**SCHOOL OF PUBLIC HEALTH**

**COLLEGE OF HEALTH SCIENCES**

**UNIVERSITY OF GHANA**

# STRENGTHENING COMMUNITY PARTICIPATION IN HEALTH SERVICE DELIVERY; A CASE STUDY OF POTREPO COMMUNITY-BASED HEALTH PLANNING AND SERVICES IN THE VOLTA REGION

**BY**

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# CANDIDATE'S DECLARATION

I Eric Oduro Fato, declare, that except for other people's investigations which have been duly acknowledged, this work is the result of my own original research and that this dissertation, either in whole or part has not been presented elsewhere for another degree.

Eric Oduro Fato (STUDENT)

Signature: ……..

Date: ……../……../…….

Supervisor: Dr Paulina Tindana (ACADEMIC SUPERVISOR)

Signature: ……

Date: ……/……/…….

# DEDICATION

This work is dedicated to my life-coaches, my dad and mum, Mr. Nicholas Kwame Fato and Mrs. Patricia Fato. I owe it all to you. Many Thanks.

# ACKNOWLEDGEMENTS

Foremost, I am grateful to God for the good health and wellbeing that were necessary to complete this thesis.

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# ABSTRACT

Community participation in health is seen as a very effective but challenging implementation approach to health service delivery and has been of great interest among health care policy planners and implementers. It is a system approach that aims at enhancing accessibility and the utilization of health services at the community level. Whilst the beginning of the idea and conceptual development of community participation are fundamentally attributed to large multinational health institutions, particularly the World Health Organization (WHO), its implementation is the ultimate responsibility of local health programme initiators.

Even though Ghana's Community based Health Planning and Services (CHPS) has been viewed as an effective strategy that mobilized community participation for making primary health care to all in Ghana, many people continue to have minimal or no access to primary health services.

This study assessed the factors that influence community participation in the Community Health, Planning and Services program and the level of community participation in the processes involved in service delivery at the CHPS level.

**Method**: Qualitative data were collected from thirteen individual in-depth interviews, two focus group discussions and a community conversation with all the major actors at the community. The various actors collectively evaluated community participation in the CHPS programme and drew up a spider-gram during the community conversation.

**Results**: The findings from the thematic analysis show that the community participated in some stages of the planning and implementation process by providing resources such as land, labour, fetching of water among others. However majority of

the informants indicated that they were not consulted about their specific health needs before the facility was established.

**Conclusion:** The study concludes that communities should be capacitated and encouraged to participate in health interventions at the community level.

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| | |
|---|---|
| CHFP | Community Health and Family Planning |
| CHO | Community Health Officer |
| CHPS | Community-based Health Planning and Services |
| CHN | Community Health Nurse |
| CHV | Community Health Volunteers |
| CHC | Community Health Committee |
| CHMC | Community Health Management Committee |
| FGD | Focus Group Discussion |
| GHS | Ghana Health Service |
| GPRS | Ghana Poverty Reduction Strategy |
| IDI | In-depth Interviews |
| ICPD | International Conference on Population and Development |
| MoH | Ministry of Health |
| MDG | Millennium Development Goal |
| PHC | Primary Health Care |
| PI | Principal Investigator |
| SDG | Sustainable Development Goals |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

# CHAPTER ONE

## BACKGROUND

The search for policy options that advance effective citizen participation in health care provision in Sub-Saharan Africa has been greatly influenced by international and regional conventions and declarations. The 1978 Alma Ata Declaration on "Health for All" by the year 2000 which considered community participation as high priority was endorsed by all African Governments (WHO, 2002b). According to Zakus & Lysack (1998), this declaration formally awakened countries worldwide that hospital based programs and physician centred care were inadequate to achieve global health. Rather, attainment of good health was thought to centre on concepts with an underlying democratic vision like empowerment, health promotion and collective action. Yet at the beginning of the new millennium, accessibility to health care remained far from reality for most households in sub-Saharan Africa. No sub-Saharan African country was able to meet the United Nations Millennium Development Goal (MDG) of reducing childhood mortality by two thirds by 2015 and the expansion of access to comprehensive reproductive health services (United Nations Sustainable Development, 2016).

In the 1990s, mounting evidence that health development was not attaining national goals stimulated discussions on feasible means of achieving health-sector reform (Ampofo et al., 2016; Derso et al., 2014). Moreover, the specific approaches of enhancing program performance remained unclear (Derso et al., 2014; Nyonator, Awoonor-Williams, Phillips, Jones, & Miller, 2005). Research identifying gaps in health outcomes called for national solutions, yet there was little concrete guidance to evidence-based policymaking and program development.

In view of this, Ghana constituted a partnership between applied health researchers and administrators to formulate an action-oriented research agenda to guide health sector reform by resolving policy debates (Nyonator, Awoonor-Williams, et al., 2005). CHPS was informed significantly by national program development experience in Asia (Nyonator, Awoonor-Williams, et al., 2005). It was initially developed as a pilot project of the Navrongo Health Research Centre in the Northern Ghnana and progressed into a national policy. The Navrongo experiment developed strategies for community-based reproductive and child health services and tested the impact of the strategies proposed and guided national reform based on lessons learned (Derso et al., 2014).

The results of the Navrongo pilot project gave birth to the Community-Based Health Planning and Services initiative which is adopted as a national strategy for providing "close-to-client" doorstep health service delivery to households. The success of the new health policy direction is predicated on effective community participation, support and ownership of the community health delivery processes (Nyonator, Awoonor-Williams, et al., 2005).

## 1.2 PROBLEM STATEMENT

There is evidence from studies which show that although the CHPS programme is considered by stakeholders in public health as a good pro-poor health service delivery strategy, particularly in rural areas, its implementation has been thwarted with obstacles that have not permitted the full realization of its benefit. (Baatiema, Skovdal, Rifkin, & Campbell, 2013a; Derso et al., 2014).

One major problem facing health service delivery in Ghana with particular reference to the implementation of the new health policy is poor community participation. This

is due to the seemingly inadequate understanding of the CHPS concept and participatory methodologies by community members who are the beneficiaries in the implementation of the CHPS program.

### 1.3 JUSTIFICATION

Community participation is very important and necessary part of health service delivery in Lower and Middle Income Countries. In order to encourage community participation, community health volunteers have been used elsewhere to compensate for severe lack of health professionals (Debpuur et al., 2002; Nyonator, Awoonor-williams, Phillips, Jones, & Miller, 2005). The goal of "Health for All by the Year 2000" and the approval of primary health care (PHC) as key to attaining this goal was emphasized by the 1978 Alma- Ata Conference (Derso et al., 2014).

Community-based Health Planning and Services is a strategy adopted by the MOH as a national programme to bridge the gap in healthcare access. Hence, the Ghana Poverty Reduction Strategy (GPRS) identified CHPS as a key element in pro-poor health services. Thus, the community-based level service provision will enable the GHS to reduce health inequalities and promote equity of health outcomes by removing geographic barriers to health care. A key component of CHPS is a community-based service delivery point that focuses on improved partnership with households, community leaders and social groups – addressing the demand side of service provision and recognizing the fact that households are the primary producers of health.

Studies have shown the important role communities undertook in PHC with evidence-based interventions that resulted in improved health (Mushi, Mpembeni, & Jahn, 2010; Zakus & Lysack, 1998). For example, the Danfa project on rural health

and family planning indicated how health workers in the village helped improved health care delivery in rural Ghana (World Bank, 1996). Other studies such as the Community Health and Family Planning (CHFP) project in northern Ghana showed a 15 per cent reduction in fertility, equivalent to one birth per woman in the general population as a result of the combined efforts of communities and Community Health Officers (CHOs) (Debpuur et al., 2002).

These interventions have demonstrated the pivotal role of communities in enhancing health care delivery and pointed out the need for more innovative strategies of improving the level of community participation.

## 1.4 RESEARCH QUESTION

Little research has been done on the assessment of community participation, and even less on the challenges of community participation in health needs at the CHPS level. Many authors discuss the importance of community participation in health decision-making and health needs assessment and the literature contains numerous descriptions of community participation in health promotion programs and some in health needs assessments. However, there are still issues to be addressed. Some of these include:

1. What are the challenges facing community participation in the planning and implementation of the CHPS concept?
2. How effective are the various steps of implementation in stimulating community participation?
3. What are the factors that contribute to the effective involvement of communities in CHPS implementation?

## 1.4 GENERAL OBJECTIVE

The main objective of the study was to assess the factors that influence community participation in the CHPS program and the level of community participation in the processes involved in service delivery at the CHPS level.

## 1.5 SPECIFIC OBJECTIVES

1. To examine community involvement at the various stages of CHPS implementation process and how that affects participation

2. To identify the factors that hinder effective community participation in the CHPS implementation process and how to overcome them.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 INTRODUCTION

As a process of bridging equity gaps in access to quality health services and removing non-financial constraints to health care delivery, the Ghana Health Service (GHS) has developed a 'Close to client' (CTC) System which revolves around community participation.

At the heart of this system is the CHPS initiative. This strategy is in line with the Service's policy of locating 'nurses in every hamlet' in Ghana (GHS, 2005).

The conceptual gap between communities and health planners or health service providers has always led to the failure of many health development projects or programmes. WHO, **(**2002a) observed that without community participation (CP) and involvement, "Health for All by the Year 2000" will not be realised.

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

## 2.2 AN OVERVIEW OF THE CHPS MODEL

Ghana introduced a new Health System Reform based on the Community-based Health, Planning and Services (CHPS) in May, 2005. The rationale of the policy reform was based on the recognition that individual households especially mothers are the primary producers of health. Kyei et al, (2006) view CHPS as a strategy which finds its roots in the primary health care component of community

participation in health care and constitute a major policy reform of the Ghana Health Service. According to Derso et al., (2014), the CHPS concept provided a drastic paradigm shift in the delivery of community level health services with the aim of achieving the Millennium Development Goals on health in Ghana.

The decision to seek health care and the type of health care sought depends on accessibility to information by the household. Increased uptake of health services by households according to the CHPS policy document depends on how health information and education are provided in ways acceptable and convenient to the people.

The strategic policy of the Ghana Health Service (GHS) is to have a three tier level of service provision within a district. They are the district hospital level, the sub-district (health centre) level and community level. The sub-districts are to be divided into zones with catchment population of 3000 to 4500 where primary health care services are provided to the population by a resident CHO supported by Community Health Committee (CHC) and a volunteer system. The CHPS model is based on research results from the Navrongo Experiment which demonstrated that, placing a nurse in the community substantially reduces childhood mortality, and combining nurse outreach with traditional leaders and volunteer involvement enhances male participation in family planning and improves health service system accountability (Nyonator, Awoonor-Williams, et al., 2005).

### 2.2.3 THE NAVRONGO EXPERIMENT

The Navrongo Community Health and Family Planning (CHFP) project was designed with dimensions corresponding to the health policy debate in the early ‘90s. The Navrongo experiment researched into means of re-tooling the community health

nurse (CHN) programme by testing the hypothesis that relocating nurses to communities, and reorienting management systems, would decrease fertility and mortality. But, specific functional components and milestones associated with this were yet to be ascertained.

In view of that, the Ministry of Health (MoH) launched a pilot phase in 1994 to investigate the appropriate components of a community health care programme in three villages by adapting various initiatives that apply techniques of social learning to operational planning (Korten, 2006; Simmons, Brown, & Díaz, 2002). This led to the implementation of pilot services in response to community health needs as discussed during focus group meetings. Such meetings were reconvened severally to recalibrate approaches according to community and worker reactions and recommendations (Derso et al., 2014). The pilot study outlined procedures for translating widespread interest in resident nurse services to elicit community donations of land, materials, labour and resources for developing a facility known as Community Health Compound for health care delivery. These facilities were built using local methods, materials and resources available. The pilot clarified project outreach approaches for translating participation in ad hoc committees for coordinating the construction process into maintained CHCs for running the community health service system. Once committees were functioning, nurses were introduced to the community, assigned to Community Health Compounds, equipped with a motorcycle, and provided with logistics and liaison needs.

Various results generated official interest in 1996 in replicating the most successful cell of the experiment in all districts of Ghana (Nyonator, Awoonor-Williams, et al., 2005).

### 2.2.4 THE NKWANTA DISTRICT REPLICATION

In 1998 a national managers' conference was convened by MoH to deliberate on the implications of the preliminary evidence established from the Navrongo experiment's model for nation-wide action, and to review a draft policy statement declaring the Navrongo community health care system as the national model for community-based care.

The first non-research practical implementation of the model was successfully undertaken in Nkwanta District aimed at addressing issues relating to the transferability and sustainability of the model (Awoonor-Williams et al., 2013).

The CHPS approach thus focuses on achieving three key objectives namely; to improve equity in access to basic health services, improve efficiency and responsiveness to client needs and to develop effective inter-sectorial collaboration. Consequently, the CHPS strategy recognizes the following basic elements including the community (as a social capital), households and individuals (as targets), planning with the community (community participation) and service delivery with the community (client focused). All of the above components of CHPS underpin the centrality of community participation in the successful implementation of the new health policy (Awoonor-Williams et al., 2013).

## 2.3 COMMUNITY PARTICIPATION

Community or public participation in health 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 organizations in support of these efforts and (d)

evaluate the effects and bring about necessary adjustments in goals and programs on an on-going basis. It is therefore a strategy that provides people with the sense that they can solve their problems through careful reflection and collective action (Zakus & Lysack, 1998). The concept is also defined by Tsouros, (2009) as "a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.

The Minnesota Department of Health, (2016) defines the concept as "the participation of members of a community in assessing, planning, implementing and evaluating solutions to problems that affect them." As such, community participation involves interpersonal trust, communication and collaboration. Such participation should focus on, and result from the needs, expectations and desires of a community's members. Gyang, (2015) defines community participation as "a wide range of practices suited to different situations or purposes, guided by a common set of values, principles and criteria." The above definitions of the concept according to Judd et al, (2001) bring to the fore certain fundamental elements of participation which often emphasize "involvement, empowerment, capacity building, multidisciplinary collaboration, equity and sustainable development". Although there is no clear consensus on the distinction between the above terms as cautioned by WHO, (2002a) it is useful to briefly clarify their meanings as they are often used interchangeably with or alongside participation.

## 2.4 ASSESSING COMMUNITY PARTICIPATION IN HEALTH CARE PROGRAMMES

Several studies have thrown light on the challenges of evaluating community involvement in health system interventions (Abelson & Gauvin, 2016; Draper, Hewitt, & Rifkin, 2010). Whilst there is the growing interest and pressure to include communities in global health practice, there is an increasing need to assess the processes underlying participatory programmes. This study combined Campbell and Jovchelovitch, (2000) conceptualisation of a 'Social Psychology of Participation' theoretical framework and 'Spider-gram' method to assess participation in health care delivery at the community level (Rifkin, 1990). Each will be introduced one after the other.

## 2.5 FACTORS THAT INFLUENCE COMMUNITY PARTICIPATION IN HEALTH CARE UTILIZATION

Community participation is gaining centrality in health decision-making and delivery systems in recent times around the world and appears to be driven by a variety of factors. Zakus & Lysack, 1(998) identify some of these factors to include (a) the recognition of the duty of people to participate in public and community affairs, including personal health (b) institutionalized health systems' inability to provide for all health related needs (c) recognition that planned social changes in health can only be achieved by focusing on the community as the locus of attention (d) diminished confidence in policies made solely by health experts, professionals and program managers (e) concerns about the cost associated with health services, the best use of limited resources (f) perceived untapped resources of voluntary public input to improve health services, and the belief that such input can make a positive difference

and (g) rising standards of living and increasing education levels, and an awareness of this among the poor all leading to raised health expectations.

# CHAPTER THREE

# METHODOLOGY

## 3.1 INTRODUCTION

The methodology used in this study is outlined in this section. The research study site, as well the sample techniques employed in this study are also presented. This section ends with the ethical considerations after the instrumentation; data collection procedures and the analysis are presented.

## 3.2 RESEARCH DESIGN

This research was a case study on the factors that influence community participation in the CHPS program and the level of community participation in the processes involved in service delivery at the CHPS level. The study used qualitative study design approach where data was collected using a semi-structured interview guide conceived on a typical CHPS implementation processes. This approach was to allow the use of the CHPS implementation processes as the logical frame for the investigation of the factors that influence community participation at the various stages of the CHPS program using purposively selected CHOs, Community Health Volunteers (CHVs), CHCs and service users as units of analysis.

The Theoretical framework: social psychology of participation and the Spider-gram method were used to assess the level of community participation that the programme enabled.

## 3.3 RESEARCH LOCATION/ STUDY POPULATION

The study was conducted in the Nkwanta South Municipality which was known to have very good indicators as far as service delivery at the CHPS level is concerned.

**Nkwanta South Municipality**

The Municipality is situated in the northern most part of the former Volta Region, now the Oti Region. It lies between latitudes 7 30° and 8 45° North and longitude 0 10° and 0 45° East. It has a land area of about 2,733 km2. The Administrative Capital of the Municipal is **Nkwanta**. The population of the Municipality according to 2010 population and housing census stands at 117,878 with 58,482 males and 59,396 females.

The study assessed the level of community participation in the planning and running of the Potrepo CHPS facility, in the Nkwanta South Municipality. In order to avoid a skewed focus on either good or poorly performing CHPS facilities, the Potrepo CHPS zone was selected purposively for this study basically due to its' average performance as indicated by the Municipal Health Directorate. The Potrepo CHPS was constructed with support from the United States Agency for International Development (USAID) Systems for Health and opened in May, 2018. Potrepo has a total population size of about 2183 people. The majority of the community people are small scale farmers who grow crops such as maize, groundnut and yam. The Potrepo CHPS facility has being functional for nearly a years at the time of the study.

### 3.3.1 SAMPLE SELECTION

A total of 25 individuals were purposively selected. The breakdown is as follows;

**In-depth interviews**

The following individuals were randomly selected as follow: 3 CHC members were randomly selected out of 6 members, 3 CHVs out of 7 functional members, 6 Service Users and 1 CHO who was the officer assigned to run the facility.

**Focus Group Discussions**

The focus group discussions conducted by study were divided into two groups where each group had 6 members. The members of group were purposively recruited as followed;

- Male group- 2CHCs, 1 CHV and 3 service users
- Female group- 1 CHC, 1 CHV and 4 service users

**Community conversation**

All the 25 participants involved in the FGD and the IDI were gathered for the community conversation which ranked the level of the community's participation.

## 3.4 METHODS OF DATA COLLECTION AND INSTRUMENTS

This study is a qualitative study that sought to examine the processes underpinning CHPS programme design and delivery, as far as social context is concerned, with the aim of assessing the level of community participation that the programme enabled.

### 3.4.1 THEORETICAL FRAMEWORK: SOCIAL PSYCHOLOGY OF PARTICIPATION

Community participation as shown by several literature revolves around political and ideological commitments to participation, contested and framed either as a basic human right, a pragmatic strategy to utilise services or as a pathway to empowerment (Morgan, College, & Hadley, 2001). This study was based on the theoretical understandings of a social psychology of participation, which stems from the model of empowerment. The social psychology of community participation was published by Campbell and Jovchelovitch, (2000) as a conceptual framework for action

oriented study aimed at exploring the pathways between social development, health and community participation.

### 3.4.2 METHODOLOGICAL TOOL: SPIDER-GRAMS

Rifkin developed the Spider-gram methodology to ascertain, visualise and assess levels of community participation in health interventions on a continuum. Using over 200 case studies for analysis (Rifkin, 1990), five indicators were identified by Rifkin:

**Needs assessment** refers to the involvement of programme health service users in deciding their health needs and in planning the community intervention.

**Leadership** refers to the involvement and representativeness of all interest groups in the community.

**Organisation** refers to how successful new community programmes are incorporated into community structures.

**Resource mobilization** emphasizes the ability of communities to rally and provide resources towards interventions undertaken in their communities.

**Management** refers to community's capacity to take decisions about the direction and development of the programmes

Every one of the indicators is located on a continuum. The original spider-gram plotted these indicators on a continuum that at one end marked narrow participation and at the other marked wide participation (Draper, Hewitt and Rifkin, 2010). How wide or narrow community participation is, is determined by each continuum as graded. The community members are asked to grade, from 1 to 5, the level of participation they felt was involved in the programme in a group setting, with 1 representing a low level of participation and 5 showing the highest level of

participation. To demonstrate this, as well as to operationalize these indicators with respect to a continuum of participation, Table 1 used the principles of spider-grams to the CHPS programme.

The levels of community participation as determined by community members can be indicated by spider-gram (see Figure 1) and be used to assess participation across programmes comparatively, with different participants in the same programme. As a result of its unsophistication, practicality, and wide usage, it has been applied in many different contexts and studies (Barker, 2007;Chilaka,2005).

**Table 1** The spider-gram indicators for CHPS adopted from Baatiema, Skovdal, Rifkin, & Campbell,( 2013b)

| **Indicators** | **Narrow, nothing, 1** | **Restricted, small 2** | **Mean, fair 3** | **Open, very good 4** | **Wide, excellent 5** |
|---|---|---|---|---|---|
| Needs Assessment | Identified or imposed by health experts without community involvement or consultation | CHPS services designed by health experts with limited community involvement | Community was consulted and involved in assessing their needs | Community involvement in needs assessment, and few services resonating with their assessed needs | Full community involvement in needs assessment with service package in resonance with their health needs |
| Leadership | Dominant-imposing CHPS committee chairman represents only committee or few elite or rich community members | Limited committee role in leadership, few representation of women or few interest groups | Few community consultation, involvement in decision-making and represent community interest | Good committee leadership role consults community, leadership constitute women representation and all interest groups | CHPS committee fully represents diverse interests, Selfless leadership roles, full community involvement in decision-making |
| Organisation | Parallel operation or no collaboration of CHPS with pre-existing community units or local structures | CHPS with pre-existing community units or structures | Limited collaboration of CHPS cooperates with few community structures | Integration and collaboration of CHPS with other community bodies | CHPS well and fully integrated and works collaboratively with other community units |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Resource Mobilization | No community support or resource contribution. Community not involved or consulted in resource allocation | Limited amount of resources raised by the community. No community control over mobilised resources utilisation | Community raised resources and fully support CHPS with limited role in controlling expenditure | Community are resourceful and supports CHPS with mobilised resources. Community involved in resource allocation | Full and active community contributions to support CHPS. community fully consulted in resource allocation |
| Management | Managed or induced by service providers (GHS). No community consultation in management decision making | CHPS operation overseen by GHS with CHPS committee role | CHPS operation overseen solely by the health committee | CHPS committee self-managed and involved community and other interest groups (women) in decision making | Committee independently managed CHPS with full community consultation and representation” |

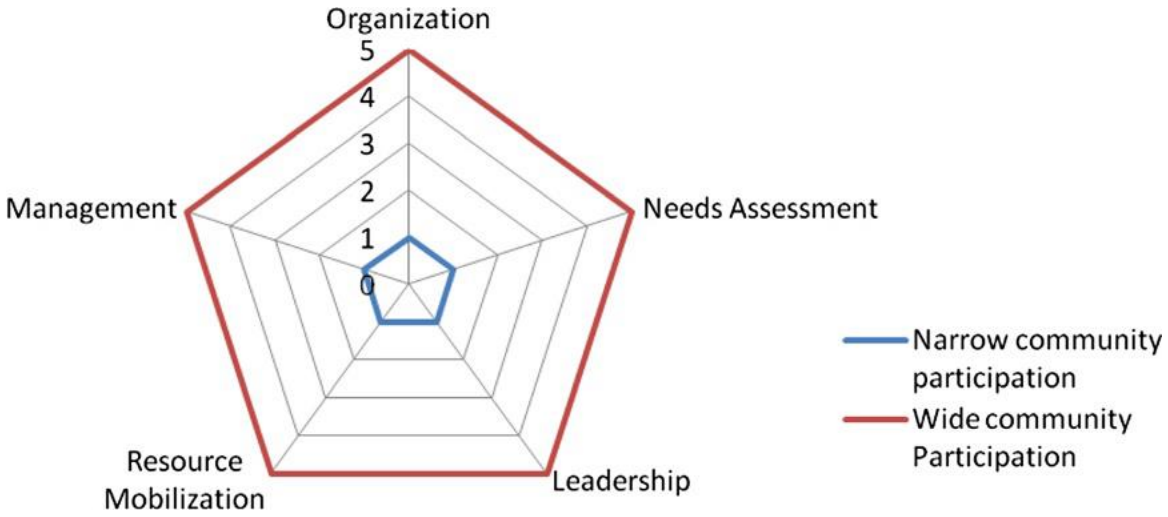


**Figure 1** Measuring community participation using Spider-gram (Draper et al., 2010).

### 3.4.3 SEMI-STRUCTURED INTERVIEWS

Semi structured interview guides were developed to elicit information through In-depth Interviews (IDI) and Focus Group Discussion (FGD) from respondents (see interview guides in appendix V).

These interviews were carried out with people who have a special position in the community and the facility. They are looked upon as representatives of the opinions and experiences of the whole group. These range from in-charge of CHPS facilities, community health volunteers, service beneficiaries and community health management committee members who are usually opinion leaders.

Key informants can give valuable and independent information about the community in a relatively short time without needing a large group in the study. However as Annett and Rifkin, (1998) pointed out one needs to be a very careful with local

leaders and some key informants. They may not represent the views of the vulnerable groups of the society.

### 3.4.4 COMMUNITY CONVERSATION

All the study participants were gathered for the community conversation which ranked the level of the community's participation in the planning and running of the CHPS compound using the Spider-gram method.

The group discussed and rated the level of the community's involvement in the planning and implementation of the CHPS program under the five selected indicators. This section was moderated by the principal investigator of this study.

### 3.4.5 PRETESTING OF RESEARCH INSTRUMENTS

Presenting of in-depth/key informant interview guides and FGD guides were done, after which the data collection tools were reviewed and finalised. The data collection was carried out over a period of two days.

### 3.4.6 QUALITY ASSURANCE

All data except the In-depth interview with the CHO were collected in the local Twi language. The study PI understood the local language and socio-cultural context of the study area. All the in-depth/key informant/FGD interviews and community conversations were audio- taped, translated into English, transcribed verbatim sorted and coded. Each IDI lasted for approximately 25 minutes to complete while the FGD lasted for approximately 50 minutes. All the data collection and analysis activities were conducted by the principal investigator.

A quality assurance check list was developed to ensure data quality, including the translation and transcription of data.

### 3.4.7 DATA ANALYSIS

Data analysis was an ongoing process during the course of the data collection. The analysis of narrative data, on similar topics from multiple sources was allowed for comparison of perspectives and triangulation of the research findings across sources. The transcripts were read multiple times and broad themes that emerged across respondents and areas of inquiry were discussed (community participation) as part of the analysis. A coding scheme that represented the areas and the sub-themes within each were developed. Each transcript was coded using the qualitative data software (QSR NVIVO software version 11). Reports on each of the broad and specific themes were produced, which aided the synthesis of key findings and the comparison of responses within and between groups. Data was summarized and presented as narratives.

## 3.5 ETHICAL CONSIDERATIONS

### 3.5.1 ETHICS CLEARANCE

Ethics clearance for the study was obtained from the Ghana Health Service Ethics Review Committee with reference number: GHS-ERC050/05/19 as shown in Appendix II.

### 3.5.2 PERMISSION

Permission was obtained from the District Directors and the School of Public Health Legon, before the research was conducted.

### 3.5.3 INFORMED CONSENT

Verbal consent was obtained from each participant and this was obtained by taking the participant through the consenting process (see appendix I). Participants were made aware that they would be digitally recorded. The recording device was only turned on once consent was obtained. They were made aware that participation was voluntary and that there was no penalty for refusing to participate.

### 3.5.4 CONFIDENTIALITY

Throughout the study, all information provided remained confidential and was only used for its intended purpose. Soft copies of information were password protected and hard copies kept under lock and key. Only the PI and those involved in the research had access to it.

### 3.5.5 ANONYMITY

Participants were assured of anonymity if they give consent. Data was analyzed in such a manner that anonymity of all respondents was assured.

### 3.5.6 VOLUNTARY WITHDRAWAL

All research participants were duly informed of their right to decline participation in the study and also had the right to withdraw from the study anytime they so wished.

### 3.5.7 POTENTIAL RISK AND BENEFITS

Participants were duly informed about the risk and benefits associated with the study. The participants were also made aware that no compensation was going to be given. The research study has the benefit of improving the CHPS system in the country.

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# CHAPTER FOUR

# RESULTS

## 4.0 LEVELS OF COMMUNITY PARTICIPATION AND FACTORS THAT AFFECT COMMUNITY PARTICIPATION

The results present the opinions and views of the study participants, representing four groups of programme actors: 1) Community health committee members, who were part of the operations and implementation team of the CHPS programme, and comprised of two male community opinion leaders and one female. They were appointed for the committee role by the chief and elders of the community. 2) Community health volunteers who were also appointed by the chief and elders from the various tribes in the community were included in the study. 3) Service beneficiaries consisted of community members who were acquainted with the processes in the initiation and implementation of the CHPS facility in the community. They were most often called upon to help with labour or small donations; 4) the health care giver who participated in the research was by other participants called health expert.

As part of the process of elucidating (individual interviews), discussing (focus group discussions) and collectively assessing (community conversation) the participation of the community in the CHPS programme, different perspectives and opinions, regarding how community participation was carried out in the programme, were inevitably raised. Although the four groups of participants eventually came to a collective decision, indicating both wide and narrow community involvement as

presented by the spider-gram in Figure 2, the study material is characterised by differing views.

## 4.1 NEEDS ASSESSMENT

The view expressed by all participants from the interviews was that the community was not involved in deciding their health needs or planning the CHPS. According to the participants, the program was designed by health experts from the district without the community's involvement. In spite of this, the evidence showed community members embraced and aided the program because it partly reflected their health needs. The quote below is a male participant's opinion on this.

'*....We were not asked what kind of services we expected from the clinic. They don't provide some important services here. They are not taking health insurance here. It is our major problem. Even though this is good, we wanted a Clinic but it is good that we have been given this because it helps small'* (Male service user in individual interview)

Averse to the overriding opinion that their needs had been pre-determined by the health expert, a minority of participants indicated there were indeed community consultations about the CHPS program before it was brought to them. This was further emphasized by interview from the community health committee secretary. The secretary reported they held two meetings with the community on issues of implementation and these were discussed and agreed by the chief and the elders who represented the people of the community before the start of the CHPS implementation. Below is an excerpt from the committee secretary in this regard.

*'The System for Health people, the district people, committee members together with chief and elders of the community met two times to discuss how CHPS*

*implementation will be done and the roles we were to play. After that there was a durbar organized for the community members to tell all the people.* (Male health committee secretary in individual interview)

Health caregivers and some beneficiaries appeared to be more acquainted with benefits of participation as compared to other service users. However, service users scored their participation in needs assessment at point-1 on the spider-gram demonstrating very low level of participation.

## 4.2 LEADERSHIP

In respect of leadership, divergent opinions were expressed by both health service beneficiaries and health care providers concerning the management and composition of the community health committee. The majority of the service users indicated that the management and membership of the CHMC represented all interest groups and served the community interests and not any individual. Few service users held dissenting views to this. Affirming the trust community members had of the community health committee's leadership role, a participant made the following comment:

*'...No! Here we live according to clans and each clan is represented on the committee and so I know anything they decide will help us. They are our people and we live with them. Nobody pays them they do this job free of charge. They know the problems.* (Female service user in individual interview)

It was however unanimously agreed that the committee leadership was completely male dominated.

*'There is only one lady on the group because she has been to school small. The rest of us, how can we join when we have never gone to school? Here it is the men who*

*can talk but we all help when there is communal labour*. (Female service user in focus group discussion)

Decisions are made by the community health committee on behalf of the community. Community members are less involved in decision making, they are informed about decisions after such decisions are taken by the committee.. Upon deliberations on the rate level for their role in leadership, point 3 of the spider-gram was agreed by service users.

## 4.3 RESOURCE MOBILISATION

The interviews demonstrated that the communities contributed in kind to support the program. Contributions in kind took the form of provision of land, water, weeding of site, providing security among others for the construction of CHPS, as well as labour. Apart from the above stated, all other cost was borne by USAID Systems for Health.

*'Our chief gave them the land free of charge. We the women fetched water, swept the compound after the place was cleared of weeds by the men, we cleaned the place after the construction, we really did a lot. The men also helped carrying mortar'* (Female service user in individual interview)

The study revealed that decisions on communal labour were exclusively taken by the community health committee. However, community members shared the view that their contribution toward the programme has given them a say over the programme. The data collected from the in-depth interviews, the two focus groups discussions agreed that their contribution toward the implementation of the CHPS has been great and as a result rated the community's participation on the spider-gram at point 5."

## 4.4 MANAGEMENT

The findings showed that the role of the community health management committee was limited to the maintenance of the CHPS facility and does not include the determination of the kind and quality of service delivery. This is largely determined by the health experts. Some service beneficiaries in the interviews also registered their concerns about the kind of services rendered at the CHPS facility and the fact that the Community Health Management Committee was unable to get the authorities to provide them with the much desired services.

This is demonstrated in the participants' quote below:

*'…No! They didn't ask us for exactly what we need. See, if you are in labour and you come to deliver, it is only the male nurse who is there to attend to you. He is not even a midwife but he is doing well. Some people are not comfortable with male nurse during labour. They don't take insurance here. They will only write the medicine for you to go and buy, they don't always have medicine. Sometimes when you are seriously sick, they will tell you to go to Nkwanta Hospital.'* (Female service user in focus group discussion).

*……We have complained to the committee to let them take health insurance but till nothing is happening.'* (Male service user in focus group discussion)

Additionally, the interviews showed that final managerial decisions were taken by the district health authority.

*'Hmmm… we have written some letters to the district for them to include some services but we have not heard or seen anything about that. Our wives are complaining that they don't get drip when they come to deliver. You have to buy all*

*the medicines except para* [Medication]. *They have to do something about this'.* (Male committee member in individual interview)

Most of the health service beneficiaries rated their participation in managing the CHPS at point-3 on the spider-gram.

## 4.5 ORGANIZATION

The study revealed that the CHPS programme successfully created all the necessary structures for the establishment of the CHPS. The structures included the presence of a Community Health Officer, Community Health Management Committee and Community Health Volunteers. The study established that all the community structures were properly carried out according to the CHPS policy guidelines in order to avert any confusion. In throwing more light on the degree of organization of the community structures, a member of the health committee said the following:

*'The chief called for a durbar and asked for a representative from each of the clans in the community and I was chosen by my people and introduced to the community during the meeting. After that, we went for a one week training in Nkwanta concerning our responsibilities as committee members'*. (Male service provider in individual interview)

Upon deliberations on the community's participation in the organization, the participants unanimously agreed to rate it at point-5 on the spider-gram.

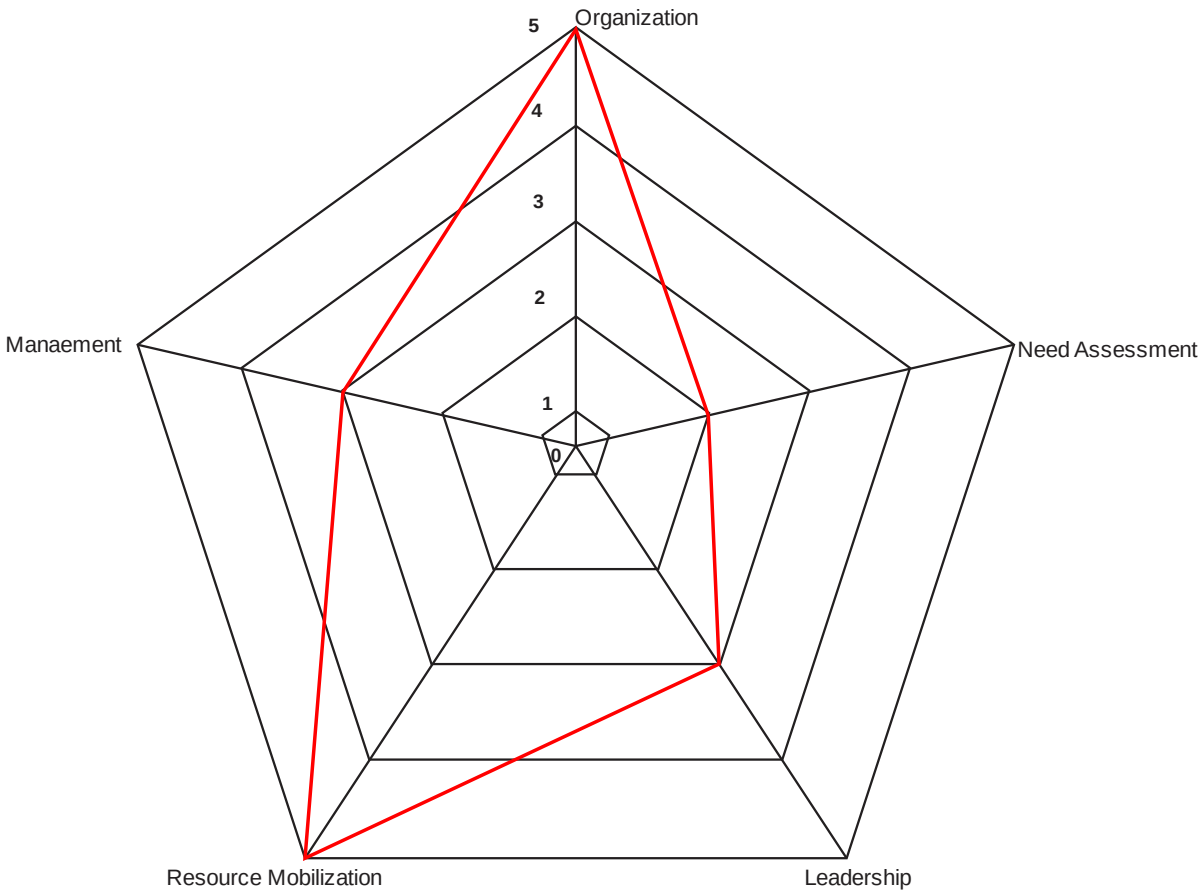


**Figure 2** Spider-gram on community participation in Potrepo

# CHAPTER FIVE

# DISCUSSION

In view of earlier assertions regarding the negative implication of low or no community participation in the implementation of CHPS programme (Derso et al., 2014), the study set out to assess levels of community participation in a CHPS programme in Ghana using a combination of spider-grams and a social psychological understanding of participation. The study has been able to highlight a range of factors impacting optimal and empowering community participation through the spider-grams and social psychological method. Some of the factors facilitating community participation included successful establishment of CHPS structures, community mobilisation of local resources to support CHPS (communities made significant 'in kind' contributions to support the program), and representativeness of community interests.

External interference from health professionals, top-down approach to CHPS design, male dominance and vertical-undemocratic community leadership and management style are some of the factors hindering community participation as shown by the study. The study revealed that management and the final decision making structures were vested under the authority of the district health directorate who made decisions without full community members' engagement, an arrangement which does not strengthen community participation.

The study results indicate that the programme was largely imposed on the community by health experts without recourse to the specific health needs of the community, a situation which will not enhance optimal community empowerment (Laverack & Wallerstein, 2001; Rappaport, Reischl, & Seidman, 1987; Wallerstein, 1992).

The use of social psychological understanding of participation (Campbell & Jovchelovitch, 2000) enabled the study to identify the factors that impede community participation in implementation in a manner that enhance community empowerment. These impediments showed an expert conceptualization of participation by community members resulting in unilateral decision-making by district health experts. In this regard the project missed out on the chances to increase the capacity of the most marginalised actors to take control over their health needs.

The study's findings substantiate the claim by Goodman et al., (1998) and Rifkin, (2009) which assert that; "the structure of community leadership is often historically or culturally determined to exclude marginalised groups including women, young people and marginalised men, with such social exclusion being widely regarded as a contributor to the health inequalities often suffered by such groups" (WHO, 2008).

In order to ensure effective and all-inclusive health care delivery, there is the need for health policy makers and planners to involve community members in discussions about service provision, where the community's opinion is taken as seriously as expert knowledge. Whilst health experts have particular expertise that can augment participation, such proficiency must include knowledge requiring community participation (e.g., gender, culture, power relation and resources). The study also reveals how failure to involve the community in planning, challenges the alignment of health care delivery with realities in the community and runs the risk of reproducing health services according to the status quo of experts' definition.

The study also revealed limited participation of community members in the CHPS programme. They were only asked to contribute in kind to maintain the CHPS compound which reflects the utilitarian value of community members in health

programme implementation. They perceived CHPS service package as one imposed on them as they played no role in determining the kind of health services to be provided at the facility. Health care providers and CHC members on the other hand asserted that the community members were properly included before the start of the programme. There were opposing views of how community participation was carried out which arguably are rooted in the unwillingness of some actors to let go their control and the quest of members of community to be more involved in decisions that directly affect their welfare. In addition, health care providers being experts are positioned in a place of power which complicates genuine power sharing in participatory health interventions.

Against the backdrop of the importance for community members to contribute with resources for the building and maintenance of the CHPS compound, demonstrating their utilitarian value which reinforces community ownership, there is the need for a lasting blueprint, with health agencies committing to provide all the necessary resources when required to support the health initiative and by developing the capacity of communities and groups so as to enable them maintain the programme and seek other avenues of funding. The lack of a sustainable source of funding for the CHPS programme runs the danger of creating a situation where failure of poor communities to contribute to the health initiative could result in them being denied access to health care.

# CHAPTER SIX

# CONCLUSION AND RECOMMENDATION

## 6.0 CONCLUSION

The findings presented by this research are indispensable to translating policy rhetoric concerning community participation into reality.

The experiences of the participants shared and findings from the analysis showed a technocratic conceptualization of community participation resulting in domination by non-elected leaders who were appointed by the chief and elders without consulting the community, male dominance and vertical decision-making where decisions were taken by the district health authority.

In this regard, for all its advantages, the CHPS programme did not meet the ideals of equal participation of all players irrespective of their gender, age or social status, with all players being fully consulted at every stage of programme design and implementation

## 6.2 RECOMMENDATION

In view of the above, for community participation to be effective and empowering, health planners and programme developers should engage with the rank-and-file community members in dialogue about service provision, where local knowledge is taken as seriously as expert knowledge.

The study findings also revealed the lack of sustainable source of funding for the CHPS programme. The programme runs the danger of creating a situation where

failure of poor communities to contribute to the health initiative could result in them being denied access to health care.

There is therefore the need for the Ministry of Health through the Ghana Health Service together with donor partners to come out with a long-term strategy to sustain the health initiative by building the capacity of community members and groups, enabling them to develop the programme and seek alternative sources of funding.

Lastly, communities should be capacitated and encouraged by the Ghana Health Service to participate in health intervention at the community level.

## 6.3 LIMITATIONS

The study only reported on the data collected from one CHPS facility. The study had a small sample size and the findings presented are based on the subjective views and personal experiences of only a few participants which make it difficult to generalise and comment on the CHPS programme in its' entirety. Secondly there may be reporting bias on the part of service providers, whose interest is to represent the institution they serve in a positive light. Lastly the spider-gram method as used is uncertain whether a ranking exist concerning the importance and level of influence of each indicator in the spider-gram. Further research should be conducted to xxxxxxx.

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# APPENDIX I

## STUDY PARTICIPANT'S INFORMATION SHEET

**PROJECT TITLE**: STRENGTHENING COMMUNITY PARTICIPATION IN HEALTH SERVICE DELIVERY; A CASE STUDY OF COMMUNITY-BASED HEALTH PLANNING AND SERVICES IN THE VOLTA REGION

**Introduction:**

My name is Mr. Eric Oduro Fato. I am master's student at the Department of Health Policy Planning and Management in the School of Public Health, University of Ghana, Legon.

**Background and Purpose of research**

Community participation in health is seen as a very effective but challenging implementation approach to health service delivery and has been of great interest among health care policy planners and implementers. It is a system approach that aims at enhancing accessibility and the utilization of health services at the community level. Whilst the beginning of the idea and conceptual development of community participation are fundamentally attributed to large multinational health institutions, particularly the World Health Organization (WHO), its' implementation is the ultimate responsibility of local health programme initiators.

Even though Ghana's Community based Health Planning and Services (CHPS) has been viewed as an effective strategy that mobilized community participation for making primary health care to all in Ghana, many people continue to have minimal or no access to primary health services.

This study will assess the factors that influence community participation in the Community Health, Planning and Services program and the level of community participation in the processes involved in service delivery at the CHPS level

**Nature of research:** This is a qualitative study which seeks to assess the factors that influence community participation in the Community Health, Planning and Services program and the level of community participation in the processes involved in service delivery at the CHPS level. We ask that you read this form and ask any questions you may have before agreeing to be in the study. The category of people involved in this study are CHC members, CHV, Service users and CHO. A total of 423 students are being recruited for participation in this study

**Participants' involvement:**

If you agree to be part of this study, you will be required to give consent in writing by signing or thumb printing a consent form. After you have given your consent, you will be asked questions bordering on the community's participation in the implementation of the CHPS project in your community.

**Potential Risks**: There are no physical risks or harm in participating in this study. However, there will be some level of discomforts, emotional upset due to the sensitive nature of some of the questions asked.

**Benefits**: There are no direct benefits of participating in this research to the participant. There would however be scientific benefits as it would add to the body of knowledge on the association that exist between social media patronage and sexual practices.

**Cost**: There will be no cost incurred in participating in this study.

**Compensation**: You will not receive payment for participation in this study.

As this study involves the anonymous completion of questionnaires, we ask that you do not type your name or any other identifying information into the survey. As such, your survey responses will not be able to be connected to your identity in any way. Efforts will be made to keep your personal information confidential. Your personal information may be disclosed if required by law.

**Confidentiality**: Throughout the study, all information provided will remained confidential and will only be used for its intended purpose. Soft copies of information will be password protected and hard copies will be kept under lock and key. Only the PI and those involved in the research had access to it.

**Anonymity**

You are assured of anonymity if you give consent. Data will be analyzed in such a manner that anonymity of all respondents was assured.

Any and all key identifies will be removed if the work is published. There will be no way whatsoever for anyone (except the PI) to be able to identify participants by their answers to any part of the questionnaire.

**Outcomes and Feedback**

The data gathered will be analyzed and reported to my institution as a requirement for the award of the certificate Feedback will not directly be given to participants. However, upon publication of the work, participants may have access to all results and findings.

**Privacy:** The questionnaire that participants will answer will be answered at their convenient location so that no other person will be privy to. That is, the participant is given the chance to answer the questionnaire in a serene environment of his choice for secrecy and protection of his/her identity.

**Voluntary participation/ withdrawal**: Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty. Your decision whether or not to participate in this study will not affect your current or future relations with the investigators.

**Funding information**: This study is being done as part of my research for the award of a Master of public health degree and is being self-funded.

**Sharing of participants Information/Data:** The data gathered will be solely owned by the author of the study and the institution enrolled.

**Provision of Information for Participants:** As participants, you will be given copies of the information sheet to keep.

## Persons to Contact

For questions about the study, contact the Principal investigator, Mr. Eric Oduro Fato, at 0249586897 or ericoduro027@gmail.com

Department of Population Family and Reproductive Health,

School of Public Health, Legon

For further clarification on ethical issues and their rights as participants if need be, please contact Ghana Health Service Ethics Review Committee Administrator,

Mrs Hannah Frimpong

The Administrator, Ghana Health Service Ethics Review Committee

Ghana Health Service, Research and Development Division

Ministries, Accra

Tel: 0507041223 and email: hannahfrimpong@ghsmail.org

# APPENDIX II

# ETHICS APPROVAL LETTER

**GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE**

*In case of reply the number and date of this Letter should be quoted.*

*MyRef. GHS/RDD/ERC/Admin/App/19/233*
*Your Ref. No.*

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
GPS Address: GA-050-3303
*Tel: +233-302-681109*
*Fax + 233-302-685424*
*Email: ghserc@gmail.com*
18th June, 2019

Eric Oduro Fato
University of Ghana
School of Public Health
Legon

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

| | |
|---|---|
| GHS-ERC Number | **GHS-ERC050/05/19** |
| Project Title | Strengthening community Participation in health service delivery; A case study of community-based health planning and services in the Volta Region. |
| Approval Date | 18th June,2019 |
| Expiry Date | 17th June, 2020 |
| GHS-ERC Decision | **Approved** |

**This approval requires the following from the Principal Investigator**

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....

DR. CYNTHIA BANNERMAN
(GHS-ERCCHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

# APPENDIX III

## INTERVIEW GUIDE FOR COMMUNITY HEALTH OFFICERS

**PROJECT TITLE:** STRENGTHENING COMMUNITY PARTICIPATION IN HEALTH SERVICE DELIVERY; A CASE STUDY OF COMMUNITY-BASED HEALTH PLANNING AND SERVICES IN THE VOLTA REGION

Target group- CHO

Introduction

Welcome the participant and briefly describe objectives of the project

Review Study Info Sheet & verbally consent the participant

Outline the format of interview

Background of interviewee

Could you please tell me a bit about yourself? No name\ i.e. your background and training?

How long have you been working as a CHO? Is there other anything you would want to add?

Thank you very much

CHPS zones demographic

What is the name of your CHPS zone?

How many communities are under your CHPS zones?

Total Population in the zone for the year 2018 provided by sub-district/ District/ Region

Total Population in the zone for the year 2018 based on community registers/ listing

Human Resource

How many staffs are in or assigned to this zone? How many of the new staff was introduced to the community and the key stakeholders?

How many staff have been orientated or trained on CHPS as CHOs (two-three weeks training on CHPS)?

Infrastructure

Is there a premise (site) from which the CHO operates in the zone?

*(If No)* where are the CHOs based, meaning from where do they operate?

a. Health Center (sub-district)

b. Only conduct home visits in the community

*c.* Other

Is there a purposefully built compound for CHPS? If yes who built it?

a. Is accommodation for the CHO included in the building?

b. How many CHOs have accommodation at the compound?

If there is no purposefully built CHPS compound, from where do the CHOs operate/ deliver services?

What, if any, type of community emergency transport system is in place? Who provided it?

CHV and CHMC involvement

Are there Community Health Volunteers (CHVs)?

a. If yes, how many CHVs are there in total in the CHPS zone?

b. How were they selected?

Were the CHVs introduced to the community through durbars or meetings with key stakeholders?

Have the CHVs received in-service training/orientation as a CHV?

How many of the CHVs have received training/ orientation as a CHV?

What supportive roles do they play in the discharge of your duties?

What are the challenges you face with the CHVs' activities?

a. Any other challenge?

Is there a Functional Community Health Committee (CHMC) for the CHPS Zone?

a. What do they do to support your facility?

When was the last CHMC Meeting held?

Have the members of the CHMC been oriented/ trained on their roles and responsibilities?

What are the challenges you face with the CHMC's activities?

a. Any other challenge?

b. What can be done to solve the situation?

District Assembly Involvement

Does the District Assembly ever conduct visits to the CHPS zone?

If yes, how often are visits held to the CHPS zone?

Does the District Assembly provide any funding to the CHPS zone to assist with your work?

If yes, what is the purpose of the funding provided by the District Assembly?

(a) Building of CHPS compound

(b) Support with operational funds (for running of CHPS zone)

(c) Support with equipment / supplies for CHPS zones

(d) Support with bonuses of CHPS zone staff

(e) Other

What is your assessment of your communities' participation the CHPS process in your zone?

a. What are the challenges?

b. Any other challenge?

c. What is your facility handling those challenges if any?

d. Any other?

Is there any other thing you would like to say or add to what you've said earlier?

Thank you very much for your time and input. We have come to the end of the interview.

Thank you.

# APPENDIX IV

## INTERVIEW GUIDE FOR COMMUNITY HEALTH VOLUNTEER/ COMMUNITY HEALTH MANAGEMENT COMMITTEE

**PROJECT TITLE:** STRENGTHENING COMMUNITY PARTICIPATION IN HEALTH SERVICE DELIVERY; A CASE STUDY OF COMMUNITY-BASED HEALTH PLANNING AND SERVICES IN THE VOLTA REGION

Target group- CHV/ CHMC

Introduction

Welcome the participant and briefly describe objectives of the project

Review Study Info Sheet & verbally consent the participant

Outline the format of interview

Background of interviewee

Could you please tell me a bit about yourself? (Your background and training)

How long have you been working as a CHO/ CHMC? Is there other anything you would want to add? Thank you very much.

CHPS approach/ community participation

What is the name of your CHPS zone?

Were there series of meetings and discussions with chiefs and leaders of a CHPS zone to introduce the CHPS concept to them and to gain their acceptance for the process to begin?

Was a durbar held to introduce CHPS to the entire community?

What was the role of the communities in the zone or your community in the CHPS implementation? (Probe for provision of land? Labour for construction from the CHC? Logistic support for CHO etc.

CHV/CHC selection

Were there discussions about the formation of a Community Health Committee?

How were you selected to serve as CHV/ CHMC?

a. What was the community's role in your selection if any?

Have you been trained as a community health volunteers?

Were you introduced to the community (ies)?

a. How was it done? (through a durbar)

Participation

What are your responsibilities? In terms of **(CHV only)**;

a. Home visits

b. Social mobilisation

c. Assisting CHOs

d. Health link

**e.** Work reach out

**f.** Have any logistics been provided to you? (**CHV only** probe further)

Challenges

What are some of the challenges that you face in the discharge of your duties?

What do you think can be done to solve those problems? Do you want to say something more?

What is your personal assessment of your community's participation in the CHPS activities?

a. What are the challenges? Is there any other thing you would like to say?

b. What is the way forward?

# APPENDIX V

## INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSION

**PROJECT TITLE:** STRENGTHENING COMMUNITY PARTICIPATION IN HEALTH SERVICE DELIVERY; A CASE STUDY OF COMMUNITY-BASED HEALTH PLANNING AND SERVICES IN THE VOLTA REGION?

Target group: FGD

Introduction

Welcome the participant and briefly describe objectives of the project

Review Study Info Sheet & verbally consent the participant

Outline the format of interview

CHPS zone

Please what is the name of your CHPS zone?

Were there series of meetings and discussions with chiefs and leaders of a CHPS zone to introduce the CHPS concept to them and to gain their acceptance for the process to begin?

a. Was there a Community Information Durbar to sensitize the communities about the creation of the CHPS ZONE?

b. How the CHPS site selected and approved?

Does your community have a CHPS Compound Constructed?

a. How was it constructed?

b. What were the roles of the communities in the zone?

Is there CHMC in your zone?

a. How were the members selected and approved

b. Was there a durbar for approval and introduction of CHMC members?

Do you have Community Health Volunteers?

a. How were they selected?

b. Was there durbar to finalize the selection and gain approval of CHVs from community and community leadership?

Was there a formal introduction of CHOs to the community at a Durbar?

Was there a final durbar to formally launch CHPS in the community?

a. If yes, were CHMC, Volunteers and CHO introduced during the durbar?

b. What about the security man for the compound?

What is your opinion about your community involvement in the CHPS's activities?

a. What are the challenges? (probe for more)

b. *If any*, how can we solve the challenges?

Do you have any other thing to say?

May be you forgot something you should have sad earlier, you are free to do so.

Is there any other thing?

Thank you very much for your time and input.

Do you have anything to say?

Thank you.