COMMUNITY HEALTH WORKERS IN THE PRIMARY HEALTH CARE (PHC) PROGRAMME IN RURAL GHANA. A STUDY AT NKORANZA

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A THESIS BEING SUBMITTED TO UNIVERSITY OF GHANA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE DEGREE OF MASTER OF ARTS IN SOCIOLOGY.

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DEDICATION

THIS PIECE IS DEDICATED TO THE RURAL MAJORITY WHO PROVIDE AMENITIES THEY DO NOT ENJOY.

DECLARATION

THIS THESIS IS THE RESULT OF MY ORIGINAL WORK AND INDEPENDENT RESEARCH UNDERTAKEN WHILE I WAS A STUDENT AT THE DEPARTMENT OF SOCIOLOGY, UNIVERSITY OF GHANA, LEGON FROM OCTOBER, 1988 - AUGUST, 1990.

ALL QUOTED SOURCES HAVE BEEN ACKNOWLEDGED.

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SIGNATURE

7/6/96

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If writing of the script was difficult and needed a lot of brain storming to put ideas together, then equally a difficult task is the typing of whatever is hand written. This is

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I must say, however, that I am solely responsible for the shortcomings which may be found in the work.

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S. OPOKU - TUFFUOR

ABSTRACT

The search for a more equitable health care delivery system to cover the majority of the people, more especially the Vulnerable groups (women and children) has led many developing countries including Ghana to adopt the Primary Health Care (PHC) programme. Primary Health Care as envisaged, is to make health care available, accessible and affordable to the underprivileged an also to enable the people and the system is to serve to participate in its planning and implementation. Community Health Workers (CHWs) have been identified as the corner-stone of such a programme. Ghana has thus found it appropriate to use such community-trained health care providers.

Using a sample of 32 CHWS, some leaders of the communities of the 32 CHWs and some health personnel in the h Nkoranza area in the Brong-Ahafo Region of Ghana, an attempt has been made to examine factors affecting the performance of CHWs in the implementation of the CHW programme in rural Ghana (chapter 1).

The thesis as demonstrated in cCapter Two, has shown that the programme took off with the participation of the communities concerned, the government of Ghana (through the Ministry of Health) and the various non-governmental organisations UNICEF, WHO, World Vision International and Catholic Secretariat. The research has however revealed that the institutionalization of the programme has not recorded much success (as shown in chapters 4,5 and 6).

The state of affairs in the organization of community clinics is attributed to among other things, the lack of community education on the programme and improper planning and development of the necessary support systems. These factors which are interrelated and interconnected have damped the enthusiasm of the community members and most of the trained CHWs, The end result is that, about 80% of the CHWs have abandoned the programme.

While some measures such as the organization of fund raising activities and the training of community leaders in management skills could be adopted locally to deal with the problems of remuneration, supervision and drug supplies, more comprehensive measures will be needed at the national level to reshape the programme to meet the needs of the rural majority (Chapter 7).

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CHAPTER ONE

INTRODUCTION

1.1 STATEMENT OF THE PROBLEM:

This thesis attempts to look at the official health sector and community related factors which affect the work of Community Health Workers who are the frontline workers, of the PHC delivery system.

It has been realised of late that it is near impossible in many developing countries to reach the rural population with clinic-based health services. Capital budgets to construct facilities and recurrent budgets to pay for staff or supplies are limited. These have been aggravated by falling prices of commodities, increasing population increasing security operations following frequent coup d'etats. Most of these countries have inadequate transportation systems, and health personnel are often reluctant to work in remote areas. In others, health services do not reach most people because they are too distant and inaccessible for technical, linguistic or cultural reasons.

Since the Alma-Ata Declaration in 1978, a keen awareness has developed on the shortcomings in the delivery of health services and the need for policies and programmes which reflect peoples requirements to an increased degree. Furthermore, it has become clear that many health interventions have to be performed by people based at home rather than in institutions. The WHO initiated the movement towards the development of a Primary Health Care (PHC) programme in the rural areas in 1975. A study carried out by Djukanovic and Mach (1975) as a joint project for WHO and the United Nations Children's Fund (UNICEF) underlined the lack of adequate health services in the villages. They advocated the appointment of PHC workers with broad backgrounds, and with a commitment to community participation. Participation was obviously necessary if health education was to be relevant in local terms and effective in changing behaviour; but there

was also the growing belief that people should have more say in decisions which would affect them and their families so intimately (Newell, 1975; Morley et al 1983).

In 1977, the WHO published its Working Guide for Primary Health Workers (PHWs) (WHO, 1977) giving detailed advice, in both words and pictures, about how to deal with local health problems. The topics ranged from childbirth and family welfare to village hygiene, and from the treatment of accidents or internal growths on ths one hand to mental disorder on the other.

This explains why many developing countries have recently been experimenting with the delivery of primary health care at the community level by promoting "self-help" programmes among villagers facilitated by village level health workers. A precedent had been set by the barefoot doctors in China, the promotoras de salud in Guatemala, and the village health workers in Niger.

Most countries have thus expressed a commitment to the CHW programme, signing Charters, making declarations and publishing policy statements, and many have set national goals and prepared programmes for the organization and management of their health systems on this basis. About three-quarters (3/4) of developing countries thus have national plans indicating how their health infrastructure may be extended and re-oriented to achieve the goals of PHC.

Since her adoption of the PHC concept in 1976, Ghana has been incorporating new approaches and activities into her national health programme. The emphasis has been on the training of health workers in broader professional field instead of using health workers trained intensively for a limited range of tasks.

In Ghana, Community Health Workers (CHWs) have been recruited as part of an effort by the Danfa Comprehensive Rural Health and Family Planning Project to augment village-based Services. The reason being that community members trained in health

education can educate their people better. Village volunteers have also assisted in the Danfa project's Mass Immunization, Malaria Chemoprophylaxis, and self-help sanitation programmes. In other village-based activities Traditional Birth Attendants (TBAs) have been trained to deliver maternal care, and health education volunteers have been taught to monitor the growth of children and to provide education on nutrition.

There seems to be two main reasons for employing such health workers in Ghana.

1. The failure of health centre-based services to meet the health needs of the people it was intended to serve and at a cost they could afford.

2. The realisation that simple medical and nursing care and the use of medicaments alone can have little effect on the environmental, social and cultural factors that cause disease and disability.

Thus the assumptions underlying PHC and the use of CHWs in Ghana are that CHWs would more successfully disseminate health information, and also that Community participation is integral to the institutionalization of CHWs programme at the Community level.

In short, Ghana is promoting CHW programme as a more equitable alternative to an earlier medical model that is primarily curative, urban and hospital-based, inadequate for its exclusion of even minimal services to the majority of the people and which has been seen as too expensive to extend to all areas.

The principles which formed the basis of the CHW approach were equity, intersectoral collaboration, community involvement, emphasis on prevention, and appropriate technology. CHW programmes were in many ways seen as encompassing all these principles: equity by extending services to neglected populations, intersectoral collaboration through working with community workers of other sectors and indigenous practitioners, and including tasks traditionally seen as beyond the health sector (such as

education on Water management and Sanitation) Community involvement through their close links with communities. It is for the realisation of this broad objective that the Ghana Government under Acheampong initiated the Brong-Ahafo Rural Integrated Development Programme (BARIDEP) (referred to in this work as "the Kintampo Project") for the training of CHWs.

It can therefore be said that the training of CHWs at Kintampo (Health Centre) and the subsequent establishment of Community Clinics (CCs) in rural Ghana in general (and Nkoranza District in particular) are part of government planned actions. They are designed to intervene in the health care delivery systems, by bringing health services to people in places that the official health services cannot reach. CHWs are thus seen in this context as a part of an instrument of development and change.

Although Ghana's PHC programme in general and the Kintampo project in particular have been in operation for over 15 years impressions one gathers through regular visits to the villages within the Nkoranza District (i.e. the pilot CHW project area) are that only few of the many trained CHWs in the area are still working. This notwithstanding, various successive governments and other non-governmental organisations working in the area of health and community development continue to place emphasis on the use of CHWs as the key to Ghana's rural health problems.

According to the annual report (1989 report) of the St. Theresah's Hospital, Nkoranza, there were only 12 "active community clinics in the district even though more than 60 people from 60 different communities had been trained in the area. The truth of the matter is that, while some communities could not establish clinics for their trainees, clinics established by others could not be sustained due to reasons to be examined later

This situation is not limited to the district; the country as a whole has caused the health authorities to suspend the training of CHWs, believing that "the whole concept of CHWs needs careful evaluation first" (Health Services Report of Nkoranza District;

1989). Adjei Sam et al (1989) have also showed that in nine districts they visited during their study on the viability of Community Clinic Attendants in Ghana, the average attrition rate per district was 74.5%. The exact rate for the various districts is given in the table below:

Table 1.1 **Community Clinic Attendant Attrition Rates for Various Districts**

DISTRICT	NO.OF CCAS TRAINED	ATTRITION	ATTRITION RATE
Afutu-Awutu Senya	59	41	70%
Suhum-Kraboa-Coaltar	69	49	70%
West Dagomba	167	NA	NA
Ashante-Akim	46	36	78
Kintampo	Only three Community Clinics were operating but on private basis.		
Bongo	16	8	50%
Wassa West	48	38	79%
Dangbe West	NA	NA	NA
Volta	NA	NA	NA

SOURCE: Summary Report on the Activities of CCAS p.3

Although data could not be found by Adjei and his team for the Dangbe West District, it was later found out (during a research into the Implementation of the Bamako Initiative Programme 1990) that only 2 of the 11 trained CCAS in the district were working. Despite this stand the interest of the Communities to have clinics is still high, for whilst most communities have recently started reviving their defunct clinics, new ones are been established in places where some could not be established initially. The time is therefore ripe for this type of sociological study in the pilot programme area, to find out what factors are affecting CHWs in rural areas. This is expected to serve as a baseline data material for PHC Planners in Ghana.

1.2 OBJECTIVES OF THE STUDY

Main Objective:

The main objective of the research is to identify official (health sector) and community-based factors that affect the functioning of Community Health Workers in rural Ghana, with particular reference to the Nkoranza area in the Brong-Ahafo Region.

Specific Objectives:

Specifically, the research will look at:

1. The type and level of MOH participation in the institutionalization of CHW programme and their role in the operations of CHWs in the study area.

2. The type and level of community articipation in the CHW programme and the effect of these on the successes or otherwise of CHWs in the study area.

3. CHW's own perceptions and experiences and how these inputs affect their work in the study area.

1.3 LITERATURE REVIEW

Cohen and Uphoff (1977), Coombs (1980) and Jancloes et al view community participation as the key to successful CHW programme. They consider all other factors that influence the work of CHWs as complementary to community participation. Jancloes et al, suggested that when people are given the opportunity to manage their own affairs and to be involved in decision making they can become very efficient and will contribute many of the material and human resources needed to organise health facilities. This is the assumption worked into the PHC and the CHII programmes. Even though Jancloes et al (op.cit) see the importance of community participation in carrying out development programmes, what they did not address themselves to is the issue of who is to do what and how. Thus whether community participation in decision making is to be carried out

by the whole community or through their representatives who are delegated specifically to do this is not clear from the argument.

Although Schumacher (1973); WHO/UNICEF (1978); Molina et al 1980 and Ballondi et al (1980), support the community participation idea, they argue that community participation in development programmes can only be effective where the people are consscientised. Thus, any programme that aims at seeking the support of the people should first educate the people to understand the programme and the specific role they are expected to play. Although education of the people is emphasised here as a tool to get a people to be involved in a development programme, the question of whether the particular project or programme is the felt need of the people is overlooked.

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

Segall and Williams (1980), Muller (1980), de Kadt (1983), and Twumasi and Freund (1988) see a direct relationship between the implementation of development programmes and the political system or the social structure of the given society. An idea derived from these writers is that people remain socially and culturally attached to such structures and their traditional patterns of leadership and/or co-operation. To Muller (1980), this can be utilized to mobilize community members in decision making about

actions to improve their health and general conditions. On social structure and community participation, the writers are of the opinion that where material resources are more equally distributed, there appears to be a better basis for community activities. Nevertheless, even in such circumstances it may be difficult to involve community members in health promotion if there are ethnic or clan divisions.

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

Although this argument is supported by Morley et al (1984) they add that part of this technological package should include knowledge of the health problems of the area. Appropriate technology should also extend to training and management strategies, and to monitoring and evaluation using precise indicators by which a community can gauge its progress in solving health problems. Morley et al have further argued that these technical factors alone will not guarantee a successful PHC programme in the rural areas, but they are essential and tend to be overlooked by those for whom social goals are paramount in PHC.

Navarro (1975), and Lamptey et al (1980) have explored the role of health personnel and social workers in the implementation ot PHC programmes. Their study has established the importance of involving health personnel and social workers actively in

government projects and community initiated ones. However, they are of the view that there is the need to find out the extent to which the people should be involved. To them, the current bureaucratic and dominant profession such as the bio-medical practitioners would have to yield a great deal of their control if the PHC system should work.

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

Samba's (1989) conclusions on PHC programmes seem to be the core of this research. Writing on PHC in Gambia, he emphasized that it is relatively easy to organise village communities, get them to select village health workers, and even to train these workers. But the crunch came after the euphoria of the honeymoon had passed - with the problems of remuneration, provision and funding of drugs on a regular basis and continual evaluation and supervision.

It is with this view in mind that the current study will attempt to identify factors affecting trained CHWs in the Nkoran District.

1.4 THEORETICAL FOCUS:

Sttudies in the use of traditional and modern medicine have focussed more on consumers of these forms of medicine with less emphasis on the structural components of the health system and its social support system. Social scientists are now getting increasingly interested in the PHC approach to health especially in the third World.

Social Science literature on PHC has seen a rapid growth since the declaration of "Health for All" by the Year 2000 in May 1977 at the 30th World Health Assembly. The 1978 World Health Organisation United Nations International Children's Emergency Fund Conference on PHC in Alma-Ata, Russia, recommended that PHC should be considered the key to the achievement of WHO's goal of "Health for All" by the Year 2000.

The Declaration of Alma-Ata defines PHC as "essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination" (WHO: 1977). It is in this context that PHC becomes an instrument of social change and development.

Granted that primary health care systems can evolve from the economic conditions and social values of specific communities, they nevertheless should have some basic components. Among these dre the promotion of proper nutrition; an adequate supply of safe drinking water; basic sanitation; maternal and child care including family planning, immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries. Maximum community and individual self-reliance for health development are essential for the (PHC) programme to be operative at the community level. To attain such self-reliance requires full community participation in the planning, organisation and management of PHC.

Since PHC is an integral part both of a Country's health system and of overall economic and social development, it has to be co-ordinated on a national basis with the other levels of the health system as well as the other sectors that contribute to a country's

total development strategy. PHC is thus an alteration in the medical system as well as an approach to rural development.

Ian Robertson (1977: 539) sees social change as "the alteration in patterns of culture, social structure, and social behaviour overtime" (1977: 539).

The justification behind the need to find an alternative health care delivery system to ensure "health for all" is simple. It is to meet the health needs of majority of the people more especially those classified as vulnerable children and pregnant mothers. To achieve this however needs an alteration in the hospital-based health care system. Such a simple conclusion fits into Toynbee's cyclical theory of social change. The key concepts in his theory are those of "challenge" and "response". According to Toynbee, every society faces challenges - at first, challenges from the environment, later, challenges from internal and external enemies. Toynbee concludes that the nature of the society's responses determines its fate. To him each new civilization is able to borrow from other cultures and to learn from their mistakes. The achievements of a civilization consists of its successful responses to challenges; if it cannot mount an effective response, it dies (Robertson, 1977: 544).

The argument being put here is that the acceptance of the PHC concept and the use of CHWs in rural areas in Ghana is a response to the challenges posed by the present health care delivery system. The limitations in the present health care delivery system which has been described as hospital-based and urban-centred and lessons learnt from other countries using community-based health workers to extend "essential health" care to their rural communities thus call for the response Toynbee talks about.

It must be said here that each process which involves a new pattern of behaviour, new attitudes, new techniques could be reffered to as an innovation. We may admit that innovation and acceptance of innovation do not occur at random but depend on the urgency of social needs, the degree of disorganisation, as well as the flexibility of society

and the degree to which change has been instltutionalised. The more dynamic a society is, the more tolerant it is toward innovation. Thus whereas traditional societies actively suppress innovation, modern societies actively encourage it.

Even here (in modern society) innovation encounters resistance, due to emotional investment in old patterns and distrust of new ones. What is more, in the same society not all innovations stand an equal chance of being accepted. In order to be accepted, an innovation must be in line with a society's needs and interests, and must be compatible with existing framework. Once an innovation is the society favourably judged, special divisions are devoted to its implementation and to promoting its acceptance in society.

From the concept of innovation discussed above, two main ideas could be derived to help in the current research.

1. The idea that innovation and acceptance of innovation will depend on the urgency of social needs and the degree to which change has been institutionalized;

2. Linton's argument that innovation must be in line with a society's needs and interests and must be compatible with its existing framework.

The PHC concept and the use of CHWs in rural Ghana from the perspective of the ODC/ILO (1976), can also be viewed as a development strategy approach. Here, various theories discussed by the two organisations, such as the "spontaneous process" models the "responsive-process" models, the "authoritarian top-bottom" approach, the "bottom-up" approach and the "holistic" approach to rural development come into play.

Like the "trickle-down" theory of development the two organisations view the "spontaneous-process" models of technical change as being automatic. Once technical change has begun, the models predict, it will spread on its own, like an "epidemic" True, some effort is required to produce the initial "infection". But this effort need not be

greater than a little nudge. All that is needed is the initial adoption of the relevant innovations by selected "change agents". Thereafter, in the fullness of time "the epidemiological process" eventually takes over to ensure widespread and rapid diffusion of those innovations. This in some way supports the Philosophy of the hospital-based health care delivery system. Once a hospital is established in an area, it serves the outlying areas and is to bring about the needed improvement in the health conditions of the people not only in town where the hospital is based but also in the hinterland. The argument also supports the "Growth Centres" Concept of rural development. Francois Perroux, the well-known French regional planner, mentioned that development does not appear everywhere at the same time. It manifests itself with variable intensities at favoured points, from which it tends to propagate outside with variable final effects for the economy as a whole. These points from which the development activities radiate to the outside territories are the nodal points of development - the "Growth Centres" "This is also the trickle-down" process of development.

The original theory of socio-economc development that accompanied the post - 1945 decolonization of Asia and Africa rested on the idea of modern society as the goal of development. Modern society supposedly had typical social patterns of demography, urbanization and literacy, typical economic patterns of production and consumption, investment, trade and government finance; and typical psychological attributes of rationality, assumptive identity and achievement motivation. The process of development consisted on this theory, of moving from traditional society, which was taken as the polar opposite of the modern type, through a series of stages of development derived essentially from the history of Europe, North America and Japan -to modernity that is, approximately the United States of the 1950.

After their political independence there was, understandably something about this mode which few African countries could resist Here were models that promised the newly independent countries rural transformation within a few years.

Reality proved perverse, however, and few of the programmes that enacted these models in Africa were successful. Target Communities proved to have an uncanny tendency to ignore innovations introduced in this way, even, when the superiority of these innovations over traditional practices were clearly beyond dispute. In time, the African countryside came to be littered with the remains of innovations which had died before adoption. Certainly, they could not be held up as proof of the spontaneity of technical change. The health system established by the colonial government and subsequntly followed by successive nationalist Governments has not brought about much improvement in the over-all health conditions of the rural masses.

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

In recent years, debates on rural development have on many occasions emphasised more on the source of the innovation. In this respect. three strategies may be distinguished, depending on whether what is advocated is manipulation of those factors from the “top", "bottom" or from "both ends". Macro-strategies consider it appropriate for governments to choose the goals and specific objectives of technical change as well as the means and specific programmes for attaining them. In these strategies, initiatives are taken at top levels, translated into appropriate directives -again, at the top and then transmitted through the intermediate layers of the local bureaucracy down to the public for implementation. If one considers the PHC concept from its Alma Ata Conference through national programmes to the community level, it will be appropriate to see it as a top-bottom approach to health development.

Strategies that advocate manipulation of the factors of technical change from the bottom see the role of governments as being not that of initiator but that of facilitator. The role of initiator is reserved for the people, who are the "subject", not "object" of development. They participate in development actively, not passively, and initiatives are taken by them at the bottom, not by government bureaucrats at the top. This arrangement is favoured for various reasons. Sometimes equity is stressed, and bottom-up approaches are favoured because they minimize cost and generally "democratize" national development. At other times special strengths are believed to lurk at the bottom, and bottom -up approaches are advocated because they tap them use them as a basis for technical change. A World-Bank president has declared, "there is no more powerful force for progress against poverty than the initiative and ingenuity of the poor themselves". At other times still conceessions are made to the "numbers" of the rural mass, and bottom-up approaches are advocated because moving that mass is thought to be easier when internal forces are mobilized for that purpose than when external forces are exerted to that end. The idea of making the people the initiators of their own health programmes to bring about the much needed development supports the above argument.

Finally, there are strategies which see the distinction between top and bottom as forced. They consider the top and the bottom to be "holistically" one: the top is no more than the end of the bottom and the bottom no more than the beginning of the top. Likewise, the division of technical change into innovation and diffusion is considered artificial: diffusion is integral to innovation, because technologist must anticipate diffusion at the innovation stage. This means that the top must work together with the bottom: the innovator must co-opt the user of his innovations into the designing of those innovations. From this angle, PHC becomes, a holistic approach to both health care delivery and rural development.

In recent years, especially since the early 1970s, there has been an increasing interest in participatory approaches to development. This interest is manifested at both the national and the international level. At the international level, most multilateral and bilateral

agencies have recognized the importance ot participation both as a means and as an objective of development. Participatory development here assumes a wider interpretation than mere increases in labour productivity, declining share of agriculture in total output, technological progress, and industrialization with the consequent shift of population to urban areas - economic growth. Here development objectives concentrate on such indices of living standards as income distribution, nutrition, infant mortality, life expectancy, literacy education, access to employment, housing, water supply and similar amenities.

A further view of participatory development puts the spotlight on human potential and capabilities. According to this view, development is seen in such terms as enhanced competence to analyse and solve problems of day-to-day living, expansion of manual skills and greater control over economic resources, restoration of human dignity and self-respect, and interaction with other social groups on a basis of mutual respect and equality. The agents to carry out this system are the CHWs who are to be supported by the rural masses.

Participation as used in the PHC system and the CHW programme can be said to cover three main areas:

1. It refers to the "mobilization" of people to undertake social and economic development projects. Typically, the projects are conceived and designed from above and the people are "mobilized" to implement them. Their participation thus consists of their contribution of labour and materials, either free or paid for by the authorities (Griffin 1990).

2. The second interpretation equates participation with decentralization in governmental machinery or in related organizations. Resources and decision-making powers may be transferred to lower level organs, such as

local officials, elected bodies at the village or country level or local project communities.

3. The third view of participation regards it as a process of empowerment of the deprived and the excluded (Gran. 1983; Oakley, 1987; Oakley and Marsden, 1984). One fact of empowerment is the pooling of resources to achieve collective strength and countervailing power. Another is the enhancement of manual and technical skills, planning and managerial competence and analytical and reflective abilities of the people. It is at this point that the concept of participation as empowerment comes close to the notion of development as fulfilment of human potentials and capabilities. On one hand, the CHW programme can be described as a conventional development project. According to Griffin et al (1990), a conventional development project is conceived and designed from outside by national and international experts, together with the paraphernalia of pre-feasibility and feasibility studies, appraisal reports, specification of inputs and outputs, calculation of internal rates and sophisticated cost-benefit analysis. The writers mention that the people for whom all this is supposed to be done exist only in the abstract as numbers whose output and productivity are to be enhanced and whose "needs" are to be satisfied. Their participation in the preparatory phase if they are lucky, may, at best, consist of some hastily organized meetings with the experts and bureaucrats at which they are "briefed" about the objectives and activities of the planned projects. In the implementation phase they are expected to carry out their pre-assigned roles". (p.226). The CHW programme can also be said to be a participatory development project. Its central concern is with the development of the moral, intellectual, technical and manual capabilities of individuals. The CHW programme in rural areas is therefore, regarded as a process for the expansion of these capabilities with CHWs as the pivot around which the programme is to revolve. The above, discussions provide theoretical perspectives from which clear research

interests on various aspects of CHWs in the PHC programme have emerged.

1.5 FIELD METHODOLOGY

Sampling:

Looking at the focus of the current thesis, that is, factors affecting CHWs, the target groups of the study included the CHWs themselves, and the two agencies (the Community and the MOH) whose activities are assumed to be affecting the functions of the CHWs. The first problem that had to be tackled was the determination of the sample frame (i.e. to establish the number of CHWs that had been trained in the area). The second was the determination of the size of the sample.

The frame was provided by the 1989 Health Services Report of the St. Theresah's Hospital, Nkoranza. The distribution of CHWs within the district was given as in Table 1.2

Distribution of Community Clinics by Status as of the Survey Data

Status of Community Clinics

Inactive

Active	Temporary	Permanently	Newly Trained
Bomiri	Boabeng	Dromankese	Tom
Bonsu	Asuano	Busunya	Koforidua
Anama	Dotobaa	Bredi	Kyekyewere
Ahyiayem	Kranka		dotobaa
Senya			Dromomankuma
Donkro Nkwanta			Akonkoti-Dumasi
Ntanaso			Asuano
Jerusalem			Boabeng

SOURCE: Nkoranza CHW survey. 1990:

Missing from the report were the names of communities which could not establish clinics for their CHWs. This had to be soughted from the CHW themselves.

Based upon the above data the CHWs were categorised into three main groups:

a. Those operating clinics (i.e. those functioning) (12)
b. Those who established clinics but had collapsed (10)
c. Those CHWs that could not establish clinics (10). Included in the last group are the five awaiting the commissioning of their clinics.

Opinion leaders (Community Development/Health Committee members) from the Communities categorized above were also included in the sample. These are the people who are supposed to lead their people to undertake development programmes including health. They would therefore know the nature and extent of involvement of their Communities in the CHW programme.

The health authorities are expected to be in-charge of the training of the CHWs. They are also to supervise, provide referral points and refresher courses for the CHWs. Their inclusion in the Sample is thus considered important as this is expected to provide some, if not most, of the health related factors affecting the functions of the CHWs.

Some health authorities at Kintampo health centre, St. Theresah's Hospital, Nkoranza, Yefri Health Post and Nkoranza Health centre were thus interviewed. They included:

a. The Medical Officer in-charge of the Kintampo Health Training school.
b. The Medical Officer in-charge of the Kintampo Health Centre.
c. Medical Officer in-charge of St. Theresah's Hospital, Nkoranza.
d. The Health Centre Superintendent at Nkoranza Health Centre.
e. The Officer in-charge of the Yefri Health Post.
f. The District Medical Officer (DMOH), Nkoranza.
g. The PHC District Co-ordinator, Nkoranza

Data Collection Instruments

Data collection from opinion leaders in the communities selected included the use of self-administered questionnaire, focussed group discussions and oral interviewing methods. Guestions covered issues like;

1. The nature and extent of community involvement in the planning and implementation of CHW programme.
2. Problems facing communities in playing their expected roles and;
3. How the functions of CHWs could be strengthened.

To determine the characteristics of CHW training and how these are affecting the operations of CHWs within the district, information was sought from the existing health institutions. Here a guide [checklist] was used. This was to help in the identification of any areas of deviations and omissions between what CHWs were supposed to do and what they are doing in their communities.

Structured questionnaires were used to obtain information from Community Health Workers (CHWs) about;

a. Selection procedures;
b. mode of training;
c. their financing during and after training
d. sources of supply of inputs;
e. regularity of the supply of inputs;
f. remuneration
g. CHWs perceptions and experiences about their work and how these are affecting them
h. what they deemed to be factors responsible for their successes and failures; and
l. how their work could be strengthened.

Documentary records from the Ministry of Health [MOH], books, journals, papers, reports from workshops and seminars related to the topic were used extensively. Also

sought from MOH were information on the PHC programme in Ghana and the establishment of the Kintampo Project.

Operational Definitions of Concepts

1. Community Health Worker (CHW) is used throughout this paper in a generic sense. Many countries and programmes call such workers by different names, including: Family Welfare Educator (Botswana), Community Health Agent (Ethiopia), Rural Doctor and Health Aide (China), Community Health Guide (India), Community Health Aide (Jamaica), Village Health Worker (Nigsria), and Barangay Health Worker (Philippines). In Ghana they are either called Community Health Workers or Community Clinic Attendants.

2. Primary Health Care Programme:
   According to the Declaration of the International Conference on PHC, PHC is a means of providing "Essential Health Care to all individuals through their first level of contact with a national health service". This is the meaning applied to PHC i.n this work.

3. Community Participation
   We do not simply mean the mobilization of the peoples to generate resources - money, labour, and materials for government -planned and - Controlled programmes, but also as a process through which the people gain greater control over the social, political, economic, and environmental factors determining their health. In specific terms community participation should not only stop at the implementation stage but in the involvement of the people at every stage of the health programme, such as initial assessment of the situation. defining the main health problems setting the priorities for the programme implementing the activities monitoring and evaluating the results, etc.

4. Success of the CHW Programme

This will be assessed by the Existence of the following:

a. A community-owned clinic

b. The premises used for the clinic should have been built or hired by the community.

c. The CHW is supervised by the Community and the MOH

d. Drugs and other inputs to the clinic is supplied by the community

e. The CHW is rewarded by the community.

Failure of the programme will be the absence of the above.

FIELD PROBLEMS

Three (3) main problems were encountered:

a. The first dealt with the inaccessibility of some of the roads due to heavy rains. This made many of the feeder roads in the district unmotorable and thus difficult to use more especially as the researcher used bicycle. This delayed the work initially.

b. The second problem was the difficulty of meeting the CHWs who had dropped out in their communities. Some drop-outs had travelled outside their communities. Several visits had to be made into some of the communities before those CHWs concerned could be contacted.

c. The final problem was encountered during the focus group discussions. Most of the opinion leaders were not committee members when the CHWs were trained and did not know much about the background of the trainees and the programme. Some could thus not respond well to the questions. In such situations, discussions were monopolized by those who were members of the committees concerned. In two villages, some former committee members had to be invited.

Limitations in the Study

a. The intention of the researcher was to record the focus group discussions. This would have made it possible for proper analysis to have been made since the whole discussions could have been replayed to detect omissions and misinterpretations or distortions of facts. This could not be done as some opinion leaders objected to the use of the tape recorder. It is possible that much useful information was lost as the researcher had to play a dual role of secretary cum facilitator.

b. Due to lack of time and financial constraints, the research could not be extended to cover the majority of the villagers. Data collection in the communities was limited to only the opinion leaders and the CHWs. If the ordinary people had been covered, it is possible that different views might have been shared on some of the major issues raised in the research. The people would have been the best informants on why they bypass the Community Clinics, why they refuse to help the CHWs in their farms and how best they think the programme can be re-organised to meet their desires.

c. No initial contacts were made with the Communities to inform them about the research. The opinion leaders were thus unaware of the arrival of the researcher. Unfortunately visits to some of the communities were in the late mornings and early afternoons. These were the times when most people had either places of work. Whilst some opinion leaders who know something about the establishment of their community clinics were missed completely as a result of this, others had to be rushed into the meetings. Such invited people usually had divided attention. In two villages, Ayerede and Bonsu, the CHWs had to be invited in the middle of the interview to attend to emergency cases. Whilst the CHW at Ayerede had to attend to a pregnant woman who had collapsed in the church house, the CHW at Bonsu had to leave the interview to attend to a boy with convulsion. Through these interruptions, information flow was usually disrupted.

The enthusiasm of the opinion leaders in talking about their clinic - "hospital" to somebody from "the University" in Accra tuned them towards something positive. They saw the fulfillment of their long - awaited desire of getting a clinic at hand. This influenced their answers to some of the questions especially those on selection and financing of CHWs. If this research is to be done again, the following will be useful:

a. The research should be done in more districts for proper understanding of factors affecting CHWs in rural Ghana.

b. The research should seek the opinion(s) of the rural masses who are the users of the services of the CHWs. This is hoped to provide useful information to planners in terms of how the people themselves see the programme, and what contributions they can make to it.

CHAPTER TWO

THE HISTORICAL DEVELOPMENT OF THE PHC AND CONCEPT IN GHANA

This chapter takes us into the history of PHC programme in Ghana. To provide an appropriate framework for such a discussion, examination is made into the history of the Health Services in Ghana. The limitations in scientific medicine in terms of coverage and cost is highlighted.

In the latter part of the chapter, the Kintampo Project where Community Health Workers (CHWs) in the Nkoranza District receive their training is discussed. Reference is also made to the role expectations and duties of organizations involved in the programme as stated in the programme's documents. This is done with the aim of identifying areas of omissions, deviations and shortcomings in Ghana's attempt to implement the PHC programme at the community level.

2.1 GHANA'S CONVENTIONAL MEDICAL MODEL

The health services of this country have emerged from the small beginnings made by the colonial powers in the early 19th Century (Sai, 1966). There is no doubt that Western style medicine as it existed in Europe was introduced into the country with the merchants and explorers from the 15th Century onwards (i.e. from 1471 when European explorers landed on the Coast for the first time). The period between 1471 and 1844 which is described as the first phase of the.development of colonial medical services was also significant in European history. It was then that Louis Pasteur's "germ theory" or "Contagionism" revolutionalised medical thinking. With this theory, the individual was atomised and cured. The theory ensured that health problems would be individualised. Here, unlike the social causation theory where the individual is treated as a whole with no separation between body and soul, the focus of the germ theory is on the biological organism. The germ theory is thus reductionistic and particularistic (Twumasi, 1975).

However, it was not until 1867 that what can be called an official medical report was written by Or. Thomas. One year after the report, the first hospital in the country was established in Cape Coast and in the same year a medical report was made to the Colonial Secretary recommending the appointment of a medical officer of health.

By 1895 medical institutions in the country had increased to 10 and a medical department was established. The personnel of the department were to be found in Accra, Ada, Cape Coast and Saltpond which were the main ports and trading centres at the time. In 1902 there were about 10 12 doctors in the whole country. Later in the year, the medical staff in the West African Colonies of Britain were amalgamated into the West African Medical staff. The idea was that the bigger unit would make for easier recruitment and flexibility in posting staff. In this early state of colonial health services, all the effort of the medical department was focussed on the health of the European personnel. The strategy took two forms; treating them promptly when attacked and segregating them from the indigenous population into specially reserved quarters in the big towns to reduce contact with infected natives. The latter policy was considered necessary because the explorers and the colonial administration had found the country beset with many communicable and preventable diseases (Sai, 1972). This fact was made clearer by Simpson in 1909 when he noted that:

"The policy has been to provide a European quarter in order that the risk of malaria infection from the insanitary conditions of native houses and from infected natives may be reduced".

Later it was realised that the health of the expatriate population could not be completely safeguarded simply by segregation and by prompt treatment alone since diseases can be transmitted from those people living in the vicinity of the Europeans. Therefore, some measure of environmental sanitation and water supplies were undertaken in some of the big towns and medical care was gradually extended to the indigenous people especially those who were working as civil servants or as house staff to the Europeans. Others who did not come within this category could have medical attention but it was entirely left to the medical personnel whether they would charge for such servicec or not. Much later,

however, the medical department accepted rcsponsibility not only for expatriates but for the population as a whole as far as it was able to.

Disease control as opposed to simple diagnosis and cure of a sick individual was also accepted as part of the responsibilities of the medical department. But preventive aspect of the work was given priority. The acceptance of disease control as part of the responsibilities of the medical department led to the initiation of some projects and organisations which made useful contributions to the improvement of health in the rural areas.

The introduction of arsenicals which "miraculously" cured yaws with only a few injections provided health workers with a most useful entry tool into the community. The success of this demonstration is responsible to some extent for the love of injections demonstrated by most patients today. Compulsory smallpox vaccination was introduced in 1920. Before this a small unit had been formed to control trypanosomiasis. However, the unit was disbanded during the 1914 - 1918 period and was re-established in 1929. The original trypanosomiasis unit was centred in Gambaga in the Northern Region. It was later enlarged and ths headquarters moved to Kintampo.

By independence, the colonial health system had developed certain features which were inherited by post colonial governments. These include:

1. A strong curative and urban bias;
2. A centralised medical administration with less activity in the rural communities;
3. Central government as the largest provider of health services (this became more strengthened in the postcolonial administration after the creation of the Ministry of Health (MOH) to be in-charge of all public hospitals and health centres).
4. The creation of government support system to compete with traditional healing system.
5. A gross North-South disparity in the provision of health care services and facilities with the southern half of the country as the greater beneficiary.

Four conditions have been identified as the root cause of this situation:

i. Emphasis on the construction of facilities rather than the provision of services;

ii. Over-sophisticated training with emphasis on specialized hospital-based services for the few, rather than preventive and promotive services for everyone.

iii. Poor and unequitable deployment of health staff.

iv. "top-down" health care delivery system with a noticeable lack of co-ordination with other sectors (social welfare, community Development, Water and Sewerage, Agriculture etc.), and little or no community involvement.

By 1956, all the health services were in the regional and some district capitals. Commenting on the rural-urban disparity, the Easmon Committee Report notes that the rural areas have been neglected. The report added that the preventive emphasis of health has not been taken seriously and that one adult in every three normally dies from preventable conditions. Sai (op cit) supports this when he observed that the number and distribution of hospitals and clinics were such that they could not offer any kind of services to more than at most 20 percent of the population. The 20 percent were mostly the urban dwellers. By 1973, majority of the doctors in Ghana were working in the urban centres. Whilst nearly 82% of the 688 doctors in Ghana were based in urban centres with population of about 20,000, the others were in communities with population between 5,000 19,000. (Republic of Ghana 1975/76 -1979/80 Part II). Surpringly one finds a situation where most of the rural communities have populations of less than 1,000.

The problem as later demonstrated by Adjei et al (1989) is not the distribution of doctors per se, but the effect of this situation on the doctor population ratio for the regions and the districts. While the national average in 1985 was given as 1:10,000. In some regions, notably in the North, the ratio was as low as 1: 44,792 while that of Greater Accra region, with 42.5% of the country's doctors, was 1:4,458. Brong-Ahafo had 1:24,132 and Nkoranza District where the research was conducted had 1:83,821 (Ministry of Health: 1985).

Touching on the unequal distribution of hospitals in the country, Ewusi in 1978 estimated that Greater Accra with about 9.4 percent ot the total population had 47 percent of total government doctors, 34 percent of hospital beds and 12.2% of all hospitals in the country. The nine regional capitals (counting the two Upper Regions as one as at that time) with only 15 percent of the total population of the country had 55.4 percent of all hospitals in Ghana and 51.2% hospital beds.

There can be no doubt that such mal-distribution of hospital facilities and personnel will affect health sector expenditure.

Analysis of health sector expenditure for the period 1976/77 1988 is done with the view of identifying the specific health sub-sectors that receive more attention. This portrays the orientation of health services.

In the past ten years the supportive services of the health sector has been allocated the highest portion of the recurrent expenditure (see table 3.1) Except for 1983, supportive services had always been allocated approximately 50 percent of recurrent resources. The components of the supportive services include general administration, manpower, medical equipment and materials and research into plant medicine and other services related to health care delivery. Over the same period, the curative subsector was scarcely allocated resources up to 40 percent of the recurrent resource except in 1983, when the subsector was allocated up to 47.6 percent of the year's resources.

For the period under consideration, promotive and preventive health had always been allocated the least of financial resources. Until 1987 preventive health always had approximately 10-14 percent of the resources. The point here is that the rural majority who are served largely by non hospital based health delivery system have once again been neglected in the area of the allocation of recurrent resources with primary health care attracting least attention.

This is demonstrated in table 2.1 below:

RECURRENT HEALTH EXPENDITURE BY SUBSECTOR

(¢000) 1977/78 - 1988)

	SUPPORTIVE SERVS.		*CURATIVE SERVS.*		*PREVENTIVE SERVS.*		*TOTAL*	
YEAR	*AMOUNT*	*%*	*AMOUNT*	*%*	*AMOUNT*	*%*	*AMOUNT*	*%*
1977/78	96,639	43.5	92,074	41.4	33,632	15.1	222,345	100.0
1978/79	164,328	49.9	124,953	38.0	39,767	13.1	329,048	100.0
1979/80	137,468	48.0	114,554	40.0	3,400	12.0	286,022	100.0
1980/81	172,926	50.8	127,314	37.4	40,162	11.8	340,452	100.0
1981/82	255,127	49.0	206,306	39.0	62,214	12.0	523,649	100.0
1982/83	232,273	38.5	288,130	49.6	84,104	13.9	605,207	100.0
1984	1,295,026	66.0	515,000	26.4	143,806	7.4	1,953,884	100.0
1985	1,609,000	50.0	1,267,442	39.0	367,435	11.0	3,343,877	100.0
1987	3,412,057	49.5	2,768,125	39.8	741,764	1.7	6,951,946	100.0
1988	4,965,143	50.5	4,494,485	45.7	372,931	3.8	9,832,559	100.0

SOURCES:

(i) MOH Health Sector Annual Estimates p.2

(ii) MOH. Planning Division.

In 1988, supportive servicss had the highest allocation of 50.5% while the curative health accounted for 45.7%. The lowest allocation of the recurrent expenditure of 3.5% went to the preventive health services.

From table, 3.1, it could be seen that whereas allocation of resources to supportive and curative health subsectors increased from 1987 to 1988 there was a considerable decrease in both the amount and real value of the resources allocated to preventive health. In 1987, 7.4 million cedis was allocated to preventive health and in 1988, the amount had

declined to 3.7 million cedis. This points to the nature and interest of government health care services in terms of the allocation of resources (recurrent expenditure).

The pattern of health sector expenditure gives an indication of the orientation of the health services in Ghana. A meagre proportion of resources was allocated to promotive and preventive health. Emphasis on curative health has consistently been expanding. Also manifested are increases in supportive sector expenditure.

The implication of heavy investment in curative health and allocation of substantial health resources to supportive service is likely to exacerbate the already deplorable health conditions of the rural areas. Most of the health facilities are allocated in the cities and a few bigger urban centres. This points out that little change if any was made in the health care delivery system by the system that was inherited from the colonial government.

The limitations in Ghana's health care delivery system as discussed above could perhaps help one to argue for the need for a more equitable system. There are however other international and issues which go to strengthen the argument better.

2.2 DISILLUSION WITH THE MEDICAL CARE MODEL

In the mid-1960s King's (1966) widely disseminated book in Europe articulated a different approach to health services, particularly in Africa. The book reflected many people's concern about the inappropriateness of the Western model of medical care being imposed on, or copied by, developing countries. It also reflected a general disillusionment with purely medical solutions. In spite of enormous inputs, many mass disease control programmes were failing for both technical and organisational reasons (Cleaver 1977).

Even though there were successes, like the reduction of yaws, the control of malaria in some areas, and later the eradication of small pox, the major debilitating or killer diseases __ such as tuberculosis, gastro-enteritis and measles __ continued to take

their toll. Many development projects, such as irrigation schemes or feeding programmes, had had the unintended consequences of actually causing more diseases (Targhi Farver and Milton 1973). There were no "medical" solutions for malnutrition, a major complicating condition in many children illness. It was clear that other solutions _ social, educational, economic and po1itica1 _ had to be sought.

King (1966) emphasised the importance of looking at the community's needs, arguing that health services and training should be culturally based. In order to increase access to health services the use of medical auxiliaries was strongly advocated and a general attitude was that appropriate technologies should be developed. It was during the mid-1960s that the idea of "basic health services" was developed, advocating the further extension of peripheral health centres and dispensaries improving access by taking services to where people lived.

The basic health services policy paved the way for the PHC approach, by recognizing the inappropriateness of hospital care for many of the health disorders that were being brought to hospitals. Furthermore it was acknowledged that many sick people lived too far away to get to hospital in time for effective treatment. Therefore it was argued that basic health services should be available, accessible. acceptable and appropriate. The medical profession's monopoly of knowledge was closely examined; dissatisfaction was being expressed with the private medical systems. Concern about the rising costs of medical treatment added weight to the doubts expressed about health systems in general. All these issues served to raise questions about the medical diseases and medical care models, and to shift health care from professionals

The issues were of course, just as relevant to the Third World. The importation of expensive and sophisticated technology and training programmes to deal with relatively rare conditions in developing countries represented a disproportionately high part o1 national health budget. Further, it was clear that sick people sought help and recovered not only from Western trained doctors but also from a variety of sources (Kleinman and

Sung 1979). The "Witchdoctor" slowly became the less pejorative "traditional" or "indigenous" practitioner and traditional midwives were recognised to be doing useful work in their communities. Thinking was thus shifted to not only PHC but the use of CHWs and what was "Medical" care increasingly became "health" care.

Much of the debate that followed centered around the diffusion of technology; how, and why, independent countries retained colonial health infrastructures, and aspired to ideals that were inappropriate to the health needs in their own countries. Banerji (1974) suggested that the inappropriateness of selection and training had alienated health Workers from the people they served. The costly emigration of newly graduated doctors to the Western developed world was indicative of a professional identification reinforced by inappropriate training, as well as the pull and push of market forces.

Pharmaceuticals also came under scrutiny for several reasons lncluding poor prescription habits, and the plethora of brand-named drugs which added to the costs of many countries' health services.

2.3 CHANGING IDEAS ABOUT POVERTY, HEALTH AND DEVELOPMENT

This changing attitude emanated from the developed countries as a guide to economic and social policy in the newly independent countries of the Third World.

Early post-second World War development theories had stressed spontaneous process models of change. The assumption made was that. through industrialisation, the less developed countries would become "developed" in the sense of having high per capita national incomes. Implicit in this assumption was the belief that the benefits of growth would "trickle down" to the rural areas. This seemed to be the path of development taken by Ghana after independence especially when it adopted the Import-substitution Industrialisation policy. This policy saw health and other social services such as education as non-productive consumption sectors.

By the late 1960s and early 1970s there was growing scepticism as to who was benefitting from development. In many countries with high rates of economic growth, the rapid rise in per capita income was firmly concentrated in the hands of a fairly small group of people and the majority were worse off than they were before.

The "miracle" of the "Green Revolution" (increases in agricultural output based on high yielding varieties of cereals) had actually led to no improvement in the productivity and income of poor farmers, but rather to increasing marginalization of subsistence farmers. One of the common explanations for poor countries' slow rates of development was rapid population growth which led to the dissipation of the benefits of the economic growth because it had to be divided among increasing numbers. In the 1960s and early 1970s it was increasingly accepted (although not everywhere) that population control (or family spacing) should integrated into maternal and child health (MCH) services.

It was perhaps the International Labour Organization [ILO] World Employment Conference in 1976 that most clearly rejected past strategies for development and identified a new priority based on the eradication of poverty, the provision of basic needs and productive employment for the potential labour force. The ILO Conference turned from a narrow focus on jobs to basic needs, with minimum targets set for food consumption, clothing, housing and the provision of essential services in the areas of water, sanitation, education, health and public transport ODC/ILO 1976). It thus became more acceptable to see health as integral component of development. Consequently, contrary to tradition, the World Bank began direct lending for health programmes in the 1980s (World Bank 1980).

The WHO started viewing health not only as the absence of disease but also as the complete physical, mental and social well-being of the individual. There was thus a search for a new health care delivery system to cover all the aspects that affect the

peoples health. This search fell on PHC. Two international organisations in particular promoted the PHC approach, WHO and UNICEF, the latter initially playing the supporting role to the health professionals. The 1978 public launching of "PHC" at Alma Ata a vehicle for "Health for all by the Year 2OOO" was the result of long discussions about policy in both organisations. In the early 1970s many people within WHO or connected with the organisation felt that basic health services were not keeping pace with changing population size and structure either in quantity or quality. This led to the setting up of a special WHO working group whose terms of reference was to examine the basic health services concept and the vertical disease control programmes. The working group {WHO 1973} reported that:

"There appears to be widespread dissatisfaction of populations with their health services.....such dissatisfaction occurs in the developed as well as in the Third World"

Among the enumerated reasons for such dissatisfaction included:

i. Failure of health services to meet people's expectations;

ii. Inadequate coverage;

iii. Great differentials in health status within and between countries;

iv. Rising costs; and

v. A feeling of helplessness on the part of the consumer who feels (rightly or wrongly) that the health services and the personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professionals, but which is not what is most wanted by the consumer.

The two main effects of this report on the development of PHC were conceptual, and promotional in nature.

Conceptually the report laid the basis for the PHC approach.. It emphasized the need to involve the consumer in order to tap local resources, to "make medicine" belong "to those it should serve" and called for a "national will" as well as "international will"

for positive health. Promotionally, the report drew attention to WHOs role as "world health conscience".

As part of the search for new solutions to problems in health services, the WHO/UNICEF Joint Committee on health policy commissioned a study of successful programmes using alternative strategies for providing health care. A number of countries, and many non-governmental organisations, had been experimenting with new ideas in health service delivery, including the Christian Medical Commission. Drawing on these health care materials it was possible to identify a number of radical approaches to traditional health delivery systems which seemed to offer hopeful alternatives.

The WHO began to take a more active role in the persuasion and promotion of a new health message. In 1975, the Director General of the Organisation, Halfdan Mahler, launched the idea of "Health for All by the Year 2000" as WHO's contribution to the UN's New Economic Order. The philosophy meant an action to achieve an acceptable level of health evenly distributed throughout the World's population. The message was that, health had to be considered in the broader context of its contributions to social development. It was in this climate of ideas {and preceded by a number of national and regional meetings on PHC) that the international conference on PHC was held at Alma Ata in 1978. From the meeting, attended by representatives of 134 governments and sixty-seven international organisations, came twenty-two recommendations {WHO/UNICEF 1978}. The Declaration of Alma Ata outlined the role of PHC. Community Health Worker (CHW) programmes were seen as one ot the strategies for the programme. In the Alma Ata document produced after the conference, the rationale behind CHWs was clear:

> For many developing countries, the most realistic solution for attaining total population coverage with essential health care is to employ CHWs who can be trained in a short time to perform specific tasks. They may be required to carry out a wide range of health care activities, or, alternatively, their functions may be restricted to certain aspects of health care ..... In many societies it is

advantageous if these health workers come from the community in which they live and are chosen by it, so that they have its support (WHO/UNICEF, 1978).

According to the WHO, "Primary Health Care addresses the main health problems in the community providing promotive, preventive, curative and rehabilitative services. The organisation acknowledged that the PHC services will vary from country to country and from community to community in the same country, however they should include:

a. Promotion of proper nutrition
b. an adequate supply of safe water and basic sanitation
c. maternal and child care, including family planning
d. immunization against the major infectious diseases
e. prevention and control of locally endemic diseases
f. education concerning prevailing health problems and the methods of preventing and controlling them
g. appropriate treatment for common diseases and injuries and
h. provision of essential drugs.

The strategy of the system is directed towards three aims:

a. to improve the accessibility (coverage) of health services by putting up a village based system to obtain essential basic services rather than for a few to receive sophisticated care
b. to improve the quality of primary health care at the point where it is most needed in the village and peri-urban areas by retraining and redeployment of PHC personnel. The aim will be to meet priority health problems of all the people
c. to improve and strengthen the management capacity to support the primary health care system at all levels. The aim will be to make more effective use of existing resources.

The proposed system will have services provided at three levels, namely Level A or community level, Level B or local council sub-areas and Level C or the district level. Level A {Community}These are areas with populations of 200 to 5,000. The communities will be encouraged to select their own health workers and also compensate them. Training and continuing technical supervision will be provided by the MOH personnel..

The functions to be performed by the Level A workers will include primary preventive and promotive procedures, simple first level curative measures with emphasis on pregnancy, management, child health promotion, environments, sanitation and mobilization for health-related community procedures.

Level B {Local council sub-areas}

These will be the first referral point from Level A and will besited within 8 kilometres (5 miles) of each Level A. The responsibilities of Level B will include:

a. technical supervision of Level workers
b. b diagnosis and treatment of persons referred from Level A
c. c giving of immunization to infants and children at Level A
d. identification of pregnant women at high risk
e. communicable diseases control activities
f. advise on waste and faecal disposal and water and flood protection
g. the collection and tabulation of data from the Level A workers, and
h. operational planning and liaison with local community leaders and the District (level C).

The district will be the key level for the PHC system and willserve as the base for planning, managernent, supervision, hedlth data collection and analysis, budgeting and financial control of the health services in the district.

It was suggested that the key person in any scheme for PHC in theThird World must be the Community Health Worker. To enable scattered populations of these extensive and still essentially rural countries to be served, substantial numbers of such workers will be needed. According to the WHO Guide referred to above, the worker will be "a man or a woman who can read and write, and is selected by the local community authorities or with their aggreement, to deal with the health problems of individual people Ithe community. Employment might be full or part-time.Remuneration could be either in cash or kind, and of the local community. There should be room reserved exclusively for this work {WHO, 1977, p.3}

The latter suggestion brought to focus the idea of community involvement in its own health care. This idea was taken from experiences in China during the 1970s.

What inspired people about the Chinese system was the active interrelationship between the barefoot doctors and their ommunities, and the claims of success of mass mobilisation gainst endemic and preventable diseases such as schistosomiasis. Not only were barefoot doctors apparently offering health cars to rural populations never before reached by formal health services, but they were accountable to and controlled by their own community through the co-operative financial schemes. These allowed them to work in the fields part-time, and provide treatment part-time. By the mid-1970s there were instances of ordinary village people receiving a short training and returning to their own villages to deliver a rudimentary primary health care services {Newell 1989}.

Around the same period (Mid 1970s), there was also increasing acknowledgement of community resources: traditional midwives were still delivering most babies with mothers and mothers-in-law giving advice. Anthropological studies added to the general knowledge that many health actions taken by people themselves were reasonable. This changing emphasis was accompanied in the industrialised world by the movement in favour of self-care and support networks, and increasing awareness about lifestyle effects on health.

It is this philosophy of finding an alternative for the hospital-oriented and urban based medical system that will cover the rural majority and that will make health an aspect of social development with the full participation of the people it is to serve that Ghana accepted and implemented it. It is necessary therefore to look at the background of Ghana's PHC system and the CHW programme.

2.4 THE DEVELOPMENT OF THE PHC PROGRAMME IN GHANA: THE KINTAMPO PROJECT

In the 1970s it became clear to health policy makers in Ghana that something radical had to be done for not much impact had been made on the health of the people despite the huge financial outlays since the 1960s. The thinking was that since the rural areas especially experience the highest mortality, morbidity and fertility rates, an integrated approach to rural health problems would be most appropriate. In view of this a rural health and demonstration centre in Ghana was established in 1965. At that time the Government of Ghana in collaboration with the University of Ghana Medical School {UGMS} approached the United Nations Development Programme {UNDP} for assistance to develop such a scheme. Although the proposal was acceptable, it was not possible for UNDP to assist immediately because of national priority ratings at the time. Consequently, in 1967 the Medical School {MS} decided to embark independently on the project. The specific objectives of the project were:

i. To investigate the state of the rural community, its social organisations, the factors that make for an effective participation in health problems and programmes and to undertake research into the most useful and efficient way of utilising the services of available manpower.
ii. To train doctors, health centre superintendents, assistant sanitarians, all grades of nurses, and other health workers specifically for their role in rural health work.
iii. To provide both during training and afterwards manpower confidently oriented and equipped to handle the problems of the community.

iv. To provide through the Danfa Health Centre Comprehensive health care and preventive health services emphasizing maternal and child health services, nutrition, health education, communicable disease control; improved environmental health and Family Planning services.

Barely two years after the founding of a Medical School in Ghana {1964} it was decided that a community health project sited in a rural area would be a useful adjunct to the teaching hospital in the effort to acquaint the new doctor with community health problems. The responsibility of organising such a rural health training was assigned to the Department of Preventive and Social Medicine of the Medical School. Such a decision might have been taken with much consideration of the records on the importance of a rural health training centre in the teaching of community health in Africa Medical Schools {Bennet, Saxton and Lutwama, 1965, Namboze 1966}. The concept had received expression in several medical schools in Africa. The Ibarapa Project of the University of Ibadan Medical School, the Kasangati Health Centre of Makerere Medical School, the Machakos rural Health Training scheme of the Medical Faculty of the University of Nairobi and the Kibaha Training Centre of the Department of Preventive and Social Medicine of the University of Dar-es-salaam are notable ones. In the organisation of any one of these projects the integrated approach has been followed. That is, the use of medical auxiliaries to provide health care to a rural community emphasing maternal and child health, health education, nutrition, environmental sanitation, immunization and communicable disease control.

It was believed from the start that the success of the project would depend to a large extent on the willing paticipation of the local community. Accordingly in selecting thc community some criteria had to be followed. Since the medical students' participation in the project activities was one of the major considerations, it was felt that the selected community should be near enough and accessible to the Medical School. At the same time it was felt that the chosen community should have characteristically rural features.

In this regard, the lack of safe water supply, electricity, secondary schools, good roads and the tendency of the young people in the villages to move to the urban centres were considered typical rural features. The presence of a common bondage and kingship among the various villages of the chosen community was considered an essential ingredient of future community organisation. In addition to common cultural and traditional bonds, evidence of already existing village development groups as well as self-help projects supported by various government agencies were looked upon as favourable conditions for the survival of such a project.

After a meeting on the 29th of March, 1967 which was adressed by the Professor of the Department of Preventive and Medicine, Danfa was selected as the headquarters of the project. The active participation of the project community was considered crucial to the success of the programme {Wurapa 1973}. Consequently the earliest consultations with the community leaders was aimed at determining their felt needs. It became clear that a hospital, water, good roads, latrines, improved farming methods, schools and a better transport system were the priorities of the community.

Wurapa mentions that although the order of the list of priorities of the programme organizers was different from that of the community, the construction of the clinic was made the focus of the activities (Wurapa 1973, 4). The strategy was that having gained the co-operation of the community through the provision of the clinic, it might be more feasible to get greater support for some of the preventive and health promotive activities. What the planners failed to foresee was how to get the community involved in a project they could not see its importance. No doubt these problems later cropped up. Sai et al {1972} mention three significant problems that had to be encountered during the initial stages of building the centre.

1. Soon after work had started, the villages reported that they could not provide the skilled labour because those they got could not be persuaded to work for the token wages they were going to be paid during the life of the building programme.

2. Work was disrupted by farm work and funerals. Whenever it rained the villagers went to their farms and failed to honour their turn for communal labour.
3. Another problem of serious consequence was the delay of the villages of Amrahia and Amanfro in joining in the construction of the clinic. They had indicated earlier that their problem of highest priority was availability of good water and not a "hospital", because they could easily travel to a hospital by public transportation. It took about 9 months to persuade them to participate in the construction of the clinic.

Added to the above is the case where some of the villages (5) in the project area had petitioned the government to close down a police post in one of the villages {Ayimensah} and turn it into a "hospital" because as was reported "they were peace loving people and therefore had no need for a police post" (Sai 1973, 15).

Despite the problems, the Danfa comprehensive Rural Health and Family Planning Project took off on January 16, 1970 with the important aim of developing effective, high quality and affordable primary health care in the rural areas. As a joint-project between the Ghana Medical School and the school of Public Health, University of California, Los Angeles, it was essentially a demonstration, teaching, and research oriented venture. A series of health ralated activities were to be undertaken later. In 1974, perhaps in an attempt to exploit the medicinal potentials of the country's flora and also to tap the knowledge of traditional healers, a centre for scientific Research into Plant Medicine was established at Mampong-Akwapim.

In 1976-77 the Health Group of the Institute of Development studies at the University of Sussex, United Kingdom, undertook a research project in Ghana in collaboration with the country's MOH and the University of Ghana. The project was in support of the Ministry's policy of remodelling its rural health services to make them qualitatively and quantitatively more responsive, to the needs of the people.

The purpose of the work was to study the possibilities of developing a PHC strategy in Ghana. It was hoped to help characterize, as far as possible, the likely form that PHC would take under the particular conditions of the country and the first steps that might be taken in its development. For this it was necessary to investigate:

a. the technical activities of the existing rural health service.
b. the economic and organizational efficiency of its units,
c. the allocation of health care resources and
d. sociological factors impinging on potential community participation in health activities.

The research was performed mainly in two districts of Ghana: Jasikan, in the Volta Region, and Birim, in the Eastern Region. Studies were made of 19 government and mission health units (hospitals, health centres, health posts, dressing stations and maternity units) that provided care at the first line of contact between the people and the health system. Two complementary methods of health care evaluations were employed: The health units were evaluated in terms of their activities, and through sociological surveys, the people's priority health needs and the appropriateness of existing and conventional practices in responding to them were independently examined.
"Good practices" were built up from four starting points:

a. a study of local health information to assess priority needs;
b. a preliminary survey of existing rural health care;
c. consultation with local medical and health care specialist;
d. and, proposals by the research workers.

A protocol was developed for a quantitative assessment of the health units including an evaluation on the quality of care, by a simple scoring method.

The areas of activity evaluated were general outpatient care, maternity care, child care, environmental sanitation, specific ommunicable disease control, and general unit organisation.

The recurrent costs of the health units were investigated in relation to the standard of the care provided and to determine the geographical distribution of health care resources in the districts. In view of the finding that a very high proportion of health unit expenditure was for drugs, a special study was made of the cost-effectiveness of prescription practices.

The sociological work sought to identify from the villagers perspective, what priority interventions were needed from the government, from themselves, or from both for an improvement in health. At the same time, the research explored the potential in villages for community participation. This involved characterizing some aspects of village institutions and social relations of authority. The possible health interventions by the vilagers that emerged from the study of their problems were related to their capacity and willingness to participate in health activities and to the question of how their health care options {home treatment, health services, traditional practitioners,"spiritual" healing}, and possible village health workers appeared to the people themselves.

The Government of Ghana was concerned about these problems,and expresssed interest in "studying and developing a new health care delivery system or systems, particularly in the rural areas of the country, where the basic health needs of large sections of the population were yet to be met" {PHC Annex 1:1978}. Cost was regarded as important because of the "almost impossible task of getting any substantial increase in the allocation of the national budget for the health sector - because the present state of the economy cannot accommodate any substantial increase in allocation without serious repercussions in other sectors of the economy". (PHC Annex 1:107). It was envisaged that a programme be carried out which embraced the approach proposed by WHO with the aim that if it proves successful it will mean that basic care can be extended to the smallest rural community for health promotion and protection and improvement in health status with only minimum increase in the cost of health care delivery.

The first direct discussions between WHO and the Ghanaian authorities concerning the programme took place in April/May 1973. During the meeting, the Ghanaian authorities agreed, in principle, to co-operate in such a programme and stated that they would welcome the programme for the reasons stated above. They proposed that the programme should be located in the Wenchi District of the Brong-Ahafo Region, and should have its headquarters in Kintampo.

The choice of the Wenchi District was carefully considered because it was desirable to have a rural area as typical as possible for Ghana and for neighbouring countries. The district is a rural area without direct influence from any large town and industrial development. The population is considered less rich than in the Southern regions and less poor than in the northern regions of the country. It was an immediate advantage to have the headquarters for the programme in Kintampo, where the Ministry of Health had the necessary housing and support facilities. Kintampo has for many years been the national centre for training of auxiliary health personnel, but it was determined that the presence of this training centre had had little influence on the population's health situation outside the town of Kintampo. The availability of training facilities in Kintampo would be an advantage for preparing governmental personnel for the approach on which the programme was to be based. The outcome of the researches and discussions led to the establishment of the Brong Ahafo Rural Integrated Development Programme (i.e. the Kintampo Project) to train Community Health Workers.

The aim of the implementation component of the programme, for which the Government of Ghana is fully responsible, is to integrate health activities into the general development process, based on the community development approach. The objective is to achieve improvements in the health status, and to promote the social well-being of the rural population through community self-help projects, decided on, organized, performed, financed and evaluated, by the community members themselves. Through such self-help projects the important preventive and promotive health care measures should be made available to and be accepted by the rural communities. The research aim of the

programme is to obtain practical experience and technical knowledge that could be used in planning and implementing similar programmes of health care systems in other areas of Ghana as well as in other countries. The objective for the evaluation component of the programme is to observe and measure the effectiveness and efficiency of introducing and applying health care through the involvement of local communities, as described above, and to monitor the whole process of developing and implementing such an approach. In addition, it is intended that the programme should enhance the capacity of the Government in the field of health service research through the training and experience gained by staff involved in the programme and by methods and techniques developed during the course of the programme.

The Kintampo Project

The first most significant step towards PHC was taken in 1976 when the MOH, with the assistance from WHO established the Brong Ahafo Rural Integrated Development Project at Kintampo for the training of Middle-Level personnel who would man the proposed PHC programme.

The project was also aimed at determining in a practical way, the social processes that would help to institutionalize the participation of traditional healers in a health care programme.

One important early element in the orientation and planning stage of the project was an "area profile survey" carried out in the first instance, in the Nkoranza Local Council area of the district. It was decided to start the programme activities in the Nkoranza area and then move to the other three local council areas in the district in turn (i.e. the Techiman, Wenchi, Kintampo areas).

The area profile survey provided the programme planners with certain basic information which was used to supplement their existing knowledge about the needs and

priorities of the area, the possibilities and experience of contacting the communities, and the nature of the local organisational patterns in the villages.

Four main organizations are involved in the project. These are the Government of Ghana through the Ministry of Health, the World Health Organisation, UNDP and UNICEF. In terms of responsibilities, the government of Ghana has full administrative, technical and operational responsibility for directing the programme. Technical advice is to be provided by WHO. The United Nations Children's Fund {UNICEF} expressed considerable interest in the approach taken by the programme and agreed to orient some of its assistance to the Government so that it could provide support to BARIDEP activities. This assistance was to be provided within the existing agreement with the MOH and other departments.

It was agreed that implementation activities should exclusively be the responsibility of the Government and limited to the level of resources which would be available should the programme activities be replicated on a broader scope in Ghan. It was agreed that the implementation of project activities would be carried out by means of the existing governmental structure(s) in the project area. The implication here is that the new system can function depending upon how well it is integrated into the nature of the existing structures.

The WHO is responsible for the provision of supplies and equipment for the evaluation component of the project. WHO is also responsible for reimbursement of salaries and allowances of the fiscally separate research or evaluation team, who were to remain in government service and be administratively the responsibility of the government. WHO also agreed to provide other materials and supplies {e.g. training aids, manuals, and demonstration aids} which might be part of "start-up" costs in the project area, but which could be replicated in other areas at minimal cost.

The MOH has administrative responsibility for the programme. The Deputy Director of Medical Services was designated as Project Director, and the District Medical Officer for Health in the programme district was identified as the Project Field Director. The government was responsible for the formation of National, Regional and District co-ordinating committees. The ministries of Agriculture, Planning, Education, Health, Social Welfare and Community Development and Ghana Water and Sewerage Corporation were to be represented on these committees. This was to ensure an inter-sectoral approach in dealing with health and illness issues. The UNDP, UNICEF and WHO were identified as ex-officio members of the committees.

Two main phases in the development of PHC implementation activities can be identified. The first, starting in February, 1975 and lasting into September of that year may be described as focussing on orientation to the community involvement approach, planning and setting the stage for co-ordination of implementation activities at the national, regional and District levels. The second phase, starting in September, 1975 introduced necessary training or orientation for government staff, intensified contacts with communities in the district and led to the specific identification and development of various appropriate community self-help projects or activities to be taken up by communities in the district.

Although no formal plan for PHC was developed at this stage, there were several main themes which were to establish the context for co-ordination and implementation. These included the orientation of field staff of the various ministries to the co-ordinated approach to be taken by the programme, and to the goals of working actively with the communities to enable them to carry out their own self-help projects. Also, intensified contacts were made with communities in the area to explain the programme's emphasis on community involvement with Government assistance in solving their own problems. A special effort was started in April 1975 to have teams made up of members of the various Department visiting the villages and explaining the nature of the contacts that would be made with the villages and describing the goals of the programme. Although

these teams had themselves gone through a two-day orientation session, there were a number of logistical and co-ordination problems (co-ordinating with Departmental itinerary, lack of availability or unsuitability of transport, accidents, scheduling problems, etc.) which resulted in the discontinuation of these briefing visits in October 1975.

One of the needs expressed by communities in the programme area was for more readily accessible medical care. This need was expressed in terms of a health post or health centre, or for a mobile clinic, these forms of care being the ones which were known in the area. The idea of a person being selected by the community to undergo a brief training to enable him or her to provide care for many or most of the recurrent health complaints was not an idea with which the villagers were familiar. The proposal was therefore put forward to the communities. Consequently, during visits to villages to identify TBAS, the Village Development Committees were also informed about the proposal to train community dispensing assistants" and if interested, asked to identify a suitable person to receive training.

A tentative programme was drawn up to train people nominated by their villages for a period of about four months, after which they would return to their communities, receive drugs and provision from the MOH, and be supported by their respective communities. The training scheme emphasised recognition of symptoms, the appropriate dispensing of a limited number of drugs, and a basic introduction to the nature and characteristics of the drugs to be used.

The training course was developed by the District Medical Officer of Health [DMOH], the Chief Pharmacist, and three Health Centre Superintendents. Classroom instructions were to be followed by practical experience working in one of the health centres or health posts in the area under the supervision of a Health Centre Superlintendent.

The designed training methodology was pretested with a small number of participants. After monitoring and evaluation, the methodology was modified to make it more suitable to the scheme.

The initial group of five participants, who started their training on 2 December, 1975, were all male middle school leavers, with one volunteer withdrawing soon after the training started.

The classroom teaching was held in Kintampo through 10 February, 1976, after which, on-the-job training emphasised the preparation/dispensing of drugs under the supervision of the phamacist. In July, 1976, the four trainees were attached to heallth centres in Kintampo {2}, Nkoranza {1} and the health post in Yefri {1}.

During their attachment to the various health facilities and while their respective communities were preparing the necessary community clinic facilities, the trainees received a government allowance of twenty cedis (¢20.00) per month.

The first community clinic was inaugurated at Jema on 17 September, 1976, with a practising CHW. The other three community clinic attendants {CCAs} began their activities in their respective communities in the following month.

By the end of 1976, the second sequence of training had started, with 30 CCAs being trained at four different health facilities in the project area. Following the principles of PHC, the approach being taken is that communities wishing to have a local clinic, should meet certain criteria, {initially they should have at least 500 inhabitants and be "far" from existing health institutions}, are requested by community Development field staff to take certain specific steps. They should nominate a person _it is suggested that the person be a literate middle school leaver _ to undergo the four month training, agree to provide maintenance of the trainee during the training period, provide a secure, clean accommodation for the clinic, and make local decisions concerning working hours, fees

for patient visits, maintenance/salary for the CCA, and general administration of the clinic. The MOH agreed to provide training, equipment, drugs, and perodic supervision.

This gives a starting point to look at the performance of CHWs in their communities and the factors that affect their work. In subsequent chapters (4, 5 and 6) therefore attention will be focussed on this issue by analysing data collected from the field.

CHAPTER THREE

SOCIAL STRUCTURE OF THE NKORANZA DISTRICT

3.1 SOCIO-ECONOMIC AND CULTURAL ORGANISATION OF THE NKORANZA DISTRICT

Introduction:

This chapter is devoted to the analysis of the social organisation of the Brong speaking people of Nkoranza. Social anthropologists who study simple societies usually begin with an analysis of the value systems of the societies they study. Assimeng (1981) is of the view that such an analysis enables the researcher to analyse what it is in the society which makes the people in that society behave and respond to situations in the way they do. It is thus important for us here to analyse the social organization of the Brongs of Nkoranza, to place the discussion on factors affecting CHWs in the area in the right perspective.

Location

Nkoranza District is one of the North Eastern Districts of the Brong-Ahafo region. It lies roughly between Latitudes 7°15" and 7°50" and Longitudes 1°30' and 2°00'W. Its surface area is estimated to be around 1200 km^2.

Population

The indigenous people of the area are Brong Speaking Akans. One however finds in the area people from all the other regions and tribes in Ghana as well as foreigners (i.e. non-Ghanaians).

Important groups among the Ghanaian migrant workers in the area are the Sisalas and the Dagombas. They are mainly farmers and charcoal burners. The District had a population of 151,801 made up of 80,090 males and 71.711 females (1984 population Census) with 3% growth rate. The population was said to be 29,008 (15,031 males and 113,977

females) urban and l22,793 (63,059 males and 57,734 females) rural. According to the 1989 Health Services Report of the St. Theresah's Hospital, 23,152 and 3,472 are under 5 years and one year respectively.

Nkoranza is a kin-based society with wide range of extended family resulting from blood and marriage relations. It belongs to the matrilineal Kinship system of reckoning descent, clanship and inheritance. Every person of free matrilineal descent is thus by birth a member of his mother's lineage (Abusua) and a citizen of the Chiefdom in which this lineage is legally domiciled. Though the people trace their descent from maternal side, the extended family relations place all relatives from the paternal side in a web of kinship system. Individuals thus have rights and obligations from both the maternal and the paternal sides. Thus, despite their matrilineal system, the individual traditionally farms on his father's farm-land and not his maternal uncle. If the individual dies, he is laid in state in his father's house and not his mother's family house or that of his maternal uncle who he traditionally inherits. The individual infant is also given name by his father even though it is believed that it is the mother who provides the "mogya" that is, the blood which gives the infant life. The individual within the Nkoranza society is also bound by customs to observe all his father's taboos including food taboos. In times of need members of a lineage are obliged to come together to make contributions. Individual family members thus make donations during marriages, naming ceremonies, and deaths. Failure to contribute during such times is considered undesirable.
Defaulters may be called by the head of family for questioning although no punishment is instituted for such persons.

Traditionally they have a political system with a hierarchical arrangement of offices. At the centre is the "omanhene" who is at the same time the Nkoranzahene. He is assisted by a traditional council composed of divisional chiefs. Below the divisional chiefs are the "Adikrofoo" who head the specific villages. Each "Odikro" is also assisted by a council of elders some of who are heads of families.

The modern political institutions include the District Secretary, the District Administration, the District Assembly, the Police, the Courts, Committees of the Defence of the Revolution, among others. There are other groups like the June 4 Movement, the 31st December Women's Movement and the Democratic Youth League of Ghana which have national character but are not considered political groups even though they help to explain government policies and programmes during community meetings and at seminars and workshops. Another important community-based institution is the town/village development committee. Even though it is part of modern political system (i.e. part of the Local Government Administrative set up} members do work as volunteers. Members of town/village development committee are selected by the villagers. They are however not given any training in management nd administrative duties. The townJvillage development committee is responsible for the development of the towns/villages. Members organise people to undertake development projects such as the building of school blocks, digging of places of convenience, construction of streets as well as the building of community clinics, water systems (wells, handpumps, pipe borne water) etc. An important feature of the town/village development committee is that members are not paid. The CHW in this way becomes a new figure (i.e. a paid volunteer) in an environment where community volunteers are not paid. He is also to be part of the decision-making body to initiate policies and programmes meant to improve the people's health.

Economic

The people are mainly farmers. Whilst the 1984 population census report showed that 60,375 of the people (34,739 males and 25.638 females) engaged in agriculture and hunting, manufacturing accounted for 2,483 of the total population; 2,302 were in social and related community services; 19 in sanitary and similar services and 2,128 were professional, technical and related workers.

Nkoranza area separates the forest Zone from the Savanna Zone. Thus the vegetation is holding is holding between Savanna an forestland. Whilst its Southern part

is found in the forest Zone, its Northern part is found in the Savanna woodland zone. Rains fall from March till October - November with a short break in August.

The ecological system enables wide range of crops to be grown. Food crops as well as cash crops are grown. These include; yam, cassava, cocoyam and plantain, cocoa, tobacco, cotton, maize and beans. Vegetables are also cultivated. Water-melon has recently been introduced to the area and its cultivation has become a major source of income for many farmers. During the major farming seasons (planting and harvesting) most of the farmers leave home very early in the morning and come back home late in the evening. Some people have huts in their farms where they spend the night at times. During such times the villages are deserted during the day time. People normally found home are the children, the aged and the infirm.

3.2 SOCIAL INFRASTRUCTURE:

Transport

Road transport is the only means of transportation system in the area. Despite the importance of road transport in the socio-economic life of the people of the area, there is not a kilometre of road that is motorable all the year round. The three major roads leading to the District i.e., the Techiman Nkoranza road, the Kumasi Ejura - Nkoranza road and the Kintampo Jema Nkoranza road, are all feeder roads. They become unmotorable during the rainy season. Most of the villages are only reached by tractors during such periods. According the the 1989 Health Services Report of Nkoranza District the poor road network and transport difficulties maintain isolated communities. Movement from most of the villages to places like Nkoranza and Yefri to seek treatment at the health facilities is thus not easy.

EDUCATION:

Education cannot be said to be well developed in the area. Educational statistics as shown by the Ministry of Education gives the distribution presented in table 2.1 below:

Table 3.1 School Enrollment in the Nkoranza District

CATEGORY OF SCHOOLS	*TOTAL NO. OF SCHOOLS*	*TOTAL ENROLLMENT*	*BOYS POPULATION*	*GIRLS POPULATION*	*AVERAGE ENROLLMENT PER SCHOOL*
Pre-School	54	4,553	2,231	2,322	85
Primary	94	12,212	6,527	5,685	130
Junior Sec. School	36	4,150	2,336	1,814	115
Senior Sec.	2	NA	NA	NA	NA

* Figures for the Senior Secondary School were not ready

Source: Planning, Budgeting, Monitoring and Evaluation Division, Ministry of Education 1990: (Report on Basic statistics and Planning Parameters for School Evaluation in Ghana, 1989190).

Even though rural-urban differentials were not made, some inferences could still be drawn from the figures produced.

Firstly, only 4,553 of the about 26,624 pre-school going age children are said to be in school. A district of over 130 towns and villages has only 36 Junior Secondary Schools and two Senior Secondary Schools. Where the villages are scattered, some children from villages without Junior Secondary Schools walk several miles to attend such schools in other villages.

Looking at the average enrolment of the Schools, another thing that seems obvious in the district is poor school attendance. For example, a Primary School of six (6) classes with a total number of 130 pupils will have an average of about 22 pupils per class. Similarly, a Nursery School with 3 streams with a total population of 85 children will have an average of about 28 children. Thus not only have fewer schools been established in the area but attendance in the existing schools is also poor.

Health Facilities

The health services in Nkoranza District are grouped into three levels, consistent with the national policy Level A, Level B and Level C. The A Level stands for the Community - Level, the B - Level for the Health Post - Level and C Level for District Level (Hospital). Supervision and control is expected to flow along these lines (from higher to lower levels).

The 1984 population census report showed that there were 12 Health care institutions in the district. All the 12 institutions were however said to be in urban centres (i.e. places of 5,000 people or more). The implication is that none of the over 127 villages (Health Services Report 1989) with populations less than 5,000 had a recognised health care institution.

Distribution of health institutions and some health personnel in the Nkoranza district at the time of the interview is shown below.

(A) Level C:	(St. Theresahis Hospital)	1
(B) Level B:	a. Level B stations (Health Post)	5
	b. MCH Outreach Clinics	16
(C) Level A:	a. Active CHWs	12
	b. Freshly trained CHWs (not working)	10
	c. Inactive CHWs	13

Source: 1989 Health Services Report: St. Theresah's Hospital.

The report indicates that the district level is staffed with seven officers.

a. District Medical Officer (from mission)
b. The PHC co-ordinator
c. 2 Public Health Nurses
d. The Technical Officer-in-Charge of Epidemiology Division

e. Senior Technical Officer in-charge of Environmental Health

f. The District Accountant

The important thing here is that in 1989, the district had a doctor/population ratio of over 1:150,000. In terms of doctor/population ratio then, the district was worse of in 1989 than in 1985 (page 41).

The Nkoranza District Health Services Report (l989) referred to earlier links the major health problems in the area to level of developement of the district. The report describes the district as a very rural agricultural district and gives the major features which include; poor road and poor transport. These according to the report maintain isolated communties. About 90 of the 127 villages in the district use unsave water. Lack of good education in general and high female illiteracy in particular coupled with lack of good education in health issues leads to the prevelance of deficiency diseases such as anemia among and malnutrition. These probably form the underlying factors of most of the health related problems in th area (1989: 2)

In 1989, the first ten leading causes of death in the Nkoranza area were given as follows:

l.	Febrile convulsion (Malaria)	29%
2.	Anaemia	14%
3.	Bronchopneumonia	7%
4.	Hypertension	6.5%
5.	Malnutrition	5.5%
6	Hepatitis	5.5%
7	Dehydration	4%
8.	Heningitis	3%
9.	Tetanus	3%
lO.	Typhoid Fever	3%

Apart from the health institutions, people also buy drugs from other sources. These include drug stores (i.e. licensed chemical sellers) small shops (i.e. people who sell all kinds of goods and also stock drugs) and drug pedlars. These drug dealers stock all kinds of drugs from tablets to mixtures, analgesics to antibiotics and injectables. There is no village in the district where at least one of such sellers is not found.

Traditional Medicine

Another group of health care providers in the Nkoranza area the traditional healers. There are all kinds of traditional medical practitioners in the Nkoranza district. There are herbalist, faith healers, traditional birth attendants spiritualists/diviners. Most of the faith healers and the spiritualist/diveners are the priests and priestesses of some known shrines in the area. Whilst most of the traditional healers in the area can be said to be generalists and treat all kinds of diseases (e.g. fits, stomach troubles, sores, fevers), others are specialists and are famous for the specific cases they treat. For example a bone-setter at Akumsa-Domase, a convulsion specialist at Bibiani, a mental disorder specialist at Kokuma and a specialist who treats urinary disorders at Breman are typical examples of such group. Cases are sent from within and outside the district to such people. Apart from such well known people, the ordinary people may also have some knowledge about the treatment of some of the common diseases and may prescribe traditional medicine that are available and accessible to the people.

It must be mentioned that the people place life and health in global frame comprising three interpenetrating sections: the sub-liminal, under - or worldly realm; and the supraliminal, or higher worldly realm; and link to those the respective powers of native medicine, western scientific medicine, and faith healing.

The traditional healers use therapeutic extracts from several sources; plant, animal, human and mineral. The genuine traditional healer has knowledge of the nature and application of a wide range of therapeutic agents from all these sources, and indeed

sees total environment as his resource The saying, "Biribiara ye aduro, Se wo nnim a wo se ennye" (Whatever is in nature is medicinal, if you do not know it, you say it is not good) amply bears this out.

This traditional healers in the area rely on the natural properties of specific materials and practices for the relief of physical malaise and ill health. These natural products are perceived as often sufficient to provide the needed cure. Thus, sores headaches, fevers, coughs, boils, itches and several skin diseases are are regarded as quite "natural" physical conditions which respond well to well-known domestic therapies.

As in all health systems, however, cures do not always succeed. When the symptoms of a disease persist after the appropriate curative agents have been used and when alternative treatment proves unhelpful to advancing the sick to health an investigation is made beyond the physical realm into the subliminal world to determine whether spiritual forces might be at work. Where confirmation is given of the existence of intrusive non-physical agencies, natural curative gents are not abandoned; they are supported and augmented with other materials and processes which are selected, on account of their mystical qualities, as capable of dealing with the spiritual factors that are identified as contributing to the state of ill-health. Very rarely does a medicineman excludes the materials of physical aspect of a disease.

Another thing which must be pointed out is the way the people combine traditional medicine with scientific medicine. The treatment of a disease may start at home (i.e. from a traditional healer) and end at the hospital or may start from the hospital and end at the doorstep of a traditional healer. At times, the two may be used simultaneously. There seems to be few traditional medical preparations which cannot be combined with hospital drugs. It is within such an environment that the research was conducted. The next chapter of the work is however devoted to the analysis of data collected.

MAP OF THE STUDY AREA

CHAPTER FOUR

COMMUNITY PARTICIPATION IN THE IMPLEMENTATION OF THE CHW PROGRAMME IN NKORANZA AREA:

4.1 INTRODUCTION:

In Chapter Two attention was focussed on the historical development and organisation of Ghana and the introduction of CHWs at both the international and national levels. The Kintampo project was examined as part of the development of this new system in the general framework of the PHC concept. This new system is supposed to be carried out with the full support and participation of the people it is supposed to benefit. This chapter deals with Community participation in the programme. The CHW training programme is examined to detect areas of deviations from the principles of the PHC concept.

As mentioned earlier, 32 CHWs were interviewed. They were found in four main categories;

those who are functioning {12}
those who have dropped out {10}
those who could not establish clinics {5} and
those awaiting the inauguration of clinics {5}.

This shows that, of the 32 CHWs interviewed, 63% were not functioning at the time of the interview. {i.e. those who operated clinics initially but later stopped, those who could not establish clinics at all and those awaiting the commissioning of their clinics}. Not much could be said about the 16% who are awaiting for the inauguration of their clinics since it is too early to know what would happen to them. The impression here is that only 37% of all trained CHWs in the Nkoranza area are still operating clinics.

Even though the CHW programme document shows clearly that the CHW could be a man or a woman, all the 32 CHWs were found to be men of elementary school background. The only special training any of them has got is the CHW programme training.

It must be pointed out that while the male dominance of the CHW programme in the Nkoranza area is in line with other CHW programmes like Burma {1978}, Ethiopia {1978}, Peru {1940s}, Tanzania (1960s) and Zambia (1981), it deviates from female dominated ones like those in Botswana (1973), China {1968}, India (1977), Jamaica {1972} and Nicaragua {1981}.

Even though no special reason has been assigned to explain the domination of a CHW programme by any particular sex, remuneration appears to be associated with the sex imbalance in the Nkoranza area. This could however be explained by making reference to other programmes. For example, whilst programmes with paid allowances or government salaries like those in Botswana, Colombia, Jamaica are dominated by females, those in Peru, Tanzania, and Zambia which are voluntary are dominated by rnales. This notwithstanding, there are other projects which are female dominated but voluntary. Typical examples are those in Nicaragua, Sri Lanka and Indonesia. However, a particular programme which can explain the remuneration factor better is the CHW programme in Burma. Whilst the CHW unpaid programme in 1978 was 90% dominated by males, the auxiliary nurse programme of 1983 which had attached to it some allowance was all female affair.

One cannot help considering if similarly male dominance of the CHW programme in the Nkoranza area is explained by the voluntary nature of the programme. Despite this stand, it will also be wrong to assume that females within the research area do not have voluntary spirit. After all, they attend communal labour and undertake many communal work which are health related. For example they organise themselves on "communal labour" days to clean water sources, sweep the villages and provide convenient places for

the disposal of domestic refuse. Besides, by the end of 1989, 46 women within the district had been trained as Traditional Birth Attendants and were performing useful health care services. This is another group of PHC voluntary service providers (St. Theresah's Hospital Annual Report, 1989). With this in view, the CHW programme which also emphasises these activities should have been more appealing to the women and added more to their roles as "health providers". Education may also not be a strong factor to account for the difference. At the time of the 1970 Census, Statistics show that 30% of females aged 6 years and above were in school or had been in school compared with 44% of males. Even though dropout rate may affect the numbers, it may be wrong to assume that all the females will drop out of school before completing the elementary school and as such there will be no female elementary School leavers in any of the villages. Why females were not selected or did not offer themselves for the CHW programme could therefore be attributed to more factors than mere remuneration and education or the voluntary nature of the programme.

Firstly, rural women in Ghana are generally heavily burdened, with daily tasks for survival. Women produce children; women are mothers and wives; women do the cooking, mending, sewing and washing and take care of men. There is little time at their disposal for voluntary work, although there may be considerable reciprocity between neighbours or families at certain times. The CHW programme which is voluntary would thus not appeal to people with little "free time".

One should also not forget that customary leadership norms favour men in the area. Public decisions concerning the communities are taken by men who dominate the traditional councils' of elders. Women are given little chance to talk during such gatherings and they exert little influence on decisions. They are subordinate to male authority and are largely excluded from high status occupations and from positions of power. It could therefore be that discussions on the CHW programme during public meetings were an all-male affair.

The male dominance may also be attributed to the lack of proper understanding of the structural context in the development of the CHW programme in the area. Men might have taken the advantage of the unemployment situation in the rural areas and either volunteered or got people to select them for the training aiming at a job.

All the CHWs were married men with 9% having two or more wives. It is interesting to note that this deviates widely from the national figure of 25.6% of all married men (GDHS; 1988). The reason for the variation is due to sampling differences and the fact that majority of the CHWs (94%) are below 50 years of age. Here, polygamy is less pronounced.

The average number of surviving children each CHW had was 5. This number is the same as the national average found out in 1988. {Ghana, 1988; pp 92-93}.

It must however be pointed out that the average for the CHWs in the research area could go higher than the present average if one considers the fact that men can still father children after 60 years. CHWs in the Nkoranza area are young people with 94% being between 20 and 49 years. The possibility of some of them having more children cannot be ruled out.

4.2 Characteristics of the CHW Training Programme

All the CHWs were found to have been trained between 1974-75 {the year of the implementation of the CHW programme} and 1989. Training of new CHWs was however suspended after 1989. The reason as had already been stated in the introduction had been partly due to the inability of some communities to establish clinics for their trained CHWs and partly the inability of others to sustain the clinics they had established. All the CHWs were trained within the district but from three different health institutions. Sixty percent were trained at the Kintampo Health Centre, 34% at St. Theresah's Hospital and 6% at Yefri Health Post. It must be pointed out that while the early trainees (1974-75

to 1985) had their training at Kintampo, those who were trained after the establishment of the St. Theresah's hospital {1986-89} had had their training at Nkoranza.

Duration of training among CHWs differed considerably. This ranged from 6 months to 18 months. Answers received on the duration of training is presented in table 4.1.

TABLE 4.1 Duration of Training among CHWs in Nkoranza: 1990 (No=32) (in percent)

Duration Months	Number of CHWs	
	Number	Percentage
Six	16	50.0
Eight	7	22.0
Nine	7	22.0
Ten	11	3.0
Eighteen		3.0
TOTAL	32	100

Source: Nkoranza CHW survey: 1990

About 50% of all the CHWs indicated that they used 6 months for the training. In all, about 95% used between 6 - 9 months for the training. It must be mentioned that the duration of training had sometimes differed within the same health institution. For example, while those trained between 1974/75 -83 at Kintampo said they used 6 months for their training, those trained in the same health institution in 1986 said they used 8 months. Such differences were also found to have existed in the other two health institutions. For example, while a CHW trained at Yefri Health Post in 1976 said he used 18 months for the training, another person trained at the same health institution in 1978 used 6 months. The situation at St. Theresah's hospital is not different. While the 1989 trainees said they took 6 months, those trained in 1986 took 8 months and still another (1989) batch said they used 10 months.

The variation in the duration of training could be attributed to the improper development of the CHW programme. There is no where in the programme document where the duration of training is specified. The organization of training has been left to individual health institutions which have been taking part in the programme. These health institutions have used different strategies from time to time depending upon their own programmes. The duration of training at any particular time in any health institution has therefore come to depend on the manner in which training had been organised. The issue deals with whether training was been conducted part-time or full-time. While those who have been on the course on full-time take shorter times, part-timers use longer periods. Further, part-timers who have lectures , once a week and break for a week took longer time than those who had lectures twice every week and took break for two weeks. The arrangement has been where participants go in for two continuous weeks or one week lectures and two weeks or one week break. All these methods had been adopted in the training of CHWs the Nkoranza area and they help to explain the variations in duration of times used by CHWs for the training in different health institutions and at different times. The implication of this pattern of training of CHWs has led to the training of health attendants with varying knowledge and different practices due to differences in the content of training. This will be discussed later.

The variation of duration in CHW training programme seems to be a common characteristic the world over. The Ghanaian situation is thus not different from other programmes elsewhere. The length of time spent on training varies considerably from 5 days in Sri Lanka through 30 days in Peru to 4 months in Botswana.

According to the objectives of CHWs set at the Alma Ata Conference, the functions of CHWs were to cover:

i) the treatment of minor ailments;
ii) health education - advising on family planning, antenatal care, health education on child survival and development;

iii) the teaching of others about diarrhoeal diseases; and

iv) home hygiene - including the building of latrines and home gardens - and various aspects of nutrition, respiratory tract infections, malaria and tuberculosis. They were also to be taught on how to treat them, as well as how to deal with common accidents such as open wounds.

Concerning what CHWs in the Nkoranza area had been trained for, multiple answers were given. This is indicated below in table 4.2.

Table 4.2 Training in Health Care among CHWs {in percent}
NKORANZA: 1990: {N = 32}

Course content	Number	Percent
First Aid	32	100
Dispense Drugs	32	100
Give Health Education	32	100
Treat Common Diseases	32	100
Leadership Skills	18	56
Give Injections	15	47
Animal Husbandry	10	31

Source: Nkoranza CHW survey: 1990

Even though some of the first CHWs elsewhere were trained to specialise in one specific disease: neonatal tetanus (Berggren 1973), childhood diarrhoeal disease (McCord and Kielman 1978), family planning {Zeighami et al, 1977} and malaria (Ruebush et al, 1985) a closer look at the above reveals two important characteristics about Ghana's programme. Firstly, CHWs in rural Ghana have been given a broad-based training. This is similar to other CHW programmes elsewhere. For example, while CHWs in Ghana have been trained in curative care, they have also been taught to give health education on

a wider range including nutrition. This approach is similar to the current Russian Feldsher programme which trains school leavers to provide care to rural population (WHO 1974).

Secondly, about 65%of the responses from CHWs interviewed were on curative care. Thus training content shows biases towards curative care with less emphasis on both preventive and promotional aspects. This feature is similar to the Indian training programme as revealed by the work of Bose {1983}. Bose points out that the emphasis on curative care made CHWs in India less effective in health education and matters related to the environment. In cases where the CHW and the community were confronted with any serious environmental health problem, there was little they could do about it without the backing of additional technical aid. The implication here is that-even though the PHC idea was to shift emphasis on health care from curative to preventive and promotional, the CHW programme has not achieved much in this area.

In one particular village (Dumasi) in the Nkoranza area the CHW has been unable to provide treatment or prevention against the Guinea worm disease. The hand-pump water system that was provided for the village by the World Vision International to provide potable water for the village had broken down and the people were ulsing the stream water which is Guinea worm infested. The CHW has done nothing in the area of health education to help the people to either boil or filter the water, or have the pump rehabilitated.

All the 15 CHWs who mentioned the administration of injections as part of their training were Kintampo trained. This was found to be true from the health authorities. The health authorities said, training started without injection but somewhere along the line it was found to be necessary and was included. However it was later stopped due to the problem of drug storage in the villages and the problem of sterilizing needles. Further investigation however revealed that the health authorities were becoming alarmed by the apparent abuse of injections by CHWs hence the banning of CHWs from injecting

patients. Those who have the knowledge are however allowed to administer injection on the orders of the District Medical Officer of Health {DMOH}.

Walt et al {1990} had asserted that it is rare for CHWs in national programmes to be allowed to give injections or vaccinations. If anything they do this illegally or under the supervision of a Primary Health Team either on outreach or at a Primary Health Facility. The fact that about 50% of the CHWs mentioned the administration of injections as part of their training shows a contrary view shared on this issue by Walt et al {199O} However, their latter conclusion that CHWs administer injections under the supervision of the PHC team supports part of the findings of this research. Why the training of CHWs to give injections was stopped in the Nkoranza area could be attributed to the abuse of functions and the absence of cold chain equipment (fridges and refrigerators). The injection problem however goes to strengthen an earlier view that the earlier training programme of the CHWs was inadequate. Trainers seem not to know the exact knowledge they were to give to CHWs. They could also not anticipate the extent to which CHWs were going to use their knowledge in their villages. Hence the controversy about CHWs and injection practices.

4. 3. COMMUNITY ASSISTANCE IN THE CHW PROGRAMME

The Kintampo programme document and the WHO Guide spell out the roles communities to benefit from the CHW programme are expected to perform. These include technical and material assistance . Specifically, they include:

a. selection of the CHWs;.
b. financial assistance during training and financial assistance after training in the form of provision of place of work, money for drugs, and remuneration;
c. supervision, and
d. provision of accumulated clinic funds to be used for other health related amenities like potable water, places of convenience, places for the disposal of domestic waste, etc.

The role the community is expected to play is based on the principle of "bottom-up approach" to community development. The assumption is that community participation in health matters at community level will lead to the elimination of many of the factors that affect the health of the people {Jancloes et al: 1980}. A major objective of the research is to examine the way communities in the Nkoranza area have assisted in the implementation of the programme and how such assistance is affecting the functions of the CHWs.

Community assistance or participation in the CHW programme within the Nkoranza area was found to have been in three main areas;

a. technical assistance which include selection and supervision of CHWs;
b. material assistance -the provision of a place of work and other materials like cupboards, benches, chairs and tables and finally;
c. financial assistance during and after the training of CHWs including financial assistance for drug supply. An important thing which was found missing here is the channelling of the accumulated funds into the development of health related programmes.

The other assistances mentioned here could be said to be in line with those spelt out in the WHO and the Kintampo Project documents. After knowing the type of community assistance, it was necessary to find out the extent to which the communities have carried out such assistance in the implementation of the programme and the effect of such assistance on the functions of the CHWs.

4.3.1 Community Involvement in the Selection and Training of CHWS

An assumption made earlier in this work is that, poor selection of CHWs may affect their functions. The argument is that where community members had been denied the democratic right to select a candidate of their own choice, they will refuse to support the person. This will erode the foundation upon which the person is to function since the

functioning of the CHW programme depends upon community participation. It was thus necessary to investigate the way CHWs in the study area had been selected.

During the focus group discussions with community leaders, it was revealed that all CHWs were selected with the consent of the community. The mode of selection was nomination and voting at public meetings organised by the leaders with members of the community present. But the CHWs presented a slightly different account of the selections. Their answers had been categorised into three main groups and presented in the table 4.3. below.

TABLES 4.3 CHWs by mode of Selection: Nkoranza: 1990 {NO. 32} {IN PERCENT}

Mode of selection of CHW	Number of CHWs	
	Number	Percentage
i. CHW selected by community	20	62
ii. CHW volunteered	7	22
iii. CHW approached by leaders alone	5	16
TOTAL	32	100

Source: Nkoranza CHW survey: 1990

The implication of the above is that it is only in 12 cases where the selection of CHWs was done without the support of the community members. The fact that 62% of the CHWs confirmed that they were selected by their communities shows that community-based selection per se is not a major problem in the area. If a CHW is to be supported by his community simply because he has been selected democratically, then about 60% of the CHWs in the Nkoranza area should be in operation by now. This supports Samba's (op.cit) argument. Samba is of the view that the problem with CHW programme is not with the organization of the people to select the CHW but to support and maintain the CHW after the initial enthusiasm of selection and training.

Thus CHWs in the Nkoranza area are not functioning well not because they were not democratically selected but because of other factors.

The most important issue in the mode of selection is where 22% had volunteered to serve their communities. It was later found out that such people as well as those who had accepted their nomination by their communities, had been influenced by other factors such as remuneration and job aspiration. This was what Walt et al {ibid} had previously noted that volunteers {and here all the CHWs could be said to be entering into a voluntary service) are often prompted by a wide variety of reasons (See Pinker, 1979; Sheard, 1986}.

Even though developed and developing societies are different and their structures and systems cannot be compared easily, studies from industrialized countries such as Britain, where over one-quarter of people over 16 years of age do voluntary work, suggest that there are three basic reasons for being in voluntary service. These are:

a. Reciprocity {helping those who have helped them};
b. Beneficence {from a sense of duty and compassion in response to others needs}; and
c. Solidarity (feeling of some fraternity with others). Pinker {1979)}.

The significance of volunteer motives in sustaining the rest of CHWs is reflected in the resources put at their disposal. About 60% of the dropouts complained of lack of remuneration. CHWs were thus not thinking of helping their societies because their societies had helped them nor were the thinking about their service as a duty. Many were those who had thought the work would later lead to employment. Others had thought the work would lead them to do more studies to become qualified health professionals, an idea which is contrary to the pinciples of the PHC. There is thus the development of conflict of interests on the part of the CHWs. Even though they have accepted to be in voluntary service, they are at the same time, expecting some rewards from their

communities and the health authorities. This might be due to lack of proper communication between the communities and the CHWs on one hand and between the health authorities and the CHWs and their communities on the other. CHWs therefore had wrong impressions about the programme before and after training. Those who are still at post also gave remuneration factor as one of their major problems. The fact that they are still in business indicates that there is more to it than remuneration to keep a volunteer in service. This issue will be addressed in later course.

Job aspiration on the part of volunteers seem not only to have affected the work of CHWs in Ghana or in the Nkoranza area but also CHWs in other countries implementing similar programmes. Perera and Perera (1985) have shown that in Sri Lanka where health volunteers are mainly young, and well-educated women who have few job opportunities, majority say they volunteer in order to give service, but they also hope that voluntary work will lead to future employment. Long term job-seeking motivation in voluntarism has been noted in CHW schemes in Nigeria (Ademyi and Olaseha 1987), Zambia (Harnmeijeo1989), and India (Agarwal 1979) Iaju 1983) where CHWs are paid a small honorarium.

It could perhaps be argued that the policy of training barefoot doctors in China, a practice which was emulated by other countries was an indigenous idea and fitted into the politics and organizational structure of rural China. However, because the structural context was not considered in the d develiopment of the CHW programme in Ghana, health planners and community leaders failed to appreciate the impact high unemployment rate among elementary school leavers in Ghanaian villages would have on the selection process. In fact, this has been a major factor affecting the commitment of CHWs.

As to the factors taken into consideration in selecting or in accepting those who volunteered multiple answers were given by community leaders. Reasons given by community leaders are classified under 5 categories and given in table 4.4.

TABLE 4.4 Selection Criteria of CHWs by Communities

In Nkoranza: 1990 (No=32) (In Percent)

Criterion for selecting CHWS	Absolute Figures	Responses
Good conduct	8	24%
Interest in community work	7	22%
Permanent Resident in Village	7	22%
Ability to Read and Write	5	17%
Interest in Health Matters	5	15%
TOTAL	32	100

Responses as indicated above, demonstrate clearly that communities placed more emphasis on the individual's conduct than on any other factor. Even though literacy was mentioned (17%) it played a less important role in the selection of candidates (5 out of the 32 cases). This might help to explain why all the CHWs are of low educational background. It appears that what communities wanted was somebody with good social standing, resident in the village and with interest in communal work.

4.3.2. Supervision of CHWS by Community

Another community technical assistance in the programme is in the area of supervising the CHWs. Supervision and control of CHWs by communities cover two main areas - the supervision of drugs and the supervision of monies realised from drug sales. Supervision is done by the executives of the village development committee or health committee. Usually it is the Chairman, the Secretary and the Treasure (or "Cashier"). Frequency of supervision differs from community to community. For example, whilst 28 of the communities indicated that they visit their CHWs once every week, 2 said they do so once every two weeks whilst another 2 mentioned once every month. These times fall within the expectations of the CHWs.

All the 12 CHWs (i.e. those operating clinics) who receive supervisory visits of once every week indicated that they are satisfied with the frequency of supervisory visits and what their leaders supervise - drugs and money. They added that such weekly visits give them the chance to hand over any clinic monies in their possession to the leaders and further enable them to discuss problems with the supervisor(s). Surprisingly none of the community committees has a supervisory checklist. Supervision is not seen as a comprehensive system to help evaluate and monitor the performance of the CHWs. The situation is made worse by the fact that none of the community committees had been trained in management skills. Supervision is thus limited to collecting monies realised from drug sales and taking inventory of drugs stock.

4 4. COMMUNITY MATERIAL ASSISTANCE TO THE CHWS

The two documents examined earlier in this work (i.e. the WHO guide and the Kintampo project document) state clearly that CHWs are to depend upon their communities for their material support. The research therefore set to find out the nature and extent of community material assistance in the implementation of the programme as this is expected to affect the functions of the CHWs.

This kind of assistance is in three areas;

a. the provision of a place of work;
b. the provision of drugs; and
c. the provision of other materials - tables and chairs, cupboards and benches to the clinics.

The 22 CHWs who answered the question threw light on how they got places to use as clinics. There are four main ways by which CHWs get places to use as clinics: either the places are provided by their communities, the CHWs themselves, or the places hired or given by certain individuals. The distribution of this is presented in table 4.5.

TABLE 4.5 Provision of Place of work for CHWs by nature of Tenancy: Nkoranza: 1990 (No = 22) (in percent)

Acquistion of place of work	Number of Clinics	
	Number	Percentage
Place owned by Community	3	14
Place hired by Community	10	45
Place provided by C.H.W.	7	32
Place provided by individuals	2	9
TOTAL	22	100

Source: Nkoranza CHW survey: 1990

* This is limited to those functioning.

The implication of the above distribution is that, 19 out of the 22 places being used as community clinics in the area have been provided by individuals. At the time of the research, only 3 villages had their own buildings. These were Bomiri, Senya and Ntanaso. Because communities could not put up their own places, individuals interested in having "hospitals" in their communties assisted in providing such places. In other cases, the places are hired from individuals. Some of these places were to be temporal. The implication here is that such places could be taken back by their owners at any time. This problem manifested itself clearly in the responses from CHWs who have wound up and those who could not establish clinics. Whilst all the five CHWs who have never operated before attributed the lack of place of work and capital for drugs as their main problems, 40% of the drop-outs said that, those who provided temporary places later demanded their premises back making the continued operation of the clinics impossible as the communities had not put up their own places. Two CHWs who had stopped reiterated that they gave up because they could not either realise enough profits to pay for the monthly rent or their communities failed to give them extra money for such an signment. Of those working, 75% indicated that one of their problems is the lack of permanent working places. Whilst this has forced some to drop out, it is currently a serious problem for about 9 out of the 12 who are in business. It might compel more to a abandon the programme if this problem is not resolved. The only CHWs who do not face

this problem are the 3 who are operating in clinics put up by their communities. This heavy reliance on individuals than on the collective efforts of the communities to provide the CHWs with place(s) of work has further implications. Such individuals according to the CHWs, always want free treatment. Included here are those who have given their premises free to their communities and those whose premises had been hired by the community but the community has not been paying the monthly rent as expected. One of the CHWs speaking in Twi simply said:

"Obiara a odwen se wamma wo moa pe se wohwe one ne yere ne ne mma kwa.

Eba saa a ese se me na me tua aduro no ka. Bebree de ka wo ha."

literally meaning; "each person who has helped you wants to get free treatment for himself and his family. If it happens like that, I have to pay for the drugs. Most of them owe here". The worse is when you go to them to demand the money. They will tell you they need their room", added the CHW. The lack of permanent premises for CHWs could be attributed to the improper development of the programme. Even though the provision of a place of work was made the responsibility of the communities, it was not made a condition for the training of the CHWs. If this had been the case, the interest of the communities in having clinics would have pushed them to put up such places. Added to this problem is where the communities have other development projects to undertake. Once the CHW is trained, the communities find it more convenient to rely on individuals than their collective efforts to put up new places.

4.5 COMMUNITY FINANCIAL ASSISTANCE TO CHWS

Commmunity financial assistance to the CHW programme in the district has been in two directions and in two forms financial assistance in cash during training and financial assistancce after training both in cash and in kind.

All the community leaders interviewed as well as their CHWs confirmed community financial support to the CHWs. There is however not a uniform allowance to the trainees.

It must be mentioned that the WHO, the MOH and the other programme agencies did not spell out any specific amount that was given to a trainee by his community at any stage of the programme. Each community was to determine the amount it would give to its trainee or trained CHW.

Allowances given to CHWs during training thus differed from community to community depending upon the financial strength of the community in question.

Below shows CHWs responses as to the amount of allowance their communities were giving them during training.

TABLE 4.6 CHWs by Amount of Allowance Given During Training Per Week: Nkoranza 1990 (No=32)

TRAINING ALLOWANCE/PER WEEK IN CEDIS	ABSOLUTE FIGURES	RESPONSES (%)
¢1,000.00	9	28
¢500.00	12	38
¢40.00	1	3
Amount not fixed	10	31
TOTAL	32	100

The highest allowance was ¢4,000.00 per month, the lowest ¢160.00. Ten of the respondents could not give any specific amount. The monies their communities gave them differed from time to time. The CHWs were also expected to use part of these allowances for transport.

CHWs and their communities maintained that financial assistance during training was not only insufficient but also irregular. Whilst 24 of the 32 CHWs showed that financial assistance during training was insufficient, 20 added that this insufficient assistance was also irregular. What this means is that communities could not always fulfil their promises of financial support to the CHWs. The only explanation given by the community leaders, is lack of funds which reminds Rifkin's (1980) warning of undue

financial strain such programmes might place on the relatively poor rural folks and the way this could dampen their spirit in participating in development programmes. Community leaders interviewed reported that apart from financing the CHW they also have to finance school building projects, pay levies, and contribute to church activities, which make it difficult to mobilize enough funds for the CHWs. This, to the CHWs is worsened by the Government's Current Decentralization Programme which demands that they initiate and support their own development projects. Asked whether they do not receive any financial assistance from the Government's Programme of Actions to Mitigate the Social Costs of Adjustment, (PAMSCAD), majority of them said they have never benefitted from it. Those who had benetitted from it (Koforidua, Dotobaa) said they had to fund over 2/3 of the projects cost from their own resources which meant taxing the people the more. Some of them even see the PAMSCAD programme as a propaganda on the part of government officials (and they mentioned "the Council") to shift their responsibilities to the people. A committee secretary in one of the villages said, "If they will ask us to finance our own projects, then they should also ask us to stop paying basic rate to them".

Another financial commitment on the part of the communities taking part in the programme is the remuneration of the CHWs. All the communities use cash allowances to remunerate the CHWs.

Like the cash allowances they received during training, there is no fixed amount paid to the CHWs. This is left to individual communities to decide. It was found out that allowance given to any particular CHW does not depend upon one's volume of profits. This is pre-determined in almost all cases, before the CHW starts work. No Community studied the revenue generated by her CHW before deciding how much to give to the CHW at the end of the month. The implication here is that, 4 communities (of those who have dropped out) were "eating" into their capital (i.e. their revolving funds) as profits generated were smaller than what they were paying to their CHWs. This according to the CHWs, reduced their capital and forced them to stop operating. This same problem is

facing few CHWs who are in business. The most interesting thing is that no single CHW could compute his monthly profit margins. Their community leaders who supervise them also do not check their profit margins. All they check is what they have got at the end of the month or over a certain period of time. This shows the weakness in the CHW programme, in terms of financial administration. This could be attributed to lack of training of the CHWs and their community leaders in financial management by the programme planners. Even though the CHWs keep records of patients attendance, this is never used for management purposes. Perhaps they keep them to enable the health authorities to know the way they prescribe drugs.

Below shows responses from CHWs indicating how much cash allowances they were promised by their communities.

TABLE 4.7 CHWs By Amount of allowance to be Paid By Communities Nkoranza: 1991 (No=22) (in Percent)

Remuneration/Month	Distribution of CHWs	
	Absolute Figures	(%)
¢1,000.00/month	9	41
¢1,500.00/month	8	36
¢2,000.00/month	5	23
TOTAL	22	100

4.5.1 Community Financial Assistance For Drug Supply

The second form of community financial assistance is the provision of cash to purchase drugs for the CHWs. This is in line with the expectations of the programme planners (Kintampo Project Report: 1978)

All the 22 CHWs, (i.e. those in and out of business) indicated that their communities gave them the initial money to buy drugs. The monies were to form the revolving funds for the clinics. Profits generated were to be used to develop other PHC activities. The figures below show examples of some of the communties' financial contributions for drug purchases (i.e. the amount of monies given by specific communities to their CHWs for the take-off of the clinics).

	Village	Amount in Cedis
1.	Bonsu	2,000.00
2.	Dotobaa	11,000.00
3.	Koforidua	12,000.00
4.	Kyekyewere	36,310.00
5.	Tom	18,000.00
6.	Asuano	11,400.00)
		*16,300.00)
7.	Ayerede	13,850.00
8.	Bomiri	8,700.00
9.	Ntanaso/Kurutu	7,710.00
10.	Jerusalem	10,000.00
11.	Dromankuma	26,300.00
12.	Senya	16,730.00

To check the authenticity of responses, these figures were later-cross-checked with records at St. Theresah's hospital and they were all found to be accurate.

Financial assistance in the form of revolving fund for drug supply was said to be grossly inadequate. Their argument could perhaps be viewed from a wider perspective. For example, in a situation where a CHW is given two thousand cedis (¢2,000.00) for drugs, the best he can do with the money will be to buy less than 1,000 tablets of paracetamol. This can serve less than fifty people (looking at the way paracetamol is

normally prescribed). Further, the profits from such drug sales will be too small to support any other PHC activity. To demonstrate this, the cost price of some of the commonly sold drugs at the clinics is presented here:

	Drug	**Cost Price at St. Theresah's Hospital**
		¢
1.	Aspirin (tabs) 300 mg/1,000	2,400.00
2.	Paracetamol (tabs) 500 mg/1,000	2,600.00
3.	Chloroquine (tabs) 250 mg/1,000	4,950.00
4.	Mebendozole (tabs) 250 mg/1,000	4,800.00
5.	Multivitamin (tabs) 250 mg/1,000	1,500.00
6.	Vitamin B Co. 1 mg/1,000	1,300.00
7.	Folic Acid (tabs) 1 mq/1,000	1,000.00
	Syrups/Mixtures	
8.	Chloroquine Syrup 1 litre	1,950.00
9.	Paracetamol Syrup 1 litre	1,850.00
10.	Multivitamin Syrup 1 litre	1,500.00

SOURCE: i. Price list prepared from St. Theresah's Hospital
ii. Receipts (records) from CHWs. (1990).

The outcome of the above is that CHWs find it difficult to buy sufficient drugs for their clinics. Where a CHW wants to win the Confidence of the people, he will have to use his own money for the purchase of drugs. In this case, the community gradually losses ownership of the clinic to the CHW. This is what seem to be happening in some of the villages. The CHW who was financed by the people of Nsunensa but who could not establish a clinic due to lack of funds now operates at Akumsa-Domase as a private practitioner. The CHW at Pinihi who is also not working said he helps people whenever they are in need and prescribes drugs for them. This supports findings of Werner, (1980)

and Muller (1980) that CHWs shortage of drugs in a community where many medicines are widely used, reduces the people's respect for them. This makes CHWs less effective, even in preventive measure . To gain the peoples confidence, CHWs acquire over - the - counter drugs in the nearest pharmacy or even in the village, the drugs which are officially barred to them (especially, of course, antibiotic injections), and then use these unsupervised .

CHWs pointed out that because they spend most of their times at the clinics (about 9 hours every day), they have very little time it any for their own farming work. Thus, the cash allowance between ¢1,000.00 - ¢2,OOO.OO a month is insignificant. This is grave given that all the CHWs are married with children. Community assistance in the form of revolving funds and remuneration is thus a problem for all the communities in the area. The end result has been the poor performance of all the CHWs in the area.

4.5.2 Community in kind Assistance to CHWs

In spite of the fact that communities are not able to reward their CHWs satisfactorily in monetary terms, they are also unable to help them in their farming work. There is not a single CHW who is satisfied with the work his community members do for him. Even through every community seems to have agreed to make at least an acre of farm for its CHW, this has hardly materialised. According to most of the CHWs, either their communities do not make the farms or farms made for them are always made late; Normally after everybody has finished with his own farming activities. The yields from such farms are invariably not encouraging. The CHWs accused both the committee members and their people. They attributed the problem to two main things. That is, the inability of their committee's in mobilising the people to give free labour and jealousy on the part of the people in offering such free labour.

The committee members saw the problem differently. They gave lack of time as their main problem. To them, majority of the people are farmers and mobilising such people during the major farming seasons is always not easy as they will be busy in their farms. This supports the work of Sai, Wurapa and Quartey-Papafio (1972) on the Danfa Comprehensive Project. The writers mentioned that work on the Construction of the Danfa Clinic was disrupted by farm work. They explained that whenever it rained the villagers went to their farms and failed to honour their turn for communal labour. Even though this experience was there to serve as an important lesson to the planners no warning was taken from it. The saying that historians learn history but never learn from history thus comes true.

People pay for the services and drugs they get at the community clinic just like they do at any other health institution in the district. They are not called upon to farm for such people. They may therefore not see the justification in paying the CHW again by offering him free labour. What worsens the situation is where the villagers know that the community pays the CHW in cash. Thus although health planners and the international agencies were prepared to expand health care coverage, they were not prepared to solve the problems inherent in the exercise. The Kintampo project in this sense can be said to have started with problems that were not going to help it to achieve its goals. Part of the problems may also be due to the type of service the people get from the CHWs. When they are not getting what they want from the CHWs and sometimes have to seek treatment elsewhere they may not see the need for providing such free labour. This supports the work of Gray (1986) in Mali and Senegal. The writer found out that the failure by communities to find local funds for primary health care (PHC) and CHWs were due to their perception that the benefits were not commensurate with the resources they would have to raise. The biggest problem however seems to be that the villagers were not briefed about the programme. They do not understand the PHC system, its structures and functions. They do not therefore know their obligations. They are only interested in the benefits but not the cost.

In a situation where CHWs are not well rewarded both in cash and in kind, it becomes obvious that they will drop out or adopt a lukewarm attitude towards their duty as CHWs. For example whilst this forced trainees to either rely on friends and relatives (31%) or on their own resources (69%), the problem, according to the Kintampo project report, forced one of the first batch of 5 trainees to withdraw from the training. Considering a situation where the highest paid CHW was given ¢2,000.00 a month, it is not surprising for CHWs to give remuneration as one of their biggest problems. It was no wonder all the CHWs mentioned that they sometimes ignore clinic duties to work in their farms to be able to cater for themselves and their families.

CHAPTER FIVE

MINISTRY OF HEALTH (MOH) PARTICIPATION IN THE IMPLEMENTATION OF THE CHW PROGRAMME IN THE NKORANZA DISTRICT

The MOH assistance in the CHW programme as indicated in the programme documents and from field research had been in two main area; technical and material assistance. MOH technical assistance was to cover the provision of training manual, tutors, provision of referral points, provision of supervisory visits and the organisation of refresher courses to up-date and up-grade the skills of CHWs.

The material assistance covers the provision of places of training, accommodation. provision of facilities at the training grounds, provision of drugs and other medical kits. Apart from the type of assistance we are also interested in the extent to which the Ministry had carried out its obligations.

5.1 MOH TECHNICAL ASSISTANCE

5.1.1 Provision of Training Manual

There were diverse views on the issue of training manual. Whilst 66% of the respondents indicated that there was no training manual(s), 34% said there was. Views did not only differ from trainees from different health institution, but also among trainees of the same health institution. Such differences could be attributed, firstly, to the problem of "recall" and secondly, the inability of the trainees to differentiate between a "training manual" and documents prepared by different tutors for lectures. The conceptual problem could have been aggravated by their low level of education.

Table 5.1 show statistics on views shared by CHWs from different health institutions on training manual.

TABLE 5.1 Opinion of CHWs on the Availability of Training Manuals by Training centres in Percent: Nkoranza: 1990 (No=32)

Health Institution	Availability of Training Manual	No. of Training Manual	Total
Kintampo Health Centre	37	63	100
St. Theresah's Hospital	37	63	100
Yefri Health Post	0		

Even though 63% of the Kintampo trained CHWs and an equal number of the St. Theresah's graduates mentioned that some training materials were given, they reiterated that these were not manuals produced at the national level (i.e. at the programme planners level). According to such CHWs, the materials were prepared by their individual teachers. This was in agreement with the health authorities point of view that no national training material was prepared and developed for the programme. Individual Heads of health institutions who took part in the training of CHWs had to develop their own training documents and strategies.

What this means is that MOH and the various agencies (WHO, UNICEF and World Vision International) which planned the programme failed in their duty to produce any planned guideline in the form of a national training manual to help facilitators in the training of CHWs. This helps to explain the differences that had existed in the content of CHW training as well as the strategies adopted. The effect has been a situation where some CHWs know how to inject whilst others do not. Those who were denied such training see it big handicap, especially where community members refuse to come to them for treatment for the simple reason that they do not administer injections.

5.1.2 Provision of Supervisory visits

In the Kintampo project document, the Government of Ghana through the Ministry of Health had the full administrative technical and operational responsibility for the direction of the programme. The technical responsibility included supervision of the

CHWs. This was to be carried out by the staff at the Level B station. That is, the Health Centre.

The CHWs and the health authorities interviewed indicated that the health authorities carry out supervisory duties. However, because of lack of staff at Level B, supervision is carried out by the District Hospital (i.e. Level C: the St. Theresah's Hospital) instead of Level B.

Each CHW receives a bi-monthly supervisory visit from the District PHC Co-ordinator who also carries out counselling duties at the hospital. According to the CHWs the supervisory team uses the times to check their records on drug supply, patients registers, monies realised from drug sales and the way they dispense drugs.

The implication here is that, there is a deviation from the principles of the CHW programme on the interrelationships that is to exist between the different levels. Lack of staff at higher levels (B and C) to carry out supervisory duties affected the morales of the CHWs. A Supervisory visit carried out once in very two months is not desirable because many worng things go on at the clinics undetected for too long. The problem is conpounded where the team may miss a visit as a result of an emergency or transportation problems. CHWs may not see a supervisor for manya months during the raining seasons when most of the roads became unmotorable. No doubt many of the CHWs who are still on duty indicated their dissatisfaction with the extent to which supervisory duties are carried out by the MOH.

TABLE 5.2 CHWs' Preference of Supervisory visits from Health Authorities in Percent: - Nkoranza: 1990 (No=22)

C.H.Ws' PREFERENCE	ABSOLUTE FIGURE	RESPONSES (%)
Once a week	11	50
Once every two weeks	8	36
Once every month	3	14
TOTAL	22	100

From the above table, it is clear that all the CHWs preferred short-interval supervisory visits. This is why the majority liked the supervisory visits of their community leaders and further opted for once a week MOH visit. Thus, the once every two months system by the health authorities could be siad to be unsatisfactory for most CHWs in the district.

In showing their preference of visits at shorter intervals, three main reasons were given:

a. To gain Community respect, since the more they are seen with the health authorities (doctors) the more their communities come to associate them with the doctors and consequently the more the communities accept them as "doctors",
b. To discuss problems with health authorities at shorter intervals; and
c. To educate community members regularly as regards the importance of maintaining efficient CHWs.

Even though studies on CHW programmes outside Ghana show different findings on supervision they would be useful here for analytical purposes. Malcom and Williams (1983) identified supervision as one of the main problems in CHW programmes. They pointed out that CHWs did not always know who their supervisors were They reported that in Botswana, many thought it was the clinic-oriented enrolled nurses instead of the community health nurses (CHWs). In Sri Lanka, all depended on the interest of the Public Health Inspector; In Colombia, CHWs complained of the high rates of turnover of supervisory staff who often did their one year compulsory social service in a rural area and rarely stayed longer; whilst in Zambia, CHWs are assumed to receive 12 supervision days per year (one visit per month) from the staff of the local rural health centre, and one annual visit from a district staff member. From Harnmeijer's (1989) study of forty Zambian CHWs, it has been noted that in reality supervision are much lower - more like one-and-a-half visits per annum.

It could thus be argued that supervision is a general problem in CHW programmes even though they are not the same every where. Whilst in some places the problem is due

to lack of staff, in others it is either due to lack of resources or lack of interest. In Ghana, and as it is happening within the Nkoranza area, the problem could be attributed to lack of manpower and resources at level B. The manpower strength at Level B was not given any consideration in planning the programme. Thus, apart from stating that Level As are to be supervised by Bs, how supervision was to be carried out was not planned at all in the programme. No adequate level B stations could be developed. Further, the Level B has no vehicle to enable it to carry out any supervisory duties. The end result is the case where Level B do not carries out supervisory duties of Level As in the district.

5.1.3 Provision of Refresher Courses

Another MOH technical assistance in the implementation of the CHW programme in the study area is the provision of refresher courses for the trained CHWs. This is carried out monthly by the St. Theresah's hospital on the first Tuesday of every month. This was found to be regular. The CHWs mentioned that the monthly seminars help them to learn new things, remind them of what they learned during training and help them to exchange experiences and share common problems. The organization of refresher courses in the Nkoranza area seems to be better than the organization of similar courses elsewhere. For example in Zambia, CHWs receive a one-week refresher course at the rural health centre every year. Refresher course is thus not a problem for the CHWs in the area. The fact that all CHWs in the area are able to meet monthly at the District hospital should have been a morale-booster for them.

5.1.4. Provision of Referral Points

The PHC document states clearly that CHWs are to refer relatively complicated cases to higher levels (i.e. either Level B or C). Since all the three levels do exist in the district, the two higher levels provide points of referrals for the CHWs. All the 12 CHWs indicated that they do refer complicated cases. It however came out that in referring cases, CHWs bypass Level B. Cases are sent straight to the St. Theresah's hospital. The explanation given by the CHWs was that Level B refer cases to the Theresah's hospital and it would thus be of no use referring cases there. As one CHW remarked, "Apart from

injections, we are same". The view being expressed here is that there is no difference between what they (the CHWs) can do and what the Level do. The difference however lies in the fact that the Level B staff are allowed to inject and to prescribe a wider range of drugs. At the time of the interview, the Nkoranza Health Centre was headed by an Enrolled Nurse supported by Community Health Nurses. All these officers are elementary school leavers like the CHWs. For such a comparison to have been made shows that the CHWs do not understand the very system they are a part. This further shows the lack of proper education about the system before the whole programme took off. As mentioned earlier on, there is lack of proper development of Level B stations in the district and as such the hospital becomes the automatic point. The implication here is that instead of the Level C dealing with more complicated issues it also has to treat cases that could have been dealt with at the B Level.

From the findings on MOH technical assistance to the CHWs, one can argue that the aspects of MOH technical assistance which are affecting CHWs in the area are training, supervision, and the provision of referral points. The provision of refresher courses on monthly basis is regular. In terms of training, what CHWs have been trained to do and what their people were expecting from the system are two different things. This demonstrates clearly that what the people need and what planners had planned for them are at variance. The people need quality of care. Thus the principle of making health care delivery system available and accessible does not work if such a system fails to meet the aspirations of the people. Such a system becomes unacceptable. This is what I will call "the missing target" in PHC and CHW programmes. This could not be foreseen by PHC planners and studies on PHC sustainability such as those reviewed earlier have also missed it.

Even though the absence of a national training manual left instructors/teachers to develop their own training materials and strategies, training went on as envisaged. The problem however was with the content of training. One therefore wonders whether the communities understood the system before they sent people for the training. The real

issue is that there is a wide gap between the views of the planners and that of the people about the functions of the CHW. This could not be bridged before the programme took off. The problem thus started with two opposing views in terms of what the real functions of the CHW should be. The development of teaching material on individual bases led to a situation where different teachers taught different things from time to time. The matter was worsened by the fact that CHWs were trained in different health institutions occupying different levels in the health system a hospital (St. Theresah's hospital) a health centre (Kintampo health centre) and a health post: (Yefri health post). The inconsistencies in course content could be seen in where some CHWs know how to inject whilst others do not.

Another important technical factor affecting CHWs in the study area is the nature and level of supervision. The CHWs are supervised by the District Health Management Team headed by the District PHC Co-ordinator who has other administrative duties at the St. Theresah's hospital. His visits which normally last for some hours are used to check many things as pointed out earlier. Such a system, prevents effective scrutiny of the CHWs as well as the Iocal committees that control the CHWs. Many things thus go on unchecked. One may add to the above, the existence of a "hospital" within the district. The fact that there is a place within the district providing "better" Services means that the people are already assured of the availability of such Services when necessary. Many of them thus bypass the Community clinics because they do not get the services they want there.

The result of the existence of a higher level serving as a referral point for the CHWs has been the elimination of the former system where higher cases were referred to Techiman, (18 miles), Kintampo (36 miles) or Sunyani (58 miles). However, this has created a situation where most people bypass the CHWs and go straight to the hospital due to the provision of "inadequate services" at the community clinics.

Malcom and Glen Williams (op.cit) sum the above in their discussions of the tasks and skills of CHWs. They noted that, "the main logistic problem is that CHWs are trained for short periods in which they can be taught only a restricted number of Skills. Yet, a CHW may often be the only trained health worker in a community and may be asked to cope with a wide variety of problems many of which he or she cannot provide answers. Compounding this, CHWs live in relatively remote areas and referrals to higher levels of the health service and supervision by health professionals are difficult to guarantee. Yet in order to sustain the quality of their work, and to reinforce their short training period, they need close supervision and support" (Walt, 1990)

5.2 MOH'S MATERIAL ASSISTANCE IN THE PROGRAMME

One important element in this research work is to find out the material role of the programme planners to assess its effect on the functions of CHWs. It is found out that apart from technical assistance, the MOH has material role to play in the implementation of the programme.

The Ministry provided residential facilities for those trainees who took their course on residential bases. This applied to the Kintampo trained CHWs. The Ministry has also been providing drugs and other medical kits to the CHWs. Such items are normally provided during the inauguration of the Community Clinics. The hospital and the health centres also serve as drug stores for the CHWs. They all buy drugs from the existing health institutions.

The Ministry has not got any special drug programme for the CHWs and thus they come in to buy drugs any time they need them. The CHWs are also requested to pay cash for the drugs. It is thus a "cash-and-carry-system". How much drugs they can carry to their comrnunities thus depends upon the amount of money they have.

It will be pertinent to state here that "modern drugs" are valued and desired by people even in very remote rural areas. This is because people are influenced by the

"medical model" of health. What they are looking for is somebody who can give them drugs when they are sick. All that they know is that when one is sick. This is due to their belief in the efficacy "pills" (tablets). What is thus the use of a system which cannot give them "essential" drugs? Walt (op.cit) argues that when primary level health facilities do not have a consistent and regular stock of medicines, their utilization rates fall. In the same way, when CHWs run out of drugs, people lose faith in them and do not consult them. This view is also supported by Ofosu-Amaah (1983) who sees poor supplies as one of the weakest points of CHW's.

5.3 MOH FINANCIAL ASSISTANCE TO THE CHWS

The MOH has no financial obligations in the programme. Health personnel who were used in the training of CHWs as facilitators were not given any allowances apart from their normal salaries. Supervisors are also not paid for their services. What is more, financial assistance after training which are in the form of remuneration of the CHWs, the provision of capital for drugs and other material inputs are made the responsibilities of the communities. Financial support of the programme thus rests on the people themselves. They have to support the CHW during and after training. They are however finding it difficult to meet the financial obligations of the programme due to their weak financial positions coupled with the fact that they have to support many development programmes.

CHAPTER SIX

CHWS PERCEPTIONS, EXPECTATIONS AND EXPERIENCES AND HOW THESE ARE AFFECTING THEIR FUNCTIONS IN THE NKORANZA AREA

This chapter deals with three main variables. That is, the perceptions, expectations and experiences of the CHWs in the Nkoranza District and how these variables affect the functions.

6.1 PERCEPTIONS OF CHWS

When the CHWs were asked what kind of training they thought they were going to have and with such a training what functions they would perform in their communities, they all mentioned that their leaders who asked them to go for the training did not tell them much about the programme. The CHWs thus seemed to have entered the programme without knowing much about what they were to do. They did not have any terms of reference. This might have been due to the fact that the community leaders themselves did not know much about the programme. This lack of knowledge about the programme could further be attributed to the lack of communication among the parties involved in the programme. That is, lack of communication between the programme planners and the community leaders, between the programme planners and the selected individuals for the training and lack of communication about the programme between the CHWs and their community leaders. The lack of communication might have resulted from improper planning of the programme. That is, the inability of the planners to educate the rural masses the programme is to benefit. This would have enabled such people to have known their roles and to be able to educate others.

When the CHWs were asked what kind of problems they thought they would face as health workers in rural communities none of them showed that he had thought of any problems. The only thing they had in mind was their farming work. This came out when answering a question as to how they were going to combine their clinic duties with their occupations (mainly farming). All the 32 CHWs indicated that their community leaders

assured them that they would mobilise their people to give them a helping hand in their farms. They further added that no problems were also raised during their training.

From the answers the CHWs gave to their perceptions on problems, it became clear that the CHWs depended upon the promises their community leaders gave them. Their hopes were that their community leaders were going to reward them for their services. The unfulfilment of such hopes would thus become a source of frustration as the situation had turned out to be in the Nkoranza area.

6.2 EXPECTATIONS:

One assumption made in this thesis is that the difference between the CHWs expectations and what they are really getting from the programme would affect their functions. One way of finding out this was to find out from the CHWs what their expectations from the programme were. It was thus necessary to find out what the CHWs were promised, what they are getting, whether they feel cheated and whether their complaints are valid.

As to what their expectations about the programme were, the responses from the CHWs showed that their expectations were in two forms and from two main directions - expectations from their communities to establish clinics for them and to reward them and their expectations from health authorities to help them when they are in any difficulties. These expectations of the CHWs were based on the promises made to them (CHWs) by the two parties as these were confirmed by the community leaders and the health personnel interviewed. The CHWs mentioned that their communities assured them that after their training, they would put up clinics for them. These clinics would be stocked with drugs through the provision of a revolving fund. Every community also promised to reward his CHW both in cash and in kind. The minds of the CHWs were thus prepared towards receiving rewards both in cash and in kind.

The expectations of cash rewards were to be later strengthened during the attachments of the CHWs to the existing health institutions for more practical work after the classroom teachings. During the field attachments, each CHW was receiving a government allowance of twenty cedis (¢20.00) per month (Kintampo Project Document, (op cit). Those who received this allowance, said they were not told the payment of this monthly allowance would be stopped when they go back to their communities. The beneficiaries of the government allowance said they were not also informed the source of the money. They did not know whether this was coming from the government in the form of a salary or from the head of the particular health institution. The lack of communication between the health authorities, and the CHWs created a false impression in the minds of the CHWs who thought that the monthly allowance would continue. When the opposite turned out to be the case, the CHWs became disappointed. What had worsened the situation is the inability of the communities to fill the vacuum created by fulfilling the cash allowances they had promised.

Another situation that seem to have been created as a result of the field attachment is what the psychologists may describe as a "conditioning effect" or "a social learning process" Their field attachments might have brought them into contact with the various categories of nurses. They might have realised that some of them are elementary school leavers (i.e. the Community Health Nurses and the Enrolled Nurses) just like them. Back to their communities they may not understand why they should not be included in the regular budget of the Ministry of Health. There is in this case, a change in aspiration.

6.3 EXPERIENCES:

Another area of concern in this thesis is to find out how the experiences of the CHWs in the communities are affecting their (the CHWs) functions. The major areas that were looked at were the time the CHWs use at the clinics, the supply of inputs, and the problems they are facing.

As to how many hours they work each day they mentioned that this differs from day to day. According to them, there are certain times one is called from bed before 6 a.m. At other times one is invited from his farm to attend to emergencies. Majority of them (about 27) representing 86% were of the view that they work from around 7 a.m. to about 11 a.m. in the morning and from 5 p.m. to about 9 p.m. each day of the week including week ends. There was only one CHW (the man at Buabeng) who said he does not work on Saturdays for religious reasons.

The average number of hours each work in a day was found to be around 8 hours. Asked whether they are satisfied with the number of hours they spend at the clinic each day, the response was negative. As to why they are dissatisfied with the time they spend at the clinics, they reiterated that their community leaders had told them that their work was going to be a part-time business and would need not more than 6 hours each day at the clinic. They wull thus have sufficient time to themselves whichc they will use for their routine work. This expectation has not materialised. This, coupled with the inability of the communities to help them in their farms make them to leave the clinics to attend to their farming work.

On the supply of inputs, the CHWs mentioned that even though their communities have not been able to buy them sufficient drugs, the health authorities have also failed to come to their aid as they promised when they were under-training.

In terms of the area of operations that is, what they are allowed to do, the CHWs, and especially those who know how to inject, mentioned that there are many restrictions in their scope of operations. Here they specifically mentioned injections. They complained that their communities believe in the efficacy of injections more than mere drugs (i.e. tablets and liquids). The communities see the miracle of Western medicine in the syringe. An old man I spoke to later on the operations of the CHWs complained bitterly about the inability of the CHWs to inject. Speaking in the local language he said "Me dɛɛ ma duro ne paniɛɛ: sɛ mo pɛ sɛ mo boa yɛn dɛɛ a, momma kwan na dokita no

mmo paniee". Literally meaning, As for me, my medicine is injection, If you want to help us then allow the doctor to inject". This goes to show the misunderstanding that improper education on the programme by the health authorities has created. The general public the programme is to benefit do not understand the PHC system and the functions of the various levels of the system. They thus expect the CHW at the Level A to do everything done by the nurse at level B or the Doctor at Level C including injections. All the 12 CHWs who are operating clinics complained that their inability to inject causes their community members to seek treatment from chemical peddlers and drug pedlars some of who do inject. Even though it is record that the District Medical Officer of Health (DMOH) has "banned the activities of drug pedlars in the area the CHWs believe that such people do exist and operate under cover throughout the district.

On the question of other providers of health services in the area particularly the traditional healers, the CHWs said the work of traditional medical practitioners complement theirs. They mentioned that, apart from treating most of the diseases that hospitals treat they also deal with diseases "which are not hospital diseases" They specifically mentioned boils and what they termed "honhom mu yadee" (i.e. spiritual sickness).

6.4 MANAGEMENT OF CLINIC FUNDS

Part of the CHWs experiences in relation to the implementation of the programme has been the management of clinic funds. Whilst in two villages (Akumsa-Domase and Akropong) it was said that the CHWs made use of the monies given them by their communities, at Asuano, it was rather the village committee members who misappropriated the clinic fund. The CHW who was trained at first by the people of Asuano left the village and now works in a different village (Ayerede) about 3 miles away.

In almost 80% of the cases where clinics had collapsed, the village development committee members admitted having used clinic funds to support other development

projects such as school buildings, street construction, re-gravelling of roads and the provision of places of convenience. As to why such a thing happens, the village committee members added that they sometimes find it difficult to raise sufficient monies through taxes to support such projects and since it is for the whole community they nothing wrong in using the funds accumulated from the clinics. One committee secretary in trying to justify why they have to use clinic funds said "the money is for the community and not the CHW we gave it to him".

CHAPTER SEVEN

7.1. SUMMARY AND CONCLUSION

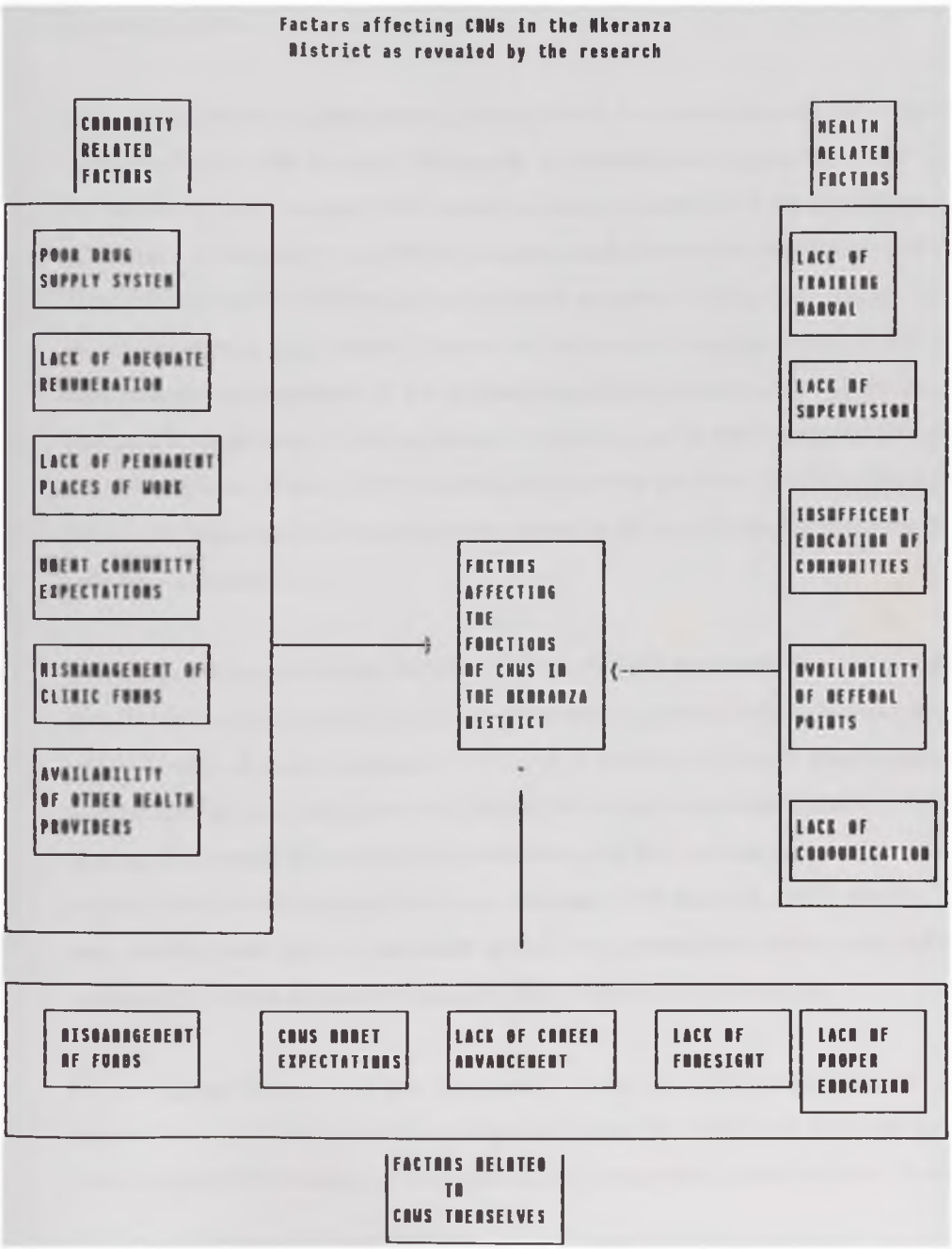
The thesis has attempted to uncover factors affecting CHWs in the Nkoranza area. Based on interviews with a sample of 32 CHWs as well as commitee members of their communtiies, an attempt has been made to look into both the health sector and the communities for the identification of such factors. Whilst some of the research findings support some past assumptions on CHW programme such as the significance of supervision, remuneration, training, financial management and expectations of CHWs and communities (Bose 1983, Rifkin 1980, Samba 1989, Walt 1990), the research has also revealed two important weaknesses in the formulation of PHC and CHW programmes. These are:

i. The principle of community financing of health programmes; and

ii. the principle of making basic health care delivery system available, accessible and acceptable to majority of the rural people.

It has been found out that factors which affect CHWs in the area come from three main sources; the health sector, the community and the CHWs own perceptions and experiences with the programme. Improper planning of the programme by the health authorities led to lack of training manuals and lack of effective supervision. Lack of proper management of drug supply from the health sector have led to a situation where the CHWs rely on their commuities for the needed support. The improper planning of the programme has also led to lack of communication between the three parties involved in the programme. This is lack of communication between the programme planners and the community leaders, between the programme planners and the CHWs and the Community leaders and their CHWs. The lack of communication has brought about misunderstanding of the programme. The CHWs and their communities are therefore demanding services which are to be performed at a higher level (Level B or C) of the PHC system to be performed at Levcl A. The failure on the part of the communities to support the

programme financially and materially have caused greater percentage of the CHWs to drop out of the programme whilst those in business are dissatisfied with their work. The CHWs unmet expectations and their poor anticipation into the nature of problems they were to face have also contributed to the dropout rate. Factors affecting the functions of the CHWs in the Nkoranza area can be represented in a diagram as follows:



7.2 CONCLUSIONS

With the current situation in the organization of the clinics, the most obvious conclusion one can draw from this research is that the CHW programme in the Nkoranza area has not been able to achieve much of its goals. This conclusion is based on the following factors:

1. From the programme planning point of view, the programme has not achieved its objective of one CHW for every 500 people. This would have required about 100 CHWs for the over 151,801 people (1984 population census figures) since the district can count more than 127 villages of over 200 population in each of them (Health Report: 1989; 19). The total number of CHWs trained in the district represent 10.6% of the number required by the programme after almost 17 years and with only 9 years to the Year 2000. The number operating represents 37.5% of those trained and 4% of the total required for the district. The implication of the figures here is that the district will not be able to achieve the PHC objective of one CHW for every 500 people by the Year 2000. Not even 2020 if the current organization and management strategies do not change and the current drop out rate is maintained.

2. The Ministry of Health has also failed to establish the needed Level B stations as specified in the PHC document (Ref. the 3 tier system). Even though it is on record that within 5 miles of every community with Level A workers, a Level B station, providing the first referral point and contact with the MOH is to be established and staffed with one or more Community Nurse Midwife practitioner, this has not materialised. So far, there are only five Level B stations in the area. Because of the lack of Level B stations in the area, coupled with lack of personnel at that level, supervision which was to be the responsibility of this level is carried out by the Hospital (that is, Level C).

3. Another area where the programme could not achieve its goal is in its inter-sectoral approach to health development where the CHW was supposed to have acted as an agent of change and development. It is documented that at the Level B station,

there must be co-operation with peripheral workers from other agencies such as agricultural home extension workers, social welfare workers, water and sewerage, community development workers and Ministry of Education. This has completely been neglected in the organization of the programme. Thus the horizontal aspects of the programme which was to embrace other agencies which carry out health related programmes had been left out. The programme is seen as the sole responsibility of the Ministry of Health (it is thus a vertical programme).

4. The programme has also failed in its community participation approach in its planning and implementation. Even though communities selected over 60% of the CHWs, the communities have not been able to provide adequate support for them during and after training. From the interviews and the discussions, "interest" was given as the major factor keeping the few (12) CHWs who are still in business. This fact was strongly emphasised by both the CHWs and the community leaders. Community leaders added that the CHWs "love" their communities. None of the CHWs receives his monthly allowance regularly. At the time of the interview, some of them had not been paid for more than six months. Typical examples are the CHWs at Bonsu, Dotobaa, Koforidua, Dromankuma and the new CHW at Asuano. Their communities have also not been farming for them as they promised. Jancloes' (1980) idea that people will become efficient and contribute many of the material and human resources needed to organise health facilities when given the opportunity has not worked in the area. On the other hand. Samba [op.cit] Conclusions support the findings in this thesis. It is not only sufficient to give the people the opportunity to organise their own affairs. It is also important to take other issues like the socio-economic background of the people and the services to be provided by the system into consideration. It is also necessary to add that the system of placing the financial burden of development programmes on the communities has proved not to be workable in the CHW programme and need to be viewed again from a wider perspective. Even though "interest" was given as the main factor keeping some CHWs in business, "Social prestige", that is, "Status upliftment" could also be a motivating factor. The CHWs are highly respected in their

communities. They command a lot of respect when it comes to matters related to health. When the doctors and the nurses are in the Villages, it is they that they look for. They have thus become part of the village power structure. No doubt they wished the health personnel would visit them at shorter intervals to enable them gain more respect.

This supports Walt's (1990) argument on voluntarism. To him, "another motivating force for volunteering time and labour may be cultural respect for, and compliance with, authority". He adds further that, "status consideration may also be important in motivating volunteers as they are in contact with health professionals such as doctors, nurses and midwives, who usually hold important positions in the community".

From the way the Ministry of Health and communities have participated in the programme as demonstrated in this work, another conclusion which this paper can draw is that the institutionlization of CHW programme in the area depends on the interest of individual CHWs and not on community or Ministry of Health participation. Community participation has been limited to the mobilization of the peoples resources of money, labour and materials. Once this is done, it is taken that the communities are participating in the programme. This is also not being effectively done in the area as the research has shown. No conscious efforts are being made by the people to have control over such factors that affect their health.

Finally it must be said that the CHW programme has not made health care delivery really accessible and acceptable to the people. The CHWs who were interviewed admitted that their community members bypass them and travel for several miles to seek treatment at the hospital at Nkoranza where they pay higher charges than they would have paid at the community clinics. From the foregoing, one could argue that the magnitude of the problem facing CHWs in rural areas in Ghana especially in the Nkoranza area could not be addressed properly before the implementation of the CHW programme. If identified at all, the problems were not addressed at both the planning and the implementation stages.

It looks as if examples of countries with successful CHW programmes such as Cuba, Tanzania China, Ethiopia, India (Kerela) the Democratic Peoples Republic of Yemen are all socialist countries with centralised regimes. They have strong administrative units at the bottom. The fear of the party is carried to the community and local leaders are so powerful that they easily get their ideas and programmes implemented because of coercion. This is completely absent from non-socialist countries.

The problem of the CHW programme seems to be that countries study and copy the idea from such socialist countries only after the programmes have been successful. They normally neglect the political and the social structures that make such programmes workable. What countries copying the system forget is that it is not easy to transplant ideas and programmes from one country with different socio-political set ups into another with different structures without a thorough underground work.

Our conclusions are clear. The concept of CHW remains valuable, and much useful work can be done by CHWs. However the government and donors must not be unrealistic in their expectations . Having said that, we do not feel sanquine about the future in national programmes. Real effort must be put in place to enhance the effectiveness of CHWs so that they do not simply extend the possibility of contact with the health system, but effectively tackle some of the community's health problems.

First, a supportive political climate in which health is viewed as part of human development and the right of each individual, is an essential starting point for a successful PHC programme. Although this commitment is rare on a national basis, it is often found to some extent within a community or, at an intermediate level of the government hierarchy. Neither higher income levels nor technically sophisticated medical services can insure health for all. What really counts is political commitment to ensuring universal coverage by health services and the intergration of health with other sectors of development.

Secondly, community participation should not aim simply to mobilise the people's human, financial and material resources. Above all also, community participation should help the people gain greater control over the factors affecting their health by making their own decision, organising their own activities, and taking greater responsibilities. This will require considerable decentratralisation in decision-making within the health system and society. All members of the community should be involved in some aspect of the health programme. The role of women is crucial to the success of PHC. As health professionals, volunteer community organisers, traditional midwives, folk headdress, and mothers, women should be in the frontline of CHW programme.

Although not analysed in detail in our literature, the ,technological appropriateness of PHC interventions is crucial to PHC success, whether measured by medical or social criteria and this should include the training of CHWs, management strategies, monitoring and evaluation of the programme and the use of precise indicators by which a community can guage its progress in solving health problems.

However, our conclusions carry a more wide-reaching warning not only for CHW programmes in the area, but for the PHC approach itself. Unless the fragile primary health infrastructures, built up with so much enthusiasm in the 1960s and 1970s, and which continue to be expanded, are nurtured and protected, they will crambble in the face of economic strategies that are inimical, to equity and state provision. It is then not only CHW programmes that will face dissolution but the whole PHC approach. Our hope is that this will not happen. The above calls for a re-examination of the whole CHW programme.

7.3 RECOMMENDATIONS

Following from the above, it could be said that even though the government of Ghana is committed to health and sees it as part of total human development and the right of every individual, this has not been committed to the CHW programme as one would

have expected. For example in 1989, the then secretary for Health in a nation wide broadcast on the topic "Improving Health Delivery Services in Ghana", acknowledged that not more than 40% of the rural people in Ghana are covered by PHC Services. He pointed out that the government was planning to double the coverage of the PHC to 60% of the rural population by 1990. The question is not whether this objective has been achieved as we enter the last quarter of 1991 but the fact that in touching on the short term action plans prepared by the government, less was said about PHC. Though the Secretary said 650 million Cedis had been allocated to finance certain emergency actions, PHC activities in such emergency actions were limited if not insignificant. For example, thc actions included:

1. An intensification of the eradication of Guinea Worm.
2. An intensification of deworning and immunisation of School Children.
3. Rehabilitation of Korle Bu Teaching Hospital, including the maternity block, an accident centre, refurbishing old Korle Bu and improvement of the water supply system.
4. Emergency rehabilitation of buildings and equipment of the Ridge Hospital, polyclinics in Accra; the Military Hospital, the Police Hospital, Komfo Anokye Teaching Hospital, Tamale Hospital, Sunyani Hospital, Effia Nkwanta Hospital and Ho Regional Hospital.

A Police Hospital is to be set up at Ho in 1989 and another in Kumasi in 1990 and 40-bed hospitals due to be set up by the Military in seven regions. A Neuro Surgery Department has been has been set up at the Military Hospital while wards are being renovated in, the same Hospital. (March 1. 1989, Peoples Daily Graphic).

Looking at the above, one realises the strong emphasis on creative and urban-based hospital system. On PHC, the Secretary said "Our Ministry is currently in the process of dramatically improving, rehabilitating and expanding all primary Health Care services as a matter of high priority"

All these efforts are ultimately dependent on active community support and participation. Only if district assemblies, traditional leaders, the CDRs, Town and Village Development Committees, the Churches, the Ghana Private Road Transport Union, Ghana National Association of Teachers, Mobisquads and other Identifiable community-based social groups work together to motivate the people to benefit from the services that are available will a break through be achieved (Sarpong op.cit).

The implication of the above is that, while the government rehabilitating and improving the urban services, local organisations are being called upon to work together to improve PHC system. This already has not achieved much. This is the more reason why we would like to put up the following suggestions as a way maintaining the present system but making it more functional.

We would however have to state those suggestions that were offered by our informants. This will show the perspective from which the people themselves view the problem.

1. The need to give CHWs a monthly allowance (of between ¢4,000.00 - ¢7,000.00). They however added that these allowances must be opened to market prices.
2. The need to intensify public education by involving the District PHC Co-ordinator in the campaign.
3. Need to raise more money to purchase drugs.
4. The need for individual communities to open Bank Accounts with the Banks.

A closer look at the suggestions reveal how simple the people see the problems facing CHWs in the area. For example, how does one increase the financial base of the communities to enable them buy more drugs and pay monthly allowances of between

¢4,000.00 to ¢7,000.00 without taxing the people the more or engaging them on community farms.

This is what the people have already refused to do. Further, to make a community farm or clinic farm means the mobilization of the people. This means changing the peoples' attitude towards community organization. It involves behavioral change. The lack of people with such academic professional competence in the area will hamper such an educational programme. What is more, the nature of training has brought about a situation where the CHWs are limited in scope. The provision of supplies and remuneration will not solve such a problem. Following from the above we would like to make the following recommendations and suggestions.

The solution of the problems facing the CHW programme in the Nkoranza area and as revealed by the current research, will need both short and long term planning as well as local and national attention. Whilst part of the problems dealing with community participation could be dealt with in the short term at the community level, answers to some others, especially those dealing with MOH participation will need more long term measures at the national level. The two should however be approached in an integrated manner.

The short term measures would have to be directed towards increasing the capital base of the CHWs, viewing the remuneration issue in a more practical manner and improving the supervisory system. On the other hand, the long term planning should aim at-orienting the CHW programme and planning its financing within MOH budget in a sustained manner. This is the only way the CHW programme would be made a permanent feature of the PHC system.

Short Term Measures:

1. Communities with trained CHWs should organise fund raising activities. Such activities should be organised annually. They should be planned to coincide with some important occasions in the communities.

Citizen and non-citizens of th communities including heads of governmental departments and financial institutions as well as organisations such as the Pioneer Tobacco Company and the Leaf Development Company should be invited to attend such fund raising ceremonies. People seem to be more willing to donate on such occasions perhaps to show off their wealth, or raise their social images or from a humanitarian point of view. If properly organised, the communities should be able to raise their capital bases through such activities.

2. There is the need for the three parties (i.e. the Health Authorities, the CHWs and the community leaders to meet and to discuss the remuneration issue at the local level. We recommend a system where the CHW is allowed to put some extra amount on the cost of the drugs he sells. This should go to the CHW as his monthly allowance. Even though not documented, such a system has been found to be working well in the Dangme West District in the Greater Accra Region among communities implementing the Bamako Initiated Programme. A caution must however be sound here. Knowing that his reward depends upon the amount of drugs he is able to sell the tendency will be over-prescription and mal-prescription. To check this, MOH supervision will have to be strengthened. With the present nature of MOH Supervision as discussed in chapter five, the development of a new system becomes abvious if this can be done. This is provided for by the third reoommendation.

3. To improve the efficiency of supervision, raise the social prestige of the CHWs as they are calling for and to enable the health authorities to have first hand information about the problems facing the communities, it is recommended that the monthly refresher courses currently held at St. Theresah's hospital should be held in the villages. This

should rotate. Part of the course time in each community should be used to check the operations of the CHW in whose community the course is being organised. The health authorities and the other CHWs should observe the CHW in question. Supervision should thus become a system of evaluation. Each CHW should be made to write a report at the end of each course. This should be summarised and compiled by the health authorities and distributed among the CHWs. Part of the time should also be used by the health authorities to educate the villagers. The villagers should also be allowed to present their problems to the CHWs and the health authorities. The outcome of such meetings should enable the health authorities to sharpen their health education tools and the organisation of the refresher courses. The duration of the course should be more than the current one day. We recommend three days.

4. There is the need to train community leaders, especially those who can read and write, in management and supervisory techniques to enable them to contribute positively to CHW supervision. Such community supervisors should be made to submit weekly returns to the health authorities. This should include patients attendance, their complaints, drug administration and monies realised from drug sales. Feed-backs should be sent to the CHWs and the community leaders who submit the reports. Where this goes with the monthly refresher courses and the bimonthly supervisory visits, supervision could be improved.

Long-Term Measures:

The following will be necessary as long term measures:

5. The present national policy guideline on the programme should be reviewed to reflect on the fragile financial situation of the rural people the programme is to help. A national co-ordinating body of the Cuban type must be set up and charged with the responsibility of planning, monitoring and evaluating CHWs operations in Ghana. For an efficient functioning of such a body, law should be promulgated to regulate CHWs activities concerning the use of drugs and abuse of functions.

6. There is the need for the development of a national training manual to regulate training. Such a manual must be adopted to suit the Ghanaian situation, not forgetting the dynamics of our rural societies. Such a manual will not only bring some form of uniformity in the content of CHW training but will give more direction to trainers themselves.

7. The fact that CHWs in the Nkoranza area are supervised by level C indicates that all is not well with Level B stations. There is therefore the need to establish more Level B stations in the district to ensure effective supervision. CHW supervision needs to become a more thorough and detailed activity, a form of evaluation, and not an infrequent chore. Supervisors could spend two to three days each month with a group of CHWs living with them in their villages. They should utilize checklists for supervision that include some notion of the quality of encounters, and they should be trained in holding group discussions with community members. Contact between CHW and supervisor should be part of continuing education.

8. In terms of cost, it is essential that the government sets problem of CHW financing within the wider debate about healthcare financing, because it arises out of the sector-wide resource constraints. Failure in the past to plan for CHW within PHC must not be continued in current and future financing decisions. The practice of placing the burden of financing CHWs on the community has been shown to be broadly unsustainable and inequitable in the area, but within the health-care system as a whole there may be possibilities for cross-subsidizing CHW programme. Such opportunities can only be identified if a sector-wide approach is adopted.

9. We suggest the institution of career advancement into the CHW programme. Almost all CHWs are eager to be rewarded by opportunities that will give them the chance to advance their carrier as health agents. It is the opportunities that are missing. Extension of hospital-based health care system to the rural areas by the government cannot be done now nor in the immediate future. CHWs would thus remain a great asset

to the rural communities and the nation. Their efficiency should be imporved through further training. Improvement of career activities in CHW programme in Nigeria, according to Stinson (1987) was able to reduce attrition rate. This demonstrates that financial reward is not always the key ingredient for improved sustainability

10. We would however caution that no matter the improvements brought into the programme, the quests of an efficient rewarding system is essential. However to discuss any financial obligations, roles to be performed by the government and the communities should be set straight. Steps should be taken not to put much burden on the people who already "have too much to bear". It must be realised that the general level of poverty which calls for CHW programmes also makes it difficult to exact voluntary participation, and community assistance.

11. There is the urgent need for the proper implementation of the inter-sectoral approach to health development. The works of Mckeown's (Study for England and Wales) and McDermott's (Investigations in New York) have clearly showed that remarkably improved personal hygiene, environmental sanitation through legislation, introduction of clean potable water, and better nutrition brought about a decline in the major causes of deaths (diarrhoea, respiratory disorders, malnutrition and other acute infections) without or with little input by the medical profession.

l2. The PHC principle of giving CHWs limited training necessary to enable them treat minor ailments and administer simple drugs has proved to be unsustainable in rural Ghana. Even though data could not be produced on the number of people who bypass the CHWs, all the CHWs mentioned that this is done. This is attributed to the type of service provided there. The must be training programme to make Community Health Workers expand their scope of operations. We recommend the use of better trained Community Health Nurses. Communities should be allowed to select people who should be trained and paid by the government. However, working in their own communities should be made a condition in the selection. This will not only solve the remuneration problem

currently facing the programme but also the shortage of such health personnel in the rural areas. It will also enable the health workers to meet the people's aspirations.

We would however have to state that for the PHC/CHW concept to be carried to a higher stage, it is essential not only to arouse the interest of CHWs but also to sustain mass enthusiasm for production throughout the period of the transition from curative based approach to health care to preventive and promotive strategy based on community participation. And this enthusiasm can be sustained not by unfulfilled promises of a rosy future, but by the people's own experience in their own life of constant improvement in their living conditions politically, materially, social and culturally.

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QUESTIONNAIRE FOR COMMUNITY HEALTH WORKERS

NAME OF VILLAGE:

A. SOCIO DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS.

1. Age:

   a. 20 - 29
   b. 30 - 39
   c. 40 - 49
   d. 50+

2. Sex:

   a. Male
   b. Female

3. Level of Education

   a. Nil
   b. Elementary
   c. Secondary
   d. Post Secondary
   e Any other

4. Any other special training related to health

   .....

5. Marital status.

   a. Married
   b. Never married
   c. Divorced
   d. Widowed

6. Number of wives (where respondent is a male)

   a. One
   b. Two
   c. Three
   d. Four
   e. Any other number (specify) .....

7. Number of children:

   a. Ever born .....

   b. Surviving .....

.../162

B SELECTION AND TRAINING OF CHWS:

8 Who selected you for the training?

a. By the community
b. By the chief

c. By the Health Authorities
d CHW Volunteered.
e. Any other person or means (specify)

How were selected?

9 What was the criteria used for your selection?

a. .....

b .....

c .....

10 when were you trained as a CHW?.....

11 Where were you trained?

a. Kintampo Health Centre
B. St Theresa's Hospital, Nkoranza
c. Holy Family Hospital, Techiman
d Nkoranza Health Centre
e. Any other place (please specify)

12 For how long did your training take?

a. 3 months
b. 6 months
c. 9 months
e 12 months
e. Any other time (specify).....

13 Can you describe briefly what you were rained to do?

a .....

b .....

c. .....

14 Was there any training manual?

a. Yes
b. No

.../163

15 If no to question 14, how did the trainers go about things?

a. .....

b. .....

16 Who financed your training?

a. The community
b. The health authority
c. I (CHW) financed myself
d The chief

e Any other person (specify).....

17 Were you given any other allowance while in training?

a. Yes
b. No

18 If Yes, how much were given per week/month?.....

19 If yes, by whom?

a. The community
b. The Health authorities
c The chief
d The church
e Any other group, individual or organization (please specify)

20 Was financial support regular?

A Yes
b No

21 Was the amount sufficient for your upkeep?

a Yes
b No

22 If the amount was not sufficient, what problem(s) did this create for you?

a, ...

b .....

.../164

23 How did you overcome the problem(s) mentioned above(22)

a. .....

b. .....

24 If no clinic why could your community not establish clinic?

25 When did you start working in this clinic

26 Who provided you with the place of you working?

a. The community
b. The chief
c. The health authorities
d. My self
e Any other person or group of persons (please specify)

.....

27
DAYBUILDINGPRESENTABSENT MEDICINEFURNTURESIZE
WALL
LOCKS
ETC

28 Tick the appropriate box against the statement(s) that briefly describe the activities you perform at the clinic.

a. Take down histroy of diseases and examine people
b. Prescribe and give drugs
c. Do inject
d. Do health education on mother and child health and family planning
e. Do home visitation to educate people on environmntsl cleanliness
f Any other duty (specify)

* Cross check with statistics if any

29 Looking at the activities you perform both inside and outside the clinic and your training, will you say your training was adequate?

a. Yes
b No

Please give explanation to your answer

.....

.....

.....

.....

30 Is there any specific thing you think should have been incorporated into your training?

a. Yes
b. No

31 If yes to question (29). what is it?

a. Yes
b. No

32 Do you think the lack of such a knowledge is affecting your work?

a. Yes
b No

33 If yes, to question (31) in what way(s)

a. .....

b. .....

34 Have you ever encountered any problem in the course of carrying out your duty (duties)

a. Yes
b. No

35 If yes to question 34, what was the problem?

a. Yes
b. No

36 Have you been referring cases tohigher levels?

a Yes
b. No

.../166

37 Which place is your referral point?

a. Nkoranza Health Centre
b. St Theresa's Hospital, Nkoranza
c. Yetri Health post
d. Holy Famly Hospital, Techiman
e. Kintampo Health centre
f. Any other place (please specify)

38 Why have you taken the place named above as year referral point?

39 By the principles of PHC, who is to provide you with drugs?

a. The community
b The health authorities
c. I was to buy them myself
d Any other person(s) or group of persons (please specify)

40 Has the person(s) or body been supply you with the drugs?

a. Yes
b. No

41 When was the last time drugs were supplied to you?

42 Has drug supply been regular?

a. Yes
b No

43 If no, what do you think has been preventing the person(s) or body to supply you with the needed drugs as scheduled?

a. Lack of funds
b. Lack of storage facilities
c. Lack of drugs in general
e. Any other problem (please specify)

44 Has drug supply been regular or forth coming, have you any other sources to obtain drugs?

a. Yes
b. No
If Yes state sources

45 Do you find the system of drug supply to the clinic to be convenient?

a. Yes
b No

46 If not, what suggestion(s) would you like to make to help improve the system of drug supply?

a .....

b. .....

c. .....

47 Who keeps the money of the clinic?

a. .....

48 How often are funds handed over to this person or body?

a. ....

* How much money has the clinic got with this person or body at present?

49 What problem(s) do you encounter from here too?

a. .....

b. .....

50 Do you receive supervisory visits from any person (person)?

a. Yes
b. No

51 If yes, who is this person(s)?

a. The community
b. The Health Authorities
c. Prices and Incomes Board
d. Pharmacy Board
e. Any other person(s) (please specify))

52 How many supervisory visits did you receive last year?

* Probe, the frequency of the visits(eg. much many visits for the past year)

.../168

53 Do you consider such visits to be useful?

a. Yes
b. No

Give reasons to your answer

a. .....

b. .....

54 When was the last time you were visited?

a. .....

55 Does any local organisation control you?

a. Yes
b. No

56 If yes, which body?

a. The village Development
b The village Health Committee
c. The chief and Elders
d. The Committe for the Defence of the Revolution
e. Any other [please specify .....]

57. Do you find this control to be helpful to you?

a. Yes
b. No

58. If yes, what is this organisation of body?

59. In what way has the mentioned organisation or body been of help to you

a. .....

b. .....

c. .....

d. .....

60. Has any local organ contributed to your poor performance (if it is so)?

Yes [] No []

.../169

61. Which local organisation?

a. The Village Development Committee
b. The Chief and Elders

c. The Churches
d. The Traditional Healers Association
e. The Youth Organisation
f. Any other group (please specify)

62 In what way has the mentioned organisation affected your work?

a. .....

b. .....

c. .....

d. .....

63. Have you ever received refresher training after your first training?

Yes [] No []

64. If yes, how has such a refresher training helped you in your work?

Yes No

a. .....

b. .....

c. .....

d. .....

65. If no to question 64, how has this problem of lck of re-training affected you?

a. .....

b. .....

c. .....

d. .....

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66. In which area of your operation would you have liked more training?

a. Curative
b. Preventive
c. Family Health Education
d. Mother and Child Health
e. Any other are (specify) .....

.....

Explain further: .....

.....

67 In your view, what do you think are the major problems facing your work?

a.....

b. .....

c. .....

d. .....

68. How do you think your work can be strengthened?

a. .....

b. .....

c. .....

d. .....

69. How best do you think Community clincs should be organised to make them more functional to meet rural health problems?

a. .....

b. .....

c. .....

70. How much were you given by your community as an initial capital for drugs?

.../171

71. Where do you buy your drugs. Could you provide the cost prices of the follwing drugs?

72. Apart from the CHW which other places do people in this community seek treatment when sick?

a. The Traditional Healers
b. Private Clinic
c. The Centre
d. Any other place(s) (specify)

.....

.....

73. Why do you think people go for treatment from such sources?

a. .....

b. .....

c. .....

d. .....

74. How did you see your work before your training?

a. .....

b. .....

c. .....

75. What problems if any did you think will face your work before you started work?

.....

.....

.....

76. How were you going to deal with the problem(s) mentioned?

.....

.....

.../172

77. What were you expecting from the programme?

.....

.....

78. Did you make this known to those who sent you for the training?

.....

.....

79. If yes, what did they tell you?

.....

.....

80. If no, why?

.....

.....

81. Was there any contract or agreement between you and your people/MOH before the training

.....

.....

82. If yes, has this been kept to?

.....

.....

83. If no, why? Will you say your experiences has been different from your expectation, if yes how?

.....

.....

.....

84. What suggestions will you make to help you in your work.

.....

.....

.....

85. Any comments. .....

.....

.....

.....

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CHECKLIST FOR FOCUS GROUP DISCUSSIONS WITH COMMUNITY LEADERS

A PRIOR KNOWLEDGE ABOUT THE PROGRAMME

1. How did your community get to know of the CHW programme?

   a. Through public education by the health authorities.
   b. Through the radio.
   c. Through the newspapers
   d. Through neighbouring communities.
   e. Any other means (please specify.....

   .....

2. What were the to be duties of your community in the programme in relations to:

   a. Financing the CHW during and after training? .....

   .....

   b. Provision of place of work?

   .....

   .....

   c. Supply of drugs?.....

   .....

   d. Any other duties (specify) .....

   .....

3. Which of these to be duties did you accept?

   a. .....

   b. .....

4. What suggestions did you make to bring improvements in the programme to make it more acceptable to you?

   a. .....

   b .....

.../175

* Which of your suggestions were accepted?

5. Which of the to be duties in Que. 2 were not acceptable?

a. .....

b. .....

6. Why were they not acceptable?

a. .....

b. .....

7. Would you have still sent somebody for training if you were not to be informed earlier about your duties?

a. Yes

b. No

* Explain further:

8. Did you think of any problems before you sent somebody for the training.

a. Yes

b. No

9. If Yes, what were these problems?

a. .....

b. .....

B SELECTION AND TRAINING OF THE CHW

10 When trained,.....

11 Where trained,.....

12. Duration of training.....

13. Who selected the trainee? .....

14. How was the person selected?.....

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15. What criterion were used for the selection?

a .....

b. .....

16. Why were the factors in Aue 15 above used as the yardstick for the selection?

a. .....

b. .....

17. What was your community's role in the training of the CHW?

A. .....

B. .....

18. What role was the MOH expected to play in the training of the CHW?

A. .....

B. .....

19. What role did the MOH play in the training of the CHW?

A. .....

B. .....

20. Was there any other person or body who was to contribute towards the training of the CHW?

a. Yes

b. No

21. If Yes, who was this person or body?

a. .....

b. .....

22. What was expected from this body or person.

a. .....

b. .....

WHERE CLINIC COULD NOT BE ESTABLISHED, ASK QUESTIONS 23 AND 24

23 Why could your community not been able to establish a clinic for your trained CHW?

a. .....

b. .....

24. What do you think could have been done to establish a clinic for the CHW?

a. .....

b. .....

25 Do you have any intention(s) to establish a clinic for him in the future?

WHERE CLINIC WAS ESTABLISHED INITIALLY BUT HAD COLLAPSED, ASK THE FOLLOWING QUESTIONS.

26 When was your clinic established?.....

27 Who provided the place of work?

a. The Community

b. The Health Authorities

c. UNICEF/WHO, World Vision.

d. Any other (specify)

28 If the place was provided by the community, through what means?

a. .....

b. .....

29. Who was supplying drugs to the clinic?

a. The Community

b. The Health Authority

c UNICEF/WHO, World Vision.

d. Any other (Specify)

30. How much cash was provided initially by your community to form the capital base of the clinic?

.....

31. Was drug supply to the clinic regular?

a. Yes

b. No

* Show how regular

32. If not, what was the problem? .....

.....

33. Was MOH supplying anything to your clinic?

a. Yes

b. No

34 a. If yes what was it?

b. On what conditions?

.....

.....

.....

35. To what extent was the MOH able to play this role?

.....

.....

36 Apart from drugs to what extent would you say your community was able to carry out the other duties it was expected to perform (refer to Que 2)

.....

.....

.....

.....

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37 Who was supervising your CHW?

a. The Community Development

b The Health Committee

c. The Health Authorities

d. Other (specify)

38. What things were checked?

a. Dispensing of drugs

b. Monies realised from drug sales

c. Utilization of monies from the Clinics

d. Any other (specify)

39. How regular was supervisory

.....

.....

40. Was any checklist used during supervisory visits

a. Yes

b. No

c. Don't know

d. Other

41. What were the terms of reference for the CHW?

a. .....

b. .....

c. .....

42. Who made these rules?

a. The town/village Committee

b. The Health Authorities

c. Other

43. Who was to enforce these rules?

    a. The Community Committee

    b. The Health Authorities

    c. Other

44. To what extent was the body or person named above able to enforce the laws or rules?

    a. .....

    b. .....

45. Was there a case where the CHW disobeyed the rules?

    a. Yes

    b. No

46. If yes, what happened when the CHW disobeyed?

    a. .....

    b. .....

47. Was the CHW paid

    a. Yes

    b. No

48. If yes, in what form?

    .....

    .....

    .....

49. If payment was in cash, how much?

    .....

50. Was payment regular?

    a. Yes

    b. No

.../181

51. If no, what was the reason?

    a. .....

    b. .....

52. What do you think was the main cause of the collapse of your Clinic?

    a. .....

    b. .....

* WHERE CLINIC IS FUNCTIONING

53. When was your clinic established

    .....

54. Who provided the place of work

    a. The Community

    b. The Health Authorities

    c. UNICEF/WHO

    d. Any other (please specify)

55. Who was to supply drugs to the clinic

    a. The Community

    b. Ministry of Health

    c. The programme planners (UNICEF/WHO)

56. Who has been suppling drugs to the clinic

    a. The Community

    b. The Ministry of Health

    c. UNICEF/WHO

    d. Any other (please specify)

.../182

57. How regular do you re-stock drugs

    a. .....

    b. .....

    c. .....

58. Who supplies drugs to the CHW

    a. .....

    b. .....

    c. .....

59. How much was given to him initially

    a. .....

    b. .....

60. If drug supply has been irregular what do you think is the cause

    a. Lack of funds

    b. Lack of supervision

    c. Shortage of drugs

    d. Any other factor (please specify)

61. When does your clinic open

DAYS	MORNING	AFTERNOON	EVENING
Monday			
Tuesday			
Wednesday			
Thursday			
Saturday			
Sunday			

.../183

62. What assignments are performed at the Clinic by your CHW?

    a. Treatment of sick people

    b. Education on Family Planning

    c. Education on Nutrition

    d. Any other (please specify)

63. What activities are performed by the CHW outside the Clinic

    a. Health Education (Family Planning and Environmental Sanitation)

    b. Immunization

    c. Organization of Communal Labour

    d. Any other (please specify)

64. How often are these activities carried out

    a. Weekly

    b. Once every month

    c. Once a year

    d. Any other (Specify)

65. Are there any other duties (Activities) you would have wished that the CHW performs but which he does not?

    a. Yes

    b. No

66. If yes, which activities

    a. Injection

    b. Admit people for few hours/days

    c. Be allowed to summon people for unhygienic conditions

    d. Any other (please specify)

.../184

67. How does the non-performance of such a task affect the functions of the CHW?

    a. .....

    b. .....

    c. .....

    d. .....

68. Who supervises your CHW

    a. .....

    b. .....

    c. .....

69. What are checked

    a. .....

    b. .....

    c. .....

70. If it is the MOH, how is this carried out?

    a. .....

    b. .....

    c. .....

71. What rules and regulations are there for the CHW to follow

    a. .....

    b. .....

    c. .....

72. Who made these rules and regulations for the CHW

    a. The Community

    b. The Health Authorities

    c. Both the Community and the Health Authorities

    d. Any other person or body (please specify)

73. Who enforces these rules

    a. the Community

    b. the Health Authorities

    c. Both the Health Authorities and the Community

    d. Any other person or body (please specify)

74. How are the rules and regulations applied

    a. .....

    b. .....

    c. .....

75. To what extent are they applied

    a. .....

    b. .....

    c. .....

76. Has any incidence ever occurred where the CHW failed to obey the rules and regulations laid down for him/her

    a. Yes

    b. No

77. If yes, what was the case

    a. .....

    b. .....

    c. .....

78. What was the sanction

    a. .....

    b. .....

    c. .....

79. What are the main contribution(s) of your Community to the CHW

a. Provision of money to purchase drugs

b. Payment of the CHW

c. Provision of place of work

d. Any other (please specify)

80. How regular has such contributions been

a. .....

b. .....

c. .....

81. If not regular, what is the case

a. Lack of interest in the CHW programme

b. Unwillingness of community members to pay their taxes

c. Misappropriation of funds

d. Any other factor (please specify)

REMUNERATION

82. In what form is your CHW rewarded

a. In Cash

b. In Kind

c. Both cash and in kind

d. Any other form (please specify)

83. If in kind, what from does it take

a. .....

b. .....

c. .....

84. How regular has this been

a. .....

b. .....

c. .....

85. If not regular, what is the cause

a. .....

b. .....

c. .....

86. Who is to see to it that this is done

a. The Health Committee

b. The town/village Development Committee

c. The Health Authorities

d. Any other (specify)

87 If reward is in cash, how much (eg per month)

.....

88. Who is to pay this

a. The Community

b. The Health

c. UNICEF/WHO

d. Any other person or body (specify)

89. Has payment been regular

a. Yes

b. No

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90. If no, what is the cause

a. Lack of funds

b. Misappropriation of funds

c. Low rate of charging people

d. Any other reason (specify)

91. Do you find the system of reward to be adequate

a. Yes

b. No

* Comment on your view

.....

92. If not, what do you thing should be done

a. .....

b. .....

c. .....

93. Does your CHW receive any other reward apart from the ones mentioned above

a. Yes

b. No

94. If yes:

a. From Who.....

b. What is the reward? .....

c. How regular?.....

d. How appropriate?.....

95. Which other places do people from your community go for treatment instead of the CHW

    a. The traditional healers

    b. A private clinic

    c. Drug sellers (including Chemical Stores, drug peddlers etc

    d. Any other places (Specify)

96. Which of these sources do you think people visit the more

    a. The traditional healers

    b. Private Clinic

    c. Drug Sellers

    d. Any other place(s)

97. Why do you think people go to such a place for treatment

    a. .....

    b. .....

    c. .....

98. How does this affect your CHW

    a. .....

    b. .....

    c. .....

IMPRESSION(S)

99. What do you think are the main factors sustaining the interest of your CHW and keeping him/her in business

    a. .....

    b. .....

    c. .....

    d. .....

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100. Do you consider the performance of your CHW to be encouraging

a. Yes

b. No

101. If yes, what are the main factors behind such an encouraging performance

a. .....

b. .....

c. .....

102. If not encouraging, what are the main factors

a. .....

b. .....

c. .....

SUGGESTIONS:

103. How best do you think the performance of your CHW can be strengthened

a. .....

b. .....

c. .....

104. How best do you think CHWs programme should be organised within this district to make them more functional

a. .....

b. .....

c. .....

d. .....