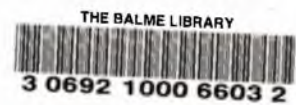


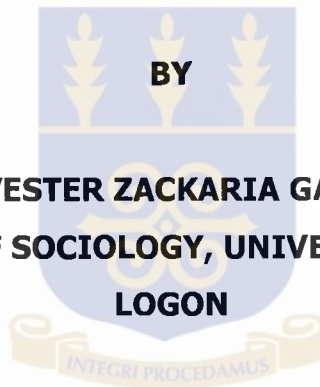


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**COMMUNITY PARTICIPATION IN HEALTH CARE
DELIVERY AND MANAGEMENT: A CASE STUDY OF
NORTHERN GHANA**

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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR
THE AWARD OF PHD SOCIOLOGY DEGREE**

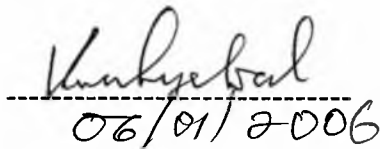
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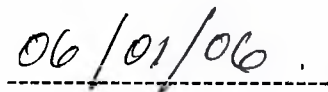
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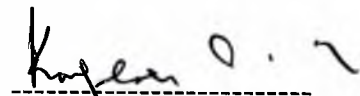


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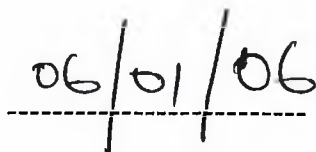

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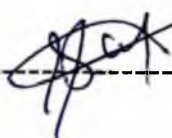
THIS WORK IS DEDICATED TO THE EMPOWERMENT OF THE SILENT MAJORITY OF PEOPLE ENGAGED IN HEALTH CARE DELIVERY MANAGEMENT WITHOUT RECOGNITION BY THE PUBLIC HEALTH SECTOR OF GHANA.



DECLARATION

THIS THESIS IS A RESULT OF ORIGINAL AND INDEPENDENT RESEARCH WORK UNDERTAKEN BY ME WHILE I WAS A STUDENT OF THE DEPARTMENT OF SOCIOLOGY, UNIVERSITY OF GHANA, LEGON FROM AUGUST, 1998 – JUNE 2003.

ALL QUOTED SOURCES HAVE BEEN DULY ACKNOWLEDGED.

SIGNATURE OF STUDENT

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ABSTRACT

This study is devoted to the investigation of a common and yet anonymous phenomenon in development management – community participation.

The objective of the study has been to explicate the nature and forms of community participation in the public health sector in order to discover the modes through which communities participate in health care delivery and management issues. The study also elucidates some determinants of community participation in the public health sector.

The study concentrates on the three northern regions of Ghana using case studies of community participation programmes. The bulk of the data was collected using key informants, semi-structured interviews and focus group discussions. The findings have implication not only for the northern sector of Ghana but for the entire country and developing world.

The findings show that communities participate in health issues in various forms: as individuals selected and trained, as traditional health experts trained or untrained and through systems of representation in teams or committees. Communities also participate as whole groups in village /community meetings and assemblies.

Communities participate in broad scope of health care delivery and management issues ranging from community entry and preparation; information, education & communication; social mobilization and curative primary health care delivery and planning. Of these aspects of participation, participation in primary curative health care delivery and management is limited in scope and the most contentious.

The findings also show that the nature of health sector participation by communities is determined by the Primary Health Care system and the current decentralization policy pursued by Ghana; health sector material and human resources, especially the orientation and capacity of the human resources; and the social and cultural conditions of the participating communities.

Although the PHC system and the decentralization policy are pursued nationwide, the findings show that the resources of the health sector – the infrastructure, capacity and

orientation of human resources vary across the northern sector of Ghana. Similarly, social and cultural conditions also vary across the length and breadth of the three northern regions. As a result of variations in health resources and social and cultural conditions, the nature and forms of participation in health care delivery and management were found to vary between regions and sometimes within districts and sub-districts.

Community participation in the public health sector of Ghana is more a means rather than an end process geared towards improvement of the health status of communities rather than confidence building and empowerment.

One key factor limiting community participation in Ghana is the inward looking policies of the Ghana Ministry of Health, which has been pro-modern scientific medicine for some time now. Thus, the de-linking of the service delivery function of the Ministry of Health from its policy function by the creation of the GHS is in the right direction towards ensuring broad-based stakeholder participation in public health in Ghana. However for the participation to be genuine and empowering, a Coalition for Participation and Partnerships model together with the strategies for its implementation is proposed.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ATP	Acute T Paralysis
ASS	Administration and Support Services
BARIDEP	Brong-Ahafo Integrated Development programme
BMC	Budget Management Centre
CBD	Community Based Distributor
CBDP	Community Based Development Programme
CBHW	Community Based Health Workers
CBS	Community Based Surveillance
CBSV	Community Based Surveillance Volunteer
CBWP	Community Based Workers Programme
CHAG	Church Health Association of Ghana
CHO	Community Health Officer
CHPS	Community Based Health Planning Services
CIH	Community Involvement in Health
CKI	Community Key Informant
CPPIH	Coalition for Participation and Partnership in Health
CRS	Catholic Relief Services
CWTs	Community Weighing Teams
DANIDA	Danish International Development Agency
DC	District Co-ordinator
DCD	District Co-ordinating Director
DCE	District Chief Executive
DDHS	District Director of Health Services
DFID	Department for Foreign and International Development
DFO	District Health Officer
DHC	District Health Committee
DHDP	District Health Development Plans
DHMT	District Health management Team
DPF	Donor Pool Fund
FACs	Food Assisted Programme
GES	Ghana Education Service
GHS	Ghana Health Service

GHSC	Ghana Health Service Council
GMNS	Growth Monitoring and Nutrition Surveillance
GOG	Government of Ghana
HEA	Health Education Assistant
HRDD	Human Resource Development Directorate
IE&C	Information Education and communication
ISC	Intersectoral Collaboration
ISCH	Intersectoral Collaboration in Health
ITN	Insecticide Treated Nets
MA	Master Trainer
MCH/FP	Maternal Child Care/ Family Planning
MLGRD	Ministry of Local Government and Rural Development
MOH	Ministry of Health
MTHS	Medium Term Health Strategy
MVSL	Manpong Valley Social Laboratory
NDSS	Navrongo Demographic Surveillance Programme
NGO	Non-Governmental Organisation
NHRC	Navrongo Health Research Centre
NID	National Immunisation Day
NORRIP	Northern Regional Integrated programme
NTBA	National Traditional Birth Attendant programme
OCT	Over the Counter Drugs
ODA	Overseas Development Agency
ORS	Oral Rehydration Sachet
ORT	Oral Rehydration Therapy
PNDC	Provisional National Defence Council
PNDC L	Provisional National Defence Council Law
PHC	Primary Health Care
PHNS	Primary health Workers
PNO (PH)	Public Nursing Officer (Public Health)
PPMED	Policy Planning, Monitoring and Evaluation Department
PRHETIH	Primary Health Training For Indigenous Healers
SDHMT	Sub District Health Management Team
SDHS	Strengthening of District Health System
SSDM	Supplies, Stores, and Drug management

STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TCRD	Technical Co-ordination and Research Department
TOT	Trainer of Trainers
TSRD	Technical Co-ordination and Research Division
UNDP	United Nations Development programme
UNICEF	United Nations children's Fund
UNRISD	United Nations Research Institute for Social Development
USAID	United Nations Agency For International Development
VAP	Village Action Planning
VDC	Village Development Committee
VET	Village Extension Team
VHV	Village Health Volunteer
VHW	Village Health Worker
VLP	Village Level Planning
WHO	World Health Organisation
ZC	Zonal Coordinator

CHAPTER 1

1.0 BACKGROUND AND NATURE OF THE PROBLEM

In Ghana, a series of policies and programmes outlining strategies for community participation in health have been implemented since the Alma Ata Declaration of 1978. The three main programmes or strategies facilitating the process are the Primary Health Care (PHC), the Medium Term Health Strategy (MTHS) document and the Community Based Health Planning and Services (CHPS) (WHO, 1978; MOH, 1996; MOH, 1999).

1.1 PRIMARY HEALTH CARE (PHC)

The PHC system and its global programmes and strategies shaped community participation in Ghana in the late 1970s and 1980s in three broad areas:

- community Involvement in Health (CIH);
- intersectoral Collaboration (ISC); and
- introduction of Tier System of Health Care Delivery.

1.1.1 Community Involvement in Health (CIH)

Community involvement in health under the PHC was interpreted in the health sector to mean three things: participation in service delivery by auxiliary staff and village level health workers, decision-making and management of health care by members of the community as well as their active involvement in proactive and preventive health development programmes. The emergence of the paradigm of CIH health was influenced by the realisation that the doctor and health workers alone might not be able to “cure” health problems without the active involvement of the patient and larger public in the treatment process.

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care [Alma- Ata declaration 1V]. The PHC “requires and promotes maximum community and individual self reliance and participation in the planning, organisation, operation and control of primary health care,

making fullest use of local, national and other available resources; and to this end develops through appropriate education, the abilities of communities to participate” (WHO, 1978: 3).

1.1.2 Intersectoral Collaboration in Health (ISCH)

Intersectoral collaboration has been one of the key strategies of the PHC system. Intersectoral collaboration means intra and inter-sectoral collaboration. Intra-collaboration in health under the PHC, sought to integrate vertical programmes that permeated health care management and delivery. As a result, district and sub-district initiatives were pursued to realign vertical programmes and to promote integrated services delivery.

Intersectoral collaboration on the other hand, sought to foster collaboration between other health care providers – traditional and modern and the public health sector on the one hand and those other sectors whose activities directly impact on health on the other. PHC “involves, in addition to the health sector all related sectors and aspects of the national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication and other sectors; and demands the coordinated efforts of all those sectors” (WHO, 1978: 3).

The MTHPS and the CHPS have re-echoed ISCH based on the understanding that multiple factors contribute to health and disease and hence the need for stakeholders to work together. Through the above programmes, the public health sector seeks to consciously promote intersectoral collaboration in services delivery, planning and management and support to the private sector – traditional and modern.

1.1.3 A Tier System of Health Care Delivery

The various programmes under the PHC have categorised levels of services delivery through institutional boundary setting. This has created new institutions, clarified roles and norms of services delivery and supervision and logistical support, crucial to the process of participation.

An innovation in this direction was the introduction of a three-tier system of health care delivery and management as a basis for boundary setting in the health sector. Such

programmes as the District and Sub-district Initiatives and the Bamako Initiative have facilitated the tier health delivery thinking. They have established management systems and programmes for building the capacity of the new institutions created to support community participation in health in the 1980s.

The tier system in health care delivery and management also ties participation in the public health sector to decentralisation and health sector restructuring in Ghana. The restructuring in the health sector can be seen as an attempt to clarify and realign areas of health delivery by the various health providers by government. Similarly the pursuance of decentralisation at the district level seeks to clarify the decision making process between sector agencies at the district level and below as well as realign vertical local level health institutions to enhance services delivery.

1.2 STATEMENT OF THE PROBLEM

Even though there appears to be a consistent blueprint on community participation in health management and delivery, how the blueprint has been translated into practice by the public health sector and participating communities has generated some confusion about the nature and forms of community participation pursued in the health sector in Ghana. As Zakus rightly observed on the global front about the promotion of community participation in health, “two decades after the Alma-Ata, the strategy originally conceived as a commonsense and straightforward approach is recognised to be fundamentally more complex” (Zakus and Lysack, 1998: 1).

Oakley made a similar point when he observed that “although there would appear to be widespread agreement on the importance of community participation for bringing about the desired redistribution of the benefits of health, there is less of a consensus on the nature and content of the participation process”. He further argues that “a wide range of equivocal terms such as ‘self- help’, ‘self-reliance’, ‘cooperation’ and ‘local autonomy’ add to the confusion” (Oakley, 1989:9). It appears participation in health means different things to different people and it is not just shades of disagreement over particular aspects of interpretation or implementation of Community involvement in Health (CIH), but as a result of clearly fundamentally opposed views as to what the process means in

practice (Oakley 1991). Uphoff (1986) refers to a state of 'pseudo participation' and argues that in many projects participation is stronger in rhetoric than in practical reality.

Certainly, there is a widespread confusion about the nature and content of community participation in health and this prompts a question about how communities and stakeholders have participated in public sector health in Ghana. It also raises the question of not only the factors that influence the process of participation but also the nature and content of participation that has emerged in Ghana as a result of the pursuance of community and stakeholder participation in the public health sector over two decades and half or so.

1.3 OBJECTIVES OF THE STUDY

This study seeks to investigate the nature and forms of participation in health and particularly how health sector factors and those of target communities have influenced the process in the three northern regions of Ghana (Northern, Upper East and West Regions), paying specific attention on the following:

- evolving nature, content and forms of community participation in health care and management;
- role of communities, health providers and professionals in facilitating participation;
- relationship between health sector reforms and community participation in health;
- challenges of community participation in public health;
- and
- recommend a model for sustaining and empowering public health sector participation in Ghana.

The following fundamental research questions are posited to guide the study:

1. What policies or strategies/programmes promote community participation in public health in Ghana?
2. How has the health sector facilitated the process of participation?
3. How has targeted communities responded to the challenges of participation in health?

4. What capacities are promoted to facilitate the process both at the health sector level and that of the larger society?
5. What kind of community participation is being experienced in the public health sector since the inception of the primary health concept?
6. How can the process of community participation in public health be sustained?

1.4 RATIONALE OF THE STUDY

Since ideas about community participation in health were being formulated and implemented in the past two decades or so, there have been many efforts to discover how best and in what ways community participation in health programmes have worked. Although some interesting and potentially useful information on the topic has accumulated, particularly in the past decade, this information is in bits and pieces about specific community participation programmes (Ofosu-Amah and Neumann, 1979; Asibuo and Odoi, 1993; Agyepong 1992; Pappoe, 1993). Studies have been skewed towards the impact of participation on health delivery (Pappoe, 1993) rather than on the process, the forms and nature of participation in the public health sector. Furthermore, there has not been any concerted effort to study community participation as an integral aspect of the restructuring of the health sector in order to evaluate how it has fared over the decades in the form of giving people and communities the opportunity to participate in health.

This study is intended to bring to fold under one, the specific experiences of community participation in Ghana in the search for the evolving forms, nature and content of community participation in health management in Ghana in general and northern Ghana in particular. It is hoped that the findings of the study will stimulate process-oriented and integrated approaches to studying participation in the health sector aimed at generating process oriented data on how best and in what ways community participation in health has fared or can be moved forward. The findings will also have practical use for people directly engaged in health sector reforms in the developing world and Ghana in particular.

1.5 APPROACHES TO THE STUDY OF COMMUNITY PARTICIPATION IN HEALTH

1.5.1 Health Sector and Participation

There has been an institutional approach to the study of community participation based on the understanding that different sectors or institutions facilitate the participation process differently (Carroll, 1992; Korten, 1980; Oakley, 1991). Using this approach Rifkin (1986) and Labonte (1993) have thrown more light on how different health models - definition of health and illness - facilitate the participation process in the health sector. Rifkin (1986) identifies three approaches to community participation in the health sector determined by three corresponding health models.

The first is the medical model or approach to health. This model has been variously described. It is perceived as an engineering model (McKeown, 1976; Engel, 1976) because it likens the human body to a machine (Pelletier, 1979) and health is defined under the model as the absence of disease or infirmity (Rifkin, 1986; Labonte, 1993). The medical model of health care can be fairly described as being reactive rather than proactive to health. The emphasis is on waiting for something to be wrong, then the sufferer approaches a medical professional and the problem is diagnosed and dealt with (Kennedy, 1983). Under this model many common conditions instead of being prevented or treated at a local level with a community focus, have a treatment / curative approach which is costly and often urban-based.

The limited vision of the medical model on the causes of ill health narrows its perspective on solution to these problems as well (Kennedy, 1983). Prevention and education dimensions when they are addressed tend to focus on individual behaviour with the health professional exhorting individuals to change that behaviour to alter lifestyles. Furthermore, the model encourages a passive non-participatory role for the layperson and the active decision making role for the health professional. Medically trained workers who try to work in the participatory manner find themselves in difficulties. Rifkin (1986) refers to community participation under this model as activities undertaken by groups of people following the directives of medical professionals in order to reduce individual illness and improve the general environment.

There is also the second model of health management called the health services approach (Rifkin, 1986) or the behavioural approach (Labonte, 1993). The change from the medical to the health services model was due to the broadening of health from medical (Physiological) to include behavioural aspects. Health from the behavioural risk-factors perspective, moves slightly beyond disease prevention and incorporates notions of promoting physical well-being (feeling good, having energy, being fit). Under this approach, health is defined as the physical, mental and social well-being of the individual and health programmes add educational, marketing and policy actions aimed at helping people to grow up with or maintain healthy behaviours. Rifkin (1986) defines community participation under this model as the mobilization of community to take active part in the delivery of health services.

The socio-environmental approach (Labonte, 1993) or community development approach (Rifkin, 1986) is the third model of health care management. This model incorporates sociological and ecological aspects of health and disease based on the understanding that social, economic and cultural factors such as poverty, level of education, unemployment and so on, influence health. Health is defined under the model as the process of enabling people to increase control over, and improve their health (WHO, 1986). Community participation evolves around the involvement of community members in decisions about how to improve health conditions. The pre-requisites to health are no longer simply disease prevention or proper lifestyles, but social development income, housing, water, food and each sector must begin to take conscious accounting of the health impact of their policies. This requires putting health on the agenda of all policy makers, emphasising on the community rather than 'institutional' service delivery organizations (Labonte, 1993).

The above thus illustrates very clearly how a dominant thinking about health can influence the organisation and management of health care, which in turn can influence the processes of lay participation in health. Thus, the prevailing health care model in practice can either promote or stifle community participation. Where there is a curative orientation to health, the activities of the health sector will focus on health services creation with health professionals determining and doing much of the decision-making. In this sense participation will be rarely promoted. Participation will be high where there is increasing orientation to public and community health care where there is the belief

that people's perceptions of health and their motivation to change health care are the critical factors.

As can be seen from this discussion, the above approach to the study of community participation tells us nothing or very little about how social and cultural factors of the target groups influence the participation process. This approach to the study of participation presents communities as passive agents in the process, but there is the need to articulate the social and cultural context of communities in the participation process.

1.5.2 The Social and Cultural Factors of Participating Communities

Approaches that articulate the role of the community in the participation process, focus on the social and cultural factors of communities and how they facilitate or inhibit participation. The concern about how socio-cultural factors facilitate the development process can be traced back to the theory of modernisation. The tenet of the theory is that certain cultural traits facilitate development whilst others inhibit it. Based on this notion, the cultures of the Third World were perceived to inhibit development, and for Third World countries to develop they were expected to adopt cultural traits of the Western World. Thus, between 1940's and 1950's health development in particular and development in general was pursued through the massive introduction of western knowledge and technology (Hardiman, 1986; Macdonald, 1993; Webster,1990).

As Stone rightly pointed out, even during the early stages of the PHC, discussions and reports on health programmes still classified local people as "an alien category, outright ignorant persons requiring all kinds of outsiders' education, advice and guidance, with respect to community participation" (Stone, 1992: 414). It also became clear that knowledge of and sensitivity to the cultures of recipient communities was pivotal to an effective PHC programme.

Thus, studies began to focus on identifying cultural traits that facilitate or inhibit community participation in public health programmes. One of such pioneering studies in this area was done by Justice (1984), which demonstrates the ineffectiveness of PHC programmes in Nepal and South and Southeast Asian countries because they were designed to meet the needs of health bureaucrats rather than those of the local people.

At the local front, others such as Asibuo and Odoi (1993) have studied factors affecting community participation in the national programme for Traditional Birth Attendants in Ghana. Factors identified to stifle participation include chieftaincy conflicts, embezzlement and mismanagement of funds, lack of leadership and poverty in participating communities. These factors were found to create a myriad of problems for community mobilisation, probity and accountability in participating communities. Motivation for those participating in health was also identified as important to participation. Where local incentives exist as motivation, participation is more encouraged than where they are absent.

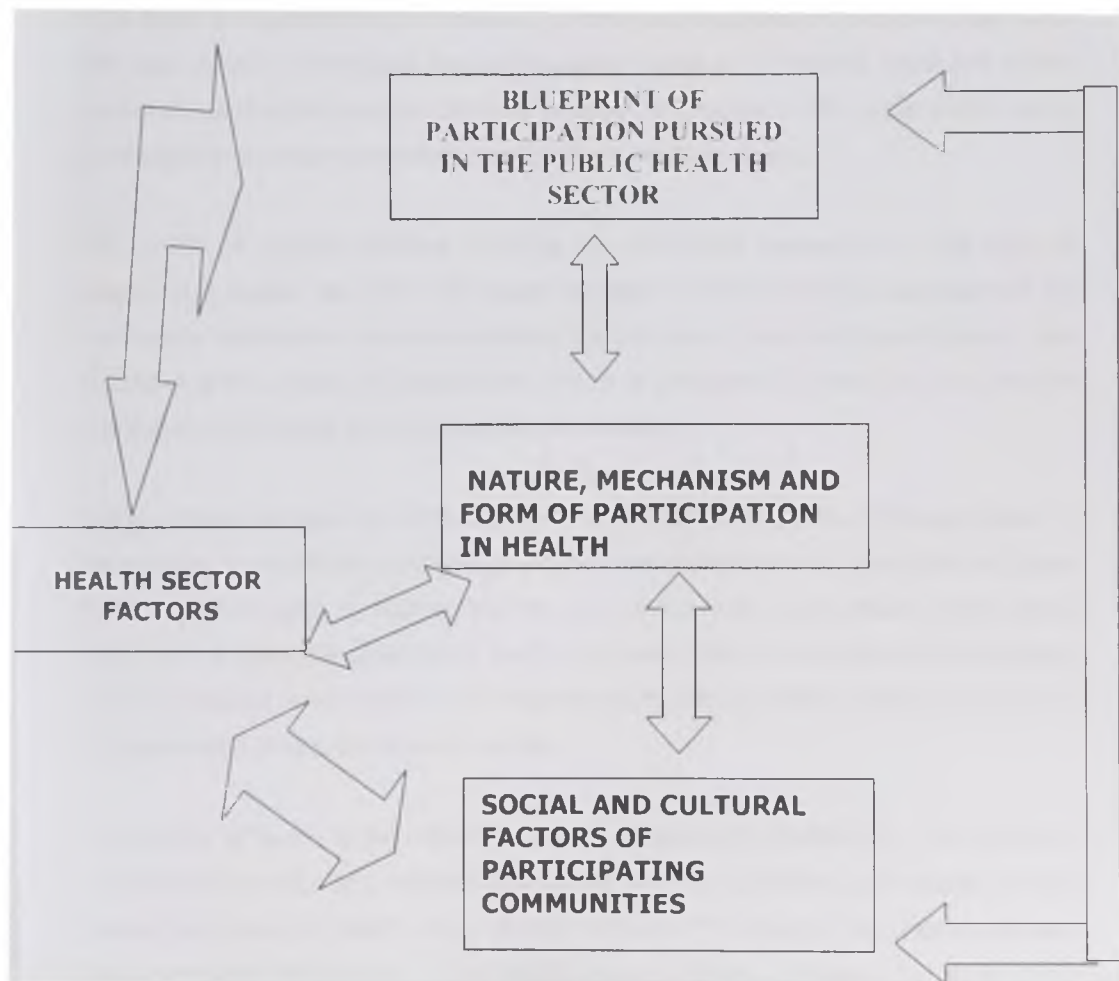
Of importance to participation in health are the perceptions of people about health and health care, especially in cultures with pluralistic health care system as pertains in Ghana where, varying medical orientations exist at both the micro and macro levels of society. Asibuo observes that although the traditional orientation to health is based on the social causation theory (Turner, 1969), that of western medicine in particular, is curing sick people and not looking at the environmental aspects (Asibuo and Odoi, 1993). He further asserts that lay people want modern health services only when they are ill, thus are not concerned about the complexes of participation. This assertion is also supported by case studies on participation done by Rifkin in Hong-Kong, Indonesia and the Philippines, which show that communities, which are involved in health activities, see the programmes as extensions of the medical profession. This also confirms the conclusion of Madan (1987) and Brownlea (1987) that not all cultures value local participation in health and the request that to enable developing countries participate in programmes in ways and values defined by outsiders, participation must be resourced and participating communities must be trained to do so.

From the discussions above, it can be seen that the participation process in the public health sector is not only influenced by health sector factors and the social and cultural factors of participating communities but also the content and nature of policies and programmes outlying participation in the sector. These three factors congeal to shape the process and must be considered together for a better understanding of the process, nature and forms of participation in the public health sector of Ghana. As noted by Vuori (1986), there cannot be one universal model of community participation. Every country has a philosophy, approach and mechanisms suited to its cultural values, traditions and political institution and any study of community participation in health must begin with a thorough analysis of not only the process of participation ~~being promoted~~ but also the

community and the health sector in which the process is promoted. As Rahnema (1992) suggests, for thorough understanding of the model of community participation in use, one needs to enquire into its roots and ramifications, going deep into the factors and realities conditioning it.

From the foregoing discussions therefore, a conceptual framework for analysing participation in health is proposed in Figure 1 below.

Fig. 1: PROPOSED CONCEPTUAL FRAMEWORK FOR STUDYING PARTICIPATION



As shown by Figure 1 above, community participation in public health care in Ghana can be expressed as a function of three intervening factors: the blueprint or policy framework for participation in health, health sector systems' factors likely to influence the process and the broader social and cultural context of participating communities. What this means is that community/stakeholder participation in the public health sector is the interplay of the three factors and any understanding of its nature and form must consider these factors together.

1.6 ORGANISATION OF THESIS

This thesis is organised into ten chapters. Chapter one discusses the problem under study. The study seeks to investigate how three factors: health sector factors, social and cultural factors of communities and the blueprint seeking participation in the public health sector, work together to shape community participation in health in Ghana.

The review of related literature including the theoretical perspective of the study is presented in chapter two. The major issues reviewed included democratic, development and community organisation theories underlying the principle of community participation. Also discussed is the concept of participation: who is to participate? In what and how and the function of participation to the various parties involved.

Chapter three discusses the methodology for the study. A qualitative technique based on case studies of community participation programmes in the Northern, Upper East and Upper West Regions is used. In chapter four the study is put in its socio-cultural context with a discussion of the social structure of health and health care in the three northern regions. The point argued is that health is an integrated entity both in health seeking behaviour and its organisation among the northern people.

The content of health sector reforms in Ghana is discussed in chapter five. The discussion tries to link the evaluation, institutionalisation and form of community participation with the content and nature of health sector reforms in Ghana. The focus of the chapter has been how community participation in the health sector of Ghana is dictated by health sector reforms from the macro-micro levels.

Chapter six, seven and eight are case studies of community participation projects/programmes. There are three broad case studies that received special attention: the National Traditional Birth Attendant programme [NTBA] discussed in chapter six, and the volunteer concept utilised under Surveillance Programmes and variations in these programmes in chapter seven, whilst the Village Workers Programme is discussed in chapter eight.

Chapter nine discusses the common themes emerging from the case studies: who participates in health and mechanisms for participation in health. The chapter also discusses community and health sector factors influencing community participation in health in the three northern regions

Chapter ten synthesizes major issues on participation in health in northern Ghana; experiences and lessons, the nature of community participation pursued in the health sector and how empowering it has been. It also examines other policy reconsiderations on community participation such as the Community-Based Health Planning Services (CHPS) and presents a model for achieving empowering participation in the public health sector of Ghana.

CHAPTER 2

2.0 LITERATURE AND THEORY OF COMMUNITY PARTICIPATION

2.1 INTRODUCTION

In chapter one, the problem of study and the model for studying participation in the public health sector of Ghana is proposed. How three factors – health sector, target community and the philosophy of participation congeal to shape community participation is the subject of this study. In this chapter, we shed light on the concepts of community and participation. These concepts connote multiplicity of meaning and forms and as such one has to be certain about the aspects of participation or sector it is being pursued as well as the nature of the target community in order to understand the processes of participation. Also discussed is the theoretical underpinning of the whole idea of community participation in health.

2.2 DEFINITIONS OF PARTICIPATION

Howes (1990) describes the distinctive new approaches to development in 1970s as the Participation School. He describes participation as an alternative development paradigm to modernisation whilst, Stone (1992) notes that no development concept has been thoroughly, consistently and fervently advocated than that of participation since the 1970s. Writing on the concept of participation, Oakley (1999) describes participation as an umbrella term that defies one single definition. Community or public participation in health, sometimes called citizen, consumer or people's involvement, may be defined as the process by which members of the community, either individually or collectively and with varying levels of commitment; (a) develop the capability to assume greater responsibility for assessing their health needs and problems; (b) plan and then act to implement their solutions; (c) create and maintain organisations in support of these efforts; and (d) evaluate the effects and bring about necessary adjustments in goals and programmes on an ongoing basis (WHO, 1978; Vuori, 1986). Rifkin (1988) summarised the definition of participation to characterise activeness, choice, and the possibility of the choice being effected. She also defined community participation as " social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanism to meet these needs" (Rifkin, 1988: 933). Similarly, a WHO study group (1991) suggests that

participation is interpreted in three different ways: participation as contribution, as organisation, and as empowerment. Although Oakley (1999) also identified three interpretations of participation - as collaboration, in benefits for those previously excluded and as empowerment, he indicated that participation could be broadly categorised into two: participation as a means and participation as an end. Participation as a means refers to a process of ensuring local cooperation and collaboration in externally introduced projects or programmes while participation as an end, is a process where participation is a goal in itself and expressed in terms of empowerment through the acquisition of skills, knowledge and experience to take responsibility in programmes/projects.

From the above we can therefore corroborate with other scholars that community participation is a strategy that provides people with the sense that they can solve their problems through careful reflection and collective action (McKnight, 1987).

2.3 POTENTIAL BENEFITS OF PARTICIPATION

One of the most attractive aspects of community participation is its widely reputed health and social benefits. While the health literature is seriously lacking in empirical studies that specifically demonstrate these benefits, it is widely accepted, based on theoretical grounds and personal experience, that it facilitates many positive outcomes (Annett, 1991; Oakley, 1989). Perhaps the most important benefit cited is the heightened sense of responsibility and conscientiousness regarding health and the concomitant gain in power achieved through the acquisition of new skills and control over resources (Dujardin, 1994). Participants have the opportunity to educate themselves to the possibilities of controlling their own destiny, often resulting in a more equitable relationship between the so-called clients or recipients of health services and the providers (Green, 1991). A related benefit is the potential for greater diffusion of health knowledge in the community and greater use of indigenous expertise (White, 1982), although achieving this goal is not easy (Stone, 1986; Woelk, 1992). Another reported benefit of the additional training and experience acquired through participation in health initiatives is that it may enhance future employment opportunities (Milio, 1974), although not all agree that jobs are likely to follow (Lysack and Krefting, 1993).

The organisation and delivery of health services are also reported to benefit from community participation. It is argued that health services are provided at a lower cost, and added resources can be brought into the system, in part due to greater access to fundraising opportunities but more especially to the availability of volunteers. Better determination of the need for health facilities, their location and size, the number and types of personnel required, recruitment procedures, as well as employment practices and personnel policies, are also expected. Equally important, is the belief that resources will more often be directed to the so-called 'felt needs' of those in the community, and that health activities will be carried out more appropriately when the community is given greater control (Zakus, 1998; Nichter, 1984). Greater local involvement is thought to decrease feelings of alienation on the part of the community and foster less authoritative relationships between the community and health officials. All of these benefits are believed, ultimately, to have a positive impact on health.

2.4 WHO PARTICIPATES?

Participation can be categorised according to the target participants. We have terms such as popular participation, citizen's participation, and stakeholder participation and so forth as explained by the historical development of the concept. The World Bank originally focuses on a particular type of participation – popular participation, with target participants defined as disadvantage people. According to Bhatnager and Williams (1992), the term "popular" refers not only to the absolute poor, but also to a broad range of people who are disadvantaged in terms of wealth, education, ethnicity, or gender. Realising the limitations of popular participation therefore, the World Bank shifted emphasis on participation by 1994, dropping the term popular and the focus on the poorest and most disadvantaged with its concern covering a wide range of "stakeholders". Participation to the bank now means a process, through which stakeholders' influence and share control over development initiatives and the decisions and resources, which affects them.

Contributing to the debate on a more inclusive view about participation, Feeney (1999) sees participation in terms of public participation, which to her is a continually evolving concept. She defines public participation as an opportunity for citizens, the public and private organisations to express their opinions on general policy goals or to have their priorities and needs integrated into decisions made about specific projects and

programmes. Participation allows members of civil society, particularly the disadvantaged the chance to discuss development plans with representatives of government and donor institutions.

2.5 LEVELS OF PARTICIPATION

Borrowing from the Cornell University Rural Development Project (Cohen and Uphoff, 1980), Rifkin (1990) has clarified what participation can mean in the field of health by distinguishing different levels participation. According to Rifkin, local people can participate minimally or most passively in the benefits of health projects in the form of services or education. At the second level, local people can participate in programme activities such as support for health facilities through in-kind or cash contributions and assuming roles as health providers or workers.

A third level involves implementation, where local people assume managerial responsibilities including decision making about how activities are to be managed. A fourth level concerns programme monitoring and evaluation. However, it is at the fifth level of participation that local people are offered the opportunity to participate in planning as well as in the translation of their own felt needs into true grassroots development. Local people actually decide what health programmes they think should be undertaken and ask health staff and government for support for their implementation. In the view of Rifkin, participation of the latter type demonstrates higher level of community participation, whilst the ability to solely initiate development projects on sustainable basis illustrates signs of maturity in community participation.

Cohen et al (1980) note that of all the different types of participation discussed, participation in implementation, that is, asking people to join and offer some kind of material contribution, and in the benefits, where people utilise health facilities etc, are the most common types of participation in the health sector. Participation in planning and evaluation, which are important kinds of participation because they offer empowerment and ownership of projects, are rare. In the view of Cohen et al, the crux of participation is empowerment and ownership.

In a bid to “seek clarity through specificity” Cohen and Uphoff (Macdonald, 1993: 89] developed taxonomy of types of participation and the four most important in their view

being, participation in implementation, in benefits, in evaluation and decision making. This framework, though a useful analytical tool, is not devoid of problems concerning how to operationalise the terms - evaluation and decision-making - on the ground.

2.6 INTENSITY OR DEPTHS OF PARTICIPATION

Discussions on depths or intensity of participation bring to fore the understanding that participation is a process; it can either be vertical or horizontal in form. Horizontal when there is mobility from one level to another and vertical in terms of intensity or depth.

Schubert developed a four-level non-watertight model of intensity on participation, especially on decision-making [Schubert, 1990; Taal, 1993].

- Information sharing among stakeholders to ensure better understanding and performance
- Consultation with the view to getting feed back
- Decision making in matters of policy, project design and implementation and;
- Initiating action by one's proactive capacity and self-confidence.

Bhatnagar et al (1992) later incorporated the first three levels into a two-level intensity model of participation in decision-making noting that they all have decision making as their core theme.

A] Contributing to decision-making [influence or consultation]

1. Information: Solicited from intended beneficiaries
2. Preferences/Judgement: Opportunities for intended beneficiaries
3. Lobbying/Advocacy: Opportunities for intended beneficiaries.

B] Participation in Actual Decision Making

1. Voice: In making decisions [joint/shared decision making]
2. Authority: To make decisions [responsible decision making]
3. Control: Over resources to make decisions effective [empowerment].

Broadly, the model presents two types of participation in the decision-making process in a continuum of intensity: influencing decision making and taking decisions which are qualitatively different with the latter being participation at a higher level. Model A1-3 represents degrees of consultation aimed at influencing decisions as one moves from 1 to 3 whilst B1-3 represents increasing opportunities for initiating and enforcing decisions. Thus, Schubert's four-level intensity model on participation is reduced to three when one puts the two types of decision making together with initiating action.

Schubert uses the term functional participation to cover non-decision making participation [Schubert, 1990]. The distinction is useful in conceptualising participation in both decision making and non-decision making terms though fraught with similar problems as Uphoff's et al: the problem of how to categorise non-functional activities that do not involve choices or decision-making.

2.7 FORMS OF PARTICIPATION

It has been observed that focusing on who participates and the level of participation are important but do not go far enough in understanding the content and nature of participation. An analysis of the content and nature of participation requires the clarification of the benefits and costs (World Bank, 1994) or the interests and functions (White, 1996) served by it to the different types of participants. The analysis of the interest constellations or the benefits and costs has to do with the forms of participation.

Pretty (1995) identifies seven forms of participation. They range from manipulative and passive participation, where people are told what is to happen and they act out predetermined roles to self-mobilization, where people take initiatives largely independent of external bodies. In-between the first two types and the last, are participation by consultation, material incentives, functional and interactive participation. Whereas consultative, functional and interactive participation have to do with decision making depending on whether one is answering questions or providing information for one to take decisions or actually taking the decisions, material incentives refer to participation through the provision of material resources. The typology presented by Pretty, especially the one on decision-making is a restatement of Schubert's et al (1990), with little modification.

White (1996) has also developed a typology of forms of participation for analysing not only mechanism of participation but also assessing the content of the process. White's typology considers stakeholder interests in the participation process. White distinguished four forms of participation: nominal, instrumental, representative and transformative. Table 1 illustrates the forms of participation and their attributes.

TABLE 1: TAXONOMY OF FORMS OF PARTICIPATION

FORM	PROGRAMME DESIGNERS/ PERSONNEL	COMMUNITIES/ GRASSROOTS	FUNCTIONS
Nominal	Legitimate	Inclusion	Display
Instrumental	Efficiency	Cost/rewards	Means
Representative	Sustainability	Leverage	Voice
Transformative	Empowerment	Empowerment	Means/ends

+Adopted from White

The first column shows the forms of participation. The second shows the interests in participation from the viewpoints of those that design and implement the programme. The third column shows how the participants themselves see their participation and what they expect from it. The final column characterises the overall function of each type of participation.

White's model is comprehensive and dynamic and illustrates four dynamics in the participation process:

- The options in the interests, functions and forms are internally diverse and tension ridden over which elements or combination of elements will predominate

at any given time. This means that participation is not static but changes over time;

- Forms and functions of participation is site of conflict;
- Forms and functions of participation are shaped through the constellation of interests and they in turn, act as feedback into the constitution of interest; and
- Interests reflect power relations, sometimes external to the participation process itself.

Thus, participation is a process determined by the interests of programme designers and implementers on the one hand and those of communities and other grassroots at the other hand. The interests of these groups do not always match neatly neither are the interests just there but are constructed by the powers involved in the process.

Similarly UNRISD makes a useful distinction between 'systems-maintaining' and systems-transforming participation [UNRISD, 1979: 20]. 'Systems maintaining' is similar to nominal instrumental and representative types of participation where people are responsive to development policies of authorities. Systems-transforming participation on the other hand is about empowerment and ownership where there are concerns for structural change and genuine democratic transfer of power to marginalized groups.

Viewed this way, the Human Development Report defines participation in terms of people having constant "access to decision-making and power, as well as in terms of economic participation "[UNDP, 1992]. The United Nations Research Institute for Social Development [UNRISD] was also quite clear about the power dimension of people's participation when it defined participation as the organised effort to increase control over resources and regulative institutions on the part of groups and movements hitherto excluded from such control [UNRISD, 1981].

Empowering participation involves groups and communities, particularly those who are poor and marginalized, developing the power to make real choices concerning health services, through having an effective say or having control over programmes. Empowerment and programme ownership go hand in hand and cannot succeed without power redistribution or rearrangement of society.

There are three perspectives to the concept of power in society: the variable sum theory, the zero-sum and the Marxian perspective [Craig and Mayo, 1997]. Within these three perspectives of power, the empowerment process of participation is more problematic under the zero-sum and Marxist perspectives where involving people previously excluded from the decision making process would imply decreasing the power of those who previously took decisions alone. Hence, the empowerment process, which implies shifts in the balance of power may be conflict ridden with implications for social transformation.

As Linda Stone rightly points out, the power dimension of participation permeates all levels of decision making in the health system and the larger community: international relationships between developed and developing countries, relationships between agencies such as WHO and UNICEF on the one hand and between local governments, inter-relationships between governments and health ministries, and so on down to the level of health committees, community health workers and rural communities, on the other. These different groups represent interest categories in the participation process. [For more information about sets of persons and levels of decision-making in participation see Uphoff, 1986]. At each level, there are struggles for control over health decisions and benefits.

From the literature surveyed above, there are three broad issues raised that should be considered when looking at the nature and forms of participation implemented by the health sector. The first is an analysis of stakeholders from both the health sector and grassroots or local community. The second has to do with areas/activities open to participation and the mechanism institutionalised to facilitate participation. Finally, one has to assess the social function of participation both from the point of view of the public health sector and the community involved. The above three broad areas would inform the assessment of the nature and content of community participation in health care and management in Ghana.

2.8 THE COMMUNITY IN HEALTH PARTICIPATION

Three perspectives to the concept of community can be identified in health literature: community as a defined geographical or catchment area [Midgled, 1986], as structured interest groups [Ugalde, 1985] and as 'at risk' groups in epidemiological language [Rifkin, 1990]. All these perspectives are interrelated and constitute boundary-setting pillars in our conceptualisation of community. None is static, even the geography of a community can be altered into wards/neighbourhood or even households, on the one hand or inter community relations such as outreach, sub district, district or even a region, depending on the issue at stake and the interest community members take on it.

The above shows that communities are complex entities, not only in their geographical and demographic composition, but also with respect to interests and concerns. These diversities in the social construction of communities have a profound impact upon every step of the community participation process, and while there may be little disagreement about the desirability of community participation, the diversity of those groups called communities can create real problems for selection, representation and accountability of individuals.

A second major issue stems from the fact that communities are rarely, if ever, homogeneous wholes. Many segments of the population can be isolated from mainstream political and social organisations, including the organizational structures of the health system. Hence, some groups within the so-called community will be unaware of opportunities for participation or find it hard to break into the system. This has been observed in the disability context where negative attitudes toward people with disabilities, low levels of education, and other historical biases have prevented the disabled political power (Balcazar et al, 1990).

Even when relatively powerless groups do find ways to participate in the mainstream, not all sub-groups within them feel adequately represented. Official leaders and spokespersons of the disability rights movement, for example, continue to be challenged by their own membership for their inability or reluctance to extend a voice to those most disenfranchised; for example, to women with disabilities, ethnic minorities, the elderly, and those with cognitive disabilities. The critical issue for advocates of community

participation is to examine much more carefully who it is that is included in the community (and thus community participation) and who is not.

The third issue relating to the nature of community is about representation. Who has the right to speak for 'the community'? Who are legitimate community representatives? As it pertains to the process of community participation, representation becomes an issue when community health workers need to be selected and when community leaders need to be identified. In both instances, individual prejudices, stereotypes, and social and political ideologies can create problems that seriously impair the ability to organize in pursuit of better health (Rifkin, 1983). One of the most obvious problems is that health initiatives reliant on public participation often place an additional burden on already disadvantaged individuals and groups (Labonte, 1989). Lysack also notes that there are important costs involved in participatory activities, including personal time, expenditures, training costs, and information compilation and dissemination costs, which are subject to peaks of demand. Unless these factors are taken into account, only the most privileged segments of society participate, thereby excluding and possibly worsening conditions for lower income citizens. For women in Southern countries in particular, as the traditional caregivers of the infirm, this has real and profound implications for the health of the community (Lysack, 1996). Unless participation is carefully developed to take these issues into account, few may be willing to be actively involved or involved for very long.

The above discussion clearly point to the view that a community is not a homogenous group all the time. A community experiences shifts in its geography, demographic composition and interest with regards to its participation or involvement in health issues/programmes. The members of a community have the prospects for participation at different levels of the community, determined by the social distribution of opportunities, power, capabilities and interests. A community can participate in health as a total group, parts of the group or individuals depending on the strategy for representation and/or the issue at stake and the corresponding interests, opportunities and capabilities in the community and the 'sense of community' [Wallestein, 1992]. In the view of Wallestein a community sense has to do with its cohesiveness, and how cohesive a community is, influences block or total participation [Chavis and Wandersman, 1990].

2.9 THEORETICAL PERSPECTIVE

Community participation can be located within the broader subject matter of development theory and practice. Development is a multi-sectoral process. The different sectors – agriculture, water, education and health, for example – are all interrelated, and changes in thinking and practice in one sector are likely to affect the others. The concept and practice of development are subject to constant change as researchers and practitioners introduce new forms of analysis and enquiry and learn more about the causes and problems of underdevelopment and poverty. These changes then influence health development.

In the early 1970s there was a reaction against the dominant model of development intervention which stressed external delivery, physical or tangible improvements and the employment of professionals to design and direct development programmes and projects (Haque et al., 1977; Long, 1978). The dominant model of development at the time may have helped to improve the living conditions of some people, but it was argued that it did little to develop the talents, skills and abilities of the mass of urban and rural poor and failed to provide any role for the poor in the development process. In contrast to that model, it was suggested that development be more people-centred, with less emphasis on purely physical improvements, and that it should more directly promote people's participation.

This new approach to development has variously been called "alternative development", "another development", "people-centred development", "counter-development" and "participatory development". The debate argued is based on two premises. The first premise was that poverty is structural and has its roots in the economic and political conditions that influence people's livelihoods. Therefore, in order to tackle poverty, it is important to develop people's ability to change these conditions. The second premise was that development programmes and projects have largely bypassed the vast majority of people; there is a need, therefore, to rethink development interventions in order to give the excluded and marginalized majority a chance to benefit from development initiatives. Whatever the terms used or the explanations given, this approach to development intervention was seen as the antithesis of what was generally referred to as "top-down" development.

The influence of western democratic theory on the community participation movement is most obvious. By arguing that ordinary citizens have a right to share in decision-making, proponents of community participation, exhibit their inspiration of democratic ideals. However, this inspiration is not based on classical notions of representative democracy (Schumpeter, 1942; Dahl, 1956; Lucas, 1976; Pennock, 1979) but rather on a modern variant of liberal democratic theory known as neighbourhood democracy, (Dahl 1990). Indeed, many proponents of community participation are sceptical of representative democracy and its potential to provide meaningful opportunities for the involvement of the masses in the political process of developing countries. Drawing on the theory of neighbourhood democracy, they advocate the creation of small-scale institutions for the realization of political aspirations in the villages and urban neighbourhoods of the Third World.

The views of the proponents of community participation are also infused with populist notions, characterized by the belief that virtue resides in simple people who are in the overwhelming majority and in their collective traditions. There are many definitions of populism but as Stewart (1969) observed, common to all of them is the idea that ordinary folk are badly done by. They may be perceived to be the victims of economic disruption or thought to suffer from the arrogance of an inflexible bureaucracy or it is believed that an indifferent establishment neglects them. In these circumstances, populist movements often arise to champion the cause of the masses and to rally to their support.

Populism has considerable influence in development studies and also in the developing countries where political leaders, intellectuals and technocrats, have embraced it. Worsley (1967) pointed out that the development plans of many Third World countries are strongly populist in character, placing emphasis on co-operative and communitarian forms of social and economic organisations, stressing the values of self-help and self-sufficiency. The mixed economy is accepted and the proclaimed objective of a populist plan is to promote agriculture and improve the levels of living of the masses. Modernization of the economy through the promotion of heavy industry is regarded as inappropriate to the needs of the people. Kitching (1982) defined populism in a similar way pointing out that its major exponents in recent times have included president Nyerere, officials at the ILO concerned with the World Employment Programme, Schumacher and the Intermediate Technology Development Group.

The influence of populist ideas on advocates of community participation has been very considerable. Indeed, it may be argued that community participation principles are a primary expression of populist ideals in the Third World today. As in populism, current community participation theory suggests that politicians and bureaucrats have exploited ordinary people and that they have been excluded not only from political affairs but also from the development process in general. The forces of modernization and rapid social change threaten their simple way of life and they face increasing hardship as a result of economic and political mismanagement. By organising local people and making them aware of their situation, community participation provides a mechanism for the mobilization of the masses and a collective means of redress.

Community organisation theory has also influenced contemporary community participation. Community organisation, a term coined by social workers, represents a collection of principles and methods for influencing change (Drevdhal, 1995). Rothman and Tropman (1987) developed a classical typology of three models of community organisation: locality development, commonly called community development, social planning and social action. Incorporated in varying degrees, are the concepts of participation people working together, starting where people are, and creating empowerment.

The community development and social action models are more grassroots or bottom-up where the community identifies the issues, is fully involved in decision-making and most often determines the process. Community development is intended to bring people together to solve community problems and build competence, consensus, and a sense of community. Social action is the most political of the models, with the intent of putting into place action that is inequity correction, institutional change, and power redistribution.

In spite of the rapid expansion of social action and community development, disillusionment with its achievements was widespread in the 1970s. Many governments particularly in Africa failed to provide adequate financial support but nevertheless extolled the virtues of self-help. Community development was soon recognized by the people to amount to little more than a slogan, which brought few tangible benefits.

The changing analysis of underdevelopment in the late 1970s and 1980s began to offer different explanations of the causes of poverty and to suggest different forms of project intervention. Poor people were seen as excluded and marginalized both from broader societal participation and from direct involvement in development initiatives. Simultaneously development policy-makers and planners began to advocate social and political participation and to devise strategies to increase poor people's direct involvement in development efforts. In development terms, recent years have been dominated by efforts to promote people's participation in development. The nature of participation advocated requires a fundamental shift both in attitudes and in methodology, to break the decades of top-down, non-participatory practice. Since the early 1990s the major donor development agencies have supported and funded the promotion of participatory development (OECD, 1994; World Bank, 1994).

The concept of community participation gathered renewed strength in the 1990s, for example, the United Nations Children's Fund (UNICEF) undertook a formal examination of the usefulness of a participatory approach to its work (UNICEF, 1990); in 1993 the Organisation for Economic Co-operation and Development (OECD) similarly undertook a detailed review of how community participation might improve the effectiveness of the work OECD supported (OECD, 1994); and in 1994 the World Bank issued a major statement on the importance of community participation in its work and took the appropriate decisions to build a participatory approach into its loan operations (World Bank, 1994).

Inevitably the re-examination of the development process filtered into the health field and began to influence the practice of health care and development. The notion of greater involvement of communities in the benefits of health development was emphasized, for example, in the 1978 Declaration of Alma-Ata. The Declaration has since served as an important guide of health policy and development in many countries. A critical element in the Declaration's emphasis on primary health care (PHC) is the involvement of people, not just in the support and functioning of health services, but more importantly in the definition of health priorities and allocation of scarce health resources, at the district level.

CHAPTER 3

3.0 STUDY METHODOLOGY

According to Oakley (1991), the approach to the study of participation can either be quantitative or qualitative depending on the focus. Where the focus is on the economic benefits, physical attendance at project activities or coverage, then a quantitative approach is suitable. On the other hand when the focus is on the growth of people, their organization and processes of participation then the approach must be qualitative. "Processes are essentially qualitative and not normally amenable to quantification for statistical analysis" (Oakley 1989: 62). Oakley further argues that, "participation is a continuing process for which it is difficult to establish fixed, quantifiable criteria" (Oakley, 1989:52). A qualitative study on community participation would be concerned with describing the characteristics and properties of the processes of participation over a period of time and then interpreting the data and information available in order to make conclusions concerning the nature and extent of participation, which has occurred. A qualitative approach would be more suitable because it is flexible, focuses on the process and is iterative (Oakley, 1999:137).

Thus, in view of the focus of this study - the nature, content and process of community participation in health a qualitative method has been found to be more appropriate. Among other things the qualitative approach ensures that in-depth attention is given to the different dimensions of community participation in health: the context, participants and their interrelations and so on. This approach also offers the opportunity for the application of naturalistic and in-depth methods of data collection. (Streubert & Carpenter, 1999).

The study is built around case studies of specific programmes, which have emphasized community participation in health. Turner (1974) observes that case studies often reveal the fragility of so called existing social order or patterns of social legitimacy. Case studies do not only identify what people do, but how they make sense of what they do (Garfinkel, 1967; Turner 1974). Furthermore, in case studies, the researcher considers the specific context of the case and examines how its parts are configured. Cases can be individuals, groups, organisations, movements, events, or geographical units. The data are usually more detailed, varied and extensive. Case study uses the logic of analytical

instead of enumerative induction (Neumann, 2000). As Ragin rightly observed “almost all qualitative research seek to construct representations based on in-depth, detailed knowledge of cases” (Ragin, 1994:92). A series of cases studies systematically selected can reveal a lot about the processes of social reproduction and transformation, and how human agents play an active role in the process.

3.1 SELECTION OF CASE STUDIES

Leedy et al (2001) proposes the multiple or collective case study approach where two or more cases are used – often cases that are different in certain key ways – to make comparisons, build theory, or propose generalisations. The chief advantage of case studies in community participation in health programmes is that they provide the opportunity to highlight and analyse specific processes by which community members actually manage their everyday health issues and attempt to resolve certain problematic situations. There are four main examples of community participation programmes for consideration as cases:

Surveillance programmes

1. Disease surveillance
2. Demographic surveillance
3. Growth and nutrition monitoring

Disease control/prevention

1. Malaria bed net programme
2. *Durancumalifasis*/guinea worm
3. Six killer childhood diseases

Primary Health Workers Programme

1. National TBA programme
2. Primary Health Care Training for Indigenous Healers (PRHETIH)
3. Community Surveillance Volunteer
4. Community Clinic Attendant

Community Health Management programme

1. Community Health Committees
2. Institutional Management Committee

For each of the four broad categories identified above, at least one sub-programme/project was purposively selected according to following:

- availability of on-going project activities on the ground to merit empirical observation
- the geographical spread of project activities to lend consistent study across sample districts and communities; and
- existence of community, sub-district and district structures for project intervention

On the whole emphasis was placed on forms and nature of local involvement and support for these programmes and their implications for stakeholder collaboration towards the provision of integrated and sustainable public health delivery system at the community level. Based on the above criteria, the following sub-programmes/projects were selected as case studies for the study.

Surveillance programmes

1. Disease surveillance
2. Demographic surveillance
3. Growth and nutrition monitoring

Disease control/prevention

1. Malaria bed net programme
2. *Durancumaliasis*/guinea worm

Primary Health Workers Programme

1. National TBA programme
2. Community Surveillance Volunteer

Community Health Management programme

1. Community Health Committees

3.2 SITE SELECTION

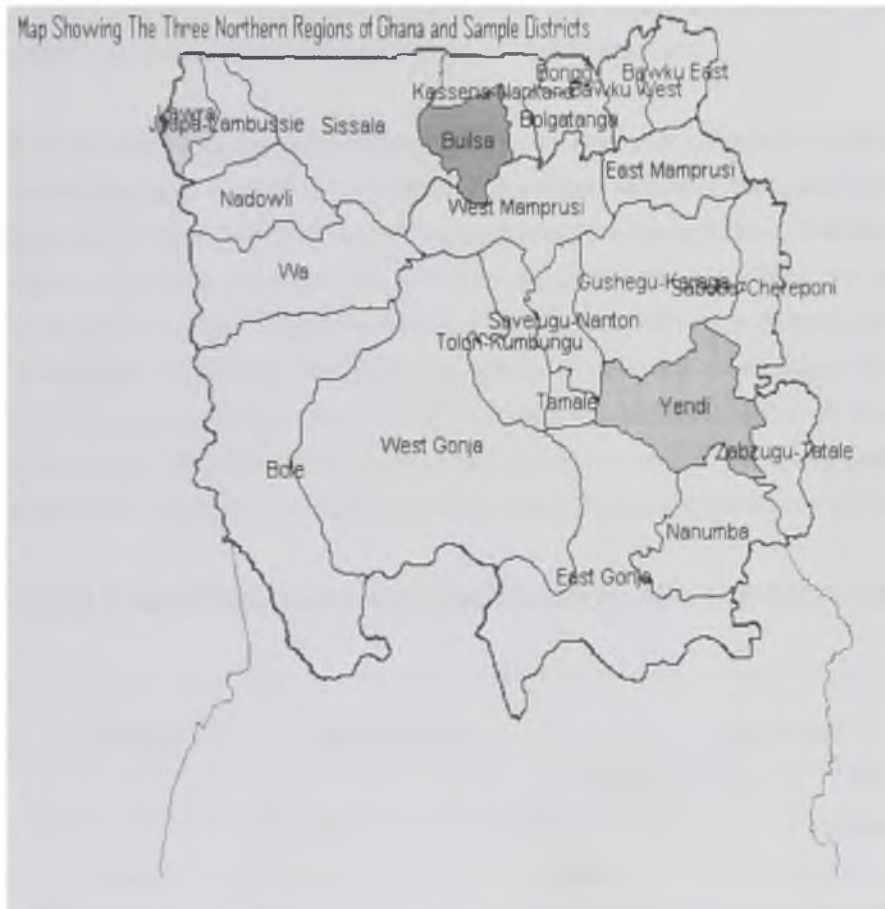
A bulk of the data on community participation in health in Ghana is available from studies in the southern sector, for example Danfa, Kintampo, Dangbe West and Ejisu (Agyepong et al 1992; Ofosu-Amaah et al., 1979) and so on. There is no comparable data on the subject on other parts of the country. Furthermore, available studies focus on specific aspects of

community participation, with narrow geographical focus and this thwarts cross-cultural and regional analysis on community participation in health across the country.

In order to bridge this data gap and for purposes of an in-depth study on lay participation in health rather than specific single community participation projects, the present study focuses on the three northern regions: Upper West, Upper East and Northern Region. Within these three regions, UNICEF model districts for integrated Primary Health Care and Basic Services constitute sample districts for the study.

Prior to 1985, the PHC system was implemented in 25 out of the 65 districts in the country and UNICEF was operating in 15 of the PHC districts with special attention given to the Northern, Upper East and West Regions. However, in accordance with the government's desire to promote PHC nationally, UNICEF's programme implementation shifted in 1987, from the 15 PHC districts to cover all 65 districts in the country (65 districts in 1985 further increased to 110 districts in 1998). In the 1990-1995 (five year) programme of action, UNICEF adopted the Model District concept for the integration of PHC and basic services. One district was selected in each of the 10 regions in the country. Two of these districts, one in the Upper East and the other in the Northern Region, were selected for the Community-Based Development Programme, to ensure synergy of programme activities for the 1996-2000 programmes. These are Builsa and Yendi Districts respectively. Yendi in addition benefited from the Northern Regional Integrated Programme (NORRIP) Health Sector programme that implemented a PHC component. These two districts have been selected due to their involvement in the implementation of PHC programmes in the northern sector of Ghana since the inception of the idea in the early 1980's.

In the Upper West Region, Lawra District was the model PHC district. Although UNICEF 1996-2000 programme of action did not cover the Upper West Region, CRS Child Assisted Food Programme is implemented in the Lawra District. In comparative terms therefore, the Lawra District has had a more focused attention on community-based health programmes than any other district in the region. Thus, the Lawra, Yendi and Builsa Districts have been selected purposively for the present study because of their long-standing involvement in community-based health development under the PHC and similar programmes.

Fig. 2: MAP OF SAMPLE REGIONS AND DISTRICTS

They offer institutionalised sub-district and community level structures for analysing the processes, dynamics and constraints of people's participation in health development in the northern sector of Ghana.

The three districts are sub-divided into twenty-one health sub-district units: nine for Lawra and six each for Builsa and Yendi. There is the presence of church-based organisations in the delivery of sub-district based health care in all the sample districts. These church - based organisations are the Presbyterian Rural Health Services and the Catholic Primary Health Care. These organisations with support from their donors have implemented

community based health experiments under the PHC system unique to each organisation. To ensure the inclusion of these innovations, the selection procedure ensured the inclusion of three sub-districts operated by a church based organisation namely Seniesa, Wiaga and Ko. Seniesa and Wiaga are in Builsa district, whilst Ko is in the Lawra district. There is currently no church based operated sub district in the Yendi District although the Church of Christ is operating within some sub-districts in the same district.

Since the study focuses on uncovering process of community participation, the selection of communities was stratified on the basis of the nature of participation: active and inactive participation - since the study focuses on the processes of participation. One active and one inactive community were selected from each sub-district covered. Thus, six communities, three active and three inactive were selected from each of the three districts, making a total of eighteen communities distributed over twelve sub-districts. Communities were selected with the support of the District Health Management Teams (DHMTs) of the respective districts since they know their communities better on issues of community participation in public health. The list of districts, sub districts and communities is indicated as Table 2.

TABLE 2: SELECTED COMMUNITIES BY DISTRICT AND SUB-DISTRICT

DISTRICT	SUB-DISTRICT	COMMUNITY	
		ACTIVE	INACTIVE
Yendi	Yendi	Zohi	Sonsong
	Jimile	Kpabia	Tijo
	Adibo/Ngani	Gbungbaliga	Gbini
Builsa	Seniesa	Dorninga	Bachugsa
	Wiaga/kanjaga	Gdedema	Chiok
	Chuchuliga/Sandema	Kaljiisa	Azuyiri
Lawra	Babile	Birifor Bapari	Birifor Chaa
	Zambo	Nyanyari	Pavuu
	Ko	Ko	Kocha

The criteria employed in the selection of communities included the following:

- Turn out of community or targeted community members at health activity in the community be it outreach, durbar, health day etc. This criterion has to do with the patronage of health activities or services by the community. It is a utilization criterion of participation employed by health workers.
- The second criterion employed had to do with the ability of the community to organise or mobilise itself for health activities or services. Here, the leadership and its organisational ability, formal or informal, were used in the selection of communities. Also considered were the leadership of selected community based organisations such as TBAs, Village Health Workers or Committees, Community Weighting Teams and other volunteers.
- The participation of existing village level auxiliaries such as TBAs, Weighing Team, Community Based Distributors, Surveillance Volunteers, and Village Health Workers etc. in programme activities for which they were trained was also considered in the selection of communities.
- Community initiatives were also assessed taking into consideration their participation in IE&C initiatives, proposals presented under the VAP programme, cash and in-kind contributions of the community towards projects, such as weanimix, water and hygiene programmes, building of schools and other structures was also used.

3.3 SAMPLE UNITS

Within the sample regions, districts, sub-districts and communities, two broad categories of sample units were involved: Institutional and community level sample units.

The institutional sample units were basically personnel from the Ministry of Health (MOH) and its collaborative agencies implementing programmes that require the participation of local communities and other stakeholders.

At the level of the MOH, regional directors of health, members of regional health teams and co-ordinators of programmes in the areas of disease control, health surveillance, maternal and child health and community nutrition constituted the sample units. Similarly, personnel overseeing the above-mentioned projects/programmes at the district, sub-district or zones, in the case of those programmes that employ zonal structures were also recruited.

Desk personnel or contact persons of civil society organisations, NGOs and line agencies working with MOH in the areas of disease control, health and nutrition surveillance and training of traditional healers or birth attendants were also selected because of their involvement with the projects under study. Personnel in this category included UNCEF Community Based programme officers in charge of the Upper East and Northern Regions and their CRS counterpart overseeing the Food Assisted Child Survival (FACs) programme in the Lawra District. The sample also included key personnel such as DCEs, DCDs, DFOs and members of the social services committees. These personnel are overseeing the programmes at the district level.

The community level sample units comprised team members of village or community level institutions and individuals. Members of village level institutions recruited as sample, included Community Weighing Teams (CWTs) Village Action Planning Members (VAP) Village or community Health Committees (V/CHCs), Insecticide Treated Nets Committees (ITN), Members of Institutional Management committees and Village Development Committees (VDCs) (where there exit).

Individual sample units at the community level were of three broad categories. The first group comprised community members selected by their communities to serve as surveillance volunteers, TBAs, Village Health Workers or other category of primary health workers.

The second comprised community leaders and opinion leaders. These were basically assembly members, members of Unit Committees, leadership of youth and women groups referred to as *nachinaa* and *margazia* in many of the communities surveyed. These are normally people responsible for the mobilisation of the youth for development purposes. In additional one or two traditional elders were covered in each of the sample

communities. Finally programme beneficiaries of the NTBA, Nutrition Surveillance and growth monitoring, and insecticide treated bed nets were covered.

Qualitative studies focus less on a sample's representativeness or on detailed techniques for drawing a probability sample. The focus is normally on how the cases or sample units illuminate the phenomena under study. According to Neumann (2000) the primary purpose of sampling in qualitative research is to collect specific cases, events or actions that can clarify and deepen understanding of the social phenomena being studied. This view has been amplified by Flick thus - "it is the relevance to the research topic rather than their representativeness which determine the way in which the people to be studied are selected (Flick, 1998:41). For these and other reasons such as the lack of sampling frames on the cases studies under review, the study employed non-probability sampling techniques.

The specific examples of non-probability sampling employed were purposeful and snowball sampling. As can be seen above, purposeful sampling was employed largely for the selection of sample case studies, institutional sample units and some categories of community level sample units such as village committees, VAP teams and other project committees as well as youth and gender leadership. The snowball sampling assisted in the selection of programme beneficiaries at the community level.

Purposeful sampling according to Patton, selects individuals for study participation based on their particular knowledge of the phenomena for the purpose of sharing that knowledge. "The logic and power of purposeful sampling lies in selecting information-rich cases for which one can learn a great deal about the issues of central importance to the purpose of the research, thus the term purposeful sampling" (Patton, 1990:169). As for snowball sampling, sampling proceeds according to connections and linkages between sampling units.

3.4 DATA COLLECTION TECHNIQUES

A methodological triangulation comprising a mix of data collection techniques such as key informants, semi-structured interviews and focus-group discussions was employed for the collection of primary data. Denzin has identified four types of triangulation for

qualitative research (Denzin, 1970): investigator triangulation, the use of several different researchers; theory triangulation, the use of multiple perspectives to interpret a single set of data; methodological triangulation, the use of multiple methods to study a single problem; and data triangulation, the use of a variety of data sources in a study.

Researchers have discussed three types of data triangulation: time, space and person. Time triangulation refers to a situation where data about a phenomenon is collected at different points in time. Space triangulation consists of collecting data at more than one site while in the case of person triangulation; data is collected from more than one level of persons, that is a set of individuals, groups, or collectives (Denzin, 1970). Denzin explains that the utility of data triangulation is based on the premise that since no single technique or method ever adequately solves the problem of rival causal factors because each method reveals different aspects of the empirical reality, multiple methods of observation must be employed.

The data for the study is categorised into:

1. Institutional level data
2. Community level data

3.4.1 Institutional Based Data

Two main types of data were collected from the institutional level. Health sector specific institutional data collected from the various levels of the health sector: MOH, GHS-national, regional, district and sub-district levels. Data collected covered issues relating health sector reforms, emerging structure and function of programmes such as the NTBA, PRHETIH, CHWP and other institutions such as health management boards, social services committee, health teams and committees. Data were also collected on issues of programmes implementation, organisation and management. Directors from the regional health administration down to the sub-district directors provided such information. This information was supplemented and validated by that from management team members in charge of specific programmes in disease control, maternal and child health, nutrition and so on. The data collected also covered aspects of district/sub-district-community relations. Key informants' interviews were largely employed in the collection of institutional base data. The other type of data had to do with inter-sectoral relationships, collaboration or partnerships and partnership management and problem solving. These data came from

sectors and agencies fostering collaborations with MOH. These agencies and organisations include Catholic Relief Services (CRS), Christian Health Association of Ghana (CHAG) traditional practitioner, Private health practitioners, District Assemblies, UNICEF and so on.

3.4.2 Community Based Data

Participatory and consensus-building techniques such as focus-group discussions and semi-structured interviews were employed for the generation of community level data. Community leadership, both formal and informal such as chiefs, opinion leaders, assembly members and members of Unit Committees were interviewed. Also interviewed in-groups were community representation on community participation programmes such as TBAs, Community Surveillance Volunteers, VAP Teams, Community Weighing Teams, Village Development Committees, Community Health Committees and other exiting village level volunteers.

In the view of Carey, a focus-group discussion is “a semi-structured group session, moderated by a group leader, held in an informal setting with the purpose of collecting information on a designated topic” (Carey, 1994: 226). Focus groups are particularly suited for qualitative data because they have the advantage of being inexpensive, flexible, stimulating, cumulative, elaborative, assistive in information recall, and capable of providing rich data (Fontana and Frey, 1994; MacDougall & Baum, 1997).

Community based data comprised, programme demands, community preparation, mode of representation on programmes, training and capacity building issues, level and degree of participation and broader programme and community relations. Focus-group discussions comprising women and men groups disaggregated by age groups (i.e. youth and the elderly), were also conducted on programme-community-relations and perceptions of the broader community on specific community-based health programme issues.

Secondary data were also collected on the four different types of programmes pursuing community participation in health. Information covered programme reports on inception, planning and implementation.

The data were collected between January and December 2000. About three months were spent in each of the three regions to collect and validate data in order to improve upon the quality of the data.

3.5 DATA ANALYSIS

Case study analysis typically involves the following steps (Creswell, 1998; Stake, 1995):

- organisation of details about the case in a chronological order, that is the specific facts about the case are arranged in a logical order.
- categorisation of data categories are identified that can help cluster the data into meaningful groups
- interpretation of single instances - specific documents, occurrences, and other bits of data for the specific meanings that they may have in relation to the case under study.
- identification of patterns - the data and their interpretations are scrutinized for underlying themes and other patterns that characterise the case more broadly than a single piece of information can.
- synthesis and generalisation – conclusions are drawn that may have implications beyond the specific case that has been studied.

CHAPTER 4

4.0 SOCIAL STRUCTURE AND PRACTICE OF HEALTH CARE IN THE NORTHERN, UPPER EAST AND UPPER WEST REGIONS

4.1 INTRODUCTION

This chapter puts in context the social structure of the processes, nature and forms of participation in health development, being studied. It looks at the social and cultural organization of the people particularly with regard to the practice of traditional medicine and the institutionalisation of modern medicine as a result of factors of social change. The chapter mirrors the attitudes, beliefs and perceptions of the people with regards to health care and its organization. It also sheds light on potentials and constraints of the people when discussing the concept of empowering participation.

4.2 GEOGRAPHICAL LOCATION

The study area covers the three northern regions: Northern, Upper East and West Regions. The area is divided into twenty-four political and administrative districts co-terminus with health administrative districts: 13 Northern, 5 Upper West and 6 Upper East regions (now 34: 18 northern, 8 upper West and 8 Upper East). The three regions of focus constituted the Northern Territories during colonial rule, with headquarters in Tamale. In 1960, the area was divided into Northern and Upper Region and in January 1986, the Upper West Region was carved out of the then Upper Region. We are therefore dealing with an area that was once a regional administrative entity.

In terms of location, the area is bounded to the east by Togo, Southwest and Southeast by Brong-Ahafo and Volta regions respectively, northward by Burkina Faso and southward by Cote d'Ivoire. It has a landmass of 97,702 square kilometres covering about 41 percent of the total landmass of Ghana. The region is flat or gently undulating. It is situated entirely within the savannah grassland characterised by scattered stunted trees, grass and scrubs. In the extreme north the vegetation is of thorn bush and sandy patches type. The land is drained by the Volta river system: the Black Volta along its southwestern and western

boundaries; the Oti to the east, the Sissili and the Volta flowing from the north into the White Volta. The area experiences two main seasons: a dry season from about October to March and a single wet season from May/June to October and peaks in August/September. Average relative humidity is 60-70 percent but lower by half during the hamattan period. During this time temperatures are higher and the wind drier.

4.3 DEMOGRAPHIC PROFILE

According to the 2000 Housing and Census results, the three regions harbour 3,317,478 people representing 17.5 percent of the population of Ghana, with the Northern Region alone having over one half (55%) the population. Seventy eight percent of this population can be found in rural areas illustrating that the three regions under review are entirely rural. In fact, the Upper West Region in particular has about 83 percent of its population residing in rural areas. The adult dependent population (<15+and >64) is about one half of the total population in the three northern regions. Furthermore, more female (51%) than male were also reported in the three regions with slightly many more females (52%) reported in the Upper East and West (GSS 2000).

The average population density of the three regions is 34 persons per sq. km. However, marked regional variations exist. The Upper East is the most densely populated area with density of 104 persons per square kilometre, which is four times [26 persons per sq. km.] that of the Northern Region and about three time the density [31 persons per sq. km.] of the Upper West Region. Population concentrations in the northeastern part are higher than in any other parts of the region. Of specific reference are the Nandom-Lawra settlements, with population density of about 80 persons per sq. km., and the Bawku East, Bolgatanga and Kasena-Nankani Districts of the Upper East Region with population densities of between 156 and over 177 persons per sq. Km.

4.4 ECONOMIC ACTIVITIES

Farming is the main occupation of the people. Farming is mainly of the subsistent type and characterised by mixed cropping and bush fallow in order to replenish the soil. The major farm implement here is the hoe. As a rule men hoe but, among some of the groups in the Upper East at least, women may hoe their own fields. Family labour tends to be the only source of labour available and the larger one's family size the better. Crops grown are mainly cereals and staples: guinea corn, millet and maize. Other crops grown include

groundnut, beans, yams and rice. Since farming is rain-fed coupled with poor agricultural practices such as bush burning, overgrazing, continuous cultivation as a result of increasing population density, returns from farming have been dwindling over the years. Currently some parts of the region face land shortage and landlessness. As a result farm sizes are fragmented and continuously been worked on.

Animal husbandry is also practiced in the area. Animals reared are cattle, sheep and goats. Chickens and guinea fowls are also kept. In most cases cattle kept are the property of the lineage or family. Animals are kept for mainly ritual purposes; however, there is the tendency to sell animals to raise money to purchase foodstuff during the lean season in view of dwindling returns from farming. The livestock people keep, though indispensable, is of less significance in their economy as a whole, as very few people possess livestock in significant quantities and significant value.

Craftwork is also practiced. Popular crafts include pottery, basketwork, ropes and strings, tanning and ladder work. Local trade has been expanding in recent times but commerce is a casual occupation ancillary to agriculture. This is quite understandable considering the fact that the area is almost entirely rural.

With a developing monetary economy hinging on subsistence agriculture, and with over reliance on human labour and the use of very simple tools the regions of northern Ghana have problems living beyond subsistence level. Over three-quarter of the population is estimated to live below the poverty line [GSS 2000]. This apparently is reflected in the manner and nature of their participation in health programmes.

4.5 SOCIAL ORGANIZATION

The people of the three regions have minor but not sharp linguistic or cultural differences. Ethnically we are referring to the Mole-Dagbane, Gruse, Gruma and Guan speaking groups according to Rattray's classification (1931). Those listed under Mole-Dagbane have a considerable vocabulary in common and a marked resemblance in structure and belong to the larger Gur group of the Niger-Congo family of Africa. Saaka (2001) also notes a great deal of ethnic and linguistic fluidity in northern Ghana, largely due to shared cultural norms, multilingualism and intermarriages between the groups in the area.

Two main settlement patterns can be discerned among the people: grouped or clustered dwelling and dispersed forms. Among the majority of the people in the Upper West and East regions and the south western parts of the Northern Region, settlements are not compact units but are composed of a number of compounds scattered over the territory occupied by the community. The Dagomba and Mamprusi village communities are however, clustered.

Although, both patrilineal and matrilineal descents are recognized with slight variations among the people of the area, the patrilineage system is the dominant descent. It is the basis of social organization and confers jural status, rights of inheritance and succession to property and office, ritual privileges and obligations and determines political allegiance. It is however worthy to note that among the Birifor, Tapolene and Vagala, both lines are reckoned. Movable property is inherited from the mother's line while immovable property such as land, livestock and ancestral shrines and medicines are handed down through the father's line.

Similarly, the main features of the domestic organization of the people appear to be the same throughout for the majority of the people. The characteristic domestic unit is the extended family system, a residential entity comprising two or more brothers (full or half) with their wives and children and possible other dependants such as old mothers and fathers. According to Fortes (1949 (b)), if fission does not occur in the lifetime of the head or the extended family it invariably occurs at his death resulting in the establishment of independent houses.

The household head, *yidana* in Mole-Dagbani is always a male, the most senior by age and generation. He has authority over the whole household in jural and ritual matters; exercises general supervision over the affairs of all members, controls the use of all patrimonial land, cattle and is the titular owner of all inheritable, non-personal property of all the members. Residence is patrilocal and villages are largely segmented into various descent groupings. Each village comprises several corporate lineages.

Marriage payments are customary, though there are local variations. The bridegroom's lineage remains liable for the full marriage payment and the transfer of the marriage-payment or the *sandano* or *sandane* in the case of the Wala or Dagomba, confers legal ownership of children.

Prior to the declaration of the north as a British Protectorate, two political systems were in operation among the people: decentralised administrative arrangement of the people of northeast and west and centralised administrative arrangement to the south and southwestern parts. Colonial occupation resulted in declaration of the entire area as protectorate in 1900, and subsequently the institutionalisation of chieftaincy in the decentralised northeast and western parts.

Chieftaincy has become a major traditional political institution of the people. The office of the chief rotates or circulates among the ruling clans or gates. The Upper tier of the political system is the paramountcy. Among those ethnic groups with centralised political origin such as the Gonja, Mamprusi and Dagomba, political authority is centralised in the *Yagbogwura*, *Nayiri* and *Yaana* respectively. The second-tier is the many divisional chiefs, who control in their turn, sub-divisional chiefs, and village and sectional heads. Individual households have their family heads. The chief has the responsibility for jural matters. However, authority in case of the administration of land is exercised by the *tendana* except in *Dagbon*. The office of the *tendana* is hereditary. *Tendanas* succeed by right of seniority or are chosen by divination from among the heads of the segments of the maximal lineage. The *tendana* is usually the first settlers of the village/town. Over the greater parts of the three regions, ritual ownership of the land is vested in the *tendana*.

As head of aboriginal descent, he exercises ritual jurisdiction on behalf of his lineage, and allocates use of unclaimed land. Land in northern Ghana, as in other parts of the country belongs to the living, the dead and those yet to be born. Thus, as appropriately observed by Fortes [1970] exercising or acquiring ownership for productive purposes is regulated by clanship and kinship ties and limited by the moral and ritual values of the ancestor cult and the earth cult. This principle is variously described as the *usufructuary* system.

The social organization of the people illustrates the strengths of kinship ties. The day-to-day living arrangement is organized around communal gathering, living and sharing common facilities. They farm together, cook and eat together and protect one other. This system of mutual arrangement has implications for community participation and health mutual schemes such as mutual aids and health insurance.

4.6 COSMOLOGY OF THE PEOPLE

There is an idea of an invisible world where other beings exist beside the *Naawmin* [God] in the worldview of the people of northern Ghana. The idea of the invisible world in the cosmology of the people portrays a dualistic perspective of nature although these worlds are not mutually exclusive in the daily practices of the people. Supernatural forces of various kinds and orientation inhabit the invisible world. These forces are considered to be subordinate to God [*Naawmin*]. They are also considered to exercise tremendous amount of influence, good or bad on the life of man. The bad spirits can be employed by witchcraft to inflict disease, pain and hardship on man. Some of these spirits and divinities have permanent or occasional cults rendered to them by people, but in no instance are they conceived to have equal standing with God [*Naawmin*].

The ancestor [*kpin*] spirit, which is rendered respect in almost every family, is in personified terms, the continued existence of departed relatives who are considered to exert influence on the living. It is believed that the ancestors are keeping watch over the activities of the living. The ancestors are therefore called upon for assistance and support during periods of hardship, pain and uncertainty. Also of protective and magical significance are medical cults [*tiibe*] and the earth shrine [*tengan*]. These cults are believed to have a key role of protecting and restoring health to man. The earth shrine in particular, is considered to have powers, which can cure barrenness and infertility. The reputation and fame of some of these cults/shrines are interethnic, some stretching beyond the northern Ghana.

The spirits [*Konton, Kpakparisi and Kolkari*] are believed to possess the secrets of nature and its functioning. It is believed that knowledge of health and illness, reproduction, socio-cultural organization and the origin of nature were received from the spirits. The spirits remain the source of prophetic knowledge and medical science. It is for this reason that most traditional medical practitioners align themselves with one spirit or the other. The law of reciprocity regulates the relationship between the spirit and the medical practitioner. The former grants the latter health and the secrets of medical science while the latter in turn offer sacrifices to the spirit at prescribed times. And so far as this mutual balance is maintained, the influence of evil spirits is minimised.

The ancestors and lesser divinities are believed to inhabit trees, hills and rivers. They are also believed to be capable of influencing almost every aspect of the day-to-day life of man,

to the extent that it is sometimes possible for man to incur their displeasure. It is for this reason that explanations of the dangers of everyday life are often sought from the supernatural realms. This is much the case in the area of health and illness.

4.7 CONCEPT OF HEALTH

Embodied in the concept of health among the people are the physical and non-physical dimensions. The physical dimension of good health is about the absence of pain and the ability to carry out normal activities of life without pain or discomfort. Other physical indicators of good health are good appetite, good sleep and normal bowel and urinary habits. The non-physical dimensions have to do with psychological and social requirements of life such as peace of mind, personal and social security, enough food to feed oneself or family and being able to have children. These physical and non-physical prerequisites are intertwined as illustrated by some respondents. "If you have good food to eat and money for your wife to cook, then you are healthy. On the other hand without peace of mind or social security, you can neither eat nor sleep. In fact you are sick of the mind". Another concept of health expressed among the people is coldness and hotness of the body. To have cold body means to have good health whilst warm or hot body means a kind of disequilibrium in the functioning of the body. Health and illness among the people as illustrated above means more than the absence of disease. It is a holistic concept referring to the biological/physical, social and psychological well being of the individual. Disease is seen as a natural consequence of man's relationship with his physical and social environment.

Based on this cosmology, one can discern two broad continuums of the theory of disease causation/illness among the people. Diseases caused by supernatural forces and those believed to be caused by nature. Supernatural causing agents include ancestors, shrines/deity and witchcraft. Under this category, it is believed that spirits such as *kunton*, *saakumine*, *Soobar* [witches], can cause illness when one breaks customary taboos or kinship obligations. The people also believe that conflicts and tensions in social relations underpin group or individual interpretation of the causes of sickness and misfortune. Naturalistic causing diseases on the other hand, are attributed to human and environmental factors such as poison, dirty food or bad surrounding. Among the Dagaaba for example, it is believed that one can contract diseases by breathing *baalonbie* [seeds of diseases] germ causing organism and getting cold, cough or catarrh.

It is however worthy to note that this scheme of classifying diseases is not watertight. What ailment acquires what categorisation depends on the social presentation, the time and quality of interpersonal relationship between the sick, the gods and ancestors and the community. As a result it is sometimes possible for a disease whose origin may be natural to be intermeshed with supernatural factors.

Based on the aetiology of disease described above, it is believed among the people that a certain category of diseases cannot be treated using scientific medicine. These include *Nantuo* or *Yogu*, *Chegbiga*, *Nsin* in Dagbani, impotence and sexually transmitted diseases [Muora] and psychosomatic illness such as madness, epilepsy and fractures. *Nantuo* or *yogu* is translated medically to mean carbuncles. *Chedbiga* or *Beraa* is a situation of generalised swelling of the body resulting from deliberate poisoning. Included under this category are 'local missiles' among the Dagaaba often referred to as *logba*.

Diseases that can be treated at the hospital include diarrhoea, vomiting, malaria and surgical emergencies such as hernia. Even then, the perceived severity or gravity of the disease determines the use of health facilities. The majority of the people in northern Ghana perceive the hospital or health facilities to be reserved for serious and life threatening conditions (Katie and Galaa, 1995; Binka et al., 1994). People generally resort to home remedies [home collection of herbs or drugs from drugstores] at the onset of illness and when that fails or the sickness becomes more severe, then specialist care, either in the form of herbal or facility treatment, is sought. In some cases where treatment protracts, care of facility and herbal treatment may be sought concurrently.

4.8 SOCIO-CULTURAL FACTORS AND HEALTH

Many health problems are seasonal. The dry and rainy seasons influence the incidence of diseases and the pattern of health care utilisation. CSM is rampant during the dry season and malaria during the wet. The often long awaited rains are associated with relief because temperatures cool down, but the incidence of malaria increases. The incidence of diarrhoea also increases, as sewerage and drainage systems become dysfunctional. Rains also cause flooding of streams, especially in grey areas in West Gonja, Bole, Savelugu, West Mamprussi, Builsa, Sissala and Wa districts.

Hygiene and sanitation is deplorable in both urban and rural settlements in the three regions. Open defecation is widely practiced in both urban and rural settlements. Adults do open defecation around the fringes of settlements while children defecate on rubbish pits. Hygienic practices such as hand washing is not widely practiced.

4.9 INDIGENOUS HEALTH PRACTITIONERS AND HEALERS

The essential element in traditional medical practice is the use of magico-religious powers in diagnosis and therapeutics. Magico-religious means such as divination is employed to determine the nature of issues in the treatment process. These include the cosmic cause of the illness, the rightful healer of the disease and in some cases, especially among the Dagomba, the safety of the healer undertaking the cure or treatment. In addition to this traditional healers also employ physical examination in determining the history of the disease.

4.9.1 Herbalists

The practice of herbal medicine is not a unified practice in Northern Ghana. It varies according to the belief and application of magico-religious powers to herbal practice. As a result various categories of herbalists have been identified. There is the category that uses physical means of diagnosis and treats disease with herbs. They concentrate only on physical diseases; believe and use divination but depend on soothsayers to do that for them. This category of herbalist is referred to as pure herbalist.

There is the second category that heals physically and psychologically. This category of herbalist handles social problems such as getting a job, winning the favour of one's wife or husband, passing examination etc. Like the pure herbalist, the fortune healer also relies on soothsayers for divination.

4.9.2 Soothsayers

Among the people of northern Ghana soothsayers offer diagnostic healing. People send their problems, including illnesses and deaths to them to diagnose the causes. Healers also consult them when they are contacted to provide healing. Soothsayers do not provide treatment or care but counselling on where to obtain proper and appropriate healing including ritual purification where relevant.

Soothsayers are generally referred to as *Bagah* in Mole-Dagbani and among the Dagomba for instance, there are *Bagah-Naa*, chief soothsayer or diviner who facilitates the selection of new soothsayers upon the death of one. This is normally by inheritance within the (*Yir*) house. The inheritance is by the male line except in rare cases where a female may be heir to herbal medicine.

4.9.3 Traditional Birth Attendants [TBAs]

The Traditional Birth Attendant (TBA) is another type of healer. Just like the herbalists, there are various categories of TBAs. Neumann et al [1976] identified two types whilst the Operation Research Project [1990] identified three. According to the Operation Research project, the majority [59%] of TBAs practice straightforward midwifery; 22 percent added spiritual practice and 19 percent were herbalists in addition to being TBAs. Other studies have also shown that some categories of TBAs use magicio-religious [oracles and herbal] means of midwifery care acquired through inheritance and supernatural means not through apprenticeship as in the case of ordinary TBAs (Boamah, 1977).

Thus, TBAs vary according to their knowledge and techniques of midwifery practice on the one hand and their client base on the other. There are TBAs who possess spiritual agents to guide their midwifery practice including the administration of herbal medicine and those who through apprenticeship and observation were socialised into midwifery practice. The first and the second types have some services overlapping in the administration of herbal medicine and the treatment of complications while the third offers support during labour and postnatal period. The client base of the latter is limited to family members and virtually every traditional home has this type of person who assists during delivery. Since the inception of the NTBA, TBAs have received various aspects of training in order for them to operate in aseptic manner.

4.9.4 Bone Setters

This category of healers handles fractures. Bonesetters are believed to be more exact in their treatment than under biomedicine. The bonesetter employs magicio-religious healing. In most cases divination marks the beginning of the treatment process and is employed to establish the cause of the problem before ritual and herbal healing is undertaken. The power to practice bone setting is inherited within the lineage/family.

Traditional health care providers constitute a very significant health resource especially at the Primary Health Care level. It is estimated that about 50 percent of Ghanaians use herbal preparations as first line treatment (MOH, 1996). The use of traditional health providers is higher in rural and peripheral areas such as the Northern, Upper East and Upper West Regions.

Twumasi [1988] cites yet another significant function of traditional health providers in the area of the functional specialisation of the illnesses they treat. Traditional healers are accustomed to dealing with social and psychological ills. The treatment protocol of traditional healers suggests that they have a better understanding of social and psychological causes of illness. This is because for the traditional healer, there is no conceptual separation between biomedical factors and social ones. They offer integrated healing based on the social causation theory as determined by the cosmology of the people.

The practice of traditional healing is also undergoing changes in the light of modernisation. Some traditional healers have engaged secretaries and nurses to attend to their clients/patients. They also record their treatment processes, take down the background histories of patients. Other healers use modern paraphernalia such as bandages, pain relievers, stethoscopes and thermometers and/or bottle their medicines. The nature and form of modifications introduced into traditional medical practice are widely reported (Oppong, 1989; Charunduka, 1986; Landy, 1977). Traditional practitioners in the northern sector have organised regional branches of the Ghana Traditional Healers and Psyche association. There are currently branches in Tamale, Bolgatanga and Wa. The desire to offer protection to members, internal control of their services and to see to the general interest of members, account for the formation of the regional branches. Training of members in aseptic methods of treatment and care and licensing are some of the benefits of coming together as an association.

4.10 MODERN HEALTH CARE

There are three main providers of modern health care services in the three northern regions. These are the private sector, non-governmental agencies and the Ministry of Health. When we consider institutional based care, or health facility care, the Ministry of Health is the major health care provider in the three northern regions operating about 81 percent of all health facilities, that is hospitals, clinics, health post and centres lumped

together. However, when we look at ownership by facility it appears the majority of the institutions owned by MOH are in the form of clinics, health posts and centres. For instance, 60 percent of all the hospitals in the area are under the operation of NGOs and the private sector. Particularly remarkable for the provision of quality and popular care in the regions is the Christian Health Association of Ghana (CHAG). Some of its hospital facilities include the Baptist Mission Hospital at Nalerigu, the Damango Catholic Hospital, Bawku Methodist Hospital and Jirapa Catholic Hospital. The Ahmadiya sect has a Hospital each in Wa and Kaleo.

TABLE 3: HEALTH FACILITIES IN NORTHERN GHANA BY REGION, TYPE AND OWNERSHIP.

Region	HOSPITAL			HEALTH CENTRE/POST/CLINIC			
	GOG	CHAG	NGOs	GOG	CHAG	NGOs	TOTAL
N/R	7	3	4	76	8	9	107
UE	4	1	9	62	8	13	97
UW	3	2	2	40	13	9	69
Total	14	6	15	178	29	31	273

Source: MOH 1998

The population size per health institution is about 19,000 people in the Northern Region, which is the highest among the three regions. The number of people per health institution in the Upper West region is about one-half of that of the Northern Region [9,559]. The three regions would need an addition of 386 facilities to meet the health facility/population ratio requirements for primary health care (MOH 1998). The majority of such facilities would be needed in the Northern Region.

TABLE 4: POPULATION PER HEALTH INSTITUTION BY REGION

Region	Population Projection From 1984	Number of Institutions	Population per Institution	Additional Facilities needed
Northern	2016681	107	18847	350
Upper East	1170404	97	12066	44
Upper West	659574	69	9559	92
Total	3846659	273	14090	386

Adapted from MOH 1998

The availability of health facilities is one thing and their accessibility and use is another. In the three northern regions, the use of health facilities is far below the 1.0 rate proposed by the World Health Organisation for sub-Saharan Africa. Utilisation figures stagger between the regions and within facilities. Utilization figures are higher for faith-based facilities compared to the government owned, for factors having to do with quality of care. Besides facility care, there is also non-facility care in the form of drug peddlers and drugstore provided by the private sector.

4.10.1 Pharmacies and Chemical Drugs Sellers

The private pharmaceutical sector has been found to play an important role in health care delivery in the northern sector of Ghana. The sector comprises of drugstore /chemical sellers and community pharmacies, with the former licensed to dispense first aid services and sell non-prescriptive drugs generally referred to as over-the-counter-drugs [OCD].

According to the zonal officer of the Pharmacy Council located in Tamale, there are 463 registered licensed chemical shops/drugstores and 11 pharmacies operating in the three northern regions in 1999. About half of all the facilities are located in the Northern Region alone as shown by Table 5.

TABLE 5: DISTRIBUTION OF CHEMICAL STORE/PHARMACY BY REGION

REGION	CHEMICAL STORE	PHARMACY	TOTALTOTAL
Northern	273	7	300
Upper East	124	3	127
Upper West	66	1	67
Total	463	11	474

SOURCE: Annual Report, Pharmacy Council, Zonal Office Tamale, 1999

The major activities of the pharmacies comprise the dispensing of prescriptions and non-prescription drugs, counselling and drug information dissemination mostly through advertisement. Five of the pharmacies offer wholesale distribution of drug with four combining that with retailing.

Drugstores/chemical shops have a wider distribution network than health facilities and a good number of them are located in peripheral districts. They serve as first line of contact for the sick, mostly in the form of self-medication and care for ailments such as malaria, diarrhoea, coughs, aches and pain.

Drugstore/chemical stores are perceived to offer cheaper services because of their low overheads. They are perceived to be more convenient in time management as the drugstore operator is the doctor as well as the dispenser. He is not likely to prescribe a drug that he does not have. The drugstore operator is client dependent, and anxious to serve clients on their own terms. The dispensers operate with human face as they sometimes offer their services on credit to their customers who are not able to make cash down payments.

As a result of these and other factors, drugstore/chemical dealers are popular. Former nurses and pharmacists from the Ministry of Health, who appear able to offer the public more convenient services outside the Ministry than within it, run some of the most popular

drugstores. They are therefore highly utilised for their convenience and for less serious and non-incapacitating illnesses.

The Ghana Pharmacy Council has classified drugs into three categories:

- Class A - injectibles and narcotics
- Class B - prescriptive such as valium and finergan
- Class C - first aid drugs, non-prescriptive

Discussions with clients of drugstores show that most drugstores in the three northern regions dispense drugs outside class C category: ephedrine, hydrochlorides, valium etc. They also offer services such as injections, stitching and in some cases abortions. Drugstore/chemical dealers operate beyond their traditional and legitimate role of providing first aid services. This has been identified as a problem by staff of the northern office of the Pharmacy Council, which is partly due to lack of control and supervision.

In a bid to address the problem the zonal office in Tamale has been organising periodic training programmes on drug care and dispensing since 1999. Supervisory monitoring is also provided though ineffective because of the vastness of the sector. Also confronting the zonal office is the problem of drug peddling by both individuals and vans.

4.10.2 Drug Peddlers

Drug peddlers by definition, are those who dispense or sell drugs /chemicals without the designated licences. They are reported to provide accessible services to the sick in rural communities outside the coverage of the legitimate modern health care practitioners [government and private].

Drug peddlers usually travel by market trucks, bicycles, and sometime on foot, visiting villages, moving from house to house to dispense drugs. The peddler's approach is more interactive and friendly. Their sales relate more to the ability to pay rather than medical regimen. Peddlers are also noted to display friendlier attitude towards their clients than do staff of the formal health sector.

Box 1: Importance of Drug peddlers as perceived by clients.

"When somebody is sick in one's compound, and does not have an idea of what drug to buy, the sick person explains the problem to the peddler and the right treatment is prescribed," a client of drug peddlers explains. According to the clients the treatment of drug peddlers is "convenient because they come to you not you looking for them". "Even when the drugs with the peddlers are a little more expensive than that of the health facility, there is still the advantage of buying from them because, you buy the quantity of drugs you can pay for". "You can buy one or two tablets of various drugs you need."

The drug peddler constitutes an important provider in peripheral communities in the area. However, they are not considered in policy issues of health care management.

4.11 CONCLUSION

Although there have been attempts to expand modern health care in the three northern regions especially, through the efforts CHAG, data show that modern health care services are still limited in terms of the number of facilities and accessibility to the majority of the people. The most accessible care continues to be from traditional/indigenous sources of care followed by chemical and drugstores. The rural nature of the three regions and the poverty level of the people explain this. The cosmology of the people also favours the use of traditional health care. In recent times traditional medical practice has been undergoing modernisation to enhance effective health care delivery in a technologically changing world.

In spite of the important role played by traditional sources of care and chemical shops and drugstores in the health delivery system of the three regions the influence of these two sectors on the determination of health policy is largely limited.

CHAPTER 5

5.0 HEALTH SECTOR REFORMS IN GHANA: IMPLICATIONS FOR PARTICIPATION IN THE PUBLIC HEALTH SECTOR

5.1 BACKGROUND TO THE REFORMS

Prior to the introduction of biomedicine in Ghana, traditional medical practitioners evolved and nurtured a medical tradition suitable to the cosmology and needs of the society and accepted by the people. However, the country entered into an era of a pluralistic medical system as a result of the introduction of biomedicine during the colonial and post-colonial periods.

Despite the interplay between the two systems in the post-colonial era, public health sector organisation and management by the Ministry of Health tended to emphasise modern, biomedicine to the neglect of indigenous medicine. The pre-colonial exclusive or monopolistic position of indigenous medicine became subordinated or only officially tolerated by government. The Ministry of Health functioned as Ministry for Modern Health or biomedicine. Although the situation is now changing, the history of colonial and post-colonial organisation and management of health in Ghana has been the history of biomedical development and management, with no decision-making role by the beneficiaries of the services.

The organisation and management of the public health sector has been based largely on the classical management model and determined by division of labour and unity of control. The division of labour is an admixture of geographical consideration by district, region or national boundaries; processes of care determined by the nature or type of care such as surgery, emergency, inpatient or outpatient care; clientele consideration in terms of whether care is targeted at children, mothers, the aged etc.

In line with the principle of unitary control, supervision was discharged along spheres of specialisation, with authority centralised around geographical boundaries from the district through to the region and national level. This resulted in a classical pyramidal system of

control the hierarchical system had authority centralised at the top or headquarters in Accra.

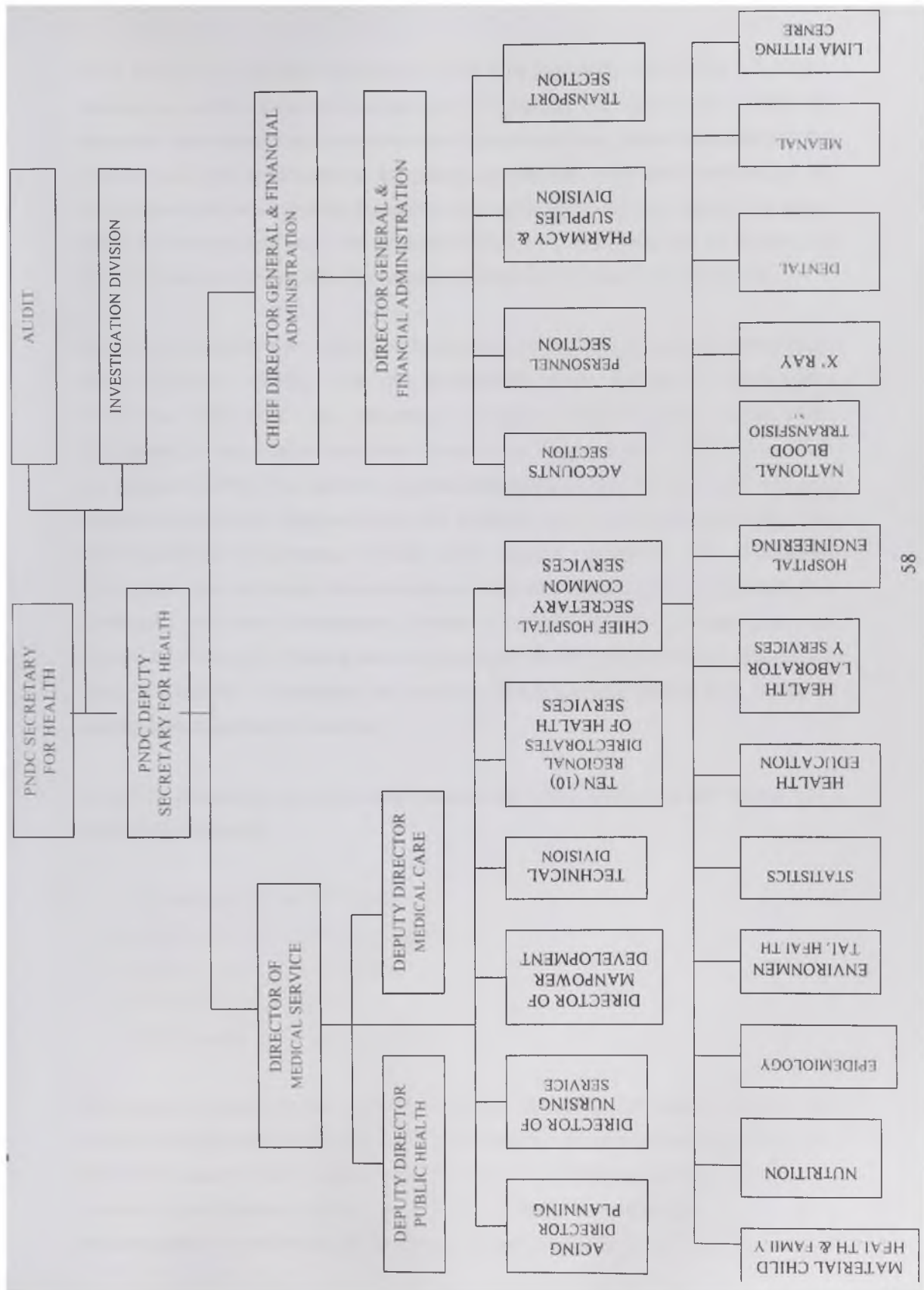
Technical programmes were organised into five specialised divisions along the three-hierarchical management structure prior to the restructuring in 1992. Each of the five divisions had its own staff at the district, regional and national levels; ran programmes in a parallel manner and acquired its own resources resulting in multiple and vertical lines of administration. The Ministry at the top was headed by a political leader and assisted by two directors. The technical wing was headed by the Director of Medical Services [DMS] while the administrative, by a Chief Director. The Chief Director had no links at all with the regions whose directors were technical men and as such reported directly to the Director of Medical Services. Health policies were formulated at the headquarters for implementation at the regional and district levels with rigidity.

This approach to the organisation and management of public health services resulted in the development of a top-down, urban-based curative health care system unable to meet the needs of the large rural public. Furthermore, it created competition between the divisions resulting in the waste of resources. There was also the alienation of some key health care providers such as indigenous health practitioners in the health care delivery system. The above constraints of the public health sector partly accounted for the implementation of the primary health care programme, which placed emphasis on community participation and inter-sectoral collaboration.

5.2 PHC AND HEALTH SECTOR MANAGEMENT

Earlier attempts at involving local people in health development and management in Ghana were based on the community development approach. The main objective of the approach was to help local communities adopt civic responsibilities in the use of their potentialities and talents in achieving desirable socio-economic and health development through self-help projects (Sanders, 1958).

The community development approach was later criticised for lack of comprehensive socio-economic plan for national, regional and district level development [Boateng, 1978], resulting in the adoption of the integrated rural development approach in the mid 1970s.



Three models of integrated development have been identified: rural-urban integration, intersectoral and or zonal co-ordination and the 'package approach' (Addo, 1978). The integrated development approach offers both programme and project integration at the sectoral level and organisational integration by defining roles and relationships for development partners including grassroots and communities. It was hoped that socio-economic development would be achieved through the mobilisation of all human and material resources to cope with the complex problems of community development.

The Danfa comprehensive health and family planning programme, the Manpong Valley Social Laboratory [MVSL] and the Brong-Ahafo Rural Integrated Development Programme [BARIDEP] are pioneering integrated health related programmes implemented in the southern sector of Ghana in the 1970s (Schott, 1978; Ofosu-Amah and Neumann, 1979). The Northern Regional Integrated Programme [NORRIP], the only integrated programme implemented in the northern sector of Ghana, came later. The above-mentioned programmes utilised both sectoral integration and community participation. Four Ministries, Departments and Agencies (MDAs) namely; Department of Community and Rural Development, Ministry of Health, Ministry of Agriculture and Ministry of Works and Housing were incorporated into the programme. In addition to these, the NORRIP incorporated the planning units of project districts as a means of building their capacities in planning.

Integrated programme activities were broad-based and to ensure greater impact they covered the following:

- the provision of health facilities;
- health promotion and immunisation;
- water, hygiene and sanitation;
- food and nutrition; and
- better housing and civic education.

The community participation initiatives covered the training of auxiliary health staff including traditional birth attendants and the formation of health committees to oversee community based health programming. The lessons of these pioneering initiatives on community participation, especially the DANFA and BARIDEP experiences precipitated the implementation of the Primary Health Care programme in 1978 by the Ministry of Health.

The primary health care programme redefined health roles and relationships within the district. It also sought to reform the vertically organised health care system into an integrated and community managed system where equitable and affordable health care would ensue. A three-tier system of health delivery was introduced: village or community, the sub-district and district. Village or community based care constituted 'primary health' whilst secondary and specialist/tertiary care were provided at the sub-district and district levels through a system of referrals. Bannerman [1983] defines primary health as essential health care based on practical, scientifically sound, socially acceptable methods and technology. Writing on the model of health development for Africa, Latin America and Asia, Bannerman notes that the most common primary health care providers in developing countries are the herbalist, healers, traditional birth attendants and practitioners. These health professionals provide appropriate care to the majority of people, with services widespread and thus largely accessible and affordable.

Training programmes have been provided to indigenous health professionals with the view to integrating them into the public health care system under the primary health care system. These programmes include the Primary Health Training for Indigenous Healers [PRHETIH], Community Based Workers Programme [CBWP] and the National Traditional Birth Attendants Programme [NTBA]. Other types of traditional healers such as Wanzams, bonesetters and drug peddlers have also benefited from various training programs (Warren et al, 1982; Ofosu-Amah & Neumann. 1979). These programmes trained auxiliary health staff such as Traditional Birth Attendants, Community Clinic Attendants, Village Health Workers or Village Volunteers. There are currently about ten thousand of such trained health auxiliaries engaged in the provision of health care countrywide.

A new system of health care management was also introduced under the PHC system in line with the three-tier health management system. This comprises the village or community health committee, sub-district health committee and the district health committee for the village, sub-district and district health levels respectively. The new management system emphasized the committee or team principle in health management.

The District Health System was adopted under the WHO Global Programme Committee in 1986 to reinforce the PHC system. A district health system under PHC is a self-contained and co-ordinated segment of the national health system embracing all health care providers at the district level. Within the district, the community is the lowest segment of the health care system and the sub-district, the intermediate. The district assumes the co-ordinating role and responsibility for integrated services delivery for its population. This is because the district is considered the most appropriate level for co-ordinating top-down and bottom-up planning; organising community participation and sectoral collaboration. In order to further forge horizontal linkages between the vertically organised programmes at the district, the Ministry of Health pursued the Strengthening of the District Health System (SDHS) Initiative (Kanlisi, 1991). Among other things, the initiative sought to:

- grant increasing fiscal autonomy to the districts and regions;
- promote teamwork;
- establish central divisions within the vertical structures; and
- facilitate planning and human resource development.

Inter-sectoral collaboration was also pursued under PHC among the MOH, government and non-governmental agencies through joint programming in areas such as Oral Rehydration Therapy, Family Planning, Environmental Sanitation and Immunisation. Prominent among the collaborating government departments were the Ministries of Local Government, Agriculture, Works and Housing and Education. On the non-governmental side were the Christian Health Association of Ghana, World Vision International and Catholic Relief Services. These agencies run programmes in health related areas such as health promotion, the provision of water and sanitation, nutrition, immunisation and the training of auxiliary health staff such as TBAs. These linkage arrangements cover, for instance, the payment of salaries of staff of some private sector providers by MOH. However, these plans fall short of formulating a national advisory body with regional and district wings for Intersectoral Collaboration (ISC).

5.3 ORGANISATIONAL RESTRUCTURING

Although the PHC system had put in place a three-tier system of health care delivery, modelled on the district health concept, there were still problems caused by vertical

management of health programmes at the top, by the close of the 1980s. As Eghan observes that, management mechanisms for intersectoral collaboration, planning and co-ordination were generally lacking or carried out in an ad-hoc, one-on-one, unsystematic manner [Eghan, 1991: 24]. There was thus the lack of integration among the main Primary Health Care initiatives, poor allocation of resources and duplication of effort between MOH and the private sector in particular. Furthermore, the Ministry of Health was still characterised by vertical programmes emanating from headquarters and running through the region, district to the sub-district, creating problems of co-ordination.

These problems deepened already existing crisis within the MOH resulting in the general realisation that

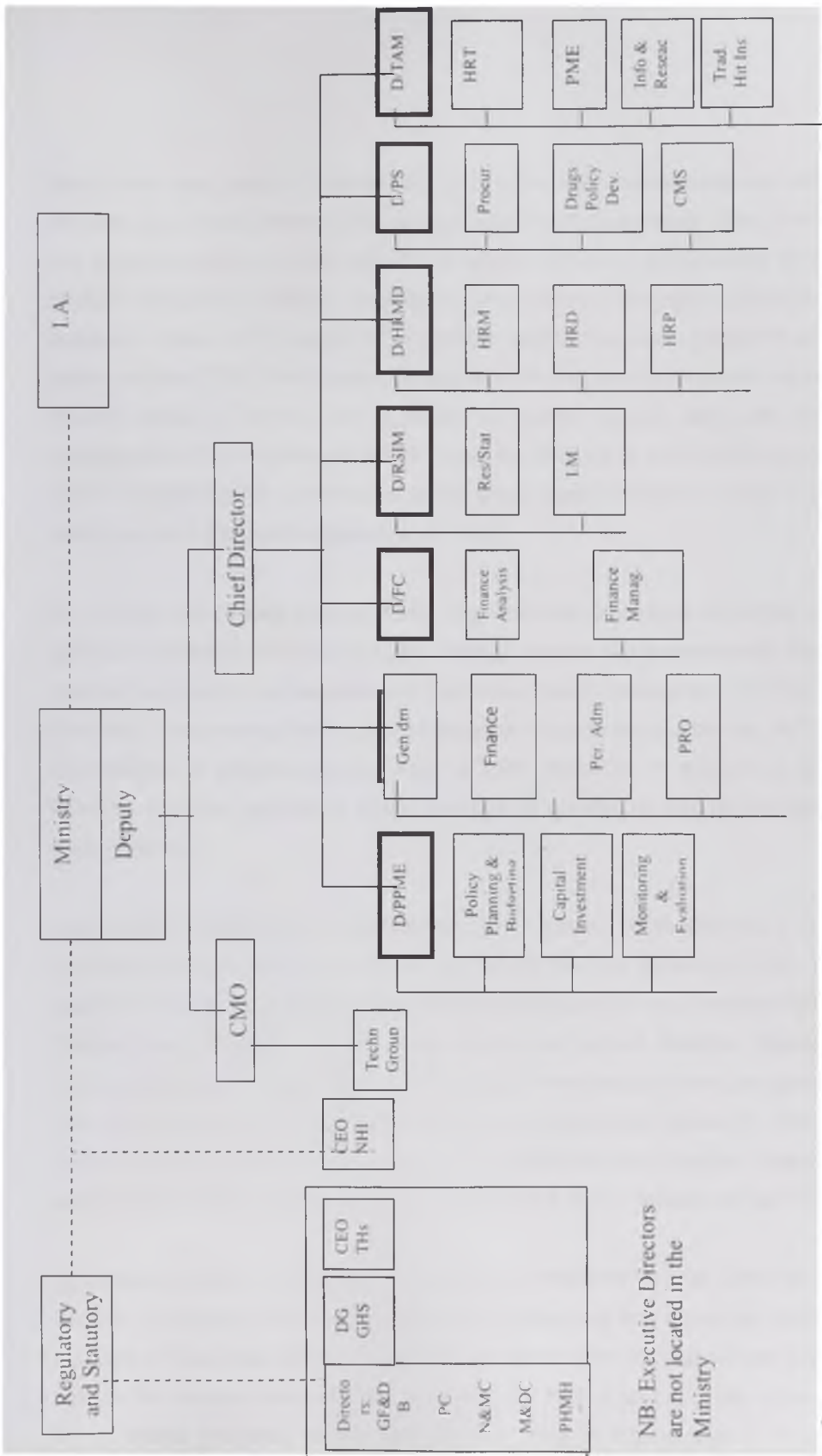
“ --- without a radical restructuring of the system of administration and management of MOH at the central, regional and district levels, and the appointment of a core group of qualified managers to key positions, no significant improvement could be made in the delivery of health services either curative or preventive” [Eghan, 1991: 23].

The need for restructuring of the MOH had become World Bank conditionality for loan sought by MOH for the second Health and Population Project by January 1990.

The World Bank inspired restructuring, which started in earnest in 1992, concentrated at the headquarters with the realignment of technical and support services into five directorates namely, Policy Planning, Monitoring and Evaluation [PPMED]; Human Resource Development Directorate [HRDD]; Administration and Support Services [ASS]; Technical Co-ordination and Research Division [TCRD] and Supplies, Stores and Drug Management [SSDM]. The new arrangement merged some divisions at the top and at the same time created new divisions to address the management problems inherent in the old management model.

The position of the Director-General with responsibilities for both the administrative and technical wings unified both wings at the top, thus eliminating conflicts emanating from their separation in the former structure. Also with the new structure planning, policy formulation, monitoring and evaluation issues, which were not given the needed impetus previously were strengthened within one of the five major divisions.

FIG. 3: ORGANIZATIONAL STRUCTURE OF THE MINISTRY OF HEALTH AS AT 2002



LEGEND

- TH – Teaching Hospital GHS – Ghana Health Service, F&DB – Food and Drugs Board, PC Pharmacy Council, N&MC – Nurses and Midwives Council, M&DC – Medical and Dental Council, PHMH – Private Hospitals and Maternity Homes Board, DG – Director General, CEO – Chief Executive Officer, D – Director, TAM – Traditional and Alternative Medicine, PPME – Policy, Planning, Monitoring and Evaluation, F&E – Finance and Administration, RSM – Research and Information Management, SP – Supplies and Procurement, PRO – Public Relation Officer, CMS – Central Medical Store, PSC – Private Sector Co-ordination, IM – Information Management, IA – Internal Auditor

One of the main areas of wastage under the previous arrangement was drug supply because each of the different programmes satisfied its drug needs. Thus, the new drug and supply division sought to establish a unitary system of procurement of drugs and medical equipment. Similarly, duplication, unnecessary competition and wastage that arose as a result of the existence of vertical programmes were gotten rid of with the creation of the TCRD. The Director-General and the five directors became responsible for broader issues of policy, the provision of tertiary special care and the overall management of the Ministry of Health. Thus, the ministry at the national level assumed direct responsibility for co-ordination of the entire health services including research into traditional medicine and its application in Ghana.

By 1997, it was judged that improving organisational arrangements further still, could generate significant efficiency in health services delivery and management. This thinking inspired the creation and separation of the Ghana Health Services and Teaching Hospitals from MOH, thus leaving the Ministry of Health to focus on the purchasing, regulation and co-ordination of services delivery. Prior to 1996, the MOH, in addition to playing this function, was also involved in direct provision of services as well as the regulation of these services.

Like all other ministries and departments in the country, MOH assumed a civil service organisational structure with functions outlined in the Civil Service Act 327, 1993. The position of the Director General under the previous structure was replaced with a Chief Director. Also, divisions such as Administration and Support Services, Supplies, Stores and Drug Management and Technical Coordination and Research were realigned into two new divisions namely, General Administration, Finance and Research, Statistics and Information Management. A new division for Traditional and Alternate Medicine with a unit for private sector health was also created as one of five divisions of the MOH.

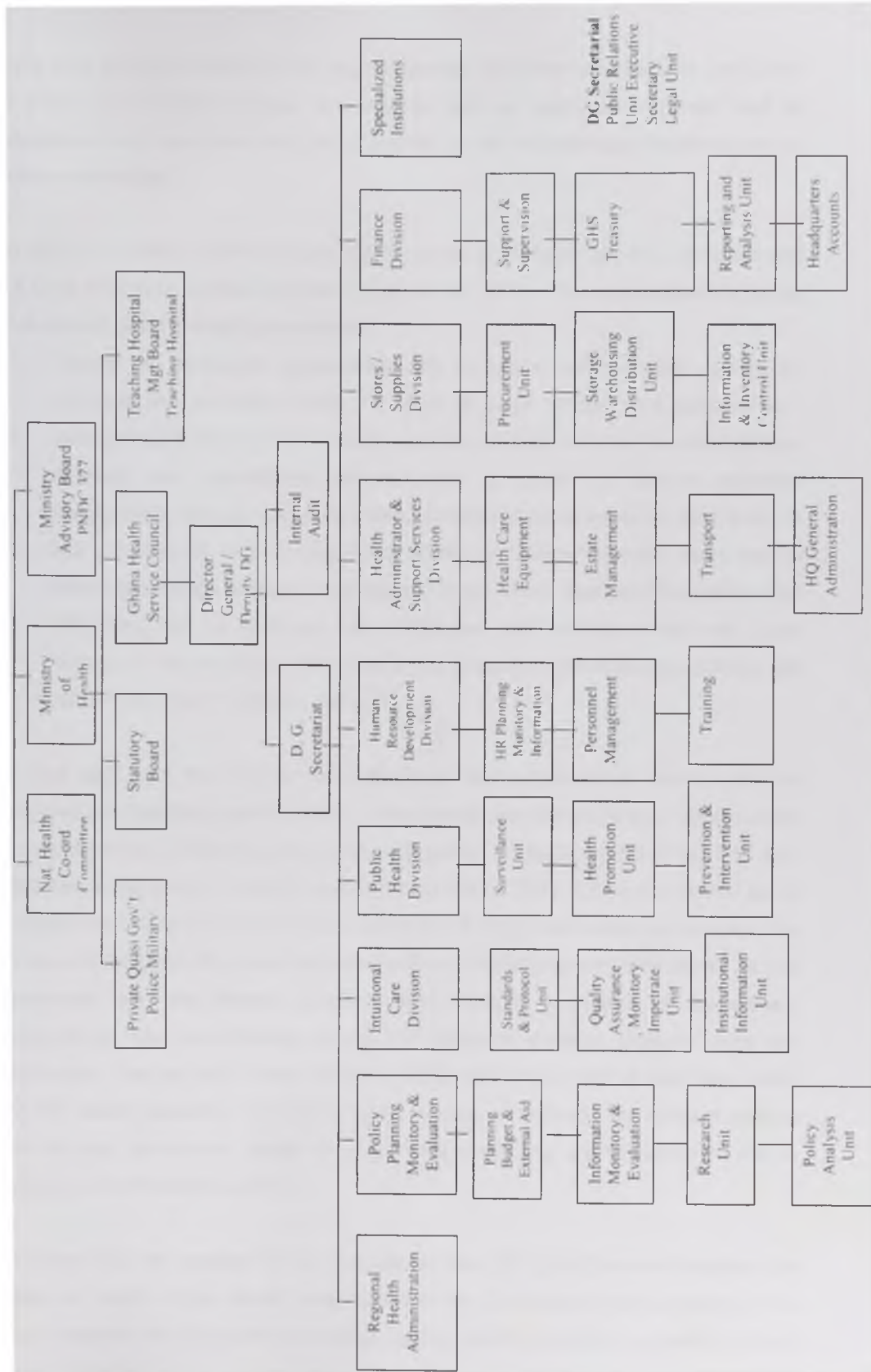
Discussions are still on going about the position of the Chief Director within MOH and the creation of separate divisions for supply and procurement and a financial controller. The outcome of these discussions will affect the structure of the MOH as we see it today. As a civil service structure however, the new role of the MOH is limited to the following: policy for all health providers, strong and effective voice in intersectoral actions, resource

mobilisation and allocation to all health providers, information for advocacy, coordination and management and services regulation.

The service delivery function of the former MOH has been passed over to the GHS. The legal instrument required for the introduction of the GHS was passed into law through ACT 525. The GHS now has Governing Council, a Director General and Deputy Director-General. They are supported in the mean time by eight directors from eight divisions created as follows: public health, institutional care, PPME, administration and support services, human resource division, finance and internal audit. Many other preparatory steps have been implemented at the National level.

MOH structures are being converted into GHS structures at the regional level and below. Two management levels are proposed: the National Executive and District Offices. The Ghana Health Services Council (GHSC) will be concerned with the operation of services as a whole, but relate directly to the National Executive. District Health Committee will perform a similar oversight role locally. Regional Directors and their staff will become integral to the National Executive, operating three departments/units: public health, health support services and clinical care unit. Like the National Executive, the Regional Directorate has three distinct types of function:

- allocating financial resources to district health offices, regional hospitals and non-teaching tertiary hospitals; and monitoring their performance. Routine management responsibilities are delegated by the Director-General and Regional Directors to Medical Superintendents and District Directors of Health Services;
- development and management of operational support systems such as personnel management; financial management, accounting and auditing; management of health information, drugs, consumables and medical equipment supply; and transport and estate maintenance; and
- technical advice, research and development in the areas of refining intervention strategies, assessing the cost effectiveness of different approaches, developing standards and performance indicators, commissioning and conducting research.

FIG. 4: ORGANIZATIONAL STRUCTURE OF THE GHANA HEALTH SERVICES

In the area of service delivery, the regions provide specialised care/tertiary care under the GHS. The regional hospital is a referral unit for specialist treatment and its management is in the hands of a team, headed by the medical superintendent and an advisory committee.

The attempt to create a district health system, which started with the PHC, is determined to a large extent, by political decentralisation in the 1990s. The decentralisation policy, which started with the PNDC government:

“sought to restructure government and its public administration system by changing the prevailing content of work of public officers and establishing a distinguishable and operational policy planning and co-ordination process between national and sub-national administration in order to ensure increased management competence in the implementation of decisions at the local level. In line with that, the internal organisation within the Ministry of Health was meant to eliminate all those activities, regardless of origin, which obstruct effectiveness and efficiency; and to introduce new techniques and activities which will cause changes in the structure, work content and process; and knowledge, attitude and skills of personnel” [Eghan, 1991: 29].

The first step was the creating of a three-tier local government system and the realignment of boundaries and functions at the district, sub district/zones or area councils with the objective of fostering grass-root participation in decision-making [Act 462 with its legislative instrument [L11589] which replaced PNDCL 207]. A new civil service law is to replace the old civil service act that established a highly centralised civil service. The new law will integrate the de-concentrated offices of central government ministries and departments with the district assembly and introduce a system of committees, subcommittees and co-ordinating council for horizontal linkages between units and departments. The law will further reinforce Article 240 of the 1993 Constitution which gave the district assembly the right to plan, initiate, co-ordinate and execute policies within its local government system thus reserving monitoring and co-ordination role to the regional co-ordinating councils.

It is hoped that the passage of the Civil Service Law 327 [1993] would transform the Ministry of Health at the district level to one of the decentralised departments of the District Assembly for it to work horizontally to the district's system of authority and not

vertically to the region. The District Assembly would assume the responsibility of health planning and make composite plan for the decentralised departments including the GHS. This process would translate sectoral collaboration at the district to external integration dictated by political decentralisation at the district level and below. However, it appears there are inherent practical contradictions between Law 462 and the operation of the GHS at the district level for now. The GHS Act has created a district health services department with a District Health Committee (DHC) having oversight responsibility. The DHC will be a sub-committee of the GHSC. The Chair of the District Assembly Social Services Sub-committee will also be the chair of the DHC.

Management of the services in the districts is the responsibility of the DDHS supported by the DHMT. Services at the district (public health as well as clinical health) are fused and co-ordinated through health management teams as a means of ensuring internal integration. Public health services comprise those delivered at the sub-district on disease prevention and control, health promotion and general education on public health matters. The district hospital constitutes a referral point for clinical services.

The District has the responsibility for the assessment of health needs of people; proposal for health plans; health education; promotion of research into traditional health practices; promotion and development of intersectoral co-ordination; and with the implementation of district plans.

The health centre/post is at the sub-district level and is responsible for integrated care in public health, clinical and maternal care. A sub-district management team is responsible for the overall planning, monitoring and evaluation of the services as well as ensuring quality services. The centre is managed by the SDHMT in conjunction with an Institutional Management Advisory Committee with representation from the community. This is an innovation in health facility management although most advisory committees are reported to be non-functional.

Community based health workers consisting of trained TBAs, community clinic attendants, community based surveillance volunteers operate at the village or community level. The use of these auxiliary staff is actively promoted in under-served areas in particular. Their responsibilities include: disease and demographic surveillance; community mobilisation for health programmes and outreach services; distribution of

vitamin A supplements; health education; help in health activities such as National Immunisation Programme, dissemination of information; and non-prescriptive family planning and antenatal care.

Institutional care is through integrated outreach, provided by the Sub-district Health Management Team. Communities are expected to undertake the monitoring and evaluation of health services, communicating their views through a range of channels, including village health committees and sub-district management teams.

5.4 SECTORAL PARTNERSHIP AND COLLABORATION

Fostering closer partnership with all health care providers has been integral to the reforms taking place in the health sector in the 1990s. The nature of the partnership has been dictated by the complexity of the pluralism of the health sector and the functional contribution of the various key players. Sectoral key players beside MOH (now GHS) include traditional health providers and the private sector. It is estimated that about 50 percent of Ghanaians use traditional sources of care as first line treatment [MOH, 1996]. There is also the private health sector comprising of two distinct groups: private-for-profit and private-not-for-profit providers. The private-not-for-profit is the NGO category that provides essentially public health services such as family planning services and the mission institutions that are in curative services delivery and also provide public health services. The private for profit organisations are predominantly curative based.

In spite of the contribution of the other health care providers, the private sector in particular, has not been involved in national health policy formulation, and their contribution to health, though significant [eighty percent of the population has easy access to traditional healers or birth attendant and almost half of the total visits to health facilities occur at the private sector] was not fully recognised by the Ministry of Health [MOH, 1996]. There is still little government support to the private sector. Furthermore, the private sector plays little role in planning and evaluation of health care. Health care planning and delivery continues to be top-down with clients' satisfaction given a low priority.

The reforms dictated by the Health Sector Medium Term Strategy, seek to systematically pursue collaboration based on partnership, mutual trust and openness, sharing of information and resources, joint planning, policy formulation and evaluation; between the Health Sector and key health related agencies with the understanding that:

- the publicly funded health service alone cannot provide the required care;
- activities of the health services alone cannot lead to the achievement of the health status objectives; and
- the private sector especially the missions/NGO providers are more innovative in providing peripheral services with community involvement.

In the area of institutional strengthening, the Traditional Practice Act, 2000 (ACT 575) has been passed and the Traditional Medicine Practice Council and Traditional Medicine Directorate established. A unit for private sector health care has also been created within PPME to liaise with mission groups, NGOs and the for-profit sector. Prior to 1997 the private-non-profit sector, especially the mission facilities received subvention from MOH for the payment of staff salaries but plans are advanced for MOH to enter into performance contract arrangements with them. Memoranda of Understandings have been negotiated with CHAG to receive funds from MOH as any other Budget Management Centre (BMC) and the financial readiness of CHAG institutions have been assessed.

There are also plans to start piloting partnerships with the profit-private groups in the area of private practice scheme with government hospitals; and rural health centres in remote and less remote and underserved areas. Private groups will also benefit from MOH training programmes to improve their services delivery.

The health sector continues to forge links with other ministries and departments with health implications. During the 1990s for instance, a multi-sectoral Guinea Worm Committee has been formed with ministries of Works and Housing and Local Government. The Ministry of Agriculture, Universities and other experts together with MOH have developed a National Nutrition Policy. MOH and GES have developed collaborative institutional arrangements under the School Health Programme and the National Population Council and MOH have provided the institutional framework for ISC. The institutional arrangements outside cabinet for the co-ordination of ISC are now being facilitated by MOH. These include guidelines for generating common interest and

commitment, for deciding funding arrangements, contributions, indicators and joint monitoring and are targeted at all levels national, regional and district.

5.5 HEALTH FINANCING

One important variant of Health Sector Restructuring is health financing. A crisis point was reached in health sector financing in the early 1980's. The situation worsened by 1983 leaving the sector with inadequate supply of basic consumable such as drugs and other medical supplies.

In an effort to save the situation from imminent collapse, the PNDC government raised user fees for all kinds of hospital services. Although mission hospitals had been charging for services for many decades previously, the history of government charges for health services began in Ghana in 1971 with the Hospital Fee Act. The act established the principle of user-fees, but the charges were in fact so low that only a minimal percentage of the total cost was recovered. The Hospital Fees Regulation of July 1985 by the PNDC government enabled the level of fees to be increased substantially. The structure of the fees adopted was that patients pay full for their drugs, except for vaccinations and the treatment of certain diseases such as leprosy and tuberculosis. Consultation charges were implemented and varied according to the level of institution. Higher fees are charged at higher facility level.

By January 1992, a revolving drug fund called Cash and Carry system had been introduced. This was cost recovery strategy geared towards improving the finances of the system for improved and sustained drug supply in the public health sector. Under the new system patients pay for the full cost of drugs and the funds generated channelled into a revolving drug fund for future procurement. To sustain the scheme drug charges constitute a proportion for full cost, transport and a mark-up.

The cash and carry system initially applied to drugs only, but later widened to cover all fees including dental and surgical treatment. In some cases advance payments are made for in-patient care. Aside ensuring the availability of continuous supply of essential drugs in all government health facilities, the system, it is argued, promotes efficiency in the use of resources at both the level of the patient and health provider. " Consumers are now more sensible in their demand for services while facilities will encourage the use of

referral services” [World bank, 1987]. It is estimated that about 8-10 percent of total recurrent expenditure of the Ministry of Health, about US\$0.30 per capita is recovered from cash and carry [MOH, 1996].

In line with plans to revise the system in the area of collection and management of funds in order to increase cash flow and to ensure that collecting facility uses funds, the cash and carry system was extended to the community level under the Bamako Initiative. Like the PHC system, the Bamako Initiative culminated from a series of reforms in response to the rapid deterioration of the public health system.

The Initiative was aimed among other things such as:

- revitalisation and extension of peripheral health care delivery systems; including the network of community health workers that provide outreach services;
- sharing of recurrent costs through community financing in the areas of user-fees, prepayment of services, local taxes and various income generating activities. The aim was to improve and extend services by generating sufficient income to cover some local operating costs; and
- community control involving community responsibility for the management of local health services. Funds generated will be controlled through locally elected health committees.

These were to ensure community's full participation in the decision-making process on issues of health [UNICEF, 1995: 7].

The financing schemes of the Bamako Initiative were piloted in ten districts in Ghana. The Yendi District was the only district in the northern sector that benefited from the programme. The programme activities in the Yendi District covered thirty communities with trained Village Health Workers and institutionalised Community Health Committees. Those village level institutions, which received training in drug management and dispensing were, supplied various quantities of drugs by July 1992.

Shortly after the start of their operation, the district was engulfed by ethnic conflict in 1993 resulting in the disruption of the process. There are indications however that, the drug accounts operated by the communities have accumulated an amount of about seven million cedis locked up in the Yendi Ghana Commercial Bank. The transfer of some personnel considered instrumental to the implementation of the programme from the district in 1996 and 1997 was alleged to have affected attempts initiated at revitalising the Bamako project.

Cost sharing schemes raise the problem of equity and the ability of the poor to pay. As a means of lessening the effects of cost sharing initiatives in the country, two types of exemption schemes have been introduced: exemptions based on disease category and the other, on client's social background. The first type covers diseases such as AIDS, mental health, tuberculosis and leprosy. The social background category relates to the poor, the aged and children. The problem with the exemption policy has been its operation; especially with regard poverty groups. The second has to do with government refund of exemptions. Although by 2000 re-capitalisation was spreading to lower level health facilities, directors of sub-districts complained that funds provided often fall below amount expended. This has led to the erosion of drug capital bases of the facilities, considering the high inflation rate in the country by 2000.

More sustaining cost sharing alternatives in the form of Community Mutual and National Health Insurance Schemes have been under discussion since 1983 as an alternative to Cash and Carry System in the country. The problem has been how to develop workable schemes that cater for the informal sector and the PHC system as well. From all indications, it seems the national insurance scheme will be multifaceted and implemented in phases. The proposed components of the scheme so far include the following considerations:

- private voluntary health insurance for self employed and others
- social insurance scheme for the formal sector, which would be covered by the new social security law
- community-based health insurance scheme and mutual health organisations for informal rural sector
- medical programmes to cover an estimated 30 percent of the population who live below the poverty line

Pilot schemes of Health Insurance are currently been implemented in four districts of the Eastern Region and in the Dangbe West, Nkroranza, West Gonja and East Mamprusi Districts. The Eastern Regional pilot is to inform the National Scheme. Of these piloted schemes, two are in the Northern Region of Ghana: the West Gonja and East Mamprusi schemes. These together with the Nkroranza scheme are managed by non-governmental agencies. In fact, the West Gonja and Nkroranza schemes are managed by the Catholic Health Services while the Dangbe West initiative is championed by the District Assembly with support from DANIDA.

Most of the schemes are limited in their geographical coverage and the scope of treatment or care. The West Gonja scheme for instance, covers a geographical radius of about ten km. from the district capital with full cost recovery for only in-patient care. Various private Health Insurance Companies including the Metropolitan Insurance Company Ltd have extended operations to the northern sector of Ghana.

5.6 THE REFORMS AND DONOR FUNDING

The reforms have also streamlined donor support to the health sector. Until the early 1990s, donor financing was mainly in the form of projects, reflecting donors' technical and strategic preferences. This resulted in fragmentation of programmes and created problems of co-ordination. It also led to inefficiencies in resource allocation between services and between geographical areas and limited government control over the way health services were being developed.

In 1992, the Ministry of Health and donors agreed on "regional funding" approach where each donor selects a region. While this had the advantage of allowing the Ministry to exert more strategic and management influence at the national level, control at the region and below, remained biased against the development of local capabilities and responsibility. In addition, differences in donor preferences and funding levels resulted in differences in the geographical density of health infrastructure, staffing and services delivery patterns perpetuating the inefficiencies of resource allocation.

As a result a new financing mechanism was established that required the pooling of donor funds referred to as Donor Pool Funds (DFP) or Health Fund. Under this

arrangement a proportion of some health partners' resources are pooled and placed under government management. This rearrangement though an improvement over the previous methods as it will make it possible for equitable allocation of resources, has received some resistance among some donors. Currently there are three main institutional arrangements governing the management of donor funds: Pooled, earmarked funds and those managed by the donors.

5.7 CONCLUSION

The above discussions show very concretely that reforms in the Ghana health sector have a very long history. There are two main types of reforms according to the focus: bottom-up and top-down. The bottom-up reforms started in the 1970s with the PHC system and the decentralisation exercise resulting in the creation of a district health system. The district health system also called for reforms at the top for better co-ordination and planning and decision making at the district level leading to the restructuring of MOH and the creation of a Ghana Health Service. The restructuring has also led to the creation of institutions for traditional and private medical providers within MOH, for the first time. These new structures and institutions are taking shape at the top but they may require corresponding institutions for the realignment of services among service providers at the district level and below.

The discussions also show that the reforms are seen as a recipe for making health care more accessible, user-friendly and ensuring efficient and optimum management and mobilisation of resources.

CHAPTER 6 - CASE STUDY 1

6.0 THE NATIONAL TRADITIONAL BIRTH ATTENDANT PROGRAMME (NTBA): A CASE STUDY OF COMMUNITY PARTICIPATION IN THE PUBLIC HEALTH SECTOR

6.1 BACKGROUND TO THE NTBA PROGRAMME

In 1989 Ghana launched a National Traditional Birth Attendant programme (NTBA) envisaged at bridging gaps in the provision of supervised maternal and child health care under the primary health care system. The programme was designed to improve the quality and expand the scope of midwifery care of Traditional Birth Attendants (TBAs) in ordinary obstetrics and family planning. Other objectives of the programme included the institutionalisation of a two-tier referral system in complicated obstetrics and the provision of essential drugs and immunization.

The importance of the NTBA programme was based on the realization that Ghana was experiencing crises in maternal and child health. This was as a result of the skewed distribution of modern maternal and child health services to the disadvantage of the rural poor, who constitute about 70 percent of the population and depend on traditional sources of care.

The inclusion of TBAs in the strategies of maternal and child health services has a long historical development in Ghana. These community workers have long been recognised for their availability, steadfastness and cultural appropriateness in caring for mothers and newly born in every corner of the country. Thus, numerous and determined efforts to upgrade their skills and improve the quality of health care they provide started in the 1970s (Neumann, 1982; MOH 1990).

The first of such efforts, the Danfa Comprehensive Health and Family Planning Project, was a joint endeavour between the University of Ghana and the University of California at Los Angeles and funded by USAID. It was initiated in the early 1970s as a demonstration, service, teaching and research project in Danfa, a rural settlement of the Greater Accra Region. TBA training was an integral component of the Danfa project aimed at reducing maternal and infant mortality in the area and evaluations of the project revealed initial successes (Neumann et al, 1986; Ofosu-Amaah & Neumann, 1979).

The second major programme was the Brong-Ahafo Rural Integrated Development Project (BARIDEP), launched by the government in the mid-1970s with assistance from World Health Organisation (WHO). The objective of the programme was to make health care delivery the responsibility of the community (Boamah, 1977) and to determine in a practical way social processes that mould a community health care project (Twumasi, 1982). Community participation in programme activities was considered a prime reason for the success of the project. The last of these efforts to integrate traditional and modern systems of health care was the Training of Indigenous Healers Project (Warren et al., 1982).

An Operations Research Project by MOH to review training programmes for TBAs in the country prior to the NTBA programme revealed that pioneering TBA programmes varied in content and orientation. The Operations Research called for a systematic national programme on TBAs, based on experiences and lessons from earlier projects (MOH, 1990). It also drew attention to the importance of a clear-cut national policy to address the role and responsibilities of TBAs in an integrated maternal and child health care system in Ghana. Such a policy was also believed to encourage and promote community involvement in matters of health care (Amonoo-Larson, 1981).

As a follow up to the findings and recommendations of the Operation Research Project, a National TBA programme workshop was organised in 1988. The workshop was charged among other things, to work out the objectives for the implementation of a comprehensive National TBA programme in the country to commence in 1989 (MOH, 1990).

6.2 PROGRAMME IMPLEMENTATION

The NTBA programme was a project of the Ministry of Health (MOH) with technical assistance from the American College of Nurse-midwives and funded by USAID and UNICEF. The first phase in the implementation of the programme was organisational resetting within the Ministry of Health to systematically implement and coordinate the programme. A secretariat of the National TBA programme (NTBA) was established in Accra, and headed by a director. Regional and district organs were also established with

new administrative routines to incorporate TBA activities at the regional, district and sub-district levels in the country (MOH, 1990).

The national secretariat of the NTBA programme comprised a director, two training co-ordinators, administrative and support staff. The programme had regional contact persons with their supporting staff serving as links between the national secretariat and the regions. A regional contact person was the head of the programme in the region. Other programme staff included: master of trainer(s) (MT), who headed the programme at the district, TBA trainer(s) (TOTs) at the sub-district or community level. Heads of other existing health programmes were co-opted at the sub-district, district and regional levels. The NTBA constituted another vertical programme initially, and through the above structure of programme personnel, a chain of TBA command structure was established to oversee the programme with the director at the apex and trained TBAs at the bottom. However, following the restructuring of MOH, TBA training activities were integrated at the district level (MOH, 1991).

6.3 WILLINGNESS OF TBAs TO RETRAIN UNDER THE NTBA

The willingness of only those TBAs who were selected to retrain in the NTBA programme was analysed since it was not every TBA who was offered that opportunity. TBAs acceptance or refusal to participate in the NTBA programme and the underlying reasons for such orientation were analysed. Of the 54 TBAs interviewed, 40 were ordinary TBAs, 6 herbalists and 8 spiritualists. Thirty (30) ordinary TBAs were initially selected to retrain in the new midwifery practice compared to all the herbalists and spiritualists sampled. In terms of the actual figures of trained TBAs however, 34 ordinary TBAs were finally retrained as against 2 each for herbalists and spiritualists over several training sessions. This means that whereas all selected ordinary TBAs accepted the offer to retrain, 4 herbalists and 6 spiritualists refused to participate in the NTBA. Some of them gave their places to close relatives practising as ordinary TBAs as exemplified by the herbalist and spiritualist TBAs at Ko and Douri communities respectively.

The herbalist and spiritualist TBAs who turned down the offer to retrain in the new techniques of midwifery care offered different reasons to support their actions. The spiritualists who rejected the offer said (they did so because) their guiding spirits objected to the NTBA deal. In the words of one spiritualist "my *kotome* (spirit) rejected

the offer because she cannot practice midwifery with people wearing green clothes (hospital based midwives and nurses)". Others noted that their spirits were antisocial and as such they could not co-operate with nurses and midwives to attend to midwifery care as envisaged under the NTBA programme.

Herbalist TBAs who turned down their invitation to retrain in the NTBA said they did so because of the perceived limitations of the programme on herbal and complicated related practice. As recounted by one herbalist in Ko who refused to be retrained, "----One time, the hospital people came to me for some herbs saying they wanted to test their efficacy. Although they have not yet reported to us the outcome of the test, they are asking us to stop the use of herbs under the NTBA programme." Other herbalists and spiritualists who declined to participate in the NTBA programme supported their decision this way: "-----we were serving our communities before the era of the white men and our people continue to come to us even though there are hospitals around now". "-----our services are satisfactory and we do not see the need to be retrained". The herbalist from Ko who refused to retrain concluded thus: "the NTBA programme was a strategy designed to do away with the last traces of our culture".

Ordinary TBAs gave their own reasons to support the popularity of the programme among them. In their opinion, the desire to retrain TBAs as an integral part of maternal and childcare was an overdue recognition by the government of the role of TBAs in community midwifery care. Ordinary TBAs, trained and non-trained, were anxious to see the NTBA programme institutionalised in the country.

In the words of trained ordinary TBAs, "there were better people who should have been trained and yet we were selected and trained". Trained TBAs, including the two herbalists and two spiritualists who offered to be retrained, described the offer as an "appeal from the government we could not refuse".

However, further discussions with the trained herbalist and spiritualist TBAs revealed that it was sheer fear rather than the desire to obey the policy of government that led to their enlistment in the NTBA programme. Each of them mentioned the uncertainty of their midwifery career outside the NTBA as the motive for enlistment. "---- - if I refuse to train and something happens during my service delivery I will be in trouble".

The above illustrates that individuals or groups of TBAs were compelled to retrain for fear of the consequences of staying out of the programme. The herbalist and spiritualist TBAs in various ways expressed this fear. Those herbalists TBAs who refused, as shown above, also harboured similar fears. As a result close relatives or assistants of ordinary TBAs (background) were encouraged to participate in the NTBA as manifested by the Ko and Douri cases. In Ko, for example, the daughter of the herbalist was trained and it was the daughter who kept her informed about the NTBA programme.

6.4 TRAINING OF TBAs AND THE NATURE OF THEIR MIDWIFERY ENGAGEMENT

The programme under discussion can be categorised into two broad components: a) new midwifery package for TBAs and b) linkage or institutional net-work system to channel the services delivery of trained TBAs and other organs engaged in maternal and child health care.

The training programme of the NTBAs was a standardised midwifery curriculum developed by the Ministry of Health, with the assistance of American College of Nurse-midwives. The curriculum is contained in a manual of three volumes entitled Manual for training of Traditional Birth Attendants in Ghana and published in September 1989. These manuals contain specific components of the package covering Maternal and Child Health Care and Family Planning. TBAs were expected to learn and put into practice these new techniques of maternal and child health intervention in their local communities.

Specific topics covered by the training programme included the following:

- prenatal care consisting general care for pregnant women in ways consonant with modern maternal and child health care;
- delivery care based on the aseptic methods of care during and after birth and care of the umbilical cord;
- the administration of complicated related care in pregnancy, delivery and child and mother related vaccinations;

- care for the mother and the newborn, breastfeeding techniques governed by hygienic and scientific knowledge and acceptable weaning practices; and
- family planning and birth spacing, emphasising the use of contraceptives such as condoms and foaming tablets.

Under the above broad thematic areas, TBAs were trained in human biology, reproduction, pregnancy and related complications, labour management and aspects of postpartum care. The training balanced TBA's practical experiences in birth management with the theoretical insights of the human biology aimed at creating a better understanding of the functioning of the human reproductive system. It was the opinion of programme staff that an understanding of the functioning of the human reproduction system by TBAs would eradicate some of the traditional mystical conceptions surrounding pregnancy and birth, which will in turn enhance the services they delivery.

The programme also prepared TBAs for the delivery of basic "Primary Health Services" in their communities and as such covered the management of minor ailments, personal and environmental hygiene, management of oral dehydration therapy, Information, Education and Communication in nutrition and general health. The training in personal and environmental hygiene was considered crucial because it oriented TBAs on hygienic methods of handling labour and the care of the umbilical cord, since the traditional methods used by TBAs were found to pose health risks to mothers and children. The training stressed the use of cleaner places for delivery, sterilised instruments for cutting the umbilical cord and acceptable hand washing techniques. These aspects of the training constitute the aseptic methods of midwifery care under the programme.

Family Planning was also given considerable attention. The incorporation of family planning into the NTBA programme was aimed at reversing the poor performance of the hospital based family planning programme in Ghana (MOH, 1989). TBAs were trained to counsel and motivate their local communities in family planning. They were also to stock and dispense non-prescriptive family planning devices or drugs in order to expand the coverage of family planning through logistic supply.

As can be seen from the rather brief summary of the curriculum, the midwifery package was relatively broad, covering all areas of traditional midwifery as well as areas of care

such as the administration of condoms, foaming tablets and oral dehydration sachets, formally outside traditional midwifery practice.

The second component of the programme realigned the services of trained TBAs within the three tier-system of the PHC. Trained TBAs were to deliver services in ordinary obstetrics in their communities – uncomplicated deliveries, dispensing of non-prescriptive family planning drugs and the provision of first aid at the community level and to refer complicated cases of pregnancy, prescriptive family planning services and cases requiring immunisations to level B or C, for attention.

The reorganisation of traditional midwifery services by MOH, however sought to avoid creating an employer-employee relationship between MOH and trained TBAs. The intention was to strengthen traditional midwifery practice as an independent maternal and child health care provider through collaborative arrangements at the sub-district and community levels of the PHC system. The services of trained TBAs were linked to the modern health system through a two-tier system of referrals. The system formalises the services of trained TBAs and makes it possible for clients of TBAs to receive specialised care at the hospital or health post. The arrangement also fostered teamwork in areas of care that brought trained TBAs and staff of MOH together such as during immunizations and outreach services. The referral system also compels trained TBAs to refer patients for special care delivered outside their administration.

Respondents of trained TBAs reported to deliver support services in community clinics on outreach days on voluntary basis. The services they deliver cover arranging outreach sites and making them ready for outreach services. This normally entails cleaning of site, arranging chairs and informing mothers about outreach days and so on. Trained TBAs assist midwifery staff of the MOH in palpation services during outreach. Where many TBAs were trained in a community, outreach participation was arranged according to shifts.

Interactions with trained TBA respondents and trainers of TBAs showed that trained TBAs participate effectively in outreach support during the dry season but encounter difficulties during the rainy season. Outreach staff confirmed that trained TBAs support is seasonal. They participate regularly in outreach activities during the dry season. Other program personnel noted that trained TBAs who insist on participating outreach activities to the

neglect of farm work often ran into conflict with their husbands who find it difficult to understand why their wives sacrifice farm work for outreach services from which nothing is earned.

The outreach involvement of TBAs serves as an opportunity for nurses and midwives to supervise their activities. It also serves as an opportunity for TBAs to interact with medical personnel. Interaction with health personnel was seen as a source of motivation for TBAs. No conflicts concerning the working relationship between TBAs and staff of modern midwifery care were reported. Community health nurses and midwives in charge of outreach visits who expressed satisfaction about their working relationship with TBAs indicated to have been happy to be called upon to assist in outreach delivery.

6.5 SUPERVISION AND LOGISTIC SUPPORT TO TRAINED TBAs

Trained TBAs received midwifery kits after graduation. UNICEF provided kits at the initial stages of the programme. The kits contained basic essential items such as razor blades, cord ligatures, cotton wool and gentian violet. The kit was to facilitate the midwifery practice of trained TBAs as specified by the NTBA. Some public health nurses observed during their supervisory visits that “most kits were now empty and it appears some of the items have been reserved for only monitoring purposes”. TBAs blamed the problem on the lack of community support and refusal of their clients to pay for services.

Other items supplied to TBAs after the training included books for recording deliveries, referral cards, non-prescriptive contraceptives and oral rehydration therapy (ORT) sachets. The contraceptives comprised of foaming tablets and condoms to be sold to members of their communities. A portion of the profit accruing from the sale of these contraceptives and ORS was to be retained by the TBA as incentive for the services delivered.

Supervision of the services of trained TBAs is tied to the entire success of the midwifery innovation. As noted by Neumann et al (1986), without follow-ups on the services of trained TBAs their interest may diminish over time making them likely to revert to pre-training habits. Three overlapping supervisory methods were observed in the three

regions: through associations of TBAs, trainers and sub-district personnel, and supervision through licensing.

State supervision is in the area of certification. Trained TBAs are offered midwifery kits and certificate after graduation. The certificate bears the name of the trained TBA and as it were, legalises her operations. The certificate also limits the operations of the TBA to Ghana and is valid for two years subject to renewal based on satisfactory operations according to the NTBA programme.

The supervision of TBAs by sub-district health personnel is, however, the most formalised and properly institutionalised channel of supervision of TBAs. One important element of this supervisory system is that the trainers of the TBAs supervised them after the training (MOH, 1990). This has an added advantage because the trainers/supervisors know those they trained and what they were taught as well as their strengths and weaknesses.

The supervision of trained TBAs serves several functions including monitoring and control of service performance. As such, a checklist is used to ensure that all the key issues are covered during supervision. Various methods of supervision were reported. Supervisors who make home visits to trained TBAs adopted an out-supervision approach. In other instances supervisors meet a group of trained TBAs within a health catchment area at a mutually agreed place and time for group supervision meeting. The home and group meetings are options for the individual trainers involved. Trainers of TBAs who reside in the same catchment area as TBAs adopt the home visit approach, whereas those who make periodic visits to the catchment area for supervision use the group meeting supervisory strategy.

Outreach staff use supervision visits to evaluate the services delivered by trained TBAs, replace used items of TBAs, collect information from TBAs record books and money from the sale of contraceptives and oral rehydration therapy. Monthly supervision was reported but trainers who reside outside the same catchment area as trained TBAs, especially in the Lawra District, conduct quarterly supervisions. On the whole supervision was reported to be irregular.

One factor influencing TBAs supervision is the workload of trainers who are normally staff of the sub-district. Sub-district staff indicated they were combining supervision with their

nursing and midwifery tasks resulting in infrequent supervisory visits. Other problems include constraints created by the weaknesses of health service infrastructure and bureaucracy. Supervision is worsened during the rainy season. During this time of the year, supervision may be impeded for several months as a result of unpaved roads.

The dependence of supplies to TBAs on supervisory visits was observed to cause shortages in the supply of some items to TBA.

A system of association of TBAs is another channel of control through which trained TBAs were expected to play an important role in the determination and control of their services. Associations of TBAs were organised in the early 1990s to bring trained TBAs within local communities together to work in a mutually supportive manner. Associations were to regulate services to ensure that trained TBAs work according to the objectives of the NTBA programme. However, data on the functioning of Associations of TBAs show that many of them were not in the position to regulate the activities of members because the associations were more interested in the welfare of members rather than defining ethical standards to govern their services delivery.

6.6 NATURE OF PARTICIPATION IN MIDWIFERY SERVICES DELIVERY AFTER RETRAINING AND SERVICES UTILISATION

Almost all the trained TBAs interviewed perceived the potential benefits of the training they received in the area of aseptic method of midwifery. Some trained TBAs indicated they were now aware of the dangers of unhygienic ways of midwifery care as a result of the training. In the words of trained TBAs, “we have come to grips with the dangers involved in conducting deliveries with unwashed hands or conducting deliveries in places like Kraals or using unwashed rags”. Trained TBAs reported they were operating according to the aseptic methods of midwifery care. “We now wash our hands with soap before conducting deliveries and use parts of our room chambers for labour and delivery”. Deliveries were previously conducted at very obscure parts of people’s homes in order to limit the stains of blood. In most homes kraals were previously used. TBAs now spread the mackintosh from the midwifery kit on the floor for the pregnant women

in labour to lie on. TBAs also said they no longer pass their fingers through the birth canal of labouring women as a result of the mastery of signs of delivery and labour.

TBAs also recounted changes introduced in the management of the umbilical cord. The cord was now tied and cut with a new razor blade after delivery and dressed with warm sheabutter, alcohol, mentholated spirit or other disinfectants. Pregnant women were asked to contribute towards the procurement of these items in order to effect compliance by TBAs.

However, it was not every trained TBA that met the requirements of the aseptic method of midwifery care. The trained herbalist and spiritualist continue to use unhygienic methods of delivery. The use of saliva to wet hands together with soil dust from the ground prior to attending labour was still practised by the trained herbalist and spiritualist. In their view, the saliva served other purposes than wetting hands and cannot be substituted for water as thought by programme personnel. The soil dust, on the other hand, is said to symbolize the *earth spirit*, whose presence is needed to ensure successful delivery.

Trained TBAs introduced prenatal care services. Under this arrangement, pregnant women are now required to register their pregnancies with a trained TBA in their neighbourhood for periodic check-ups and it is this TBA who would offer prenatal care or make the necessary referrals to the hospital should that become necessary. Pregnant women who fail to register their pregnancies risk being denied care at health facilities during delivery. This requirement is however, found to be difficult to implement because of the network of kinship relations in rural communities where everybody is related to everybody else.

Furthermore, in traditional midwifery practice, women undertake prenatal care only during pregnancy complications and that could entail travelling several kilometres to seek a herbalist or a spiritualist TBA's services. As long as there were no complications of pregnancy, there is no need seeking the services of a TBA prior to labour. Thus, the introduction of prenatal care requiring regular visits to trained TBAs by pregnant women, especially those experiencing stable periods of pregnancy, is considered to be unnecessary and thus resisted by clients of trained TBAs.

Trained TBAs keep records of their midwifery care. Trained TBAs were supplied with record books and delivery records are kept with the assistance of literate relatives since none of the TBAs can read or write. Where there are no available literate relatives, recording is done by the nearest literate in the community. Some TBAs wait for health personnel to come and do the recording during supervision visits. As a result, delivery records were reported to be incomplete. Records not kept include antenatal visits and condition and history of deliveries conducted by TBAs. Records kept on births cover the date of birth, sex and state of child - life or dead delivery.

Trained TBAs also mentioned the introduction of changes in the management of pregnancy complications. Trained TBAs were to concentrate on normal deliveries thus reserving complications of pregnancy and labour to level B and C institutions. Complicated pregnancies are categorised as red card referrals. Other aspects of care such as tetanus vaccinations and child immunizations were also to be handled during outreach visits to the community by health personnel under blue card referrals.

Clients of trained TBAs were, in most cases, not prepared to effect red card referrals. Clients who resisted referrals possessed the following characteristics: they were too financially weak to effect referrals, lived in inaccessible communities to level B and C areas or were not able to adjust to the bureaucratic requirements of the health post or hospital. Clients' work schedules also influenced their reaction to referrals. Clients, who were not able to effect referrals for one reason or the other, viewed trained TBAs who insisted on referrals to be insensitive to the needs of clients or "not down to earth" and questioned the basis of trained TBAs' new found knowledge. Some clients did their best to frustrate the institutionalisation of red card referrals by either ignoring them or ridiculing those TBAs who made such referrals.

On the part of trained TBAs, all the categories promptly refer blue card cases. What differed between them was on red card referrals. Red card referrals are promptly made by ordinary TBAs compared to the other two. The herbalists and spiritualists TBA who previously treated red card related cases prior to their training under the NTBA continue to administer ritual and herbal medicines during complications and refer them only after ritual and herbal medicines had failed.

The orientation of trained TBAs towards blue card referrals is generally positive. Trained TBAs refer children and mothers for vaccination and immunization respectively. Children are referred for vaccination against the six killer diseases as soon as they can literally “see the sun”. Mothers too are referred for neonatal immunization against tetanus during delivery or early after delivery. Clients of TBAs, on their part, carry out blue card referrals. As a result, staff of modern maternal and child health care reported increases in vaccination and immunization coverage.

The success of the blue card referrals system could be partly attributed to the outreach on wheels which deliver blue cards services to clients of TBAs in their local communities thus, saving them the time and money required for travelling for these services. Further more, UNICEF, to make the services affordable to rural women, subsidized vaccines and other services delivered to clients by TBAs during outreach.

Trained TBAs deliver Family Planning services under the NTBA. Herbalists and spiritualists TBAs said family planning counselling was a difficult task for them because of the scope and nature of the traditional midwifery tasks they perform. Most TBA herbalists and spiritualists regard family planning counselling as meddling in client’s private family affairs. A trained TBA spiritualist in Nyanyari community recounted that it was impossible for her to ask a client to limit or space her births because she was not the one feeding the children. In her view, to use her position to counsel on family size limitation or birth spacing would be tantamount to “seeking trouble”.

Other herbalists and spiritualists see their role in modern family planning counselling as showing double standards. As recounted by a trained TBA herbalist, “how can I help some clients to get pregnant and deliver, others to stop delivering frequently, and yet others to stop because they have had enough children? She continued, “it is God that has the power to distribute children according to that procedure not man”. In her view, family planning counselling will “make us create enmity with our clients because they would not understand the yardstick upon which our counselling is based”.

The “dispersed” nature of the clients of TBA herbalists and spiritualists makes it difficult for them to conduct postpartum visit during which family counselling is given. The clients who visit TBA herbalists and spiritualists during postpartum are those offered assistance to deliver and this category of clients was least likely to listen to the counselling of the

TBA herbalists or spiritualists on matters relating to family planning. Ordinary TBAs were better disposed to offering family planning counselling because they offer delivery care to family members, but this is not always an easy task. Some ordinary TBA noted that “--- we are sometimes confronted by our daughters-in-law for having accused them of going to their husbands at the wrong time”.

One other issue that puts TBAs in a dilemma concerning family planning was the individual personal characteristics of TBAs. Almost all TBAs who were trained had large families. Only under very rare instances will one find a TBA without a large family size since self-experience in childbirth is one of the ingredients of traditional midwifery training. It was increasingly difficult for TBAs to counsel others on family size limitation and child spacing because TBAs themselves possessed large families.

The situation was similar on family planning referral. No referrals were made on family planning among the trained TBAs interviewed. Neumann et al in their evaluation of the Danfa project (Neumann et al 1979) also observed a similar trend on family planning referrals. When TBAs were asked why there were no referrals on family planning, the general response was that they had not encountered complications requiring hospital referrals in family planning. In the view of some TBAs, “it is not all our clients who have enough faith in our knowledge of modern family planning to listen to us on family planning referrals. Referrals on pregnancy complications were taken seriously because of the danger they pose to the mother or child. This situation is different on matters of barrenness and infertility since they are the likely referrals we can make”. As confirmed by one ordinary TBA, “those people in this village who require modern contraception beside the one we have, understand family planning better than us and they will not rely on us to refer them to the hospital”. For many rural women, the best place to visit concerning problems of barrenness and infertility is the TBA spiritualist or herbalist and not the hospital. They will only visit the hospital after trying in vain available traditional sources of care.

TBAs reported mixed successes across and within categories on the sale of the foaming tablets and condoms. Some TBAs indicated that their communities were buying whilst others reported the contrary. Other TBAs reported that only the condoms were being bought in their communities - an illustration that male family members were responding more favourably than their female counterparts. The attitude of the people towards the

sale of the non-prescriptive devices varied from community to community. Better patronage of the non-prescriptive contraceptives was reported in sub-urban and urban communities such as seats of district governments than in rural communities. In urban and sub-urban communities, both male and female couples as well as youth above the age of 18 were free to buy contraceptives from trained TBAs serving in the neighbourhood. The situation was rather different in rural homogenous communities. In rural communities, trained TBAs refused to sell contraceptives to teenagers and unmarried people. Even couples who needed foaming tablets and condoms found it difficult to go forward. Rural people were afraid to buy the non-prescriptive devices because they thought trained TBAs would disclose their family planning practices to other members of their community. "The people complain that if they come to buy contraceptives we will go about saying that so and so are using contraceptives and this will be embarrassing to hear" reported some TBAs. Some rural communities had to adopt strategies of purchasing the devices and at the same time hiding their identity from TBAs. In Douri, and other communities, bulk purchases enabling a group of male couples or female couples to purchase a quantity of contraceptives together was initiated at the beginning of the NTBA. This strategy was however not sustained and further investigations about it revealed that the intention of the bulk purchases was to rid the area of those contraceptives rather than for safe sex purposes. As one trainer of TBAs in Ko health catchment area noted, "our people are shy, for that matter it is difficult for the TBA to talk about family planning freely". It is also difficult for a man or woman to approach a TBA on matters of contraception". This observation on the people's attitude towards sex life is further confirmed by Kuukure's remark about the Dagaaba: "the traditional approach to sex is one of naturalness, dignity and respect, not prudery, nor obsession, nor nervousness even in the face of nudity". "Sex is seen in terms of procreation and as something vital for the survival of the family, the patrilineage and clan" (Kuukure, 1985: 143).

Several reasons may be attributed to such differences in the utilization of foaming tablets and condoms in the area. Whereas the people in rural communities are still governed by traditions, those in the urban communities have been introduced to new ideas as a result of urbanization and western education. Western education and urbanisation have been observed to alienate people from traditional attitudes and beliefs. Twumasi (1979) observed that education and urbanisation enable people to escape the kinship system in which authority is vested in the head of the lineage.

The people's reluctance to accept family planning could also be explained by the high incidence of infant mortality among them. Infant mortality in the area stands at 103 per thousand and childhood mortality is 132 with the region recording the highest infant and childhood mortality in the country [MOH, 1989]. Mothers see reduction of childhood mortality and morbidity resulting from comprehensive health care as providing sufficient assurances of the survival chances of children for fertility regulation through the use of contraception. Increased childhood survival and acceptance of family planning has been documented in Taiwan and India [Freedman and Takeshitu, 1964].

The utilization of the delivery services of trained TBAs is influenced by factors other than those relating to the quality of the services they offer after the training. The utilisation of the services of trained TBAs was determined among other things by the history of one's pregnancy. Women with stable pregnancy histories said they were favourably disposed to using the services of trained TBAs than those with unstable pregnancy records. Women who had safer deliveries in the past said it was okay for them to deliver with trained or non-trained TBAs.

Those women who had experienced unstable pregnancies and complications of labour pointed to the need for special attention during pregnancy and were rather disappointed that the training had restricted the midwifery care of trained TBAs to ordinary obstetrics. For both groups of clients, therefore, the training of TBAs has not had much impact on the utilization of care since the latter is covered by referrals under the NTBA and the former does not see the need to discriminate between TBAs.

Other clients reported convenience as a factor determining their choice of TBA during delivery. Rural clients would like to go about their normal activities until such a time that it was necessary for them to deliver in their homes amidst family members rather than in an informal institution. This means that any TBA around could be called upon to assist in the delivery management without taking into consideration whether or not she was trained.

Cost of delivery was also mentioned as an important factor in the choice of delivery services. Cost was measured not only in fees for labour management, but also the cost of having to travel outside one's local community in order to seek supervised delivery. The cost becomes too much to bear in communities where there are no regular transport services to areas of supervised delivery. Seasonal factors were also mentioned. Some

husbands were reported to be reluctant to allow their wives to leave the village for supervised pregnancy related care during the rainy season.

The major worry of women concerning the provision of midwifery services are those relating to complicated obstetrics and not ordinary obstetrics, which can be provided by almost every elderly woman. The training of TBAs in the attendance of ordinary obstetrics under the NTBA programme was perceived as an advantage to the care of non-interventionist types of delivery and therefore having little impact on the utilization of delivery services as shown by the responses of clients of TBAs. Clients who reported that the training of TBAs was likely to influence their choice of TBAs care, were literate women settled in rural communities. For this group of clients who used to travel long distances for pregnancy related care, the training of TBAs offers them a credible choice in maternal and child health care.

The institutionalisation of a fee-for service in rural non-monetised communities and at the same time restricting the services of trained TBAs to non complicated types of deliveries are the identified contradictions of the NTBA programme in most rural communities of the region. It is therefore not surprising that both ordinary trained TBAs and non-trained herbalist and spiritualist TBAs would want the issue of complicated related management addressed by the NTBA in the future.

6.7 AREAS OF COMMUNITY PARTICIPATION AND SUPPORT TO TRAINED TBAs

The NTBA programme, and earlier programmes for TBAs identified community participation to be essential for programme success. As a result, strenuous efforts were made from the onset of the NTBA programme to establish rapport with community chiefs and opinion leaders, brief them on the purpose and content of the programme and to get them to help identify traditional birth attendants to participate in the programme. Communities were involved in the initial selection of TBAs for the training. Communities, through their opinion leaders and elders, ensured that experienced and devoted practising TBAs are enlisted for training. Among other things selected TBAs were to have permanent residence in their communities. The majority of selected TBAs were aged women.

Communities were also involved in the planning of graduation ceremonies for newly trained TBAs. They were encouraged to support the services of TBAs in cash and/or kind on a permanent basis. For instance, communities without structures for TBAs to conduct their deliveries were to construct such structures through communal labour. At the initial stages of the programme, many communities were able to build housing structures. There are reported cases of structures constructed in Adibo in the Yendi district, Nandom-Ko and Zambo in the Lawra district and around the Seniesa area in the Builsa district. Most of these structures were constructed entirely on local resources – sandcrete and thatch and some of them have been allowed to collapse over the years.

Associations of TBAs were organised in the early 1990s to collaborate with their communities in safeguarding the interests of trained TBAs. Associations of trained TBAs were established in the Lawra and Builsa districts for peer problem solving and community relations. District, sub-district and zonal branches were formed. In the Lawra district bi-annual meetings were organised in December and June in addition to the different sub-district and zonal meetings. Many of these associations no longer hold meetings and as such have become dormant.

TBAs did not charge fees for delivery care and labour related management prior to the NTBA. A quantity of millet or flour and cowries or a fowl were traditionally offered to the TBA to perform the rite involving the washing of eyes since the people believe that blood can cause blindness. Moslem communities provide TBAs with meals and meat between the period of delivery and the naming ceremony. In recent years, soap and other gifts are offered together with the traditional requirements.

The NTBA programme sought to institutionalise a form of remuneration or financial support for TBAs not comparable to the services they deliver but based on the ability of the people to pay. The remuneration of TBAs was to be decided by each community. Communities were expected to improve on their previous methods of rewarding TBAs. In the words of one master trainer, “if thank you symbolized appreciation for the services of TBAs in your community then you were expected to build upon that”. In line with this, some trained TBAs with the consultation of their communities agreed on mechanisms of remuneration including specified fees for some of the services delivered by trained TBAs. Fees agreed upon ranged between C 2,000 and C 4,000 in the Builsa district and C 5,000

to C 10,000¹ in the Lawra District. In communities where a fee-for-service was agreed upon as compensation for the services of TBAs, problems were reported concerning the enforcement of payment. Trained TBAs in fee-paying communities reported only few clients paying for their services. Clients simply refuse to talk about the fees after delivery and TBAs also find it difficult to contact them. Profits accruing from the sale of contraceptives and ORS were also low, as communities were not patronising the sale of non-prescriptive devices.

The poor performance of the fee-for-service system introduced by most communities as remuneration for the services of trained TBAs may be explained by factors such as the social network of relationships in rural communities where trained TBAs operate. In the rural social setting, everybody is related to everybody else and in such cases a TBA cannot sit down aloof to see a kinsman in pain without offering assistance. It is also worthy to note that some aspects of life, especially healing, are not completely monetised among the people of the three northern regions. Furthermore, the kinship system continues to provide social support to its members and partly explains the problems involved in administering a fee-for-service system among rural communities.

It must also be remembered that TBAs perceive their services in midwifery delivery as divinely ordained since it is associated with procreation. As a result, most TBAs are therefore proud to be engaged in services committed to mankind. In spite of the lack of remuneration for their services, some trained TBAs are still enthusiastic about the fact that they offer vital services to their communities. For others too, time is not on their side. The burden of community services is becoming greater than they can handle on voluntary basis. In the latter's view, if "the people are refusing to appreciate the services we are rendering to them, then it is better we return the midwifery kits and call off our services".

6.8 CONCLUSION

Ghana launched a National Traditional Birth Attendant programme (NTBA) to bridge gaps between urban and rural peripheral areas in the provision of supervised maternal and child health care under the primary health care system. The importance of the NTBA programme was based on the realization that Ghana was experiencing serious

¹ Fees for 2000

inadequacies in maternal and child health. This was as a result of skewed distribution of modern maternal and child health services to the disadvantage of the rural poor, who constitute about 70 percent of the population and depend on traditional sources of care (GSS, 2000).

The programme was therefore meant to improve the quality and expand the scope of midwifery care of Traditional Birth Attendants (TBAs) in ordinary obstetrics and family planning. The NTBA also introduced a two-tier midwifery referral system meant to interface traditional and modern midwifery services delivery.

The findings show that the NTBA introduced aseptic methods of midwifery care among trained TBAs and promoted blue card referrals for vaccinations against tetanus and immunisations of children. However, the success of family planning services delivery by trained TBAs was mixed.

The core areas of community participation in the NTBA – the institutionalisation of fee-for-services and the restricting of the services of trained TBAs to ordinary obstetrics and non-prescriptive family planning – turned out to be the major contradictions of the programme. These two aspects of the programme were found to have great influence on the patronage of the programme by the various types of TBAs operating in the selected communities and the subsequent use of the services of trained TBAs by clients.

Furthermore, the NTBA, which started before the health sector wide restructuring and was later integrated into the plans and programmes of the districts and sub-districts, was still perceived by many health workers as a special programme requiring special funding.

CHAPTER 7

7.0 CASE STUDY II: HEALTH SURVEILLANCE PROGRAMMES AND COMMUNITY PARTICIPATION IN PUBLIC HEALTH ACTIVITIES

7.1 INTRODUCTION

In this chapter surveillance and disease control projects/programmes evolving around community participation are discussed. There are currently three types of surveillance programmes pursued by the Ministry of Health and its collaborative agencies in the three northern regions. These include: demographic surveillance, disease surveillance and growth and nutrition surveillance. Each of these programmes is built on community participation in its own peculiar way and this chapter looks at health surveillance programmes and community participation.

7.2 DEMOGRAPHIC SURVEILLANCE

The Navrongo Demographic Surveillance Programme (NDSS), which started in 1993, is modelled on a longitudinal population registration system that monitors demographic dynamics and supports studies on the determinants of morbidity and mortality and associated problems of high fertility in the Kassena Nankana District of the Upper East Region. The Navrongo Health Research Centre (NHRC) pilots the programme (BinKa et al, 1998).

7.2.1 Community Key Informants

Communities covered by the demographic information surveillance system are involved in the collection of vital data. Each community has an informant to the programme, designated as Community Key Informant (CKI). This is normally a respected and trusted member of the community. It is normally a person who can collect and release information about the community to an outsider without fear or interference from other members. As a result most Community Key Informants are male, advanced in age and normally a community elder or opinion leader. The community key informant acts as vital link between

the demographic field supervisor of the Health Research Centre and individual communities covered by the demographic surveillance system (Binka et al, 1994).

Prior to the community key informants' concept, communities were briefed about the demographic information system and the perceived role communities could play in it. Communities were later asked to present one representative each, most of who were appointed/selected during community meetings by popular consensus.

Community key informants collect vital information about his community on pregnancy, births, deaths and migration between the periods of successive visits of an assigned demographic supervisor to the village/community. This is always a period of ninety days. During this period, it is the responsibility of the CKI to ensure the collection and collation of all vital information and passing it on to the field supervisor so that no information is lost. This is done with the help of literate members of the community as most key informants cannot read and write. The field supervisor verifies and validates information during community visits. Validated information is passed on to the data unit for processing. The Navrongo Health Research Centre currently has a network of about 170 community key informants operating in all the communities covered by the surveillance systems.

As motivation for their work, key informants receive a token of money for every unit of vital information passed on to the supervisor. The project also motivates family members who assist with information on births to acquire birth certificates. Programme personnel indicated satisfaction with the performance of CKI so far because of their dedication to service and the reliability of the data they collect. Out migration, which is a cause of high attrition among other types of health volunteers, is low because CKIs are mainly aged. It is the view of programme personnel that the success of the system requires careful study for replication in health surveillance programmes countrywide.

7.3 GROWTH MONITORING AND NUTRITION SURVEILLANCE (GMNS)

Growth and nutrition surveillance is the heart of UNICEF's Community Based Development Programme (CBDP). The Ministry of Local Government and Rural Development (MLG&RD) implements the programme through District Assemblies. In the Northern and Upper East Regions, Yendi, Builsa, Tolon Kumbugu, Bawku East and Zabzugu Tatale and Savelugu

Nanton districts are currently implementing growth and nutrition monitoring programmes as components of the CBDP after the Tolon-Kumbungu pilot in 1996. It is estimated that the programme currently covers about seven hundred communities. The reduction of high levels of malnutrition and mortality among children and women and, the enhancement of the overall development of the districts concerned, are the main objectives of the programme (Brouwer, 1998).

The growth and nutrition surveillance has four components: growth monitoring of children under five years; nutrition surveillance; vaccination against major childhood killer diseases; and information, education and communication to parents with faltering growth. Communities were trained to participate in the weighing and monitoring process and on how to identify problems of malnutrition and mobilise resources within the community for their intervention using the triple – A approach: assessment, analysis and action.

The inclusion of communities in the process was to, among others:

- access them direct periodic information on their children's growth and nutrition status;
- enable communities take direct action on causes of malnutrition as part of their Village Action Planning;
- enable communities follow changes in the level of malnutrition in order to be able to assess the impact of implemented actions; and
- enable communities to track causes of malnutrition related to food intake and diseases such as diarrhoea and fever.

7.3.1 Community Weighing Teams

Each community has constituted a Community Weighing Team (CWT). Village Health Committees facilitate the selection of teams comprising of four people: two males and two females. These people have permanent residence status in their communities and are able to read and write. They also command the respect and trust of the larger community.

Community Weighing Teams (CWTs) were trained to equip them with the skills of weighing and knowledge of how to analyse and interpret the results to mothers of children under five.

The training covered the following areas below:

- the objectives of the growth monitoring and nutrition surveillance programme;
- responsibilities of Community Weighing Teams;
- how to carry out weighing;
- maintenance of scales;
- discussion of growth charts and how to fill charts;
- how to interpret growth chart; and
- discussion on problem about meeting and discussion of charts.

There were also practical sessions during the training where trainees held weighing sessions with children and were offered the opportunity to read their results for group discussion.

The detail responsibilities of the CWT's include the following:

- organisation of monthly growth and nutrition monitoring sessions
- calibration of weighing equipment before sessions;
- registration of under five children and their mothers;
- measurement of under five children during sessions;
- filling of questionnaire for under five children;
- filling of growth charts of measured children;
- calculation of medium weight-for-age;
- follow-up on non attendance;
- follow-up on parents with malnourished children for support;
- maintenance of equipment and material; and
- dissemination of results to entire community.

Data collected by the community weighing team are passed on for the Village Action Planning (VAP). This process is facilitated by a team comprising elected assembly members, technical officers from the Departments of Health, Agriculture and Community Development

and three village representatives of men, women and the youth. The Village Action Planning process is guided by the conceptual framework of the UNICEF Global Nutrition Strategy and the triple A-process of assessment and analysis of the causes and effects of the problems of malnutrition and the required action at the village/community level. An action agreed upon is adopted as a self-help action. Once a self-help action has been identified and adopted, VAP assumes the responsibility of resource mobilisation with the support of the District Assembly, UNICEF and other donors where possible (Brouwer, 1998).

7.3.2 Project Management and Supervision

A team of Community Health Nurses are attached to the programme in each of the sub-districts charged with the responsibility of supervision at the sub-district level. They also serve as links between the sub-districts and districts in providing backstopping and logistic support to Community Weighing Teams and other outreach staff involved in the programme. Among others, results on weighing sessions made on summary sheets are sent to the district while questionnaires, attendance and summary sheets are made available for weighing sessions at the community level.

The District Nutrition Officer and the head of MCH have overall responsibility for project co-ordination and supervision at the district. Their specific responsibilities include the following:

- making available logistics such as material, transport and fuel for the operations of the community health nurses;
- monitoring and supervision of community nurses at the sub-district level;
- compiling data from sub-districts; and
- providing information on changes in levels of malnutrition and predisposing causes.

7.3.3 Perceptions of Selected Communities about Growth Monitoring and Nutrition Surveillance (GMNS)

An evaluation of the first pilot communities of the GMNS in 1998 show that members of the community weighing teams, mothers, opinion leaders of four pioneering communities were happy with the programme.

Mothers were particularly of the view that they had acquired knowledge on malnutrition and faltering. They indicated that they were now able to monitor the health of their children. In one of the communities a mother remarked that “in the past weighing and filling of growth charts were done by nurses, and mothers did not understand what they did as they did not get enough information”. They did not understand what nurses were looking for by conducting the measurements. With the involvement of mothers in the process “we now understand what the charting process is about”. Mothers claim they are now in the position to discuss and find solution to the problems of faltering children. Similarly, mothers in another community noted that “we have seen the importance of preparing weaning foods and we have also learnt how to prepare these foods under this project”.

Members of Weighing Teams also expressed satisfaction with the programme. Weighing Team Members explained that they have acquired the skills to diagnose cases of faltering and to recommend solutions to mothers.

Members of the communities were equally satisfied with the programme. In two of the communities, men and women remarked that, “our children were healthier than before”. According to them, they no longer sent their children to Tamale hospital. They cited the incidence of convulsion, which used to be high to have reduced in the years following the implementation of the programme. This was corroborated by one opinion leader who stated that “ in the previous years I had to sell my goats to pay for the cost of treatment of my children, but this year I did not have to sell any goats”. These assertions buttress the successes of immunisations done alongside the weighing.

All the communities indicated that the results of the weighing sessions are discussed immediately after the monitoring sessions. Mothers have agreed upon the house of the community *makazia* as suitable venue for holding fora for the dissemination and discussion of results. During discussion sessions, steps are also taken to assist mothers with malnourished children find solutions to their problems. Some decisions taken in the communities under review include using local diets high in nutrition for baby feeding, stopping the habit of sending daughters-in-law to their mothers to deliver and the need to support literacy activities of women in their communities in order to optimise the benefits of the programme among others.

7.3.4 The Performance of the GMNS Programme

Some of achievements of the GMNS were reported to include increase in the motivation and interest of parents in child welfare activities resulting in overall increase in the number of children attending weighing sessions. In some of these communities men have developed interest in child welfare activities and encourage their wives to send their children to weighing sessions. Personnel of the MOH attributed increase in immunisation in the participating districts in 1996 to the GMNS.

Awareness was raised among parents and the larger community on issues touching on the growth and health of children. Quite particularly, was attention created on the need to take cases of moderate malnutrition of children more seriously.

Up-dated data on nutrition and growth monitoring are made available under the programme. For instance, the data arising from the weighing sessions are reported in the quarterly reports of the Sub-District Health Management Team. These data are used for preparation of project proposal and descriptions of the nutrition situation of children in the District. The Department of Community Development is also reported to use the data to monitor the implementation of the programme and training of Village Action Planning Teams.

7.3.5 Constraints and Challenges of the GMNS

Some challenges were identified with regard to programme implementation and data quality. It was difficult recruiting enough mothers who could read and write in project communities. As a result, it turned out that the only one member on the team who could read and write did much of the work.

There were also complaints about delays and time spent on weighing sessions. These delays were partially due to the late reporting of nurses to weighing sessions because they commuted from Tamale daily to the district without regular means of transport. Late arrivals to weighing sessions also meant that the supervision required of community nurses during the weighing sessions, was not properly done.

Other problems had to do with the quality of data collected by weighing teams. Various types of errors ranging from the use of scale equipment to reading and calculation errors were being reported (Brouwer, 1988). Reading errors were reported in each of the pioneering pilot communities. For instance, of the total of 154 cases of master list reading, 96 representing 66 percent of total cases contained reading mistakes. Reading errors or mistakes result in misclassification and underestimation of weights.

There were also cases where birth dates for the same child varied between the birth register and youth chart. For instance, in 18 cases (22.5%), the birth dates in the register was different from that on the growth chart. Similarly, in another 8 cases (10%) the birth date on the growth chart was later than the actual birth date resulting in the use of lower age in the calculations. Errors were also reported on the use of weighing equipment touching on how to zero and what minimum clothing the child should wear during weighing. Other errors detected had to do with filling of questionnaires. Prevalent among them was wrong entries and omissions. There were also problems of calculation.

7.3.6 Strategies to improve programme implementation.

Refresher training programmes to address problems of the quality of data (weighing process, filling of growth charts and reading master chart) as well as on how to use the data at the community level should be provided to the various stakeholders at the community level (mothers, CWTs, and opinions leaders) to sharpen their skills and attitudes about the programme.

Ways should be found to integrate the GMNS into the routine Management Information System of the Ministry of Health where it can inform planning and decision-making not only within MOH but other stakeholders of the district health system (department and agencies, and private-for-profit and the private sector engaged in health). Perhaps, the location of the data unit within the District Planning Unit will serve this purpose better.

MOH and the district assemblies must explore sustainable ways of increasing mobility of community Health Nurses to improve upon the supervision.

7.4 DISEASE SURVEILLANCE

The National Policy on disease surveillance requires that incidence on communicable diseases are reported by health institutions to the District Medical Officers with copies to the Regional Director of Health Services on weekly basis. However, certain diseases may be reported by the quickest means to the Epidemiology Division when immediate intervention is required.

The institutional hierarchy system is used for data collection and reporting on communicable diseases to ensure systematic and immediate notification on communicable diseases. Thus, MOH collates the data from the various institutions reported to it in the district, analyse them and make follow up if necessary, before forwarding the information to the regional office. At the regional level, the data from the various districts are collated and submitted to the Epidemiology Division in Accra at the end of every month following analysis and action at the region.

Data on non-communicable diseases are submitted routinely at the end of every month from individual health units, with other data on routine monthly morbidity activity reported to the centre of Health Statistics through the respective Regional Director of Health Services. The data on in-patient cases are also treated the same. The surveillance system has an in build feedback loop, where processed data is disseminated back to the districts and regions quarterly for planning purposes.

Although private modern health practitioners are indicated in the surveillance system, no reporting is done yet.

7.4.1 The Guinea Worm Experience

The major component of the strategy for the eradication of *Dracunculiasis* in Ghana is community surveillance. It consists of regular collection, synthesis and analysis of data on guinea worm cases in order to identify high-risk endemic communities and mode of transmission. The surveillance system is often preceded by a planning phase comprising base line and case search in endemic communities.

7.4.2 The Surveillance Structure

The guinea worm structure established the village volunteers at the village/community level. The village volunteer was linked to sub-district or zone through a Zonal Co-ordinator, who was in turn linked to the district by a District Guinea Worm Co-ordinator. At the regional level was the Deputy Regional Co-ordinator assisting the Regional Co-ordinator.

Under the guinea worm surveillance system for instance, worm incidence were reported by the village volunteer (VV) from an endemic community to the Zonal Co-ordinator (ZC) who collated the data at the sub-district level or zone and in turn, reported them to the District Co-ordinator (DC) at the district level. The District Co-ordinator synthesises the data from the zones for the Deputy-Regional Co-ordinator who also reported it to the Regional Guinea Worm Eradication Programme Co-ordinator. The Regional Guinea Worm Eradication Programme Co-ordinator was the senior medical officer responsible for public health in the region.

The same channel was used for purposes of health education, training and distribution of household filters. Support materials for these activities were transmitted from the regional level to the village or communities through the top-down approach. At the village level, village volunteers were responsible for health material distribution and submission of returns.

The guinea worm surveillance structure in the Northern Region for instance covered twelve of the thirteen districts consisting of twelve District Co-ordinators, two hundred and twenty Zonal Co-ordinators and about five thousand volunteers, one-half of whom were females. Again, we see a vertical arrangement emerging for project management under the guinea worm control programme.

7.5 THE COMMUNITY BASED SURVEILLANCE SYSTEM (CBS)

The community disease surveillance system was first started in the Northern Region in 1998 as a replication of the guinea worm experience in integrated disease surveillance. It was extended to cover the Upper West and East regions in 1999 and the entire country in 2000.

As the name implies, this is a community based surveillance system built upon the guinea worm surveillance system. Central to the programme is the Guinea Worm Volunteer who was trained on disease surveillance in order to tap on his experiences on guinea worm surveillance. Building on the experience of village volunteers and the support enjoyed from their communities, the responsibility of village volunteers was expanded to cover the surveillance of other diseases in their communities beside guinea worm. The structure of the guinea worm surveillance system was also expanded under the community based surveillance system to enhance the performance of the new role assigned the volunteers. Areas affected in the restructuring were the zones and districts. In the Northern Region for instance, 80 extra zones were created and the 12 districts carved into 24 to ensure effective information reporting and dissemination under the community based surveillance system.

7.5.1 Elements of the Surveillance System

Diseases monitored under the community surveillance system are *cerebra spinal meningitis* (CSM), acute flaccid paralysis (AFP) with polio and measles in addition to the guinea worm. In 1999, neonatal tetanus was added to the list of diseases. These diseases were considered to have “serious health importance and high priority in the regions” according to health authorities. In addition to the public health importance, the diseases covered are infectious and the reporting of which has always been militated by socio-cultural factors. Volunteers are also expected to collect information on births and deaths because of the public health concern of these vital events. Information on births and deaths are analysed further. In the case of births, name, age and sex should be provided. Deaths are also to be categorised into infant, maternal and other deaths.

The surveillance structure of the guinea worm programme was adopted for the reporting of diseases and vital events covered by the community surveillance system. Information about birth/death episodes and incidence of the listed diseases collected at the community is reported to the Zonal Co-ordinator or sub-district staff at the end of the month. However, the volunteer is expected to report serious episode cases to the Zonal Co-ordinator immediately for transmission to the nearest health facility for verification and action.

These reported data are analysed at the sub-district level. Incidents requiring immediate action are attended to at that level. At this level, all maternal and infant deaths are thoroughly investigated. Verbal autopsies are conducted to establish the causes so that

potential epidemics are detected early for action. New births reported are also traced to ensure that children are placed on routine immunisation and receive doses of vitamin A.

Districts undertake visits to their sub-districts at the close of the month for the data. These data are then collated at the district level. Where necessary, follow-ups are also done on special cases. Finally, teams from the Regional Community Surveillance Unit visit the districts by the middle of the month to collect the information. These data are then inputted and analysed with a computer and the information partially integrated with the health information system of the disease surveillance unit (Maes & Zimicki, 2000).

7.5.2 Functions of the Volunteer under the CBS

Aside the provision of a community register on vital events and on incidence of diseases, the volunteers also assist in mobilising communities for the provision of health services during national immunisation exercises, immunisation mop-ups organised occasionally to cover less accessible areas and for the distribution of vitamin A supplements in rural and outlying districts, especially during the farming season. Volunteers are also expected to carry out health education on epidemic borne diseases such as diarrhoea, cholera, CSM, anthrax and malaria. The volunteer is also the intermediate link between the community and the health system.

7.5.3 Retraining of Volunteers

CBS volunteers were trained in the use of disease/events register and the diagnosis or identification of the clinical symptoms of the disease covered by the surveillance system. Since most volunteers are illiterate, diseases and events are presented pictorially on sheets of paper with spaces provided beside them for simple tallying. One sheet is provided for a given month with twelve constituting a register for the year. Local names were identified and agreed upon for all the diseases and events covered to enhance reliable reporting. A volunteer indicates a tick besides the appropriate disease or event episode that occurs in the community or village. In larger community, village volunteers depend on community members for information on morbidity/mortality cases. A two months pilot programme was also organised for volunteers with supervision from health staff in the Builsa and Lawra districts where the programme was newly started.

7.5.4 Performance of the CBS System

Information from monitoring reports conducted in the Northern Region in 1998 show that a total of 3776 communities/villages were reporting on the village surveillance system by December 1998. Of these the communities reporting monthly increased from 51 percent in January to about 75 percent by December 1998 and 74 percent in 1999 (Maes & Zimicki, 2000). In the Lawra and Builsa districts, reporting started in September 1999 with only some of the sub-districts.

The data show that reporting is not timely in most districts as zonal co-ordinators often wait for volunteers to send reports to them instead of the other way round. Some other reasons that were reported to lower reporting rates included difficulty in access due to seasonal rains as well as routine difficulty of access to "overseas" communities. In addition, there were reported cases of shortages of funds for reimbursement of transportation cost incurred by zonal coordinators.

Evaluation conducted on data reliability in March 1999 also revealed that only data from two out of the thirteen districts were reliable. Reported data problems stem from errors on information compiling, child and infant definition and lack of information validation. Regular monitoring and refresher training for volunteers are steps planned to overcome problems. Most volunteers do not know the cut-off point between the ages of an infant and that of a child, when reporting infant and child deaths. As a result most infant deaths are classified under children. There is also a problem of identifying maternal death that occurred few months after pregnancy or delivery.

The data also show that there are no problems identifying the diseases covered by the surveillance system except neo-natal tetanus (deaths within 28 days of birth) stemming from socio-cultural factors. This is because such deaths are often not classified under infant deaths and as such not suggestive of neo-natal tetanus for further investigation.

The majority of volunteers cannot carry out analysis of births and deaths because of the high illiteracy rate among them. Two out of every three CBS volunteers are illiterate in the Northern Region and in the Upper East and West Regions, the situation is better; where one of every three is an illiterate. The data also show that except in the Upper

West Region where there are a few female volunteers, almost every volunteer is a male in the Upper East and Northern Regions.

The three northern regions have high prevalence of vitamin A deficiency among children in the country. As a result the regions have put in place a supplementation programme, with the support of UNICEF, where children between 1-5 years receive doses of vitamin A each year. The vitamin A supplement programme is tied to the community surveillance programme. An assessment of the programme indicates that the CBS system has helped to define the target population that requires vitamin supplements by districts and even communities. Also, with volunteers providing vitamin supplements at the community/village level, mothers no longer have to travel longer distances to obtain supplements and that has gone a long way to improve vitamin A deficiency among children in the region.

Beside this immediate use put to data from the surveillance programme, available data show that there is low awareness of the practical uses of the data collected from the surveillance programme among volunteers and staff of DHMTs in the region. This is demonstrated by the fact that less than 25 percent of the districts in the Northern Region have utilised the data for planning purposes since the inception of the programme in the Northern Region, two to three years ago.

Thus, the surveillance data serve a crisis management function in the three regions covered. The system has signified the early detection of diseases especially reporting on strange events such as sudden deaths leading to the detection of anthrax, cholera etc. The death of ten infants within a specified time in the Zabzugu District created attention to the lack of maternal and childcare services in the area leading to the establishment of a clinic.

However, looking at the routine data as basis of planning (on any) other actions, not much have been done. As usual the data is collected, inputted and that ends it.

7.5.5 Perceptions about the Benefits of the CBS

Community members indicated that through the system the volunteer “gives health people reports about the diseases of the village and this has resulted in the improvement of the health of the community”. Others indicated “we now see health personnel more often in

the community” or that “relationship with health workers has improved” resulting in “improvement in responses to our health situation”.

In the case of the CBS volunteer, some of them stated that the system “helps people to be free from diseases”. “We are able to find illness and eliminate them” and that “people are getting aware of their health”. One recurrent response was that the CBS has introduced a partnership between the health system and communities through the community level health workers.

Health personnel on the other hand indicate that the programme “facilitates easy and early reporting and ensure vigilance at the community level”. “As an opportunity to get the community involved so that they understand their health problems”. “To know what problems the community has so that the SDHT can act”. Sub district personnel reported that “their community members were more co-operative now” and that they use the data from the CBS for planning purposes. The CBS “helps us to know what is going on in the villages and this makes planning easier”.

7.5.6 Motivation

Besides minor allowances and incentives in the form of T-shirts given to volunteers during yearly refresher workshops, the driving force for many rural based CBS volunteers is their motivation to serve their communities. In the view of these category of volunteers “ we offer services to our communities and that makes us feel satisfied”. For the urbanite volunteer the motivation comes from the fact that they serve as first-line contact for development agents in their communities. The job offers them the opportunity to interact with health personnel coming from outside the community on regular basis.

No institutionalised support for volunteers by the communities they serve were reported. Thus, in the Northern Region, free medical treatment has been instituted for sick volunteers.

7.5.7 Challenges of Community Surveillance

High illiteracy rate among volunteers is one of the problems confronting the surveillance system. The problem of data quality and the inability of communities to use data, stem from the high illiteracy rate among volunteers.

The mobility of volunteers is also found to be limited. Most volunteers are handicapped in their community movements because of lack of transportation. This often impedes the swift reporting schedule required by the system.

The system works well under strict supervision along the ladder. However, supervision is a problem at the zone level and below. Health professionals indicated that quarterly instead of the monthly monitoring is done because “new issues keep cropping up – NID, training invitations to the regions, workshops and so on”. A regular supervision system should have been able to reverse some of the errors and mistakes besetting the system. Sub-district and district level staff blamed the problem of supervision on the lack of competent health personnel.

Motivation is also identified to affect the system. One health staff laments about the dwindling spirit of voluntarism in rural communities. There is thus a volunteer fatigue that is working without any assistance/support. This results in the lack of commitment of volunteers.

It could be said that communities are acting as agents of information generation for the health services under the CBS system in the interim. Steps should be taken in the coming years to ensure greater community participation in the programme especially with regards to uses the data can be put to by communities so as to improve their social and economic status.

7.6 DISEASE CONTROL

7.6.1 Malaria Control Programme

The Accelerated Programme for Malaria Control has a community participation component and was implemented since 1992 in all the regions of Ghana. The WHO guidelines, objectives and strategies for prompt and adequate treatment of malaria cases to reduce mortality and morbidity are being followed. Consequently, there has been a series of training programmes for both medical personnel and community members in malaria management and control in order to improve upon efficiency.

Yendi District was one of the selected districts for the accelerated implementation of malaria control programme. Community level activities of the programme covered the following:

- training of TBAs, traditional healers and chemical sellers on correct dosage of chloroquin and paracetamol;
- training of mothers and child caretakers in the recognition and management of fever;
- provision of malaria treatment guidelines to Community Based Health Workers [CBHW]; and
- community sensitisation about the availability of malaria services in their communities.

The implementation of the programme was preceded by an advocacy on malaria control in order to draw attention to the importance of the disease and to marshal community support and involvement in the eradication programme. Advocacy programmes targeted traditional chiefs, opinion leaders and women representatives. Community based health workers in the district benefited from the training of malaria management as a means of preventing and reducing malaria related morbidity. Various categories of Community Based Health Workers that benefited from the training included the following:

- 32 Staff members from nurseries and crèches in Yendi and its environs
- 38 TBAs
- 63 Village Health Workers /Volunteers

- 27 chemical sellers and others

Programme implementation was affected by the 1994 ethnic conflict, thus bringing programme activities to a halt in the district

7.6.2 Malaria Bed Net Programme

The use of impregnated material as a tool to vector control of malaria started in the second half of the 1990s in the Northern Sector of Ghana. The Insecticide Treated Mosquito Nets programme (ITN) was started in Yendi and Builsa after the success of an earlier trial in the Kasena Nankana District. The ITN was a programme of co-operation between the GOG and UNICEF from 1996 – 2000. The programme was supported by DFID, formerly British ODA (Elden et al, 1999).

The objectives of the programme were to:

- promote the use of ITN as a component of the National Malaria Control using Community Based Projects in the two districts;
- demonstrate the feasibility of introducing ITN at an affordable cost for rural communities;
- strengthen community structures for distribution, treatment and monitoring of mosquito nets and chemicals in the districts concerned; and
- support collaboration of health authorities and district assemblies in responding to the problems of malaria.

The ITN programme covered a total of twenty-five communities. Ten communities were in Yendi while the remaining ones in the Builsa District.

7.6.3 Elements of Community Participation in ITN

The programme was integrated with other Community Based Development (CDB) activities and co-ordinated by the Village Action planning (VAP) teams at the community level. A VAP team constituted seven members comprising three community representatives, an

agricultural extension worker, a district assembly member, an extension officer from the Department of Community Development and a community health nurse.

There was a local agent selected by the community to be responsible for stocking and sale of nets. The agent obtained his supplies from the District Assembly stores, which was issued to community members based on terms of financing agreed with the community.

Each community also selected a treasurer, who undertook monetary transactions concerning purchasing of nets. Payments from the sale of nets were made to the community treasurer who passed it onto the District Finance Officer (DFO) for saving with the Bank. In Yendi, sales from nets were lodged with an account for Community Based Development Programme [CBDP] activities. In Builsa a separate account was operated with the rural bank at Sandema for bed net sales.

There was a community agent in charge of the treatment of nets at each of the twenty-five communities. In the Builsa District there was a two-member treatment team who oversaw net treatment. A token was collected for every treatment undertaken.

UNICEF supplied nets and permethrin for the programme. These were stocked at the district medical store/district assembly for supply to community agents on request with payment of nets done during subsequent request for more nets.

Communities participated in the planning and decision making of the project especially concerning the modalities for financing the nets was high. The prices of nets were fixed taking into consideration the purchasing power of target communities and the prevailing prices of nets in the open market. The prices of nets enjoyed subsidy from UNICEF in order to make them affordable. Once prices were fixed for the different type of nets, communities evolved their own selling mechanism. Two of such methods were in use at the time of the data collection: full purchase and part payment. Under the latter, the customer contributes gradually towards the cost of the net and takes delivery when payment has been fully effected. The pricing system introduced some flexibility in the sale of nets and made it possible for community members unable to make outright purchases to own nets. Agents were expected to keep records of sales, including information on the background of purchasers of nets.

At the district level, the ITN programme was integrated with the UNICEF supported rural community based project (CBDP) and co-ordinated by the District Co-ordinating Director. In the Builsa district for instance, a three-member Monitoring Committee (MC) to enhance project implementation was put in place. The DDCD, a representative of MOFA and the Community Development Officer in the district were members of the committee. The committee had the overall responsibility for monitoring and coordinating the ITN activities and for linking up the various components of the project.

Training was provided to the various programme actors. VAP teams and extension staff were trained to provide IE&C on the causes of malaria, prevention of the disease, vulnerable groups and the usefulness of bed nets. Similarly community agents received training on record keeping and treating of nets.

7.6.4 Benefits of the ITN

A progress report on the ITN programme in 1999 revealed that there was a high level of awareness about the treated mosquito nets in the communities visited. There was also positive change of community perception about malaria and an improved appreciation of the relationship between mosquitoes and fever/malaria than previously reported in the baseline data. These changes were partially attributed to the IEC activities of the VAP teams (Elden et al, 1999).

Discussions with some few men and women who owned nets testified to the benefits of treated nets thus “the nets are killing mosquitoes, bed bugs and other insects which get in touch with them”. Some respondents reported few cases of malaria since they started using the nets. One schoolteacher said he had spent less money on mosquito sprays and malaria drugs since he started using nets for himself and the family.

There was evidence of community participation in all major aspects of the project particularly during the situational analysis, distribution and treatment of nets, selecting and instituting a locally acceptable financing scheme, and in monitoring project activities. There appeared to be successful intersectoral collaboration between the health sector and other sectors notably the district assembly, unit committees, and VAP teams.

The UNICEF subsidy of the nets and the flexible financing scheme adopted by communities, helped in making ITN more accessible to the rural communities surveyed.

7.6.5 Constraints

Although intra stakeholder working relationship was reported to be good, for instance VAP Team members working collectively and community agents and treasures co-operating, that of inter stakeholder collaboration needed improvement. The different stakeholders appeared to work in isolation in most cases. There was no single person with the responsibility for linking up all the different aspects of the project.

There was an initial misunderstanding about the sale of the nets in some communities in the Upper East Region especially in communities sharing boundaries with the Navrongo trial project area and in the community base development project area where the nets were being sold. This was because the trial communities were supplied nets free while those in the community base development area paid for their nets. It took some time to get this erroneous impression dispelled.

Lack of funds for out-right purchase of nets was also raised. Although credit sales were allowed with procedures for repayment, many net communities were reluctant to continue with it because those who bought on credit were refusing to pay. In some communities the number of debtors soured. In spite of the problems mentioned above, the programme was reported to reduce the incidence of malaria in the community especially among mothers and children.

7.7 CONCLUSION

There are currently about three distinct surveillance programmes pursued by MOH and its collaborative agencies in the northern sector of Ghana: disease surveillance, demographic surveillance and growth and nutrition surveillance. The programme activities of each of the above are built on community participation requiring the selection, training and use of community members in defined surveillance activities such as reporting of special events or diseases, collation of information and use of data collected for informed health decisions at the community level and above.

The findings show that surveillance structures have expanded health service structures for reporting on important health diseases and events resulting in the generation of lots of data at the community level. It has also created awareness about the causes of some health conditions and promoted healthy lifestyles.

The main problems about community surveillance activities have to do with the quality of data generated and putting data to effective use.

CHAPTER 8

8.0 COMMUNITY HEALTH WORKS PROGRAMME CASE STUDY III: VILLAGE HEALTH WORKS

8.1 BACKGROUND

A nationwide programme to make Village Health Workers frontline health workers was launched by MOH after the success of the Danfa and Kintanpo WHO-sponsored experiences. Prior to the national programme, Village Health Worker programmes in the northern sector of Ghana were small scale and dictated by the discretion of the MOH and the different NGOs engaged in the health sector. In the Northern, Upper East and West Regions, the Catholic Health Services, the Presbyterian Health Services and Ministry of Health were pioneering institutions implementing small-scale VHWs programmes until the standardisation of the programme by the Ministry of Health with support from UNICEF in the late 1980's.

Village/Community Health Workers programme assumed a national dimension following the establishment of the District Health Management Team concept in 1986. The management team structure, spanning from the region through to the district and later the sub district, became the institutionalised structure overseeing the implementation of the programme. The programme was abandoned between 1993/94 because of the excesses of some Village Health Workers who gave injections and traded in drugs outside their mandate of operation. As a result, the programme, especially that of the southern sector of Ghana, was discontinued. However, the northern sector, because of its peculiar situation of persistent staff shortage, was encouraged to continue with the programme. Health sector managers reported that the inertia of the southern sector later caught up with the north around the second half of the 1990's, especially in 1996/97. Currently, only some CHAG organisations such as the Presbyterian Rural Health Services and the Church of Christ operate Village Health Workers programme in the Yendi and Builsa districts in particular. Village or Community Health Workers Programme has been described as "bridges" between communities and health services in the global vision of health for all (Ofosu-Amaah, 1983) and as "pillars" of Health for All (WHO, 1987).

8.1.1 Selection of Village Health Workers

In the northern sector of Ghana, and elsewhere, communities undertake the selection of CHWs since they know their people better. Selection is done in a number of ways ranging from consent to voting for members during community meetings arranged purposely to select VHWs. In most cases, community leadership in the form of chiefs/opinion leaders, church elders are involved in recommending the appropriate people. The involvement of church leadership, particularly by church-based NGOs in the selection process is meant to check abuses associated with the selection process as was discovered with pioneering and national based programmes and to ensure that qualified and responsible people are recruited for the work.

Among others, people with the following qualities are often preferred:

- community spirit/interest of community at heart;
- dedication to serve;
- permanent residence in the community;
- ability to read and write; and
- strong and energetic community members.

As a means of ensuring that committed and well-behaved people are recruited, most communities select trusted, reliable and respected members to serve as VHW. Although literacy is a criterion, it is seldom met in most communities. Interactions with communities revealed the few available literates enlisted, are often school dropouts who offer themselves as stepping for employment. Similarly, although most programmes encourage female to enlist, the gender mix is often difficult to fulfil. As a result most functioning volunteers are male. In the Builsa District for example, only twenty percent of Village Health Workers were female.

8.1.2 Training

The different Village Health Worker programmes use different training modules based on the WHO recommended curriculum for training VHWs (WHO, 1987). The content of most training programmes normally centre on the following:

- environmental hygiene and sanitation issues;
- child and maternal care, especially in the area of nutrition and immunisation;
- water hygiene;
- first aid and primary health care especially in the care and treatment of diseases such as malaria and diarrhoea;
- cases requiring referrals; and
- drug dispensing and management.

Recent training programmes address the management of STIs including AIDS and environmental issues. The length of training normally vary between the different programmes and spans between two weeks to a month.

Discussions with personnel of church-based health organisations revealed that their VHW programmes normally comprised a practical training component where trainees work on attachment with a clinic or on outreach rounds to demonstrate mastery in the skills expected for the work. Emphasis is placed on the following during the practical training:

- ability to weigh children and do charting;
- dispensing of drugs appropriately;
- consultation; and
- record keeping.

Trainees are passed out after successful completion of the programme. The graduation ceremony takes place as part of a community durbar where communities with grandaunts are invited to participate. During this ceremony, members of the community are educated again about the programme. They are also told about the responsibility of the community towards the VHW. Trainees are certified during the ceremony and the certificate acts as the legal basis for their operation.

After graduation, VHW are supplied drug kits. They receive prescription guides/booklets indicating the conditions under which the different drugs provided should be dispensed. In addition, the book entitled Where There is No Doctor is provided by some church based organisations.

8.1.3 Functions of Village /Community Health Workers

Functions performed by village and community health workers vary by the different programmes; the functions performed by them in the northern sector of Ghana however cover a vast area of health concerns.

The provision of levels A- health service is undertaken by VHWs. As required by the PHC systems, level A or community health services are to be provided by trained community members serving as community health workers. This explains why some programmes, especially the Church of Christ Primary Health Care programme, refer to them as Primary Health Worker [PHWs]. Care provided at this level covers first aid, treatment of minor illness, dehydration, cuts and wounds, malaria and diarrhoea. Village/Community Health Workers are trained and provided with first aid kits containing 'basic drugs' such as chloroquine, paracetamol, vitamins, oral rehydration sachets, gentian violet etc, to care for the primary health needs of their communities. UNICEF provided kits under various programmes including the Bamako Initiative in the Yendi District of the Northern Region. The Presbyterian Primary Health care programme also provides drug kits to its village health workers operating in the Upper East Region. These drugs are sold at mark-ups in order to sustain drug revolving funds provided under the programme. Under the Bamako programme for instance part of the profit accruing from the sale of drugs was used for the motivation of Village Community Health Workers and community development initiatives.

According to sub-district personnel, Village Health Workers conduct home visits in their communities. These visits are undertaken to encourage people to attend child welfare clinics and antenatal care delivered through outreach services by the sub-district health services to their communities. Home visits are also undertaken to monitor sick people who were treated during outreach visits and discharged, to assess their progress.

Village/Community Health Workers assist in community entry and social mobilisation for health activities in their community. These involve awareness creation about health programmes and services. Community members are informed and encouraged to participate in outreach services, immunisation programmes, national immunisation days and special health durbars or talks. They serve as interpreters to health personnel who do not understand the language of the locality.

Communities within a sub-district are served through outreach programmes. These are arranged periodically, usually monthly. Community health workers reported they complement the effort of sub district staff in the provision of these services. Services rendered normally cover the tidying of outreach sites, arranging furniture as well as assisting with weighing, immunisation etc. done under the supervision of outreach personnel.

In line with the PHC three-tier health care system, Village Health Workers are expected to refer illnesses that require specialised or secondary care such as injections to the health facility. To strengthen this provision on referrals, personnel of some church based programmes reported they have made their VHWs now responsible for ambulance calls. VHWs make ambulance arrangements for the transportation of referred patients to a health facility. Bicycles have been provided to facilitate the effective performance of this duty and in the view of VHWs this has averted delays previously associated with referrals under the National VHWs programme. Sub-district health staff responsible for the operations of VHWs also reported improvements associated with referrals by VHWs in their sub-districts as a result of the availability of bicycles to them.

VHWs also had the responsibility for water issues: the protection of water sites, site construction and care, collection and determination of tariffs and hygiene and sanitation. The latter function has been de-linked from their current roles following the establishment of Water Management Committees to be solely responsible for water under the community water and sanitation programme.

Some district and sub-district health managers overseeing VHW programmes reported that pioneering VHWs were trained to administer injections in some parts of Ghana. However the abuses in the administration of injections, impersonations as doctors by VHWs and problems stemming from practical difficulties in the storage of vaccines and sterilising of needles resulted in the termination of the administration of injections by VHWs.

8.1.4 Motivation and Community Support

Once a community selects its Village Health Workers it is normally its responsibility to support them in the delivery of the services they provide. District and Sub-district teams indicated that members of the community are expected to evolve ways of motivating their VHWs on sustainable basis. For instance, under pioneering programmes, communities decided to provide labour on the farms of VHWs to compensate for the time lost, as a result of the services they provide to the community.

Discussions with VHWs and members of communities show that no systems of motivation for VHWs have been institutionalised in the three northern regions. In fact, there are no records of institutionalised community support to Village Health Workers under any of the programmes. Even those communities that decided to support their VHWs could not implement the decision on long-term basis. This partly accounts for the collapse of earlier programme and it is also the subject of perennial complaints among VHWs in recent times even though many of them indicated they became VHWs initially to assist their communities or out of patriotism.

The Bamako Initiative also made an arrangement for VHWs to receive a fraction of the mark-up accruing from sale of drugs, as motivation (UNICEF, 1995). However due to poor sale of drugs resulting in low turn over, this has not been possible in many of communities. As a result of the above, various programmes have institutionalised ways of motivating VHWs. One means of support, although not consistent, is incentives provided during training in the form of feeding stipend, T-shirts, lanterns and kerosene etc. Some Church based programmes such as the Presbyterian Health Services have institutionalised elaborate motivation packages including outreach stipend and free medical services to Village Health Workers. They have also institutionalised yearly best Village Health Worker award schemes to provide motivation to VHWs.

These rewards, though an improvement over those provided under MOH's pioneering programmes, are still considered meagre by VHWs. According to VHWs, they cannot constitute sustainable support for committed and hard working Village Health Workers. As a result the search for a sustainable system of motivating VHWs has become a perennial issue and one cannot hold a meeting with VHWs without the issue coming up for discussion.

8.1.5 Monitoring and Supervision

The supervision of Village Health Workers is normally the responsibility of the trainers. However, various programmes made specific arrangements for supervision and monitoring. The Danfa and Kintanpo programmes used Community Development Committees [VDCs] in addition to the Health Education Assistants [HEAs]. The Village Development Committees monitored attitudinal and financial aspects of the programme while the HEAs focused primarily on PHC activities including Health Workers and TBAs. Similarly, the NORRIP trained Village Extension Teams (VETS) to undertake the supervision of Village Health Workers and Volunteers. Currently, Community Health Officers [CHOs] have the responsibility for supervising VHWs or volunteers under the proposed Community Based Health Planning Strategy [CHPS] (Ofosu-Amah & Neumann, 1979; MOH, 1999).

Monitoring is tied to outreach programmes under the church based VHW programmes to ensure that trainers of VHWs and sub district staff conduct regular and extensive supervision visits. Furthermore, quarterly review meetings are organised for peer problem solving among VHWs. These meetings bring VHWs within the sub district together and offer opportunities for reinforcing information on difficult tasks.

Except the church based programmes and special MOH projects such as the Kintanpo, Danfa and UNICEF programme districts, supervision of VHW was reported to be sporadic and ad-hoc. This was particularly so with the large-scale national programme. Factors including mobility problems arising out of lack of transportation, lack of logistics and inadequate staffing were indicated to account for irregular supervision and monitoring.

Supervision serves the following functions:

- checking treatment and records of finances on the activities of VHW;
- provision of logistics such as drugs; and
- checking performance against guidelines.

As a result a lot of things go wrong when monitoring and supervision are irregular because logistics supply and supervision were tied together. These together with the lack

of motivation and support for VHWs partly explain some of the problems associated with earlier VHWs programmes.

8.1.6 Performance of VHWs after Training

Unlike earlier or pioneering VHWs who engaged in practices outside their recommended role such as performing injections and the administration of drugs requiring prescriptions, sub-district staff and directors of church based health services indicated VHWs under small scale and pilot programmes are performing up to expectation. According to staff of the Church of Christ and the Presbyterian Health Services, VHWs assist health personnel during outreach services, carry out FIRST AID care, do social mobilisation and disseminate information on health issues in their communities. In 1998, VHWs reported to have attended to about 300 patients and made 24 ambulance calls in the Builsa district alone.

Programme personnel of the Presbyterian PHC reported few cases of mismanagement of drug kits and misbehaviour resulting in the withdrawal of kits and the licenses of VHWs. This is perhaps an indication that with the right supervision and support VHWs can really act as bridges of the Primary Health Care programme.

8.2 VILLAGE HEALTH COMMITTEE PROGRAMME

In line with the requirement of the PHC, Village Health Committees were to be established at every community or designated level A service point. The committee was to serve as the local arm of the MOH charged with the responsibility for co-ordinating and overseeing general health care and management including the operations of VHWs, TBAs, other volunteers and water, hygiene and sanitation committees. Water activities were later taken over by water committees, established solely for that purpose.

8.2.1 Selection

The selection of committee members was similar to that of other village/community level health workers, however, the composition of the team was guided by two criteria: that used by MOH and its specialised programmes such as NORRIP and Navrongo pilot on the one hand and the criteria employed by NGOs, especially CHAG on the other. Examples of the CHAG programmes are those currently ran by the Presbyterian Rural Health services and the Church of Christ PHC programme in the Upper East and Northern regions respectively. The MOH concept of a VHC is to integrate existing VHWs operating within a community or village into a body or committee in addition to that, the NGOs, demand the representation of other distinct community groups such as traditional leadership, women and youth, depending on the community under consideration. The criteria of the NGOs seek to forge bonds between the health workers in a locality and other existing groups. Hence, in heterogeneous communities, sectional representation is demanded on the committee. As a result, membership of committees ranges from three to eight, depending.

Positions and responsibilities are shared among committee members to make them effective. Common positions existing on committees include the following: chairperson, secretary, treasurer, and hygiene and sanitation officer. Occupants of positions fulfil recommended responsibilities that go with the position. The position of hygiene and sanitation was created for information; education and communication purpose, geared towards eliciting attitudinal changes. Local health workers were expected to sit on the committee as ex-officio members and to participate in the activities of the committee during meetings.

8.2.2 Training

The training of VHCs centre around two key issues basically: training in leadership and problem solving on the one hand and in resource mobilisation and management on the other. The training on leadership focuses on skill development for the positions they occupy on the committee and also in team building. The management-training component on the other hand covers record keeping and aspects of financial management and accounting. The latter was designed to equip committees with skills needed for drug procurement and monitoring, and in aspects of resource management for community development programmes.

In addition to the above, the committee receives training on the PHC concept, especially the hierarchy of referrals and the working of a sub-district. The depths in which these are treated vary from one programme to another and the duration of the training programme.

A few VHCs' respondents in the Seniesa Sub-district of the Builsa District indicated that the training they received has been useful for their task performance but would require additional training about the policy on exemptions and aspects of health financing in order to make them more effective. They also need frequent refresher training in aspects of financial management.

The general impression about VHCs by health professionals in the district and sub districts was that they have become dormant in many communities where the MOH operates.

8.2.3 Functions VHCs

As indicated somewhere in this chapter, community health committees are local health development structures charged with co-ordinating and overseeing health issues at the community level. In line with this objective, committees play a vital role in problem solving. They handle conflicts between outreach health staff and communities. They also play such roles as assisting new health personnel posted to communities, especially sub districts to settle by finding accommodation etc. for them.

One tradition inherited from the Bamako Initiative is the responsibility of the committee to procure and monitor drugs including the operation of drug accounts. This was an attractive aspect of the job among committees and in some communities; VHCs were reported to have mismanaged their revolving drug funds.

Under the church based programmes, VHCs drug-resolving accounts are managed at the sub districts while VHWs are supplied with drug kits, which they replenish on periodic basis, usually after the sale of drugs. Under these arrangements the responsibility of the committee is assisting village health workers unable to pay for drugs retrieve the money from debtors. In some communities VHWs have depleted their boxes because of credit sales.

One other responsibility of VHCs is to mobilise the communities toward the provision of structures to house the operation of Community Health Workers. In the past, this was described as the period of community clinics where almost every community constructed a structure no matter the suitability. These structures were constructed mainly through community mobilisation of labour and other resources such as land and money in some cases. In some communities local materials were used for building and roofing and in others, cement and roofing sheets were secured through NGOs to supplement local effort.

Although many of these structures have collapsed due to lack of maintenance, some of them have been upgraded into health posts and are still currently operational in some sub-districts. The contribution of communities through the provision of labour, land, and in some cases cash, has come to stay and some NGOs refer to it as the demand driven approach to community development.

8.2.4 Decision Making

VHC guidelines require them to hold periodic meetings. Two types of meetings are recommended: Committee meetings and one for the entire community. The latter are meant to solicit the views of the community about important issues as well as keeping the community informed about the working of the committee. Regular meetings are envisaged to make committees transparent and responsible to their communities and to whip the interest of the larger community on matters of the committee.

The data revealed that VHCs hold both meetings. Committee meetings are always a preparation for general meetings and are held to seek consensus on issues requiring the co-operation and involvement of the larger community. However, as a general rule among VHCs meetings are not regular once committees have been established. The tendency is to find VHCs meeting frequently when newly established, however meetings are organised as and when there is a problem when committees become old. Community representatives contacted indicate that 'we used to meet often, every market day, but these days we meet when there is a problem to solve'. 'What is the point meeting when there is nothing for discussion' retorted a member. One other problem indicated by members of committees is that members want to be entertained any time they attend a meeting.

Members of VHCs also indicated that organising meetings in the wet season is often difficult as that is the period when people are busy. During this time meetings are organised only when it is absolutely necessary.

Meetings centre on issues concerning social and resources mobilisation towards the construction of community clinics during the inception of the programme.

8.2.5 Monitoring and Supervision

Supervision of VHCs is the responsibility of their Sub-district Health Management Teams. However, donor-sponsored Village Health Worker programmes may devise specific approaches for ensuring that supervision is carried out. For instance, under the NORRIP programme, VHCs were supervised by Village Extension Teams [VETS]. Similarly, Community Health Officers [CHOs] are charged with the supervision of VHCs under the Navrongo Pilot programme.

Supervision by sub-district personnel may take the form of outreach visits and periodic review meetings. The latter methods are used by the Presbyterian Rural Health Services. Supervision has been found to be regular among special programmes and church based ones.

Supervision serves as motivation to members; among some VHCs the occasional interaction with sub-district staff spurs them into action. It also serves as an opportunity for members to discuss other programmes and problems with sub-district staff in order to find solutions to them.

8.2.6 Constraints of VHCs

Only very few VHCs are functional currently. In the northern regions, the activities of VHCs are still going on only in some parts of the Upper East Region. These areas are the Presbyterian operated sub-districts and the Navrongo piloted districts for VHC programme. In fact, with the exception of the Navrongo VHC pilot in the southern sub-districts, the MOH operated VHCs no longer function in many parts of the three Regions.

One apparent reason for this is the lack of effective monitoring and supervision of VHCs as done when special funds were allotted for PHC activities. Such funding has ceased as a result of financial restructuring in the health sector creating logistic bottlenecks for supervisors. Motivation to members of the committee is also a problem. Membership to the committee is voluntary as such interests of members wane over time.

There were also cases of mismanagement of community funds reported against pioneering VHCs who managed drug and water funds. These and others raised doubts about the integrity of some VHCs resulting in the lack of interest in VHC's activities among some sectors of the community and health professionals.

8.3 CONCLUSION

The community level (Level A) was observed as the weakest link in health care delivery in Ghana resulting in the adoption of the Primary Health Care system in the 1980s. As a means of strengthening community level health care delivery, Community Health Worker also known as Village Health Worker or Primary Health Care Worker programme was initiated. The programme was encouraged particularly in the northern sector of Ghana because of its precarious situation of health infrastructure and personnel at the time. This led to the proliferation of Village/Community Health Workers programmes by non-government agencies particularly the church based organisations.

Village/Community Health Workers were provided training to diagnose and treat minor illnesses, promote healthy lifestyles and refer cases. The Bamako Initiative and UNICEF supported and empowered community health workers with essential drug kits as part of the tools needed for their outreach services.

The data from the case studies show that Village Health Workers provided a wide range of community or outreach services covering, first aid, treatment of minor illness, dehydration, cuts and wounds, malaria and diarrhoea. They also conducted home visits and performed ambulance call services.

The findings show that on the whole, Village Health Workers produced by Church Based Organisations and special programmes were more successful in their task performance than those trained under the MOH. Special and Church Based Organisations were more successful because they were better resourced to provide supervision and backstopping support to VHWs on the ground. Their VHWs were also more motivated.

The findings also show that fewer case of mismanagement of drugs and misbehaviour in the use of drugs and injections were associated with church based programmes compared to those of MOH.

To ensure the smooth management of the activities of VHWs, Village Health Committees were established to co-ordinate and oversee the operations at the community. As with VHWs, members of the committees were selected by the community and trained to acquire skills in community mobilisation and problem solving. The activities of constituted community health committees were reported to be short lived. Currently, many of the VHCs are dormant and ineffective due to lack of regular monitoring and supervision by MOH.

CHAPTER 9

9.0 COMMUNITY PARTICIPATION IN HEALTH – ACTIVITIES AND MECHANISMS

9.1 INTRODUCTION

This chapter synthesises the data on the various case studies on community participation in the public health sector of Ghana in the three northern regions. The chapter is organised under the following themes: who participates in public health issues at the community level and mechanisms of participation, how the public health sector and communities facilitate participation in the sector and the constraints in community participation in health.

9.2 WHO PARTICIPATES IN HEALTH AT THE COMMUNITY

9.2.1 Social Organisation for Participation

The case studies show that various programmes specify the areas for community participation. These usually include the construction of room space for village level staff to operate, remuneration of volunteers, payment of user fees in some cases, selection of community members for group/committees or those willing to train as community level volunteers and for co-operation with public health personnel for project or programme implementation.

The data show that the actual participation in the above activities by the community takes various forms either as groups or individuals depending on the health programme. Individuals are involved in two forms: based on ascribed status or standing in the community and stemming from their own personal achievement or on merit. In the former instance, people in authority or leading positions in the community, unit/ward or the district are covered. Recognition is given to the modern and traditional authority systems as may be determined by the programme or the community. Gender and other considerations are creeping in; in recent times, including consideration for youth and women leadership groups such as *magazia* or *Nachinaa*.

In the second case, people are roped into project participation, as individuals based on their own standing or by merit of achievement but normally have to undergo retraining. Selection of individuals is done democratically or by consensus. However, various programmes specify different ways of individual participation. Trustworthy individuals and or those with sense of community spirit are recruited. They are expected to be committed to the common course of the community and be in the position to sacrifice for its development. Guinea Worm volunteers, community-based-distributors, community clinic attendants, disease surveillance volunteers and village health workers belong to this category.

There is the other category under the second group embracing indigenous health specialists of high reputation such as birth attendants, herbalist and healers of various categories. They participate in public health programmes based on merit or achievement normally after retraining. Different programmes, however, target the different types of traditional health specialists with different degrees of success. Participation through collaboration at the level of specialised groups - TBAs, healers, private sector and so on - is being explored as indicated by the data.

There is also a team or committee principle in participation at the community level. Both ascribed status and individual achievement are required for recruitment into teams and committees. Here although individual merit counts in the selection, participation is oriented towards working as group or team. Examples of such institutions/structures are Community-Weighing Teams, Village-Planning Teams, Village Health Committees and Health Institutional Management Teams. The different programmes specify the size and composition of the group/committees as well as the functions. Participation here is modelled on teamwork, group dynamics or collective decision-making, and shared responsibilities are essential for their functioning.

The data on team or committee avenues of participation show that this is not an effective way of participation in the public health sector as teams often become dormant after a short life span of operation. Of the various types of committees/ teams established in the health sector, very few of them were found to be functioning. Key problems identified include the diffusion of responsibility of members over time, and the dominance of the enlightened or literate members of the team.

The last mechanism for participation is one by the entire community where the community as a whole is expected to participate in some specified programme activities such as attending meetings to select representatives on committees or individuals, take decisions or provide labour for the construction of room space for village level staff to operate, contribute to remunerate volunteers and pay user fees. Here the opportunity for participation is not restricted but open to every one that has the capabilities.

The case studies show that community organisation is important in facilitating broader or the larger community participation. Successful task performance depends on the larger community reorganising itself into legitimate smaller units based on wards/sections and age-grades for effective mobilisation and action. Broader community participation has been found to be more successful in communities with sectarian, gender and age-based institutions or structures for social mobilisation and leadership.

The mechanisms for participation at the community level summarised above are not exclusive or watertight. Data from the specific case studies show that people can participate in more than one of the forms discussed. In most of the communities visited, individual volunteers of the CBS system were also members of Village Health Workers or members of Weighting Teams or serving on Village Planning Teams or Community Health Teams. Except under the CBDP requirements, most of these networks were informal. Where these linkage or network systems exist they offer mechanisms for co-ordinating and integrating programmes at the village or community.

Thus, it can be seen that communities participate in health programmes not as whole communities, but as units and smaller groups of the whole. Networks between groups/units serve as rallying points for participation and the units may be called upon to participate in different assignments under one programme. However, the way the different units of the whole community foster participation, depends on their distinctiveness and the array of functions they are assigned. It also depends on the ability of the various units to network with each other. The case studies show that communities with active participation records were those with multiplicity of units with different objectives but well linked together through network system – formal or informal. Of all the mechanisms of participation, community leadership is very crucial. Leadership provides a sense of vision and legitimacy to the process.

9.3 NATURE OF PARTICIPATION IN HEALTH

9.3.1 Selection of Auxiliary Staff

In those health programmes where community level auxiliaries such as TBAs, VHWS, Village Volunteers and Community Weighing Teams are used, their selection is normally the prerogative of the community. Various programmes specify guidelines on who is suitable for task performance, and when teams/committees are involved, their composition. Across the different programmes examined, guidelines require a mix of qualities. These include residential status, availability and ability of the candidate. Such factors as gender, literacy, and sectional representation in the case of very large heterogeneous communities, are now being considered in recent times. Of the latter set of factors, the literacy and gender criteria are sometimes difficult to attain in most communities.

Community members argue that in addition to the requirement of specific programmes, they consider other factors such as dedication and devotion to service, community spirit, trust and reliability of those selected to serve at the community level. Those who engage in such services also indicated they volunteer because of their commitment to serve their people. Communities reported to employ various selection procedures in appointing people to serve on prescribed positions. These include the following: selection by consensus; voting; community leadership such as chiefs/headmen; and volunteering.

These must be seen to complement each other in the selection process rather than alternatives. What happens in most communities is that community/group leadership presents nominees to the larger community during meeting for consideration based on consensus building. There were few reported cases of leaders hand picking individuals to represent the community. The situation where people vie and openly contest for positions through voting was not widely reported.

These processes of recruiting representatives for participation on behalf of the larger community are meant to give legitimacy to the process and wherever they are properly constituted, serve as unifying organs for participation.

9.3.2 Social Mobilization and Health Promotion

The case studies show that social mobilisation is one of the popular ways of involving people in health care and management either as individual members or as groups of the larger community. Social mobilisation entails a set of activities undertaken in order to gear a community into action. These include community preparation and orientation, community mobilisation, information, education and communication (IE&C) and mobilisation for programme implementation. Mobilisation for these activities requires the use of different approaches targeting varying groups and individuals.

Community level data show that members of communities are periodically informed about health programmes such as outreach days, National Immunisation Days (NID), mop-up programmes, durbars etc to solicit their participation. TBAs, CBS volunteers, CTWs and in some cases, teachers play the role of information dissemination in many districts. Community auxiliary personnel also serve as agents of health education in their communities. VAP members and CWTs are particularly engaged in health education activities at the village level.

Social mobilisation also entails mobilising community members to participate in health related projects such as the construction of clinics or health centres, weeding on a health compound and payment of contributions towards initiated programmes. Social mobilisation is organised either through the traditional authority system or formal groups or organisations. Specialist group associations are being introduced in the health sector for aspects of social mobilisation across groups. TBAs have problems organising themselves while there are proliferation of associations in traditional healing. In cases where the different groups operate without networking, that sometimes breeds suspicion, resulting in competition and conflict between groups.

The case studies show that mechanisms of social mobilisation vary from one programme to another and from one community to another. However the gender and age-based groupings were found to be pivotal for successful and broad-based social mobilisation at the community level because they provide avenues for mobilising homogenous groups of similar aspirations.

9.3.3 Disease Surveillance and Growth Monitoring

Communities monitor the incidence and prevalence of diseases such as: CSM, polio (ATP) measles, guinea worm and neonatal tetanus. Surveillance volunteers have been selected and trained in almost every community in the Northern Region. In the Upper East and West Regions some communities were yet to be covered by the close of 2000. Surveillance reporting is about 80 percent of all communities for the Northern Region and reporting started in September 2000 for the Upper West and East Regions. Demographic information on births and deaths are also reported. This is done under the disease surveillance programme and other programmes such as the NTBA, and in some sub-districts in Navrongo.

The other aspect of surveillance is growth and nutrition monitoring undertaken during monthly anthropometrical measurement of children by Community Weighing Teams (CWTs) under the supervision of community health nurses. Communities participate in growth and nutrition monitoring under the CRS-FACS and the UNICEF Community Based Development programme. Vital information on malnutrition, wasting, incidence of diseases such as diarrhoea and malaria among children is made available to mothers under the programmes.

Health professionals indicated that the surveillance data constitute current health information on disease prevalence and incidence in the districts, sub-districts and some specific communities. Discussions with CBS personnel also revealed that such information is being utilised for health planning in some districts, but the scope of use is limited to the determination of Vitamin A capsule and for NID planning purposes. Similarly although discussion sessions are held with some communities on data generated from the CBS, very few communities have been able to put such information to practical use.

The problem with the surveillance system is its duplication and data unreliability especially the analysis made on diseases and growth charting. The other problem is the low utilisation of information. In many districts the information is treated as routine and stored away as usual.

9.3.4 Contribution of Material Resources

Information on the contribution of communities through the provision of material resources in the form of labour, land, water, sand and stones is replete from the case studies surveyed and data collected from the field. The NTBA, the World Food Programme, CRS-FACS programme and the Bamako Initiative all required communities to provide structures in the form of room-space for the operation of community level programmes. Some communities also initiated their own programmes leading to the construction of community clinics in the three northern regions during the 1980s and early '90s. The community provided land, labour and other in-kind contribution for the construction, while the programmes, technical support, cement and roofing materials. The case studies show that many communities meet these requirements without hesitation. Community level data reveal that under the Bamako Initiative, almost all the thirty communities covered by the programme in the Yendi District constructed village level structures for use by VHW in order to qualify for programme support. Structures in over fifteen communities were still in operation after the conflict in 1994. The data show that many sub-district structures were upgraded from these local structures following the creation of sub-districts in early 1990s in the three northern regions, through the joint efforts of communities and NGOs.

Although some communities have been frustrated by the health sector for not upgrading their community level facilities to clinics or providing health staff for the operation of clinics, the data show that communities are up to the task of providing structures when such requirement is officially put before them. This is one aspect of participation many communities have demonstrated success due to the abundance of in-kind resources [land and labour] at the community level. The problem though has been how to maintain and manage the structures. Once structures have been built, communities often perceive them to belong to the public health sector, thus reneging their responsibility to maintain and manage them on long-term basis.

9.3.5 Financial Contribution

Community participation in financing takes various forms as shown by the data and case studies. These include remuneration to community level staff, the raising of funds for maintenance of health facilities or infrastructure and payment for drugs. In the case of user fees, health services previously provided free now attract fees, although fee levels are lower for primary/community level care [Legislative Instrument 313]. Community members are now expected to pay for their drugs from community level providers such as TBAs, Village Health Workers and CBDs. The payment of drugs and consumable at this level is in line with the cash and carry system or other drug initiatives such as the Bamako Initiative aimed at generating funds to ensure that supplies of drugs and other consumable are replenished.

Programmes using auxiliary services give communities the opportunity to determine the level of charges/fees they should charge. For example, under the NTBA, TBAs were to negotiate fees/charges with the community. However, very few of them were able to agree on charges/fees and there are reports of non-payment of agreed fees in many of these communities. Clients complain they cannot pay for the services and TBA find it difficult to enforce the fees because they are normally in kinship ties with the women they render their services.

Data about payment for drugs at the community level show that not all members of the community pay for the drug they obtain from auxiliary staff. TBAs are particularly affected by the non-payment of the non-prescriptive drugs they stock. The situation is better with VHW, although some cases of default payments have been reported in some communities. Payment for drugs is a new phenomenon and appears difficult to be institutionalised at the community level. The result is that auxiliary staff are without drugs resulting in the over reliance on peddlers in peripheral communities.

9.4 PARTICIPATION IN SERVICES DELIVERY IN THE PUBLIC HEALTH SECTOR

9.4.1 Community Auxiliaries

There are various modalities for community members, individuals and groups to play roles in health services delivery. Under these arrangements, ordinary community members, men and women, selected or appointed by community members and trained as auxiliaries in aspects of care delivery and management. These include CHWs, community clinic attendants and community-based distributions. Each of these groups is providing specific aspects of what is termed as Primary Health Care Services in specific sub-districts or communities in the three northern regions. They are grouped together as Primary Health Care Workers or Volunteers.

The data show that the geographical coverage of these types of auxiliary health providers is limited. In fact CHWs and clinic attendants are piloted in sub-districts of Kasena Nankana under MOH and in those districts operated by the Presbyterian Rural Health Services and the Church of Christ.

The above category of personnel are certified and licensed to operate in care delivery through the use of non-prescriptive drugs (on the counter drugs) such as painkillers to treat simple ailments such as headaches, wounds, diarrhoea and so on. They are normally not allowed to give injections or drugs requiring prescription except in some few rare cases. Their operation is restricted to peripheral and outlying communities where access to facility care is limited. Primary Health Workers as they are often called, receive intensive theoretical and practical training ranging from about two months to a year depending. They are provided with prescription books normally after graduation and supported through intensive supervision.

Except the Navrongo pilot programme, the Ministry of Health no longer trains community level auxiliaries. The Ministry, however, collaborates with NGOs and other agencies in training community-based distributors to provide non-prescription drugs, information, education & communication and counselling in family planning.

TABLE 6: COMMUNITY AUXILIARIES BY SUB DISTRICTS

Sub District	No. of Communities	No. of Health Facilities	Outreach Points	Community Auxiliaries			Health Committees	
				TBAs	CCAs	BBSV	Old	Functioning
Lawra District	157	9	116	206	41	118	106	0
Nandom	23	1	13	34	2	21	23	0
Lawra	23	1	19	34	0	19	22	0
Ko	17	1	12	32	0	11	16	0
Babile	22	1	21	26	3	14	3	0
Zambo	18	1	11	25	8	13	12	0
Puffien	18	1	10	16	1	13	1	0
Baseble	18	1	12	24	12	13	11	0
Downmine	3	1	8	9	5	6	8	0
Eremon	10	1	10	6	10	8	10	0
Bulsa District	120	6	81	81	0	190	6	5
Sandema	26	1	12	10	0	54	1	0
Fumbisi	24	1	19	16	0	48	1	1
Sinersi	16	1	13	15	0	32	1	4
Chuchuliga	16	1	13	14	0	10	1	0
Wiaga	26	1	12	13	0	28	1	0
Gbedema	12	1	12	13	0	18	1	0
Yendi District	328	7	120	108	0	364	59	10
Adibo	37	1	17	12	0	41	10	0
Bunbonayilli	41	1	18	20	0	46	8	0
Gnani	42	1	20	10	0	46	10	0
Jimile	32	1	10	15	0	34	10	3
Sang	33	1	15	19	0	35	9	7
Yendi	143	2	40	32	0	162	12	0

Source -Field Data, 2000

Family planning is another area of care primary health workers or volunteers are allowed to provide through the activities of CBDs. The case studies show that the activities of CBDs are largely in the hands of NGOs such as PPAG and the Red Cross of Ghana.

Health professionals argue that the administration of primary level care at the community level requires close supervision and efficient backstopping support. Unfortunately the structure of the present public health system, even though it has penetrated into the sub-district level, is not capable of providing these services to support auxiliary level practice at the community level. In the absence of support services, curative care provided by auxiliaries is fraught with abuses. Directors of district and sub-district health services capitalise on the abuses of VHWs under the national programme to discourage the operation of community level auxiliaries in curative health services. This has resulted in the underdevelopment of level A services in the northern sector resulting in the use of level B and C services for primary health care. The operation of drug peddlers and the problem of over consumption of drugs in peripheral communities in the region testify to the lack of community level auxiliaries in the delivery of curative care at the village or community level.

Considering the above twin problems of peripheral communities, personnel of Church Based Primary Health Workers Programme question directors of MOH, as to which is better, whether to condone with drug peddlers and over consumption of dangerous drugs in rural communities or support the operation of trained Village Health Workers in specified aspects of curative health care delivery.

9.4.2 Traditional Healers

Allowing the participation of indigenous or ethno-medicine in modern health through collaborative arrangements is perceived as one variant of the model of community participation. Neumann et al (1982) identified the potential positive effects of linking biomedicine and ethnomedicine. These include: better access to high quality care for patients and an increased likelihood of appropriate referral for severe or special cases of disease or injury; and opportunity for indigenous practitioners to increase their diagnostic skills and knowledge; relieving the excess demand on western medical services; and a means for government to expand health services in a relatively inexpensive way. Similarly, Twumasi [1988] advocates a health care that relies on traditional medical

practice and paramedical auxiliary as means of redressing the uneven distribution of health care staff in Ghana. Writing on the model of health development in Africa, Asia and Latin America, Bannermann [1983] observes that traditional practitioners offer basic health care to the disadvantage and undeserved groups constituting about 80 percent of the population of the world and ought to be recognised for the provision of primary care.

The WHO, through its various expert committees also demonstrated the importance of traditional healers in health care delivery in the Africa sub-region. At its 57th session in November 1975, the executive board produced a paper on "Health Manpower development: training and utilisation of traditional healers and their collaboration with health delivery system" [WHO, 1975]. The WHO regional committee for Africa also at its 26th session in Kampala in September 1976 deliberated and produced a paper on Traditional Medicine and its Role in Development of Health Services in Africa [WHO, 1976b]. However, the most comprehensive recommendation with respect to traditional medical integration with modern health is contained in the Technical Report Series Number 622 [WHO, 1978]. The recommendation provides four levels through which action can be taken to effect integration of traditional healers. These are at the international, national, professional and consumer levels. At the national or country level, aside of calling for national policies to institutionalise the traditional medical practice, that is providing overt and legal recognition, there are many views on the model of participation between traditional and modern medicine.

Neumann et al [1982] suggested eight possibilities for linkages which briefly stated include the following: government licensing of healers with predetermined levels of competence, with recruitment of some part of rural health teams, the foundation of training schools for different groups of healers, training selected traditional healers to update their skills and then hire them as employees of the Ministry of Health, encouraging cross cultural exchange via workshops for government health personnel, research into pharmacopoeia of traditional medicine and modifying the training of physicians and midwives to include elements of traditional knowledge and care.

According to some social scientists, participation could be in the form of integration between traditional and modern practitioners where both practitioners are employed in the services of the ministry of health; independence practice of both traditional and modern medicine but recognised and regulated by government; widespread training of

indigenous midwives to provide baseline and referral services [Sargent, 1989]; the incorporation of traditional healers and practitioners into hospitals or referrals between doctors and healers without one unduly controlling the other.

While the incorporation of traditional healers as service providers in the modern health sector, has been frequently discussed by governments and funding agencies, attempts to actualise it in practice are limited. Some of the activities undertaken in this direction include research at the Centre for Scientific Research into Plant Medicine, the Primary Health Care Training for Indigenous Healers in Dormaa-Ahenkro and Nandom and other programmes for such healers as Wanzams and bonesetters. These programmes, which were implemented in the 1970s and 1980s, organised training courses in aseptic and hygienic ways of healing for traditional practitioners. In the Nandom area in particular, bonesetters were offered the opportunity to operate together with modern health practitioners at the hospital in Nandom. A similar programme was implemented in Duong in the Upper West Region.

These novel experiments were however short lived because of problems inherent in the traditional healing profession. Some of these problems have to do with the heterogeneous nature of traditional herbal practice and those associated with what should constitute training and course content for healers. There is also the danger of defining traditional medical knowledge in terms of technical herbal practice, thus ignoring the symbolic ritual aspects of it.

Current attempts at fostering the participation of healers in modern health care have led to the establishment for the first time, an Office for Traditional and Alternative Medicine Directorate within the MOH. In the Upper West and East Regions, traditional healers are reorganising themselves through the Ghana Psychic and Traditional Healers Association. The registration of healers is complete in the Lawra and Builsa Districts and in the Yendi District plans are underway to get traditional healers registered. Health personnel feel that the registration of traditional healers will foster the way for dialoguing with them on possible areas of partnership.

The major setback of the process has been funding; which sector is to fund local collaborative activities for the dialogue, including the reorganisation of healers. Furthermore, the process has been characterised by mutual suspicion between the health

sector and the other traditional practitioners on the one hand and between the different healing groups on the other. There are currently about five splinter groups of traditional healers/practitioners. These include the Ghana Psychic and Traditional Healers Association; Ghana National Association of Traditional Healers; Plant Medicine Association; Traditional Services Organisation; and Northern Sector Association.

9.4.3 Traditional Birth Attendants

Collaborative measures between traditional Birth Attendants and MOH under the PHC has been evaluated to be successful in many respects. Through the NTBA, modern maternal and child health care collaborates with TBAs in the distribution and coverage of supervised midwifery care and non-prescriptive family planning services based upon modern midwifery thought and practice. TBAs retrained in modern midwifery delivery are delegated aspects of midwifery care that could be subjected to empirical control and testing, generally referred to as ordinary obstetrics.

The model of collaboration between TBAs and MOH classified complicated obstetrics, vaccinations and immunisations under referral midwifery delivery, to be provided at either the health post or hospital. Other services previously delivered by TBAs in areas such as herbal and ritual medicine but difficult to subject to empirical tests (herbal and ritual medicines) have been discouraged. The delegation of ordinary obstetrics and family planning to trained TBAs (restricted to sale of non-prescriptive devices and counselling) was aimed at redistributing supervised obstetrical and family planning to cover a broader majority of the people who live in the rural areas and depend solely on TBAs for midwifery care.

Trained TBAs are obliged under the programme to refer complicated obstetrics as a result of the difficulty in assessing TBAs' competence in these areas of care. Immunization and neonatal vaccinations are also to be delivered by modern health personnel at either the health post/ hospital or during outreach services and may require clients to travel to the health post for hospital for care.

There is also a principle of collaboration based on standardisation and control of the midwifery care of TBAs by personnel of modern maternal care at the sub-district level. Control mechanisms include the withdrawal of certification and monitoring and supervision of the services of trained TBAs.

One area that has been successful in the collaboration of traditional practitioners and the public health sector is traditional midwifery delivered by TBAs. The NTBA has institutionalised traditional midwifery practice within modern midwifery care and practice. As a result the operation of TBAs is now widely accepted within MOH and international circles. In the Northern and Upper Regions, trained TBAs are responsible for about one half of all supervised delivery in the area [MOH, 1996]. This is explained by the fact that midwives are primarily concerned with maternal and child health care whilst traditional healers perform a wide range of health and allied functions with practices based on supernatural and magical phenomena alien to modern health care.

Of these areas of collaboration, trained TBAs auxiliary role in teamwork during outreach services and blue card referrals are reported to be successful. However, the results of other areas of collaboration are mixed. The outreach engagement of TBAs has been successful because it has boosted the morale of trained TBAs. However trained TBAs view outreach services, as a big burden to them since it attracts no remuneration of any sort.

9.4.4 Other Modern Health Providers

The provision of modern curative health care is not the preserve of the public health sector in many of the districts covered by the study. The private sector (private-for-profit) and NGOs (private-non-profit) are actively engaged in the provision of such care. Of importance is the contribution of drug and chemical stores who operate at areas where public health services are less accessible. The data however, show that government support, to private health providers particularly chemical and drug sellers in the three northern regions, has been in the area of regulation and training. Training programmes have been organised for members of private chemical sellers in some districts, particularly the Builsa District of the Upper East Region and plans are under way to extend such services to the remaining districts in the northern part of the country.

As with the private-non-profit sector, government is providing support in training, salaries of staff and the provision of some logistics. In some districts in the northern part of the country sub-districts are allocated to the private-for profit sector to concentrate their services delivery. In the Builsa District for instance, the administration of the Senese sub-

district is in the hands of staff of the Presbyterian Health Services and similar arrangements were reported in the Bolgatanga district. The Catholic Diocesan Health Services is also allocated designated sub districts in the Builsa and Lawra districts and some part of the northern sector. These arrangements, it must be noted, are still limited in scope as there are no institutionalised collaborative mechanisms involving other stakeholders in private sector practice.

Furthermore, MOH is taking steps to enter into contracting arrangements with the private-non-profit sector to provide services they have comparative advantage over the GHS.

9.5 PARTICIPATION IN PLANNING AND DECISION-MAKING

The community level data and case studies indicate that communities are consulted or participate in decision-making process especially those touching on local health and development issues. Views of communities are sought on matters relating to where to locate primary or secondary health services - outreach and static programmes. Communities also make input on issues concerning social mobilisation, dissemination of information, material or other forms of contribution and the implementation of community level programmes.

Communities also have the responsibility for contributing towards the formation of district development plans including health under the new district planning arrangements. Under the local government structure, existing community and sub-district structures such as unit committees and assemblypersons facilitate the process. Unit committees now exist in almost all the districts surveyed but have been found to be dormant and incapable of mobilising communities towards influencing the formation of development plans. It is only in UNICEF's Community Based Development districts that broad avenues exist for the participation of communities in decision-making through the Village Level Planning (VAP) process.

Under the CBDP, planning starts at the community level through community meetings facilitated by the Village Level Planning Teams (VAP) with technical support from Extension Teams (ETs) comprising technical personnel from various line agencies.

Quarterly meetings and review sessions are district level meetings with representation from the communities. These meetings are meant to synthesize community plans into district/sectoral composite ones or review the implementation of plans already agreed upon. Quarterly and review meetings offer communities and health auxiliaries the opportunity to indirectly influence the decision making process. In Builsa and Lawra districts for example, TBAs and VHWs meet on quarterly basis for peer review and problem solving. Review meetings are also seen as a source of motivation to the group/community as they offer the opportunity for people to be heard on their involvement in health issues and to discuss problems and find solutions to them.

Consultative meetings about outreach programme and the monitoring and control of programmes at the community level were also reported in Yendi, Builsa and Lawra districts. Issues relating to the siting of outreach clinics; dates of outreach visits and number of communities to benefit from an outreach are not decisions taken exclusively by staff of the sub-district. These are normally consultative decisions involving the community or communities and the sub-district or district staff depending. Hence sub-district management teams as well as the district health management teams and community leaders such as chiefs, assemblymen or headmen participate in such decisions.

Durbars also serve as avenues for decision-making. Some districts hold open discussions sessions or durbars on health problems. Normally an important problem in the area is chosen and the assemblymen, headmen and other opinion leaders are involved together with members of the community affected by the problem. Open discussions were reported only in the Sandema Sub-district and are resorted to during disasters such as the upsurge of cholera in the district after the 1990 floods in the northern sector of Ghana.

At the district and sub district level, management teams are the decision-making organs and sometimes they do this in consultation with other stakeholders such as programme officers of NGOs and other donor agencies working with the public health sector. Programme officers of NGOs and donor agencies are occasionally invited to meetings and planning sessions organized by district and sub district teams. Similarly, agencies collaborating with MOH have counterpart programme officers at the public health sector called contact persons/desk officers who, are sometimes invited to the planning and

working sessions of the collaborating agencies. Quarterly trimester meetings are similar arrangements institutionalised under the CDBP in the Yendi and Builsa districts and under the CRS-FACs programme in Lawra for planning and review of district and community plans.

In the CDBP districts all sectoral departments including health and NGOs operating in the district, participate in the planning and review sessions. These sessions offer the rare opportunity for joint planning and decision making by all Ministries and Departments and their collaborating development partners. Similarly, in districts where some sub-districts are managed by the private-non-profit sector, members of the private-non-profit sector are sometimes represented on the district management team. It must, however, be noted that the above arrangement offering broad base participation in decision making at the district and sub district level are not institutionalised across board and even under the CDBP process, traditional healers and private health providers are not represented in the process.

9.6 FACTORS INFLUENCING THE PARTICIPATION OF COMMUNITIES

9.6.1 Lack of Awareness about Project/Programme Concept

The case studies show that community preparation and orientation is integral to all programmes seeking community participation and the effectiveness of participation depends on the success of community preparation. Preparation and orientation normally cover the first set of activities preceding programme implementation undertaken to create rapport between project personnel and target community and to inform the community about the project concept. These consultations usually commence with the community leadership and diffuse to the other stakeholders and the larger community.

Within MOH, talks and durbars are usually the approaches employed for awareness creation and information sharing on projects. These are consultations undertaken to create awareness of already packaged programmes in order to ensure their acceptability. Interactions with community members about the case studies examined indicate that community members often lack thorough information about programmes before their implementation. There were many instances during the community level contacts members of communities visited indicated to lack awareness about programme activities

they were expected to participate as required by the programme concept. This is often as a result of the fact that community preparation is rushed by staff or seen as an end in itself. As remarked by one respondent "health personnel often perceive community entry and preparation as a planned activity to be performed without regard to the set of linking activities the entry is to help accomplish." Community entry, animation and preparation are not normally given the desired attention by staff of Ministry of Health or its partner organisations charged with implementing programmes requiring community input.

The other problem has to do with the approach to community preparation. The field data revealed that community preparations continue to be done under the extension approach. The extension format is based on the principle that knowledge and expertise is being brought to the community for adoption. Although this mentality is changing, the participation and facilitation approach has remained in theory rather than in practice in many of the communities visited and case studies reviewed.

9.6.2 Capacity of Community Members

The acquisition of the requisite skills and orientation by members of the community is key to effective participation in health. As a result training is required to orient community level auxiliary staff of their new roles, equip them with new skills towards health promotion and towards creating the desired attitudes for healthy life styles in their communities. Thus, training is crucial to effective community participation and this training must be provided by the health sector.

The case studies show that community level training programmes have been organised for the various categories of actors identified under the specific community participation programmes: TBAs CBSV, CBD, Village Health Workers programme etc. However closer examination of training programmes revealed that most of the programmes sought to impart only skills and knowledge perceived to be necessary for the performance of the task assigned under the programme. Very few of the programmes have identified training in communication and animation to be relevant for community level auxiliaries.

The data also show that except the NTBA training module, none of the other programmes have a standardised module, designed and tested nationwide. The rest are specific to regions or districts. The case studies also reveal that the distribution of

training programmes for approved auxiliary health personnel is uneven. This is based on the fact that some deprived communities were found to lack some categories of auxiliary personnel: TBAs or the other types of volunteers. In Bonbunayili sub-district of the Yendi District for instance, the first complement of TBA training took place only in October 2000 although the programme started in 1990 in the three Northern Regions. The same can be said about the Community Based Surveillance volunteers under the CBS programme. The case studies reveal that although all communities in the Northern Region have at least a trained volunteer, the same cannot be said of the Upper West and Upper East Regions where about 50 percent of the communities are yet to be served by trained volunteers.

Related to the issue of training are refresher programmes to update the knowledge of trained personnel. Although these are organised in the form of workshops for health management staff and nurses, the same cannot be said of community level auxiliary personnel. The data show that only auxiliary staff operating in districts with specially sponsored donor programmes as CDBP, FACS or Church Based Organisations, benefit from frequent refresher programmes. Health sector personnel attribute the problem to funding that is, the inability to raise the needed funds for refresher training.

9.6.3 Motivation of Auxiliary Staff

It is normally the responsibility of the community to define and institutionalise systems of reward to motivate community level volunteers. Under the NTBA, communities were required to build upon the traditionally agreed system of motivation provided to TBAs prior to their training. Similarly, the VHW and the volunteer programmes also held communities responsible for designing systems of reward to motivate auxiliary staff for the services they render. The data show that few communities agreed on systems of rewarding auxiliary staff. These communities agreed on fee-for-payment for the services of TBAs. Other communities agreed to work on the farms of their volunteers to compensate them for the lost time. However, in many of these cases, no community was reported to have fulfilled the system of reward agreed for their auxiliary staff for the services they provide. As a result no community has institutionalised any system of reward as motivation for community level health staff.

Seeing the plight of community level staff, some programmes have devised alternative systems of reward for their staff. In the Northern Region for example, surveillance volunteers are now granted free medical care. The Presbyterian Health Services also offer the same treatment to Village Health Workers. These complement programme souvenir such as T- shirts and other materials and benefits enjoyed during training, etc. The failure of communities to institutionalise systems of reward for their community health workers stem from the lack of transparency on the part of programmes on the rights and responsibilities of people assigned roles at the community level. The other problem has to do with the failure of members of project communities to understand the concept of voluntarism. Community members often find it difficult to comprehend why volunteers continue to serve on programme activities when there are no direct benefits accruing to them. They ask “why needy people avail themselves for project/programme activities for no economic return”. In the light of no satisfactory explanation to the puzzle, community members maintain that volunteers derive some intrinsic benefits from their positions and as such do not merit any special provisions from their communities. Stemming from this, the participation of community representative on programme activities becomes partial, as they have to keep other jobs as a means to earn a livelihood.

9.6.4 Illiteracy and Community Participation

The data show that the majority of primary health workers are illiterate or semi-literate. One District Director of Health laments that, “ 80 percent of all serving auxiliary staff are illiterate who do not normally know when the month ends, how much being able to complete records and do analysis successfully”. Almost every traditional birth attendant is an illiterate, and three out of five community based surveillance volunteers are also illiterate. In the case of community weighing teams, it is estimated that one out of every three is an illiterate. The lack of people with the requisite level of education as a result of high rate of school dropout in the three northern regions affects the calibre of community representatives and the understanding of their roles in programmes.

According to the Ghana Living Standard Survey (2000) about one-third [32%] of the adult population have never being to school. Those reported ever being to school are either middle/basic school leavers [33%] or school dropouts [25%]. This gloomy picture of school attendance is however worse in the three northern regions. Available data on adult literacy [in English] also show that only 6 percent of the adult population in the

rural savannah of the country is literate and the figure is lower for female [3.7%] than male [8.1%] (GSS, 2000).

The low level of education and literacy, affect their effective participation in a number of ways. Aside the difficulty of recruiting the right community level auxiliaries, illiteracy fetes ignorance and low awareness of the concept of participation. The case studies show that school attendance and the ability to read and write are a requirement for representation on community level programmes or serving as auxiliary staff.

Twumasi (1975) also asserts the importance of literacy in community participation, especially the ability to read and write. In his view the success of any local health programme is intimately related to the prevailing socio-economic condition, the prominent of these being literacy.

9.6.5 Community Leadership

Data from the communities surveyed show that strong and effective community leadership facilitates people's participation. Leadership plays several functions including community mobilisation, organisation, and the legitimisation of health programmes as was revealed during group and community discussions.

Leadership for community participation in health draws from both the traditional and modern. The authority system of the traditional non-formal system comprises of chiefs, headmen, opinion leaders and elders. Leadership of the formal or modern system includes unit committees, assemblypersons and leadership of organisations or youth groups. One of such youth groups of immense importance is the position of the youth chairman, known as *Nachinaa* among the Dagombas, and his female counterpart, the *Magazia*.

The Chairman or youth leadership is an innovation in community leadership and is vested a lot of authority and respect in most communities in the Northern Region. In the Yendi area in particular, the youth leadership is an important agent for development. She/he links the community with the outside world and one cannot formally interact with the community without his/her nod/approval. She/he mediates in youth matters and mobilises the community for communal activities and development programmes.

The centralised and non-centralised traditional political history of the area under study presents two faces of the chieftaincy political system. In communities where centralised political system was hitherto practised, there are institutionalised channels of power and authority over the community. Similarly, there exist strong traditional leadership.

This cannot be said of communities with non-centralised political histories. Although chieftaincy now forms the central political authority in these communities there is no well-defined hierarchy of power, authority and control. Similarly, the authority and respect awarded to the institution is less comparable. Hence it requires more than customary traditions to wield strong authority in these communities for social mobilisation and legitimacy.

Institutionalised channels of power and authority give rise to strong traditional leadership, which is found to fetter swift flow of information and social mobilisation for development. This cannot be said about communities with non-centralised political system. Although centralised traditional system is a force for swift dissemination of information and social mobilisation of resources – human and material resources, it thwarts empowering participation. This is because the people look up to leadership for decision-making. As a result, the ordinary people are sidelined in the decision making process. The chances of empowering participation are stronger under communities with non-centralised political system where the people can challenge the views of leadership.

Decentralisation and modernisation have led to the introduction of formal system of authority. An upshot of some of these institutions is assembly person and members of unit committees. The relationship between the modern and the traditional system is sometimes characterised by suspicion and tension. With these developments, the problem has been how to develop systems of participatory leadership institutions that would not marginalize either the traditional or modern leadership.

Programmes requiring their own groups for programme relations such as VAP under the CBDP, FACS under the CRS, Health Committees; seek the representation of both traditional and modern leadership structure. Discussions with health professionals and membership of existing groups show that, in most cases the onus of getting these groups

to function effectively lies with the efforts of representatives of the modern formal institutions who are able to read and write.

One constraint with this system of leadership has been how to foster collaborative interplay between the traditional and modern systems of authority co-existing in our communities for participatory development. Communities able to strike this balance in traditional and modern leadership relationship for participatory development present cases of success in community participation.

9.6.6 Voluntarism and Participation

The case studies and community level data show that village level participation is modelled on voluntarism in all programmes and around the entire three regions. Although different programmes have institutionalised ways of motivation, participation at the community level is based largely on voluntarism. People who choose to work on community level health programmes receive no pay for the work. There is the strong believe on the part of health programme personnel and the larger community that community level participation should be based on service to one's community.

Although the data show that people are initially motivated by the drive for community service, there is always a sense of self interest attached and the nature of self-interest depends on the status of the volunteer. Self interest in the form of values such as beneficence or solitarily, or even by a consciousness of sin was found to be associated with the middle class in Britain (Pinker, 1979). In the northern regions where the majority of volunteers are poor farmers, school dropout – in fact, people from the lower echelons of society, the self-interest in voluntarism is not far fetched.

Among most community level health workers, voluntary work is often seen as an avenue to paid work. People take up these opportunities with the view of being paid regular stipend of money. Before this is done, it means they have to depend on a source of livelihood. Thus, the crucial ingredients in voluntarism are money, time and commitment. A secured economic and social life makes voluntarism possible or even attractive, and may give volunteers satisfaction they do not get from paid work (Sheard, 1986).

Men and women who are committed to voluntary work usually do that from a secure base – economically. This cannot be said about the people involved in voluntary

positions in programmes modelled under community participation in the northern sector of Ghana. Programme personnel of community participation projects decry the diminishing spirit of voluntarism among rural people. This is quite understandable considering the scope of poverty in the northern regions and the trend over the years. According to information on trends of poverty in Ghana, the incidence of poverty in the Northern, Upper West and East Region is the highest with over two-thirds of the people living below the poverty line (GSS, 2000). The question therefore is how the poorest of the poor can engage in effective participation on voluntary bases.

Within this state of affairs the commitment of volunteers is often shared between programmes and opportunities from which they draw their main livelihood. This therefore explains why volunteers perform better during the dry than the wet season in most rural farming communities. It also explains the reason why men dominate community participation programme than women. Men being heads of family have control over their time than women who occupy subordinate positions in the family.

The fact that people see voluntary position as stepping stone for paid jobs or some sort of regular economic reward partly explains why most communities renege in rewarding their members who volunteer positions in community health programmes.

9.6.7 Self-reliance Initiatives

There is a strong feeling of dependence on external agencies in most communities. This feeling is particularly strong towards NGOs in recent times. Where programmes are initiated, people look up to the same agencies or bodies to provide full funding for facilities including their management. Cases of the refusal of communities to maintain village level facilities and complaints about programme services being expensive and beyond the reach of beneficiary communities are replete in the data on community participation from community interactions. One such case has been complaints about the high cost of impregnated mosquito nets sold in project communities (though subsidized) under the Community Based Development Programme in the Builsa District.

Although, poverty is often sited as a problem in the northern regions, programme officers complain it cannot be the cause of every problem. The issue of priority setting and judicious use of people's resources partly explains the problem of dependence or the

dole-out attitude as some social scientists put it (Galaa et al., 1996). The dependence on external agencies for development may be explained from the nature and approach to community development in northern Ghana during the colonial and the post-independent period (1960s and 70s). Community development during this period centred on the provision of community goods schools, hospitals, community centres; which were equally maintained and managed by outsiders in the interest of the community. Projects were conceived outside the beneficiary communities and later thrust on them even when such projects may have nothing to do with their felt and basic needs, which were often not sought.

Participation was conceived only in terms of the utilisation of the facilities without any economic obligation. This was the concept of community development used by both government and the churches especially the Catholic Church, which championed very strongly rural development in the western and eastern parts of the northern sector of Ghana. The above has created the attitude among community members that the government and external agencies have the responsibility for community development. And the goods of community development belong to the external agencies and it is their responsibility to make them function. This perspective to development presents members of the community as passive recipient of the benefits of development programmes.

The above position presented is not to argue that the people of the three northern regions have no history of communal spirit where groups or members of the community come together to support each other. This is far from the truth. There is ample evidence of communal support arrangements in the form of *Kodita, Kpariba and Kpetaa*. These communal arrangements are mobilised towards the creation of individual property or goods. In fact, some northern people with specialised skills such as healing and blacksmithry did not capitalise them but placed them for the benefit of members of the larger community. The mobilisation of communal labour for the creation of communal goods and resources is a colonial and post-colonial creation, normally with external initiation.

The point argued is that although communal spirit and social mobilisation towards development, is not new in the northern sector, community projects in the form of water supply system, clinics and schools, their creation and management started during the colonial era and developed during the post colonial era within the concept of what is

often referred to as the top-down-approach. This is the genesis to the understanding of the development of community spirit and attitude towards the creation and management of community goods. The northern sector of Ghana began experiencing this type of development in the late 70s through the PHC system and the community clinic concept, with the support of specialists in the form of TBAs, herbalist etc.

This was further given impetus under the Operation Feed Yourself concept and the Village Development Committee or PDC initiatives. These are being institutionalised under the district level decentralisation now on course through the leadership of town, ward and area councils and unit committees. Participation in the management of community assets is gaining currency in water and health related programmes and among communities operating the Community Based Development Programmes in the three northern regions through the institutionalisation of management organs such as water and sanitation committees and Village Level Planning Teams [VAP].

There are also avenues in the development process such as community meetings and review meeting sessions that offer members of the communities the opportunity to initiate and manage development and health programmes in the northern sector. The scope of communities experiencing these new perspectives of development aimed at developing and sustaining community spirit in development programme is still narrow.

9.6.8 Community Settlement Pattern

Intra and inter community mobility by village level auxiliary health workers and volunteers surfaced as a constraint to community participation especially in such areas as social mobilisation and those activities requiring visitations to the homes of individual members of the community.

Intra community mobility was reported as a problem in the Upper West and Upper East Regions where houses are located far apart. Within some of the communities, inter-house distances are about two kilometres far apart, making movement by foot difficult. This is particularly a problem for female volunteers, who rely on foot transport for the transaction of their duties. There are also a number of male community level workers without bicycles to facilitate intra community mobility when carrying out their work.

It is also worthy to note inter-community mobility as a problem in some parts of the districts in the three regions under consideration. Some of the areas affected most are communities to the southwestern part of the Builsa District, the Western part of the West Mamprusi District and northeastern parts of the Savelugu Nanton District. These are generally referred to as “overseas” because of inaccessibility to the area during the rainy season, normally between August and October.

9.6.9 Turnover of Auxiliary Staff

Although earlier studies on Village Health Workers show a high attrition and dropout rate of community auxiliaries [Gill, 1988; Enge et al., 1984; Adjei Sam et al., 1984], the findings of the present study point to the contrary. Looking at specific programmes, the dropout rate of CHW from current programmes appears to be low overall. For instance, programme personnel of the Presbyterian Rural Health Services indicate a dropout of one to two village health workers per year in the Bolgatanga District. Similarly, the Tamale regional co-ordinator of the CBSV programme indicates the change over of volunteers to be rare, except in very few cases of reported deaths and promotion to zonal co-ordinators. The low reported attrition rate with current auxiliaries may be partly explained by better motivation systems enjoyed by them.

The data however, show that the attrition rate of TBAs is comparatively higher than other auxiliaries as shown by Table 7.

TABLE 7: DROPOUT OF TBAs FROM NTBA

DISTRICT	TRAINED	FUNCTIONING		DROP OUT	
Lawra	218	206	94%	12	6%
Yendi	116	88*	76%	28	24%
Builsa	92	81	87%	11	12%

Field Data 2000 * TBAs trained between 1990 and 1999 (20 TBAs trained in Bunbonayili in 2000 not included).

Except in the Yendi district where about an average of two TBAs dropout of the programme yearly, the figure is one TBA for the other two districts. The higher dropout rate of TBAs in the Yendi district is partly explained by the displacement of TBAs during the 1993/4 ethnic conflicts in the Northern region. Witchcraft accounts for about one third of all TBA dropouts in the Northern Region with little or no effect in the remaining two regions. Of all the factors, death is the most significant, accounting for about 90 percent of all dropouts in the Upper West and East Regions. Dropout through incompetence and misconduct was found to affect only Village Health Workers. However, only few cases were reported yearly in the Builsa and Bolgatanga Districts, resulting in the withdrawal of their drug kits.

Besides complete dropout from programmes, there were reported cases of seasonal dropout. Health auxiliaries are reported to be generally more active during the dry than the wet season. Auxiliaries combine their health assignments with farming, which is the main occupation, during the wet season.

9.6.10 Gender Issues

The sub-ordination of women in rural communities in particular and the country at large stifles their participation in development programmes including health. The case studies show that almost all programmes encourage the participation of women. However, actual

participation of women was found to lag below expectation in many of the case studies examined except in areas that are traditionally women dominated such as traditional midwifery, weighing of children and growth and nutrition monitoring programmes. In fact, the majority of trained TBAs are women and the fifty percent men-women ratio in the composition of community weighing teams has been attained in many communities.

However, in gender-neutral programmes such as the Community Health Workers and the Disease Surveillance Programmes, men representation and participation outweigh women's particularly in the Yendi and Builsa Districts. One reason for the dominance of men in programmes over women seems to be the issue of time. In most rural communities, women are generally over burdened with work. They hardly have spare time for themselves and this may explain the predominance of men over women. The other reason may be that men use their dominant positions in the family and society at large to side-step women when enlisting for programmes and in decision-making. There is also evidence to suggest that rural women are often reluctant to offer themselves for leadership position in community participation programmes due to the fear of ridicule should they fail to perform. These and other reasons continue to weigh against the participation of women in programmes.

9.7 PUBLIC HEALTH SECTOR FACTORS INFLUENCING PARTICIPATION

Besides a district focused health care system with well-defined system of referral, staffing levels and their orientation, staff turnover, supervision and logistic supply are crucial for the facilitation of community participation by the MOH and its affiliate institutions.

9.7.1 Staffing

Staffing in the health sector is a complex variable in community participation. Institutional restructuring from the level of the district and below calls for staff with the requisite knowledge, numbers and orientation to man district level institutions and ensure that community health is promoted. However, staffing numbers have been found to be inadequate at both the district and sub-district levels; and it appears the situation is better at the district level where almost all the districts have the minimum professional staff for a functional District Health Management Team. What is reported lacking at the district, is administrative staff and in some districts, especially those with district hospitals, these functions are provided by the district hospital. The staffing situation as

expected, is more serious at the sub-district level. No sub-district in the three northern regions can boast of full complement staff with some sub-districts managed by lone professional staff with the rank of a community nurse midwife. The lack of full complement staff at the sub-district level is affecting sub-district community level relations especially in the monitoring and supervision of community level health staff such as surveillance volunteers, TBAs, VHW and CBDs.

9.7.2 Orientation of Health Sector Personnel

Health professionals at various levels have roles to play in promoting community participation. At the national level the orientation of personnel influence what issues communities are allowed to participate. In Ghana, the issue of participation in services delivery is a contentious issue and public health professionals at the national level disfavour the participation of communities in some aspects of creative health delivery, often under the pretext of the danger augment surrounding health care. The orientation of health professional at the national level is crucial in shaping the policy of community participation in creative service delivery. Similarly, the attitude of district health professionals towards participation as well as their understanding of the concept is crucial for implementation and sustenance of the process. Data from regional and district level contacts with health personnel show that regional and district directors in the three northern regions are positive towards community participation. They see community participation as integral to successful health services delivery in the northern sector of Ghana. In the view of district health directors, "community participation will lead to the provision of socially acceptable health services and increase positive attitudes to health care ultimately".

The perceptions of district level health personnel about participation had to do with proactive behaviour such as environmental cleanliness, the non-engagement in life threatening attitudes, such as smoking, alcoholism, hygiene and sanitation. Participation was also perceived to include the involvement of communities in IE&C programmes in order to create awareness on health issues in communities and resources mobilisation. Very few district health personnel however, mentioned the involvement of communities in decision-making as an aspect of participation. On the issue of stakeholder collaboration, district health personnel saw the need for involving other health care providers in health

services delivery only after they have received training in aseptic methods and techniques and their operations strictly supervised by the health sector.

The case studies and interviews also reveal that only a few personnel at the sub-district level received training in public health. The majority are technical staff trained to provide clinical services. In fact, the majority in-charge of sub-districts are medical assistants with curative health orientation. Many of these staff with curative health orientation lack skills for promoting community participation such as advocacy, community entry, animation and participatory rural appraisal methods.

9.7.3 Movement of Health Personnel

Related to the issue of staffing are transfers. The way the transfer of public health personnel is handled was reported to adversely affect community participation projects, community and health centre relations, the working of institutional management committees and the collapse of some programmes such as the Bamako Initiative in the Yendi District.

Interactions with district and sub-district personnel in the three northern regions during data collection revealed gross ignorance on their part, about community initiated activities or projects and the status of on-going ones at the districts and sub-districts covered, under the explanation that personnel were newly posted to those areas. This happened in Sang, Jimile and Adibo in the Yendi District, in Chuchuliga, Senisa and Kadema in the Builsa District, and in Babile and Zambo in the Lawra District. In some sub-districts such as Sang, the transfers were mass, resulting in the posting of new personnel to the sub-district. The nature and manner of handling transfers in the districts and sub-districts revealed that no proper handing over is done. In most cases handling over notes do not cover community participation initiatives or programmes. This may point to the lack of institutionalisation of community participation initiatives or projects within the broader objectives of health care delivery at the district and sub-district level for the purposes of monitoring. The lack of the institutionalisation of community health projects and special initiatives by heads of sub-districts or districts, may account for the fact that workers transfer go to affect the functioning of such projects. Thus, it is the conviction of some health professionals in the Yendi District that the gradual transfer of all the personnel associated with the implementation of the

Bamako Initiative out the district partly explains the inability to revive the programme after the ethnic conflict in 1994.

9.7.4 Logistics and Supervision

Supervision and monitoring of community level auxiliary staff is undertaken in a number of ways. One method employed is certification after completion of the course. Certification is a kind of license authorizing community health workers to operate officially in the communities. This is normally done in public through a durbar where all stakeholders are invited to attend. During such gathering the modus operandi of the participation is explained to the community and the community asked to play a watchdog role in ensuring that the services are performed according to defined programme requirement. This is particularly so in the delivering of curative care.

The certification is withdrawn when one performs contrary to programme specification. Only few instances of the withdrawal of certificates from VHWs have been reported in the sample districts. Normally, it is those who train the health workers (TOTS) who undertake the supervision. This was the method used prior to the institutionalisation of the sub-district system in the health sector. The advantage with that system was that those who trained the health workers know their strengths and weaknesses during the training, which they were expected to reinforce during supervision.

However, following the institutionalisation of the district and sub-district health system, supervision has become the responsibility of the sub-district and integrated into routine outreach services and carried out at predetermined periods usually, monthly. However, they are sometimes infrequent depending on the season, as some communities are less accessible during the wet season.

Supervision through outreach visits is more regular than previously undertaken by trainees of community level staff and special people trained for the purpose. In recent times, review meetings are being organised in order to supervise and monitor village level health auxiliary staff or Community Health Workers. These are usually organised at the sub-district capital for group supervision. Quarterly review meetings are used for TBAs by MOH in the Builsa and Lawra Districts. The NGOs with the health sector organise more frequent review meetings for their TBAs and VHWs.

Monitoring and supervision serve several functions including backstopping, service regulation and control, collection of records and information and motivation. Many community level auxiliaries draw intrinsic rewards from interacting with sub-district staff at the community level and this serves as inspiration to them. They are also useful for problem solving specially through peer exchange of experiences. Sub-district staff indicated that supervision has improved in their sub-districts with the supply of transport and communication equipment. However, supervision was better in those sub-districts receiving special programme support under UNICEF or CRS programmes. Infrequent supervision is blamed on low staff levels, seasonal factors and unplanned programmes such as workshops, often dumped on the sub-districts from the district and above.

Community level mechanisms for supervision are being experimented. These include the use of Village Development Committees and now, Community Health Committee or Teams and the use of associations of specialised groups collaborating with the health sector. The latter was experimented with trained TBAs in the Lawra and Builsa Districts with little success. These innovations are confronted with problems associated with group/committee participation and as such are ineffective.

Supervision of the services of community level auxiliary staff is tied to the entire success of community participation (Neumann (1986). This is because without regular supervision the services and interests of auxiliaries would diminish over time and they are likely to revert to pre-training habits. The lack of supervision of auxiliary staff under the National Village Health Worker Programme explains the excesses of the Village Health Workers in the 1980s and early 90s leading to the abolition of the programme.

9.7.5 Funding of Programmes

The data show that participation is donor driven in many respects. Health sector reforms under the PHC leading to the institutionalisation of community participation programmes such as the District and Sub-district Initiatives and the Bamako Initiative were pursued with donor funding. The NTBA and current programmes such as the growth and nutrition monitoring and disease surveillance are also donor funded although the Ministry of Health may have initiated them.

The data also show that there is little support from communities to the above-mentioned programmes. Many of the communities are not even able to support their local representatives or auxiliaries on projects at the community level. As a result the bulk of the funding for community participation is the responsibility of donor agencies and NGOs. The inability of health centres in the districts to organise Institutional Management Committee meetings regularly in the Upper West Region following the pullout of DANIDA from the region as well as the inability to organise VAP review meetings in VAP communities in the Builsa District for 2000, clearly illustrate the importance of donor funds in community participation programmes.

9.7.6 Health Sector Restructuring

In the past, the implementation of community participation projects within MOH always resulted in organisational resetting to systematically implement and co-ordinate them. The PHC system created a PHC co-ordinating secretariat. Similar arrangements were made for the implementation of the National Village Health Workers Programme, the NTBA and Guinea Worm Eradication programmes and so on.

As part of the organisational resetting, regional and district institutions are created with new administrative routines to incorporate new programmes within the MOH structure. These normally involved the appointment of co-ordinators to run programmes at the various levels, sometimes with Trainer of Trainers appointed also at each level. Before the restructuring in 1992, the formula for organisational resetting was comparable to the creation of vertical programmes making it possible for projects to be controlled from either Accra or the regions.

Following the decentralisation exercise and the development of the District and Sub-district health systems, there have been attempts to implement programmes using existing health management structures such as DHMT and SDHMTs. Within the district, the implementation of programmes is now the responsibility of the district management team with special co-ordinating responsibility on the specialist on whose purview the programme falls. In line with these developments vertical programmes have been realigned with routine MOH management structures.

Within the new structure of the MOH, the NTBA now functions as part of the Technical, Co-ordination and Research Directorate [TCRD] and as a wing of MCH/FP under Safe Motherhood programme in IE&C, management support and training. At the regional level, the programme is part of the RHMT with the schedule officer [contact person] as PNO [PH]. The DHMT has the responsibility for TBA issues at the district level with the district public officer being the schedule officer or any body appointed by the DHMT. Similarly responsibilities rest with the SDHMT at the sub-district level and the trainers are primarily midwives. Similarly Institutional Management arrangements offer other opportunities for participation at the district and sub-district levels and these institutions should be devolved further to the local level.

9.7.7. Institutional Capacity of Health Districts and Sub-Districts

The District and Sub-District Health System reforms, which started in the late 80's with the Primary Health Care System, remodelled health care administration and delivery into a three-tier system to be contained within the district. The reforms encouraged district-centred health management, resulting in the development of the District Health Management Team system. Currently all the twenty-four health districts in the three northern regions have some degree of autonomy. District health management responsibility is in the hands of professional health personnel with training in public health education. Office administration facilities and equipment have been provided by ODA to ensure effective management.

Over one hundred and forty sub-districts health structures have also been created by December 2000: seventy in Northern, forty-two Upper East and thirty-five in the Upper West Region. Sub-district health management has also been institutionalised with the formation of Sub-district Health Management Teams. Through capacity building programmes under the strengthening of districts and sub-districts initiatives pursued in the northern sector in the early 1990s, teams have acquired management skills. Sub-district teams operate from their health centres with the support of interim management committees, which have community representation. The formation of Interim Management Committees started in the early 1990s and the majority of centres had their management committees established in the northern sector by 1992. Quarterly meetings were organised by management committees and pioneering meetings of committees centred on the formation of health committees, cash and carry, TBA and village health

worker training, and health centre finances. User-fee exemptions, recovery of fees from patients and the maintenance of health centre equipment such as cold chains etc are issues of concern to management committees in the Upper West Region, where most of the management institutions are still functioning although meetings have become less regular. Bi-annual instead of the agreed quarterly meetings, were organised by most management committees by the close of the year 2000. In the Builsa District only the Institutional Management Committee of the Fumbisi health centre was reported to be functioning while the Jimile and Sang management committees were those still functioning in the Yendi District.

The communication situation in most districts and sub districts has also improved. In the Upper West Region in particular sub-districts are equipped with radiotelephone system, linking them and their districts on the one hand and with the regional directorate on the other. Sub-districts have also benefited from Save the Children Fund/DANIDA MOH collaborated transport policy programme, which has led to the supply of motorbike to sub-districts. Personnel of districts and sub-districts have acquired bike riding and preventive maintenance skills and supplied motorbikes to cater for their transport requirement. These developments have facilitated easy movement of staff of the sub-districts.

Health districts now operate their own financial budgets following recent financial reforms introduced in the health sector. This has increased resource flow to sub-districts making it possible for them to meet recurrent expenditure needs, fuel and equipment maintenance.

Various forms of arrangements for community level services delivery have been introduced under the reforms. For example, communities without static facilities are provided with outreach services at predetermined period of the month. During outreach visits professional health personnel provide integrated services. The data show that almost every community receives one outreach visit per month in the three northern regions.

There are auxiliary health workers resident at the community level at communities quite distant from the sub-district facility. These are trained TBAs and CBSVs, which are

present in almost every community. The services of CBDs and VHWs are however limited to few communities and districts in the regions under discussion.

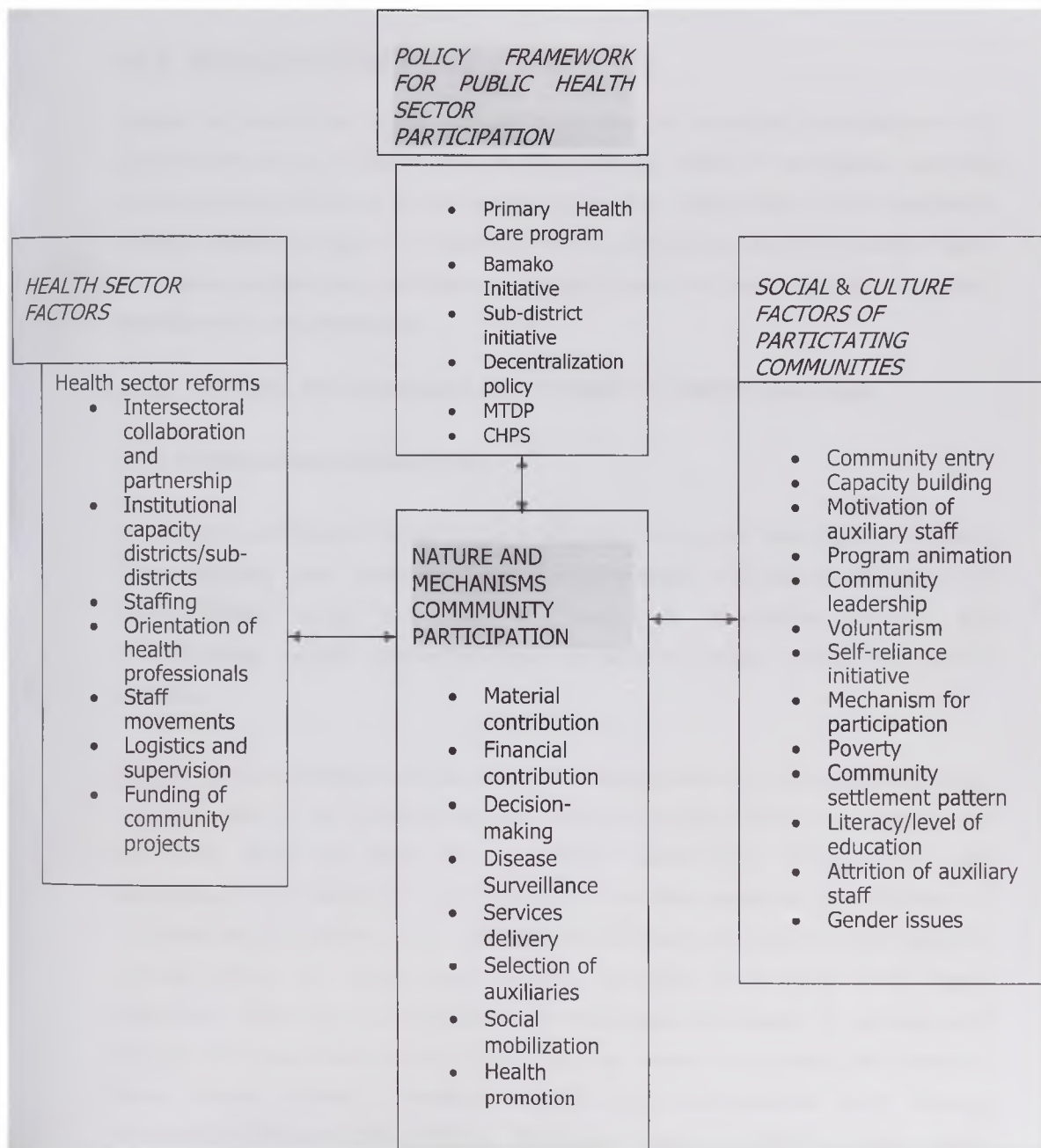
In spite of attempts to extend health care to the doorsteps of people in the three regions, the situation remains unclear with regard to the structure and functioning of institutions for community level health management. Efforts to institutionalise Community Health Committees failed in many districts in the Northern and Upper Regions. The data point to isolated cases of effective Village/Community level Health Management Committees. And these isolated cases are restricted to CHAG sub-districts especially those operated by the Presbyterian Health Services under their Village Health Worker programme. Some donor-led programmes such as the CBDP and the FACS programmes by UNICEF and CRS in Yendi, Builsa and Lawra Districts respectively have established community level structures to co-ordinate and oversee community level planning and problem solving. The CBDP organs are called VAP Teams while the CRS counterparts are village volunteers with subgroups overseeing health development and food management. The operation of these is limited to few communities in the three northern regions and is on experimental basis.

Thus, the absence of community level health structures to co-ordinate health planning and problem solving among community members and their village level organs/units is a shortcoming in the restructuring of community level care in the northern-sector. The institutionalisation of the unit committee concept has not caught up with this challenge in many communities visited. The institutionalisation of the three-tier health system through the district and sub-district system has thus made it possible for setting boundaries for health sector participation: primary/secondary and tertiary level care. It has also established a framework for the administration of referrals, especially the ones from the community level. Finally, the issue of health management and administration has become a stakeholder issue and not a preserve of health staff. Although much progress is made on the former issue, the progress on the latter is mixed as demonstrated by the data on the functioning of health management or institutional teams at the district level.

From the above discussion the causative and contributing factors of community participation can be summarised graphically in the figure in page 170.

Fig. 6. FACTORS INFLUENCING COMMUNITY PARTICIPATION

**FRAMEWORK FOR CAUSATIVE AND CONTRIBUTING VARIABLES OF
COMMUNITY PARTICIPATION IN PUBLIC HEALTH IN GHANA**



CHAPTER 10

10.0 CONCLUSION AND PROPOSED MODEL FOR PARTICIPATION AND PARTNERSHIPS IN THE PUBLIC HEALTH SECTOR OF GHANA

10.1 INTRODUCTION

Chapter ten synthesizes the nature and mechanisms of community participation in the public health sector of Ghana. Also discussed are the forms of participation and how empowering participation has been in the sector. The chapter looks at the relationship between reforms pursued in the health sector and participation, and recommends a model for achieving empowering participation in the health sector of Ghana including macro-micro strategies for its implementation.

10.2 NATURE, MECHANISMS AND FORMS OF PARTICIPATION

10.2.1 Community and local level

Communities participate in broad scope of activities in the public health sector of Ghana. These activities cover community entry and preparation, information, education and communication, social mobilisation to aspects of programme planning and implementation where communities make contribution in ideas, material and financial resources.

Communities also participate in the delivery and management of curative health services. However, there is no consensus on the scope of services delivery communities can participate. Under the global PHC programme, communities, through VHCs could participate in the treatment of all manners of ailments except the administration of injections and prescriptive drugs. Although this still forms the basis for participation in services delivery for Village Health Workers operating under church based health institutions, MOH seems to disfavour such broad-base participation by auxiliary staff because of abuses experienced over the years. The current policy within MOH seems to favour services delivery in ordinary obstetrics and non-prescriptive family planning delivered by TBAs and CBDs [MTHS]. This partly explains why MOH no longer employ

the services of Village Health Workers. The case studies show that participation in curative health services by community auxiliary staff is the most contentious and public health professionals are divided on this aspect of participation because of the inability of the public health sector to effectively monitor the participation of auxiliary staff in curative services delivery.

Community participation in needs assessment and planning issues was reported to be limited. Even though communities are involved in data collection through surveillance and growth monitoring programmes, actual use of the data in community problem assessment is rarely done. The CBDP and FACS offer communities the opportunity to engage in project or programme planning through the VAP and Village Health Committee systems respectively. However, the opportunities offered by the CBDP and FACS are limited to seven districts covering about one hundred and fifty communities in the three northern regions (UNICEF and CRS project districts). Further more, the process still requires facilitation in order to cultivate the desired effect.

Thus, although a wide-range of public health activities/services is open to the participation of communities, actual participation, as shown above may be limited from one community to another as a result of the varying infrastructure of the communities involved, nature of the district or sub-district health programmes or the specific health provider involved. Consequently, community participation in public health issues vary across communities, health sub-districts and districts, and among the different health providers engaged in modern health care delivery. These variations are the source of the confusion about community participation in the public health sector.

Communities participate in health in various ways: through individuals selected and trained or health experts in traditional healing retrained to play assigned roles, especially in care delivery. They also participate through forms of representation, normally in-groups, teams and committees either formed or already existing in the community. The findings also show that group and team forms of participation serve as platform or umbrella for bringing together members involved in the first two forms of participation for purposes of problem solving. As indicated by the data, community level health workers are often encouraged to attend group/committee/team meetings. The skills, orientation and motivation of participating individuals, determine the success of the first type of participation. In the case of the other two, group dynamics are key to success.

Group forms of participation as expressed in institutions such as Community Health Committees and Institutional Management Committees have been found to be less active as they easily become dormant. In the case of the first two forms, participation is targeted at individuals who have skills to bring to bear on the process of health care delivery and management. Finally, communities participate as a whole in specific health assignments or project activities and in selecting members to represent them.

The above channels through which communities participate in public health affairs are not exclusive; but represent a variety of ways through which community members participate, sometimes, serially or concurrently.

Community participation serves different interests in the health sector. Under the PHC system and related programmes, community participation was perceived by health sector professionals and designers to extend supervised and quality primary health care services to the community or level A. Through the participation of communities, the public health sector seeks to harness both human and material resources of communities for health services delivery and development, and the extension of the coverage of health services. Participation was aimed at minimizing costs through the use of community level auxiliaries without MOH creating employer-employee relationship with them in health care services delivery and management.

Although the above continues to influence public health sector policy on participation, participation under the MTHST and the Community-Based Health Planning and Services (CHPS) seeks to ensure that public health services are tailored to the needs of the communities so as to increase the patronage of services and legitimise projects. Emphasis is no longer placed on the extension of the coverage of services alone but also on their acceptance and utilisation. Thus, participation in the public health sector plays an instrumental role – a means of making health services available, efficient and accessible socio-culturally. Because participation is geared towards improving the coverage and quality of health services, the outcome of participation is normally measured using service output indicators and not process indicators.

The case studies show that the needs and interests of members of the community determine the nature of their participation. Community participation on the part of TBAs is seen as an opportunity offered them by the government/or public health sector to

serve their people - an undeserved privilege, some of them thought they cannot shirk. In the case of auxiliaries, the motivation to participate in health is guided by the determination to provide services to members of their communities. And there are yet some of them who see the opportunity as stepping or leverage for paid work or opportunity for social recognition. The above thus shows that the interests of programme designers and implementers on the one hand and those of community members and other grassroots on the other hand, as far as participation is concerned, do not always match neatly neither are the interests just there but are constructed by the participation process (White, 1996).

The findings also show that community participation in health is more a means rather than an end process - geared towards improvement of the health status of communities rather than confidence building and empowerment. Although the means-type of participation has its own capacity building component, it is more geared towards creating and improving services and not changing power relations. It is within this context that Rifkin's (1996) classification of participation as target oriented and as empowerment is more appropriate. In the target oriented framework, participation is characterized by the following: a way of mobilizing community resources to supplement health services; a means to an end; passive, responding to professional direction; and best evaluated by quantitative methods.

The empowerment participation on the other hand, is a means of giving people power over their health choices; active and based on community initiative; a process whereby communities are strengthened in their capacity to control their own lives and make decisions without the direction of professional authority; and best evaluated by qualitative method.

10.2.2 Participation through Collaboration and Partnerships

The case studies point to community participation through partnership and collaborative arrangements. The collaboration of the public health sector with private health sector providers is progressing slowly in the three northern regions. In the Lawra and Builsa districts in particular, private non-profit sector providers are allocated designated health sub-districts to concentrate their operation in order for their services to make the desired effect. There are also support mechanisms provided to the private-non-profit sector and

sub-district staff of these agencies to benefit from training and workshops aimed at capacity building. Personnel of the private-non-profit sector are also involved in decision-making at the sub-district and district through representation on sub-district and district management teams. In the districts where Church Based Health Providers operate in selected sub-district, they are represented on sub-district and district teams. Guidelines are however, required to formalise the relationship.

The situation is however, different in the area of local collaboration with the private-for-profit sector. Links between the public health sector and the private for profit sector are being fostered and the focus is more on the enactment of the necessary laws and legislation to regulate the private-for-profit sector practice. In line with these developments, traditional healers are now required to seek licenses from the District Assembly as a precondition for operation. There are also Information, Education and Communication programmes targeted at the private-for-profit sector, such as chemical drug sellers and pharmacies in the northern sector. These activities geared towards fostering collaboration and partnerships are still limited in scope and private -for-profit sector and public health sector local collaboration in the area of decision-making in particular is being tackled slowly.

Writing on integration of the traditional and public health sectors, Bichmann reported that although full integration between the traditional and public health sector was possible in the area of what he terms as "primary medical resources – drugs, techniques and empirical knowledge, what one finds in practice is "structured co-operation" within mutual referral systems (Bichmann, 1979: 178). The public health sector tries to incorporate traditional medical knowledge by grouping and supervising them as a special category of auxiliaries. The case studies show that collaboration between traditional healers at the local level and the public health sector has been limited to midwifery services delivery in the area of ordinary obstetrical care and family planning. Complicated aspects of care under traditional midwifery practice has been discouraged and designated under referrals. Not much has been achieved on local partnership and collaboration between the public health sector and traditional healing. Healers are still undergoing institutional organisation in many of the district surveyed to be able to foster collaboration with the public health sector.

Except at the Community Based Development Planning programme districts, where integrated planning is done involving selected communities, sector departments and NGOs, there are no visible signs of collaboration between MOH and other Ministries and Departments [MADs] in the three regions. There is evidence that MOH collaborates with those non-governmental agencies operating in the health sector such as CRS, PPAG and bilateral agencies such as UNICEF and WHO. However, the specific programmes define the nature of the collaboration and institutional networking. In most NGO programmes, focal persons are appointed within MOH for programme monitoring and such persons also participate in programme review and planning activities. However, NGO programme personnel are not invited to attend District Health Management Team meeting or to participate in planning sessions.

10.3 PARTICIPTION AND HEALTH SECTOR REFROMS

Reforms pursued within MOH and the whole issue of participation, are intricately linked together. Historically, the idea of community participation in health marks a paradigm shift in the modelling of health services. The PHC system marks the beginning of major health sector reforms in Ghana resulting in the re-conception of health and the definition of a three-tier system of services delivery and health care administration.

The PHC system developed a district health system but instead of integrating programmes, it created vertical institutional arrangements within the public health sector. Vertical programmes proliferated district and local level institutions for participation, creating problems of co-ordination and supervision in the public health sector. Thus the health sector reforms and the nation wide district-led decentralization exercise pursued in the 1980s and 90s sought to strengthen the institutional capacity of the districts for decentralised decision making and services provision.

The reforms redefined the functions of MOH, created the GHS and realigned vertical programmes within the public health sector. This has given impetus to the integration of services especially at the district level and below for local participation. It has also resulted in the redefinition of roles in the health sector in the following areas: policy formulation, planning, service delivery, support systems and supervision and training. The process has legitimised the role of the district as planning and service delivery entity with policy issues reserved for the regions and above.

The reforms have contributed to the expansion of health institutions and management mechanisms beyond the district level for local participation in health. Districts and sub-districts now have management teams and sub-district health centres have also established institutional management committees. Institutional capacities of the districts and sub-districts have also been strengthened for the facilitation of local participation in aspects of training, supervision and logistic backstopping for services promotion and delivery.

The restructuring of MOH has resulted in the creation of a directorate for traditional medicine and a unit for private sector health within the Policy Planning Unit. The strengthening of the Policy Planning Unit of MOH contributed to the formulation of the Medium Term Strategic Framework of Action for the first time. The policy has refined health policy in general and community participation within the framework of the CHPS. For a long time, the policy on participation was in bit and pieces and determined mainly by global programmes on participation leading to variations in actual participation along programme lines.

The CHPS seeks to provide an integrated policy for community participation in health. The policy unifies already existing strategies of community participation into an integrated whole entailing a systematic procedure for implementation at the various levels: district, sub-district and the community. Within the CHPS, professionals at the district level and below and community members are actively engaged in the delivery of primary services. The key features of the CHPS are:

- community participation in primary health and family planning services delivery through Community Health Committees and Volunteers;
- mobilising and reorienting MOH and district assemblies to support the initiative at the district;
- use of volunteer or health worker, TBA etc. as community level auxiliary staff
- reliance on health committee initiative at the community level;
- requires the provision of a structure to house the operation of volunteer or health worker;

- sub-district/district support and other programmes on contact/zonal representatives, charged with the responsibility for co-ordination and supervision; and
- locating Community Health Officer in communities within a community compound.

The strategy reaffirms the district health system with sub-district and community structures as agents for consensus building and problem solving on health. The strategy also integrates aspects of the process into a comprehensive programme cycle for systematic implementation. However, the model of participation proposed is internal to the public health sector since due recognition was not given to other health providers in the process. CHPS can therefore be seen as a strategy of the GHS to extend health services to the community level and not a strategy for broad based community and stakeholder participation in health delivery.

This therefore brings to fore the lingering question of whether the MOH as an organ of service delivery in the country can facilitate a broad based health sector participation that is empowering and based on partnership. Or whether genuine health participation structures can be part of the structures of the Ghana Health Services. It is the expectation that the implementation of the Ghana Health Services Act will make it possible for MOH to facilitate stakeholder participation in public health genuinely, which is without favouring the modern health sector as was done in the past.

Despite the progress made in local participation in health as a result of the reforms introduced within MOH and by the nation wide decentralization exercise, there are still constraints to participation emanating from the lack of clarity of the policy on the role of auxiliary staff in curative health services delivery. There is the need for consensus building on what role auxiliary health staff at the community level should play in curative care. Of particular importance is the clarification of the position of Village Health Workers.

The institutional restructuring for community level participation has also fallen short of a clear-cut institutional arrangement for aligning and coordinating the services at the community level. The status of the Health Committee System for planning at community level and problem solving in health remains unclear. It is now uncertain what constitutes the acceptable institutional arrangement for community level care within MOH for all

community service providers. The absence of such broad based institutions or structures isolates community level health workers making them unable to come together to plan or take health decisions affecting their communities or for purposes of problem solving. Similarly, the lack of such structures creates problems about health sector care policing and the provision of technical backstopping to community level auxiliary staff.

The reforms in the Ghana public sector precipitated by the decentralization exercise have led to the proliferation of sub-district structures by sectoral departments nationwide. However, the sub-districts created by the MOH appear to be more institutionalised than those of the other sectors including the area, zonal councils and unit committees. The case studies reveal that sectoral sub-districts are operating independent of each other. There is the need for an alignment of sectors at the sub-district level for purposes of integrated participatory planning for health development. However, the question of which sector is to play the role of coordination in the process, remains unanswered. The District Assembly is facilitating integrated planning at the district level under some special programmes such as the CBPD. However, the experience so far shows that some districts politicise development programmes thus making them less effective. This may partly explain the reason for the MOH staying outside the District Decentralised Department system. There is therefore the need for a neutral organ to facilitate the process in order to give it the desired legitimacy.

Other areas of policy concern are logistics and motivation. The case studies show that the role of communities in motivating auxiliary level personnel is nothing to be desired. As a result various programmes have initiated forms of motivation for their community level auxiliaries resulting in the lack of uniformity in motivation systems for auxiliary staff. There is the need for building consensus on systems of motivation to be provided in the public health sector for auxiliary staff and other actors involved in community participation at the local level. There is also the need to define the role of communities in providing systems of motivation and other support systems.

10.4 PROPOSED MODEL OF COMMUNITY PARTICIPATION

The data show that the restructuring of the Ghana health sector and the adoption of CHPS model have repositioned community participation as a means of achieving health services objectives or goals. Participation in the public health sector is meant to mobilise the economic and social resources of communities to achieve predetermined health targets. The results of participation as determined by the targets are considered to be more important than the acts or processes of participation and the outcomes are measured using health services indicators.

The type of participation being pursued is not far reaching enough. It has failed to allow broader participation in public health sector planning, decision-making and services delivery by communities, civil society organisations and the private sector. It also lacks appropriate methodology and techniques to measure the participation process. Furthermore, the means-type-participation under review has succeeded in developing wide range of health services structures but lacks adequate health development structures to facilitate and co-ordinate collaborative and partnership arrangements among health providers and stakeholders.

There is therefore the need to put emphasis on participation as a process in which confidence and solidarity among communities and stakeholders are built up to ensure active, genuine and empowering participation. This type of empowering participation can be achieved by deepening the restructuring in the public health sector to enable MOH to position itself as a neutral coordinating body of all health care providers and not an appendage of the modern health care sector. This is what Coalition for Participation and Partnerships in Health (CPPIH) seeks to do.

CPPIH is a process designed to offer all health stakeholders – communities, civil society organisations, private sector – full partnership, complete and sustainable involvement in all stages of the public health care delivery process - identification of needs, selection of priorities, planning, implementation and evaluation. CPPIH is modelled on empowering participation and as such stresses equality among health care providers that should lead to power sharing between the public health sector and other health care providers in decision-making in health matters under the facilitation of MOH.

CPPIH seeks to enhance awareness and build up partnership and participation structures outside the control of the formal structures of GHS as a fundamental condition for effective participation in the public health sector services delivery and management. The proposed system of participation is envisaged to change existing institutional arrangement and to foster resource pooling and joint planning mechanisms among health providers.

- CPPIH provides an institutional framework for community and stakeholder participation in health;
- Framework for services delivery management and resource mobilization; and
- Indicators and procedure for measuring participation.

10.4.1 Institutional Framework

Health development requires personnel of the public sector to work outside their established hierarchies and organisation and develop networks and forms of collaboration that are significantly different from the traditional working patterns of the public health sector. Many health development agencies such as civil society organisations, the private sector and other sectors such as education, agriculture, water and sanitation which operate outside the public health sector require this form of organisational arrangement for parity in partnerships and collaboration.

A model such as Coalition for Participation and Partnerships in Health (CPPIH) satisfies such an organisational requirement. The coalition or network shall comprise representatives of all the key and distinct health care providers in the country, befitting the plurality of the Ghana health sector: public, private, traditional and other providers (MOH 2001). The coalition should have sub-district, district and national structures.

The coalition will interface with MOH and individual distinct health providers in the health sector and serve as conduit for joint planning, monitoring and evaluation at the various levels of the district health system. It would also serve as the mouthpiece of MOH partners, offer mechanisms for broad based representation by the community and other

stakeholder and provide mechanism for problem solving within the partnership framework.

Community Level

Coalition for Participation and Partnerships in Health (CPPIH) at the community level will comprise the various groups in the community. These will include representatives of chiefs and opinion leaders, leaders of religious, youth and women groups. In addition there should be a representative of the Community Health Team. The functions of the CPPIH should include the following:

- develop greater local consciousness on health issues;
- community mobilization for health;
- problem solving ;
- partnership management;
- environmental hygiene and sanitation;
- resource mobilisation for health services financing/ Health Insurance; and
- motivation of health providers at the community level.

In addition to the CPPIH, there should be a Community Health Team (CHT). The composition and functions of the Community Health Team should differ from the one proposed under CHPS. The new health team at the community level should comprise all distinct health providers at the community such as TBAs, herbalists, volunteers, chemical sellers, community weighing teams and so on. The Health Team at this level should have the responsibility for providing primary health care including the following:

- disease and nutrition surveillance;
- ordinary obstetrics and growth monitoring;
- non-prescriptive family planning services;
- sale of non-prescriptive drugs; and
- management of referral services.

The proposed community health team will be a health service delivery structure while CPPIH serves as a health development structure at that level.

Sub District

The coalition structure at the sub-district would be higher than the sub-district health delivery structures: Sub-district Health Management Team and other health services structures. It should comprise representatives of NGOs and private sector providers in health care in the sub-district as well as representatives of ministries and departments whose activities have bearing on health. The SDHMT should be represented on it. CCPIH should have the broad objective of overseeing health development issues in the sub-district. The specific functions of the coalition at the sub-district should include the following:

- management of a data bank in the sub district;
- strengthening existing community health structures through capacity building and planned development activities;
- facilitate the sharing of resources, material and information;
- facilitate joint programme planning, implementation and monitoring;
- coordination of joint health programmes; and
- management of partnerships/collaboration and problem solving.

District Level

The highest decision making body on health in the district will be CPPIH. Its membership should comprise representatives of all distinct health groups (NGOs and private sector providers) providing health care in the district and Ministries and Departments including representatives from the District Health Management Team. To ensure the principle of partnership and parity among the various representatives, a representative of MOH from the region will chair the coalition.

The functions of the coalition at that level include:

- defining health needs;
- harmonising health priorities into district health plans;
- monitoring local health services provision;
- executing health programmes and projects in the district;

- regulation of health services; and
- partnership management and problem solving.

10.4.2 Services Delivery and Community Mobilization

To reflect the growing pluralism of health providers in the health sector, the delivery of health services under CPPIH will be modelled on partnership and collaboration within defined geographical areas: a system of zoning at the sub district level. The process must be facilitated by MOH by defining a framework for the partnership and service areas. This will require very clear and comprehensive District Health Development Plans (DHDP) specifying priority areas to guide the activities of all stakeholders in the sector at the district level. All key actors in the sector must be involved in the development of the DHDP through their coalitions.

Secondly, a multiple zoning arrangement will be implemented in order to tackle the problem of lack of coverage of specialised care and competition between service providers. Distinct health providers with demonstrated capacity and personnel to provide primary and secondary care on the ground should be allocated sub-districts or zones. Most of the Christian Health Association of Ghana (CHAG) members qualify to operate sub districts under this arrangement. This is because the church based NGOs in particular, have enormous experiences in the delivery of health services. Such a zoning arrangement is currently practiced in some districts.

Under the above arrangement, those providers with limited capacity to operate a zone or those that provide specialized services with relative advantage in areas such as community mobilisation, immunisation, nutrition, family planning, bone setting, mental health etc, should be encouraged to enter into broad coalitions with other providers within defined geographical areas. This means that health providers within the private and public sectors, with different functional specialisation will be encouraged to come together to provide services for the public sector under contracting arrangements. This arrangement will streamline community level services under the network and partnership arrangement.

10.4.3 Indicators for Monitoring CPPIH

The findings show that participation is normally monitored indirectly through the health sector output indicators. Coalition for Participation and Partnerships in Health (CPPIH) proposes a mechanism for direct monitoring of the activities and processes of community participation focusing on the following:

- health development structural arrangements: the scope of the institutionalisation of the process (health management and development structures) at the various levels and the necessary legislation for partnerships passed at the national level in order to give the process the desired legitimacy;
- activities – local health initiatives in the area of awareness creation on public health issues and problem solving and so on;
- procedure for action: framework for joint decision-making at all levels such as meetings, review meetings and joint planning sessions instituted;
- capacity and orientation of partner: level of awareness about CPPIH at the various levels, demonstration of culture of partnership and skills for community mobilisation, communication and animation; and
- Political will: commitment to district level decentralisation, resources flow and legislations for partnership managements.

10.4.4 Precondition for Success

- Commonality of purpose: The provision of health services is the responsibility of many agencies who should be prepared to come together;
- Sharing of knowledge and resources: sectors have knowledge of activities and programmes to pursue and must ensure that these are shared with other stakeholders operating in the same area;

- Goals and Objectives: Health goals and objectives must be agreed among partners. Similarly, objectives must be seen as intelligible to all parties;
- Training – training in the culture of partnerships and skills necessary for fostering participation and partnership; and
- Political support – provision of the needed legislations and resources for partnership management and problem solving.

The assumptions of the model include the following;

- That the health sector is open to the participation of all recognised health care providers and that no single provider has sole responsibility for the health of the people;
- That there is the genuine commitment of MOH to facilitate and promote community and stakeholder participation in health; and
- Health care providers know their health care needs.

10.5 STRATEGIES FOR THE IMPLEMENTATION OF CPPIH

10.5.1 Institutional Restructuring For Local Collaboration

The data show that the necessary institutional arrangements to facilitate empowering community participation and partnership in the public health sector are lacking both at the district and the community levels. This is because, what the CHPS has done is to extend GHS structures to the community level through the activities of the CHO. The Coalition for Participation and Partnerships in Health fills that institutional gap for broad and empowering participation. However, the implementation of the model needs to be pursued within a well-defined institutional framework.

Within this framework, there is the need to streamline the organisational mechanism of the various distinct health care providers: private-for-profit sector including traditional healers and private-non-profit. It appears the private non-private sector has established

clear institutions for internal regulation and networking with the other sectors. The private-for-profit sector including traditional healers has to do the same. Comparing the modern private sector with traditional healers, it appears the problem of the reorganisation of the sector has more to do with the traditional sector, and ways must be found to facilitate that process. At the district level, the District Assembly should facilitate the process without politicising it, as it is being done with the VAP planning process in some communities. Distinct lines of specialisation or defined areas of operation should constitute the principle for the organisation of the various sectors as a solution to the problem of lumping different specialities together, which creates conflicts. Once these splinter units are established, the CPPIH will become the rallying organ of the splinter groups and thus a mechanism to ensure the networking of the different specialist groups. CPPIH strives on internally well-organised splinter health providers within the district. Networked institutions will be decentralised below the district where the joint planning and decision-making will be done.

The principle of partnership envisaged under CPPIH requires equal relationship between the partners. It also requires that the process be facilitated by MOH. MOH will play the role of a neutral coordinating body and not an appendage of the modern health sector. The present institutional arrangement of the health sector of Ghana now puts the MOH in the position to adequately facilitate health sector collaboration and partnership effectively. In the past the service delivery role of the MOH made it more aligned to modern health care delivery to the disadvantage of the other sectors, especially the traditional health sector. The creation of the GHS and the de-linking of the policy role from the service delivery of MOH can be seen as a boost to genuine collaborative and partnership institutional arrangements between service providers in the public health sector.

Disengaging MOH from its service delivery function and restricting its role to policy and broader planning issues for the health sector as a whole and not the modern health sector alone, sets the institutional framework for facilitating broad based health sector participation. This will also do away with the suspicion that has characterised the relationship between MOH and other health care providers.

An important aspect of the institutionalisation process is the enactment of the necessary legislations to give partnership structures the desired legitimacy. This process must start

with a framework for partnership between the public and the private sectors in the country. This process will establish the legal basis of partnerships as well as the principles and mechanism for problem solving. This process has begun at the national level by the National NGO Policy and Partnership Framework and MOH and the Ministry of Private Sector Development must lobby the process to get the bill passed.

10.5.2 Framework for Participatory Planning and Decision Making

The findings reveal that there is policy gap of a clear framework for participatory decision-making involving all key health providers at the various levels of health delivery. CPPIH replicates the Village Level Action and Planning process across the board in the health sector. Such a strategy will offer communities, healers, TBAs, chemical sellers and others the opportunity to participate in planning and decision making and offer opportunities for information sharing and problem solving in a holistic manner. That aside, there is the need to define the processes and procedure for decision-making at all levels of the health sector: e.g. planning sessions, review meetings for problem solving, training sessions etc. The processes for participation should also be defined in terms of objectives and outcomes for monitoring. Similarly participatory monitoring mechanisms should be implemented to track the processes of participation.

10.5.3 Framework for Stakeholder Orientation on Participation and partnerships.

The lack of thorough understanding of the concept, tools and principles of participation has been identified as one of the constraints of participation confronting various stakeholders in health care delivery and management. There is the need for a broader orientation on Coalition on Participation and Partnerships. The orientation should cover all the stakeholders on the process, principles, objectives and strategies.

Orientation of Health Providers

The data show that participation and partnerships are weak where health professionals themselves have no proper understanding of the concept of participation being pursued in the sector. In most instances, participation is reduced to awareness creation for individuals and groups to enable them engage in proactive health behaviour. Such a narrow conception of participation affects its implementation, especially empowering

participation, in the health sector. The training for health professionals must aim at succinctly defining the concept of participation as perceived under CPPIH so that a broader consensus is achieved across health professionals in the public health sector.

Related to the above is training on how to facilitate the process of participation in the health sector. The content of such training should focus on developing facilitation and animation skills of district level health professionals on aspects of community entry and preparation, communication and broader aspects of animation so that communities can set targets in health and work towards achieving them.

The case studies reveal that knowledge in public health among health professionals is not enough for the development of community entry and animation skills and aside, the majority of district based health professionals, possess only technical skills without community development and mobilisation skills.

Similarly the training in CPPIH should be extended to cover other distinct health care providers – civil society organisations, traditional health practitioners and the private for profit sector. The proposed partnership arrangement also calls for change management within partner organisations for confidence building and collective action. There is therefore the need to address change management issues within the respective organisations forging partnership arrangement. The fundamental importance of the following in change management must be addressed:

- strong and visible leadership. People must know that the process is 100% supported by their superiors, all the way to the top, and that they are not in any way being subversive, working against the organisation's values or jeopardising their chances of promotion by working with the private sector,
- inclusivity. Nobody should be marginalized from the debate. Information should be clear and freely available. No body should have to rely on supposition or gossip. If people have concerns or worries, they should be able to vent them openly; and
- when we have concrete examples in place, use them to improve understanding, for many, it is not until they can see the nature and the benefits of a new way of

doing things that they will truly understand it, and have any fears allayed. It is worth considering using media such as one-page fliers, short videos, radio interviews or field trips to disseminate the experience.

An enabling environment or a culture of partnerships is also imperative for the implementation of CPPIH. It is worthy to note that in the early stages of rolling out a programme misunderstanding, resentment and /or mistrust on either side can develop and existing ones deepened and further fed by the various players' differing organisational values, and the often better resource position of the private sector. MOH should anticipate this, and take steps to address these problems through training activities to address the following specific issues about partnerships at the district level for selected service providers.

- How partners determine their roles and responsibilities;
- How they determine the pace and substance of their actions;
- How to ensure that individual partners deliver on their respective commitments;
- How individual partners safeguard their own interests, especially in situations of unequal power, access, and control;
- How to resolve communication bottlenecks; and
- How partnership conflicts are resolved.

The pursuance of the above activities is crucial to establishing the norms of collaboration – resources pooling, sharing of ideas, responsibilities and benefits or risks by partners and evolving a culture of parity in relationship characterized by constructive dialogue, transparency, confidence, mutual trust and respect and consensus building, essential for building and sustaining partnerships.

Community Level Orientation

Community level orientation should also be two-faced, targeting the orientation of identifiable community groups and institutions on the one hand and the larger community on the other. Broadly, community orientation should aim at the following:

- gaining entrance into the community and establishing trust with old ones;
- getting to understand the social structure of the community better;

- creating awareness and seeking legitimacy for the implementation of programmes;
- defining roles the community can play in programmes on continuing basis;
- agreeing on mechanism for role performance and understanding changing roles over time; and
- process of reviewing participation.

Community orientation should be integral to any health sector and community points of contact and should be on a continuing basis. This orientation must start first with local level health organisations and community leadership structures and then diffused to the larger community.

Once the process is started at the level of community, groups and organisations and their leadership, then the larger community can be roped into the process. The difference between the process at the community level and that of community organisation or groups is that training may include developing skills in communication to enable leadership at the group or organisational level to orientate the broader community about the process. The process of participation must be guided by partnership, and community based institutions and groups should have specific roles to perform in the orientation process.

10.6 Strengths of CPPIH

CPPIH proposes a framework for broadening participatory planning and decision-making involving all distinct key health providers engaged in the health sector of Ghana. This framework is different from the traditional working of the public health sector. The model replicates the village level action planning process that engages community representatives and technical line agencies in the planning process together. The framework seeks to reposition community participation in health as a health development issue and not just a service delivery programme.

CPPIHS also provides a framework for integrated and holistic health care delivery by all key health care providers through zoning and contractual arrangements modelled on the principle of partnership based on horizontal and vertical integration to ensure the provision of plural, holistic services within defined geographical areas. The model

replicates the benefits of network and collaborative programmes in the health sector and at the same time ensuring that services are holistic and not in bit and pieces as being done now.

For the first time a methodology for measuring and monitoring directly, the processes of community participation is proposed. Measuring the processes as well as the outcomes of participation will create awareness and whip interest in promoting community participation at the par of other health sector programmes.

The anticipated obstacles to this model are obvious. They include the centralised national administrative structures that are resistant to local participation, unwillingness of health professional to accept the participation of traditional and indigenous health care providers in public health care and the rigid sectorial and vertical structures of the national health system. There is also the issue of cost of participation since the results of a process-orientation-participation will require time and above all patience.

10.7 CONCLUSION

The findings show that communities participate in health issues in various forms. Communities also participate in broad scope of health care delivery and management issues ranging from community entry and preparation; information, education & communication; social mobilization and curative primary health care delivery and planning. Of these aspects of participation, participation in primary curative health care delivery and the management of related facilities are the most contentious and limited in scope.

The nature of health sector participation by communities is determined by the Primary Health Care system and the current decentralization policy pursued by Ghana; health sector material and human resources, especially the orientation and capacity of the human resources; and the social and cultural conditions of the participating communities.

Although the PHC system and the decentralization policy are pursued nation-wide, the findings show that the resources of the health sector – the infrastructure, capacity and orientation of human resources vary across the northern sector of Ghana. Similarly, social

and cultural conditions also vary across the length and breath of the three northern regions. As a result of variations in health resources and social and cultural conditions, the nature and forms of participation in health care delivery and management was found to vary between regions and sometimes within districts and sub-districts.

Community participation in the public health sector plays an instrumental role – a means of making health services available, efficient and accessible socio-culturally. Under the PHC system and related programmes, the participation of stakeholders was sought to extend supervised and quality primary health care services to the community level. Although this continues to be the focus of public health sector policy on community participation, participation under the MTHST and the Community-Based Health Planning and Services (CHPS) seeks to ensure that public health services are tailored to the needs of the communities so as to increase the patronage of services and legitimise projects. Emphasis is now on both the extension of the coverage of services as well as their acceptance and utilisation.

One key factor limiting community participation in the public health sector is the inward looking policies of the Ghana Ministry of Health, which has been pro-modern scientific medicine for some time now. The de-linking of the MOH policy function from its service delivery function by the creation of the GHS is therefore in the right direction towards ensuring broad-based stakeholder participation in public health in Ghana. However for the participation to be genuine and empowering, a Coalition for Participation and Partnerships model together with the strategies for its implementation is proposed.

The proposed model together with the strategies, when implemented will set the agenda for the provision of holistic and integrated care based on partnership and collaborative arrangement. This agenda also seeks to institutionalise participation in the health sector at the par of other programmes such as health care delivery, family planning, health education immunisation, and maternal and child health etc. and not as a supporting programme as in the past.

APPENDIX

INTERVIEW CHECKLIST FOR SAMPLED COMMUNITY PARTICIPATION PROGRAMMES [PROGRAMME PERSONNEL OF SAMPLED PROJECTS]

Name of Project/Programme

What is this programme about?

What is the nature of your involvement?

What do/did you do for the project

How did you come to be involved in the project?

What are the various stakeholders of this programme/ project: community level, district level, regional level and donor level

What is the nature of involvement of each of these?

[What does each of these do]

How has the programme met the living conditions, needs and problems of the various stakeholders: community level, District level, regional level and donor level

Which of these do you relate with more closely?

What is the nature of your relationship with the various stakeholders mentioned: community level, District level, regional level and donor level

How supportive is each of these stakeholders to your work

What contribution to the project did you solicit from each of the stakeholders?

- ideas, views and suggestions
- actions/decisions
- information sharing
- material support: money, labour
- immaterial support

What avenue are/were used in soliciting the various forms of support mentioned?

- session planning workshops
- review meetings
- debriefing

How effective are/were these opportunities

At what stage of the projects were the various inputs solicited?

What training has the various stakeholders being given?

How effective has the training been for each?

What are the current training needs of the various stakeholders?

Indicate the level of involvement in decision making of each of the stakeholders:

- community level,
- district level,
- regional level and,
- donor level

In what ways has the project utilised the human and material resources of stakeholders?

What decisions can you take on the project?

What procedures are employed when making these decisions?

How effective are the procedures mentioned?

How have you supported the participation of the various stakeholders?

What challenges did you encounter in promoting stakeholder participation?

- Community
- District
- Regional
- Donor

What are/were your achievements in promoting stakeholder participation?

How satisfied are you with the participation of partners/stakeholders

How shared responsibility and accountability for the project was/is ensured?

What are the effects [positive and negative] of the project on the various stakeholders:
community level, District level, regional level and donor level

Looking back at the programme what would you have done differently in order to ensure genuine participation of partners?

INTERVIEW CHECKLIST (STAKEHOLDERS OF SAMPLED PROJECTS INCLUDING COMMUNITY LEADERS).

Name of Project/Programme-----

What is this programme about?

What is the nature of your involvement in the project?

What do/did you do for the project?

How did you come to be involved in the project?

At what stage of the project were you involved?

How has this programme met your living conditions, needs and problems of the community?

Who are the other stakeholders of this programme?

Which of these do you relate more closely?

What is the nature of your relationship with them?

How supportive are the other stakeholders to your participation?

What contribution have you made to the project?

- ideas, views and suggestions
- actions/decisions
- information sharing
- material support: money, labour
- immaterial support

How were these contributions made?

- durbars

- planning workshops
- review meetings
- debriefing sessions

How effective are/were these opportunities

At what stages of the project were the contributions made?

What training/ orientation have you received since your involvement with the project?

How effective was the training/orientation?

What are your training needs?

Indicate the nature of your involvement in decision making in the project/programme

In what ways has the project utilised your human and material resources?

What decisions can you make about the project?

What procedures are employed when taking decisions?

How effective are these decision-making processes?

What challenges do you face in participating in the project?

What are/were the achievements of the project through your participation in the project?

How satisfied are you with the participation of other partners
/stakeholders?

How satisfied are you with your participation in the project?

How was/is shared responsibility and accountability for the project ensured?

In what ways can your participation in the project be enhanced?

INTERVIEW CHECKLIST (Village Level Health Workers-Traditional Birth Attendants (TBAs)
Village Health Workers (VHW) Surveillance Volunteers (SV) and Village Health
Committees etc).

Could you tell me how you were selected for training?

What went into your training, duration, content?

What do you do after the training?

How long have you been working in your present position?

Community Support

In what ways are your community involved in your activities?

- Construction of building for operation, remuneration for services and some form of appreciation for services delivered
- Control and regulation of services
- Utilisation of services

External support

Have you received any support from outside the community?

- Purpose of support, source, nature, conditions and how was support utilised.

Supervision

- Who supervises your work?
- What are they looking for during supervision?
- How is supervision done (Do they come to you or you to them, groups or individual, timing, frequency, problem solving etc)
- How satisfied are you with the supervision?
- How can supervision be more effective?

Refresher Training

What kind of refresher training have you received, course attended, who funded them, content, duration?

How useful is each of training in your work?

What are your current training needs?

Support after Training

Were you provided any logistics, drugs, kits etc after training?

Who provided them and how are they replenished?

Nature of certification

Collaboration /Linkages

What networks have you fostered in your work- within the community and outside?

Do you interact with other village level workers and what is the nature of interaction?

What institutions exist for networking and collaboration between Village level health workers?

What are the benefits for collaboration and networking?

What problems do you face in networking and collaboration and how are they solved?

Level of Satisfaction

How do you like the work you are doing now?

What is your source of motivation or dissatisfaction?

How can this work be made more satisfying to you?

What challenges do you face in the work your do?

How can these be solved?

MEMBERS OF MANAGEMENTTEAMS (req./district and sub-district)

Discuss the history of each of the programmes under which the different community level organs operate

What are the objectives of each of these programmes and issues of programme implementation?

What support have you given to each of these programmes by district/sub district teams?

Discuss issues of supervision – capacity to do supervision, how it is done, and problems with supervision and how it can be improved.

In what ways does the district or sub district support volunteers?

Discuss the achievements of each of these programmes?

How do team members perceive participation of communities and stakeholders in health (how are they involved)?

How does the Team facilitate participation at the district/sub districts?

How are decisions taken at the sub district and district level?

How are other stakeholders – communities, civil society organisations and the private sector- at the district/sub districts involved in the decision making process?

How satisfied is the participation of other stakeholders?

What are the key challenges to community participation in the district/sub district?

How can these be solved?

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