University of Ghana http://ugspace.ug.edu.gh

RE48. M76
bltc C.1
G377866

THE BALME LIBRARY
3 0692 1007 3705 3

University of Ghana http://ugspace.ug.edu.gh

COMMUNITY PARTICIPATION IN EYE HEALTH CARE EDUCATION IN THE UPPER WEST REGION

BY

AMATUS G. MONTII

THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF M.A. ADULT EDUCATION DEGREE

DECEMBER 2003

University of Ghana http://ugspace.ug.edu.gh

G377866
RE48.M76
blt c c.1

University of Ghana http://ugspace.ug.edu.gh

TABLE OF CONTENT

Table of Content ii

Dedication v

Declaration vi

Acknowledgement vii

Abstract viii

CHAPTER ONE

1.0 INTRODUCTION 1

1.1 Short history of eye care service in the Upper West Region 2

1.2 Statement of the Problem 3

1.3 Purpose and Objectives of Study 3

1.4 Research Questions 4

1.5 Definition of terms 5

1.6 Delimitation and Limitation of the study 7

1.7 Significance of the study 7

Theoretical framework 8

1.8 Participatory Development view 8

1.9 Popular participation view 10

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction 13

2.1 Concept of Community Participation 13

2.2 Reasons for local Participation 21

2.3 The Primary Health Care Concept in general 23

University of Ghana http://ugspace.ug.edu.gh

2.4 Community participation in Primary Health Care.....24

2.5 Community Participation in Development 28

2.6 Development Strategy Approach 32

2.7 Community Education 35

2.8. Professionalizing Grassroots Activities.....36

CHAPTER THREE

METHODOLOGY

3.0 Introduction 40

3.1 Research Design.....41

3.2 Population..... 42

3.3 Sample 43

3.4 Data Collection Instruments 44

3.5 Data analysis 45

3.6 Profile of the area of study.....45

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF RESULTS

4.0 Introduction 46

4.1 Demographic characteristics of Respondents 47

4.2 Importance & purpose of community participation to community members...48

4.3 Planning eye health care programmes with the communities 50

4.4 Community contribution 51

4.5 Methods and strategies used for effective community participation 53

University of Ghana http://ugspace.ug.edu.gh

CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction 55

5.1 Demographic characteristics of Respondents 55

5.1 Importance and purpose of community participation.....56

5.2 Planning eye health care programmes with the community 58

5.3 Availability of Ophthalmic services in the communities 60

5.4 Community contribution 61

5.5 Methods and strategies used for community participation 63

CHAPTER SIX

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

6.0 Introduction 65

6.1 Summary of the study 65

6.2 Conclusion 68

6.3 Recommendation 69

References 71

Appendix 'A' Interview Schedule 74

Appendix 'B' Questionnaire for NGOs 78

Appendix 'C' Questionnaire for Eye Health Workers 80

Appendix 'D' A Map of Ghana Showing Area of Study .....82`

University of Ghana http://ugspace.ug.edu.gh

DEDICATION

Dedicated

To

Mr. Cletus N. Montii, my lovely brother,

Who pulled me to school,

Constantly encouraged me

And urged me on to climb the educational ladder.

University of Ghana http://ugspace.ug.edu.gh

DECLARATION

Apart from the references, which have been duly acknowledged, I declare that this piece of work is entirely the outcome of my own original research. I also declare that this dissertation has never been submitted either in part or whole for any award of a degree or anything else anywhere.

I am therefore, solely responsible for any omissions and errors.

CANDIDATE: AMATUS GANDAAYI MONTII

SIGNED: .....

DATE:.....

SUPERVISOR: A. K. AMEDZRO

SIGNED: .....

for

DATE: 6/6/2006

University of Ghana http://ugspace.ug.edu.gh

ACKNOWLEDGEMENT

I wish to acknowledge with profound gratitude, Mr. Albert Amedzro, my supervisor for his immense contribution, patience, and excellent supervision to the successful completion of this dissertation.

I am also thankful to Mr. Kusi Nkrumah, the Head of the Teaching & Research Unit, Institute of Adult Education, for his kind and constant advice, suggestions, and encouragement when things were becoming difficult for me.

To my friend and colleague, Mr. Daniel A. Akologo, who supported me in divers ways, I say 'M'puusya'.

I acknowledge the numerous authors whose work I have used to make this dissertation a success. To all, I say many thanks.

To Juliet and Little Michelle, who gave me peace of mind to concentrate on my work, I say God bless you.

University of Ghana http://ugspace.ug.edu.gh

ABSTRACT

The purpose of this study is to determine whether rural communities in the Upper West Region participated in eye health care education programmes. The study was in two phases.

In the first phase, 200 people from selected cluster communities were interviewed. These selected communities were chosen using the simple random sampling technique. After this, purposeful sampling technique was used to select eight community members from each of the twenty-five local communities. The aim was to find out from the local community members whether they participated in eye health care education programmes, and how they helped in combating blindness and eye problems in general in their local communities.

From the study, it came out that the rural communities did participate in some of the activities such as taking part in the decision-making and availing themselves for voluntary eye health care work.

However, they could not participate fully due to abject poverty, inadequate methodology used in educating them on eye health care issues, inadequate capacity building techniques on the part of the facilitators, and de-motivation among others.

The study recommended some ways by which rural communities could participate effectively in eye health care education programmes irrespective of their socio-economic status.

University of Ghana http://ugspace.ug.edu.gh

Rural communities could be supported with poverty alleviation programmes to bring them out of this abject poverty to enhance their participation in the programmes. Additionally, rural communities should be encouraged to participate in the eye health care education programmes and practised maternal and child health care seriously. It is also important that rural communities are educated to see the importance of immunizing their babies against the six childhood killer diseases as an important issue in their life.

In summary, the study notes that though the concept of community participation in rural development in general is appealing, if its real implementation is hampered by complexities and difficulties like abject poverty, inadequate teaching methods and capacity building techniques, local communities in the Upper West region will still continue not to participate fully in all community development programmes including eye health care education programmes.

University of Ghana http://ugspace.ug.edu.gh

CHAPTER ONE

INTRODUCTION

Over the last three decades there has been a shift in global development policy and practice with emphasis on community participation towards sustainable development. Any effort towards development therefore requires the mobilization of resources and especially human resources in the rural areas. This is clearly seen in the numerous rural development programmes and projects that continue to be launched in many developing countries aimed at making the rural people part of the process of development. To this end, many governments have begun to introduce decentralization as a way of achieving rural development. The decentralization policy has been introduced into the health sector too. The launching of the Primary Health Care concept in the late 1970s in Ghana provided the framework within which health delivery services recognize and promote active participation of communities in health care programmes.

In Ghana, a great deal of attention has been placed on rural development in recent years. The need for rural development is very pressing in view of the fact that the rural people in Ghana constitute about 70 percent of the total population (Twumasi 2001). Incidentally, it will be noted that despite various attempts to encourage popular participation in development, the response from rural communities has been very limited. In the Upper West Region, it is noted that poverty, indifference, and apathy have hampered the participation of community members in eye health care education programmes being implemented by NGOs and other agencies. Indeed, community

University of Ghana http://ugspace.ug.edu.gh

participation in the eye health care education is low. It will also be observed that the communities are not involved in the decision-making process on primary eye health care issues (Swiss Red Cross Document, 1990).

1.1 A short history of eye health care services in the Upper West Region

In September 1990, the Roman Catholic Diocese of Wa, the Swiss Red Cross Society, and the Ghana Red Cross Society formalized, by signing an agreement that stipulated their respective roles and partnership to promote eye care services in the Upper West Region. This marked the beginning of eye health care service and education in the region. It was also the first move toward community participation in eye health care programme. The chiefs, assemblymen and women, and volunteers were involved in the promotion of eye health care through education in the communities. But this initial participation did not last long. It is still not known why the community participation did not last. However, the main aim of this partnership was to bring eye care services closer to the people. In 1993, the second agreement was signed between Swiss Red Cross and the Ministry of Health to improve the participation of communities in the existing eye clinic in the region. This implies that before the creation of the Upper West Region, there were virtually no eye care services in that part of the country. By 1996, the partners had signed three consecutive agreements each of which constituted a new phase in the eye care services. The role of each partner was spelled out to include financial support by Swiss Red Cross, community mobilization by the Ghana Red Cross Society through primary eye care volunteers, and medical expertise to be provided by Ghana Health Services. The number of eye clinics increased from one to six. Outreach education

University of Ghana http://ugspace.ug.edu.gh

programmes also encouraged the patients' patronage of the eye clinics. Patients and community members acknowledged that access to eye care services has improved. So community members then began to come out once again to avail themselves to be trained as volunteers in eye health care education.

1.2 Statement of the problem

The problem of community participation in primary health care, especially in eye care, in the communities in the Upper West Region continues to be a source of worry to many people including parents, teachers, benevolent groups, and some NGOs. While various NGOs, notably Swiss Red Cross Society, Christoffel Blindenmission, Sight Savers International, and International Trachoma Initiative, among others, have been working hard to educate the rural communities on eye health care, several studies have revealed that the participation of the local communities has not been very encouraging. With my active involvement in primary eye health care education in the Upper West Region, I was motivated to investigate into the level of participation of rural communities in eye health care education programmes in the study area. In view of the above, the question, one asks is: To what extent are the rural communities in the Upper West Region participating in the eye health care education programmes?

1.3 Purpose and Objectives of Study

The purpose of this study is to identify the need for participation of rural communities in health care programmes, in particular, and the on-going eye health education in the Upper West Region. The study will also examine experiences and best

University of Ghana http://ugspace.ug.edu.gh

practices in effective participation in health care programmes so as to provide suggestions through which rural communities in the region will participate actively and then support and sustain projects and programmes initiated by NGOs and other groups aimed at improvement in their eye health status.

The study can generally be described as evaluative and its goal is towards the enhancement of community participation in the eye health care education programme in the Upper West Region. So this research focuses on the following objectives:

- To examine the extent of the community participation in the eye health care education programme in the region.
- To find out the reasons underlying the limited participation of community members in the eye health education programmes.
- To examine methods and strategies used in teaching the community members the six healthy rules of eye health care.

1.4 Research questions

The following questions are being used to guide the study.

- Who takes the decision on the eye health care project?
- What are the methods used by the various organizations in the creation of awareness on the eye health education?
- How were the capacities of the communities developed to participate in the eye health care?
- Who were involved in the awareness creation and capacity building on the eye health care?

University of Ghana http://ugspace.ug.edu.gh

- Which agencies were involved in the development of the programmes?
- Who determined and provided the resources for the eye health care projects?
- What contributions were anticipated by the project from the relevant stakeholders?
- What accounted for the low participation of communities in the programme?
- At what level is the community participation in the eye health care education programmes implemented by the NGOs?

1.5 Definition of Terms

An attempt is made to give operational definition of certain terminologies used in this research.

Community

The word community is operationally defined as "The people living together in some form of social organization and cohesion'

Participation

For the purpose of this study, participation is active involvement of the communities in decision-making, implementation, evaluation, and sustainability of a project.

University of Ghana http://ugspace.ug.edu.gh

Community education

Community education refers to interacting with community members on eye health care messages in a way that will be understood, absorbed and practised by community members.

1.6 Delimitations and Limitations of the study

The researcher could not get to more rural areas he intended to reach because two tributaries of the Black Volta River overflowed their banks during the data collection period making travelling impossible. Also village settlements were far apart such that it always took three to four hours for the researcher to walk from one village to the other. There were no accessible road networks in the area of study due to heavy rainfall so all journeys were made on foot.

1.7 Significance of the Study

The beneficiaries of this study are the local people in the community because this study will help them understand and use the six rules for healthy eyes and also know the importance of the eye health education. The eye health personnel in the communities under the study will also benefit because the researcher will educate volunteers to see the need and to support eye health care programmes in the community in future. The District Health Management Committee will have useful information about the eye health situation in the communities under study and based on this information the committee can carry out more outreach services even if the study is over.

University of Ghana http://ugspace.ug.edu.gh

The District Health Administrators can use the study results to develop more vibrant health campaign programmes in those communities which are adamant to community participation in other developmental work. NGOs, which are willing to help poor communities in the region, will have first hand information about community participation in developmental projects and community contribution in those areas. Finally, this research may serve as a foundation stone for other researchers interested in community participation in eye health care to build on to improve the living standard of the people living in those communities.

Theoretical Framework

1.8 Participatory Development view

A view of participatory development puts the spotlight on human potential and capabilities. According to this view, development is seen in such terms as enhanced competence to analyse and solve problems of day-to-day living, expansion of manual skills and greater control over economic resources, restoration of human dignity and self-respect, and interaction with other social groups on a basis of mutual respect and equality. Participation is advocated by Participatory Action Research (PAR) theorists cited in Wolgang (1999) as the only way to save development from degenerating into bureaucratic, top-down and dependency creating institutions. They do not question the validity of the institution, per se, which most of them consider could be a powerful instrument in the hands of the oppressed. They do insist, however, that, for development to play its historical role, it should be based on participation. Genuine processes of dialogue and interaction should thus replace the present subject-object relationships

University of Ghana http://ugspace.ug.edu.gh

between interveners and the beneficiaries, thereby enabling the oppressed to act as the free subjects of their own destiny. The agents to carry out this system are the community health workers who are to be supported by the rural masses. If voluntary community groups are to be usefully incorporated into an eye care programme, it is important to understand the way they think and work. According to Sutter et al. (1998), for people to participate in rural community projects, they must understand the importance of the project concerning their health. They see no point in dividing life into different compartments. For them, a healthy life includes good crops, stable families, healthy children, and a strong body. A community project must be variable enough to be attractive to the participants.

Participation as used in the PHC concept can be said to cover three main areas:

1. It refers to the mobilization of people to undertake social and economic development projects. Typically, the projects are conceived and designed from the top and the people are mobilized to implement them. Their participation thus consists of their contribution of labour and material, either free or paid for by the authorities (Griffin 1990).
2. The second interpretation equates participation with decentralization in governmental machinery or in related organizations. Resources and decision-making powers may be transferred to lower level organs, such as local officials, related bodies at the village or community level or local project communities.
3. The third view of participation states that it is a process of empowerment of the deprived and the excluded (Gran, 1983, Oakley & Marsden, 1984, Oakley, 1987).

University of Ghana http://ugspace.ug.edu.gh

One fact of empowerment is the pooling of resources to achieve collective strength and countervailing power. Another is the enhancement of manual and technical skills, planning and managerial competence and analytical and reflective abilities of the people. It is at this point that the concept of participation as empowerment comes close to the notion of development as fulfillment of human potentials and capabilities. On one hand, the eye health care education programmes can be described as a conventional development project. According to Griffins (1990), a conventional development project is conceived and designed from outside by national and international experts, together with pre-feasibility and feasibility studies, appraisal reports, specification of inputs and output, calculation of internal rates and sophisticated cost-benefit analysis. Writers mention that the people for whom all this is supposed to be done exist only in the abstract as numbers whose output and productivity are to be enhanced and whose needs are to be satisfied. Their participation in the participatory phase, if they are lucky, may consist of some hastily organized meetings with the experts and bureaucrats at which they are briefed about the objectives and activities of the planned projects. In the implementation phase they are expected to carry out their pre-assigned roles. The eye health care education programme can also be said to be a participatory development project. Its central concern is with the development of the moral, intellectual, technical and mutual capabilities of individuals in the community. The programme is therefore regarded as a process of expanding these capabilities with the community members as the pivot around which the programme is to revolve. The above discussions provide theoretical perspective from which clear research interest on various aspects of community participation in PHC programmes in general have emerged.

University of Ghana http://ugspace.ug.edu.gh

2.9 Popular Participation View

According to Orlando Fals-Borda, Anisur Rahman and other PAR theorists, cited in Sachs (1999), popular community participation is a methodology within total existential process; aimed at achieving power and not merely growth for the grassroots population. To them, the aim of such participation is to achieve power:

> "A special kind of power – people's power- which belongs to the oppressed and the exploited classes and groups and their organisations, and the defense of their just interests to enable them to advance towards shared goals of social change within a participatory system'.

They opine that, that is the way to save development from degenerating into a bureaucratic top-down and dependency creating institution. They stress that, for development to play its role, it should be based on community participation. Genuine processes of dialogue and interaction should thus replace the subject-object relationship between the interveners and the intervened, thereby enabling the oppressed to act as a free subject of their own destiny.

They further outlined some assumptions underlying this approach: they posit that, firstly, obstacles to people's development can be overcome by giving the population concerned the full opportunity of participating in all activities related to their development; secondly, community participation is justified because it expresses not only the will of the majority of the people, but also, it is the only way for them to ensure that the important moral, humanitarian, social, cultural, and economic objectives of a more humane and effective development can be peacefully attained; thirdly, dialogical

University of Ghana http://ugspace.ug.edu.gh

interaction and other similar activities can make it possible for all the people to organize themselves in a manner best suited to meet their desired ends.

According to the PAR theorists, the popular participation concept is to perform certain participatory functions which include cognitive, social, political and instrumental. They explain that, cognitively, community participation had to regenerate the development discourse and its practices on the basis of a different mode of understanding of the realities to be addressed. They say that popular participation is to carve out a new meaning and image of development based on different forms of interaction and common search for popular knowledge. On the political function, they maintain that popular participation is to provide development with the task of empowering the voiceless and the powerless. The instrumental function, they posit that, it is to provide the actors of development with new answers to the failure of strategies and to propose new alternatives with a view of involving the common people in their own area. They say that, the social function is to involve all institutions, groups and individuals involved in development activities to rally around the new construct in the hope that participatory approach would finally enable development to meet everyone's basic needs and to wipe poverty in all its manifestations.

University of Ghana http://ugspace.ug.edu.gh

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0. Introduction

Although there would appear to be widespread agreement on the importance of community participation for bringing about the desired distribution of the benefits of development, there is less of a consensus on the nature and content of the participation process. Oakley (1989) argues that a wide range of empirical terms such as 'self-help', 'self-reliance', 'co-operation' and 'local autonomy' add to the confusion.

In this chapter an attempt will be made to look at: the concept of community participation, reasons for local participation, the primary health care concept in general, community participation in primary eye health care, community participation in development, development strategy approach, community education, and professionalizing grassroot activities.

2.1. The Concept of Community Participation

According to Rahnema cited in Sach (1999) the words 'participation' and 'participatory' appeared for the first time in the development jargon during the 1950s. The social activists and field workers who had joined the development bandwagon in the hope that they could help the oppressed 'unfold, like a flower from a bud' had come up against a reality which was totally different from their earlier expectations. This led them to attribute most of the development projects to the fact that the population concerns were kept out of all the processes related to their design, formulation, and

University of Ghana http://ugspace.ug.edu.gh

implementation. In their great majority, they started to advocate the end of 'top-down' strategies of action and the inclusion of participation and participatory methods of interaction as an essential dimension of development. They maintain that at the other end of the line, the Development Establishment was obliged, some years later, to recognize a structural crisis. Donors and recipient national governments were witnessing the fact that billions spent on development projects had failed to produce the expected results, often even adding new problems to the old. Even McNamara, then President of the World Bank, had to admit, in 1973, that 'growth was not equitably reaching the poor. In his view, growth had been accompanied by greater mal-distribution of income in many developing countries.

Following the recommendations of many of their own experts, a number of major international aid organizations agreed that development had often been floundered because people were left out. It was found that whenever people were locally involved, and actively participating in the projects, much more was achieved with much less, even in sheer financial terms.

They said that the consensus thus reached amongst the planners, NGOs and field workers brought about an important change in the relationship between the different parties to activities. ECOSOC itself recommended to member states 'to adopt participation as a basic policy measure in national development strategies. As it stands now, participation is the most accepted concept, which even very repressive regimes in the Third World have tried to promote as one of their objectives. They posit that various reasons can be identified for the unprecedented interest governments and development

University of Ghana http://ugspace.ug.edu.gh

institutions have recently shown in the concept of participation. Some of these reasons included

1. Participation is now perceived as an instrument for greater effectiveness as well as a new source of investment: Participatory processes bring to development projects what they need most in order to avoid the pitfalls and failures of the past, that is, a close knowledge of the field reality which foreign technicians and government bureaucrats do not have.
2. Participation is becoming a good fund-raising device: Particularly in the last ten years, the electorate and the media in donor countries have demonstrated increasing interest in development-oriented NGOs. According to a DAC report, already in 1983, no less than $3.6 billion in NGO support was granted by European countries, a sum almost three times larger than the total funds allocated to developing countries through UNDP. This is perhaps due to the reputation acquired by NGOs that their participatory and less bureaucratized approaches have allowed them to meet the needs of the people with greater efficiency and at less cost. In order to avoid such views leading to further cuts in their financial resources, governments and inter-governmental organizations now seek to demonstrate their ability to be, at one and the same time, professional and participatory. Finally, as the governments of the recipient countries also sense the new advantages of bending with the participatory wind, they are all playing lip service to participation in the hope of continuing to increase their chances on the foreign aid market.

University of Ghana http://ugspace.ug.edu.gh

In its present context, participation, according to Karl Polanyi's description, has come to be disembedded from the socio-cultural roots which had always kept it alive. It is now simply perceived as one of the many resources needed to keep the economy alive. To participate is thus reduced to the act of partaking in the objectives of the economy, and the societal arrangement related to it. It is in this sense that one should understand Lerner and others (1980), when they consider that traditional societies are not participants. For the modern construct of participation, a person should be part of a predefined project, more specifically, an economic project, in order to qualify as a participant.

Despite the professed faith of most developing countries in people's participation in the development process, it has largely remained a theory. In most developing countries, the poor and the disadvantaged, who are mainly women and children, have mostly been by- passed by the conventional development process (Singh, 1992). Programmes of development have suffered due to inadequate participation of the local people. It is necessary, for purposes of success that factors that affect people's participation are identified and the necessary measures for enlisting the full participation of local people are built into such programmes.

The term, people's participation has been used by different people to mean different things. Banki (1981) quoted in Singh (1992), states that "peoples participation is a dynamic group process in which all members of a group contribute to the attainment of group objectives, share the benefits from group activities, exchange information and experience common interest, and follow the rules, regulations, and other decisions made by the group"(Singh, 1992).

University of Ghana http://ugspace.ug.edu.gh

One obstacle that should be cleared is the exact content of the concept of community participation. Bamberger (1992) suggests that the involvement of intended beneficiaries in particular programmes phase/stages affect some indices of the programme performance than others. He then poses a question whether the involvement of intended beneficiaries in all phases/stages of a programme is essential for the programme to be described as participatory. In other words, he asks whether participation is relevant at certain phases/stages. He goes further to ask whether participation in different stages is equally feasible in different types of rural development programmes. For these to be answered, the exact content of the concept of participation being referred to must be cleared.

The concept of community participation can also be considered primarily from the point of view of the functions involved. Several dimensions can be looked at from this viewpoint, for example, involvement in decision-making, in resource contribution, in supervision, among many others. Many writers, including Oakley (1989), state that sharing in the benefit of a programme in their concept of participation. There is one major source of conceptual confusion. This view of participation by these writers tends to pre-empt the scope of empirical studies into relationship between participation and programme performance. If a participative programme is defined as one which, among other things benefits are shared equitably, then it can be argued that there is not much need to enquire whether community participation promotes the equitable sharing of benefits. It is also important that the benefits derived or expected from the rural development programme be specified. Apart from the fact that it is difficult to discern the real goals of a given programme, there is also the conceptual and technical difficulty of

University of Ghana http://ugspace.ug.edu.gh

coming up with meaningful and acceptable indicators of a particular benefit. The concept of livelihood, for example, is difficult to apply as standard evaluative criterion if the benefit of a programme is described as improving the livelihood has many components such as income, educational level, housing conditions and it is difficult to address all of them.

One other confusion relating to the issue of community participation is the question of modes and forms of participation. Some writers, including List (1981), tend to define participation in terms of particular institutional characteristics of a programme. The presence of a particular mode or institutional structure does not guarantee popular participation. However, particular modes or channels of community participation, may be more favourable than others for generating benefits to participation of rural development programme. Different approaches are used in examining the concept of community participation. Oakley (1981) points out that a review of the literature reveals disagreement as to whether community participation is essentially a process, a programme, a technique or a methodology. Community participation is a matter of degree, and there are many different kinds of community participation. Not all kinds of community participation or involvement are always appropriate or possible. There is the need therefore to sort out what kinds of community participation are supportive of a given development objectives in specific situations for given programme or projects.

The study considers community participation or community active involvement as behaviour of the people and uses the functions or activities performed or expected of beneficiaries to examine the effectiveness of the people's involvement at different stages of the project cycle. This is based on the assumed hypothesis that community

University of Ghana http://ugspace.ug.edu.gh

participation by intended beneficiaries in the design and implementation of rural development programme is a determinant factor in the effectiveness of such programmes.

According to Boyce and Ballantyre cited in Thomas and Thomas (2000), there are three main components of community participation – community participation as a contribution, community participation as organization, and community participation as empowerment.

Firstly, they explained that community participation as a contribution is the voluntary donation of human resources to a common good or goal. To them, this purpose values the efficiency obtained in meeting project objectives through the people's own efforts. It implies that community interests are cohesive and that, internal community conflicts can be resolved through democratic processes. They maintained that community participation as a contribution is intended to be initiated by the authorities in a top – down fashion and does not necessarily imply that control and direction of activities pass on to the local people.

Secondly, they posit that community participation, as organization is the process of organizing or arranging people in common activities. They emphasized that in this purpose of participation, the origin and form of the organization are crucial in that some community organizations are conceived and introduced by external agents such as the government bureaucracy, while others emerge and take form from the process of community members' own involvement.

The third component, according to them, is community participation as empowerment. This is about the development of management skills in local people and the ability to make decisions which affect their lives. Boyce (1993) supports them by

University of Ghana http://ugspace.ug.edu.gh

stating that community participation as empowerment assumes that people have a right to self-organize and that internal conflict between social groups are able to be resolved at the local level. Rifkin (1986) cited in Maya et al. (2000) posits that to address the issue of participation is to address the issue of power. He explained further that the empowerment purpose of participation acknowledges the need for community members to exercise power and then value the social equity, which is achieved when this happens.

Paul (1987) says that community participation is an active process whereby beneficiaries influence the direction and execution of the development projects rather than merely receive a share of project benefit.

Cohen & Uphoff (1977), Coombs (1980), and Jancloes et al (1982) view community participation as a key to successful eye health care education programmes. They consider all other factors that influence the work of eye health workers as complementary to community development. Jancloes et al (1982) suggest that when people are given the opportunity to manage their own affairs and involved in decision-making, they can become very efficient and will contribute many of the material and human resources needed to organize health facilities.

Even though Jancloes et al. see the importance of community participation in carrying out development programmes, what they did not address is the issue of who is to do what and how. Thus, whether community participation in decision-making is to be carried out by the whole community or through their representatives who are delegated specifically to do this is not clear from the argument.

Also, although Schumacher (1973), Molina (1980), WHO/UNICEF (99/178), and Bakondi et al. (1980) support the idea of community participation, they argue that

University of Ghana http://ugspace.ug.edu.gh

community participation in development programmes can only be effective where the people are conscientized. Thus, any programme that aims at seeking the support of the people should first educate the people to understand the programme and the specific role they are expected to play. Although education of the people is emphasized here as a tool to get people to be involved in a development programme, the question of whether the particular project or programme is the felt need of the people need not be over emphasized.

2.2. Reasons for Local Participation

People's participation may be seen as the process by which the rural poor are able to organize themselves and through this organised effort identify, and plan, implement and evaluate their own needs. Such action is self-generated, and based on having access to productive resources and services (Bortei-Doku, 1991)

The arguments that have been raised in favour of local people participating in their own development include the following:

(i) Focus on the rural poor: When poor people participate directly in projects that are meant to benefit them deliberate efforts are focused on them. This ensures that resources reach those previously excluded from getting access to development inputs.

(ii) Self – Organisation and self-reliance: The basic principle for working with the rural poor is to develop structures and organisations that can make the poor self-reliant. Such organisations would be the people themselves, managed and structured in a manner that prevents undue external dependence.

University of Ghana http://ugspace.ug.edu.gh

(iii) Income and employment generating activities: One major argument in favour of local participation in development programme or project is its link to economic resources. Therefore, promoting specific income generating activities that create economic benefits enhances the rural poor's confidence. Increased economic activity is a solid ground for the empowerment of the rural poor and access to a greater share of available development resources and services.

According to Thomas (1995), local participation in community projects and programmes helps to improve programme implementation. As people participate in decision-making and other forms of participation, they facilitate the implementation of those decisions that were arrived at. This also has a high relationship with programme sustainability. Community involvement can also improve productivity by enlisting neighbourhoods to help in programme execution and service delivery. Here neighbourhoods go beyond accepting implementation to joining implementation. Examples of this assistance could range from direct contribution of labour to the programme to advocacy on the benefits of the programme to individuals and the community at large (Thomas, 1995).

Mclvor (2000) has also noted that participation ensures sustainability and successful implementations of programmes as the people develop the feeling of project ownerships. He further states that when women and children are involved in a programme, it helps them to develop confidence and abilities to tackle other issues that

University of Ghana http://ugspace.ug.edu.gh

affect them. Community participation also leads to the utilisation of local know-how and the adoption of appropriate technology and suitable project sites.

2.3 The Primary Health Care Concept in General

Studies in the use of traditional and modern medicine have focused more on consumers with less emphasis on the structural components of the health system and its social support system. Social scientists are now getting increasingly interested in the primary health care approach to health delivery, especially in the developing world. Primary Health Care has seen rapid growth since the declaration of 'Health for All' by the year 2000 in May 1977 at the 30th World Health Assembly in Alma-Ata, Russia. The 1978 World Health Organization/ United Nations International Children Emergency Fund Conference on PHC in Alma-Ata, Russia, recommended that PHC should be considered the key to the achievement of WHO's goal of 'Health for All' by the year 2000. The eye health care and education is one of the major components of the PHC. The 'Vision 2020; The Right To Sight' is as the result of the PHC Conference.

The declaration of Alma-Ata defines PHC as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO: 1977). It is in this context that PHC becomes an instrument of social change and development. Granted that PHC systems can evolve from the economic conditions and social values of specific communities, they nevertheless should have some basic

University of Ghana http://ugspace.ug.edu.gh

components. Among these are the promotion of proper nutrition, an adequate supply of safe drinking water, basic sanitation, maternal and child care, including family planning, immunization against the major infectious diseases, prevention and control of locally endemic diseases, education concerning prevailing health problems and the method of preventing and controlling them, and appropriate treatment for common diseases and injuries. Maximum community and individual self-reliance for health development is essential for the PHC programme to be operative at the community level. To attain such self-reliance requires full community participation in the planning, organization and management of PHC as stated by Thomas &Thomas (2000). Since PHC is an integral part both of a country's health system and the overall economic and social development, it has to be co-ordinated on a national basis with the other levels of the health system as well as other sectors that contribute to a total developmental strategy. PHC is thus an alteration in the medical system as well as an approach to rural development and community participation.

2.4. Community Participation in Primary Health Care

Lele (1975) posits that community participation means, in its broad sense, to sensitize people and then to increase the receptivity and ability of people to respond to development programmes, as well as encourage local initiatives. List (1981) sees community participation to include people's involvement in the decision-making process, in implementing programmes, sharing in the benefits of the development programmes and their involvement in an effort to evaluate such programmes.

University of Ghana http://ugspace.ug.edu.gh

Most evaluation of community development initiatives in health projects, assign minor importance to community participation, or simply count the number of community members who are involved in project activities (Farrant, 1991). In explaining problems in community participation in service delivery, analysts have tended to criticize the motivation of individual community members, or the negotiation process between different interest, as being defiant rather than examining the basic organization and structures which inhibit or support the process (Nilson 1996).

In reviewing the development of Primary Health Care in the 1970s, it will be recognized that it was initiated as an essential part of the movement towards community participation in service delivery. The Primary Health Care concept was promoted initially as a grassroots initiative to bridge the gap between an increasing burden of quality health in developing countries and the scarcity of professional and financial resources (WHO 1981).

Indeed, in the field of health care service delivery, there are vastly different interests for example, the sick, family members, other community members, professionals, and bureaucrats who have in turn widely varying needs, and who require unique methods of mobilization (advocacy, self-help, awareness raising). Perhaps, the most unique challenge is in addressing the breadth of these community interests, needs and mobilization methods.

Farrant (1991) has also pointed out that community participation is supposed to be a key strategy in health and other community development initiatives. However, in most developing countries there is little resource support for it in practice. Health and rehabilitation development are often understaffed, and limited in their funding which

University of Ghana http://ugspace.ug.edu.gh

preclude public involvement in needs identification, skills development, and ongoing participatory activities.

Bose (1983), on the other hand, sees a relationship between people's perception about the services rendered by the eye health care education programme and the extent to which the people participate in such programmes. To him, rural masses tend to perceive their health problems in terms of getting access to medicine, doctors, and hospitals. They, therefore, tend to judge the community eye health workers negatively because of the limited competence in curative health care. The end result of this situation among the people these eye health care workers serve is a feeling of helplessness and frustration and this affects community participation in eye health care education programmes. Two things are, however, not clear from Bose's view. Firstly, whether the views expressed about the community rural health educators represent the views of the educated elites or that of the common rural masses is not distinguished. Secondly, what impact education/conscientization of the people about the programme and the function of its structures can make on their participation is not clear.

Segal & Williams (1980), Muller (1980), de Kadt (1983), and Twumasi & Freund (1988) see a direct relationship between the implementation of development programmes and the political system or the social structure of the given community. An idea derived from these writers is that people remain socially and culturally attached to such structures and their traditional leadership and co-operation. To Muller (ibid), this can be used to mobilize community members in decision-making about actions to improve their health and general conditions. On social structure and community participation, the writers are of the opinion that where material resources are more equally distributed, there appears to

University of Ghana http://ugspace.ug.edu.gh

be better basis for community activities. Nevertheless, even in such circumstances, it may be difficult to involve community members in health promotion if there are ethnic or clan divisions.

The Institute of Development Studies (IDS) of the United Kingdom research group (1978) considers technical support as another factor that affects primary health care programmes at the community level. First, the IDS consider community participation in the rural areas, as an enthusiastic contribution towards the promotion of health needs. However, the report maintains that the villagers are extremely conscious of their lack of technical knowledge as far as health matters are concerned. They are, therefore, confident that advice from outside will be more useful. In the opinion of the IDS report, therefore, any approach directed towards the institutionalization of primary eye health care programme at the community level without the active involvement of health personnel and social workers will fail. It must, however, be mentioned that at what point and in what form the health personnel are to be involved in the programme are not shown.

Morley et al (1984) support this argument. They say that part of this technical package should include knowledge of the health problem of the area. According to them, appropriate technology should also extend to training and management strategies, and to monitoring and evaluation, using precise indicators by which a community can gauge its progress in solving health problems. Morley et al (Ibid), have further argued that these technical factors alone will not guarantee a successful primary eye health care programme in the rural areas, but they are essential and tend to be overlooked by those from where social goals are paramount in primary eye health care education programmes.

University of Ghana http://ugspace.ug.edu.gh

2.5. Community Participation in Development

The word community is used widely amongst health workers, rural developers, agriculturists and politicians. They discuss among others community health care, community eye care, community participation, community involvement, community needs, community decisions and many more. Some people who use these terms would have difficulty defining exactly what they mean. But they imagine that communities are homogeneous, with a strong sense of belonging together. They have the illusion that communities are eagerly waiting for them to initiate concerted community action. Then they believe all community members will act as one body. But in reality, every village is composed of individuals and various groups of people, all with different interests. Village elders may share or quarrel over issues of power. Church groups share their faith, but may exclude those with different beliefs. Wealthy and poor people have different interests. Each of these individuals and groups react, to project initiatives according to their own interests.

Navarro (1975) and Lamptey et al. (1980) have explored the role of health personnel and social workers in the implementation of primary health care programmes. Their study has established the importance of involving health personnel and social workers actively in government projects and community initiated ones. However, they are of the view that there is the need to find out the extent to which the community members should be involved. To them, the current bureaucratic and dominant professions such as the bio-medical practitioners, would have to yield a great deal of their control if the primary health care system should work.

University of Ghana http://ugspace.ug.edu.gh

Securing financial support for primary health care programmes in general has been identified as a major bottleneck. While Rifkin (1980) is against any form of financial strain on the already poor village folk with regard to the support of their health delivery services and project, Molina et al. (1980) and Jancloes et al. (1982) are in favour of asking community members to contribute materially, financially or otherwise towards projects they have initiated. They, however, stressed that the government should be apt to detect any dissatisfaction among the community members when they seem to have been unduly taxed.

In their 'Project with People', Oakley et al. (1991) define people's participation as the process by which the rural poor are able to organize themselves and through their own organization are able to identify their need and share in the design, implementation and evaluation of the participatory action. Such action, according to them, is self generated, based on their access to productive resources and services, their labour and the continued security of that access. It is also based on their initial assistance and support to stimulate and sustain the development action programme. Cohen & Uphoff (1977) define community participation in virtually identical terms as 'including people's involvement in decision-making process, their involvement in implementing programmes and decision, their sharing in the benefits of the development programmes; and or their involvement in effort to evaluate such programme.

According to Midgley (1986), community participation denotes the involvement of people in community affairs. This view is supported by Sheng (1990) whilst Westguard (1980) cited in Adarkwa and Diaw (1999) sees community participation as giving equal opportunities to groups and movements to increase and have greater control

University of Ghana http://ugspace.ug.edu.gh

of resources and institutions. To Paul (1987), quoted in Sheng (1990), community participation is an active process by which beneficiary or client group influences the direction and execution of a development project with the view of enhancing their well-being in terms of income, personal growth, health, self-reliance or other values they cherish.

Picciotto (1992) postulates that community participation is the aggregation of human transaction, which occurs voluntarily in a society to ensure sustainable and equitable growth. Schubeler (1996) says that community participation in health services is a process where people as consumers and producers of health services influence the flow and quality of health services available to them. He noted that participation is not however limited to development of projects alone. Amstein in Diaw (1992) view community participation as a process of action by which the local people reflect on their own interest or contribute their energies and resources to the system which governs their lives. He maintains that community participation involves planned mobilization from above and voluntary participation from below. He explains further that a more recent development strategy has evolved based on the reflection of changing ideas on the nature and purpose of development commonly described as development from below. He emphasizes that this type of development is based primarily on maximum mobilization from each area's natural, human, and institutional resources, with the primary objective being the satisfaction of the basic needs of the inhabitants of that area. Stohr & Taylor (1981) cited in Diaw (1992) see community participation as leaders organizing their subjects and the subjects offering their services voluntarily.

University of Ghana http://ugspace.ug.edu.gh

Norwegian Agency for Development (NORAD 1989) sees community participation to mean more than gaining local acceptance for project and strategy proposals, and being able to recruit local voluntary labour. It also means that the initiative, need and opinion of the target group must be important premises in planning the project, defining goals, and choosing strategies. And the responsibility for decision-making and management must be shared with them. The common element that runs through all definitions is: involvement of local people in the decision-making, voluntary service, contribution, and sharing of the fruit of their labour. Community participation is voluntary involvement in the decision-making of the local people in the planning, organizing, implementing and monitoring and evaluation of community programmes. NORAD reveals that community participation is one of the basic principles and characteristics of community development. It maintains that community participation is a cardinal principle and a fundamental requirement for any local community to benefit from a donor. It stresses that development assistance and people's participation are therefore a fundamental principle, a basic attitude and a necessary pre-condition for a meaningful change.

Hay Jnr. et al. (1990) claim that national policy makers, international aid organizations, and scholars all advocate community participation. Yab (1983) in Nientiel et al (1990) posits that community participation can be seen as a self-generating activity which has an educational effect and which can enhance the emergence of self-reliant and co-operative communities. There have been series of arguments put forward by advocates of community participation. Hay Jnr. et al (1990), state that community participation helps to bring about voluntary mobilization and application of previously untapped local

University of Ghana http://ugspace.ug.edu.gh

resources, skills and energies for the purpose of improving the quality of life of the entire community.

Adarkwa & Diaw (1999) add that community participation plays an important role in need assessment. According to them, it allows people to express their needs, problems, and priorities. They emphasize that community participation allows technocrats to obtain information about local conditions, needs and attitudes without which development programmes are likely to fail.

Gajanayake & Gajanayake (1993) believe that participation of people provides an effective means to mobilize local resources and organize and tap the energies, wisdom and creativity of people for development activities. They added that experience in development activities suggest that there is a significant correlation between the level and intensity of people participation and the increase in the success of development activities.

2.6 Development Strategy Approach

According to Sutter, Foster, and Francis (1998), there is disagreement in PHC thinking about the best way to start an eye health project in a community. While some think the project should be started through village development activities, using the 'bottom up' approach, others think community health programmes should be directed by a medical person from above, using the 'top-down' approach. Sutter et al. (1998) argue that projects that are initiated through the 'bottom-up' approach stimulate people's participation at a faster rate. They maintain that people learn faster to plan and work together, see which essentials of life they are lacking and what they can do about them for themselves. They also claim that it makes community members more aware of health

University of Ghana http://ugspace.ug.edu.gh

needs and self-assured about making their demands on health matters to those in control. They posit that even though self-help projects are limited by social, economic and political structures, the programmes can develop skills to bring about effective community participation and encourage people to work for more fundamental change in their health status.

The PHC concept and community participation in eye health care issues in Ghana from the perspective of the ODC/ILO (1976) can also be viewed as a development approach. Here various theories discussed by the two organizations such as the 'spontaneous process model', 'responsive process model', 'authoritarian top-bottom approach' and 'bottom-top approach' as mentioned by Sutter et al (1998), and the holistic approach to community development come into play.

Like the trickle down theory of development, ODC/ILO view the spontaneous process model of technical change as being automatic. Once technical change has begun, the models predict, it will spread on its own, like an epidemic. All that is needed is the initial adoption of the relevant innovation by selected change agents. Therefore, in the fullness of time the epidemic process eventually takes over to ensure widespread and rapid diffusion of those innovations. This supports the idea of the hospital-based health care delivery system. Once a hospital is established in an area, it serves the outlying areas and it brings about the needed improvement in the health conditions of the people not only where the hospital is based but also in the rural communities. Francois Perrux, the well- known French regional planner cited in ILO (1976), mentions that development does not only appear everywhere at the same time. It manifests itself with variables intensified at favoured points, from which it tends to propagate outside with

University of Ghana http://ugspace.ug.edu.gh

variables final effects for the economy as a whole. These points from which the development activities radiate to the outside territories are the nodal points of development.

On the other hand, responsive process theories see a possibility for intervening in technical change decisively to facilitate it. Technical change, they hold, could be brought about through a judicious manipulation of certain external factors. In this connection, considerable effort has been made at both theoretical and empirical front to identify those factors and to ascertain their exact role. PHC concept in this sense fits into this general concept since some kind of intervention is instituted.

Strategies that advocate manipulation of the factors of technical change from the bottom see the role of the government as not being that of an initiator but that of a facilitator. The role of an initiator is reserved for the people, who are the 'subject' not 'object' of development. They participate in development actively, not passively, and they take initiatives at the bottom, not by government bureaucrats at the top. This arrangement is favoured for various reasons. Sometimes equity is stressed, and bottom-up approaches are favoured because they minimize cost and generally democratize national development. At other times, special strengths are believed to lurk at the bottom, as a basis for technical change. A World Bank President, Mc Namara, has declared 'there is no more powerful force for progress against poverty than the initiative and ingenuity of the poor themselves.'

University of Ghana http://ugspace.ug.edu.gh

2.7. Community Education

Bowers (1977) explains that community education concerns the acquisition of skills and knowledge by people in a community to improve upon their quality of life. Fellenz and Coker (quoted in Brookfield 1983) define community education as the process of identification of community needs and the marshalling of resources to meet those needs so that the community and all its members can grow through social and educational programmes. This means social, health and educational progress of the community is contingent upon satisfying community's needs leading to community participation in all developmental programmes. This view is also shared by Boucouvalas (1979) cited in Brookfield (1983). According to him, the ultimate goal of community education is the development of self-guiding and self-directed communities, which are able to identify and satisfy the needs of their community members through community participation, co-ordination, co-operation and collaboration of all community members. Decker (1979) cited in Brookfield (1983), on the other hand, thinks community education encourages community participation in development which brings about a comprehensive and co-ordinated delivery system by providing educational, health, social, and recreational services for all people in a community. Community education for participation represents the how (practice and programmes) and the why (theory and principles) of teaching this social and behavioural technology to local groups for the sake of facilitating individual learning, group problem solving and community building (Compton and McClusky, 1980 quoted in Brookfield, 1983).

Community education brings about community participation and this can be in the form of capacity building or training the individual or groups to acquire knowledge and

University of Ghana http://ugspace.ug.edu.gh

skills and to see the importance of community participation as a vital role for them to play in the development of their communities. This education can be in the form of seminars, community sensitization, and workshops. According to Battern (1960), cited in Brookfield (1983), community education for participation provides the knowledge needed to assist the people to control their own future with benefits to themselves. Dunham (1970) posits that community education is one of the principles of community development. He maintains that community education is one of the powerful tools used by non-governmental organizations to enter into communities and urge them through their needs assessment for effective participation in all developmental projects including health.

An important feature of community education is the involvement of the community in determining the education activities relevant to their needs. It is the process of increasing the capacity of individuals to understand their reality. This will enable them to initiate appropriate action to deal socio-economic and political forces of oppression within the community to enhance personal and community development. Community education is to bring people together to help one another and in the process, help themselves. This mutual support leads to social change whereby communities work as a group rather than as individuals. It encourages the formation of social and voluntary groups for common goals. Community education is, therefore, a process in which views of the local people are tapped and with collective efforts educational activities are undertaken to respond to the concerns, expectations and needs of the people.

Education to change habits and attitudes in eye health education is very important in helping communities to participate in their developmental programmes. According to

University of Ghana http://ugspace.ug.edu.gh

Sutter et al (1998), what people do and think about issues has to be changed, and that, change in behaviour will automatically lead to good health. They maintain that good health education should help people become aware of the root causes of their poor health. They emphasize that good community health education should address the good things that the people do, enhance their self-confidence, build upon the people's own experience and help them to effect changes in their environment and making eye health more attainable.

2.8 Professionalising Grassroots Activities

In another development, Sachs (1999) noted that to involve the patients in their own care was the instrumental task which the participatory concept has been assigned by development. Change agents and NGOs were identified as suitably qualified instruments for this function. The notion of change agent was introduced, mainly, as a substitute for the professional expert hired by a development project. The intention was to do away, through this non-professional grassroots-oriented intermediary, with subject/object relationships and to replace the alien authority of the outsider with a co-actor whose role was to intervene primarily as a catalyst in a process of self-regeneration.

In reality, however, the change agent often ended up by exceeding his role as a catalyst beyond all recognition. Acting, in most cases, as a promoter or professional of participation, rather than a sensitive party to a process of mutual learning, he became sometimes a militant ideologue, sometimes a self-appointed authority on people's needs and strategies to meet them, and often a barefoot developer lacking the professional competence of the expert. Few were actors genuinely seeking to learn from the people

University of Ghana http://ugspace.ug.edu.gh

how they defined and perceived change, and how they thought to bring it about. The change, of which they considered themselves the agents, was only the projection of a predefined ideal of change, often highly affected by their own perception of the world and their own ideological inclination.

As for NGOs, they were given a special status, on the ground that being non-governmental organizations, they could avoid many of the pitfalls of development projects implemented by bureaucratized government agencies. Yet here too, most of these organizations became only better agents for the delivery of similar projects. As such, the main donors did not take much time to conclude that they could become their best allies in all projects needing a participatory source for marketing purposes.

On the whole, neither the promises of change agents, nor those of NGOs, succeeded in genuinely involving the patients in their own care. The new instrumentalities of participation served to promote a kind of fast food or do-it –yourself development, made out of the same old ingredients. On the other hand, the very patients who were encouraged to go back to their self-care traditions became dependent on the new breed of barefoot specialists, either parachuted in from abroad as volunteers, or trained on the spot. In short, more refined and deceitful means of action and persuasion came to be added to the paraphernalia of development institutions. The growing role of NGOs in development activities, and the great financial means at their disposal, give them, now, unprecedented possibilities for further professionalizing grassroots activities. Thus, as one goes on digging into archaeological site of the many development construct that are falling apart, trying to see more clearly in the rubble that once impressed so many because of their solid appearance, a number of questions come to mind. One

University of Ghana http://ugspace.ug.edu.gh

wonders whether the new participatory approaches actually lead to any substantial change in the nature of development, or whether they serve only as band-aid operations to give a new lease of life to an ageing institution. Did such methods as dialogical interaction, conscientization and participatory action research really succeed in halting the processes of domination, manipulation and colonization of the mind? Can they really help bring about new forms of knowledge, power, action, and know-how, needed to create a different type of society? All these questions remain unanswered when participation is analysed broadly. Thus, as one goes on digging into archaeological site of the many development construct that are falling apart, trying to see more clearly in the rubble that once impressed so many because of their solid appearance, a number of questions come to mind. One wonders whether the new participatory approaches actually lead to any substantial change in the nature of development, or whether they serve only as band-aid operations to give a new lease of life to an ageing institution. Did such methods as dialogical interaction, conscientization and participatory action research really succeed in halting the processes of domination, manipulation and colonization of the mind? Can they really help bring about new forms of knowledge, power, action, and know-how, needed to create a different type of society? All these questions remain unanswered when participation is analysed broadly.

To sum up, participation is no longer the taboo it was only two decades ago. On the contrary, all developers seem to have definitively adopted the idea of community participation as a reliable asset for their own future.

University of Ghana http://ugspace.ug.edu.gh

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter describes the methods adopted for the study. It looks at the research design, the population of the study, the sample, the research instrument, and the data collection and analysis.

3.1 Research Design

The evaluative design was used for the research. This design seeks to inspect all available information concerning community participation in eye health care education programmes in cluster communities in the Upper West region. The researcher's interest is in finding out the reasons why the local communities are not participating effectively in the eye health care education programme. Qualitative evaluative research design involves the collection of data in order to find answers to questions concerning the current status of the subject under study. Qualitative evaluative research designs are directed towards the determination of the nature of a situation as it exists at the time the study is being conducted. According to Fraenkel and Wallen (1993), obtaining answers from a large group of people to a set of carefully worded questions and carefully administered questionnaires, lies at the heart of qualitative evaluative research. One advantage of this design is that there is no difficulty of ensuring that questions on the evaluative design are clear to all especially when the interview method of gathering data is used. Secondly, it produces good responses from a wide range of people. The evaluative design is also

University of Ghana http://ugspace.ug.edu.gh

chosen because it provides a more accurate picture of events and aims to explain people's perception and behaviour. For Frenkel and Wallen (1993), the evaluative research design is more appropriate when the researcher intends to evaluate some aspects of a population by selecting unbiased samples of individuals who are asked to respond to interview schedules. Polit and Hunger (1995) posit that evaluative design has the big advantage of providing a lot of information from the large sample of individuals. The evaluative design was considered the most appropriate method that would help find the level of community participation in the eye health care in the Upper West Region. So the interview schedules were developed based on community participation at the planning, implementing, monitoring, and evaluation stages. The researcher himself administered the interview schedules.

3.2 Population

The population of the study comprises all adults living in the Upper West Region. The study seeks to establish the broadest possible generalization from a sample that will be representative of the target population. It is impossible to observe all the communities in the region, but a carefully selected sample can yield good information characteristic of generalization.

The aim of the research is to find out the reasons why local community participation is so low in eye health care education programmes. It is purely an adult involvement in community activity. The choice of minors in this programme as a sample population would not have been good enough for the researcher to obtain the results that he anticipated.

University of Ghana http://ugspace.ug.edu.gh

3.3 Sample

This study is about community participation in the eye health care education in the Upper West Region. The scattered nature of communities in the Upper West region and the lack of any comprehensive sampling frame for rural communities or a consistent and systematic numbering of these communities make it difficult to use any single sampling techniques in choosing a sample. Kish (1967) cited in Twumasi (2000) pointed out that when individuals' selection of elements seems too expensive and difficult, survey tasks could be facilitated by selection of cluster.

The cluster sampling technique was, therefore, used to select the 200 community members who were interviewed. There are five districts in the region. These were used as clusters in the research. Ghana Health Service has already zoned all the districts into sizeable communities for effective deployment of its community health nurses. These communities were used as units from which a simple random sample was done to select five communities from each district. To select the five communities from each district, the names of all the communities were written on strips of paper and folded into small pieces. They were put in a box and mixed up. Then, five communities were selected from each district using the random sampling technique (lottery system). In all, twenty-five communities were randomly selected. The communities selected included the following: Billaw, Fielmuo, Bugbelle, Gollu, and Tumu (Sissalla district); Piina, Kpari, Sentu, Nyubulo, and Han (Jirapa/Lambusie district); Ko, Nandom, Lissa, Puffein, and Gangankpe (Lawra district); Yaala, Duori, Kaleo, Sombo, and Sabuli (Nadowli district); Wechiau, Lassia, Issa, Wa, and Tuolu (Wa district). Purposive sampling technique was

University of Ghana http://ugspace.ug.edu.gh

once again used to select eight adults each in the various communities for the interview. The reason for using this technique was to get accurate information from the eye volunteers in the community. If the random sampling were used, there would have been the tendency that some useful information would have been missed. In doing this, the assemblyman of the community is contacted to see if there was an eye volunteer in the community that has been sampled.

Two hundred 200 local community members were randomly chosen and interviewed. The reason for choosing them was that, they lived all their lives in the communities and as such they can say much about the local community's participation in the eye health care education programmes.

3.4 Data Collection Instruments:

Questions in the form of interviews were administered to selected community members to indicate their level of participation in the eye health care education in their communities.

Due to the largely illiterate population from which the research sample was selected, interview was used as the research instrument. The person-to-person method was adopted. The questions were read and interpreted in Dagaare and Sissali (the indigenous languages of the study area) to each respondent in the chosen language. There was no problem in using the local language because the researcher spoke both languages fluently. The questions were open ended and close-ended. The close-ended questions saved the respondent's time and energy for answering the questions. According to Kerlinger (1973) close-ended questions have the benefit of obtaining uniformity of

University of Ghana http://ugspace.ug.edu.gh

measurement and hence high reliability of compelling the respondent to answer to suit the response wanted as well as making coding easy. The open-ended questions gave the respondents the freedom to express themselves.

The structured interview schedules that were used to solicit their views on local community participation in eye health care education programme can be found under Appendix A.

3.5 Data Analysis

Data collected from the field were edited to ensure consistency of responses under various sections. The data were then analysed using frequencies and percentages. Throughout the work, tables were used to help the researcher gain an overall view of findings to identify the trends, and to display the relationship between parts of the findings.

3.6 Profile of the area of study

The Upper West Region is located in the Northwest part of Ghana. Wa, the regional capital, is located about 800 kilommtres away from Accra. The Upper West Region is one of the least developed and resourced regions in Ghana. It is mainly rural and has a scattered population. The road network is very poor. The 2000 Population Census estimated the population to be about 591,621. The literacy rate is about 11.3 percent. About 95 percent of adult women have never been to school. The predominant occupation is subsistence farming.

University of Ghana http://ugspace.ug.edu.gh

The Upper West Region has five administrative districts- Wa, Nadowli, Jirapa/Lambusie, Lawra, and Sissala. There is one regional hospital, four district hospitals, 66 health centers (23 of which are either Catholic or private). There is one referral eye centre at the regional hospital in Wa, and one eye unit in each district. There is one ophthalmologist, no optometrist, and nine ophthalmic nurses, 160 volunteers and 75 school health teachers in primary eye care.

University of Ghana http://ugspace.ug.edu.gh

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF DATA

4.0 Introduction

This chapter presents the data obtained during the field investigation. The information consists of answered questionnaire administered to four NGOs, nine ophthalmic nurses and interview schedules for 200 local community members. The data analysis is based on the proposition that local communities in the Upper West Region do not participate effectively in eye health care education programmes as before even though NGOs are working hard to bring about primary eye health care to their doorstep.

The data collected on community participation in eye health care education are presented and discussed under the following sub-headings:

1. Demographic characteristics of respondents
2. Importance and purpose of community participation to the local community members;
3. Planning eye health care programmes with local community members;
4. Areas of community participation in the eye health care programmes;
5. Methods and strategies used for community participation in eye health care programmes.

University of Ghana http://ugspace.ug.edu.gh

4.1 Demographic characteristic of respondents

Table 4.1 Sex differentials of respondents

Sex	Frequency	Percentage
Male	100	50
Female	100	50
Total	200	100

In Table 4.1 an equal number of males and females responded to the interview schedules. This equal representation was to ensure a fair opinion from both sexes.

Table 4.2 Age levels of Respondents

Age	Frequency	Percentage
18-28	40	20
29-39	70	35
40-50	65	32.5
51 and above	15	7.5

Table 4.2 above depicts respondents' age levels. It is shown that, those who fell between the age group of 18 to 28 were 40, representing 20 percent of respondents. The table also shows that those who fell between the ages of 29 and 39 represented 35 percent. However, respondents within the ages of 40 and 50 were 65, representing 32.5 percent; while a low record of 7.5 percent represented those who were 51 and above.

University of Ghana http://ugspace.ug.edu.gh

Table 4.3 Educational background of respondents

Level of education	Frequency	Percentage
Primary/ Middle School	45	22.5
Junior Secondary School	30	15
Senior Secondary School	25	12.5
Post Secondary	15	7.5
Tertiary	5	2.5
Illiterates	80	40
Total	200	100

Table 4.3 shows that the majority of respondents were those who never had basic education. Forty-five respondents, representing 22.5 percent, were those who were either primary dropouts or middle school leavers. It also indicates that, 12.5 percent and 7.5 percent were those who had attained senior secondary and post-secondary education respectively. However, only 5 respondents representing 2.5 percent attained tertiary education.

4.2 Importance of community participation in eye health care programmes

Boyce and Ballantyre cited in Thomas and Thomas (2000) posit that the main purposes of community participation are firstly to contribute in the form of voluntary donation of human or material resources to a common goal; secondly, to organize in

University of Ghana http://ugspace.ug.edu.gh

common activities in the communities, and thirdly to empower the local people to take decisions which affect their lives.

Table 4.4. Importance of community participation.

Whether community participation is important	Frequency	Percentages
Yes	200	100
No	0	0
Total	200	100

On the importance of community participation, all the 200 people interviewed as shown in Table 4.4 indicate that community participation in community projects is important.

Table 4.5 Source of Community information on eye care Programmes

Source of information	Frequency	Percentage
Volunteers	200	100
Opinion leaders	200	100
FM Station	200	100
Nurses	200	100
Neighbours	200	100

Table 4.5 shows the pattern of responses given by respondents on the available sources of information on eye health care programmes to the communities. The various sources identified by all respondents included volunteers, opinion leaders, FM Stations

University of Ghana http://ugspace.ug.edu.gh

nurses and neighbours. All the 200 respondents said that volunteers, opinion leaders, the two FM Stations, nurses, and their own neighbours gave information to the communities when there was an eye health programmes.

4.3 Planning eye health care programmes with the communities.

The Norwegian Agency for Development emphasized in its document (NORAD 1989) that for communities to get involved or participate in development projects in their areas, the local communities should be involved in the planning, execution, monitoring and evaluation of the projects. It was for this reason that respondents were asked if the eye programme was planned with them.

Table 4.6 Planning eye health care programme with community members

Community involvement in planning	Number	Percentage
Yes	194	97
No	6	3
Total	200	100

Table 4.6 above shows that 97 percent of respondents said that they were involved in the planning of every eye health care education programme in the various communities. However, a low number of six respondents representing 3 percent expressed the contrary view.

University of Ghana http://ugspace.ug.edu.gh

Table 4.7 Ophthalmic Nurses Visit to local communities

Nurse's visit	Number	Percentage
Yes	145	72.5
No	55	27.5
Total	200	100

Table 4.7 shows that 72.5 percent representing 145 respondents said ophthalmic nurses come to the communities to give eye health care education and services. However, a low record of 27.5 percent, representing 55 respondents said they had no ophthalmic services in their communities.

4.4. Community contribution to eye health care programmes.

Table 4.8. Provision of educational materials

Respondents were asked to state the level of material contributions communities make towards eye health care education. The responses of respondents are indicated in Table 4.8 below.

Educational materials	Frequency	Percentage
Yes	95	47.5
No	105	52.5
Total	200	100

University of Ghana http://ugspace.ug.edu.gh

Table 4.8 above shows that out of the two hundred respondents only 95 representing 47.5 percent said they contributed frequently towards educational programmes on eye health service; while a high number of one hundred and five said they did not contribute materially to the educational programmes of eye health care services.

Table 4.9 Provision of labour and accommodation

Labour & Accommodation	Frequency	Percentage
Yes	200	100
No	Nil	Nil
Total	200	100

In Table 4.9, all the 200 who responded to the interview said that they provided labour to all developmental programmes that came into the community. Hundred percent of respondents also maintained that accommodation to house the ophthalmic nurse, who served as facilitator, was taken care of by the community members. All the respondents equally mentioned that they provided the feeding needs of health workers who visited the community.

Table 4.10 Contribution of Finance to support eye health care education.

Contribution of finance	Frequency	Percentage
Yes	25	12.5
No	175	87.5
Total	200	100

University of Ghana http://ugspace.ug.edu.gh

From Table 4.10, it can be seen that only 12.5 percent of the respondents contributed money to support eye health care education programmes. On the other hand 87.5% of respondents said they could not contribute money/cash to support the programme.

Table 4.11. Peer education on eye health care education

Peer education	Frequency	Percentage
Yes	150	75
No	50	25
Total	200	100

Table 4.11 deals with whether local community members share or exchange ideas with their colleagues who might not have attended eye health care meetings. The table shows that 75 percent of them educated their peers on eye health care programmes. 25 percent of respondents however, responded to the contrary.

4.5 Methods and strategies used for effective community participation.

Table 4.12 Methods and strategies used during community eye health care education programmes.

The 200 respondents were asked whether methods like simulation, group discussion, theatre, and others were used during the education. They said that no specific methods were used.

University of Ghana http://ugspace.ug.edu.gh

The 4.12 table below shows that no method was used.

Different Methods:	Frequency	Percentage
Yes	Nil	Nil
No	200	100
Total	200	100

Table 4.12 above depicts respondents view on methods and strategies used by eye health care deliverers to mobilize communities for eye health care programmes. Table 4.12 shows that eye health care facilitators used the same strategies and methods to involve communities in their programmes. None of the 200 respondents, representing 100 percent mentioned any differences in methods and strategies used by eye health care deliverers in educating community members to take active part in eye health care education programmes.

University of Ghana http://ugspace.ug.edu.gh

CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

In this chapter an attempt is made to discuss the results of the research findings under the following sub-headings: demographic characteristics of respondents, importance of the communities participating in community development projects; the involvement of the local community members from the planning to the evaluation stage of eye health education programmes; the availability of ophthalmic nurses services in the communities; areas of community participation; and the methods and strategies that eye health service deliverers use in encouraging community members to participate effectively in eye health care programmes.

5.1 Demographic characteristics of respondents

Sex of respondents

Table 4.1 indicated the respondents' sex differences. It was realized that both sexes (male and female) had equal representation of 100 respondents each. This, however, was to ensure that equal chances for both male and their female counterparts to freely express their views on the community members participation on the eye health care education programme.

Age of respondents

Table 4.2 showed the age difference among respondents. It was realized that respondents who aged between 18 and 28 representing 20% were people who had just completed the junior or senior secondary schools. They were rather interested in furthering their

University of Ghana http://ugspace.ug.edu.gh

education in the formal institutions or entering into craftsmanship. They did not show interest in participating in community development programmes. Notwithstanding, respondents who aged between 29 and 39 representing 35% were the active group. They constituted the young and energetic group and were always active in community programmes in general and eye health care programmes. They were always ready to take up voluntary activities and provide free labour to support community work. Respondents aging between 40 and 50 represented 32.5% concentrated on their families, chieftaincy affairs, and the aged. They relinquished community development activities into the hands of the youth. The 7.5% of the respondents being people above 51 no longer took part actively in community work. They formed the older group; they supported the chief and, therefore, concentrated on giving advice to the youth.

Educational background of respondents

It is widely on record that education is one of the important bedrocks of any kind of development endeavour and that illiteracy itself is an obstacle to development. It was, therefore, prudent to ascertain first hand information about the educational background of respondents so as to be able to make an informed observation on the pattern of community participation in eye health care education programmes in cluster communities in the Upper West region.

Table 4.3 showed that 80 respondents (40%) were illiterates. This pre-supposes a high level of ignorance among members of the various communities. It could be said that the situation was further aggravated by the fact that, as high as 22.5 percent (45 respondents) were those who had achieved a low level of education and at best of Middle School standard.

University of Ghana http://ugspace.ug.edu.gh

Notwithstanding the above, it is interesting to note that 15 and 12 percent respectively were those who had attained Junior Secondary and Senior Secondary education. The table also showed that, only 7.5 and 2.5 percent had received Post-Secondary and Tertiary education respectively. On the basis of the fact that education, as a bedrock of development is on the low record as depicted in the study, it could be conferred that community participation in development agenda such as eye health care education programme was low.

5.2 Importance of community participation.

According to Paul cited in Sheng (1990), for communities to participate in any development programme the community members must be made to see the importance and value of that programme. He explained further that communities, which did not see the importance of a programme, would not participate in the execution of that programme. Boyce and Ballantyre in Thomas and Thomas (2000) also postulated that communities are always ready to be part of a development project if they understand the execution of the project to be enhancing their well being in terms of income, personal growth, health, self-reliance, or other values the community cherishes. In Table 4.4, it was indicated that all the respondents have realized the importance of the eye health care education programme to fall in line with the community needs. Further probing and field observation showed that community participation fostered unity among them. They emphasized that community participation in all aspects was very important since community members had the chance to choose what they needed but not what other people thought they needed. This is in support of Gran (1983) who said that people's

University of Ghana http://ugspace.ug.edu.gh

understanding of project development is a process of empowerment of the deprived and excluded. Apart from the above, respondents also indicated during in-depth discussion that, members, by way of appreciating the significance of participation in project development in terms of ownership and benefits, have contributed in the form of labour and local for the construction of eye clinics and other health facilities. This is inline with Griffin (1990), who opines that if people understand projects, their participation consists of their contribution of labour and materials either free or paid for by the authorities.

In the researcher's view, participation of communities in development projects including eye health care education programmes is justified because it expresses not only the will of the majority of the people, but also it is the only way for them to ensure that the important moral, humanitarian, social, cultural and economic objectives of a more humane and effective development can be peacefully attained.

Source community information on eye programmes

Table 4.5 in chapter four showed how local community members got information about eye health care education programmes. They mentioned different ways by which they got their information on the eye health care education campaigns. All the 200 interviewees said that eye volunteers in the communities usually informed them about eye care programmes. The table also indicated that 100 percent of the respondents agreed that whenever information about eye care programme got to their opinion leaders, they in turn gave it to all the community members through gong-gong beating. They all further agreed that they got information from the radio through the local Fm stations. They also said

University of Ghana http://ugspace.ug.edu.gh

that, apart from the above-mentioned sources of information, individuals within the community either consciously or unconsciously also gave information to people with eye problems and also about eye health care programmes. All the people interviewed in the district capitals also said that they got information about eye health care education directly from the nurses themselves. A summary from the table indicated that information concerning community programmes, especially eye health care education programmes, got to their communities without any hindrance.

5.3 Planning eye health care programmes with the community

Most social analysts have attributed most of the failures of development to the fact that the population concerned was kept out of all the processes related to their design formulation and implementations. Rahnema cited in Wofgang (1999) stresses that a number of major international aid organizations agreed that development projects had often floundered because people were left out. It was found out that whenever people were locally involved, and actively participated in project planning processes, much more were achieved, even in sheer financial terms. In Table 4.6, 97 percent of the people interviewed about their involvement in planning and decision-making in eye health care programmes agreed that they did take part in the planning and execution of the programmes. Further probing indicated that communities participated in the planning of eye health care programmes through their involvement at various levels of decision-making by way of organizing and scheduling meetings (together with health care providers) for eye health activities; organizing of various communities for eye screening

University of Ghana http://ugspace.ug.edu.gh

on planned schedules-often with the involvement of community health care providers; and the mobilization of resources for eye health care projects through needs assessments.

The above agrees with Adarkwa & Diaw (1999) who posit that community involvement in decision-making plays an important role in needs assessment. According to them, it allows people to express their needs and priorities. They emphasize that when people are given the chance to be involved in such planning processes, they become committed to the programme and do all they can to support and sustain it. Development policies tend to create induced and addictive needs, many of which strongly condition the minds of their target population. When the rural people are made to depend on such needs and other modern services, their participation in public activities and policy-making decisions is mostly used to secure general support for the same needs and services.

It could be inferred from the results of the study that, members of the various communities have a high aptitude for eye health care programmes. This equally denotes relatively high percentage coverage of community members in eye health care services.

5.4 Availability of Ophthalmic services in the communities

According to a WHO (1981) document on Primary Health Care, the concept of primary health care is to provide health care services to communities in different ways. WHO mentioned some of these ways to include the promotion of proper nutrition, adequate supply of safe drinking water, basic sanitation programmes, maternal and child care, family planning, immunization against the major infectious diseases, the methods of preventing and controlling these diseases, and appropriate treatment, especially in the area of eye related diseases.

University of Ghana http://ugspace.ug.edu.gh

Table 4.7 in chapter four showed that 72.5 of th respondents said that ophthalmic nurses came to the communities to give eye care services and education. During further probing, respondents stressed that the nurses educated them on how to get and maintain healthy eyes. They testified that the ophthalmic nurses did community/ school screening, trained volunteers for peer education concerning the six rules for healthy eyes, and administered eye drugs. The study further revealed that community education on preventive and curative measures for a healthy environment was ensured. However, 27.5 percent representing fifty-five respondents said they did not know any of the ophthalmic nurses. Further questioning of respondents revealed that in some communities it only the community health nurse who moved from house to house to attend to community members health needs. On the whole, it could be generalized that ophthalmic services in the various communities have risen to appreciable levels despite the fact that a few communities did not benefit from such services because they were not available to them. This is in line with what came out of a study conducted by Battern (1960). He posits that education for community participation provides the knowledge needed to assist the people to control their future through the practice of healthy practices that will bring benefits to themselves.

5.5 Community contribution to eye health care programmes

Respondent were asked to state the level at which educational material were contributed at the various communities to support eye health care programmes. Table 4.8 in chapter four indicates the responses of respondents. In table 4.8,most of the communities could not provide educational materials for their own programmes. Out of the 200 people

University of Ghana http://ugspace.ug.edu.gh

interviewed, only 95 of them representing 47.5 percent said that their communities could provide educational materials. On the other hand, 105 representing 52.5 percent of respondents said that it was not just possible for them to provide any educational materials because they could simply not do it. They emphasized during further probing that most of the time they have difficulty in getting food to eat let alone getting money to buy educational materials. The majority of them further indicated that they were prepared to offer their labour but they did not have money to provide educational materials. It was for this reason that respondents were asked to state if they all provided labour and other facility.

In table 4.9 in chapter four all the 200 respondents said that they provided labour for all developmental projects that came into the community. It was revealed during the interview that communities members contributed their labour towards the construction of community clinics that house the eye health care project in the various communities. Further probing revealed that accommodation to house the ophthalmic nurse, who facilitated eye health care educational programmes, was provided by the local community members. Apart from shelter for the ophthalmic nurse, they also mentioned that they provided food and water as and when necessary to the health workers who visited their community.

On community members ability to contribute financially to support eye health education programmes, respondents indicated their views as depicted in Table 4.10 in chapter four. In Table 4.10, it was realized that only 12.5 percent of respondents said they contributed financially to support eye health care education programmes. On the other hand, the majority of 87.5 percent said they could not contribute money or cash to

University of Ghana http://ugspace.ug.edu.gh

support such programmes. Further probing indicated that the low level of financial contribution was the result of high incidence of poverty among the communities. On the whole the result of the study seemed to suggest that though community members have showed a degree of willingness to contribute cash to community project including eye health care education programmes, they were indeed handicapped as a result of the lack of viable economic capacity.

It was also realized from the study that peer education was one of the fundamental contributions communities could offer to their members. Table 4.11 in chapter four showed that community members shared or exchanged ideas with their colleagues who might not have attended eye health care meetings. This is important because community participation in progammes bring about unity among its citizenry. In table 4.11, 150 representing 75 percent of respondents indicated that they educated their peers on eye health care needs. This high figure is indeed commendable as far as communities' willingness to learn and improve upon their living conditions is concerned. On the contrary, 25 percent of respondents said they did not carry out peer education because they themselves never had access to eye health care education. Following further questioning during the interview, respondents from the district capitals in particular, maintained that they did not carry out peer education on eye health care simply because they believed that most community members must have benefited from radio programmes offered through Radio Upper West, and Radio FEREED. Therefore, they did not see the need to go telling people about what they termed 'dead news' On the whole it could be observed that, though an average number of 50 respondents did not favour peer education, nevertheless it has been recognized in the communities as an effective

University of Ghana http://ugspace.ug.edu.gh

communication tool that could be used to influence the pace of adult education in eye health care programmes.

5.6 Methods and strategies used for Community Participation

According to Griffins (1990), development projects are conceived and designed from outside by national and international experts, together with pre-feasibility and feasibility studies, appraisal reports, specification of inputs and output, calculation of internal rates and sophisticated cost-benefit analysis. When this happens, the project experts somehow design methods and strategies to get the local communities participate effectively in development projects. But they often forget that eye care programmes tend to isolate eye from other health problems. The experts in their offices make their own plans to achieve their aims in the control of eye diseases. Eye health care workers and their communities or voluntary groups are then used as vehicles to implement the experts' interests. But the community members' lives are directly affected by health interventions. They have their own views of the world and want to do things their own way. In the study to find out the methods and strategies adopted by eye health care deliverers to ensure community participation in eye health care programmes, all the 200 community respondents in Table 4.12 in chapter four agreed that health educators used the same methods/strategies to get community members involved in eye health care programmes. Further probing of respondents mentioned awareness creation, capacity building and volunteerism as strategies used through various methods such as drama, role-play, simulation and focus group discussions to get the communities to participate effectively in their eye health care programmes. However, it is the researcher's observation that, role playing and popular

University of Ghana http://ugspace.ug.edu.gh

theatre could be a way to solve problems in the community. This is important because there are situations where open discussions would be offensive and could polarize the various parties involved.

University of Ghana http://ugspace.ug.edu.gh

theatre could be a way to solve problems in the community. This is important because there are situations where open discussions would be offensive and could polarize the various parties involved.

University of Ghana http://ugspace.ug.edu.gh

CHAPTER SIX

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

6.0 INTRODUCTION

Community participation is a process whereby the people organize themselves and through their organization are able to identify their needs, share in the planning design, implementation, and evaluation of the participatory action. This chapter attempts to give a summary of the study on community participation in the eye health care education of the rural communities in the Upper West Region. This is followed by the conclusions and recommendations of the study.

6.1 Summary of the study

Community participation in development projects is a global policy now. Any form of community development requires the mobilization of both material and human resources in the local community. Many development projects, launched in many developing countries, aim at making the rural communities part of the process of development. In recent years, great attention is being placed on rural development through community participation. In Ghana, the government has begun to introduce decentralization as a way of achieving rural development and encouraging rural communities to participate in developing their own communities. In the Upper West region, it is noted that poverty has limited the participation of community members in development projects. The eye health

University of Ghana http://ugspace.ug.edu.gh

care education programme seems to have suffered most since community participation in this area seems to have been left in the hands of only people having eye problems. NGOs who initiated eye health education programmes seem to have enjoyed little community support. One wonders why this lack of community participation was so marked in the region. This study was then carried out to find out the reasons underlying the limited participation of the rural communities. The research revealed that the level of rural community participation was not limited only to the provision of volunteers to be trained as community eye health workers, but the people recognizing the importance of their participation in community developmental programmes was also very paramount. However, the major obstacle that made the rural people not to participate fully in development projects in general was poverty. Poverty causes poor health. Sutter et al (1998) state that the burden of poverty includes mental stress, exhaustion, isolation, illiteracy, powerlessness, undernourishment, and illness. All these were prevalent among most of the rural communities in the area of study.

Furthermore, methods and strategies that were used by eye health care agencies to motivate rural communities to participate in eye health care projects were limited to awareness creation and volunteerism. Capacity building, as a way of encouraging communities to participate actively in the eye care programmes, was limited only to the training of volunteers from the local level. Through these methods, people were only trained to identify people with eye problems. The method however neglected capacity building of skilled labour.

As pointed out by Thomas & Thomas (2000), community self-reliance requires full participation in the decision-making, planning, organization, and management in all

University of Ghana http://ugspace.ug.edu.gh

development projects. The research revealed a low level of participation by the rural communities in the planning, organization, and management of the eye health care education programmes. This was due to the fact that the rural communities are poverty-ridden.

The nine ophthalmic nurses and other health care delivery agencies took up awareness creation through the composition and use of songs related to eye diseases prevalent in the local communities on the local FM stations to encourage community participation. Secondly, the teaching of the six rules of a healthy eye to rural communities was not ignored. But there were no follow-ups to see whether these cultural practices were carried out properly or not.

It can, therefore, be said that community participation, as pointed out by Jancloes et al (1982), suggests that, when people are given the opportunity to manage their own affairs and involved in decision-making, they can become very efficient and will contribute many of the materials and human resources needed to organize health facilities. The level of the rural community participation in the eye health care was therefore hampered by poverty, partial involvement of the local people in decision-making, planning, organization, implementation, and evaluation of the eye health programmes. Lack of vibrant methods to bring about effective awareness creation also contributed to the limited participation of the rural people in the eye health education programmes. Finally, lack of empowerment of the rural people made them feels humiliated thereby bringing self-pity.

University of Ghana http://ugspace.ug.edu.gh

6.2 CONCLUSIONS

Community participation according to Pateman cited in Thomas & Thomas (2000), must include: participation by someone; participation with someone; participation in something; and participation for a purpose. He debunks participation idea where an individual merely takes part in a group activity; where an individual is merely given information on a decision affecting him/her before it is executed; or where an individual is present at a meeting but has no influence. The study revealed that local community participation in the Upper West region was in line with Pateman definition of community participation.

The study however, showed that local communities participated to some extent but they were unable to participate fully. Their involvement was limited simply because they were poor.

Secondly, appropriate methods and strategies of awareness creation to let the local communities know about eye health care education programmes were not used. Local community members were de-motivated by this, and it often resulted in the people abandoning the programme.

Thirdly, though the study showed a marked level of capacity building effort in some communities, field observation revealed that it was virtually non-existent in most communities.

All these issues, especially poverty, are causing the rural communities in the Upper West Region not to participate effectively in eye health care education programmes. Local communities could participate effectively in eye health care programmes if they would be supported to put up community programmes/projects that

University of Ghana http://ugspace.ug.edu.gh

could help alleviate poverty in their communities. The study therefore calls for some measure of recommendations that could help strengthen the level of community participation in eye health care education programmes in the Upper West Region.

6.3 Recommendations

Following the summary of the study and the conclusions drawn above, the following recommendation are suggested as contribution towards improving and sustaining eye health care programmes in the Upper West Region:

1. In order to improve the community participation in eye health care education in the local communities, poverty alleviation campaign programmes should be extended to the areas to help reduce the amount of poverty among the people.
2. Community members should be encouraged to participate in decision-making in respect of activities for eye health promotion that will take into consideration the views and opinions of others.
3. Community members should take their nutrition seriously. They should grow and eat food rich in vitamin A. They should make a habit of eating bodybuilding foods. They should promote breastfeeding of babies till about the age of 18 months.
4. Community members should improve their hygiene and sanitation programmes in order to control the spread of diseases and also to eliminate their breeding sites. They can do this when they build and use properly constructed latrines, burn and bury all refuse.

University of Ghana http://ugspace.ug.edu.gh

5. The local government, through the District Assemblies, should provide the communities with their basic needs, like fresh clean water, public places of convenience.
6. District Health Management Teams should intensify their community education, especially on maternal and child health education. For instance, pregnant women should be educated on eating foods rich in vitamin A, maintain good antenatal care, avoid self-medication, and keep themselves clean all the time.
7. Lactating mothers should be taught to keep their babies' eye clean, maintain their personal hygiene, report of any discharge or abnormality of their children's eye to the nearest eye clinics, and ensure that their children are immunized against the six childhood killer diseases.
8. NGOs, which work to improve the eye health of any rural community in the region, should always involve the local community members in the decision-making, planning, implementation, and evaluation of the programme even if the people are poor.
9. The community ability to improve its environment depends on co-operation shared responsibility, maintenance and good leadership. So, community leaders should show good leadership qualities in order to encourage their community members to participate effectively in development projects

University of Ghana http://ugspace.ug.edu.gh

REFERENCES

Bamberger, M. (1986). The Role of Community Participation in Development Planning and Project Management, Washington D. C., The World Bank.

Bose, (1983). 'Community Health Worker Scheme': An Indian Experiment in Darid Martey et al. in Practicing Health for All., Oxford University Press

Brookfield, S. (1983). Adult Learner, Adult Education and the Community, Open University Press.

Cohen, J. M. and Uphoff, N. T. (1977) Rural Development Participation: Concept and Measures for Project Design, Implementation and Evaluation in Rural Development, Cornell University.

Conde, J. et al (1979). The Integrated Approach to Rural Development, Health and Population; Development Centre of the Organization for Economic Co-operation and Development, Paris.

Coomb, P. (1980) Meeting the Basic Needs of the Rural Poor: The Integrated Community-Based Approach, New York, Pergamon Press Inc.

Diaw, K. (1992).' Citizen participation in planning for growth and development in Ghana' in Aryeetey, E. (ed) Planning African Growth and Development: Some Current Issues, Accra, ISSER/UNDP

Institute of Development Studies (IDS) Research Group Report (1978), Health Needs and Rural Ghana; IDS, Brighton.

Jankloes M. et al. (1982). 'PHC Experimental Project in Pikine Senegal; World Health Forum:' An International Journal of Health Development, WHO, Geneva.

University of Ghana http://ugspace.ug.edu.gh

Jancloes, M. (1984). 'Could Villages do better without their Volunteer Workers?' An International Journal of Health Development, WHO, Geneva. Volume 5

Lamptey, P.R. et al. (1980).' Training Village Health Workers in Rural Ghana' 'World Health Forum: An International Journal of Health Development; WHO, Geneva, Volume 1.

Lele, U. (1975). The Design of Rural Development- Lesson from Africa, Baltimore, Johns Hopkins University Press.

List, F.A.N. (1981) 'Popular Participation in Basic Needs-Oriented Development Planning' Labour and Society, ILO, Geneva.

Lund, F.J. (1987). The Community-Based Approach to Development, University of Natal, South Africa.

Madan, T.N. (1987).'Community Involvement in Health Policy: Socio-structural and Dynamic Aspect of Health Belief' World Health Forum. WHO, Geneva.

Molina, g. et al. (1982). How to select community health leaders, World Health Forum, WHO, Geneva, Volume 1.

Nelson, N. and Wright, S. (1995). Power and Participatory Development: Theory and Practice, Intermediate Technology Publication, London

Oakley, P. (1989). Community Involvement in Health Development- An Examination of the Critical Issues, WHO, Geneva.

Oakley, P. et al. (1991). Project and People, ILO, Geneva

Overseas Development Council(ODC)/International Labour Office(ILO), (1976). Employment, Growth and Basic Needs: A One World Problem., New York.

University of Ghana http://ugspace.ug.edu.gh

Paul, S. (1987) 'Community Participation Development Projects: The World Bank Experience' in Reading in Community Participation, Washington D.C.

Polit, D. F. and Hungler, B. P. (1995). Nursing Research Principles and Methods, (5th Edition) J. B. Lippincott Co. Philadelphia, USA.

Rifkins, S. (1980). 'Health and Human factor' Readings in Health Development and Community Participation, Christian Medical Commission, World Council of Churches, Geneva.

Schumacher, E.F. (1978) Small is Beautiful, Harper and Row Publishers Inc, N.Y.

Singh, K. (1992). People's Participation in Natural Resources Management, Workshop Report 8, Institute of Rural Management, Anand, India

Sutter, E. et al (1998). A Village Struggles for Eye Health, International Centre for eye Health, London.

Twumasi, P. A. & Freund, P. J. (1985) 'Local Politicization of PHC as an Instrument for Development.' A case study Community Health Workers in Zambia. Social Science and Medicine, Volume 20.

Twumasi, P. A. (2001). Social Research in Rural Communities, (2nd Edition) Ghana Universities Press

WHO/UNICEF, Alma Ata 1978, Primary Health Care Report of the International Conference on Primary Health Care, Alma Ata, USSR, WHO, Geneva.

Wolfgang S. (ed.) (1999). The Development Dictionary – A Guide to Knowledge and Power, Witwatersrand University Press, Johannesburg.

University of Ghana http://ugspace.ug.edu.gh

APPENDIX 'A'

INTERVIEW SCHEDULE FOR THE COMMUNITY MEMBERS

Demographic characteristics of respondents

1. Name of community.....
2. Sex of respondent: .....
3. Age of respondent: .....
4. Educational background of respondent: .....
5. Has any organization ever come to your community to do some thing for you?

   .....
6. If yes, can you mention any of such organizations?

   .....

   .....

   .....
7. What things did such organization come to do in the community?

   .....

   .....

   .....

   .....

   .....
8. Do ophthalmic nurses come to check your eyes? .....

University of Ghana http://ugspace.ug.edu.gh

9. If yes, how do you often get the information that someone or group of people are coming to check your eyes?

.....

.....

.....

10. Are the community members always involved in the planning of eye health care programmes? .....

11. If yes, where do you gather to plan? .....

12. Are you happy that you are always involved in the planning of such community programmes? .....

13. If yes, what do you do to ensure that programmes of this nature succeed in your community?

.....

.....

.....

.....

.....

14. Is it important for you to participate in such planning programmes?.....

15. If yes why do you think it is important?

.....

.....

.....

.....

University of Ghana http://ugspace.ug.edu.gh

16. Do you provide accommodation and food to the eye nurses who visit you on eye health care programmes?

.....

.....

.....

.....

17. Do community members provide labour to support eye health care programmes?

.....

.....

18. Do you make contributions in the form of educational materials to support eye health care programmes?

.....

.....

.....

19. Do community members contribute financially to support eye health care programmes?

.....

20. If yes, how often do you do that?.....

21. If no, why have you never contributed money to support the programme?

.....

.....

.....

.....

University of Ghana http://ugspace.ug.edu.gh

22. When the people who bring the programme to the community are gone, what happens to the programme?

.....

.....

.....

.....

.....

23. Are there any methods and strategies adopted to ensure community participation in eye health care programmes?

.....

.....

.....

.....

24. Give any other information about your participation in community programmes in general.

.....

.....

.....

.....

University of Ghana http://ugspace.ug.edu.gh

APPENDIX 'B'

QUESTIONNAIRE FOR NGOs

1.What is the name of your organization?.....

2. How long has your organization been working in the eye health education campaign in this region? [ ] years

3. Do you involve the district assemblies in your eye health care programmes?
[ ] Yes [ ] No

4. If yes, mention areas of involvement.
[ ] Awareness creation
[ ] Capacity building
[ ] Training
[ ] Provision of personnel
[ ] Drugs
[ ] Funds

5. How do you deliver eye health education services?
.....
.....
.....
.....

6. What service delivery strategies do you use?
[ ] institutional care
[ ] community outreach
[ ] community-based
[ ] others

7. Do you involve the communities in planning the eye health programmes?
[ ] Yes [ ] No

8. If yes, how ?
.....
.....
.....
.....
.....

University of Ghana http://ugspace.ug.edu.gh

9. If no, why?

.....

.....

.....

.....

.....

10. Have communities been participating in your eye health care programmes?

[ ] Yes [ ] No

11. If yes, in what form?

[ ] they provide accommodation
[ ] they provide labour
[ ] they provide materials
[ ]they provide volunteers to be trained
[ ] they do peer education
[ ] others

12. Is your organization satisfied with the level of community participation?

[ ] Yes [ ] No

13. If yes, mention the level of satisfaction.

.....

.....

.....

.....

14. What methods and strategies have you used for effective community participation in eye health care programmes?

[ ] Awareness creation
[ ] Capacity building
[ ] Empowerment
[ ] Volunteerism

University of Ghana http://ugspace.ug.edu.gh

APPENDIX 'C'

QUESTIONNAIRE FOR EYE HEALTH WORKERS

1. Do you go to the rural communities to give eye health care services?
   [ ] Yes [ ] No

2. What eye care services do you provide?
   [ ] Community education
   [ ] Community eye screening
   [ ] Training of volunteers
   [ ] Eye drugs

3. Are individuals required to pay for any of the services?
   [ ] Yes [ ] No

4. If yes, how much are they required to pay?
   ..... cedis

5. If no, who bears the cost?
   .....
   .....

6. Are the individuals capable of paying?
   [ ] Yes [ ] No

7. If yes, indicate level of payment.
   [ ] Satisfactory (above 59%)
   [ ] Average (50%)
   [ ]Unsatisfactory (below 50%)

8. Are communities informed about your outreach programmes?
   [ ] Yes [ ] No

9. If yes, how?

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

University of Ghana http://ugspace.ug.edu.gh

10. Have the communities been participating in the eye care programmes?
[ ] Yes [ ] No

11. If yes, in what form?
[ ] they provide accommodation
[ ] they provide labour
[ ] they provide materials
[ ] they provide volunteers to be trained
[ ] they do peer education in eye health
[ ] others

12. Do you involve NGOs working in eye health in the region in your eye programmes?
[ ] Yes [ ] No

13. If yes, mention areas of involvement.

.....

.....

.....

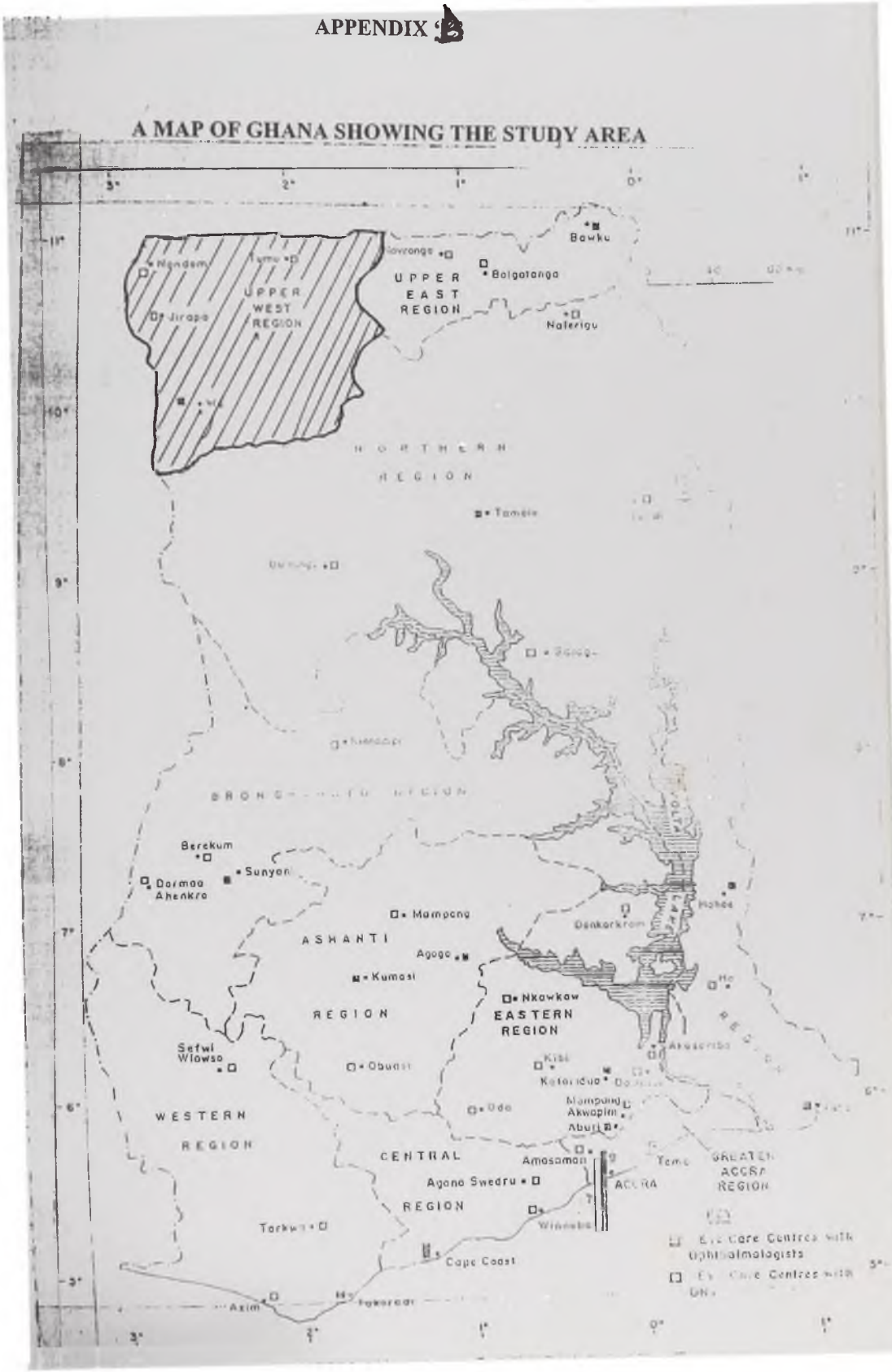
.....

.....

.....

.....

University of Ghana http://ugspace.ug.edu.gh

APPENDIX B

A MAP OF GHANA SHOWING THE STUDY AREA