communities) are difficult”, “They would not pay”, “They are ignorant”, “They are illiterates” were very popular with the health professionals.
5. Some health professionals did not know the number of communities in their catchment area.

B. COMMUNITY FACTORS

1. Unwillingness of the communities to contribute financially.
2. Lack of support for the TBAs, VHVs and SDHMT members from the communities.
3. Absence of Village Health Committees in the communities. [The VHVs, TBAs, the SDHMT members, all work as individuals but not as a team]. There was also lack of Town Development Committees in most communities.
4. The presence of soothsayers and shrines. They serve as alternative health providers. Most communities especially in Holomuni and Lasia-Tuolu Sub-districts did not participate in health programmes. When they are sick they go to the soothsayers or the shrines.
5. Lack of communication between community leadership (SDHMT member) and the rest of the community was observed in some communities.

## 5.0 DISCUSSION AND CONCLUSIONS

The Wa District Health Administration set up a number of community health structures with the intention to get communities more involved/participating in health programmes in order to improve coverage and utilization. MCH/FP programme was found to be a better representative ( a proxy) for the programmes to be studied for the extent of community Participation, for reasons already explained in the introduction [cf 1.5].

Four subdistricts, with 8-10 communities selected from each subdistrict, were studied. The four subdistricts which were selected out of the 14 subdistricts by simple random sampling were: Charia, Holomuni, Lasia-Tuolu and Poyentanga.

### 5.1 Extent of CP

The extent of CP in MCH/FP programme was assessed based on the following five factors: Needs Assessment, Organization, Resource Mobilization, Management and Leadership.

The results of the study for all the subdistricts/communities revealed that the Needs Assessment was made by the health professionals. The District Health Management Team observed low coverage and utilization in health services and attributed them partly to low CP. In order to improve CP the DHMT wrote circulars to the subdistricts to set up community health structures which included Subdistrict Health Management Teams (SDHMTs), Village Health Volunteers (VHVs), Community Based Distributors (CBDs) of family planning contraceptives, and

Trained Traditional Birth Attendants (TBAs). There was no evidence of involvement of the community/subdistricts before these circulars were sent to the health professionals at the Level B Clinics to inform the Communities to set up these structures. It is therefore clear that a chance to involve the communities at this point was missed. Applying the ranking matrix [Cf 4.3.1] this was considered narrow for each subdistrict, and ranked 1 (for each subdistrict).

Concerning the ways which the communities had been mobilizing the resources it was found out that most of the communities in the four subdistricts spent a calculated amount of time to organize outreach centres and mobilize the people to utilize the MCH/FP services. However these volunteers (the VHVs, TBAs, CBDs, etc) were not supported in any way. Most TBAs for instance assisted delivery free of charge. They received no remuneration from the communities apart from sometimes receiving ₵1,000.00 -₵2000.00 from the husbands of the pregnant women. All financial decisions were made at the managerial or subdistrict level. The absence of a forum for a broader discussion prevented development of a financing system at the village level. MCH services were free of charge, however the communities paid for family planning services. All meetings were financed by the DHA. In addition to these general features the following specific characteristics were observed in each subdistrict.

1. Poyentanga Subdistrict had started generating a Communal Fund or Loan Scheme to support the helpless in time of need. Each community was to pay ₵10,000.00. At the time of the study only ₵59,250 (26.6%) of the money had been collected and the project was

yet to be fully implemented. The amount collected so far was kept by the health staff. The people were willing to participate in communal labour. So been the situation, CP was considered to be mean (fair), and ranked 3.0, but there is some evidence that it may become broader in the future through continuous health education in the communities.

2. Charia Subdistrict as already reported [cf 4.2.3] had also decided to established a Communal Fund or Loan Scheme. The idea was sold to the SDHMT/VHVs by the health professionals. The communities were however not willing to contribute. No money had been paid yet. Besides the SDHMT had levied each community an amount of ₵5,000 which would be used to pay half of the watchman's salary every month (i.e. ₵10,000 per month). Most of the people attended communal labour. This situation made CP to be seen between restricted and mean and was assigned a score of 2.5.
3. In Lasia-Tuolu Subdistrict the SDHMT decided to pay part of the watchman's salary. However the communities did not pay their contributions, and the idea had almost been abandoned. Response to communal work was fair. In addition to the general findings the CP was assessed as restricted, and ranked 2.
4. In Holomuni Subdistrict there was no financial contribution. It was also revealed that attendance to communal work especially in Holomuni village where the clinic was situated was very poor. Community organisation/mobilization was very good in some communities but very bad in other communities. Applying the ranking matrix this made CP to lie somewhere between narrow and restricted. It was assigned a score of 1.5.

On organizational issues the study looked at how the community members were selected to the afore-mentioned structures, and whether these structures were functional (active) or not [cf 3.1.2]. It was revealed that in all the subdistrict:

The communities were asked [by the health professional] to form separate structures - SDHMT members, VHVs, CBDs, TBAs - to promote CP.

Some of the community representatives were selected by the health professionals. Some were selected by the chiefs or assemblymen. Some of them for instance the chiefs and assemblymen were made automatic members based on the circular sent to the communities from the DHMT. There were also some of the community representatives who were selected by the entire community members.

Meetings for all these communities structures were financed by the District Health Administration (DHA). [Funds from DANIDA-HSSP]

Meetings were not held regularly, with the worst subdistrict being Holomuni Subdistrict.

The TBAs and VHVs were fairly active in all the subdistricts. However in the case of SDHMTs they were mildly active in Holomuni Subdistrict, fairly to fully active in the other subdistricts. Poyentanga Subdistrict had in advantage the presence of CBDs some of whom were very active. Based on these assessments the CP in Organisation of MCH/FP activities was scored as follows:

Poyentanga Subdistrict	3.5
Charia Subdistrict	3.0
Lasia-Tuolu Subdistrict	3.0

As far as management of MCH/FP programme was concerned it was observed that:

In all the subdistricts there was no involvement of the communities in planning MCH/FP activities as well as monitoring the CBDs and TBAs.

The TBAs played, active roles in delivery. For instance in 1997 out of the 37% coverage for supervised delivery, 22% was done by the TBAs.

During MCH/FP outreach programme the TBAs, VHVs and sometimes the SDHMT members played supportive role. For instance organising the venue and mobilising the people to utilize and services. Sometimes they were involved in the weighing and charting of the weights.

In Poyentanga Subdistrict the CBDs were actively involved in family planning services.

At the SDHMT, TBAs and VHVs meetings the performances indicators of MCH/FP services were evaluated. However since meetings had not been regular especially in Holomuni Subdistrict, CP at this stage might sometimes be nil.

Applying the ranking matrix this made CP to lie between restricted (small) and mean for Poyentanga Subdistrict, and was assigned a score of 2.5. For the other subdistricts CP was seen rather restricted, and each subdistrict was assigned a score of 2.0.

On the issue of leadership it was noted that:

Most of the SDHMT members and the VHVs were locally elected by the entire communities. However few of them were imposed on the communities by either the health professionals or the chiefs.

The SDHMT members were active at the subdistrict level. Most of them were inactive at the community level. They neither consulted their communities before meeting nor gave them feedback after meeting.

The composition of SDHMT by sex was found not to be representative. Apart from Poyentanga Subdistrict, the number of women in the SDHMTs were unacceptably low.

Almost all the communities were represented on the SDHMT in Charia and Lasia-Tuolu subdistrict. In Poyentanga subdistrict there were 40 communities and 23 (57.5%) of them were not represented on the SDHMT and indication that leadership was restricted.

In Holomuni Subdistrict the SDHMT was inactive, and as mentioned earlier [cf 4.2.5] the health professionals did not even know them.

This situation made CP to be seen restricted and assigned a score of 2.0 for Holomuni Subdistrict. CP in each of the other three subdistricts was seen to lie somewhere between restricted (small) and mean (fair), and was assigned a score of 2.5.

The overall assessment of how broad or narrow was the extent of CP in each of the four subdistrict was determined by the mean score for each subdistrict.

As presented in the Pentagram Model Holomuni subdistrict was found to lie

between narrow and restricted [the mean score was 1.8]. Charia and Lasia Tuolu subdistricts with mean scores of 2.2 and 2.1 respectively were found to lie more in the restricted domain. The extent of CP for Poyentanga subdistrict which was the widest of all the four subdistricts [with a mean score of 2.5] was seen to lie between small (restricted) and mean (fair).

All the “Pentagrams” show that the most strained area was on Needs Assessment. Management, Resource Mobilization and Leadership factors also were no better. The least strained area was on Organization. The study contradicts that of Swai 1993 which showed organization as the most strained. That study was done in Kpongu and Sing communities in Wa District. This study however confirmed that of Laleman and Annys (1989) which showed Needs Assessment as the most strained area and Organization as the least strained.

Even though the extent of CP in the subdistricts could best be described as either restricted (small) or between restricted and mean (fair) there were some positive features which if improved could broaden the extend of CP. The study also detected some negatively reinforcing factors which ought to be discarded in order to improve CP in Wa District. These factors which influence (either enhance or hinder) CP are discussed below.

## 5.2 Factors which Influence CP

The study revealed a number of factors (both health service and community factors) which enhance or hinder CP. These factors have been listed and some discussed in chapter 4. [cf 4.4.1 and 4.4.2]. Few of these factors will be highlighted here.

### 5.2.1 Health service factors

The study revealed that most of the health staff had adequate knowledge of their catchment area. They knew the number of communities in the catchment area, the size and the boundaries. This was considered as a positive feature because with this knowledge they (health professionals) could involve all the communities in their catchment area or subdistrict in any health programme, but not only a section of the communities. This finding confirmed that of Letsa et al 1992. There were some few health staff who did not have adequate knowledge of their catchment area and this was seen as a factor which could hinder CP.

Most of the communities saw the MCH/FP programme as relevant, even though some respondents were against family planning. Nevertheless, the fact that majority of the people now see the programme as relevant was counted as a positive feature to promote CP. Interestingly, MCH/FP coverage has started increasing and even though coverage was relatively low it was far better than in the eighties and early nineties when the communities saw the programme as irrelevant.

Low degree of consultation of health programmes with communities was also observed. However to promote CP there is the need for the health professionals to consult the communities frequently. The time aloted for health education in the

communities was also short (about 30 minutes per month in a community). To enhance CP there is the need to educate the people frequently especially the opinion leaders. Nevertheless the study revealed that these opinion leaders were not benefiting from the health education. In all the subdistricts studied the health professionals indicated that they gave health education to the communities during MCH/FP outreach or static programme. This invariably meant those people who did not attend MCH/FP services notably the opinion leaders who could promote CP, were not benefiting from health education programme.

Good relationship between the health professionals and the communities was also seen as a health service factor which could enhance CP.

#### **5.2.2. Community factors**

The existence of local organizations and/or groups (e.g. TBAs, SDHMT, CBDs, VHVs etc) were seen as strong supporting features which could enhance CP. Absence of community conflicts in most communities was another positive feature.

The study also revealed a few negatively reinforcing factors. These included unwillingness of the communities to contribute financially, and sometimes and labour, towards health development; poor quality leadership especially the SDHMT members in some communities; absence of team work at the community level; and the influence of soothsayers and fetish priests in some communities especially in Holomuni, Lasia-Tuolu and Charia subdistricts.

Most of these communities were not used to contributing to support social services such as health and education. Previously they were not doing that. It is a new thing to them now. Even though some of them were relatively poor, with

persistent sensitization through health education they (the communities) would be prepared to contribute their widow's mite towards health development.

The negative effect of the role of soothsayers and fetish priests on CP and health services utilization/coverage could not be underscored. In some communities most of the people went to the soothsayers and fetish-priest for their health needs or solutions to their health problems. Such people would not spend money, time and energy to participate in any health programmes.

### **5.3 Conclusions**

In conclusion, this research has been able to bring to light in pictorial form, the extent of CP in four studied subdistricts in Wa District. The extent of CP for these subdistrict were either restricted (small) or lied somewhere between restricted (small) and mean (fair). Since these subdistricts were representatives of all the subdistricts in the district it could be inferred that the extent of CP in Wa District was below mean. At best one could say that it was moving from restricted (small) towards mean (fair). There were however positive features identified which could improve CP in the near future but some reservations must be made because this also means that all the identified factors which hinder CP should be done away with.

Since the extent of CP was small (restricted) or lied between small and mean it could partly or fully account for the low coverage/utilization of MCH/FP services as well as other health services. However since only subjective and qualitative indicators were used no correlation could be established between small or poor CP and low coverage/utilization. Nevertheless, theoretically it is said that when played

according to the “laid-down rules” CP can improve coverage and utilization (Pappoe, 1993) and that low CP can lead to low coverage/utilization (Swai 1993).

The “Pentagram Model” applied to this study has been quite useful in eliciting the responses to the indicators of development of CP process. It is easy to handle provided the questions are well formulated to suit the programme or project. The ranking matrix, is equally easy to adjust to suit the programme or project to be assessed. This study supports the usefulness of the tool [The Pentagram Model] as reported by Rifkin et al (1988), Laleman G. et al (1989), Birchmann W (1989), Rifkin S.B (1991), and Swai (1993).

The results of the four subdistricts on the Pentagram suggest two things. One is an area where the professionals can have marked influence and this is on “Need Assessment (the MCH/FP package is always determined by health professionals) and Management” They can easily influence this by predetermining the sort of management and/or Needs Assessment they would like to have in a professionally induced programme such as MCH/FP.

From the Pentagrams these two areas that is Management and Needs Assessment were the most strained. The second thing which came up was on the other three remaining factors/indicators - the organization (of community structures), Resource Mobilization, and Leadership. These are the areas where the community can act more strongly than professionals.

The sustainability of the achievements of any health programme and their further development is expected to be by the community and for the community. Health professionals should see themselves as a resource to the community and not otherwise. The “Pentagram Model” seems to be having the ability to alert the health

professionals on their extent of yield towards the community. This suggests that the “Pentagram Model” might be a good tool for the managers of programmes/projects to weigh their influence against community’s influence on the development of the process of CP. The model might also be a good tool in predicting the outcome of a given programme/project.

Lastly, the “Pentagram Model” provides a common language for the different observers and makes it possible to pinpoint and describe the dynamics of this complex field (Community Participation). The criteria for scaling the different factors/indicators will most probably vary from programme to programme.

## CHAPTER SIX

### 6.0 RECOMMENDATIONS

To enhance CP in health programmes/projects the following recommendations are made to the various stakeholders.

#### 6.1 Director of Medical Services:

1. A standardized framework on the extent and/or level to which the public or communities should participate in health programmes/projects should be developed especially in areas of planning, implementation, monitoring/evaluation, and financial mobilization.
2. The Training Unit should develop modules on CP which must be used to train all health professionals especially those working at the community level to upgrade their knowledge.

#### 6.2 DANIDA HSSP

1. The level at which DANIDA-HSSP is financially supporting the meetings of these community structures (SDHMT, TBAs, etc) according to my findings, has been found to be useful and must be encourage
2. DANIDA should assist the Upper West Regional/District Health

Administration to give financial incentives or otherwise to these community health structures especially the TBAs to ensure sustainability. However with time the burden should be shifted to the communities themselves to support these structures.

### **6.3 Regional/District Health Management Teams**

1. There should be in-service training on CP for all health staff in the region in general, and in Wa District in particular.
2. In all programmes the communities should be actively involved in the Needs Assessment, Planning, Implementation, Monitoring/Evaluation, Organization and Resource Mobilization.
3. The RHMT and Wa DHMT should come out with an incentive package for the Community Structures (the TBAs, SDHMT, VHV's etc.). It was revealed from the study that some community members, well advanced in age (over 60 years), travelled over 20 kilometres on foot to attend meetings. [A TBA from Charia Subdistrict walks more than 60 kilometres.] It is envisaged that if these people are not motivated they will give up.
4. Two of the subdistricts, Poyentanga and Charia had started or at least were about to raise Community Fund or Loan Scheme to support the poor in the communities when they are sick. The DHMT should encourage these subdistricts as well as selling the idea to the other subdistrict. These communities must also be well educated on the government medical exemptions scheme.
5. The CBDs were found to be very useful in the communities, however on records they were found in Wa and Poyentanga subdistricts. The

DHMT should identify CBDs in the other subdistricts

6. The roles of SDHMT and VHV should be defined for them.
7. The composition of the SDHMTs was found to be unfair. There were few women on the teams, and some communities were not represented. The DHMT must make sure women are fairly represented on the team. It must also make sure the communities are fairly represented.
8. A strategic health education/IE&C Campaign or programme aiming at discouraging the communities especially those in Holomuni and Lasia-Tuolu subdistricts, from consulting sooth-sayers/shrines on health issues must be embarked upon.

#### **6.4 Level B Health Workers**

1. The time and frequency for health education or health talks during MCH/FP programme should be increased. The maximum of 30 minutes which was used at the time of the study was grossly inadequate.
2. Health education on the importance of family planning should be reinforced and all rumours/myths on the use of contraceptives should be dispelled.
3. Health education on MCH/FP should not be given to only the women who come to the outreach/static clinics, but also to the men especially the opinion leaders. By virtue of their domineering role they are the most important agents for change and also for community participation.
4. The study revealed an element of negative attitude of the health professionals towards the communities. Health professionals should

desist from making unhealthy remarks about the communities such as “They are difficult”, “They would not pay”, “They are illiterates” etc.

5. Health professionals should educate the communities on the need to contribute financially or otherwise to support health programmes.

#### **6.5 The Communities**

1. The communities should support the community health structures especially the TBAs.
2. The SDHMT members, VHVs, TBAs and CBDs must educate the rest of their community members on the need to contribute in cash or in kind to support health programmes.
3. The SDHMT members, etc should consult their communities before meeting, and provide them feedback after meetings.
4. The SDHMT members were found to be less active at the community level. They should improve their performance.

#### **6.6 Researchers**

1. The Upper West Regional/District research teams should conduct a study on health professionals perceptions on and attitudes towards CP.
2. Further investigations into the activities role of soothsayers on CP should be conducted.
3. The pentagram model has been found to be very useful. It should be used periodically to assess the extent of community participation in health programmes/projects.

**REFERENCES**

- Adams L. and Smiths J (1989) : Community Participation in Health Promotion, WHO Health Cities Project, London, England.
- Alirigia R. (1997) : Community Participation in Health - The Zurugelu Concept. Navrongo Research Centre, Navrongo.
- Amuah E. et al. (1990): Evaluation of the performance of community clinic attendants. Accra, Ghana.
- Annet. H and Rifkin, S.B. (1988): Improving urban health guidelines for rapid appraisal to assess Community Health needs. WHO/SHS/NHP/88.4 pp. 28.
- Askew. I.D. Planning and Implementing Community Participation in Health Programmes. In : Akhtar, R. (1991) : Health Care Patterns and Planning in Developing Countries. London, Greenwood Press pp. 3 18.
- Beausoleil, E.G et al (1978) : The Brong Ahafo Rural Integrated Development Programme (BARIDEP) : A Review of Three Years Experience. Kintampo, Ghana.
- Bichmann, W (1989) : Community Involvement in Nepal's Health System, Frankfurt pp 14.
- DANFA (1979) : Danfa Rural Health Project Ghana.
- GOG/UNICEF Survey Report 1993, Upper West Region.
- Goldsworthy, D (1988) : "Thinking Politically about Development" Development and Change Vol.19 pp.505-530.
- Griffiths. H (1974) April) : The Aims and Objectives of Community Development Community Development Journal, Vol.9 No.2 pp 89-95
- Krueger, R.A. (1988) : Focus Groups: A Practical Guide for Applied Research, Sage Publications, Beverly Hills, California.
- Laleman, G. et al (1989), Sept.) : Understanding Community Participation : A Health Programme in Phillipines, Health Policy Planning 4(3) : 251 - 256.
- Letsa, A. Y. et al (1992) : Factors Influencing Community Participation in Health Related Activities, MOH, Volta Region Ghana.
- Mair B. et al (1993) : Assessment of District Health System.
- McCracken, G. (1988) : The Long Interview. Sage Publications, Beverly Hills, California.

- MCH/FP Annual Report 1993. MOH, Accra Ghana.
- MCH/FP Annual Report 1995. MOH, Accra Ghana.
- MOH (1995) : Annual Report. Accra, Ghana.
- Novrongo Project (1994) : The Zurugelu Concept. Navrongo Research Centre Navrongo.
- Oakley, P (1988) : Conceptual Problem of Monitoring and Evaluation of qualitative objectives of rural development; *Community Development Journal*, Jan. 23(1) : 3 - 10.
- Oakley, P. (1989) : *Community Involvement in Health Development. An examination of the critical issues.* WHO, Geneva.
- Obeng-Quaidoo I (1991) : *Analysis of Qualitative Data : The African Context*, School of Communication Studies, University of Ghana.
- Pappoe, M.E. (1993) : *Household Participation in Health Development: Some Determining Factors*, McGill University, Montreal.
- Pilips. D.R. (1990) : *Health and Health Care in the Third World*, John Wiley and sons.
- Rabbow M. (1991) : *Role of Village Health Committees as a tool in Community Participation Based Health activities: A case study from Ghana [M.Sc. Thesis, Heidelberg University]*.
- Rifkin, Susan. B (1980) : *Readings in Health Development and Community Participation. Contact* . Special Series No.3 Geneva. Christian Medical Commission.
- Rifkin, S.B. (1983) : *Planners Approaches to Community Participation in Health Programmes: Theory and reality. Contact* Oct. [75]: 1 - 6
- Rifkin, S.B. (1990) : *Community Participation in Maternal and Child Health/Family Planning Programmes*, Geneva, WHO.
- Rifkin, S.B.; Muller F and Bichmann W (1988) : *Primary Health Care: On Measuring Participation. Social Science and Medicine*. 26(9) : 931 - 940.
- Rifkin. S.B.; Bichmann, W and Shresta, M (1989) : *Towards the Measurement of Community Participation. World Health Forum*. Vol.10 ; 467 - 472.
- Sterky, G (1980) : *Towards another Development in Health. Contact* Special Series No.3 pp 11 - 19 June.

- Swai, I.F.M. (1993) : Assessment of the extent of community participation in Health Programmes in Wa District, Upper West Region. Ghana.
- Upper West Region (1995) : 1994 MOH Annual Report, Wa.
- Wa DHA (1998) : District Profile. Wa, UWR.
- Watkins, S.J. (1989) : Health for All by the Year 2000, HFA 2000 News, Autumn No.9 Oldman, England pp 1.
- WHO (1978) : Report on the International Conference on Primary Health Care. Alma Ata USSR. Sept. 2 - 6 Health for all series No.1. Geneva, WHO
- WHO (1978) : Primary Health Care. A joint WHO/UNICEF Report. Geneva WHO.
- Winch et al (1992) : Effectiveness of Community Participation in Vector-borne disease in Latin America.

ANNEX 1 RIFKIN'S RANKING MATRIX. Sources: SWAI 1993, RIFKIN et al 1998.

INDICATOR	NARROW (NOTHING)	RESTRICTED (SMALL)	MEAN (FAIR)	OPEN (MUCH GOOD)	WIDE (VERY GOOD)
RESOURCE MOBILIZATION	Meagre resources raised by community. No fees for services. Committees do not decide on resource allocation	Paying for the services but committees do not control the use of collected money.	Periodical fund raising by the community but not controlling the expenditure	Periodical fund raising by the community. Committees control the use.	Considerable amount resources raised by or otherwise. Committees allocate the money collected
ORGANIZATION	Committees imposed by planners and are inactive.	Committees imposed by planners but mildly active	Committees imposed but became fully active.	Committees actively cooperating with other community organizations/groups	Existing community organizations involved in creating the committees.
NEEDS ASSESSMENT	Professionally identified. Committees, organizations imposed on community.	Dominating professional views. Community interests considered.	Community Health Leader (CHL) active representing community views and assesses needs.	Committees actively representing the communities and assess the needs.	Community members in general involved needs assessment

Contd.

INDICATOR	NARROW (NOTHING) +1	RESTRICTED (SMALL)	MEAN (FAIR)	OPEN (MUCH GOOD)	WIDE (VERY GOOD)
MANAGEMENT	Induced by health services, CHL. Supervised by health staff	CHL manages independently with some involvement of committees. Supervision only by health staff.	Committees self-managed without control of CHL's activities.	Committees self-managed and involved in supervision of CHL.	CHL responsible to committees and actively supervised by committees
LEADERSHIP	Wealth monitoring and health staff taking charge. (Imposed leaders/chair persons). No heterogeneous committees.	Committees not functioning but CHL works independent of Social interest groups.	Committees functioning under the leadership of an independent CHL.	Active committees taking initiative.	Committees fully represent variety of interests in community and control CHL's activities.

**GUIDE FOR LEVEL B. CLINIC WORKERS**

**BACKGROUND INFORMATION**

NAME: Mr/Mrs/Ms/Miss.....

RANK/STATUS:.....

STATION:.....

1. How did you arrive at the idea of:
  - I) Forming an SDHMT?.....
  - ii) Choosing VHVs?.....
  - iii) Training TBAs?.....
  
2. How were the selections done?
  - I) SDHMT members?.....
  - ii) VHVs?.....
  - iii) TBAs?.....
  
3. Are you assisted by the communities during MCH/FP
  - I) Outreach Services?
    - a) Yes, All Communities
    - b) Yes, Some Communities
    - c) No
  
  - ii) Static services?
    - a) Yes, All Communities
    - b) Yes, Some Communities
    - c) No [skip to Q]

4. Which people from the communities assist you? [probe SDHMT, VHF, CBDs, TBAs. etc].....
5. What kind of assistance do you receive from the communities?.....  
.....
6. Who plan for MCH/FP activities?.....  
.....
7. Are the communities involved in the planning? Yes/No
8. If Yes to Q7 how do you involve them?.....
9. At which meeting(s) do you discuss MCH/FP activities?.....
10. Do the communities come with suggestions? Yes/No
11. How often do you monitor/supervise
  - (a) TBAs activities?
  - (b) CBDs activities
12. Do you involve the community members? Yes/No
13. If yes to Q12 which category of people do you involve them?.....
14. What do you understand by community participation?.....
15. Are you satisfied with how the communities are participating in MCH/FP programmes? Yes/No
  - a) If Yes, give reason.....
  - b) If No, what do you think is lacking most?.....
16. Do you think community participation can work effectively in your sub-district?  
Yes/No.  
Give reason.....
17. Why are the communities not utilising MCH/FP services?

- I) ANC.....
- ii) Delivery.....
- iii) PNC.....
- iv) FIP.....
18. How can you motivate the community to help you improve MCH/FP coverage?  
Give suggestions.....
19. Name any category of people from the community you think can help you  
improve MCH/FP coverage?.....  
.....
20. How do you send message to a community concerning an impending MCH/FP  
outreach services?.....
21. How do you rate the performance of the following categories of people in  
supporting MCH/FP services? Rate them as:
1. Poor 2. Fair 3. Good 4. Very Good 5. Excellent
- I) SDHMT.....
- ii) TBAs.....
- iii) VHVs.....
- iv) CBDs.....
22. Do you carry out health education activities in communities separately?  
1. Yes 2. No [skip to Q24]
23. If Yes, how many times in 3 months?.....[END]
24. If health education is done alongside MCH/FP activities what time do you a lot for  
it each time?.....  
Is this enough? Yes/No.

## ANNEX 3

## KEY INFORMANT INTERVIEW GUIDE FOR

1. CHIEFS
  2. LANDLORDS
  3. WOMEN LEADERS
1. Do(es) the SDHMT member(s) from your community consult you/community before attending SHMT meetings?.....
  2. If yes how do(es) he/she/they do it?.....
  3. Do you/community receive feedback from him/her/they after SDHMT meeting?.....
  4. If yes, how is it done?.....
  5. How would you assess the performance of your SHMT members) ?.....  
Give reasons:.....
  6. Do you think he / she / they / is / are representative of the community ?.....
  7. How would you assess the performance of the VHV(s).....  
Give reasons : .....
  8. Do (es) the VHV(s) consult the community before VHV's meetings ? Yes /No
  9. Do you receive feedback from him / her / they after a meeting ? Yes / No
  10. If yes, how is it done ?.....
  11. How would you assess the performance of the TBA(s) in your community ?  
.....  
Give reasons : .....
  12. What support has the community been giving to the TBA(s) ?.....
  13. Do you meet in the community to discuss issues of MCH/FP programmes (ANC, PNC, F/P, CWC, IMMUNIZATION) ?  
  
If yes, what do you discuss about.....

And with whom ?.....

14. What part is the community supposed to play during MCH/FP outreach services ?.....  
.....

15. How relevance are these MCH/FP services to the community ?

a) Immunization.....  
.....

b) ANC.....  
.....  
.....

c) PNC.....  
.....

d) CWC (Growth Monitoring).....  
.....

e) F/P.....  
.....

16. What do you think is your role in promoting community participation in health activities?

.....  
.....  
.....

## ANNEX 4

IN-DEPTH INTERVIEW GUIDE FOR VILLAGE HEALTH VOLUNTEERS (VHVs)

Name:.....

- ..... 1. How were you selected as the villages Health volunteer (VHV)?.....  
.....
2. What made the community selected a VHV ?.....  
.....
3. How did you go about the selection of SDHMT members ?.....  
.....
4. How did you go about the selection of TABs for training ?.....  
.....
5. How do you organize VHVs meetings ?.....  
.....
6. Who organize the meeting ?.....
7. Who finances the meetings ?.....
8. [If community is not financing now]. Do you think community can finance your meetings ? Yes/No.  
Give reasons:.....  
.....
9. What are your functions as VHVs ?.....  
.....
10. What are the main issues you discuss at VHVs meetings?.....  
.....
11. Do you discuss issues of MCH/FP programmes (ANC, PNC, CWC, SHS.

IMMUNIZATION, etc) at your meetings ? Yes/No.

12. If yes, what roles are you supposed to play during MCH/FP outreach services ?.....  
.....  
.....

13. If NO, Why ?  
.....  
.....

14. Do you as the VHV feel part in decision taking at VHV meetings ? Yes / NO  
Why do you say so ?  
.....  
.....

15. What part do you play when health workers come to your community for MCH/FP outreach services ?  
[Explain].....  
.....

16. Do you consult your community before VHV meetings ? Yes NO  
If yes, how do you do it ?  
.....  
.....

If NO why ?  
.....

17. Do you give them feedback from meeting ? Yes ?NO  
If yes, how do you do it ?  
.....  
.....

If NO, why ?  
.....

18. Do you ever meet with the SDHMT member(s) and TBAs (s) in your community to discuss issues relating to MCH/FP activities ? Yes/NO

If        yes        how        often        do        you        meet        ?

.....  
.....  
.....

19. What are some of the problems you face in discharging your duty as VHV ?

.....  
.....  
.....  
.....  
.....

20. What do you think can be done to improve community participation in health activities in your community ?

.....  
.....  
.....  
.....

**ANNEX 5****FOCUS GROUP DISCUSSION GUIDE FOR SDHMT MEMBERS/TBAs****A. NEEDS ASSESSMENT**

1. HOW was the decision to train TBAs/ form SDHMT taken? What about VHVs and CBDs?
2. Were you (Communities) consulted for your opinions about the decisions to form these structures?

**B. ORGANIZATION**

3. How did you go about the selection of SDHMT members? TBAs for training? What about the VHVs and CBDs?
4. How do you organize SDHMT/TBAs meetings? Who organize the meetings [probe health professionals or community].
5. What are your roles as SDHMT/TBAs?

**C. MANAGEMENT (of MCH/FP Programmes)****(i) Planning**

Are you involved in the planning of are you involved?

**(ii) Implementation**

7. What roles do the community(ies) play during MCH/FP static/outreach programmes?

**(iii) Monitoring/Evaluation**

8. Are any of the community members involved in the supervision/monitoring of the activities of TBAs? CBDs?
9. Do you discuss achievements and constraints of MCH/FP programmes at your meetings?
10. Do you see MCH/FP programmes (ANC, PNC, CWC, Immunization, etc) as relevant to your community(ies)?  
If Yes, how? [Probe benefits of MCH/FP programmes]  
If No, why?

D. RESOURCE MOBILIZATION

11. Who finances your meetings? (If communities are not financing now) Do you think you (the communities) can finance your meetings?
12. Could you briefly discuss the ways in which the community(ies) is/are supporting and/or contributing to the health service.
- (Prob communal labour  
providing food etc to health workers  
mobilising community to utilize MCH/FP services  
etc.

E. LEADERSHIP

15. Do you consult your community(ies) before/after SDHM/TBAs meetings? Yes/No
16. What has been the relationship between you and the rest of the community(ies) (b) health workers?
17. What improvement changes in health have you brought since you became  
(a) an SDHMT member(s)?  
(b) a trained TBA(s)?

ANNEX 6

CHECKLIST

1. Sub-district  
.....
2. Catchment area
  - Number of communities.....
  - Number of outreach centres  
.....
  - Number of outreach services per month per community  
.....
3. Presence of TDC/VHC
  - Number of communities with TDC.....
  - Number of communities with VHC.....
4. Functional SDHMT, VHVs and TBAs

- Expected number of meetings/year			
- Number of meetings held			
1996			
1997			
1998			
Meeting place clinic outside clinic			
- Meeting held regularly (Yes / No)			
Minutes book available (Yes / No)			
Minutes recorded (All, None, Some)			
Composition			
Males			
Females			
Total			
Every community represented (Yes/NO)			

5. Number of communities without

- a) SDHMT member.....
- b) VHV.....
- c) Trained TBA.....

6. Attendance at meetings (last three meetings)

- a) SDHMT
  - Meeting 1 .....
  - Meeting 2 .....
  - Meeting 3 .....

(NIA = Information not available)

7. Functional CBDS

- Available of contraceptives  
(Very Good, Good Fair, Poor)
- Patronage:  
(Very Good, Good, Fair, Poor)

8. School Health/Life skills Teacher

Level of involvement in school health services.

- Planning (Yes / No)  
Specify.....
- .....
- Implementation (Yes / No)  
Specify.....
- .....