



RA552.G5Az9
bltc C.1
G368250



**COMMUNITY PARTICIPATION IN THE COMMUNITY-
BASED HEALTH PLANNING AND SERVICES (CHPS)
PROGRAMME IN NKWANTA DISTRICT, VOLTA REGION,
GHANA**

A DISSERTATION SUBMITTED BY

THOMAS BAVO AZONGO

TO

**THE SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF GHANA
LEGON**

**IN PARTIAL FULFILMENT OF REQUIREMENTS FOR THE
AWARD OF**

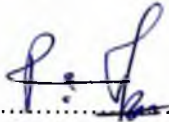
MASTER OF PUBLIC HEALTH (MPH) DEGREE

AUGUST 2002.

DECLARATION

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

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


.....

THOMAS BAYO AZONGO

ACADEMIC SUPERVISORS:


1.

PROF. ISABELLA QUAKYI


2.....

DR. GLORIA QUANSAH ASARE.



DEDICATION

I dedicate this piece of work to my children [Lydia Nyab-ma, de-Klerk Nyaba and Henry Sapark] for missing me during my many years of schooling.



GLOSSARY OF ABBREVIATIONS

1. CHPS..... Community-based Health Planning and Services.
2. CHFPP..... Community Health and Family Planning Programme.
3. CHO..... Community Health Officer.
4. CHN.....Community Health Nurse
5. CHC.....Community Health Compound
6. CHV.....Community Health Volunteer
7. DDHS..... District Director of Health Services
8. DHMT..... District Health Management Team
9. FGD..... Focus Group Discussion
10. MOH.....Ministry of Health
11. NHRC..... Navrongo Health Research Centre
12. PHC..... Primary Health Care
13. SDHT..... Sub-District Health Team
14. WATSAN..... Water and Sanitation Committee
15. WHO World Health Organization



TABLE OF CONTENT

	<u>Page number</u>
Declaration	i
Dedication	ii
Glossary of abbreviations	iii
Table of content	iv
Acknowledgment	vi
Abstract	vii
CHAPTER ONE	
1.1 Introduction	1
1.2 Background to the study area	3
1.3 Statement of the problem	8
1.4 Objectives of the study	10
CHAPTER TWO	
Literature Review	11
CHAPTER THREE	
METHODOLOGY	
3.1 Study Design	18
3.2 Methods of Data Collection	18
3.3 Sampling Procedure	19
3.4 Community entry/ Ethical clearance	20
3.5 Data processing and Analysis	21
3.6 Limitations of the Study	23
CHAPTER FOUR	
FINDINGS/RESULTS	
4.1 Basic Characteristics of Respondent/ participants	24
4.2 Assessment Results	
4.21 Needs Assessment	25
4.22 Leadership	28
4.23 Organisation	31
4.24 Management	32
4.25 Resource Mobilization	33
CHAPTER FIVE	
CONCLUSION AND RECOMMENDATIONS	
5.1 Conclusion	36
5.2 Recommendations	36
5.21 The CHOs	37
5.22 The Health Volunteers	39
5.23 Tutukpene Health Center	39

5.24 Costing and Evaluating Community Contributions	40
5.25 Inter-sectoral Collaboration	40
5.26 Adopting CHPS in the Districts	40
5.27 Surveillance	41
REFERENCES	42
APPENDIX	44



ACKNOWLEDGEMENT

This work has been successful due to the immense contributions of many persons and organizations to whom I owe a great deal of gratitude. I am particularly indebted to the following:

1. The School of Public Health- for the good training I received to be a Public Health Practitioner.
2. The University for Development Studies (UDS)- for the sponsorship given to me to pursue the MPH course.
3. My supervisors. Professor Isabella Quakyi and Dr. Gloria Quansah Asare have been my Academic advisors. They have guided me in writing up this dissertation. Also their painstaking reading and corrections in the write up has been of immense benefit. Dr. Koku Awoonor-Williams offered invaluable guidance and support during my fieldwork. He was not just my field supervisor but also an inspirer with good leadership qualities, vision and initiative that I aspire to emulate.
4. The entire staff of the Nkwanta DHMT. Particularly Mr. Constant Dedo and Miss Gifty Sunu who offered me assistance in Data collection.
5. The chiefs, elders, Assemblymen, men and women of all the CHPS zones in Nkwanta district for the patience and cooperation I enjoyed from them during the period of data collection.
6. All the Community Health Officers- for helping me to organize the focus group discussions and interviews in their operational areas.

It is with deep sense of appreciation that I acknowledge the contributions of all these and many others in this enterprise. I can only pray that the Almighty God richly bless them all.

ABSTRACT

The main strategy used in the Community-based Health Planning and Services (CHPS) initiative in Ghana has been the incorporation of community participation in the planning and delivery of basic Primary Health Care services. Accordingly the thrust has been on two main processes: mobilization and reorientation of the health care system as well as mobilization of the traditional society and social systems within which the programme operates. The CHPS programme has been adopted and is being implemented in the Nkwanta district for four years now. Rapid assessments indicate some positive results in health status indicators of the people.

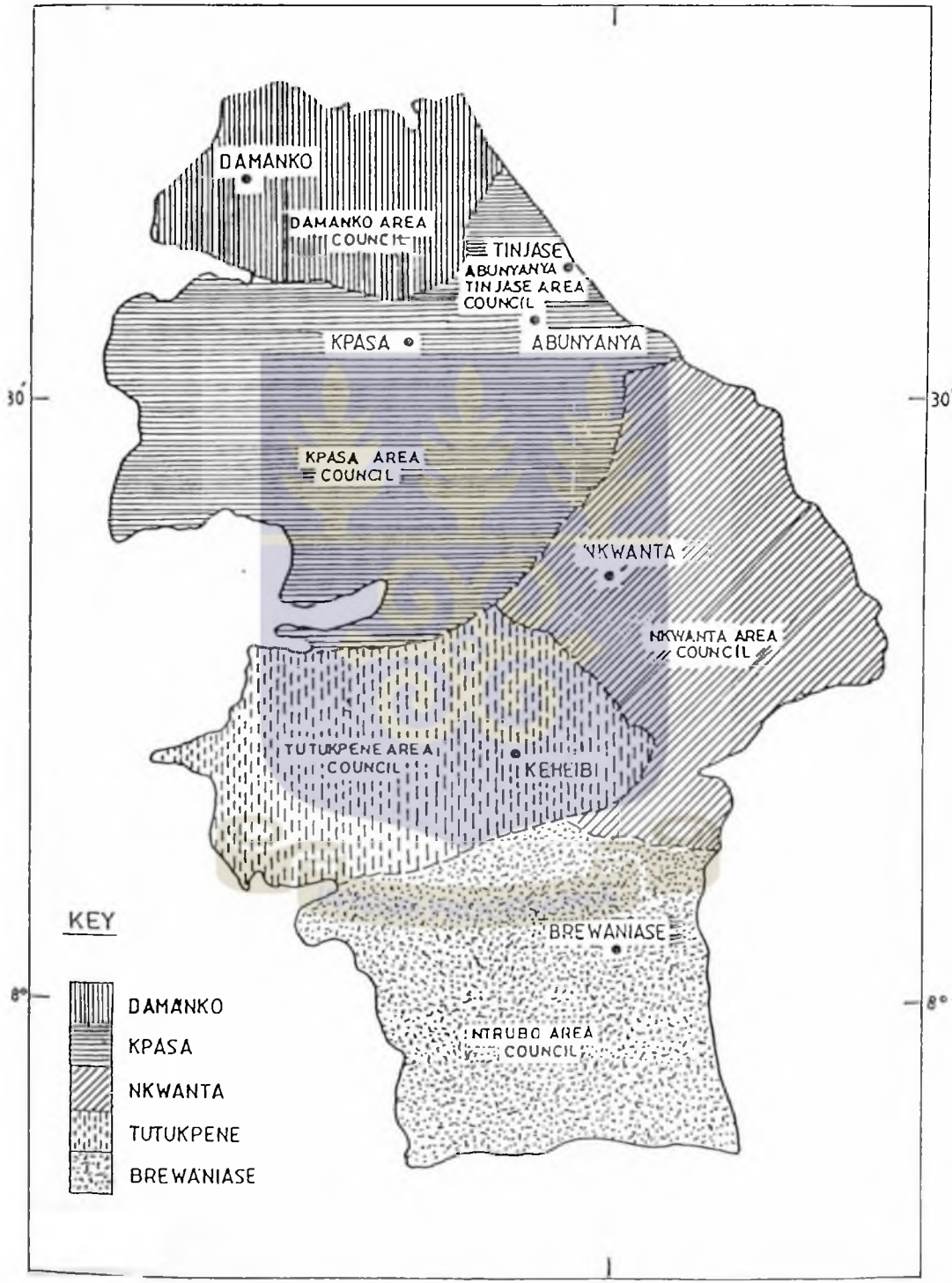
An in-depth assessment of the two main processes has become imperative. While the DHMT tried to evaluate its own performance in mobilizing the health care system, this study also tried to concurrently assess the communities' participation, with the hope that this would complement efforts to achieve a combined result that will offer a sense of direction and sustainability of the programme.

Methodology used in this study involved mainly qualitative techniques such as Focus Group Discussions with community opinion leaders; in-depth interviews with care providers and in-depth interviews with administrative managers of the programme. The Focus Group Discussions were done in all the six CHPS zones. Views on the level and kinds of community support and involvement in the programme were solicited. Analysis was based on themes that centred on the five components of the Rifkin Model for assessing community participation: Needs assessment, Leadership, organization, Resource mobilization and Management.





Findings indicate that involvement of the community members in the planning, implementation and evaluation of programme activities has been high. Their in-kind support has been the main motivation for the direct service providers (i.e. the Community Health Officers) to continue to stay and work with the people. The people are generally satisfied working with the programme managers and some NGOs as their main source of cash flows and technical support while demonstrating a sense of ownership for the programme and feeling they equally contribute to its operation and sustainability. However, how long the often-overworked care providers would continue to be motivated by the communities' modest support systems is of great concern to community members themselves as well as to the programme managers.

It is recommended that steps be taken to explore workable mechanisms to sustain the self-help and self-reliant spirit of the people as well as workable motivational packages for the care providers. Community enthusiasm for CHPS provides the possibility of developing community "hospitals" at least in Nkwanta district. This could be intimation that hospitals per se would not continue to be the ultimate means of acquiring health care in rural communities. As such the steps taken by government and the MOH/GHS to implement CHPS in other parts of Ghana is in the right direction.

30



KEY

-  DAMANKO
-  KPASA
-  NKWANTA
-  TUTUKPENE
-  BREWANIASE

30

CHAPTER ONE

1.1 INTRODUCTION

In trying to achieve the policy goal of providing adequate, efficient and equitable Primary Health Care services to all Ghanaians, in the face of dwindling human and material resources, the Ministry of Health has had to develop innovative and pragmatic health intervention strategies. One such strategy is the Community-based Health Planning and Services (CHPS) programme, a package of rural health care system developed out of the experiences of the Community Health and Family Planning Programme (CHFPP) at the Navrongo Health Research Center in the Upper-east region. The Kassena-Nankana District in the Upper-east region has been the pioneering district in the experimentation of the approach while Nkwanta district has been playing a leading role in adopting and implementing the approach.

CHPS is a process of strategic planning and implementation of Primary Health Care activities within a community with the full involvement and participation of the community members. It is a process that emphasizes preventive health care and education through effective communication and community mobilization. The main activities include:

1. A situation analysis of health care delivery within a given community
2. Community consultation on health needs and prioritization of such needs
3. Identifying and mobilizing resources both within and outside the community
4. Designing a culturally appropriate service delivery package

5. Providing health and family planning services to community members on an individual and household basis and
6. Conducting early diagnosis and treatment of common ailments and timely referral of serious cases.

The key players in this process are:

- Community Health Nurses (re-designated as Community Health Officers {CHOs}) reoriented in outreach service delivery, community entry and mobilization. They live in the communities to provide health care and family planning services
- Community Health Volunteers (CHV) who carry out dissemination of basic health and family planning information and services within communities and compounds complementarily with the CHOs
- Community Health Committees who manage and guide the health volunteers and also provide traditional authorization and advocacy to the process, and
- District Health Management Teams (DHMTs) and the Sub- District Health Teams (SDHTs) that provide logistics, training, monitoring and supervisory support.

This study is focused on assessing the role of community involvement and participation in the CHPS process after four years of its implementation in the Nkwanta district of the Volta region of Ghana. The assessment was done using a modified Rifkin model. It is envisaged that the results of this study will complement that of a concurrent study by the

DHMT aimed at assessing the performance of the DHMT itself, in providing additional information on the momentum and direction of the CHPS process in the Nkwanta district.

1.2 BACKGROUND TO THE STUDY AREA

LOCATION

Nkwanta district is the largest and the most deprived of the twelve administrative districts in the Volta region, occupying the northeastern part of Ghana and at the northern part of the Volta region. It is boarded to the east by the Republic of Togo, to the North by the Northern region, Kete-Krachi district to the West and Kadjebi district to the south.

CLIMATE

Nkwanta district is situated in the semi-equatorial climate region. The climate is characterised by a rainy season from May to September and a Dry season from November to February. The annual rainfall varies from 1500-1750mm to 1250- 1500 mm in the North with average temperature varying from 25 oC in March/April to 24 oC in July.

SOCIO-DEMOGRAGHY

Nkwanta is a typical rural area with a population of 152,293 inhabitants (2000 Ghana Population and Housing Census), (but head count conducted by the DHMT in 1999 gave the district a population of 187,221), with an annual growth rate of 1.8% and a population density of 25 inhabitants per square kilometers. The main centers are Nkwanta, Kpassa, Damanko and Brewaniase, which are also the market centres in the district. The district is

divided into 5 sub-districts namely Nkwanta, Tutukpenne, Kpassa, Damanko and Breweniase sub-districts.

The ethnic composition is highly varied. The Konkombas, Kotokolis, Basares and the Kabres are predominant in the northern part, concentrating mainly around Kpassa and Damanko. The southern part is composed of the Ntrobos, who are mainly in and around Breweniase. The Atwodes, Adeles, Challas and Ewes tend to occupy the central part that is, Nkwanta town. This pattern tends to give a fairly ethnic homogeneity in the 217 communities in the district. Other tribes like the Ewes, Krachi, Loso, Nawiris, Chokosis and Fulanis tend to spread across the entire district.

TRANSPORT AND COMMUNICATION.

Transport and telecommunications systems are poorly developed in the district. The main road from Kajebi through Nkwanta to Damanko is in very bad state, yet this road carries intensive traffic often with seriously overloaded trucks between the Northern region and the south. The hilly nature of the hinterlands makes the minor roads leading to these areas even more unmotorable, with some communities becoming inaccessible during the rainy seasons. Telecommunication system is virtually non-existent except a few Motorola services in some government offices including the DHMT. Mails are brought via any reliable Hohoe-Nkwanta vehicle once a week.

AGRICULTURE

Over 75% of the population is involved in subsistence farming activities but the district is also an important production area for crops like yam, sheanut and groundnut. Citrus, palm fruits, cassava and plantation are also grown but not in commercial quantities. Gari processing is also common. Other crops grown are rice, beans, corn and cocoyam. Small-scale fishing is widely practiced along the rivers and lakeside.

HEALTH

There are insufficient refuse disposal facilities. Public latrines are few even in the urban centres. Indiscriminate defecation in the bush at the outskirts of the towns is most prevalent. Uncontrolled refuse dumping is generally practised and the lack of staff of the Environmental Health Division makes supervision almost non-existent. Many of the refuse dumps in the urban areas are not well maintained, nor incinerated, not fenced and are located too close to houses and rivers, posing a serious Public health threat. Indeed a study carried out by the DHMT in 1997 showed that a large population of schoolchildren in the district especially Nkwanta township were infested with different types of tapeworm especially *taenia* and *hymenolepsis nana*. However environmental sanitation in the rural communities appears to be better than that in the urban settlements.

The entire district has no pipe-borne water system. The traditional sources of water are rivers, streams and ponds around the town and in the dry season the quality and quantity

deteriorate drastically. Guinea worm infestation poses a serious health problem causing a lot of disabilities and absenteeism from work. The Volta Lake is an important source of water for the villages along its shores, but Bilharzia is a serious threat to the people's health. DANIDA, an active NGO in the area has tried to provide boreholes to some communities but this only works out to approximately one borehole per 15,000 people, leaving more than 60 % of the people without access to safe drinking water.

On the average, about ten people live in one house and most houses have 3-5 small rooms posing overcrowding problems. About 90% of the buildings are constructed with mud and roofed with thatch. In the larger towns a few concrete buildings with iron sheet roofing are present but most of these are public or government buildings.

There are 20 health facilities in the district of which 70 % are government-run including the CHPS zones, and the remaining 30% Mission or private-run. Notable among these is the Nkwanta Government hospital where the only government doctor resides, and the St. Joseph's Clinic at Nkwanta where occasionally one or two expatriate doctors come to work.

With the introduction of the CHPS concept in the past four years the CHPS zone are now the main health facilities for most of the communities in the hinterlands. Out of the 17 Community Health Nurses in the district six are used for the CHPS programme, one stationed in each CHPS zone. These six nurses together provide comprehensive Primary Health Care to 23.2 percent of the people in the district (occupying 42 of the 217

communities in the district) who otherwise would not have had access to any health facility. Plans are underway to create five more CHPS zones, which will cater for an additional 15.1 percent of the people in the district, occupying 19 communities.

Population distribution of the CHPS zones in Nkwanta district (2002)

CHPS zone	Population	No of communities	% of sub-district	% of district	Sub-district
Bonakye	6880	8	14.6	4.6	Kpassa
Keri	4936	5	14.3	3.3	Nkwanta
Nyambong	6145	6	17.9	4.1	
Kecheibi	5041	8	34.4	3.4	Tutukpene
Bontibor	5749	7	25.1	3.9	Brewaniase
Obanda	5749	10	25.1	3.9	
Total	34500	42		23.2	

Population distribution of the proposed CHPS zones

CHPS zone	Population	No of communities	% of sub district	% of district	Sub-district
Sibi	7909	3	27.0	5.3	Damanko
Agou-fie	4556	4	9.7	3.1	Kpassa
Azua	4919	5	10.5	3.3	Kpassa
Chaiso	1564	3	4.5	1.1	Nkwanta
Alukpatsa	3391	4	23.1	2.3	Tutukpene
Total	22339	19		15.1	

1.3 STATEMENT OF THE PROBLEM

Effective and sustained involvement and participation of community members is crucial for the success and sustainability of any community-based health intervention programme. In view of this several activities were undertaken, with huge cost in time and resources, to first ensure the cooperation and authorization of the people themselves at the community level before the implementation of the CHPS programme.

The CHPS programme in Nkwanta involves two main processes aimed at bringing health closer to the people: mobilizing the health care service system and mobilizing the traditional society and social systems. As part of activities to sustain the CHPS process the Nkwanta DHMT planned to initiate studies to assess and evaluate its operations. The DHMT wants to first assess its own performance, as the main key players in mobilizing the team, to enable it have a sense of the extent to which it is contributing to the process. To complement the efforts of the DHMT this study is done simultaneously to assess the other key player (the community) in order to determine how far mobilizing the people has been achieved. It is hoped that the combined result of the two studies will provide relevant information about the progress and direction, and hence a sense of the sustainability of the CHPS programme

Some preliminary surveys carried out by the DHMT (Annual Report, 2000) on the impact of the operation have revealed some encouraging results: immunization coverage in the district was the lowest in the region before the adoption of the CHPS programme. However the adoption of CHPS (1997-1999) led to significant increases in coverage for the vaccine-

preventable diseases. From 1996-1999 BCG increased from 30.5 percent to 60.0 percent; measles from 27.7 to 48.1 percent and DPT from 18.6 to 37.0 percent. During that period reported cases of measles reduced from 130 to 42 cases.

But how far can we attribute these achievements to the communities' own effort? To what extent can we rely on the continued support and cooperation of the communities for the continued existence and operation of the CHPS programme especially when funding from DANIDA, World Vision and the District Assembly dwindles or winds up completely? What is the contribution of individual community members, and to what extent do they take part in decision-making? To what extent do the communities see the programme to be their own? These, among others, are important questions the managers of the programme and other stakeholders would want to ask and find answers to.

It is in the light of these pertinent questions that an assessment of the level of community participation and involvement is crucial and imperative.



1.4 OBJECTIVES OF THE STUDY

BROAD OBJECTIVE

To assess community participation (using the Rifkin Method) in the CHPS programme in the Nkwanta district

SPECIFIC OBJECTIVES

1. To determine the extent of community participation in the CHPS process using the following factors:

- Needs assessment
- Leadership
- Organization
- Resource mobilization
- Management

2. To make recommendations that would improve and sustain community participation in the CHPS process.



CHAPTER TWO

LITERATURE REVIEW

There are two major conceptual and practical difficulties that underline attempts to define and interpret community participation. These concern the terms “community” and “participation” in their separate entities.

Definitions of community in the literature range from “a group of people living in a particular area having shared values, cultural patterns and social problems” (Agudelo, 1983), to “a group of people distinguished by their shared interest” (Midgley, 1986) and community being target populations or “at risk” groups of people (Rifkin et al, 1988). Participation has also been defined variously by various authorities, but three characteristic which all the definitions have in common have emerged: participation should be active; participation should involve choice with individuals having the right, responsibility and power over decisions which affect their living; and that this choice must have the possibility of being effective whereby mechanisms are either in place or can be created to allow this choice to be implemented.

Bermejo and Bekui (1993) have defined community participation as “...a process whereby specific groups, living in a defined geographic area and interacting with each other, actively identify their needs and take decisions to meet them.” According to Atim (2000) community participation means substantively involving local people in the selection, design, planning and implementation of programmes and projects that will affect them,

thus ensuring that local perceptions, attitudes, values and knowledge are taken into account as fully and as soon as possible.

Susan Rifkin [1988] , who has carried out a great deal of research on community participation, offers a definition that is most often cited in the literature. According to her community participation “is a social process whereby specific groups with shared living needs in a defined geographical area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs”.

The Ministry of Health in Ghana sees community participation as a process of initiating dialogue with various members of a particular community in a structured manner with the view to genuinely consulting them as equals in a programme of activities that aim at building a team between programme managers and community members to jointly understand health problems in the community, to find solutions to such problems and to act to solve these problems using as much human and material resources as possible from the community (MOH, GHANA,1997) .

Thus in the Activity Sequence (contained in the CHPS implementation Guide for District Health Management Teams) certain activities are demanded the performance of which is meant to promote community participation. These activities include the following:

- Dialogue with community leadership leading to community leaders acceptance.
- Community information durbar leading to informed community.
- Selection and reorientation of community health committees

- Compilation of community profile
- Durbar to launch the CHO
- Selection/training of Community Health Volunteers.
- Durbar to launch the CHVs
- Approval of CHV by the community.

In Ghana, attempts have been made at promoting community involvement and participation in Primary Health Care. These include the Danfa Rural Health Project (DANFA, 1979), the Brong Ahafo Rural Integrated Development Programme (BARIDEP, 1978) the Ashanti Akim Rural Health Programme (1979), the Guinea Worm Eradication Programme, Nkoranza Community Health Insurance Scheme, Akyemfo Sanitation Project, Mobile Community Clinic. Others include the Community-directed Treatment for Onchocerciasis and lymphatic filariasis with Ivermectin, and the Dangbe-West Health Insurance Scheme. All these projects concluded that the active involvement and participation of the communities in the provision of essential health care led to the solution of several health problems at the local level.

For the purpose of this study community participation may be defined as the active involvement of community members in the identification of their needs, the mobilization of local resources and local implementation of plans to satisfy local needs including health related programmes that promote their welfare.

Rifkin et al (1988) suggested a series of five key indicators that could be applied to the district level in order to assess their potential involvement in any health programme. The use of qualitative indicators will tell us in any specific programme whether participation has become narrower, broader or remained unchanged. The five factors influencing the process of participation are identified as:

- Needs Assessment
- Leadership
- Organization
- Resource mobilization and
- Management.

From each of these factors a continuum is developed (each one radiating from the same point) with wide participation at one extremity, and narrow participation where the continuum meets. Each continuum is then divided into a series of points and a mark is placed on each one that most closely describes participation (by the five factors) in the health programme. These marks are then connected in a spoke configuration. In this way it can be shown the degree of breath of participation to describe a baseline, which provides for comparative assessment either at a later date or by other assessors.

Laleman, et al (1993) used this approach in the assessment of community participation in the Community-based Health Programme (CBHP) in the Munoz-community in the Philippines. Retrospective analysis of the programme revealed very clearly that the absence of a needs assessment with people was a major obstacle for the development of a community-based process. It illustrated also that a special effort should be made to build on

existing organizations. These usually have their own fora for dialogue and discussion, offer the possibility of incorporating the health programme into existing structures and provide several opportunities to find durable solution for the problems of leadership, organization, resource mobilization and management. All the people involved in the Munoz programme wanted to go beyond the scope of merely providing some medico-technical interventions thus involvement of the population in the planning, implementation and evaluation of the activities was a major objective. Laleman et al [1993] concluded that while this analytical approach does not aim to produce an objective and quantitative measurement of a particular situation, it does provide a common language for the different observers and makes it possible to pinpoint and describe the dynamics of the complex field of assessing community involvement.

Schmidt et al (1996) in their study described an experience where District Health Programme staff used the Rifkin method to assess the current community participation in their programme in Tanzania. Their findings/conclusions are summarized as follows:

- Needs Assessment:

Needs assessment was placed on point 5 of the continuum. The information taken from the interviews pointed to the fact that, in general, the majority of the village was involved in the assessment of the needs.

- Leadership:

Leadership was considered restricted, remaining at point 1 on the pentagram. It was perceived that the village leader made almost every decision by himself without consulting the different councils of the village.

- Organization:

Organization was placed on point 2. The conclusion of the assessment was that the VHC was a creation of the family Health programme rather than of the village people.

- Resource mobilization:

This was placed at 3 on the continuum.

- Management:

Management was seen as restricted. This ranking was based on the finding that the VHC was rarely involved in the supervision of the Village Health Workers (VHWs). Officials rather than village-based organizations or individuals carried out this task.

In general the Schmidt et al [1993] study showed that the Rifkin Method is not only a valuable tool contributing to the management of district health programmes but it also provides stimulation to programme staff to investigate and seek support for community participation at the local level.

Lessons learned from the Navrongo Community Health and Family Planning project (NHRC, 1998) offers a good guide to the CHPS process in the Nkwanta District. The “Zurugelu Approach” (mobilising traditional social institutions for PHC) demonstrated that mechanisms for traditional governance and group action could be utilised for communicating with communities to achieve community participation. Liaison with chiefs,

elders and lineage heads and the co-operation with village peer networks and group leaders can legitimise and explain family planning to men. Durbars are particularly useful for health education and family planning. Chiefs, elders and community leaders welcome dialogue with MOH staff and seek regular exchanges and hence a regular programme of community dialogue and exchange should be part of every DHMT programme.

The YZ (Yezura Zenna, Health Representative) has proved that volunteerism can be an important resource in the implementation of MOH PHC programmes (NHRC, 1998). The YZ (Health Representative) is a new and effective volunteer cadre in the CHFPP in Navrongo. Similarly there is a good spirit of volunteerism in the CHPS process in Nkwanta. Every CHPS zone has one or two volunteers who help the CHO in her day-to-day activities. These were selected by the communities, trained by the DHMT and inaugurated at durbar organised for such purpose.

Another lesson from the scaling up of the Navrongo Experiment is that communities will donate labour for the construction of CHC, promote health services in durbars, and welcome family planning activities. However seeking cash outlays for cement, iron sheets, and other construction supplies delay CHC construction and impedes programme.

CHAPTER THREE

METHODOLOGY

3.1 STUDY DESIGN

The study is a descriptive qualitative study, employing Focus Group Discussions and in-depth interviews in all the six CHPS zones in the district. These zones consist of a cluster of five to eight communities that coincide with the political electoral areas, with the biggest and most often the centrally placed being the location of the community health compound. This arrangement was found convenient for conducting focus group discussions involving opinion leaders and women groups of each of the six zones.

3.2 METHODS OF DATA COLLECTION

The main techniques used to collect data were Focus Group Discussions and in-depth interviews. The FGDs involved community Health Committees (CHC) and opinion leaders of each of the CHPS zones numbering nine to twelve. The opinion leaders consisted of the chief or his representative, the Assembly Member for the electoral area, the Community Health committee chairman, church elder or pastor, a WATSAN (Water and Sanitation Committee) member, the CHO, the women organizer, and three or four community elders. Views on the level and kind of community support and involvement were solicited based on a modified Rifkin model that centred on needs assessment, leadership, organization, resource mobilization and management.

Discussions with the community health committees were mainly based on the criteria for their selection, their roles and their relationship with the CHOs.

All the FGDs were conducted in the local dialect and tape-recorded. After every FGD translation and transcription into English was done because the local dialects were used with the help of an interpreter.

The interviews consisted of key informant interviews with each of the CHOs as well as in-depth interviews with the DDHS and the CHPS coordinator. These interviews tried to solicit information regarding the extent to which the design and operation of the programmes gave room for community participation as well as their opinion on the participation of the people. [See interview Guides in Appendix]

Reports on recent studies and seminars concerning the Nkwanta CHPS programme were also reviewed.

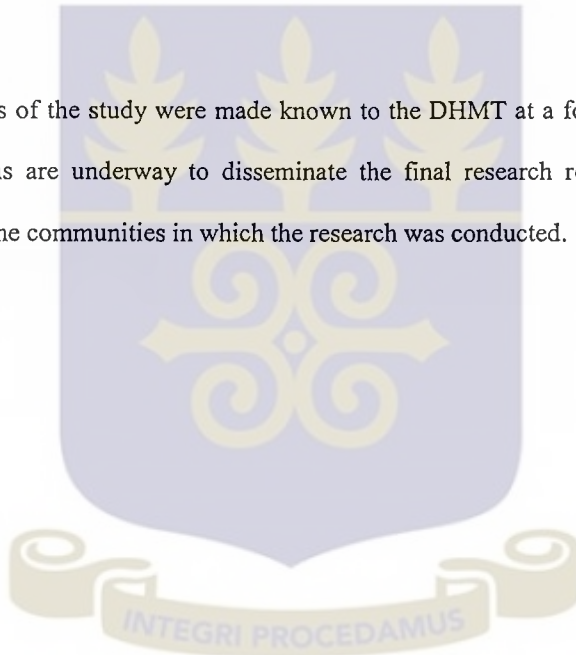
3.3 SAMPLING PROCEDURE

The opinion leaders were chosen on the basis of their leadership and organizational roles in the communities. The community health committees coordinate the health activities and as such their opinion was relevant. The women groups were selected at random from the main community in which the health compound was situated. Each of the six CHOs was interviewed because of their frontline role in the day-to-day operation of CHPS. The DDHS and the CHPS coordinator represent the DHMT who exercise administrative role in the CHPS process.

3.4 COMMUNITY ENTRY/ ETHICAL CLEARANCE

Consent was sought from the district health authority, the chiefs and assembly members of the areas of the CHPS zones. Individual verbal consent was sought from the interviewees as well as the participants of the FGDs. For the FGDs and the in-depth interviews, the participants themselves decided on the time and venue for the discussions and interviews. In conducting the FGDs special care was taken not to ask culturally inappropriate questions.

The initial findings of the study were made known to the DHMT at a forum organized for that purpose. Plans are underway to disseminate the final research report to the entire district including the communities in which the research was conducted.



3.5 DATA PROCESSING AND ANALYSIS

Data was analyzed manually using the modified ranking matrix/ scale (designed by Rifkin et al (1988) based on five factors- needs assessment, leadership, organization, resource mobilization and management.

Factor	Scale/indicator				
	Very low (+1)	Low (+2)	Fair (+3)	High (+4)	Very high (+5)
Needs assessment	Professionally identified committees imposed on community	Dominating professional views. Community interest considered.	Only community leader representing community views and assess needs	Committees/opinion leaders representing community and assess needs	All community members involved in needs assessment
Leadership	Leaders are imposed. Do not represent the community's views.	Committees/organizations not functioning mildly active. Only few members are active and represent the community's views	Committees very active but some communities not represented	Active committees well represented by most communities.	Committees fully represent variety of interest in communities.
Management	No active involvement of communities in planning, implementation and monitoring	Health staffs manage independently with some involvement of committees in some aspects.	Communities play active role in managing the CHPS programme but decisions are imposed by health authorities	Co-management. There is partnership in planning, implementation, monitoring and evaluation of programme.	Self-management. Communities in control of planning, implementation, monitoring and evaluation of the programme.
organization	Committee members	Committees imposed by	Only community	Entire community involved in	Entire community

	imposed by planners/ health professional and are inactive	health professional but are active.	leaders or a few individuals were involved in creating the committees but are active.	creating the committees. Committees active but financially dependable.	involved in creating committees. Fully active and financially independent
Resource mobilization	No or meager resources raised by community. No support/ contribution of any form. No community mobilization/ organization.	No financial contribution. But contribute in labour and social or community mobilization. Provide no assistance to VHVs, CHO	Periodic fund raising community to support CHOs VHVs, meetings, but don't control the expenditure. Organize periodic human resource to help the above groups	Periodic fund raising by the community. Committees control the use of funds.	Considerable amount of resources raised by community to support health activities. Committees allocate the money collected.

The modified Rifkin Pentagram

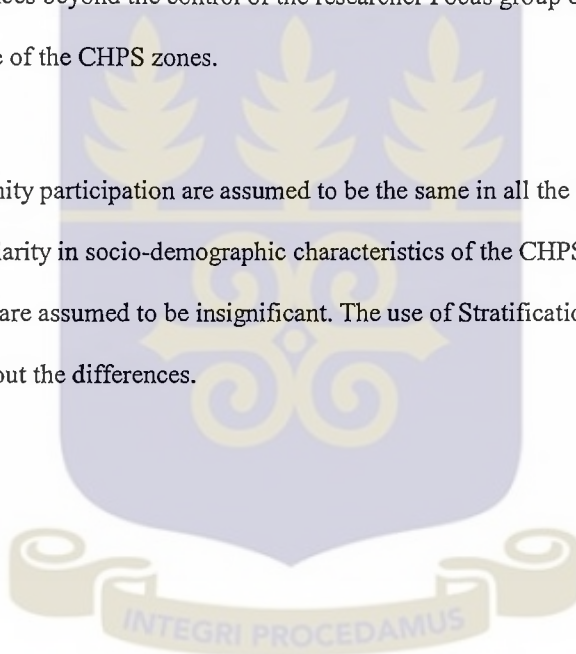
The model involves the development of a continuum of the five factors (needs assessment, leadership, management, organization and resource mobilization). The continuum has a wide participation at one end (+5), thus the community carries out the planning, implementation, monitoring and evaluation of the programme with the health personnel as resource persons. At the other end is narrow participation (+1), thus professionals make every decision without involving the people. Between these two ends are various graduations: +2, +3, +4 giving various levels of participation. Marks were then put on the point that best describes the nature of participation that is obtained. The five continua thus obtained are placed equidistant from each other and from a central point.

3.6 LIMITATIONS OF THE STUDY

1. The design of the study is purely qualitative, employing only Focus Group Discussions and In-depth interviews. This is largely because of the model (Rifkin model) used for the assessment. The data would have been best analyzed using Textbase Beta computer package. But time constraints could not allow soliciting for this kind of analysis.

2. Due to circumstances beyond the control of the researcher Focus group discussions were not conducted in one of the CHPS zones.

3. Levels of community participation are assumed to be the same in all the CHPS zones. Also due to the similarity in socio-demographic characteristics of the CHPS zones these possible differences are assumed to be insignificant. The use of Stratification methods could have brought out the differences.



CHAPTER FOUR

RESULTS

4.1 BASIC CHARACTERISTICS OF RESPONDENTS/PARTICIPANTS

FGD participants

In all fifteen focus group discussions were organized, three in each of five CHPS zones (the FGDs in Bonakye could not come on). A total of 134 participants were involved. The participants in each zone consisted of a group of the opinion leaders, the community health committee, and a group of women. The opinion leaders consisted of the Assemblyman of the electoral area, the chief or his representative, the Chairman and a member of the community health committee, the CHO, the women organizer, a senior TBA, the pastor and three or four elders representing some of the other communities. The women group consisted of between 10 to 12 women aged 19-45 years chosen at random.

Membership of the community health committee comprised of:

- A representative of each of the communities making up the CHPS zone
- A generally recognized and respected women's leader in the zone
- A generally recognized and respected male in the zone
- A representative of the unit committee/ area council
- The Assembly man for the area
- Elder representative of the paramount chief of the area.

Distribution of FGD participants in the CHPS zones

CHPS zone	Opinion leaders	Women group	Health committee	Total
Keri	10	11	8	29
Kecheibi	9	10	8	26
Bontibor	12	11	7	30
Obanda	12	12	7	31
Nyambong	10	10	8	28
Total	53	54	38	134

Interviewees

Each of the CHOs in all the six CHPS zones was interviewed. The CHOs aged between 26-42 are all trained community health nurses who voluntarily offered to be CHOs.

The medical officer in charge of the Nkwanta hospital who is also the District Director of Health Services was also interviewed. The other interviewee was the coordinator of the CHPS programme.

4.2 ASSESSMENT RESULTS4.2.1. NEEDS ASSESSMENT

This was found to be good graded +4 on the Rifkin matrix. Most participants said all the communities were sensitized on the need to adopt CHPS. This took the form of sub-district forums.

This is the final activity in the process of building up alliances, developing understanding and support as well as creating the basis for community ownership and participation for implementing the CHPS programme. These were organized to educate and inform various sections and categories of people in the sub-district on the relevance of CHPS to resolving

the inadequacies in the existing community level health service delivery system. Two main objectives were achieved: firstly, commitment of communities to the new health program expressed through suggestions of ways in which communities could participate in implementing the programme. Secondly to obtain clear understanding of what CHPS is and what it is not on the part of the community members.

The main activities of the fora included:

1. Presentation by the DDHS and his team:

- The district health service profile and the program of action to address the problem of access and quality of service in the selected communities with the existing health resources.
- The difference between CHPS and the previous system of health delivery in terms of planning, participation and placement of nurses in the communities.
- The CHPS program and the role of communities in its implementation particularly in,
Formation of community health committees,
- Construction/ acquisition of community health compounds
Zoning of the Subdistrict and the locating of nurses in the zones.
- Conditions that qualify communities for participation in the program; and
- The health center as a referral point in the CHPS implementation.

2. Open forum. Leaders and members of the various groups represented at the forum were given the opportunity to:

- Seek clarification on issues
- Comment on the new health program- express their fears and anxieties, and
- Suggest ways in which the communities could contribute to implementing the new program.

3. The paramount chiefs who presided over these fora were given the opportunity to express the views of the traditional leadership on the implementation of the program.

The communities that adopted CHPS later said in some cases the communities organized meetings themselves and invited the health authorities to assess them for inclusion into the CHPS programme. As the Assemblyman from Keri said:

“We were praying for a programme like this. So when we heard of CHPS we mobilized ourselves and contacted the health authorities in Nkwanta to find out how we could also have such clinics”

There was also the need for advocacy and consensus building among all other health workers in the district, as explained by the DDHS:

“It was also noted that it was equally important to sensitize all health personnel about the programme and the intention to begin such programme in the districts. This sensitization process took the form of durbars of all health workers. The importance of getting all health staff to know about CHPS was grounded in the fact

that the perceptions and reactions to its implementation can help to sustain the programme since it will not be seen to be a programme only for "rural health nurses" - DDHS

4.22 LEADERSHIP

There is a community health committee in every CHPS zone. These committees are formed by chiefs and people with the DHMT and SDHT as facilitators. This is a group of responsible personalities selected from various sections of the community and its leadership to promote community ownership and participation in health care delivery. Each CHPS zone has a CHC comprising of the following:

- A representative of each of the communities making up the CHPS zone.
- A representative of the unit committee/area council
- The district Assembly member from the area.
- A generally recognized and respected women's leader
- A generally recognized and respected male in the zone.

The functions and responsibilities of the community health committees include the following:

- Provision of liaison between traditional leaders and health authorities
- Organization of communal activities in support of health programmes, such as communal labor and fund raising activities in support of service structures.
- Advocating community health and family planning activities
- Settling disputes arising from the work of the CHO, volunteers and other programme activities

- Supervising the work of health volunteers engaged in either disease surveillance only and or basic primary health care and family planning service delivery in the areas of:
 - Financial management of drugs and family planning commodities accounts,
 - Managing the volunteers stock of drugs and family planning commodities, and
 - Supervising the maintenance of other logistics of the volunteers such as bicycles.
- Operates in close collaboration and consultation with the SDHT and the CHO
- Advises the SDHT on community reactions and involvement in programme activities.
- Accepts advice and supervision from the SDHT on technical issues concerning programme implementation such as the performance of volunteers I service delivery and performance and attitude of the CHOs in serving the community.
- Serves as a protector institution to all health personnel operating in the locality and takes special responsibility for their security. In all the CHPS zones a watchman is provided for the CHO.

In all the CHPS zones the community health committees play an effective role in retrieving monies owed to the health facility.

“Most of the people here are very poor, so when they come for treatment I cannot refuse them. I give them the treatment on credit. The committee members help a lot in making these people repay the money. The committee members stand for them and as soon as they get the money they come to pay through the committee”- CHO at Kecheibi.

All the health committees were said to be very democratic in their functions: organizing meetings for people to air their views about the programme and taking decisions in consultation with the people. As the CHO for Bontibor CHPS zone expressed:

"The chairman of the health committee is very good. He visits the compound regularly and if there is problem he informs the other members. Then they meet and also invite me and the assemblyman"- CHO at Bontibor.

The CHPS coordinator was also seen to be part of the leadership and worked very closely with them.

"Anytime he visits this place (Keri) he makes sure me or any other member of the committee is informed beforehand. There is no decision made concerning the programme in this zone without consulting the chairman or the Assemblyman. He accepts whatever we tell him to be the problems here and tries to help us solve them"- Health Committee chairman at Keri.

The CHOs were also found to be generally working very hard to the satisfaction of the people.

"The nurse here is very hard working. She has never turned away any patient no matter the time of the day he or she comes to the clinic"- community elder at Obanda.

“The nurse here is hardworking and devoted but because she is the only one she often gets very tired. But the volunteer is so good that they can work together throughout the day especially on market days”-opinion leader at Bontibor.

Hence the health committees generally provide the community leadership in the program, are active and have representation from most communities. Leadership was also therefore found to be high (+4).

5.23 ORGANIZATION

The DHMT was generally seen to be the main organizers of the programme. In all the FGDs the DDHS was mentioned as the main brain behind the CHPS programme.

“Dr. Awoonor and his team have played leading roles in bringing to us this CHPS. When we wrote letters to him for this programme he sent his assistants to assess us. Then after that he gave us the go ahead. When he saw our enthusiasm and participation he arranged for the NGOs to assist us”- chief of Bontibor..

The officer responsible for the day-to-day supervision and monitoring of the programme is the CHPS coordinator. He pays regular visits to the CHPS zones. During these visits he finds out the problems of the CHOs and the concerns of the health committees. He also supplies materials and items and inspects the health compounds for maintenance.

These visits are very important not only to find out problems but also to reassure the nurse that we are interested in her welfare.

The activities of the Health committees have helped greatly in surveillance system in Nkwanta district. In the Nyanbong CHPS zone the Health committee has been able to sensitize the entire community to feel compelled to report any cases of sickness, birth death or any unusual event. Any of these events is reported to any of the committee members who in turn report to the CHO. The CHO then makes the necessary documentation and forwards to the surveillance officer in Nkwanta. The surveillance officer in Nkwanta makes follow-ups of the reported cases and then makes weekly feedback reports to all the CHOPS zones. Included in these feedback reports are the performances of all the CHPS zones. In this way all other CHOs know the performance of the others.

4.24 MANAGEMENT

This is placed on scale +4.

Management of the programme is generally a partnership between the DHMT and the communities in the areas of planning, implementation and evaluation. This co-management arrangement is made possible by the wide room of flexibility the DDHS gives to all the agents involved in carrying out the programme activities.

Both the CHO and the coordinator of the programme are given their own impress to manage. This arrangement has made the CHOs feel more autonomous in their new professional role, and this conveys a sense of pride and status that was lacking in their former roles.

Here I am boss of my own. I am the manager and the accountant as well. I face a lot of challenges alone and when I overcome them I feel very happy and satisfied. - CHO at Bonakye.

4.25 RESOURCE MOBILIZATION

This indicator was given a score of +4 (i.e. high) on the Rifkin scale.

The main contribution of the communities in the CHPS programme is in building up the community health compounds. The health compound is a housing facility where the CHO lives and dispenses health care. It is a two-bedroom facility with a living room and a separate room for providing health care to patients. There is also a pavilion in which maternal and child health MCH services are given.

In all the communities the people provided the land, labour, sand and gravel, wood for the construction of the health compounds. The main community mobilizers in all these activities are the health committees. However the basic equipment used have been provided for by the DHMT with the help from DANIDA and World Vision, two main NGOs in the area.

The people are limited in the area of financial contribution, as this elder from Nyanbong said:

“We would have wished we could contribute financially to support our nurse but here the ordinary man cannot even get one thousand cedis. However we are ready to do anything within our strength to keep this CHPS going”.

In all the zones the health committees organize people to weed around the compounds. In five of the zones the community members have helped the CHO to put up farms as stated by the health committee chairman in Obanda.

"We know she is our doctor here day and night, so she cannot get time to make a farm to supplement her salary. We have made a cassava and maize farm for her and the community is in charge of maintaining it till harvest time".

The CHOs in all the CHPS zones also enjoy gifts from the community members. During the harvest season most people bring to her some yam, cassava and corn.

"We give her these foodstuffs so that she can continue to stay with us and help our women and children when they are sick". - Assemblyman of Kecheibi CHPS

At Obanda Keri and Bontibor some community members occasionally come to help the nurse to cook and to wash her clothing. All the zones have watchmen who are employed and paid by the health committees.

All the CHOs have one or two volunteers who have been accepted as volunteers on the basis of their leadership and membership of a social group in the community, proven record of active participation in communal work and proven record of stable character, volunteerism, trustworthiness and honesty. When the communities choose the volunteers they are given training by the DHMT and presented to the people at a durbar of chiefs and people organized for such purpose. Having been selected from the various communities they serve as a link between the community leadership and the Health community and the

SDHT in the dissemination of information on programme implementation. They also serve as links between the CHOs and individual families.

"The volunteers are very good. Whenever madam is not there they take up most of her duties. They can treat minor cuts, can dispense drugs, give advice to patients. They can even help when a child who is convulsing. In fact they are very good and devoted to their work" - elder from Nyambong CHPS zone.

In general the health volunteers help to:

- Provide curative and preventive services for malaria and diarrhea
- Provide family planning services and counseling
- Deliver health education talks and
- Take part in disease surveillance activities.



CHAPTER FIVE

CONCLUSION AND RECOMMENDAIONS

5.1 CONCLUSION

Community participation in the CHPS programme in Nkwanta district was generally found to be high. The operation of the programme has been a functional and interactive process between the health care practitioners and community members. There is high enthusiasm and spirit of self-help. The people are involved in a partnership with professionals in planning and implementation, monitoring and evaluation of programme activities. The communities are involved in decision making process and contribute immense resources. Their in-kind contributions have been the main motivation for the CHOs to continue to stay and work with them. The people are generally satisfied working with the programme managers and some NGOs as their main source of cash flows and technical support while feeling they own the programme and a sense of duty to contribute to it's operation and sustainability.



5.2 RECOMMENDATIONS

It is encouraging to find that community participation in the CHPS process in Nkwanta district is high. This gives an indication of sustainability of the programme since such community-based programmes depend very much on the communities' involvement and participation. However this communal spirit of involvement and sense of ownership for the programme did not come automatically and should not be taken for granted. In adopting CHPS the programme implementers had to concretely conceptualize its operations by

doing a thorough situational analysis and applying a great deal of initiative and innovation.. Tremendous amount of work was done with huge cost in time and resources to first secure the cooperation and authorization of the people themselves at the community level before implementing the programme.

Every community has the potential of active participation in any programme meant for their welfare. But the level of actual participation in a programme will depend on how community members have been made to perceive the programme through effective community sensitization, mobilization and education. The DHMT and the SDHT of Nkwanta did a great job in this regard.

Therefore while making the following recommendations for the enhancement of the CHPS process, the DHMT and the SDMT is strongly commended for their successful pioneering role in the CHPS process in Ghana.

5.21 THE CHOs

Inter personal relationship

Community participation in CHPS is strongly associated with the attitude of the CHOs who are the front-line service providers. A good interpersonal relationship between the CHOs and community members will go a long way to enhance continued participation and hence improvement in health indicators. It is therefore recommended that the DHMT should undertake periodic surveys on the community's views on the attitude of the CHOs. This stems from the fact that the DDHS has had occasion to receive complaints from some

CHOs about the uncooperative attitude of some community members. But in order to have a fair and well-informed idea about issues it is equally important to hear what the people also say about the attitude of the CHOs.

Motivational factors

Out of the 17 CHNs in the district only six of them are involved in CHPS and they provide primary health care to 23.2 percent of the people in the district, who otherwise would not have access to any health facility. More so these CHOs are stationed in very deprived areas where they lack basic social amenities and are separated from their spouses. Even though the communities try to do whatever in their capacity to motivate them workable motivational packages should be explored to further motivate them to continue to give up their best in those difficult and trying conditions. Among the incentives the CHOs ask for include T.V sets, loans for housing schemes, sponsorship of their children's education and continuous education in the form of refresher courses for them. The DHMT could create buffer of CHOs so that after every three years of work at a particular zone she could go for further course in midwifery or other course to upgrade her knowledge and skills.

Reorienting all CHNs

The efficient and effective use of Community Health Nurses as CHOs in the CHPS programme demonstrates that working as CHOs in the CHPS process is indeed the rightful job for all CHNs. As such, the curriculum for the training of CHNs should be enriched to include rural sociology, managerial and leadership courses, and interpersonal relationship.

These courses will enhance them with the requisite knowledge, skills and attitude to work in rural deprived areas in the country.

5.22 THE HEALTH VOLUNTEERS

It is noted that the community health volunteers play a significant role in the CHPS programme. To sustain their morale, enthusiasm and spirit of volunteerism the DHMT should continue as they are doing to motivate them by giving them bicycles, inviting them for workshops in Nkwanta and giving them in-service training to upgrade their skills and competencies. Regular meetings with them to discuss their problems will help boost their morale.

5.23 TUTUKPENE HEALTH CENTER

The Tutukpene health centre has been closed down for some time now. Some of the reasons for the closure of this huge well-equipped health center includes lack of a proper need assessment and low attendance of community members. An in-depth research should be conducted to unearth the underlying causes of these problems. Turning this center into a CHPS facility and following similar steps for the establishment of CHPS could make is very useful to the people. Responses I got from my interaction with the Assemblyman for Tutukpene intimates this is feasible.

5.24 COSTING AND EVALUATION OF COMMUNITY CONTRIBUTIONS

The hallmark of community participation in the CHPS is the in-kind contributions of the people in terms of providing labour, wood, foodstuffs and security for the CHOs. It is important to cost all these contributions so that the people can tell quantitatively their level of support for the programme. This will also make it possible for all the communities to know how much each is contributing relative to the other. The quantified amounts of the contributions of all the communities should be made known to them at durbars and those with more contributions commended.

5.25 INTERSECTORAL COLLABORATION

DANIDA and World Vision International have made significant contributions in the CHPS process by helping to build Community Health Compounds and donating motorbikes for the CHOs. While commending these organizations for those contributions, it is suggested that they intensify their educational programmes in those areas to help empower the people.

Not too much enthusiasm is shown by the District Assembly. Their effective involvement in the CHPS process will go a long way to sustain the programme. Workshops should be organized to educate them on the CHPS process

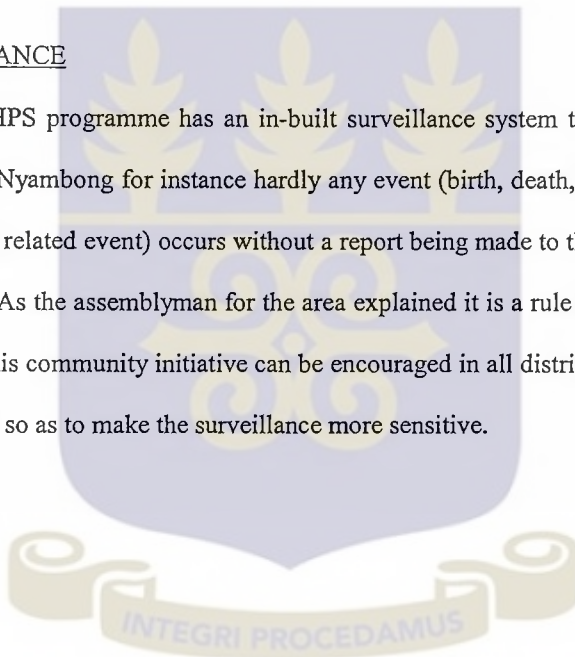
5.26 ADOPTING CHPS IN THE DISTRICTS

An important lesson that should be learnt from the CHPS process in Nkwanta is “starting small”. Once a DHMT is convinced that CHPS should be started, it should start on a pilot basis. On the basis of success of the pilot programme the programme can then be scaled up.

The Nkwanta team has demonstrated that without funding from external sources, CHPS can be implemented all the funding from the NGOS were solicited only after demonstrating that local resources could be mobilized to start a health programme. To be able to do this requires building a good team driven by a leadership with vision, initiative and innovation. This team should build mutual trust with the communities. Giving promises that can and must be fulfilled is key to building this mutual trust.

5.27 SURVEILLANCE

The Nkwanta CHPS programme has an in-built surveillance system that is very efficient and effective. In Nyambong for instance hardly any event (birth, death, outbreak of disease or unusual health related event) occurs without a report being made to the health committee and to the CHO. As the assemblyman for the area explained it is a rule in the area to report all such cases. This community initiative can be encouraged in all districts that are trying to implement CHPS so as to make the surveillance more sensitive.



REFERENCES

1. Address by Dr. H. Mahler, Director General of WHO, to the International Conference on PHC, Alma-Ata, 6 September 1978, in **From Alma-Ata to the year 2000: Reflections at the Midpoint.**
2. Atim, C et al: **Training of Trainers manual For Mutual Health Organizations:** ABT Associates Inc, September 2000.
3. Bermejo, A and Bekui, A.: '*Community Participation in Disease Control*', **Social Science Medicine**, Vol. 36 no 9.
4. Ong, B. N: **Rapid Appraisal and Health Policy**, Chapman and Hall, London, 1996.
5. Laleman, G.and S. Annys: '*Understanding Community Participation: a Health Programme in the Philippines*'. **Health Policy and Planning, A journal on Health in Development**, vol. 8, no 3, September 1993.

6. **Medium Term Health Strategy Towards Vision 2020**, MOH, Accra, 1999.
7. Navrongo Health Research Centre (NHRC), MOH: **The Navrongo Community Health and family Planning Project: Lessons Learned, 1994-1998.**
8. **Nkwanta District Health Services Annual Report, 2000.**
9. Rifkin et al: '*Primary Health Care: on measuring Participation*', **Social Science and Medicine**, 26 (9)
10. Schmidt, D.H. and S. B. Rifkin: '*Measuring Participation: Its Use as a Management Tool for District Health Planners based on a Case Study in Tanzania*', **International Journal of Health Planning and management**, Vol.11, 1996.
11. Twumasi, P. A: **Social Science in Rural Communities**, Ghana Universities Press, Accra.

APPENDIX

(A) IN-DEPTH INTERVIEW GUIDE FOR THE DDHS

1. What factors influenced your decision to adopt CHPS
2. What steps were taking in implementing the programme?
3. What have been the challenges/ problems
4. What steps are taken to sustain CHPS
5. What are your impressions about the level of community enthusiasm and participation in the programme

(B) IN DEPTH INTERVIEW GUIDE FOR THE CHOS

1. Why/ how did you become a CHO?
2. What activities are carried out in this CHPS zone?
3. Which communities are within your coverage area?
4. What is the population of your coverage area?
5. What facilities are available in this CHC?
6. How do the communities contribute to the programme?
7. What are the major problems / challenges that you face as a CHO?

© FOCUS GROUP DISCUSSION GUIDE FOR OPINION LEADERS IN THE CHPS
ZONES

NEEDS ASSESSMENT

1. How were the initial needs of the community identified?
2. Who were involved in the process of the needs identification?
3. Are there new needs?
4. Why should the programme continue?

The image shows a large, semi-transparent watermark of the University of Ghana crest. The crest is a shield-shaped emblem with a blue background and gold elements. At the top, there are three stylized gold leaves. Below them is a gold scroll with the word "LEADERSHIP" written in blue capital letters. At the bottom of the shield, there is a gold banner with the Latin motto "INTEGRI PROCEDAMUS" written in blue capital letters.

LEADERSHIP

1. Who make up the leadership of the programme?
2. Is the leadership democratic or autocratic?
3. Is the leadership capable?
4. Is there the need to change the leadership?

OGANIZATION

1. Who are involved in carrying out the programme?
2. Is there effective collaboration between these groups?
3. Are community members involved in carrying out th programme activities?

4. Will the community be able to continue with the programme if donors withdraw her assistance?

RESOURCE MOBILIZATION

1. Who contributes to the programme in terms of finances and human resource?
2. What has the community contributed and what percentage of this is total programme cost?
3. Whose interest is served by the allocation of resources?
4. How are resources mobilized?

MANAGEMENT (DECISION MAKING)

1. How are decisions made? i.e. Are ideas discussed then decisions made through collaboration, or are decisions imposed on the programme?
2. Would you like to see this process changed, if so how?
3. Rate the influence the leaders and the individuals have in determining activities and the actions of the programme. Who do you think has the most influence?
4. Has this level of influence, which the different groups (i.e. leadership, individuals and community exert), changed since the programme began? If so how, and in which direction?