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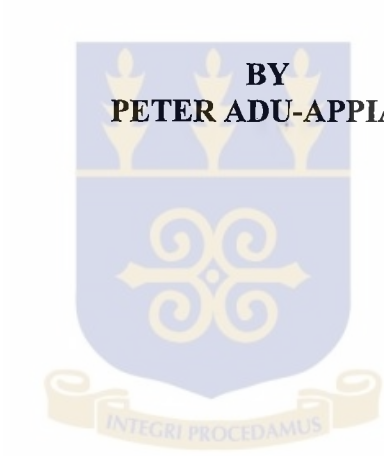
COMMUNITY PARTICIPATION IN THE PRIMARY HEALTH CARE PROGRAMME IN AKWAPIM NORTH DISTRICT, EASTERN REGION

BY
PETER ADU-APPIAH



THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF M. PHIL DEGREE IN GEOGRAPHY AND R ESOURCE DEVELOPMENT

JUNE, 2002

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DECLARATION

I, Peter Adu-Appiah, do hereby declare that this thesis consists entirely of my own work carried out in the Department of Geography and Resource Development under a joint supervision of Naa Professor J. S. Nabila and Dr. S. Agyei Mensah and that neither in part nor whole has this been presented for award of another degree elsewhere. All references are duly acknowledged.

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DEDICATION

This work is dedicated to my mother, Mary Agyei, and my late father, A.K. Nkrumah, who in spite of his deteriorating conditions of health continued to support and encourage me, which have contributed in no small way to bring me where I am today.

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The work could not have been possible without the full co-operation of the Budget and Treasury Division of Akwapim North District Assembly particularly the officer in charge, Mr. E. K. Adusei, Mr. Paul Bediako (S. T. O.—DC), Mrs. Kate Mensah, Senior Nursing Officer and Sampson Asante all in the District Health Management Team, Tetteh Quarshie Memorial Hospital (T. Q. M. H.)—Mampong. My sincere gratitude also goes to Mr. Quaye of Tetteh Quarshie Memorial Hospital who provided me all the necessary statistics and other information I needed to make this project successful.

My final appreciation goes to my parents Madam Mary Agyei and the late A. K. Nkrumah, my brothers and sisters especially Matilda Pinamang and Cecilia Pokuah Agyemang. God richly bless you all.

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ABSTRACT

This study is about community participation in the Primary Health Care programme in Akwapim North District. Twenty-four years have passed since Primary Health Care (PHC) was first introduced at the Alma-Ata conference. In 1985 the World Health Organization (WHO) completed a 'Review of PHC'. Such evaluations have shown that many of the problems of the PHC are concerned with the management of PHC. An analysis of some of the management problems shows that they are deep seated and requires a fundamental reappraisal of the existing systems.

Against this background, a study was undertaken to collect data in five communities in the District, and the extent to which the community is involved in the programme was examined. This was done with the conviction that improved community participation in the concept would go a long way to reduce incidence of diseases and also reduce the frequency of avoidable deaths in the study area. Social and cultural values of the people in Akwapim North District were taken into account in the study since any interventions based on established values and practices are more sustainable. The study looked at levels of community participation at both rural and relatively urban settings in the District.

Though participation in general in the study area was not encouraging apart from immunization programmes, it was worse among the rural dwellers. This was due mainly to the fact that many have not met PHC personnel before. It was discovered that the socio-economic status of respondents influences the degree of participation. It was also realized that intensive education about the PHC programme is required to enhance

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participation.

In conclusion, it can be said that community participation in the primary health care programme in Akwapim North District was not encouraging, therefore, if recommendations made in the study would be implemented, it will enhance participation at all levels in the programme and help ensure health for all.

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CHAPTER ONE

BACKGROUND OF THE STUDY

1.1 Introduction

Mortality levels in Sub-Saharan Africa are very high as compared to the rest of the world. Whereas levels range between 40 and 60 years in life expectancy at birth in Sub-Saharan Africa, it is over 70 years in the developed countries (World Population Data Sheet, 1994). In recent years, however, various governments have been making attempts to reduce the high morbidity and mortality patterns. These attempts call for strategies and actions in the health sector to be based on the concept of Primary Health Care (PHC). This has brought mortality decline in Sub-Saharan Africa in recent years. For example, under-five mortality rate has decreased from 120 per 1000 live births in 1970 (UN/WHO, 1999) to 69 per 1000 live births in 1995 (World Population Data Sheet, 1995).

In the past, the principal efforts of health practitioners have been directed at the treatment of infirmity rather than at its prevention. There are compelling reasons to believe, however, that this strategy will in the long run be a losing battle. Consequently, many workers in the general field of community health have argued that primary prevention, that is attempt to prevent infirmity and, therefore, to reduce the rate of occurrence of disorder in the population at large, is in the long run the only acceptable strategy that we have available to us. The purpose of these activities is to prevent the occurrence of ill health rather than to merely limit its duration once it has already occurred (Bloom, 1968).

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The role of PHC in international health is associated with the worldwide conference that was held at Alma-Ata and that proclaimed "Health for all by the Year 2000" (WHO/UNICEF, 1978). The participants at the conference proposed that the delivery of PHC should be made available to people throughout the world and that this care needed to be based on current technology and acceptable practical methods. It also proposed that members of communities needed to be involved in all aspects of the planning and implementation of health services.

This research seeks to find out the extent to which the community, which is the main beneficiary of the programme, is involved. It will also study the role of the health providers in the discharge of their duties to help ensure health for all. Moreover, the physical facilities such as hospitals, health centres, clinics and how well they are equipped would also be looked into.

1.2 Statement of the Problem

Half a century ago, the estimated infant mortality rate worldwide was 156 per 1000 live births, now it is 54 per 1000. Average life expectancy was about 46 years then; now it is 66. Smallpox was still called "the scourge of the human race"; now it is 20 years since the last person died of the disease. Paralysis from poliomyelitis was dreaded in both rich and poor countries; now the disease is close to being eradicated worldwide. The prospects are also good for eliminating leprosy, measles, neonatal tetanus and micronutrient deficiencies (Bryant et al/WHO, 1998, vol. 19. No. 1 p. 1).

Many other favourable contrasts of these kinds can be drawn, and one could say that for the world as a whole, human health has improved more during the last half century

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than in any other period we know about. This reflects the much wider process of economic and social development, but it is also the result of remarkable achievements in the health sector.

However, we should also look at some of the other changes that have occurred. During the same 50 years, the world's population has increased considerably, gaps between the rich and the poor have widened, a number of hitherto unknown lethal diseases have appeared and shown their capacity to spread with frightening rapidity, health hazards caused by environmental deterioration are increasing, the costs of heath care are spiraling, and the absolute number of people without access to the basic necessities for health is increasing, despite the continued increase in coverage with essential services. Formidable problems have been solved, but others have replaced them. With the emergence of HIV/AIDS, which has the capacity to wipe off human race on the face of the earth, if unchecked, there is the need to embark on vigorous measures to improve or protect the health status of people all over the world.

The Alma-Ata conference in 1978 was an important milestone in the struggle for health. The conference was organized in response to wide spread dissatisfaction with the existing health services. Despite great efforts by countries and the World Health Organization (WHO) in the late 1960s to improve and extend services, large numbers of people, particularly in the rural areas of developing countries, remain with no access to health care. Primary Health Care was seen as the route to health for all.

Primary Health Care as outlined at Alma-Ata calls for three developments; universal availability of essential health care to individuals, families, and population groups

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according to need; **involvement of communities in planning, delivery and evaluation of such care (community participation**—author's emphasis); and an active role for other sectors in health activities. Making essential care universally available calls for a more equitable and efficient use of health resources. The conference provided a green light for implementing primary health care concept, but passing resolution is one thing, implementing them is quite another. Very little has been done towards the attainment of the objectives set at the Alma-Ata conference since 1978.

Eight specific elements of PHC were identified at Alma-Ata. At the level of individual, the family and the community these eight elements must come together to constitute PHC. At the level of central bureaucracy each element exists in a separate government ministry. Hence, intersectoral collaboration is a key element of PHC. However, because of rigid compartmentalism in government ministries there has been more discussion than action outside the health sector (Ebrahim and Ranken, 1988). Hence, flexibility and adaptation in long established bureaucracies are essential. For an uninhibited development of PHC it may be necessary to take a careful look at existing organizations and structures, both within the administration and at the community level.

One basic element in the PHC is the full involvement of the community in all aspects in the discharge of PHC programmes. My personal experience in Asante Akim North District when I was attached to the PHC Unit at Agogo Hospital revealed that this aspect, that is, the involvement of the people, needs revolutionary measures to improve upon it. During this period, whenever some of my colleagues and I visited

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the people and talked about preventive health care, what we were usually told was "you little kids what do you know to tell me what is good for me" The people in the area were not willing to abandon their old ways of life, which could be disastrously detrimental to their health. A typical case in point is what is happening in Wassa Akyempem, a mining town near Tarkwa. A town of about 10,000 residents prefers to seek medical treatment from spiritual centres like "Nkaba" Gardens, fortune-tellers and malams. Their resort to unorthodox methods of healing has rendered a modern clinic built by Satellite Goldfields Limited (SGL) a white elephant. According to a medical assistant in charge of SGL clinic, Mr. Wilson Enyi Okpa, attendance is so poor that for three or four consecutive days, nobody from the community would report for treatment (Mirror, March 25 2000, p. 1). This study sought for solutions to these problems so that the people would accept and participate in the process of health delivery to ensure Health For All (HFA).

1.3 Literature Review

Review of the literature is divided into three main sections. These are the concept of the PHC programme as an alternative form of health delivery system; the community participatory approach to PHC; and the objectives of community participation. Each section is reviewed below.

1.3.1 The Concept of PHC

A great deal has been written about primary health care before and after the Alma-Ata Declaration in 1978. Almost all nations of the world were represented at the meeting and discussions ranged far and wide. The unanimity of the decision indicates that PHC is considered desirable and possible in all types of political, social, economic and cultural environments (Ebrahim and Ranken, 1988). A number of publications by

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the World Health Organization, in its series "Health For all", provides clarification on strategies, managerial processes, monitoring and evaluation. There has also been a wealth of literature in scientific journals and in the form of books. This is because the concept of PHC is more than a programme. It entails change. It requires changes in concepts and ways of thinking. Its implementation is a process that calls for wide-ranging changes in established systems and institutions as well as in communities.

The question of how to ensure the "Health For All People" and the ensuing debate during the 1970s and the appointment of Dr. Halfdan Mahler as the Director General of WHO in 1973 played a very active part in stimulating debate on these questions. It was during this period that the idea of Health "For All by the Year 2000" began to emerge as a suitable visionary goal, and that of primary health care as a realistic strategy for attaining it (Bryant et al/WHO, 1998, p.80-81). Initially, many regarded PHC as a rudimentary form of medical care, on a par with traditional healers, "barefoot doctors", and the like (Bryant et al/WHO, 1998). They saw it as suitable mainly for places in which no modern medicine was available.

Situations in some developed countries particularly, the United States seem to give credence to this assertion. As a WHO member nation, the United States has endorsed PHC as a strategy for achieving Health for all by the Year 2000. However, PHC with its emphasis on broad strategies, community participation, self-reliance, and a multidisciplinary health delivery team, is not the strategy for improving the health of the American people (Stanhope and Lancaster, 1984).

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However, experiences in four industrial countries with different socio-economic settings—Canada, Finland, Hungary and the Netherlands—are indicative of the relevance of the programme in the advanced countries (WHO, 1990, pp. 30-53; 98-132; and 188-201). A typical example is the striking reduction in mortality from ischaemic heart disease and injuries in Canada, which must be due at least in part to a reduction in risk factors as a consequence of preventive programmes (WHO, 1990).

The cost of health care is increasingly becoming more expensive. In 1994 for instance, Americans spent $982 billion, or nearly 14% of the gross domestic product (GDP), on health care (Shalala, 1994). This percentage is 40% higher than in Canada, the country that spends the next largest amount (Altman, 1995). This figure is expected to rise to 2.1 trillion or 20% of the GDP by the year 2003, if nothing is done to halt this course (Shalala, 1994). These increased costs have been accompanied by another significant problem, which is more pronounced in developing countries: poor access to health care. PHC plays important role here since it provides the most affordable health care available to all. Because of the concern to cost, access, and quality of health care, significant change is expected in the next decade. According to Stanhope and Lancaster (1996), several trends including demography, technology, and economics, will have an impact on the way these changes will evolve.

Bryant et al/WHO (1998) consider inadequacies in information systems, decision-making mechanism and other support systems as the areas that need attention for strengthening health care. They believe that "the concept of PHC is still not understood clearly enough"; and that scientific medicine—abetted powerfully by market forces—pushes on as if equity problem did not exist" (Bryant et al/WHO,

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1998, pp. 107-115). One could not agree more with them as far as information management in the health sector is concerned. Information must flow among various health institutions, which have common problems on hand. For instance, records of a patient transferred from one health centre to another must be sent to the receiving centre for purposes of continuity and an effective administration of the ailment. The means through which such information should be transferred should be cost effective and fast enough.

It has been argued that hospitals and PHC are different poles of the health care system, and that money spent on one means less for the other. Some people would prefer to enhance the position of PHC at the expense of hospitals. Others, who see hospitals as the repository of the best that medical care has to offer, believe they should not waste their time on other facets of health care (Bryant et al/WHO, 1998). At a meeting on the role of PHC, held in February 1997 in Gombe State, Nigeria, to reconcile these two points of view, PHC was seen as a key to attaining health for all, but hospitals must not be allowed to remain aloof.

The WHO's call for "Health for All by the Year 2000" heralds the greatest exercise in management by objectives undertaken on a global scale. Many countries have responded with national policies, statements of intent and plans for including PHC into the national planning process. According to Ebrahim and Ranken (1988), however, there has often been less success in the translation of these plans into actions, except in the case of a few countries and several pilot projects. Whereas the pilot projects have helped to evolve the basic technology of PHC and have provided a

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measure of the required administrative support, there has been less evidence of success in applying the system.

World Health Organization (1990) observes that finance has been a major problem, which hinders the development of PHC programme. Given that the proportion of government resources devoted to health in poor countries is already small and not deployed in the most cost-effective way, the challenge in some of these countries is to maintain the levels of development already reached. New sources of finance and improvement in the use of existing resources hold out the hope of gains in PHC without additional central government funding.

Those responsible for political and administrative decisions are often inadequately supplied with data in the health sector (Woelk and Moyo, 1995). Increasingly health management systems are being set up to make up for the deficiency. This is an institutionalized and systematized form of collecting, processing and presenting health information, with the aim of using the data for management, planning and decision-making. Another important area is the monitoring of disease, especially the tropical diseases with a high incidence rate such as Malaria (Kirton et al, 1992) and Tripanosomiasis (Sleeping Sickness) (Rogers and William, 1993). Geoinformation Systems (GIS), sometimes with the help of satellite data, are nearly always used for such complex subject material. Because of their analytical capabilities, these provide new scope for investigating mechanisms by which diseases are spread as well as their control (Mott et al, 1995). These systems, however, make very high demand on the qualifications of the user and the costs of installing a GIS are comparatively high

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(Bogarts, 1991). They are therefore, only of limited use in the daily routine of a developing country like Ghana.

The World Bank asserts that health is now considered as a basic component of human capital and, hence, an important basis for development (The Bank, 1986). This is very true for several reasons. For instance, improving the health status of women would not only free them from the danger of diseases, but it will also increase their capacity to participate in the economy. Also, as traditional support systems decline in influence and an increasing number of women come into contact with the modern health care system, the health sector becomes a major focus of activities for the promotion of values on breast-feeding, small family size and birth control.

A major portion of literature in health and population has concerned itself with measuring the health status of population. According to Barke and O'Hare (1986, p. 55), the simplest way of measuring the health service provision and, hence, the health status of a population is through the use of life expectancy. They notice that even though life expectancy in the less developed countries has increased by a dramatic 50% between the 1940s and the 1970s, it still remains far below that of the more developed countries. Life expectancy at birth is only 55 years, a reflection of the low health status of the population resulting from low availability of health service.

Many authors have tried to establish a relationship between the Gross National Product (G.N.P.) and health levels. Goldthorp (1993, p. 23) has found out that G. N. P. and health service provision are not everywhere related. He observes that in Sri Lanka, Cuba, China and Panama, the health levels and the level of health service

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provision are higher than incomes suggest while in the Middle East, the health levels are lower than suggested by incomes. He advances that in Sri Lanka, there exists an active health programme based on PHC while in the Middle East little has been done to improve on the health status among the majority of the people. Barke and O'Hare have also noticed that, Tanzania, one of the poorest countries in the world has achieved a greater health level than its G. N. P. suggests due to a vigorous programme of primary health care. Inasmuch as one would not find any difficulty accepting the findings of both Barke and O'Hare, and Goldthorp, one must not lose sight of the fact that, all things being equal, a country with higher G.N.P. relative to its total population (GNP per capita) will perform better in the area of health service provision, than a country with a smaller G.N.P per capita.

Other findings on health service provision have focused on the relationship between health care delivery and the social environment. In a study of Costa Rica using multiple regression analysis, Rosero (1988) finds out that the expansion of PHC accounted for 43% decline in infant mortality between 1972 and 1980 while increased secondary medical care accounted for 32% as against 25% for economic progress. Orugubole and Caldwell (1983) believe that mortality decline in rural Nigeria is not really a matter of overcoming ignorance but providing a sufficient density of health service of a reasonable calibre. Adeokun (1986) sees it in a slightly different way. He is of the opinion that mortality decline can only be achieved through increase in the number of medical doctors, massive public education, reduction of economic difficulties and the reduction of population growth. The two positions taken by Orugubole and Adeokun are necessary for total development of the health sector.

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It has been a priority of many governments in developing countries to provide access to medical care especially for children. This concern has led many governments to establish large public health care system that provides medical care free of charge (de Ferranti, 1985). The recent financial crisis in the Third World has induced many of these governments and international donor agencies to re-evaluate the policy of free access and to consider charging user fees for medical care. Proponents of this policy argue that revenue from it can be reinvested to improve allocative efficiency (de Ferranti, 1985; Jimenez, 1986). Opponents of this view argue that user fees will cause substantial reductions in medical care utilization especially among the poor (Cornea et al, 1987; Gilson, 1988). There is no doubt that health institutions need to be adequately equipped to meet the health needs of the people. However, questions are asked as to whether the revenue generated from user fees will go to improve the institutions with which it was intended for. There is also the question of affordability considering the generally low-income status of majority of the people especially in developing countries.

1.3.2 The Community Participatory Approach to PHC

The philosophy of community participation is not new in development circles. It made its way into International Development Assistance Thinking (IDAT) during the late 1960s and early 1970s (Cook and Donnelly-Roark, 1994). Some studies that evaluated the failure of the first two decades of International Development Assistance to eliminate world poverty suggested that the mere transfer of western models might not respond very well to the realities of life in the developing world. Participation in planning by the beneficiary communities was, therefore, recommended as a way of ensuring that projects serve the needs and priorities of the beneficiaries and also

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would be appropriate to their political and socio-cultural context (Huntington and Nelson, 1976; Chambers, 1983). Also a review of the Bank's financed projects in mid 1980s shows that failure to attend to social variables (through participation) in project design and implementation led to the failure to attain project aims and sustainability (Kottak, 1985).

The concern for popular participation in development in Africa is a recent development, and according to Cook and Donnelly-Roark (1994), it is the brainchild of NGOs. The NGOs took the initiative at the UN General Assembly in 1988, which led to the organization of the International Conference on Popular Participation in the Recovery and Development Progress in Africa, held in Arusha, Tanzania in 1990. The agencies, Government and Non-governmental Organizations at the conference adopted an "African Charter for Popular Participation in Development and Transformation" also known as the ARUSHA DECLARATION (Cook and Donnelly-Roark, 1994, p. 86). This charter, among other things, called for the establishment of new partnership with the people, ensures the involvement of women at all decision-making and protects people's basic human rights. The principle of popular participation in social and economic development programmes, including health development is now widely accepted. For about two decades now, the development community in Africa has moved away from top-down approaches towards more participatory bottom-up approaches. This is due to the recognition that participation is crucial if not the ultimate way to achieve both short-term development and long-term sustainability. In the same vein, health providers are beginning to appreciate the necessity for incorporating local participation into health care delivery system.

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Participation in development is said to be development to be achieved with the people and for the people. Brown and Wyckoff-Baird defined community participation broadly as "a continuum, from limited input into decision-making and control to extensive input into decision-making and ultimate stewardship of the resources" (Brown and Wyckoff-Baird, 1992, pp.43-52). At the level of specific policies and programmes, however, the concept is understood and interpreted in different ways and is very much influenced by political and socio-economic milieu. For instance, participation has been defined as "a way of factoring local behaviour and beneficiary assessments of risks, costs and benefits into project design...those assessments consist of rational economic decisions in the context of the social/cultural and economic environment, they are inclined to be misunderstood by, or better still the decision in question" (Cook and Donnelly-Roark, 1994, p. 85).

Paul (1987) portrays the controversy surrounding the definition of participation. He argues that, the definition of participation is a matter in which there is considerable disagreement among development scholars and practitioners. For certain activist groups, participation has no meaning unless the people involved have significant control over the decisions concerning the organization to which they belong. Development economists tend to define participation by the poor in terms of the equitable sharing of benefits of projects. Yet others view participation as an instrument to enhance the efficiency of projects or as the co-production of services. Some would regard participation as end in itself, whereas others see it as a means to achieve other goals. These diverse perspectives truly reflect the differences in the objectives for participation that might be advocated by different groups (Paul, 1987, p. 2).

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It appears there is no single definition for participation so long as the milieu of community participation varies. Perhaps what matters is whether there is unanimity or not academic work on participation must go on. In line with the research work going on in the midst of diversity, World Bank, in its in-depth study of twenty bank-support operations that are considered participatory, defined popular participation as a process by which people, especially disadvantaged people, influence decisions which affect them (World Bank, 1991a). Here the disadvantaged people refer not only to the absolute poor, but also to a broader range of people who are disadvantaged in terms of literacy, ethnicity, and gender among others. Also 'influence' as used implies more than mere involvement in project implementation or sharing in the project benefits. This definition is inciting and purposeful. However, the operating definition of community participation for this research is that by Paul as "an active process by which beneficiary/client groups influence the direction and execution of a development project with a view to enhancing their well being in terms of health, income, personal growth, self reliance or other values they cherish" (Paul, 1987, p. 3). This definition first of all implies that, the context of participation is the development/programme of which the Primary Health Care concept is no exception.

Secondly, the focus is on the 'active process' by which beneficiary communities/groups 'influence', rather than being influenced by government agency or non-governmental organization. The beneficiaries become the object and subject of development, which is the brain behind community participation.

Thirdly, the involvement of the beneficiary communities is not for mere sharing of project benefits or like the practice of democracy where 'participation is just by

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voting', but rather participate to ensure that their needs are reflected and they as well work towards its realization. However, health matters are highly specialized area, which requires considerable period of training to play any meaningful role in its delivery. In view of this community participation in the primary health care is highly restricted to functions, which are not highly technical and can be performed by some level of training. This notwithstanding, if a PHC programme is well designed and the roles to be performed well defined, popular participation would not be a problem even among people with little educational background.

Lastly, community participation refers to a process and not a product. It, therefore, presupposes that participation is an on going process and not static. It has feedback loops to ensure self-assessment to ensure realization and sustainability of the project. From the operational definition, it is worth cautioning that community participation in the project context should not be construed to mean that the nature and scope would be uniform in all cases. In defining community participation it is important to recognize that the community is self defined entity. Only those within the community know who belongs and who does not. Communities are made up of different stake holders that have a variety of defining characteristics, for example, gender, class, power, ethnicity, religion, age, etc. (BSP, 1993).

1.3.3 Objectives of Community Participation

Notwithstanding the variations in the nature and scope, community participation seeks to achieve one or more of the following objectives: empowerment, beneficiary capacity building, increase project effectiveness, improving efficiency and project cost sharing (Paul, 1987). These are discussed in turn:

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i Empowerment: According to Farrington et al, (1993), the shift in some branches of development theory during the 1980s away from the prescription of top-down approach, towards an alternative development model, has at its root a conception of empowerment as a form of social change brought about by local problem-solving technique acquired through participation. Development, therefore, should lead to an equitable sharing of power and to a higher level of people, in particular the weaker groups', political awareness and strengths. Any project or development activity is then a means of empowering people so that they are able to initiate actions on their own and thus influence the processes and outcomes of development.

Empowerment aspect of development is one that places emphasis on enhancing decision-making, autonomy, local self-reliance, direct (participatory) democracy, and experiential social learning. Its starting point is the locality, because civil society is most readily mobilized around local issues. In reality, empowerment would not be realized from top-down development approach either imposed from outside or our immediate leaders, rather it should be brought about through people's own involvement in development.

ii Capacity building: Another objective of community participation closely related to empowerment is building the capacity of beneficiaries with regards to decision-making. By capacity building we mean the efforts aimed at strengthening the skills and knowledge of the beneficiaries so that they could take on responsibilities for managing segments of the project themselves (Paul, 1987). Capacity building is believed to be the in-built mechanism to ensure sustainability of a project, especially foreign supported projects, after the withdrawal of the supporting agency concerned.

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In most cases beneficiary participation in especially monitoring and evaluation makes the project ongoing and self-sustaining (Cook and Donnely-Roark, 1994).

The ability to empower and build genuine capacity of beneficiary communities and untrained elected officials need ongoing skills upgrading, so that beneficiaries can manage local planning at all stages of the project cycle without continual donor support. In the words of Oakley "participation helps to break the mentality of dependence which characterizes much development work and as a result, promotes self-awareness and confidence and cause rural people to examine their problems and to think positively about solutions" (Oakley, 1991, p. 172).

Participation in essence, is concerned with human development and increase people's sense of control over issues, which affect their lives, help them to learn how to plan and implement and on a broader scale prepare them to participate at both regional and national levels of decision-making. In short, capacity building through participation ensures high likelihood of project sustainability.

iii Effectiveness: Community participation also has the power of increasing the effectiveness of the programmes as instruments of health promotion and rural development. Effectiveness refers to the degree to which a given objective is achieved.

In the view of Oakley (1991), many development projects, in the past, have not been effective in achieving their objectives because local participation has often been overlooked. Participation allows local people to have a voice in determining objectives, make their local knowledge and resources available, which contribute to

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better design, setting realistic objectives to meet the needs of the people and implementation after careful consideration of local constraints and for that matter project effectiveness.

iv. Efficiency: Participation is believed by many writers to have the power to ensure efficiency because of timely beneficiary input. Efficiency implies greater chance that available resource will be used judiciously. It expresses cost-benefit or input-output relationships (Paul, 1987). Participation minimizes misunderstanding, promotes interaction, agreement and cooperation and thus, time and energy spent by professionals explaining or convincing people of a project's benefits. It is also cost-effective since, if rural people are taking responsibility for a project, fewer costly external resources would be required and highly paid professional staff will not be tied down in the details of the project (Oakley, 1991).

v. Cost sharing: Community participation is also meant to ensure that beneficiary communities contribute in their own small way, either in the form of labour, cash or undertake project maintenance. This issue of cost sharing, in essence reduces the burden of the financiers while at the same time putting the sense of ownership in the beneficiaries It could also be taken to mean a way of preventing abuse and misuse.

vi. Sustainability. Oakley has argued strongly that an important aim of making participation part of a project is to ensure the sustainability of the project after the withdrawal of the development partners (Oakley, 1991). According to him, experience suggests that externally motivated development projects frequently fail to sustain themselves once the initial level of project support and input either diminish or are withdrawn. Participation is, therefore, seen as an antidote to this situation in that it can ensure that local people maintain the project's dynamics. Others including Haile

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(1980), have argued that participation ensures understanding of the project hence, their ability to extend the project even after the withdrawal of the initial funding.

1.4 The Objectives of the Study

The main objective of the study is to find out extent of people's participation in the Primary Health Care programme in Akwapim North District.

Specifically, the study seeks to achieve the following:

a) Assess the nature of the health delivery system under the PHC concept.

b) Investigate what factors influence participation in the programme and recommendations made to improve community participation.

c) Evaluate the effectiveness of the participatory approach to PHC programme.

1.5 Assumptions

i) Success of the PHC programme depends on community involvement or participation.

ii) Immunization is very necessary for child health.

1.6 Conceptual Framework

The framework for health promotion activities devised by Ewles and Simnett (1992) provides a useful model to help clarify the activities with which the health promoter may be involved. It is not the intention of Ewles and Simnett that the framework should be viewed as a rigid classification. Indeed they are at pains to point out that activities may not always fall neatly into the identified categories and that overlap will inevitably occur. They also stated clearly that the framework cannot encompass the entire gamut of activities and that some health promotion will occur both informally

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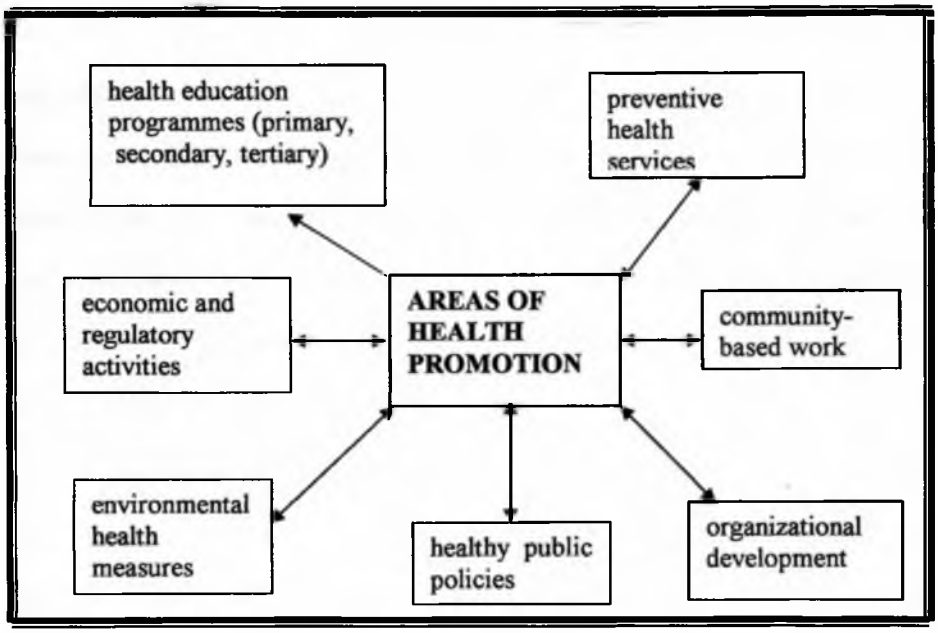
and accidentally. Of great importance, according to the authors, is that health promoters should be aware that health promotion embraces a wide range of activities. The framework comprises seven areas of health promotion activities as shown in figure 1.1, and is concerned with "planned, deliberate activities". Each of these seven areas will be considered individually and suggestions as to how such a framework can be applied to PHC as a strategy in promoting community health will be provided.

Figure 1.1: A Framework for Health Promotion Activities



Source: Ewles and Simnett (1992).

1.6.1 Health Education Programmes:

The majority of health promotion programmes fall into the category of primary health education, that is, education directed at "healthy" people. Example of such education includes general life style, healthy eating, fitness or exercise, sexual health, good hygiene and many more. However, it is unrealistic to expect that all members of the population will always be at an optimum state of health and strategies for both secondary and tertiary health education are required. For example, a community nurse

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may adopt the role of facilitator of a "sensible drinking group" set up specifically to help those for whom excessive consumption of alcohol has become a contributory factor towards their present state of ill health. Such practices can be replicated or incorporated into the operations of the PHC unit in the Akwapim North District.

1.6.2 Preventive Health Services:

A prime function of primary health care is the provision of preventive health services. A type of services offered is variable and depends on the size and nature of the communities as well as the philosophy of the PHC unit. But it is likely that the majority of PHC units provide both voluntary and statutory health screening and many offer immunization programmes. This aspect of the framework is one of the most frequent routines being carried out by Tetteh Quarshie Memorial Hospital in conjunction with the Ministry of Health, especially immunization/vaccination against childhood killer diseases.

1.6.3 Community-based Work:

The village level provides an opportunity for people to engage in self-help activities. Such activity is "community-led"; the communities identify their own health needs and actively participate in addressing them. An example could be a group of people who have concerns about their health and set up their own health related discussion group, facilitated by the community health nurse.

1.6.4 Organizational Development:

Recent years policy development in PHC has tended to focus on sexually transmitted diseases especially HIV/AIDS, nutritional and maternal and child health care, family planning, and immunization.

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1.6.5 Healthy Public Policy:

Community health nurses are well placed to influence management about policies that may affect the wider population, for example, policies aimed at improving and increasing facilities for immunization.

1.6.6 Environmental Health Measures:

In recent years environmental issues have been high on the agenda of PHC professional, not only in relation to improving physical conditions of the environment, but also in respect of the effect of working activities on the health and well-being of the community at large.

1.6.7 Economic and Regulatory Activities:

In about four decades ago, government legislation has attempted to provide safeguards in respect of ensuring sound delivery of health services in Ghana. The Food and Drugs Law, and the Private Hospitals and Maternity Homes Act (1958) were enacted to ensure that curricular and examination methods conform to professional standards. A regulatory body was to be established for the regulation of traditional and alternative medicine aimed at integrating services and based on registration of practitioners and associations at district, regional and national levels (MoH, 1996, p. 20). All said and done, cooperation is essential if legislation is to be successful as a measure of health protection.

It must be emphasized here that, the various health promotion areas are not treated in isolation by fragmented institutions and policies. They are linked in a complex nexus with the community. The model is, therefore, modified as shown in figure 1.2 to show how sustainable development of the PHC programme can be achieved through community participation. This new model is based on the idea that sustainable

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development cannot be achieved when programmes and policies leave out the beneficiaries. This implies that any programme that seeks to promote the health status of the people must involve the local people, whether government or non-governmental agency is implementing it. In this way, the model argues that participation will ensure sustainable primary health care, which will lead to sustainable development in health, that is, health development that meets the needs of the present generation without compromising the ability of future generations to meet their own health needs.

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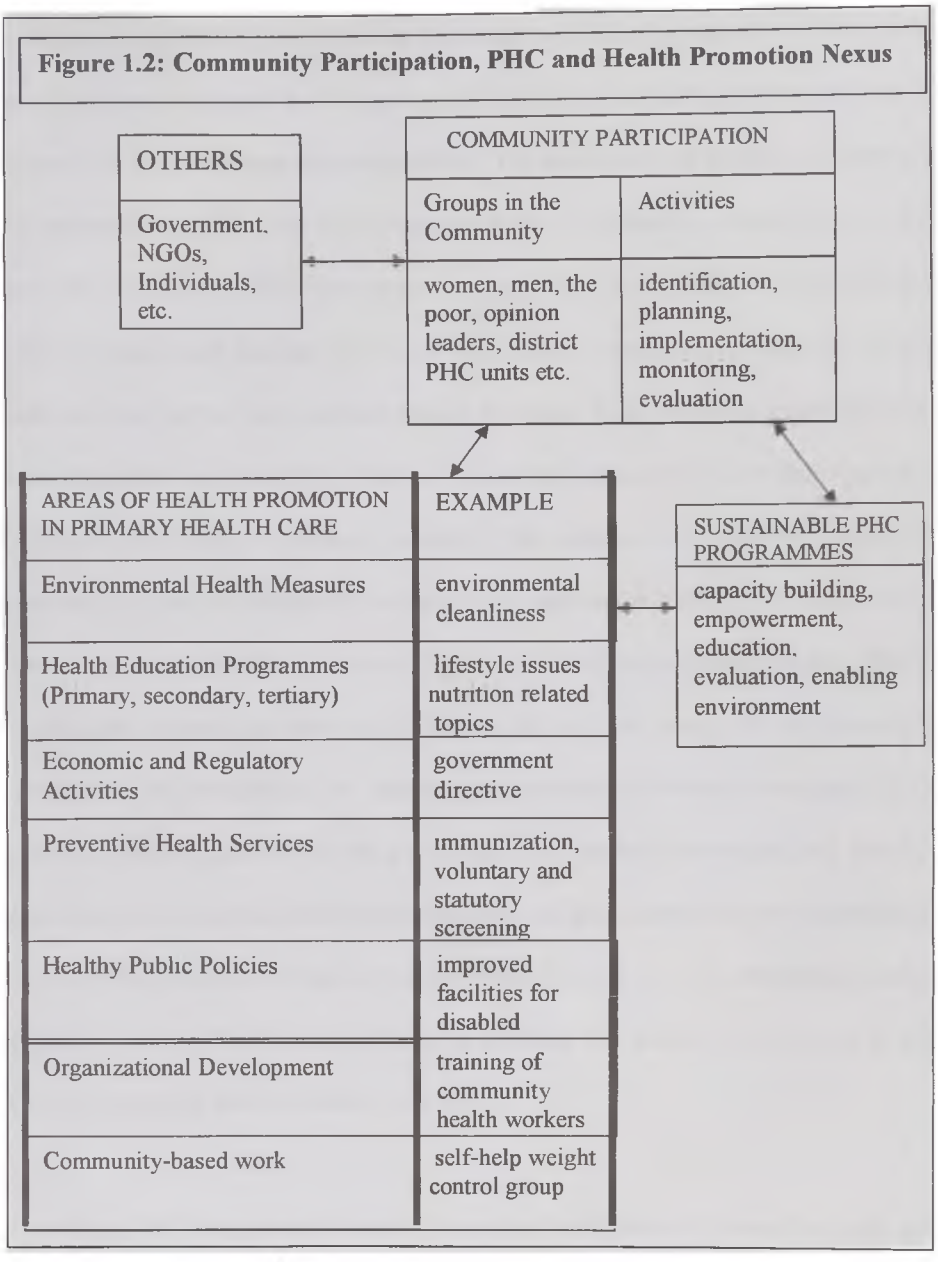
Figure 1.2: Community Participation, PHC and Health Promotion Nexus



Source: Adapted from Ewles and Simnett (1992).

For the PHC programme in the district to flourish for the benefit of the people and to ensure its sustainability there is the need to rope in all stakeholders—the communities, medical personnel, government and non-governmental agencies. The people in the community must be empowered to build the necessary capacity to take

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up certain aspects of the programme in the structure of the programme or if it happens that a programme initiated by foreign agency left it the host community could step in and continue so as to ensure its sustainability. The seven areas of health promotion are very relevant to the Districts PHC programme for the following reasons. In the first place, the District is predominantly rural except some few towns, which are dotted along the main road linking Accra and Koforidua. Consequently, majority of the people are not served with modern health facilities. It is, therefore, important that health education and preventive health services are intensified to obviate imminent catastrophic outbreak of diseases. Secondly, the existence of Centre for Scientific Research into Plant Medicine in the district will facilitate adoption of the fourth item in the Areas of Health Promotion in figure 1.2 which is captioned Healthy Public Policies and especially when the clarion call at this stage of the country's development is availability of alternative medicine in herbal medicine. In a community where majority of the people are not gainfully employed and for that matter poor, the important role herbal medicine can play cannot be over emphasized. It is, therefore, imperative that conscious effort is made towards integrating herbal medicine into any health policy design to improve the status to the people in the district in particular and the country as a whole.

In summary, the framework for health promotion activities can be used to guide the health-promotion work of a practising community health nurse and is a useful reminder that such work covers a broad range of activities. But as well as recognizing the areas of health-promotion activities, community nurses need to acquire and develop skills and abilities which will enable them to put their knowledge of health promotion into practice.

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1.7 Methodology

1.7.1 Sources of Data

The study drew on two main sources of data—Secondary and Primary. Secondary data comprised published and unpublished sources. A greater part of the information was obtained from World Health Organization (WHO) magazines, World Health Forum series, Internet and United Nations Children Fund (UNICEF) publications. In addition, information from the World Bank publications, Akwapim North District Administration and Tetteh Quarshie Memorial Hospital was also used.

The primary data was collected from some selected communities in Akwapim North District. The choice of the district is based on the fact that it is one of the numerous districts in Ghana where Primary Health Care programme is vigorously being pursued. Also, the district is one of the areas in Ghana where income level is low because the area is neither industrial nor agricultural. Based on these, the District was chosen since the PHC programme is largely geared towards improving the health of the underprivileged in society.

1.7.2 Methods of Data Collection

The study employed a wide range of research techniques. A questionnaire designed on the basis of the outlined objectives was administered in some towns and villages to collect information on the programme's outset and design, funding and implementation, management and maintenance and more importantly, the communities' involvement in the primary health care programme.

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The selected towns and villages are Akropong, Mampong, Tinkong, Kurutuase, and Asempaneye. Stratified sampling technique was used in the selection of towns and villages. All settlements in the District were divided into three categories based on total populations. The first category consists of settlements with population between one and five hundred people, which is mainly rural. The second category is settlements of between 501 and 2000 people which is the intermediate between the rural and urban settings. The final category consists of settlements of over 2000 people, which is relatively urban in outlook. This was done to enhance comparisons of the rural and urban settings as far as involvement in the PHC programmes is concerned.

Akropong was chosen as a sample town because it is the largest settlement in the District in terms of population size besides it being the capital of the District. Mampong was also chosen due to the fact that it houses the only hospital in the District and also the second largest town in the District. Kurutuase and Asempaneye (first category) and Tinkong (second category) were selected randomly through lottery technique. In this instance, all villages with population between one and five hundred were numbered and folded and randomly picked. The same procedure was applied to settlement with population of between 501 and 2000.

Two sets of questionnaire were also designed after a reconnaissance visit to the area in November 2000 and later administered in March 2001. Additional information was gathered in May 2001 to supplement what was gathered earlier on. In all 100 houses were visited in five selected towns and villages in the district. Two persons were selected from each house and whoever was selected must be more than 15 years

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especially those in the reproductive age group. Table 1.1 shows the design for selection of houses.

Table 1.1: Design for Selection of Houses for Questionnaire Interview at the Sampled Towns and Villages.

Town/village	Total Number of Houses	No. of Houses Selected
Akropong	2282	30
Mampong	1509	28
Tinkong	137	18
Kurutuase	32	14
Asempaneye	28	10
Total	3988	100

Source: Author's construct, 2001.

In the sampled towns and villages, systematic random technique was used to select houses. Depending on the size of the town or village, houses were selected in an orderly manner. For example, in Mampong a relatively bigger town, every tenth house as against a fourth in Asempaneye, a smaller village, was selected starting from a specific point in space. In each of the towns or villages selected, attempt was made using the housing units to divide respondents into the relatively rich and poor. The total number of houses selected in each town or village was not proportional to the number of houses in that town or village. This is because this study focuses more on rural people who are generally the poor and underprivileged and cannot, therefore, most often afford costs of hospital-based health care. Sampled villages have proportionately higher sample size than the towns. A total of 200 respondents were selected from all the selected towns and villages. Ninety percent of the respondents

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were women while the remaining 10% were men. These percentages were chosen on the premise that it is usually women who are mostly in charge of health issues in a family and who attend to hospital for family planning, nutrition and maternal and child health education among others.

The questionnaire consisted of variety of closed and open-ended questions asked in the commonly spoken Twi language. Most questions were open-ended in which interviewees were asked to give reasons, opinions or comments. The close-ended questions demanded 'Yes or No' answers. Some of the questions to the people in the community were: Do the people in the community take part in the PHC programmes? If yes what aspects of the programme are the people involved in? How many children do you have? Have you immunized them against the major childhood killer diseases? If yes, do you see immunization of children as necessary for sound child health, etc. Table 1.2 shows the sampled towns and villages.

Table 1.2: Design of Selected Towns and Villages for Questionnaire Interview.

TOWNS/VILLAGES	TOTAL POPULATION (2000 Census figures)	SAMPLE SIZE	
		MALE	FEMALE
Akropong	9974	6	54
Mampong	9152	5	51
Tinkong	1229	4	33
Kurutuase	176	3	25
Asempaneye	108	2	17
Total	20639	20	180

Source: Author's construct, 2001.

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All the selected houses were covered. In a situation where all the house members present were not of the right age, the house is revisited until all the potential interviewees were covered. In a situation where there were a large number of people who qualify to be interviewed, the first two to have contact with were interviewed but others normally joined in the discussion to give some vital information, which were often recorded on a tape. In addition, personal in-depth interviews were organized for some opinion leaders, assemblymen, health officials, and NGOs, who have something to do with the PHC programme in the district. About 30 patients or those who brought their sick relatives to health institutions for medical care were interviewed.

Participant observation method of data collection was also applied. Here, on three occasions, the author accompanied the PHC unit personnel in Mampong to embark on their periodic outreach programmes in Osubeto, Odwobi and Awoyekrom. These outreach programmes helped me acquaint myself with the actual work on the ground and to have a deeper appreciation as far as primary health care programme is concerned.

One other mode of data collection, which was extensively utilized, is Focus Group Discussion (FGD). The focus group discussions covered the District Health Management Team (DHMT) in Mampong Tetteh Quarshie Memorial Hospital, Women and Men's groups in the five sampled towns and villages selected. In all an average of nine people were involved in each discussion and lasted averagely about 49 minutes. Two assistants were employed to play the roles of a moderator and a note-taker respectively while the author acted as a supervisor and making sure the

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tape recorder functioned properly and also to make sure conducive atmosphere was created for uninterrupted flow of discussions.

1.7.3 Methods of Analysis

Analysis of the data was done using both qualitative and quantitative approaches but more emphasis was placed on qualitative analysis. Quantitatively, elementary tools of statistical description such as distributions, percentages, averages, and measure of dispersion, supplemented by suitable diagrams were used. Also, descriptive analysis using what other countries, particularly Nicaragua and Gambia, have done in their attempt to utilize the strategy of primary health care to improve health delivery was used.

1.8 Rationale of the Study

Health is very important for development, and poor health has been identified as one of the greatest obstacles to development in the Third World. Ill health consumes the scarce financial resources of most Third World countries and reduces the availability and productivity of labour (Barke and O'Hare, 1986). It is, therefore, important that health of people must be safeguarded always.

The rationale for investigating community participation in the PHC programme is basically due to the fact that, hardly do we find a systematic study on the response of community to the PHC programme in Ghana, notwithstanding the concept's immense potential as a readily accessible and affordable means of disease control and prevention. My personal experience during post Advance Level National Service as a PHC facilitator also stimulated the urge to conduct this research to find solutions to

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these teething problems. The principle of "go to the people, learn from them, and start from what they know" is as valid in the field of health as in any other field of development. Past experience, for instance, in India has shown clearly that little can be achieved unless the community identifies with a programme and can recognize its benefits for itself.

Community participation is one of the cardinal principles of achieving the objectives of primary health care concept. It may perhaps be universally acknowledged as the cornerstone of sustainable health programmes. Community participation may also be seen as the key to utilization of available health care services. It has often been emphasized that community participation/involvement in health care should fully comprise all disciplines of development process e.g. needs assessment, priority settings, planning/strategy development, resource mobilization, project development, implementation and utilization, and monitoring and evaluation. Discussions with health managers and service providers have, however, revealed very little community involvement in above areas. The discussions have shown that community involvement/participation in health programmes, occurs mostly in areas like:

i. Contributions through development levy.

ii. Communal labour.

iii. Utilization of available service.

Health workers often complain of poor community participation when they are referring to:

a) Low attendance of Maternal and Child Health clinics/immunization programmes.

b) Low out-patients attendance.

c) Low attendance of nutrition rehabilitation centres etc.

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Community participation as envisaged and planted in the principles of PHC has not been nurtured to mature. It is against this backdrop that the major constraints to effective community participation were studied. Such studies facilitate a more meaningful community involvement/participation and promote the health and well being of the people.

1.9 The Study Area

The study was carried out in Akwapim North District, which is one of the 15 districts in the Eastern Region of Ghana (see figure 1.3). The District lies approximately between latitudes 6° 08[I] and 5° 52[I] north of the equator and between longitudes 0° 19[I] and 0° 01[I] west of the Greenwich Meridian. The District is bounded by five districts. These are Akwapim South in the southwest, Suhum Kraboa Coaltal in the east, New Juaben in northwest, Yilo Krobo in northeast and Dangbe West in the south. The dominant physical features in the District are ridges called Akwapim Ridge, and valley, which make the topography of the land highly undulating. The relatively high scarps in the District make it one of the coolest areas in the country.

Administratively, Akropong is the capital of the District and it is approximately 64 kilometers from Accra, the nation's capital and lies northwest of it. In terms of health delivery, Mampong can be said to be the capital of the District since it houses the only hospital in the District where the DHMT is also located. The District has a total population of 108,638 and two constituencies, namely: Okere and Akwapim North. There are three main ethnic groups These are Twi, Guan and Okere (Kyerepon) speakers. However, there are other minority groups such as the Gas, the Ewes, and Northerners.

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A visitor's first impression of the District is one of relative prosperity especially in towns like Mampong, Mamfe and Akropong, the district capital. The District is a mountainous region with orderly arrangement of valleys, hills and plains. History has it that the Akuapems were largely farmers who used their land in the past for the growing of oil palm, food crops such as plantain, cocoyam, corn etc. According to available account, in the latter half of the 19th century, when cocoa was first introduced in the Akuapem area, the palm oil industry was losing popularity and the farmers rushed into new cocoa industry to take advantage of its higher profit.

The resultant clearance of the forests for cocoa cultivation exposed the soil to weather vagaries. Consequently, cocoa tree lost its great economic importance in the whole of Akuapem state. This set in motion large movement of people in search of favourable lands elsewhere for cocoa cultivation. This has stifled the growth of population in this district as the district is at the moment neither industrialized nor commercialized rural economy.

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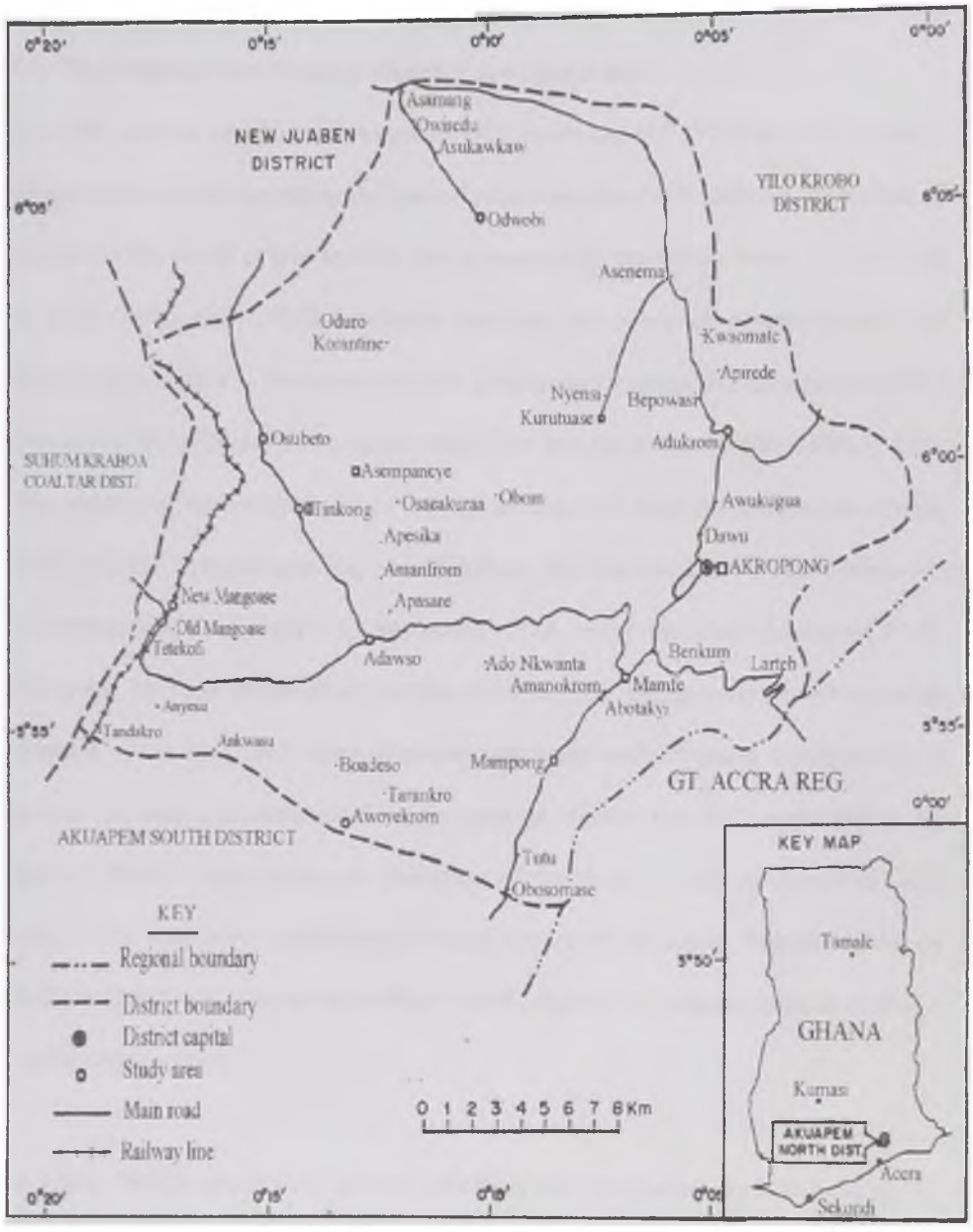
Figure 1.3: Map of the Study Area

MAP OF AKWAPIM NORTH DISTRICT SHOWING SOME TOWNS AND VILLAGES



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CHAPTER TWO

THE CONCEPT OF PRIMARY HEALTH CARE

2.1 The Origin of the Primary Health Care Programme

The PHC movement officially began in 1977 when the 30th WHO Health Assembly adopted a resolution accepting the goal of attaining a level of health that permitted all citizens of the world to live socially and economically productive lives. At Alma-Ata in 1978, WHO and UNICEF together endorsed the policy of community-oriented primary care (COPC). However, the idea girding and framing this approach had first been given full expression in practice some four decades earlier (WHO, 1999, p. 436). The locale was the southern tip of Africa, far removed from the intellectual driving forces of the English-speaking world before the Second World War. Alma-Ata conference was held from 6-12 September 1978, under the chairmanship of B. V. Petrovsky, Minister of Health of the then Soviet Union. Delegates from 134 countries attended. Of course, there were dissenting voices as well, stressing the absurdity of aiming for such a patently unachievable goal as "Health For All", especially in the light of WHO's own maximaist definition of health as "a state of complete well-being" This resolution, nonetheless, became known by the slogan "Health For All by the Year 2000" and captured the official health target for all member nations of World Health Organization.

In 1981, WHO established global indicators for monitoring and evaluating the achievements of Health For All by the Year 2000 target. In WHO (1986) these indicators are grouped into four categories: health policies; social and economic development; provision of health facilities; and health status. An important part of the global indicators is the emphasis on health as an objective of socio-economic

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development (Mahler, 1981). In this context, health improvements are a result of efforts in many areas including agriculture, industries, education, housing, communications, and health care. Because PHC is a much political statement as a system of care, each United Nations member country interprets PHC in the context of its own culture, health needs, resources, and system of government.

Although the original definition of PHC has at times been misunderstood, it is important to understand the Alma-Ata declaration as the basis for PHC and the global evolvement of this strategy over the past 10 to 15 years. For instance, as a WHO member nation, the United States has endorsed PHC as a strategy for achieving the goal of health for all by the year 2000. However, PHC, with it emphasis on broad strategies, community participation, self-reliance, and a multidisciplinary health care delivery team, is not the primary strategy for improving the health of the American people (Stanhope, 1996). The national health plan focuses more on disease prevention and health promotion in the areas of most concern in the nation.

Since the Alma-Ata conference, the outgrowth and interest in world health and how best to attain it, have been tremendous. This interest is reflected in a growing need among people around the world to know and understand the issues and concerns that affect health on a global basis. This is important in the light of the fact that many countries have not yet experienced the technological growth in their health care systems that has been realized by more developmentally advanced countries such as the United States.

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2.2 The Primary Health Care System in General

Primary Health Care is generally defined as essential care based on practical, scientifically sound and socially accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1978). It includes comprehensive range of services as public health, prevention and diagnostic, therapeutic, and rehabilitation services. Full participation means that individuals within the community help in defining health problems and developing approaches to address the problems. The setting of PHC is within all communities of a country and permeates all aspects of society. PHC encourages self-care and self-management in health and social welfare aspect of daily life. People are educated to use their knowledge, attitudes, and skills in activities that improve health for themselves, their families and their neighbours. The desired outcome from the PHC strategy is the individual, family and community self-reliance and competence.

A PHC system is organized in such a way that the care gradient rises from the village level up to the national level. Operated efficiently, the PHC system will make available, through its referral system, highly specialized care to any villager who requires it. The most peripheral level of care will carry out simple functions, which are within the competence of the peripheral health worker. The various levels are briefly explained below:

The Village Health Post: The simplest health facility is the village health post. The health post may be the home of the village health worker or a room in the house of the village head. It could be a structure built by the villagers and operated by the village

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health worker who may be the trained traditional birth attendant, healer, or the local peasant farmer. The health post offers elementary health care to the villagers who may number from 100 to 4000. The village health worker's responsibilities depend on the health needs of the community, on his orientation, the specific tasks assigned to him to perform such tasks. These tasks may include the administration of prophylaxis against specific diseases such as malaria, vector control, control of communicable diseases, maternal and child health, food hygiene and nutrition assessment of children aged 1-5 years, environmental sanitation with emphasis on the teaching of hygienic methods of disposing of human and domestic wastes, the diagnosis and standard treatment of specific minor ailments, health education, follow-up care, and the administration of routine medications to patients with chronic ailments such as leprosy and tuberculosis. The recognition of patients with conditions, and their referral to the next higher level of service and record keeping, are important functions of the village health worker.

The Health Centre: This is usually a health unit of the Ministry of Health. There is an increase in personal and community preventive health activities and more intensive health education activities. A health centre gives a wider health care coverage to a larger population often ranging between 20,000 and 80,000, depending on the population density of the areas served by the centre. Some health centres have mobile clinics attached to them which use itinerant health workers in the villages for which the health centre is responsible to carry out maternal and child health and communicable disease programmes.

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The composition of the staff of a health centre is more varied and reflects the extent of the services carried out in the health centre. The staff may comprise all, or a combination of the following; namely a medical officer who may either be a permanent staff member or as a consultant who visits the health centre on a regular basis.

The services offered in a health centre should include all the activities which a family would require for health promotion and health maintenance, for the care and cure of any ill health which does not require prolonged hospitalization and for necessary rehabilitation. The health centre works in close collaboration with the district hospital. In some administrations the medical officer in charge of the district hospital is also in charge of the health centre. The health centre may then depend on the district hospital for logistic support and medical and other supplies. Patients are referred from health centre to the district hospital.

The District Hospital: This unit gives relatively more comprehensive medical and health coverage to a larger population than the health centre and its staff include medical officers, nurses, medical assistants, midwives, public health technicians, laboratory technicians, drivers and other such paramedical personnel as in the health centre. Health posts, health centres and the district hospital comprise the network of PHC in the rural area. There are general hospitals' outpatients departments and comprehensive health centres in large towns, which, because they are the first point of contact to town dwellers, will also be giving primary health care to these people. Patients from a district hospital are referred for more advanced health care to general

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or specialist hospitals such as paediatrics, orthopaedic or psychiatric hospitals and from any of these when necessary to a university teaching hospital.

The need for a clearly defined chain of referral is critical to effective health care. It is essential to have a good and sufficient communication system between the staff at the point from where the patient is referred and the staff at the point to which the patients is referred. At the completion of treatment the patient should be returned to the unit from where he was referred, to enable him to continue his treatment and his rehabilitation. This is vital for continuity of care but it is an area, which is sadly neglected by many health institutions in the developing countries.

The PHC workforce comprises a multidisciplinary team of health care providers. Team members include many professionals such as generalist and public health physicians, nurses, dentists, pharmacists, optometrists, nutritionists, community outreach workers, mental health counselors, and other allied health professionals. Community members are also considered important to the team.

Central to the concept of PHC is that individuals, families, and communities take the major responsibility for their own health. The roles of the health professionals and health systems are to assist and support this process. The implications of this concept are serious for a health system, which has monopolized health care. New roles are now being demanded of health professionals and institutions. Their functions must change from being providers of health services to enablers.

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Enabling skills and methods are not widely understood and taught within the present health systems. Methods and techniques of working with communities have much in common with those working in large organization, even though the way in which they are applied would vary greatly from place to place. PHC asks for a bottom-up approach for setting targets and identifying needs. They in turn determine top-down actions and decisions. In other words, health systems and related organizations need to set their objectives and determine their activities in relation to those expressed by the communities in which they serve. Such working style calls for a continuing process of dialogue, popular consultation, organizational adaptation and change.

Recognizing that there would be differences among countries with respect to the implementation of PHC because of local customs and environments, it was anticipated that several major components should be included in each plan. These components included:

a) an organized approach to health education that involves professional health care providers and trained community representatives;
b) aggressive attention to environmental sanitation, especially food and water sources;
c) the involvement and training of community and village health workers in all plans and intervention programmes;
d) the development of maternal and child health programmes that would include immunization and family planning;
e) initiation of preventive programmes that are specifically aimed at local endemic problems such as malaria and schistomiasis;

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f) accessibility and affordability of services for the treatment of common diseases and injuries;

g) the availability of chemotherapeutic agents for the treatment of acute, chronic and communicable diseases;

h) the development of nutrition programmes; and

i) Promotion and acceptance of traditional medicine.

The aim of participants at the Alma-Ata conference was to emphasize universal access and participation and to encourage a reallocation of resources, if needed, to reduce the inequality of health care that existed among the nations of the world. They encouraged community participation in all aspects of health care planning and implementation and the delivery of health care that was 'scientifically sound, technically effective, and socially relevant and acceptable' (WHO/UNICEF, 1978, p. 2).

2.3 The Implementation of the Primary Health Care Programme in Ghana

The health education in the country, including access to health services, is at present substantially below expectation. This is reflected in the low life expectancy (currently around 56 years at birth compared to average of 62 years for all low income countries); and high rates of infant, child and maternal mortality (Ghana Vision 2020, 1997).

In addition to poor health outcomes there are systematic problems that affect the delivery, efficiency and efficacy of health services. There is, therefore, the need for

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introducing programmes that will help establish a broad enabling environment for health.

The Government of Ghana pursued a policy, with the goal of achieving health for all by the year 2000, through a decentralized Primary Health Care (PHC) delivery system. Before the Alma-Ata declaration of PHC in 1978, the country had started some form of PHC programme on a pilot basis. The Ministry of Health has taken the PHC as a cornerstone of health service delivery in the country. All the components of the PHC as enshrined in the Alma-Ata Declaration are being implemented in the country through various health delivery programmes. Significant among these are programmes geared towards the promotion of health of mothers and children. As a result, much emphasis has been placed on the Expanded Programme on Immunization (EPI) and Maternal and Child Health (MCH) programmes.

Thus the goal of the health sector is to maximize the total amount of healthy life of Ghanaians and all persons resident in Ghana, regardless of age, sex, origin, ethnic group, religion, political affiliation or socio-economic standing.

The government of Ghana, as a way of addressing the difficulty of reaching rural areas and neglected urban communities with modern health care, has been pursuing PHC initiative, in the hope of providing basic health care to the disadvantaged population in those communities. The Ministry of Health designed a PHC delivery system consisting of three tiers: These are: i) Level A; ii) Level B; and iii) Level C.
Level A is community based and consists of a community/village clinic, operated by a Community Health Worker, who is a volunteer. Also operating at Level A are

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Community Heath Inspectors and Traditional Birth Attendants. Level B and C form the first referral points as well as the principal management foci of the PHC system. The formal health services operations start at B, with Medical Assistants, Nurses, Midwives, Disease Control and Nutrition Technical Officers operating at Health Centres.

The Level C, that is, the district level, is a self-contained segment of the National Health System with a District Health Management Team (DHMT) taking responsibility for the implementation of PHC activities in the district. Currently, management of health services in the District has taken a step further with the formation of sub-districts, each unit with a management team. Currently, the PHC programme in the District has been divided into five sub-districts.

Among the six key problem areas for the health sectors, identified by the Government of Ghana and UNICEF in a situational analysis of children and women in Ghana in 1990, are diarrhoeal disease control and immunization of children against vaccine-preventable diseases. Since these two problems can be tackled within the context of the PHC, ongoing efforts at dealing with the problem have been within that context and form part of child health services which are also a part of Maternal and Child Health (MCH) services of the Ministry of Health, Ghana.

2.4 Organization of PHC Activities in Akwapim North District

Akwapim North District is one of the districts in the Eastern Region, which is relatively served with a number of health institutions. Currently, there are 16 Maternal and Child Health and Family Planning centres located in the various health centres

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and in the Tetteh Quarshie Memorial Hospital (T.Q.M.H.) at Mampong. The health centres are located in towns such as Akropong, Larteh, Twumgoaso, Aseseso, Amanfrom, Adawso, Yensiso and Kwamoso among others.

Like the national PHC programme, the Akwapim North District PHC programme is divided into three main tiers—Level A; Level B; and Level C. Level A deals mainly with minor injuries, care of pregnant women by the traditional birth attendants, education of communities on pressing health issues such as family planning, HIV/AIDS, nutrition related topics etc.

The Level B serves as the first referral point for the Level A. In addition to the 16 Maternal and Child Health/Family Planning centres, the District is divided into 5 Sub-districts, and has 3 private clinics namely, Yensiso Clinic, All Saint Maternity Home and Obosomase Clinic. Level B coordinates the activities in both Level A and C.

At the district level (Level C) there is one main hospital in the district namely Tetteh Quarshie Memorial Hospital which is located at Mampong. Tetteh Quarshie Memorial Hospital houses the District Health Management Team, which supervises and coordinates the activities of the health institutions in the District. The PHC unit in the hospital apart from its traditional role as supervisory and coordination of all the health programmes in the district, it also embarks on regular outreach programmes in areas where there are no static PHC units.

Even though, the health institutions lack logistical and financial support and faces acute personnel inadequacies, they appear to be doing their best to help the people in

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the district who seek medical help from them if one considers the fact that Doctor-Patient ratio in the district is over 12070 in the year 2000. Table 2.1 gives a brief insight into the extent to which the district is equipped with health facilities and the following description of the main hospital in the district, Tetteh Quarshie Memorial, gives a rough idea about the state of health institutions in the district.

Table 2.1 Health Facilities in the District

LEVELS	NUMBER OF HEALTH INSTITUTIONS IN THE DISTRICT	NUMBER OF DOCTORS
Level A	Not Available	No Doctor
Level B	15 Health Posts and Health Centres	Visiting Doctors from T Q M H —Mampong
Level C	1 Hospital	9

Source: T.Q.M.H., 2000.

Tetteh Quarshie Memorial Hospital

Records show that a son of the then Gold Coast, from Christiansborg (Osu) Accra, by name Tetteh Quarshie introduced coçoa into this country in 1879 and that the first cocoa plantation was cultivated at Mampong Akuapem in the Eastern Region. Through the ages this cocoa crop established itself as the main export crop and indeed the backbone of the economy of this country. It was, therefore, befitting that a monument be raised in memory of this worthy son of the land. The joint provincial chiefs initiated this idea in 1950, which voted an amount of $25000 for a children's clinic. The following Akuapem doctors—the late Dr. Asiedu Ofei, the late Ansah Koi, and the late Dr. Oku Ampofo took up the matter and a local board for the project was set up in 1952. A large hospital was rather contemplated by this board and who presented a proposal to Ghana Cocoa Marketing Board (GCMB) for assistance.

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In 1955, a Legal Trust Board of ten members, known as Managing Trustees was set up with a capital grant of $450,000 from the Ghana Cocoa Marketing Board (GCMB). This original capital grant was later supplemented by another $120,000 from the same GCMB.

After a considerable controversy about the location of the hospital, Mampong Akuapem was finally selected. Therefore, in appreciation of Tetteh Quarshie's effort in bringing cocoa to Ghana, the president of the first Republic of Ghana, Osagyefo Dr. Kwame Nkrumah of blessed memory, laid the foundation stone of the hospital at Mampong Akuapem on 4 March 1959. At the function, Dr. Kwame Nkrumah said "this foundation stone is being laid in honour and memory of Tetteh Quarshie, pioneer of the cocoa industry in Ghana, and as a token of debt this country owes to farmers". The hospital was completed and started admitting patients in February 1961. The hospital was constructed with a bed capacity of 150. Facilities at the T.Q.M.H. as at the year 2000 are the following:

1. OPD with ten consulting rooms
2. An Ophthalmology Department
3. ORL/ENT
4. X-Ray Department
5. Traumatology
6. An Obstetrics and Gyaenacology ward with two theatres
7. Pharmacy
8. Laboratory/Administration Complex
9. Energy Recovery/Casualty Wards
10. Isolation Ward

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11. Medical Ward

12. Surgical Ward

13. Maternity Ward

14. Paediatric Ward

15. V.I.P. Ward

16. Three Well-Equipped Theatres

The following are also available:

Catering department with staff canteen; laundry; C.S.S.D.; maintenance; an endoscopy set; Electrocardiograph Madeira; an ultra-sound machine; 14 cots; 5 radian warmers; 6 transportable incubators; 17 baby cradles; 11 IBM computers; 11 printers; 2 power generating plants; 5 microwaves; 1 colour TV. The present bed capacity of the hospital is 170 excluding cots, which are 16 in number and 5 incubators. The hospital also has 9 doctors, 50 nurses and 112 paramedical staff. The catchment area of T.Q.M.H. covers approximate population of 154,450. This includes Akwapim North, part of Akwapim South and Dodowa and its surrounding areas. Figure 2.1 is a map showing towns where the various health centres are located in the District.

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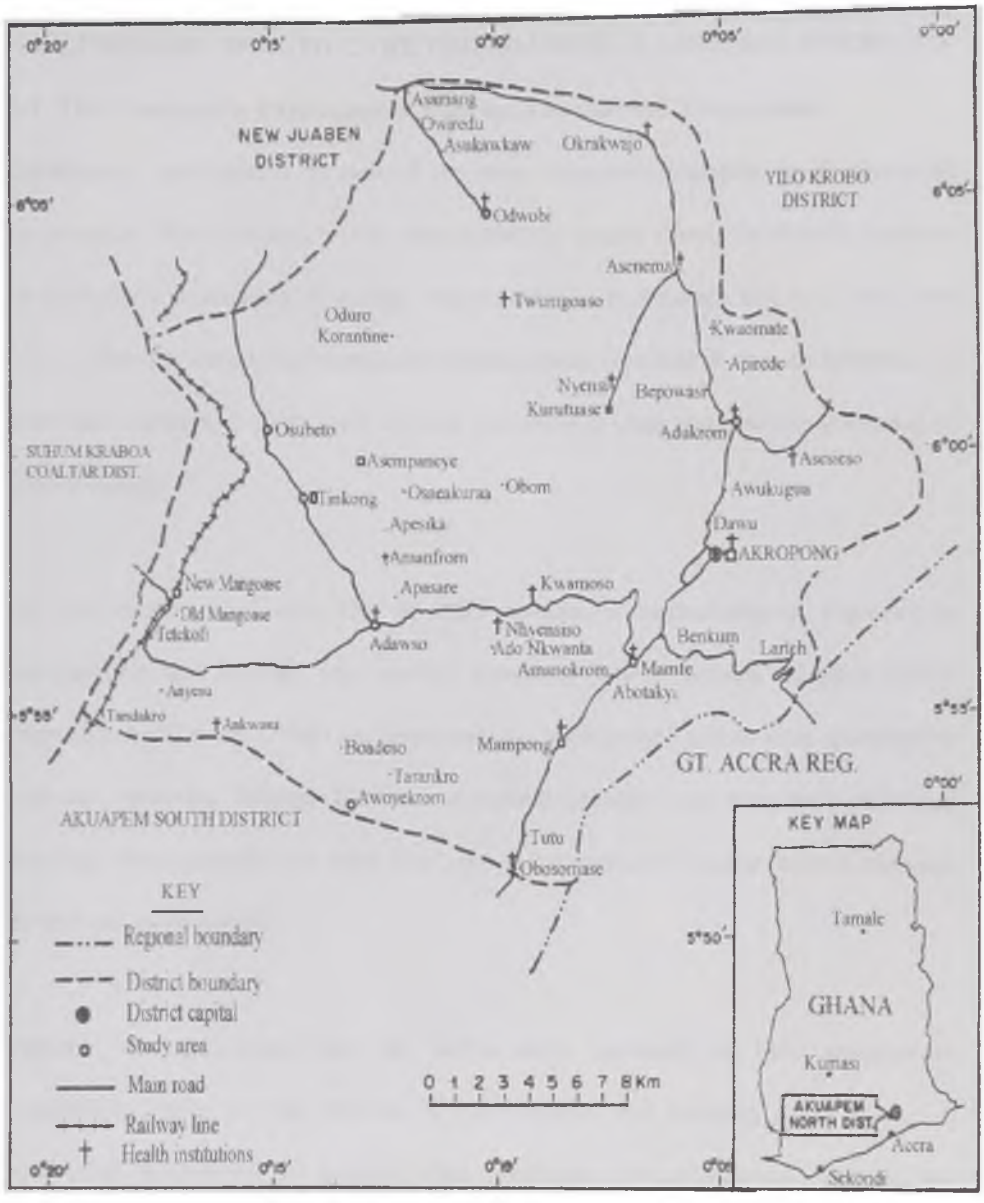
Figure 2.1:

MAP OF AKWAPIM NORTH DISTRICT SHOWING LOCATIONS OF HEALTH INSTITUTIONS



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CHAPTER THREE

EVALUATING THE CONCEPT OF COMMUNITY PARTICIPATION IN THE PRIMARY HEALTH CARE PROGRAMME: A GENERAL OVERVIEW

3.1 The Community Participatory Approach to the PHC Programme

Community participation is one of the most essential principles in development cooperation. What is meant by this term is that the people should be directly involved in a project's conception, planning, implementation and accept that it is their own effort. Like the concept of sustainable development of which it is a component, the word participation is often used without providing a clear and definite statement of what it means.

An examination of project files of PHC revealed a methodological approach to participation that do not vary widely from the four principles of participation identified by Oakley (1991) as: emphasis on participation rather than quantitative outcome; ensuring balance between awareness creation and economic activities; building where possible on local base; and maintenance of regular contact between people and project staff.

Perhaps we may argue that the participatory approach of PHC programme emphasized more on the process of participation and building local base, i.e. traditional institutions, as against other principles. The ideological base of the programme as observed from the methodology was the assumption of an existing local capacity and that the existing institutions are capable of ensuring participation but what is needed is intensive education and awareness creation.

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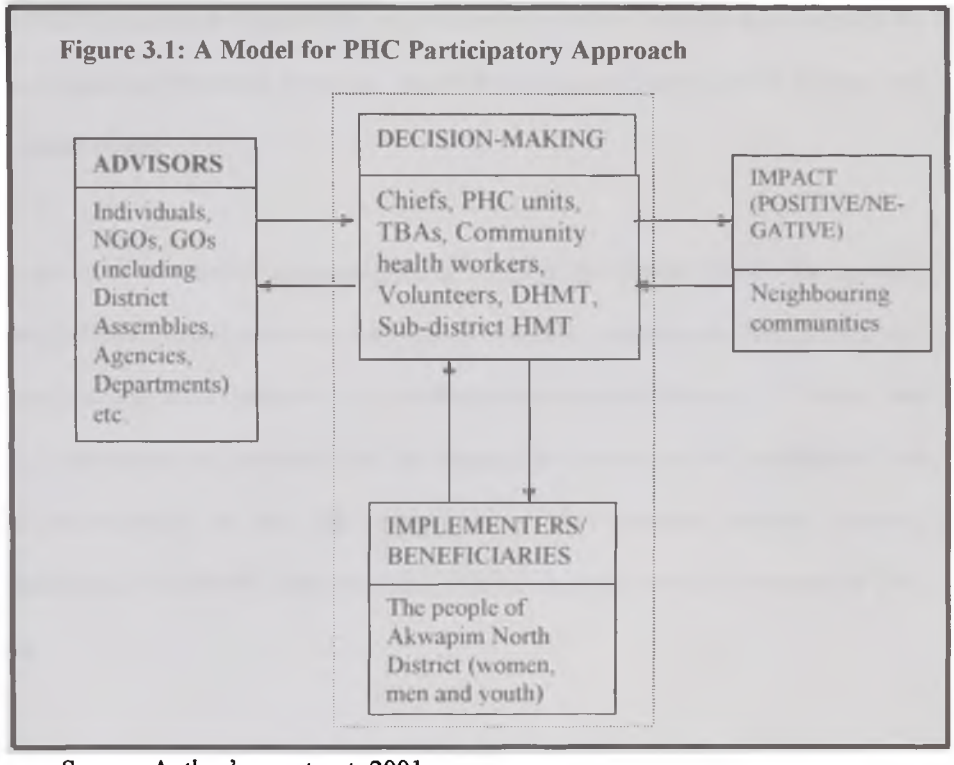
It is in recognition of this that the people of Akwapim North District should be made to play an important role in decision-making, planning, implementation, monitoring and evaluation of primary health care activities. The observed participatory approach to the delivery of health services can be summed up diagrammatically in figure 3.1

The participatory approach to the PHC programme as summarized in figure 3.1 indicates the building blocks or the key groups involved.

Figure 3.1: A Model for PHC Participatory Approach



Source: Author's construct, 2001.

The Central role of coordinating activities between all stakeholders is given to the District Health Management Team at the Tetteh Quarshie Memorial Hospital in Mampong who interacts and acts with the Sub-district Health Management Teams, the various PHC units, Traditional Birth Attendants, Village Health Workers,

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volunteers among others. This group constitutes the engine of the PHC programme; they take major decisions on the programmes, which the PHC units implement.

The PHC units' personnel are employed by the Ministry of Health to steer the affairs of the areas within their jurisdiction under the decentralization process of Ghana. They also mobilize people for health promotion campaigns such as immunization, HIV/AIDS awareness programmes etc. Actively involved in these programmes are Tetteh Quarshie Memorial Hospital, Health Posts/Health Centres in the district, and the communities.

This group constitutes the decision-making body but the District Health Management Team (DHMT) coordinates any decision on the PHC programme. The DHMT was formed, among other purposes, to coordinate between the Ministry of Health, and health institutions on one hand and the communities who are the beneficiaries and part implementers of the PHC programmes. They conduct periodic outreach programmes. The DHMT also provides technical assistance to the personnel of PHC units.

The PHC units in turn give training to the Traditional Birth Attendants and community health workers. They organize and supervise immunization/vaccination campaigns and provide education of pressing national health issues.

Another important component of this group is the community. Even though the cardinal principle of primary health care is community participation in all aspects of the programmes, it is here that one cannot really identify precisely where the

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community is actually involved apart from being called upon to participate in national immunization campaigns and being advised to breastfeed their new-born babies. One area the community is seen to be part is maternal and child health programmes. Even here, they are only beneficiaries of the services and no role for them as far as decision-making, planning, implementation and evaluation are concerned.

As far as major policies and directions and the financing of the PHC programmes are concerned, the Ministry of Health is the sole player even though non-governmental organizations do play a limited part in these aspects. For example, the Presbyterian Church of Ghana is actively involved in the implementation and financing of PHC programmes in Agogo Presbyterian Hospital in Asante Akim North District. In Akwapim North District religious bodies and NGOs are doing similar thing. Example is All Saint Maternity Home owned by the Roman Catholic Church.

3.2 Criteria for Evaluating Participation

Participation has now become an accepted and recognizable objective in development programmes and projects but the issue of its evaluation has come into question. Whereas concerns for participation in development emerged in mid 1970s, interest in its evaluation is a recent development (Oakley, 1991). The crux of the matter is that both conceptually and methodologically, the evaluation of participation is still in its relative infant stage. It is against this background that Lassen (1980) commented on a paucity of practical 'guide-lines' on how to evaluate participation. Rahman (1980) has questioned whether it is possible to have a general analytical framework for evaluating participation in development projects. However, some schools of thought

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have begun to question the issue and to experiment with different ways although they lack authoritative insight to the complex issues.

Oakley in 1991 made some important points that worth noting. To him, the parameters and the content of any evolution of participation will necessarily be linked to the operational understanding of participation. On the one hand, if this understanding is limited to the notion of economic benefits derived from successful projects, physical attendance at project activities or extended project coverage, then evaluation will probably be largely quantitative. On the other hand, if the operational understanding is more closely linked to participation as a process with a series of qualitative objectives, then the evaluation will demand an alternative form. That is, it cannot be assumed that the more commonly used quantitative, linear approach to evaluation would be appropriate to evaluation of participation. Clearly, there would be a quantitative dimension to participation; there would also be a qualitative dimension, which needs to be evaluated. The evaluation of participation would be concerned with the analysis of a dynamic quantitative process and not merely the measurement of a static physical outcome.

However, this concern has come up against a basic problem of how to evaluate participation. Paul (1987) has stated that it is not an easy task to evaluate the outcome of participation in relation to its objectives. The central problem is how to disentangle the process of participation from project structure and factors, which influence the functioning of this structure. There is also the problem of identifying and explaining the project's influence, as opposed to that of other socio-political forces on the process of evaluation.

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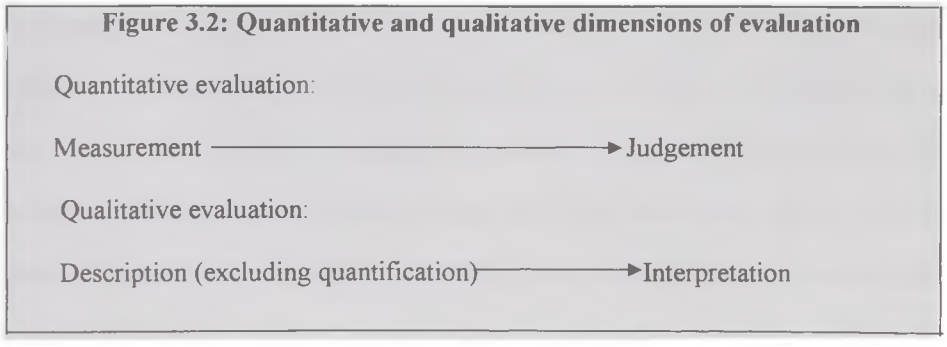
In essence the question here is what form of evaluation would be more appropriate to the understanding of the process of health promotion programme? In reality there would be in one sense two broad outcomes of participation, which serve as a foci for evaluation: Here, participation is evaluated in terms of tangible or physical contributions or outcome of the project or programme. In that case, we may look at man-hours spent on the programme, the number of outreach programmes conducted, amount of money spent by local people as against that of the foreign or from external sources and share of social and economic benefits between all interested parties.

The second process would be qualitative evaluation. This concerns with describing the characteristics and properties of a process like participation over a period of time and then with interpreting the data and information available in order to make statements concerning the nature of the participation, which has occurred.

Essentially qualitative and quantitative evaluations are two complementary but distinct approaches that have been summarized graphically by Oakley as follows:

Figure 3.2: Quantitative and qualitative dimensions of evaluation



Source: Oakley, 1991.

At this critical point, the observable concern of this study is a search for an approach, which is not based exclusively on the measurement of material or economic

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outcome, but also able to explain what happens in the health delivery system as primary health care programme in Akwapim North District that seeks to promote participation. The context of PHC is health delivery system with improve health for all as a critical aim. These are relatively abstract concepts, which though have quantitative characteristics, have more qualitative dimensions and that its analysis requires more qualitative concerns.

Participation is a phenomenon that occurs over time and cannot be measured simply by 'single snap-shot' form of exercise. In this case, this evaluation process will emphasize more on qualitative analysis of the process but will not shun quantitative analysis.

The quest for indicators for the purpose of evaluation of participation has been a marathon phenomenon. There are numerous agencies, individuals and groups working to find indicators for evaluation purposes for instance Oakley (1985), FAO (1991), to mention but few have tried to harmonize field-bases indicators for evaluating participation but most of these were on quantitative indicators. We understand indicators to mean the means by which the outcome of a project can be understood and, in one form or another, measured or explained. It is argued in some circles that indicators should accurately reflect changes that have taken place, they should be identifiable and observable, should be intelligible and above all unambiguous in order to avoid confusion.

In terms of relevant indicators of process of participation, Hamilton (1978) suggests that we should identify 'critical traits' Lassen (1980) also refers to 'vital signs'

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whereas Charlick (1984) proposes that the 'what, 'how' and 'where' of participation should be the basis for evaluation. Conversely, Rifkin, et al, (1988) have developed a broad continuum from 'wider to narrower' participation as two extremes within which it should be evaluated. Oakley has suggested both quantitative and qualitative indicators, which have been summarized in table 3.1. In spite of these numerous suggestions, diversity in opinions on appropriate indicators of participation is not likely to end today so long as project context and objectives differ.

Table 3.1: Quantitative and Qualitative Indicators for Evaluating Participation

Quantitative		Qualitative	
Economic Indicators	-The measurable economic benefits of a project by the use of commonly employed quantitative techniques as who is participating in the project's benefit. An analysis of those sections of the rural people who have directly benefited and a quantitative assessment of this benefit and their lives and the future ability to sustain the level	Organizational growth	-Allocation of specific role to project group members -Emerging leadership structure and formalization of group structure.
Organization Indicators	-Percentage of rural adults within a project area who have knowledge of the existence of the project organization. -Percentage of rural adults within a project area who are formal members of the organization meetings.	Group behaviour	-Changing nature of involvement of project group members and emerging sense of collective will and solidarity.
Participation in project activities	-Number of project groups or associations of project groups formed. -Number and attendance rates at project group meetings. -Total workdays contributed by members to acquire positions in other formal organizations.	Group self-reliance	-Increasing ability of project group to propose and to consider course of action
Development momentum	-Number of project members who received some kind of formal training from the project. -Internal sustainability, or the ability of the project group to maintain its own development momentum		

Source: Oakley (1988).

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It is against this backdrop that Oakley (1991) suggests field-based indicators based on aims and objectives of the project concerned as most appropriate for the project's evaluation.

The aims and objectives of primary health care programme participatory approach, although not so different from other development programmes could not be evaluated in the same way as Oakley (1988) or Uphoff (1988). However, it must fall in line with acceptable criteria. It is in line with this that critical traits as decision-making and control; local resources used in the implementation; local knowledge, number of local people involve in the processes of health delivery, hospital attendants, response to mass programmes such as immunization campaigns and film shows intended to give health education, and share of benefits are selected in this study for evaluation of the participatory approach of PHC programme in Akwapim North District.

Under decision-making/control, pertinent questions to be answered include decision/control over the fixing of programme facility user charges, when and where to conduct educational programme in order to get maximum attention, how much to give volunteer health workers and where to incorporate traditional healers into the programme. Questions relating to local resources used in the implementation of the programme centre on labour: skilled (paid) and unskilled (unpaid). For the assessment of local knowledge, efforts were made to know the number of respondents aware of the PHC programme and its financiers; training received for the purpose of participating in the programme activities; and the importance of the programme.

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3.3 Effectiveness of the PHC Community Participatory Approach

The Government of Ghana through the Ministry of Health introduced the primary health care programme in Akwapim North District. The actual year in which the programme was introduced could not be told, as there was no official record in this regard. Some officials guesstimate somewhere 1982-83.

The participatory approach of PHC appears to be working effectively though a lot more could be done. A critical examination of the participatory approach of PHC reveals that:

a) the ultimate power is in the hands of the district health management team on behalf of the Ministry of Health;

b) the day to day administration of the programme is in the hands of the PHC units in the District;

c) the implementation of the programme rests on the health institutions, the TBAs, Community Health Workers among others; and

d) at the implementation stage, the community plays very limited role. The community is the direct beneficiary of the programme.

The programme participatory approach is structured such that coordination and monitoring of activities are done in a way that makes the implementation of the programme easier and follow-ups simpler. The sub-districts prepare and submit monthly reports of their activities to the District Health Management Team at Tetteh Quarshie Memorial Hospital. This enables the DHMT to scrutinize the activities at the sub-district level, which ensures checks and balances in the programme.

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The District Health Management Team together with health experts have a duty to give regular refresher courses to the Village Health Workers, Traditional Birth Attendants and other health volunteers in the district. The district health management team also collects, collates and records all reports from the five sub-districts for analysis and a projection into the future.

The PHC units are expected to embark on regular outreach programmes to complement the efforts of the health institutions and the community health workers. These are done in areas where there are no permanent health providers and promoters so that no one is left out in the quest to give health to the people. On the day-to-day administration of the programme the PHC units have been effective to some extent, though there are some setbacks. The units face huge financial and logistics problems, which hinder smooth implementation of their programmes. For instance, the units lack motorbikes and other means of transport to visit all areas under their care.

Community participation in Primary Health Care concept presupposes that the health of the people should rest in their own hands with medical personnel only serving as enablers to the people. However, the nature of health delivery is such that one has to acquire the requisite knowledge in medical field to perform any meaningful role in health promotion. This makes it difficult for ordinary person with no knowledge as far as medication is concerned to administer health services. The people in the community participate in the programme through their response to the primary health care activities such as disease prevention education, immunization, weighing, attending for medical aid as soon as one feels signs of infirmity etc. However, the specialized nature of medical field should not be used as an excuse to preclude the

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people at the grassroots from participating since adequate training can ensure their full participation in the programme.

Heath workers in most developing countries have failed in establishing an ongoing dialogue and rapport with the communities they serve. Countries like China and Cuba which have achieved a breakthrough in health in a remarkably short time ascribe their successes largely to popular awareness and participation in health activities and not to advanced technologies operating from within hospitals (Ebrahim, 1985, p. 150). It should be emphasized that the success of a community-based health programme is to be judged not so much by the improvements in vital statistics as by the increased knowledge and skills of the people to manage and solve their health problems. A tangible evidence of such an approach will be the extent to which local resources and initiatives have been mobilized for sustained efforts over time.

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CHAPTER FOUR

LEVELS OF COMMUNITY PARTICIPATION IN THE PRIMARY HEALTH CARE PROGRAMME IN THE DISTRICT

4.1 Introduction

This chapter identifies four levels as far as participation is concerned in the primary health care programme in general terms and the extent to which the various categories participate in the programme in Akwapim North District. The four levels of participation are: the individual, the family, the community and the health institutions as discussed below.

4.2 Participation at the Individual Level

The level 'A', which is community-based, consists of 25 Village Health Committees, 5 Private Midwives, 77 trained Traditional Birth Attendants and a number of volunteers. There are also an unspecified number of people who operate without proper documentation and licensing even though their activities are considered inimical to the health of the people, yet they are 'necessary evils' especially in places where modern health facilities are not available or accessible to them due to high medical bills or their remoteness to the nearest health centre.

The roles of village health committees are mobilizing and helping health personnel to organize health promotion programmes as mass immunization campaigns, HIV/AIDS education, and community clean up exercises. They also assess the health needs of the people and take remedial measures to address them in collaboration with and support from the district assembly and other stakeholders. For instance, if a village faces the problem of accessibility to health care the committee deliberates on this and comes out with appropriate measures to deal with it.

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Individuals in a community have important roles to play as the impact of their services is better felt than what the orthodox hospital-based curative services can provide for the poor. For instance, it has been the experience in several countries that when health care is being provided through auxiliaries, village health workers (VHW) and trained traditional birth attendants (TBA), over 80-90 percent of the clients tend to be families from the poor and low-status groups. It is, therefore, important that more people are given the training as village health promoters (VHP) in order to reach majority of the people. The Centre for Rural Integrated Environmental Development (CEFRIEND) is doing marvelously well in this direction. This local NGO has trained some youth in the district to serve as Peer Educators (PEs) and Village Health Promoters (VHPs) whose main functions are to educate their peers and advise those who encounter health problems and to make the health services more relevant to their problems. They also promote the sale and use of condoms to help check the spread of HIV/AIDS and to prevent unwanted pregnancies in the area. This means shifting the emphasis to preventive and promotive aspects of health care from the predominantly curative care to which most health workers have been conditioned by their training. Unfortunately this curative care is almost inaccessible to majority of people who are poor and cannot afford such services thereby alienating them from the available health services.

While the community is familiar with Western health care facilities, the traditional system is still popular. These included herbal therapies, spiritual healing and the use of 'fetishes' This has its precursor for the way and manner our forefathers approached the sick, which was predominantly based on spirituality and was bequeathed to the present generation through so many years of sustained practice.

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To ascertain the involvement of the people, the research sought to find out the level of participation in the implementation of primary health care programme. Among 200 respondents who were interviewed, 57% (114) of the people do not play any role in the programme while only 27% (54) said they play one role or another. The remaining 16% did not respond to that question. This prompted a follow-up special interview of five of them to find out why they could not answer a simple 'Yes or No' question. It was then realized that they did not know what primary health care programme is all about resulting in their inability to answer some of the questions. There were questions on number of people trained or given some form of training in order to participate in the programme. Participation at the individual level is, therefore, only visible by 77 trained traditional birth attendants and five private midwives.

4.3 Participation at the Family Level

Primary Health Care is proposed to act as an 'enabler' It enables individuals, families and communities to achieve health through better awareness and by bringing together services and resources to provide basic needs and basic health care. Dealing with health provision and management has been realized to be multifactoral in dimension, which must be tackled from all fronts in order to ensure health for all. Many programmes designed to ensure 'Health for All' cannot be achieved without the provision of basic needs such as nutrition. Thus, some have focused on improving nutrition as a means to better health, integrating other health activities with a range of nutrition-improvement measures. Changes in household behaviour have been viewed as the key to success, and a variety of interventions have to address this need. Important among these have been growth monitoring—a recurring activity which not

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only facilitates interaction between the health system and needy children and their mothers but is also an instrument, which helps all members of a family target their efforts and measure their achievements, thus enabling overall improvement of health status. Regular growth monitoring is a communication strategy to improve child-rearing behaviour, addressing nutrition as well as overall health care. It calls upon households to utilize their own resources, thus potentially reducing dependence on outside technologies and resources. It calls for continuous attention to the needs of each child, thus introducing 'care' as the critical factor in nutrition rather than health or even food itself.

At the family level parents have a duty to educate their children on pressing national health issues which can go a long way to complement efforts of government, multinational organizations, non-governmental organizations and other stake holders in their attempt to fight dreadful diseases like the HIV/AIDS. Campaigns against vaccine-preventable diseases aimed at eradicating such diseases, as poliomyelitis, diphtheria etc. must also be zealously participated by parents. Family level participation in the primary health care programme in the Akwapim North District is on the low side considering the fact that parents do not freely and easily discuss matters critical to health of the children especially reproductive health issues which have long lasting implications not only on the mother but also the child as well.

In terms of decision-making, implementation, monitoring and evaluation, families cannot be said to be actively involved in the programme. The evaluation of participation includes the financing of the programme. Information on participation was gathered on the basis of local resources used in the implementation of the

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programme and any other physical materials used. It was found out that no special monetary burden is put on the people in the study area and that the only way funds are sourced from the people is when they utilize health services and a fee is paid. The Ministry of Health and for that matter the central government has always been the sole financier of the programme. According to the planning officer at the Akwapim North District Assembly, Mr. E. K. Adusei, the assembly gives financial and logistic support occasionally to the PHC units.

4.4 Participation at the Community Level

Community involvement in health is one of the precepts of 'Health for All'. And yet, throughout the decade of the 1980s, experience of community-generated, community-led and community-implemented health care has been limited. Even when examples have been found, it has been difficult to document and understand the essential ingredients of these experiences, which have wider applicability and use in accelerating community participation in health care. It is not unusual to find that the village community considers health services as part of the government administrative system and as something imposed on them by an 'outside' authority (as it is the case in Wassa Akyempem, page 5—Mirror, 25 March 2000). The lack of communication between health personnel and the villagers, together with the social, cultural and educational gaps between them, often leads to alienation of the people. This encourages the community to resort to traditional methods based on superstition and indigenous practitioners even though they may be more expensive in monetary and casualty terms. The conventional health practitioners, therefore, have a duty to make sure that they bridge the gap between them and those they interact with so as to gain their full participation in an attempt to promote health.

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For sustainable development of any community initiated programme communities have to design and implement specific community-level actions in large-scale programmes. By and large, these efforts are aimed at tackling critical, widespread health problems. But community involvement is ensured from the inception of the programme through careful design and introduction of programme elements. It is sustained by continuous assessment and feedback. Accountability is the cornerstone of these larger-scale community-based programmes. It should not be seen to be hijacked by few groups of people who will lord it on others just because they have been given some responsibilities to manage certain aspects of the programme.

Another area of evaluating participation is the people's response to health promotion activities such as immunization/vaccination, and hospital/clinic attendants. Available records show that a lot of people take keen interest in immunizing their children. From table 5.6 in page 96, 81% of the children born in the year 2000 were immunized for B C G representing 4373 of 5350. In table 5.6 the 5350 represents the number of infants between 0 and 11 months in the year 2000. Women In Fertility Age (WIFA) as of the same period was 22% of the estimated population of 133760 in the same period. Appendices 3a, 3b, and 3c in pages 129, 130 and 131 show immunization figures for the months of January, June and December 1999 respectively. Participation at the community level in the district generally is not widespread as no definitive programmes have been laid down to get the entire community on board in the PHC programme.

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4.5 Participation at the Health Institutional Level

Among other functions, there are three main areas of hospital involvement towards health promotion viz. direct support to PHC, community health development activities, and basic and continuing education of health personnel. This outlines the main processes through which hospitals can become the springboard of PHC within their catchment areas. If these processes are to get firmly rooted and flourish hospitals will have to change their culture. Instead of being the receiving station of cases referred by the peripheral clinics the emphasis should be on an outgoing flow of information, technical support, materials and equipment to strengthen the peripherals. Coverage has to have priority over diagnoses of rare diseases; better nutrition through local food production over treatment of deficiency disorders; intersectoral activities over individualism. Such a change of emphasis requires a great deal of reorientation of the training of hospital personnel and their operations.

The health institutions in the District have a full range of PHC activities including maternal and child health care, control of endemic diseases, health education, domiciliary visits and basic curative care. Some health institutions have helped in the formation of health development committees in their localities, and the training of village health workers and TBAs to serve as a catalyst for improved health. The work of the Village Health Workers is mostly on a voluntary basis initially, although they derive some small profit from the sale of medicines.

The health team plays a key role in facilitating the villages to undertake the self-study and community actions that lead to a broader achievement of health for all through regular workshops aimed at creating awareness, empowering the people to take their

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own initiative, and sensitizing them about taking their health into their own hands. The community leaders, therefore, choose a member of the community, get him or her trained as a community health worker to enable him or her provide community services. The person chosen could be a reproductive health promoter who is highly motivated not because he/she receives fat salary from any quarters but because he/she has been trained to accept the fact that if couples have six or eight or ten children, it is not good for his/her community and most importantly the reproductive health of the mother. Besides, village health worker knows that he/she is doing something good for the people which urges him/her on to want to continue providing these services without any meaningful remuneration in return of the services he provides.

In areas where there are no static PHC units the District Health Management Team trains peer educators who act as community-based distributors and health promoters whose functions include advising and referring critical cases of infirmity to the health post or health centres as appropriate. Community-based Distribution (CBD) of contraceptives can be helped or hindered by gender norms. Community-based services that bring contraception counseling and information into peoples' homes can help women obtain control over their fertility, and thereby enhance their autonomy and self-esteem. CBD programmes can compensate for the lack of health-care facilities available to men. And, community-based programmes can improve the status of female workers, who may have limited opportunities for employment. Since hospitals are expected to play limited role in the promotion of health it reinforces the fact that enabling environment is created for the communities to manage their health matters. Hospitals are expected to play a pivotal role in this direction.

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CHAPTER FIVE

ASSESSMENT OF THE COMMUNITY PARTICIPATION IN THE PRIMARY HEALTH CARE PROGRAMME AND THE HEALTH OF THE PEOPLE

5.1 Socio-economic Impact of Community Participation

Participation has been defined as "a way of factoring local behaviour and beneficiary assessments of risks, costs and benefits into project design... those assessments consist of rational economic decisions in the context of the social/cultural and economic environment" (Cook and Donnelly-Roark 1994, p. 4). Community participation is essential for the development of every project. People's involvement in activities meant to benefit them has a great deal of impact on that activity which will also go a long way to determine the extent to which the people are going to benefit from it. The socio-economic impact of community participation in the primary health care programme in Akwapim North District is going to be analyzed in the light of morbidity and mortality levels, disease pattern, education and financing of the PHC programme.

5.1.1 Morbidity and Mortality Levels

To study spatial and temporal variations in morbidity and mortality, it is necessary to use comparative measures or indices of morbidity and mortality for the periods and areas under consideration. The basic measures are essentially rates of incidence, relating the number of out-patients and deaths to a unit of population, commonly 1000, in a particular interval of time. The interval is invariably one year, to avoid the complicating effect of seasonal morbidity and mortality variations on comparability of rates. Unfortunately, for the analysis of these two variables the unit of population is not clearly defined as the catchment areas of the health institutions selected are not

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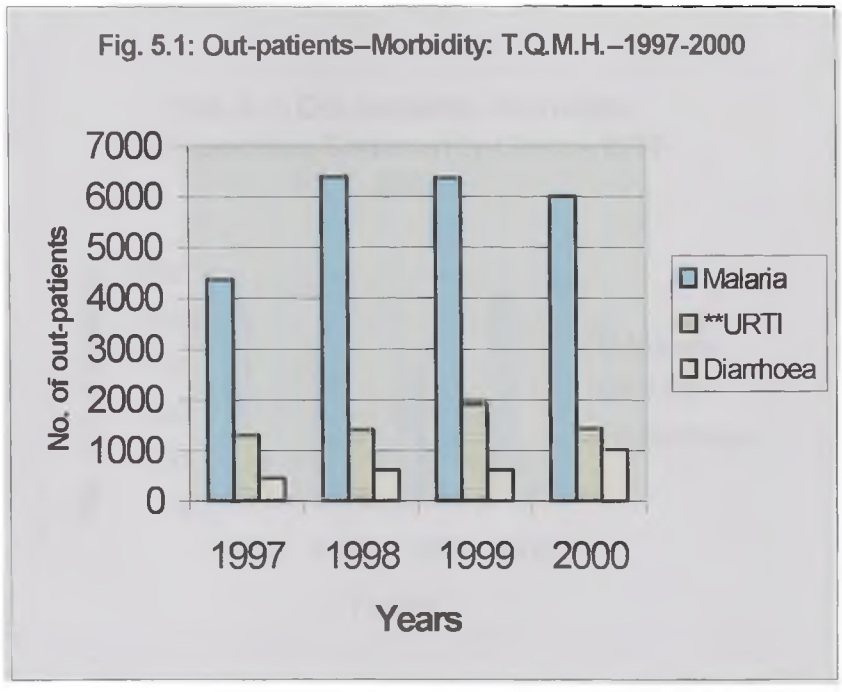
well defined. In view of this, records of the top three diseases are going to be used to assess the frequency of out-patients in T.Q.M.H., Okrakwajo Health Centre, Adukrom Health Centre, and Okuapeman Community Clinic.



Source: T.Q.M.H. Annual Reports, 1997-2000.

A careful look at figure 5.1 shows almost a constant figure in 1998 and 1999, and a slight decline in 2000 of malaria cases reported at the Tetteh Quarshie Memorial Hospital. However, malaria cases rose sharply from 4375 in 1997 to 6386 in 1998 an increase of 46%. The rehabilitation work that took place at the hospital in 1997 that led to the closure of some of the departments was used to explain the marked difference between 1997 and the remaining years.

****URTI—Upper Respiratory Tract Infection.**

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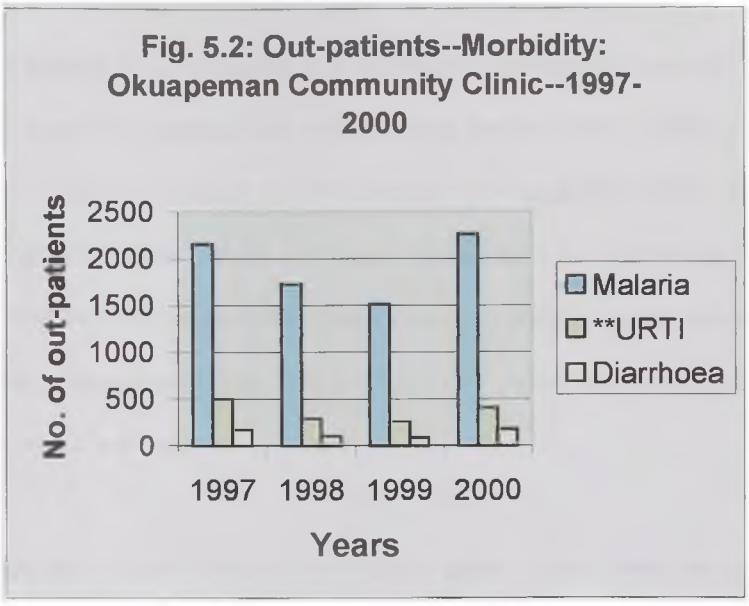
The increase in cases of out-patients as far as URTI is concerned is not abrupt as it is the case of malaria. The percentage increase was 9. On the other hand diarrhoeal cases increased by 39% between 1997 and 1998. The following figures represent the three other health centres.



Source: T.Q.M.H. Annual Reports, 1997-2000.

Fig. 5.3: Out-Patients—Morbidity Adukrom Health Centre

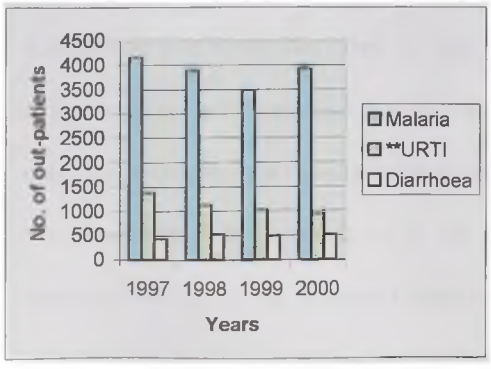
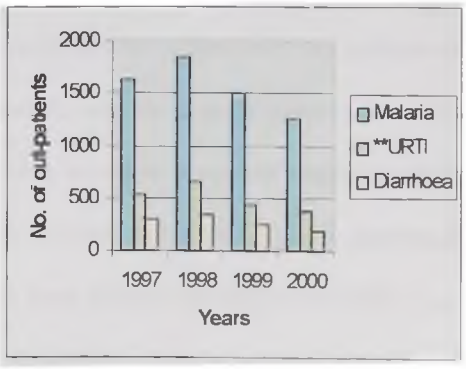


Fig. 5.4: Out-Patients--Morbidity Okrakwajo Health Centre



Source: T.Q.M.H. Annual Reports, 1997-2000

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Available statistics in Okuapeman Community Clinic show a consistent decline of reported cases of all the three diseases from 1997, reaching a minimum level in 1999 and rising again in 2000 as shown in figure 5.2. For example, malaria cases fell from 2154 in 1997 to 1509 in 1999, a decrease of 30% and rising again to 2257 in 2000, an increase of 50% from the 1999 figure. At Adukrom Health Centre, malaria out-patients records were similar to that of Okuapeman Health Centre. In 1997, 4255 malaria cases were reported but dropped to as low as 3459 in 1999, a decrease of 17%. It, however, increased by 13% between 1999 and 2000. There was a steady decline of URTI from 1379 to 1114 and a further drop to 1019 and to 939 in 1997, 1998, 1999 and 2000 respectively. Diarrhoea cases were relatively stable apart from an initial increase from 430 in 1997 to 522 in 1998, which was relatively a significant increase of 21% though.

In Okrakwajo Health Centre, the trend is quite distinct from all other centres discussed, in the sense that the three diseases selected follow the same trend. When one changes all others change. For instance, malaria cases increased from 1622 in 1997 to 1841 in 1998; URTI increased from 522 to 654; and Diarrhoea also followed the same trend when it increased from 300 to 334. This does not necessarily mean that a change in one causes the other. In fact, when further investigations were conducted at the various health centres for an explanation for why the disease patterns were the way they were, various reasons were given which would be discussed shortly together with response from respondents in the communities. All these changes happened between 1997 and 1998. Reported cases in the three diseases declined from 1998. One significant thing about the pattern of these diseases is that the rates of change are almost the same for all the three diseases in these health centres. When Dr. Obeng

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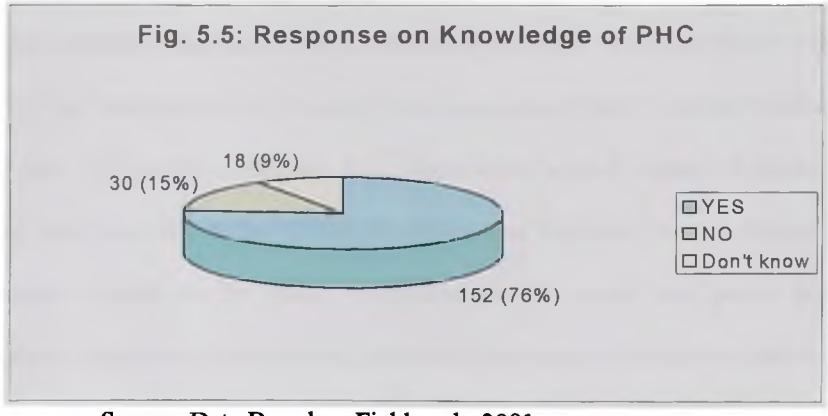
Agyemang was asked to give his views on the reported decline of out-patients in Okrakwajo Health Centre, he intimated that the people in the community have been conscious of their own health thereby contributing immensely to the decline of incidence of diseases in that area. He attributed this to the work of health promoters and peer educators who are providing counseling services to the people in the district. Further probing from respondents in the community was done to find out whether the PHC concept has had an impact on the rate with which people fall sick. When they were asked if they knew anything about the PHC concept, their response is represented by figure 5.5.



Source: Data Based on Fieldwork, 2001.

Further question was asked on whether there are community health workers in the sampled towns and villages, and if there were do they consult them when they fall sick, the following figure represents their position on the latter questions.

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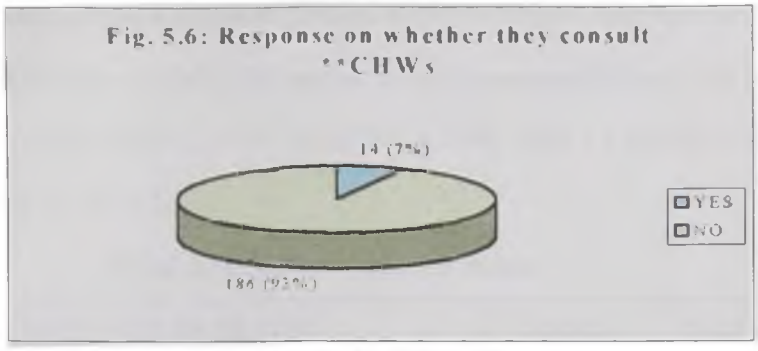

Source: Data Based on Fieldwork, 2001.

From the responses of the people in the communities, it appears that the primary health care programme contributed significantly towards the reduction of reported cases of out-patients in the various health institutions. Out of 200 respondents, 152 (76%) confirmed that they knew something about PHC. A further 186 (93%) attested to the fact that they mostly consult these community health workers whenever they fall sick. The probable inference from these is that a good number of infirmities may have been attended to by CHWs in which case they may not be reflected in the available records at the health institutions, which could also partly explain the apparent reduction of out-patients. However, the impact of preventive services on the number of out-patients cannot be ruled out. But for the year 2000 where there were increases in frequency of diseases in Okuapeman and Adukrom Health Centres, all thing being equal, one could have safely asserted that, generally there has been a steady improvement in health of the people in the community.

Mortality pattern on the other hand, has some striking characteristics completely distinct from the morbidity pattern discussed above. Unlike the morbidity pattern where there was falling morbidity occurrence in almost all the health institutions

****CHWs—Community Health Workers**

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studied, mortality shows a consistent increase in T.Q.M.H. from 41 in 1997 to 129 in 1998, a sharp increase of 215%. The number of deaths increased further from 129 to 217, which is 68% increase in 1999, and to 264 in 2000. Table 5.1 shows the top 10 causes of death in T.Q.M.H.

Table 5.1: Top Ten Causes of Deaths

CONDITION/CAUSE OF DEATHS	TOTAL	% OF TOTAL
1. Hypertension	47	12.3
2. Congestive Cardiac Failure	38	9.9
3. Anaemia	37	9.7
4. Cardio Respiratory Failure	37	9.7
5. Cardio Vascular Accident	29	7.6
6. Pneumonia	22	5.7
7. Cardiac Arrest	19	5.0
8. Malaria	16	4.0
9. Diabetic Mellitus	14	3.7
10. Intracranial Hemorrhage	13	3.4
Total of All Others	111	29.0
GRAND TOTAL	**383**	**100.0**

Source: T.Q.M.H. Annual Report, 1999.

5.2 Pattern of Diseases

The disease pattern in the District shows consistently high figures for malaria cases in all the health centres where data were collected. A careful look at available figures in health institutions quoted in pages 74 and 75 depict a slight declined in morbidity. For instance, reported cases of malaria dropped from 1622 to 1251 in Okrakwajo Health Centre. Opinions of respondents were sought on how they see the health conditions of the people in the district for the past ten years and the following is what they had to say.

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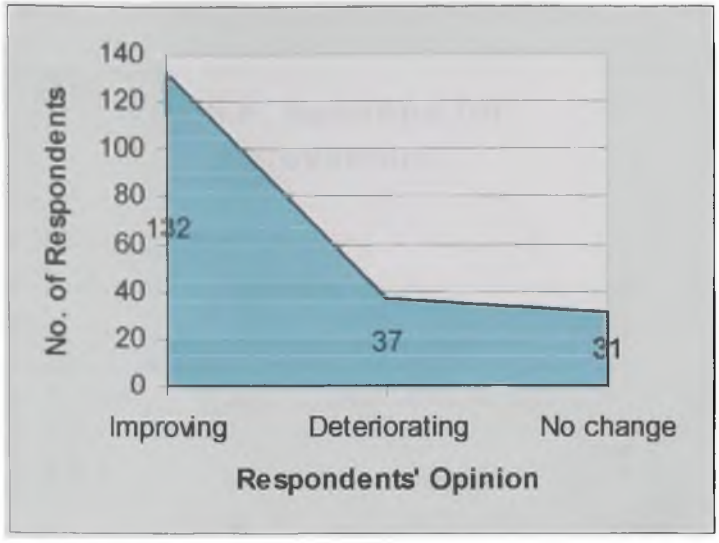
Figure 5.7: Health Status since the Past Ten Years



Source: Data Based on Fieldwork, 2001.

About 66% of the respondents believe that the health status of the people in their communities has improved. These improvements were attributed to availability of essential drugs even though many believe that they are too expensive. They also believe that it is the results of God's protection, immunization campaigns and improvement in environmental cleanliness thereby reducing environment-induces diseases. Thirty-seven out of the 200 respondents, which constitute 19%, were of the opinion that conditions of health have actually deteriorated. The remaining 15% believe there has been no change in the health status of the people for the past ten years.

Figure 5.8 shows the distribution of reasons assigned by respondents as the forces behind the improved health status. "A", "B" and "C" represent availability of drugs;

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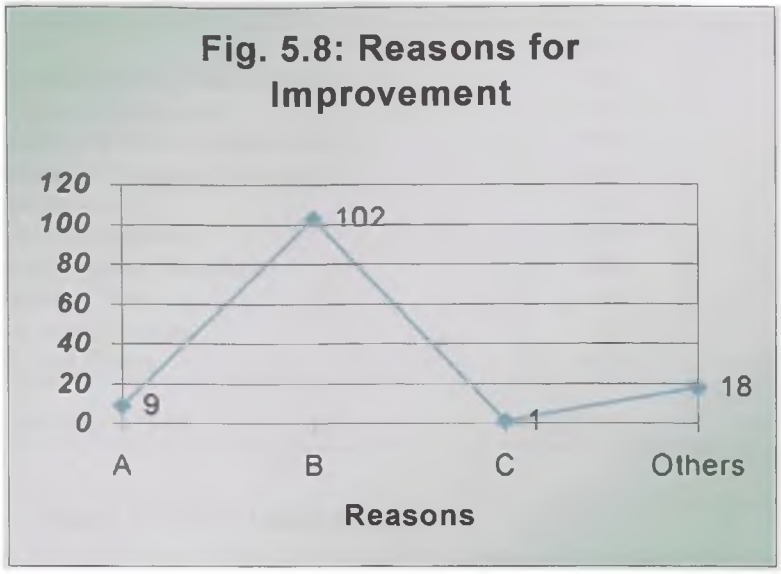
preventive health education and immunization; and God's protection respectively in figure5.8.



Source: Data Based on Fieldwork, 2001.

Note: 'A' denotes Availability of Drugs; 'B'—Preventive Health Education and Immunization; 'C'—God's Protection.

The 132 respondents who share the opinion that health status of the people has improved, 7% (9) of them believe that it was due to improved availability of drugs while 77% (102) were of the view that it was largely because of preventive health education given to the people. The 14% (18) of the respondents designated "others" attributed the perceived improvement to factors such as improved accessibility in terms of number of lorries plying the area which enables them to access the health facilities in the district, increased number of health centres, the urge of some of the health personnel to deliver high quality services to their patients among others. Two respondents did not give any reasons. Table 5.2 shows the top ten causes of consultation at T.Q.M.H. in 1999.

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Table 5.2: TOP TEN CAUSES OF CONSULTATION/MORBIDITY

CONDITION/CAUSE	TOTAL	% OF TOTAL
1. Malaria	6413	27.0
2. Upper Respiratory Tract Infection	1906	8.0
3. Diseases of Oral Cavity	1521	6.4
4. Pregnancy Related Complications	1504	6.4
5. Accidents (Fractures, Burns etc.)	1246	5.2
6. Hypertension	1124	4.7
7. Acute Eye Infection	1122	4.7
8. Gynaecological Disorders	928	3.9
9. Disease of Skin	712	2.9
10.Diarrhoeal Disease	592	2.5
Total of All Others	6676	28.3
GRAND TOTAL	23744	100.0

Source: T.Q.M.H. Annual Report, 1999.

5.3 Education

The focus of this research, with regards to the impact of education on community participation, is whether health education has impacted on people's attitude towards involvement in all facets of the programme, from the perspective of respondents who are the object and at the same time the subject of analysis. There are a number of agencies involved in health education programmes apart from what is given to pupils through formal education in classrooms. Other agencies such as Plan Parenthood Association of Ghana (PPAG), PHC units, and non-governmental organizations particularly CEFRIEND, as far as the district is concerned are also involved in health education.

The PPAG is mainly involved in family planning and related issues. Its activities are conducted mostly in the form of organized forums where resource personnel are

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invited to deliver a talk on family planning related topics after which the floor is usually opened for the people to asked question bothering their minds. Most respondents reported that film shows are the most interesting aspect of PPAG's educational programme.

There is a white lady from Canada called Margaret Scott, who has shown great concern on the health of the people. She has been going round the district meeting and educating the people about the need for one to protect and safeguard his or her health at all times. It is also common knowledge that this woman sometimes provides drugs and other items to needy people from her own resources. One thing gathered from the respondents was that they like this woman and are ready to listen to her any time she is willing to talk to them. This is one of the surest ways of getting the people involved in the PHC programme.

The PHC units with its affiliate sub-division such as Maternal and Child Health (MCH), Family Planning, Food and Nutrition etc. are the main foci of analysis in terms of people's participation in the PHC programme. PHC units undertake educational programmes in various forms. One of them is sending some of their personnel to go out and talk to the people on pressing health issues, which are of grave concern to the Ministry of Health and for that matter the government. In places where there are no static PHC units regular and periodic (normally monthly) outreach programmes are embarked upon in order to reach out to communities, which may not have access to PHC services due to technical or financial problems. The Maternal and Child Health together with Nutrition divisions concentrate more on family planning and reproductive health. Matters usually discussed include breastfeeding, child

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bearing and child spacing, eating habit for mother and child among a host of other preventive health measures. Health education is a cardinal element not only to MoH or PHC units but also the beneficiaries of the programme themselves. This was demonstrated when they were asked 'what they, the respondents, think should be done to encourage people's participation in the PHC programme' Table 5.3 represents the views of the respondents.

Table 5.3: Response on how to Improve Community Participation

Responses	No. of Respondents	Percentage (%)
Involve them in decision-making process	8	4.0
Involve them in implementation stage	3	1.5
Educate them about PHC programmes	182	91.0
Give them financial incentives	2	1.0
Others	5	2.5
Total	200	100.0

Source: Data Based on Fieldwork, 2001.

From the table above, it can be seen that the majority of respondents have a conviction that for people to avail themselves with the PHC concept and to fully involve themselves in its programmes they must be well informed about what it stands for. As many as 182 respondents share this view, which constitutes 91% of total respondents.

In spite of the huge role health education can play towards whipping up community's interest for improve participation in the primary health care programme, it was realized that, not enough has been done in this direction. 'How often respondents

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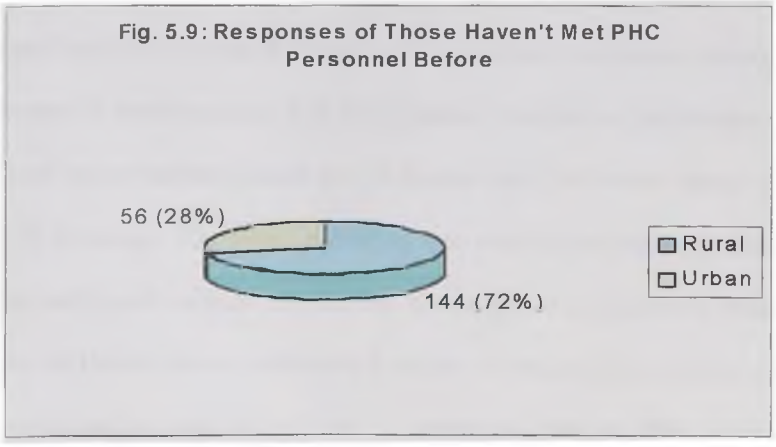
come into contact with the PHC personnel for such educational programmes', the result was not encouraging. It is even worse in the case of rural communities as Table 5.4 and Figure 5.9 depict.

Table 5.4: How Often the People in the Community Meet PHC Personnel

Response	No. of Respondents	Percentage (%)
Once Every Three Months	17	9
Once Every Six Months	74	37
Once Every Year	57	28
Not at All	40	20
Others	12	6
Total	200	100

Source: Data Based on Fieldwork, 2001.

Out of two hundred respondents, 20% of them had never met any PHC personnel as far as dissemination of health educational issues are concerned. The problem is more pronounced in the rural areas as compared with the relatively urban areas*.



Source: Data Based on Fieldwork, 2001.

*** See page 30 for sampled towns and villages and their total populations.**

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A further 57 respondents stated that they meet their PHC personnel for similar exercise once every year. This together with "not at all" respondents constitutes 49% of those who do not have access to the people who are supposed to educate them on regular basis. The most unfortunate thing about this phenomenon is that majority of this category of people are rural dwellers who need this type of education more than any other category of people. Under this circumstance, the very people who are supposed to ensure that the programme runs effectively seriously undermine the cardinal principle of PHC, which is community participation. There is, therefore, the need to take a critical look at this to ensure that optimum participation of the communities is achieved at all times and places.

5.4 Programme Financing

Money to some people 'is not only the most important thing but the only thing'. One serious setback to successful implementation of PHC activities is money (WHO, 1990). Interviews with health personnel in T.Q.M.H. revealed that the most daunting problem inhibiting the progress of PHC programmes is financial resources to procure the necessary logistics for smooth running of its activities. As Madam Juliana Addo, senior community health nurse at T.Q.M.H., puts it "the goal of the Primary Health Care concept was to achieve health for all by the year 2000 even though that has proven to be a mirage. This means providing free medical care to large numbers of people who really need medical care but who cannot afford it themselves. Meanwhile the Ministry of Health which is the main financier of the programme lacks adequate financial resources to cater for all that is needed to promote PHC programmes efficiently".

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Fieldwork reveals that the PHC programme is wholly financed by the central government subventions through the Ministry of Health with occasional help from the district assembly and a non-governmental organization called CEFRIEND especially when there is Mass Immunization Campaigns. Apart from these sources little revenue is generated from the small fees they collect from regular child check ups, what is referred to as 'Weighing'

This aspect of the programme is one of the crucial areas where community participation is badly needed especially in a developing country like Ghana where we are often told that 'the government alone cannot do this or that' The people can be educated and convinced to understand that it is in their interest to contribute a token towards the running of the programme so that they can derive maximum benefit from it since the programme is there to serve their interest. The PHC programme in Akwapim North District is not endowed with enough resources like all others in the country apart from that of the Asante Akim North District where the programme is given a cushion in both logistical and financial terms to complement their effort, from Presbyterian Church of Ghana, which established Agogo Hospital, and virtually run the PHC unit. With no such privileges in Akwapim North District and governmental sources woefully inadequate the only option available to them is to generate funds internally for the day-to-day running of the programme.

5.5 Sustainability of the PHC Concept

The strength and future sustainability of Primary Health Care programme dwell on its economic, social and health programmes not as separate programmes or entities but rather as integrated whole. It is asserted that programmes that treat economic, social

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(including health), and ecological programmes separately would not be sustainable. Primary Health Care programme in order to ensure sustainable health development, sought to promote community participation, conserve the social norms and traditions such as traditional health delivery system, and preservation of the environment to reduce spread of diseases.

This research has as one of its basic objectives a critical examination of factors which influence participation in the PHC programme in the district so as to find out if new ideas could be incorporated into the programme to improve efficiency, therefore, making it sustainable—including contribution to improvement of health of the people, cultural identity, and social cohesion and participation.

Medically, the contribution so far made by the concept of primary health care to the health status of people cannot be overemphasized. This assertion is largely manifested in Nicaragua. Under the dictatorship of Somoza in that country, health care was abysmal for the vast majority of Nicaraguans. The average life expectancy was 54 years of age for men and 52 for women who were the hardest hit by maladministration exhibited by Somoza. Malnutrition was rampant and affected 7 of every 10 children. Children between the ages of 1 and 2 years exhibited a mortality rate of 20%, with infant mortality comprising 120 of 1000 live births in the urban areas and 300 of 1000 live births in the rural areas. The chief causes of deaths among older children included tetanus, measles, and dehydration from gastroenteritis and diarrhoeal conditions, which are all preventable.

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In July 19, 1979, the Sandinista government took control of Nicaragua after a very bitter and hard-fought revolution. One of the postwar initiatives was the formation and implementation of countrywide health drive that was designed to provide universal access to primary, preventive, and community care services for all Nicaraguan residents. The Sandinista campaign promoted health education and the training of health care volunteers to promote personal and environmental cleanliness and good nutrition and to provide vaccinations against preventable diseases in local villages and communities. In addition, the government wished to initiate a plan to eradicate polio and malaria. All available nurses who were working in Nicaragua were engaged to assist in these activities. Furthermore, a call went out worldwide for nurses and physicians who were trained in primary care, community, and public health to assist the Sandinista government with their effort.

Nicaraguan nurses received special training in maternal and child health and were taught the principles of community and public health. They staffed many neighbourhood and rural clinics and provided free parental care, medications and food supplements. As part of this programme, all infants and children were guaranteed free primary and disease preventive health care. Popular participation was the order of the day and they succeeded in gradually improving the health of the people.

This clearly shows that when people are encouraged, made to take active part and leave the control over the programme in their hands, with governing agency or department playing monitoring and supporting roles, it will go a long way to influence the extent to which they will participate and the effectiveness of the programme.

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Unfortunately, the efforts of the Sandinistas were dissolved as a result of another bloody political revolution. Nicaragua has become one of the poorest countries in the Western Hemisphere and fall behind Haiti, which has held that distinction for decades. Universal access to primary and preventive care no longer exists. Neither polio nor malaria has been eradicated (McGuire, 1995).

Another country where participation by communities has helped in ensuring the success of a programme designed to improve the health of the people is the Gambia. In the Gambia a community-based strategy was tested, in which a traditional snack food was promoted as a dietary supplement to improve women's nutrition during pregnancy (WHO, 1996). The results suggest how community nutrition programmes can be designed so as to ensure sustainability. By and large, the lessons learned are also applicable to other types of community health programme. What necessitated the adoption of this strategy was that women in rural areas of the Gambia were nutritionally stressed because of heavy workloads, closely spaced pregnancies, and dietary deficiencies. Their poor nutritional status contributes to complications during pregnancy and childbirth, maternal and neonatal mortality, maternal anaemia, and low birth weight of babies.

The Gambia Food and Nutrition Association, a non-governmental organization, which has been involved in community-based and nutrition projects since 1990, and has been active in seeking ways to improve women's nutritional status got involved in ameliorating the problem. The Association tested a community-based strategy involving the promotion of *futu kanya*, a traditional snack food made with millet,

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sugar and groundnut paste, all of which are produced locally, as a dietary supplement for pregnant women during the rainy season.

Some key components of the project were:

- training of local women's community management committees to coordinate the preparation and distribution of *futu kanya*;
- education on nutrition for male and female members of the community;
- community involvement in all phases of *futu kanya* production;
- regular supervision of participating villages by project staff; and
- collaboration with local staff of the Ministry of Health.

The results of the evaluation showed that the project was quite successful in terms of community involvement in the production and promotion of *futu kanya*. Virtually all the community interviewees reported that *futu kanya* had a positive effect on the pregnant women who consumed it. They stated that these women had more energy than during previous pregnancies and that babies were born big and strong and remained healthy subsequently.

Examples of situations where attempts have been made to improve the health of majority of the citizenry through vigorous and determined community participation in the PHC concept can be found in countries where health status has been said to be higher than income suggests. Such countries include Burkina Faso, Tanzania and India. All these examples go to confirm the assumption that "community involvement or participation is of paramount importance for the effective implementation of the PHC programme".

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Field investigations reveal no such intense approach towards execution of PHC programmes in the Akwapim North District, as it were in Nicaragua and in the Gambia. No specific programmes have been designed to capture the entire community the way it was in the Gambia. There is, therefore, the need to invigorate our approach to all activities concerning PHC programme. This can be done by embarking on nationwide educational crusade to sensitize the people for full participation of all including politicians, medical and paramedical personnel, teachers and practically any body who can contribute his/her quota to uplift the concept of PHC to the level where its benefits can be utilized by all. It is only when people are informed and believe that they are going to derive benefits from something that they will put maximum effort into it, which will go a long way to enhance its long-term sustainability.

5.6 Initiatives in Primary Prevention Methods

Most childhood deaths in the developing countries can be prevented if children are adequately breast-fed, correctly weaned and protected with immunizations against common childhood communicable diseases. One of the major roles of family health is the promotion of preventive paediatrics. Preventive paediatric starts during the prenatal period when health workers must commence the orientation of pregnant women about the need and the importance of breast-feeding. It also includes the necessity for adequate balance meals to prevent anaemia and premature or small-for-date babies, and the need for tetanus prophylaxis.

Over the years, the main efforts of health practitioners have been focused too much on diagnosing and treating diseases rather than preventing them. In a country where income level is so low to the point that many people do not think of visiting medical

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centres when they fall sick making avoidable deaths a common feature in Ghana in particular and developing countries in general. This makes it imperative to direct much resource towards disease prevention in which case resources that the government spends in importing sophisticated medical equipment and drugs, which are severe drain on our limited foreign earnings, can be directed to other areas for the betterment of all Ghanaians. The following are some of the preventive health activities.

5.6.1 Expanded Programme on Immunization (EPI)

Immunization is one of the most powerful weapons for the primary prevention of infectious diseases. Smallpox was once a serious disease, which infected many people. It has now been eradicated as a result of well-organized vaccination campaigns. Poliomyelitis, whooping cough, diphtheria, tetanus, tuberculosis and measles are all serious diseases, which can be effectively prevented by immunization.

Fortunately, the people of Ghana are ready to respond to calls on immunization as shown by respondents in the study area. When they were asked whether they have immunized their children against the six childhood killer diseases the response was overwhelmingly positive as shown in figure 5.10.

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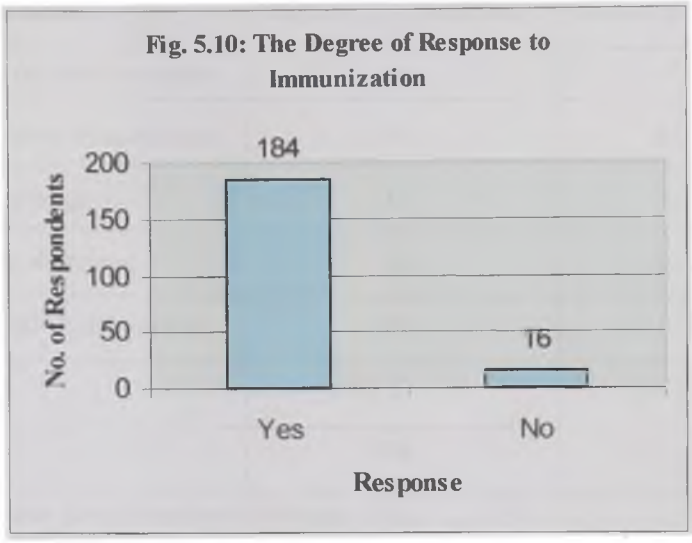

Source: Data Based on Fieldwork, 2001.

From the figure 5.10, out of 200 respondents interviewed 184, which is 92%, have immunized their children while only 16 respondents have not and out of the 16 is 81% who are yet to give birth or have not been able to give birth at the time these interviews took place. The three respondents, who have not immunized their children when asked to explain why they have not immunized their children, could not give any reasonable answer. When probed further to find out whether their decisions were based on religious beliefs or time constraints, or any other factors, they could not confirm or deny that as well. Moreover, respondents were asked if they see immunization of children as necessary for sound child health, there was a 100% positive response. When asked what they have observed to make them think that immunization is necessary for sound child health. Table 5.5 summarizes their views.

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Table 5.5: Immunization as a Necessity for Sound Child Health

Reasons	Number of Respondents	Percentage (%)
They don't fall sick frequently	31	17
It has prevented some diseases	58	31
They look stronger	11	6
They are not deformed	17	9
Protected them from sickness	62	34
Others	5	3
Total	184	100

Source: Data Based on Fieldwork, 2001.

Immunization aspect of health promotion is very crucial to this study as it forms the integral part of the second assumption, which states, "Immunization is very necessary for child health" It is of absolute necessity that all children in the catchment area of a family health care service be given full immunization coverage within 12 months of their registration at the clinic. The clinic supervisor must regularly evaluate the immunization coverage of the children. It is unreliable to use the number of daily immunization as a yardstick for the effectiveness of immunization activities since it is possible that only a fraction of children who attend the clinic complete their immunization schedule. Regular random sampling of the immunization cards of the children who attend the clinic must be carried out. If mothers do not bring the children to clinic, as they should, the clinic staff should extend its immunization service and go into the houses to immunize the children. A careful look at the immunization monitor in page 95 (table 5.6) shows 81% immunization rate of BCG which is given soon after a child is born whilst for the TT'2 the rate fell to 50% which is due mainly to the fact that it is given some months after a child's birth. The immunization status of every

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child at every visit to the clinic must be checked, and if the child is well and due for an immunization, it must be given before leaving the clinic. Health workers must constantly remind mothers that most children who are unprotected against childhood communicable diseases will suffer these diseases and die, become maimed or suffer long periods of ill health.

The schedule of immunization will depend on a country's health profile but all the developing countries will protect their children against tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis and measles.

Table 5.6: Immunization Monitor—2000, Akwapim North District

Estimated Population (Year 2000) = 133760; WIFA (22% 133760); 0-11 Months (5350).

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
B.C.G	Actual	356	344	437	382	400	407	411	370	341	273	346	307
	Cumulative	356	700	1137	1519	1919	2326	2737	3107	3448	3721	4066	4373
	Percentage	7	13	21	28	35	43	51	58	64	69	76	81
Measles	Actual	268	283	345	302	297	292	304	231	231	238	245	213
	Cumulative	268	551	896	1198	1495	1787	2091	2322	2553	2791	3036	3249
	Percentage	5	10	16	22	27	33	39	43	47	52	56	60
DPT' 3	Actual	310	340	383	357	319	303	292	266	336	297	299	256
	Cumulative	310	650	1033	1390	1709	2012	2304	2570	2906	3203	3502	3758
	Percentage	5	12	19	25	31	37	43	48	54	59	65	70
OPV' 3	Actual	316	343	382	374	325	321	294	272	326	286	295	254
	Cumulative	316	659	1041	1415	1740	2061	2355	2627	2953	3239	3534	3788
	Percentage	5	12	19	26	32	38	44	49	55	60	66	70
TT' 2	Actual	192	276	316	188	225	221	246	207	237	286	240	186
	Cumulative	192	468	784	972	1199	1418	1664	1871	2108	2394	2634	2820
	Percentage	3	8	14	18	22	26	31	34	39	44	49	50
Y/Fever	Actual	189	206	274	314	292	341	352	186	266	208	271	487
	Cumulative	189	395	669	983	1275	1616	1968	2154	2420	2628	2899	3386
	Percentage	3	7	12	18	23	30	36	40	45	49	54	63

Source: Immunization Returns, T.Q.M.H., 2000.

5.6.2 Nutrition Education

More than half of the children in the developing countries are malnourished (Adegoroye, 1983). Because of this they are very susceptible to infections and disease

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germs, which are rampant because of countries' poor socio-environmental conditions. Family health workers must equip families with the necessary information to enable them to select, prepare and serve nutritious meals prepared from suitable and locally available foodstuffs to their families. Individual and group health education concerning nutrition, food demonstration classes and daily supervision of feeds are some of the activities, which a family health clinic should include in its nutrition education programme. In addition to regular weighing of children at the clinic, health workers must identify, during their visits to the homes, children who show signs of incipient malnutrition.

Investigations into food situation in the District unfortunately portray a gloomy picture according to the respondents. They were asked to give their impressions on levels of food production and access to food for the past ten years, whether there has been an 'increase', 'decrease', or 'no change', their views are represented by table 5.7.

Table 5.7: Levels of Food Production and Food Availability for the Past Ten Years

Response	Number of Respondents	Percentage (%)
Increasing	14	7
Decreasing	86	43
No Change	100	50
Total	200	100

Source: Data Based on Fieldwork, 2001.

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Majority of the people in the study area conceded that there has either been a decline in food production and for that matter its availability or there hasn't been any significant change in these two variables over the past ten years. Only 7% (14) out of the 200 respondents believe that there has been some increase in food production and availability in Akwapim North District. This scenario particularly calls for pragmatic approaches in solving the problem of food inadequacy in the District in order to forestall any calamitous eventuality since lack of food could easily compel people to eat any food they could lay hands on notwithstanding the health problem that could result from it.

5.6.3 Utilization of Clean Water

Water is the most common substance on earth. It covers more than 70% of the earth's surface (The World Book Encyclopedia, 1993, p. 116). It fills the oceans, rivers, and lakes, and is in the ground and in the air we breathe. Water is everywhere. Without water, there can be no life. In fact, every living thing consists of water. Our body is about two-thirds water. Our demand for water is constantly increasing. We live in a world of water. But almost all of it—about 97 percent—is in the oceans. This water is too salty to be used for drinking, farming and manufacturing. Only about 3% of the world's water is fresh (unsalty). Most of this water is not easily available to people because it is locked up in icecaps and other glaciers. By the year 2000, the world's demand for fresh water may have doubled what it was in the 1980s. As our demand for water grows and grows, we will have to make better and better use of our supply.

Unfortunately, much of our water is being polluted. Water pollution is one of our most serious environmental problems. It occurs when water is contaminated by such

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substances as human and other animal wastes, toxic chemicals, metals and oils. Pollution can affect rain, rivers, lakes, oceans, and the water beneath the surface of the earth, called *ground water*.

Polluted water may look clean or dirty, but it all contains germs, chemicals, or other materials that can cause inconvenience, illness, or even death. Impurities must be removed before such water can be used safely for drinking, cooking, washing, or laundering. The effects of water pollution on the health of humans are enormous. Water polluted with human and animal wastes can spread typhoid fever, cholera, dysentery, and other diseases. About 75% of the United States community water supplies are disinfected with chlorine to kill disease-causing germs (The World Book Encyclopedia, 1993). However, disinfections do not remove chemicals and metals, such as polychlorinated biphenyls (PCB's), chloroform, arsenic, lead, and mercury. In our situation in Ghana, because of low level of technology and income, we cannot afford the U. S. example so what is for us is to mobilize whatever resources available to protect our natural sources of water. It is also necessary to educate people to treat impure water before drinking, cooking, or any other use one wants to put it to. A probe into the availability of water in the District for the past ten years revealed the following.

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Table 5.8: Degree of Access to Potable Water for the Past Ten Years

Response	Number of Respondents	Percentage (%)
Increasing	28	14
Decreasing	80	40
No Change	92	46
Total	200	100

Source: Data Based on Fieldwork, 2001.

To most respondents interviewed, access to pure water is really a problem and it is increasingly getting out of hand. The three villages—Tinkong, Kurutuase and Asempaneye—rely on hand dug wells, which dry up during dry months of every year according to some opinion leaders in the villages. In Akropong and Mampong where they have some sort of pipe-borne water, the situation is no different, as there is highly intermittent flow of water, thereby forcing the inhabitants to walk long distances for well-water which is equally unreliable. Generally, 40% (80) of the respondents assert that access to potable water has deteriorated in the past ten years, whilst 46% (92) believes that there has been no change in access to water. In view of this, education on the use and treatment of water is essential if a significant reduction of incidence of diseases is to be achieved.

5.6.4 Environmental Sanitation.

Most disease causing agents live in the environment. Their survival depends on the state of the environment. The health of the people, therefore, indirectly depends on how the environment is kept. In spite of the role environment plays towards the health status of people, it has been in many ways polluted. Environmental pollution refers to

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all the ways by which people pollute their surroundings. People dirty the air with gases and smoke, poison the water with chemicals and other substances, and damage the soil with too many fertilizers and pesticides. People also pollute their surroundings in various other ways. For example, they ruin natural beauty by scattering junk and litter on the land and in the water. They operate machines and motor vehicles that fill the air with disturbing noise. Nearly everyone causes environmental pollution in some way.

Environmental pollution is one of the most serious problems facing humanity today. Air, water, and soil—all harmed by pollution—are necessary to the survival of all living things. Badly polluted air can cause illness, and even death. Polluted water kills fish and other marine life. Pollution of soil reduces the amount of land that is available for growing food.

When the respondents were asked to give their impressions on the environmental sanitation of their area in the past ten years, 50% (100) agreed that there has been some form of improvement in sanitary conditions in their areas while 37% (74) said it is actually deteriorating. The remaining 13%, which makes up 26 of the 200 respondents declared that there has been no significant change in the environmental conditions in their areas.

5.6.5 Awareness Programmes

Creating health awareness among people especially in rural areas where access to health facilities is almost always a problem, either because of non-existence of medical facilities or the people simply cannot afford it, such exercise needs to be

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tackled from all fronts. In the first place, the Health for All goals require that nurses not only provide highly specialized care at the primary level, with roles including those of facilitator and manager of health care. The central concern of nurses in primary care should be the prevention of disease and disability. This requires them to educate individuals and families on healthy life styles, and communities on the primary prevention of ill health and on protective and supportive measures. Nurses also have a duty to educate other categories of health care personnel.

With the arrival of the Primary Health Care approach comes with the involvement of nurses in diagnostic and intermediate levels. Nurses are today required to teach community health workers and traditional birth practitioners to carry out many of the functions that nurses themselves have normally performed. They also have to undertake tasks and responsibilities formerly reserved for doctors, including the examination of patients, the treatment of acute conditions, the identification of sources of health problems, and the prevention of major diseases. The roles enumerated above are crucial and nurses have to play them with utmost dexterity since it is they who are closer to the people and interact more with them.

5.7 Inhibiting Factors of the Primary Health Care Programme

Several red lights have been encountered in the implementation of primary health care programme. One serious check to PHC is money. Resources are inadequate at all levels. The staffing levels required for optimum running of the health units have not been met, and this has hindered the integration of activities. Shortage of funds, moreover, curtails the services the health units can offer. The Ministry of Health has difficulty in supporting the costs of projects originally financed by external resources.

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Another red light has to do with weak management. Even if additional health resources were made available to the health budget from inside or outside the country, very little improvement in PHC would be realized if they were used in the same way. Most health resources go to providing unnecessarily sophisticated curative health care, which is becoming more expensive to those who have to use it. Little money is left for health promotion, disease prevention, and the provision of curative care to the rest of the population. The concept of PHC has not been properly assimilated by all health workers or indeed by the population as a whole. In the eyes of many, PHC is limited to services offered by community health workers. Not all managers of health units have been trained in health services management. Since resources have not been adequately decentralized, there is no incentive for those in charge of units to engage in micro planning for their areas.

Most ministries of health do not have the ability to undertake the dual tasks of delivering health services and mobilizing communities for more than routine activities over short periods of time. Self-help schemes to build clinics, improving water resources or building access roads have been some of the few examples of activities undertaken. The enthusiasm soon wanes after the task is completed, and without continuing support or encouragement interest is not sustained. Some difficulties arise from the level of socio-economic development of the country as a whole. For example, the low level of literacy hampers health activities. In the study area, illiteracy is pervasive especially in the rural settings of Tinkong, Kurutuase and Asempaneye. As many as 35% of the 20 respondents in Asempaneye, a village, were illiterates whilst only 3% have had no formal education at all in a relatively urban area

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of Akropong the district capital. Further, among the 84 rural respondents, there was not a single graduate from any tertiary institution. Table 5.9 shows level of education in the various sampled communities.

Table 5.9: Level of Formal Education in the Sampled Towns and Villages

Towns/villa-ges	LEVEL OF FORMAL EDUCATION					
	No Education	Basic	Secondary/ Technical	Tertiary	No. of Respondents	Percentages
Akropong	2	29	25	4	60	30
Mampong	2	31	22	1	56	28
Tinkong	8	16	12	0	36	18
Kurutuase	7	13	8	0	28	14
Asempaneye	7	8	5	0	20	10
Total	26	97	72	5	200	100

Source: Data Based on Fieldwork, 2001.

The greatest of these problems is that of supervision. Where the network of health service is not properly organized, the village health worker remains unsupervised, and this is very dangerous to the community as well as the health worker. Health workers who operate in static units such as the health post are often tied down to their units by a heavy curative workload which prevents them from looking beyond the confines of the four walls of the health post. Community health aides/assistants are paid by the central government and because the government is usually financially handicapped they employ only a few of these cadre of health workers who are expected to supervise an unrealistic number of villages and village health workers. Unfortunately most workers do not posses the means of transport to make them mobile enough to carry out their supervisory functions. In fact, at the Tetteh Quarshie Memorial

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Hospital, where the general overseeing and coordinating body is housed, the only mode of transport for such activities is two motor bikes which are also in demand for other purposes thereby putting too much pressure on them and also not getting access to them at the right time. Furthermore, most of the community health aides/assistants also lack supervision by a higher authority. The result is that the village health workers are left to their own devices. Many of them take on more curative functions than they have been taught, and the preventive and promotive aspects of their functions are neglected.

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CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Summary

The world's attention has been directed to the need for the adoption of technologically practicable and socially acceptable health care programme to put a halt to numerous avoidable infirmities and deaths since the Alma-Ata Declaration in 1978. The solution, therefore, lies in the adoption of sustainable health development approach where people—nation-states, communities and individuals—decide on their own needs and work vigorously for its accomplishment.

This participatory research project describes a mechanism by which individuals from communities are involved with the process of identifying and examining the health problems of their community and the potential ways to design solutions for them. A comparative analysis of programme process and product from different settings around the world was used to determine the success and failures of the programme. One typical example is Sandinista government approach to primary care in Nicaragua in the early 1980s.

Primary health care is a programme seeking to achieve sustainable health development through community participation in the promotion of health. In line with this, the programme was conceptualized in a manner that incorporates all sectors of the economy. This is based on the fact that, health cannot be promoted in isolation and without a corresponding improvement and support from other sectors. The primary health care programme in Akwapim North District like all others in the country has three tiers: namely Level A, Level B and Level C. All these levels must

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coordinate effectively for rural-based primary health care to be carried out successfully.

The participatory approach was based on a model where there is a bilateral interaction between the communities as a group and the Ministry of Health. In fact, the success or failure of the programme depends on each side fulfilling its part as far as the programme's activities are concerned. Various governmental agencies come under Ministry of Heath to perform primary health care functions. These are the health posts, health centres and T.Q.M.H. in Mampong as far as PHC in the District is concerned. The communities consist of the general public, the opinion leaders, the trained community health workers and traditional birth attendants.

The Ministry of Health through its affiliate agencies performs various roles such as defining policy direction, decision-making, planning, implementation, monitoring and evaluation of the programme. For instance, the ministry determines the health policy of the country while the PHC units and the health institutions implement whatever is outlined in the health policy in line with the goals and aspirations of primary health care concept. The role of the community is found in areas of receiving the services of the health personnel and to a limited scale, supporting implementation of the primary health care programme by such people as traditional healers, traditional birth attendants, and community health workers.

At the sub-district level, the sub-district health management committee organizes and coordinates all the activities in the primary health care programme while the district health management team supervises and coordinates all programmes in the District.

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The role of the community in the implementation of primary health care programmes is restricted mainly due to the technical nature of health issues that require specially trained people to deliver, and to a larger extent the lack of well defined roles to be played by the people in the study area. This notwithstanding the community cannot be left aloof since one of the objectives of the PHC concept is to transform the community from being receivers to enablers who can take their own health maintenance into their own hands. It implies that, the community be given some basic education and training that can enable them practice lifestyles required to ensure healthy living. Unfortunately, this is the area where not much, if any at all, has been done.

The area where there is a significant level of community participation is the people's willingness to respond to immunization/vaccination campaigns as shown in page 95. It is apparent that the people in the district are aware of the consequences of failure to immunize ones child against the major childhood killer diseases.

6.2 Conclusion

Based on the background of the general objective of this study to analyze the participation of the people of Akwapim North District in the Primary Health Care programme, the analysis has shown a low level of community participation in some aspects of the programme. From the above findings it can be concluded that, the level of community participation in the primary health care programme in the Akwapim North District is extremely limited. Apart from communities responding to few programmes such as film shows meant to educate them on specific health issues, they

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remain more or less aloof in almost all processes of decision-making, planning, implementation, monitoring, and evaluation of PHC programmes. In contrast, however, there is high level of knowledge about preventive health measures, which is manifested in respectable response to immunization and other related measures such as weighing.

There is an urgent need to correct this fundamental problem, which is very critical to the programme. The ability of a country to develop highly depends on the health status of her people. With the increasing threat of the most dangerous disease, HIV/AIDS, which has the capacity to decimate human population if not checked, mankind has no choice than to involve all and sundry in the fight not only against HIV/AIDS but malaria, URTI, and all life-threatening diseases. In fact, community involvement in the primary health care programme really needs attention; many lives are lost from avoidable and preventable diseases due to lack of knowledge of basic health issues.

6.3 Recommendations

6.3.1 Community sensitization, motivation and mobilization

Central to effective community health care are sensitization, motivation and mobilization of the community. Community health care belongs to the people. The target community should be sensitized to the need for community health care until it becomes the community's felt need. They should be motivated to want to do something to meet this felt need and to improve health care in their community, and be encouraged to mobilize the required human and material resources to do so. Community mobilization is getting people involved and committed to achieving a

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goal. The people should be assisted to become more aware of their community, take an in-depth look at that community, identify the felt as well as the real needs, have a belief or faith that something can be done to relieve these needs and that most of the resources to achieve these are within the competence of them, possess a desire and a willingness to use such resources to ensure the continued existence and improvement of their community.

It is definitely not an easy process. It is time-consuming, requires tenacity, persistence, patience, forbearance, a positive outlook, a love of people and a tolerance and an understanding of those who may appear difficult to win over.

Health workers have a responsibility for community mobilization, and this is where a resident health worker is at an advantage over another health worker who lives away from his community. For effective community mobilization the health worker must possess a thorough knowledge of his/her community. He/she must make him/herself acceptable to the community and speak the language of the people. The health worker must identify with the villagers; share their concerns, hopes and aspiration for improved health and social status; recognize community needs; be approachable; demonstrate good conduct and appearance; be a good role model; identify opinion, group and community leaders; possess a clear understanding of the hierarchical structure of the community and move through such structure in all matters concerning the community. He/she must participate in community activities and festivities, organize and hold meetings with community groups, make useful and practical suggestions, respect other people's opinions and be willing to learn from others. The community health worker must, when required, supply technical resources, identify

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formal and informal health agents in the community and collaborate with them to mobilize the community to desire and to work to achieve a better standard of health.

6.3.2 Health Education by Health Workers

Health education should run like a thread through, and be built into all clinic activities. Health education must be carried out at group and individual levels in the clinic or health centre. Traditionally, a health worker before the beginning of a clinic gives a health education talk on a specific topic of common concern. This should be carried out with the full involvement and participation of people who are old enough to join in. However, nothing like this is done in most health institutions today. The closest they have come to is the morning devotion before the commencement of clinical activities. This form of health education must be reintroduced and vigorously enforced so as to keep incidence of diseases to the barest minimum.

6.3.3 Adaptation from other Societies

Moreover, the Nicaraguan and the Gambia examples can be replicated in the District especially so when food is a scarce commodity. It shouldn't necessarily be *futu kanya* as was the case of the Gambians but something that suits the peculiar conditions of the study area.

6.3.4 Strengthening Community Initiative

There is the need to inculcate the sense of community responsibility and ownership in health development programmes. Community involvement ranges from participation in activities defined by outsiders, to the management and ownership of activities developed primarily by community members themselves. The community must be

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encouraged and guided to set out their own health programmes that will promote their status of health. Compatibility with community norms and values is also very essential in every programme designed to promote the health of the community. Traditional norms and practices must be built on, to win widespread acceptance and involvement of the people. Programmes design to boost the health status of the people, which require the participation of the community, must be in consonance with the traditions of the people.

6.3.5 Fusing Tradition with Modernity where Applicable

It is also crucial to build on existing social units and roles of the community. It is always easier to develop the existing activities in collaboration with traditional communicators, traditional birth attendants and the community management committees, the intention being to build on their established roles. For instance, if it is HIV/AIDS awareness programme that has to be carried out, it will have the required impact if the health worker and/or the traditional birth attendant are effectively used as a medium of communication to the people.

6.3.6 Refresher Courses for Health Workers

There should be motivation, training and supervision of community actors. The roles of key community actors involved in health promotion programmes must be carefully defined and regular, adequate training given to them. It was realized during the fieldwork in March 2001, that the community health workers were not adequately supervised and updated on current happenings in the field of health.

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6.3.7 Community Contributions

An important means through which sustainability of a programme can be ensured is community contribution of resources towards the running of the programme. The programmes in the District are wholly financed by the government in which case a delay in the release of funds by government stalls their implementation. It is, therefore, recommended that programme managers, in conjunction with community members, should attempt to identify strategies such that communities contribute a progressively greater amount of the resources required to sustain the programme.

6.3.8 Strengthening Intersectoral Collaboration

Collaboration with community development agents in other sectors apart from health should also be strengthened. This can be achieved by collaborating with such sectors as agriculture, communications, environment and education among others, so that any efforts embarked upon by the Health Ministry can be complemented by other ministries. The health sector personnel should reinforce, for example, the maternal nutrition intervention during contacts with members of the community and to attempt to collaborate with educational or agricultural agents. Support for community-based interventions from development agents working in various technical fields could contribute to sustainability of the PHC.

6.3.9 Involving Prominent Personalities in Society in Health Education

Fieldwork reveals that not much education has been given to the people about the primary health care programme. Communities and households are unlikely to be motivated to solve their own health problems and to remain committed to doing so unless they have an understanding of them and their root causes. It is, therefore,

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imperative that the educational aspects of the programme must be adequately enforced. In this regard eminent people and those who command the respect of the communities can be encouraged to take active part. Personalities like Margaret Scott, the Canadian volunteer, the Member of Parliament of the area or any such personalities who can easily catch the attention of the people can be encouraged to give a talk on pressing health issues so as to get the needed messages to the target population.

It is hoped that if all the recommendations mentioned above are implemented and strictly complied with, the concept of PHC would be rejuvenated and popular community participation improved for a better health for all.

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APPENDIX 1

DEPARTMENT OF GEOGRAPHY AND RESOURCE DEVELOPMENT, UNIVERSITY OF GHANA. LEGON

Questionnaire on—Community Participation in the Primary Health Care Programme in Akwapim North District—for Respondents of the Communities in the District.

Note: Please Tick Where Necessary

PERSONAL DETAILS

1. Sex: a] Male[ ] b] Female[ ]

2. House number:.....

3. Age:.....

4. Occupation: a] Unemployed[ ] b] Teaching[ ] c] Farming[ ]
   d] Business[ ] e] Others(specify).....

5. Religion: a] Christianity[ ] b] Islam[ ] c] African Tradition[ ]
   d] Others(specify).....

6. What is your level of formal education? a] No Education[ ] b] Basic[ ]
   c] Secondary or Technical[ ] d] Tertiary[ ]

7. Personal/individual income level (per month) in cedis. a] Zero-20,000[ ]
   b] 20,000-100,000[ ] c] 100,000-200,000[ ]
   d] 200,000-500,000[ ] e] Over-500,000[ ]

GENERAL INFORMATION

8. What is the name of the town or village you live in?:.....

9. How many children do you have?:.....

9.1 Specify their ages if any: a] First child..... b] Second child.....
   c] Third child..... d] Etc.....

9.2 Have you immunized them against the major childhood killer diseases?

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a] Yes[ ] b] No[ ]

9.3 If yes, do you see immunization of children as necessary for sound child health?

a] Yes[ ] b] No[ ]

9.4 If yes why do you say so.....

9.5 If you don't take part in immunization programmes, what is/are the reason(s)?..... Is it: a] Religious[ ] b] Cultural[ ] c] Financial[ ] d] Time constraints[ ]

10 Which of the following is your first point of call whenever you have health Problems? a] Community health worker in this town or village[ ]

b] Hospital, clinic or health centre near you[ ] c] Faith healer[ ]

d] Herbalist[ ] e] Others(specify).....

11. Do you know any thing about primary health care (PHC) programme?

a] Yes[ ] b] No[ ]

11.1 If yes, do you play any role in this programme? a] Yes[ ] b] No[ ]

11.2 Since when did you become aware of PHC programme?.....

12. Was the PHC programme identified and planned by the Ministry of Health in the District? a] Yes[ ] b] No[ ]

12.1. If no, who was/were responsible for that? Specify .....

13. Which aspects of the programme do you like? Specify.....

14. Which aspects do you dislike? Specify.....

14.1 How could it be changed? Specify.....

15. Do you take part in Mass Immunization Programmes embarked upon periodically by the Ministry of Health? a] Yes[ ] b] No[ ]

15.1 If yes, how many times have you taken part? Specify.....

16. Have you realized any improvements on the health of your children as a result

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of these immunization programmes? a] Yes[ ] b] No[ ]

16.1 If yes, what kind of improvement?.....

17. How often do you meet the PHC personnel in your area?

a] Once every three months[ ] b] Once every six months[ ]

c] Once every year[ ] d] Not at all[ ] e] Others(specify).....

18. What usually do the PHC personnel discuss with you? Specify.....

19. Who implement the plans and programmes of the PHC programmes?

a] The people in the community[ ] b] The personnel from PHC

c] The people in the community in conjunction with PHC personnel[ ]

d] Others(specify).....

20. Are the people in this community actively involved in the planning, decision-making, implementation and evaluation of the PHC programme?

a] Yes[ ] b] No[ ]

21. Do you have community health worker in this town or village? a] Yes[ ]

b] No[ ]

21.1 If yes, do you consult him/her when you face health problem?

21.2 If you don't consult him/her can you tell why? Is it because of

a] Financial constraints[ ] b] Religious beliefs[ ]

c] Cultural background[ ] d] Others(specify).....

22. What do you think should be done to get people actively involved in the PHC Programmes? a] Involve them in the decision-making process[ ]

b] Involve them in implementation stage[ ] e] Educate them about PHC programmes[ ] d] Give them financial incentives[ ] e] Others(specify)..

23. How do you assess the health situation in this town or village for the past ten years? a] Improving[ ] b] Deteriorating[ ] c] No change[ ]

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23.1 Give reasons.....

24. Level of/access to the following for the past ten years:

	Increasing	Decreasing	No Change
a] Health Facilities	.....	.....	.....
b] Sanitation	.....	.....	.....
c] Food Production	.....	.....	.....
d] Potable Water	.....	.....	.....

25. In what ways has the community benefited from the PHC programme?.....

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APPENDIX 2

DEPARTMENT OF GEOGRAPPHY AND RESOURCE DEVELOPMENT, UNIVERSITY OF GHANA. LEGON

Questionnaire on—Community Participation in the Primary Health Care Programme (PHC) in Akwapim North District—for Officials of the PHC Units

Note: Please tick where necessary

PERSONAL DETAILS:

1. Date:.....
2. Name of respondent:.....
3. Sex: Male[ ] Female[ ]
4. Status of respondent:.....
5. Religion: a] Christianity[ ] b] Islam[ ] c] African Tradition[ ]
   d] Buddhism[ ] a] Others(specify).....

GENERAL INFORMATION

6. How did the PHC programme introduce in the district?.....
7. How were the aims and objectives determined?.....
8. What roles do the opinion leaders in the community play in the programme formation and implementation.....
9. Do you organize immunization/vaccination programmes in the district?
   a] Yes[ ] B] No[ ]
   9.1 If yes, what kinds of immunization/vaccination?
   a] immunization against dysentery[ ]
   b] immunization against whooping cough[ ]
   c] immunization against diphtheria[ ] d] others(specify).....
   9.2 Who supervises these immunization programmes if there are any?.....

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9.3 Who finances these immunizations?.....

10. What has been the response of the communities during immunization campaigns?

a] Very encouraging[ ] b] Fairly encouraging[ ] c] Not encouraging[ ]

d] Poorly responded to[ ] e] Others(specify).....

11. What is your assessment of the impact of the immunization programmes on the Health of children? a] No improvement[ ] b] Considerable improvement[ ]

c] Others(specify).....

12. Do the people in the community take part in the PHC programmes?

a] Yes[ ] b] No[ ]

12.1 If yes, what aspects of the programme are the people involved in?

a] Decision-making process[ ] b] Implementation programmes[ ]

c] Evaluation stage[ ] d] Others(specify).....

13. Are those involved in the programme given some kind of remuneration?

a] Yes[ ] b] No[ ]

13.1. If yes, what form does it take?.....

14. How often do you conduct outreach programmes?

a] Once every week[ ] b]Once every month[ ]

c] Once every four months d] Others(specify.....

15. What usually is the response of the communities when you undertake these outreach programmes? a] Satisfying[ ] b] Appalling[ ]

c] Encouraging[ ] d] Not encouraging[ ] e] Others(specify)...

16. Do you have static PHC units in the District? a) Yes[ ] b]Not[ ]

16.1 If yes, how many static units are there in the District?.....

17. Can you tell where at least three of the static units are located.

a] ..... b] ..... c] .....

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18. How will you rate the performance of the static PHC units in the villages.

a] Excellent[ ] b] Very good[ ] c] Good[ ] d] Bad

e] Very bad[ ]

19. Would you recommend that the practice of the PHC concept is a waste of money so the government should concentrate on hospital-based health care or that more funds should rather be channeled into PHC programmes in order to improve efficiency and achieve results? a] Concentrate on hospital-based health care[ ]

b] Shift resources from hospitals to PHC programmes[ ]

c] Strike a balance between the two[ ] d] Others(specify).....

20. How do you assess the state of the PHC programme in the District?

a] So far so good[ ] b]Not all that bad c]Not good[ ]

d] There is room for improvement[ ] e] Others(specify).....

21. Which category of people utilizes the PHC services?

a] High income earners[ ] b] Middle income earners[ ]

c] Low income earners[ ] d] Poor people[ ]

e] Others(specify).....

22. How long does it take to train a community health worker?

a] One month[ ] b] Two months[ ] c] Three months[ ]

d] Four months[ ] e) Others(specify).....

23. What do you think should be done to mobilize and empower local people for improved health? a] Give them financial incentives[ ]

b] Give them education on health related issues[ ]

c] Give them incentives in kind[ ] e) Others(specify).....

24. What are some of the lessons learned from the programme?.....

25. Does any NGO play a role in the PHC programme? a] Yes[ ] b] No[ ]

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25.1 If yes, what is the name of that NGO?.....

25.2 What specific roles do the NGOs play?.....

26. Are those involved given some form of remuneration? a] Yes[ ] b] No[ ]

26.1 If yes, what form does it take?.....

27. Do you foresee any problems associated with or likely to inhibit smooth operations of the PHC programme in future?

27.1. If yes, what kind of problem?.....

28. Did the programme have a special design because they want local people to participate? a] Yes[ ] b] No[ ]

29. What is the common sickness in this community, if any?.....

30. When sick where do the people normally go for treatment?

a] Hospital at Mampong[ ] b] Nearest clinic or health centre[ ]

c] Herbalists or faith healers[ ] d] Community health worker[ ] Others...

31. Have you observed any change in disease pattern of this area?

a] Yes[ ] b] No[ ]

31.1 If yes, since when?.....

31.2 What could be the possible cause(s).....

32. Comment briefly on the health situation of the people in this town or village.....

APPENDIX 3a

AKWAPIM NORTH DISTRICT MONTHLY IMMUNIZATION RETURNS FOR JANUARY, 1999

District MCH Clinic	B C G				Measles				DPT 1				DPT 2				DPT 3			
	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL
Akropong	15	-	-	15	25	-	-	25	30	-	-	30	27	-	-	27	40	-	-	40
Mampong	30	-	-	30	27	7	-	34	22	-	-	22	23	-	-	23	31	-	-	31
Kwamoso	7	-	-	7	16	2	1	19	15	1	-	16	8	-	-	9	12	1	-	13
Aseseso	10	-	-	10	12	8	-	20	8	13	6	27	10	5	-	15	16	11	2	29
Nyensi	9	1	-	10	9	2	1	12	10	2	-	12	11	1	-	12	18	1	-	19
Twum Goaso	20	-	-	20	20	16	-	36	8	2	-	10	10	5	-	15	25	5	-	30
Larteh	13	-	-	13	16	14	-	30	20	-	-	20	21	-	-	21	15	-	-	15

Source: Immunization Returns, T.Q.M.H., 1999

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APPENDIX 3b

AKWAPIM NORTH DISTRICT MONTHLY IMMUNIZATION RETURN FOR JANUARY, 1999.

District MCH Clinic	B. C. G.				Measles				DPT. 1				DPT. 2				DPT.3			
	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL
Akropong	45	25	-	70	45	50	23	118	48	17	7	72	26	21	3	50	43	35	7	85
Mampong	57	-	-	57	18	1	-	19	27	-	-	27	11	-	-	11	8	-	-	8
Kwamoso	20	15	-	35	15	2	-	17	3	-	-	3	5	-	-	5	12	-	-	12
Aseseso	9	1	-	10	6	2	-	8	4	6	-	10	8	2	3	13	8	4	4	16
Nyensi	22	-	-	22	17	3	-	20	21	-	-	21	18	1	-	19	30	2	-	32
Twum Goaso	-	-	-	-	15	-	-	15	12	5	-	17	10	7	-	17	24	10	-	34
Larteh	17	1	-	18	30	15	-	45	14	-	-	14	28	-	-	28	18	-	-	18

Source: Immunization Returns, T.Q.M.H., 1999.

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APPENDIX 3c

AKWAPIM NORTH DISTRICT MONTHLY IMMUNIZATION RETURN FOR JANUARY, 1999.

District MCH Clinic	B C G				Measles				DPT. 1				DPT. 2				DPT 3			
	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL	0-11	12-23	24+	TOTAL
Akropong	10	7	-	17	12	17	-	29	10	3	-	13	15	7	-	22	10	10	5	25
Mampong	-	-	-	-	14	-	-	14	10	-	-	10	9	-	-	9	20	-	-	20
Kwamoso	5	-	-	5	8	-	-	8	4	-	-	4	7	-	-	7	8	-	-	8
Aseseso	10	-	-	10	7	5	2	14	9	-	-	9	14	-	-	14	16	-	-	16
Nyensi	15	2	-	17	15	3	-	18	10	3	2	15	14	1	2	17	20	1	-	21
Twum Goaso	36	-	-	36	8	-	-	8	3	3	-	6	5	5	-	10	20	-	-	20
Larteh	11	-	-	11	20	7	-	27	9	-	-	9	-	-	-	12	15	-	-	15

Source: Immunization Returns, T.Q.M.H., 1999.

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APPENDIX 4

ALMA-ATA DECLARATION

In the international conference that took place in Alma-Ata in 1978, the following is the unedited report of what became known as Alma-Ata Declaration: The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year nineteen hundred and seventy-eight, expressing the need for urgent action of all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following declaration:

I

The conference strongly reaffirms that health, which is the state of complete well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that attainment of the highest possible level of health is a most important worldwide social goal, the realization of which requires the actions of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people, particularly between the developed and developing countries and within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a new international economic order, is of basic importance to the fullest attainment of health for all and the reduction of the gap between the health status of developing and developed countries. The promotion and

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protection of the health of the people are essential to sustain economic and social development and contribute to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care (author's emphasis).

V

Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. In the coming decades a main social target of governments, international organizations, and the whole world community should be the attainment by all peoples of the world by the year 2000 a level of health that will permit them to lead a socially and economically productive life. PHC is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential care based on practical, scientifically sound, and socially acceptable methods and technologies made universally accessible to individuals and families in the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. It forms an integral part both of the country's health system, of which primary health care is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact for individuals, the family, and the community with the national health system bringing health care as

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close as possible to where people live and work, and it constitutes the first element of a continuing health care process.

VII

Primary Health Care

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of the social, biomedical, and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly;

3. includes education at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; provision of essential drugs;

4. involves, in addition to health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food industry, education, housing, public works, communication, and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, implementation, operation, and control of PHC making

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fullest use of local, national and other available resources; and to this end, develops through appropriate education the ability of communities to appreciate;

6. should be sustained by integrated, functional, and mutually-supportive referral levels, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers, as applicable, as well as on traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community; and

VIII

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

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The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international community to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.