

Enhancing Community Participation in Health Service Delivery: A Case Study of Community-Based Health Planning and Services (CHPS) Nadowli District in the Upper West Region

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Abstract

One major problem facing health service delivery in Ghana with particular reference to the implementation of the new health policy, the Community-Based Health Planning and Services (CHPS), is poor community participation. This is due to the seemingly inadequate understanding of the CHPS concept and participatory methodologies by Community Health Officers (CHOs) who are the frontline staff of the Ghana Health Service (GHS) in the implementation of the CHPS program. This study examined the knowledge of CHOs in the CHPS concept and the approaches in facilitating community engagement processes as some of the factors influencing the level of community participation in CHPS.

The study was conducted in 10 selected CHPS zones in the Nadowli district of the Upper West Region of Ghana. Three set of survey questionnaires were employed bearing in mind the objectives of the study. One set of questionnaire was administered to a sample of 18 Health staff that included CHOs and Sub district In-charges. The other questionnaires were administered to 56 CHVs/CHCs and 28 selected community opinion leaders in sampled CHPS communities.

The findings present a situation of mixed understanding of the CHPS concept and methodology by CHOs and their immediate supervisors (SDHTs) who are the vanguard in the implementation of the CHPS program .The study observed a generally low level of community involvement at the various stages of the CHPS implementation processes. This is partly attributable to the inadequate knowledge of CHOs in the CHPS concept and skills in facilitating community engagement processes. The paper further argues that heterogeneity of the CHPS communities does not pose an obstacle to participation with effective community entry and facilitation of working together processes. It concludes that to enhance community participation in CHPS, practical innovative strategies of improving CHOs' understanding of the CHPS concept, community dynamics and skills in facilitating participatory methodologies must be re-visited.

Keywords: Community, empowerment, enhancement, facilitation, *heterogeneity*, participation,

1.0 Introduction

The history of the search for policy options that promote effective citizen participation in health service delivery in Sub-Saharan Africa has been chequered and influenced by international and regional conventions and declarations. The 1978 Alma Ata Declaration on "Health for All" by the year 2000 which gave high priority to community participation was endorsed by all African Governments (WHO, 2002). According to Zakus & Lysack

(1998), this declaration formally alerted nations worldwide that physician centred care and hospital based programs were inadequate to achieve global health. Rather, attainment of good health was thought to centre on concepts with an underlying democratic vision like empowerment, health promotion and collective action. Yet at the dawn of the new millennium, accessibility to health care remained a distant dream for most households in Sub-Saharan Africa. No Sub-Saharan African country is on target toward meeting the United Nations Millennium Development Goal (MDG) of reducing childhood mortality by two thirds by 2015 and the expansion of access to comprehensive reproductive health services has also been an unfulfilled goal of many African governments (Bawah et al. 2006).

A decade after the regional commitment to the 1994 Cairo International Conference on Population and Development (ICPD) agenda, concerns are still raised about the fact that reproductive health programs in the region are not working. In Ghana, the demographic role of family planning programs remains the subject of unresolved policy debate. In the light of the above, a national experimental study was commissioned by the Navrongo Health Research Centre in 1994 to develop practical and innovative ways of attaining the ICPD goals. The Navrongo experiment developed strategies for community-based reproductive and child health services tested the impact of the strategies proposed and guided national reform based on lessons learned (Bawah et al. 2006).

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

1.1 Objectives of the study

The objectives of the study are:

1. To investigate whether CHO’s knowledge of the CHPS concept and approach in facilitating participatory methodologies have influence on the level of community participation in CHPS.
2. To investigate the level of community involvement at the various stages of CHPS implementation process and how that affects participation
3. To find out the factors that militates against effective community participation in the CHPS implementation process and how to overcome them.

1.2 An overview of the CHPS model

Ghana introduced a new Health System Reform system based on the CHPS in May 2005. The rationale of the policy reform was based on the recognition that the individual households especially mothers are the primary producers of health. Kyei et al. (2006) view CHPS as a strategy which finds its roots in the primary health care component of community participation in health care and constitute a major policy reform of the Ghana Health Service. The Community-Based Health Planning and Services (CHPS) for Akosa (2005) provide a drastic paradigm shift in the delivery of community level health services with the aim of achieving the Millennium Development Health Goals of Ghana.

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

The strategic policy of the Ghana Health Service is to have a three tier level of service provision within a district. They are the district hospital level, the sub-district (health centre) level and community-based level. The sub-districts are to be divided into zones with catchment population of 3000 to 4500 where primary health care services are provided to the population by a resident Community Health Officer (CHO) supported by Community Health Committees (CHC) and a volunteer system. The CHPS model is based on Navrongo research results demonstrating that placing a nurse in the community substantially reduces childhood mortality, and combining nurse outreach with traditional leaders and volunteer involvement enhances male participation in family planning and improves health service system accountability (CHPS policy document, 2005). The CHPS approach thus focuses on achieving three key objectives namely, to improve equity in access to basic health services, improve efficiency and responsiveness to client needs and develop effective intersectoral collaboration. Consequently, the CHPS strategy recognizes the following basic elements including the community (as a social capital), households and individuals (as targets), planning with the community (community participation) and service delivery with the community (client focused). All of the above components of CHPS underpin the centrality of community participation in the successful implementation of the new health policy.

1.3 The concept of community

Varied definitions in the literature on the term “community” suggest that it is fundamentally a fluid concept. Green & Mercer (2001) define community as a “group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings”. Kristina et al. (2006) describes community as “complex and dynamic”. In their view, conditions both within and outside the community such as existing political and economic structures that support participation or public knowledge about health conditions, affect community readiness to act. Tsouros (2009) expands on the above definition to argue that different people tend to understand the concept of community differently and this can influence community participation practice. A politician, for Tsouros, may focus on communities defined by political constituencies; an urban planner may focus on communities defined on agreed geographical boundaries; a public health physician may focus on communities of risk groups; and a member of the public may focus on a community of which he or she feels to be part, whether defined by the local neighborhood, shared use of facilities or affinity with a particular population group.

From the above definitions, a community can be said to mean different things to different people in different situations. This assertion is buttressed by Zakus & Lysack (1998) when they argue that communities are very heterogeneous entities, not only in their demographic composition, but also with respect to their interest and concerns. From their perspective, this diversity has a profound impact upon every step of the community participation process, and while there may be little disagreement about the desirability of community participation, the diversity of those groups called communities can create real problems for selection, representation and accountability of individuals.

1.4 What is Community participation?

Community or public participation in health may be defined as the process by which members of the community,

either individually or collectively and with varying levels of commitment: (a) develop the capability to assume greater responsibility for assessing their health needs and problems; (b) plan and then act to implement their solutions; (c) create and maintain organizations in support of these efforts and (d) evaluate the effects and bring about necessary adjustments in goals and programs on an ongoing basis. It is therefore a strategy that provides people with the sense that they can solve their problems through careful reflection and collective action (Zakus & Lysack, 1998). The concept is also defined by Tsouros (2002) as a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change

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

Consultation often forms an integral part of statutory urban and rural planning processes and involves people being referred to for information and asked their opinions. Although this implies that communities’ views may be taken into consideration, it does not generally mean that people are actively engaged in the decision-making process.

Involvement is a term often used synonymously with participation. It implies being included as a necessary part of something.

Empowerment is a process whereby individuals or communities gain confidence, self-esteem and power to articulate their concerns and ensure that action is taken to address them. The practice of empowerment draws inspiration from the philosophy of conscientization

Community capacity-building is development work, involving training and providing resources that strengthens the ability of community organizations and groups to build structures, systems and skills that enable them to participate and take community action

Sustainable community development is a way of working underpinned by commitment to equity, social justice, participation and empowerment that enables people to identify common concerns and that supports them in

taking action related to them. It also takes over a long period of time if not forever.

1.5 Factors influencing increased community participation in health service delivery

Community participation is gaining centrality in health decision-making and delivery systems in recent times around the world and appears to be driven by a variety of factors. Zakus & Lysack (1998) identify some of these factors to include (a) the recognition of the duty of people to participate in public and community affairs, including personal health (b) institutionalized health systems' inability to provide for all health related needs (c) recognition that planned social changes in health can only be achieved by focusing on the community as the locus of attention (d) diminished confidence in policies made solely by health experts, professionals and program managers (e) concerns about the cost associated with health services, the best use of limited resources (f) perceived untapped resources of voluntary public input to improve health services, and the belief that such input can make a positive difference and (g) rising standards of living and increasing education levels, and an awareness of this among the poor all leading to raised health expectations.

According to Qingwen Xu, (2007) the recent interest in community participation is premised on the perceived benefits that participation brings to programs in terms of added efficiency, sustainability, and collective community power. This point is carried further by Zakus & Lysack (1998) who assert that one of the benefits of community participation is its widely reputed health and social participation. They argue that health services are provided at a lower cost, and added resources can be brought into the system, in part due to greater access to fundraising opportunities and the availability of volunteers. Participation in their view brings about better determination of the need for health facilities, their location, size, the numbers and types of personnel required. It is believed that resources will be more often directed to the so-called "felt needs" of those in the community and that health activities will be carried out more appropriately when the community is given greater control. Greater local involvement is thought to decrease the feelings of alienation on the part of the community and foster less authoritative relationships between the community and health officials. All these benefits for Zakus et al are believed ultimately to have positive impact on health.

There are many recent developments in the literature which have been influential in putting community participation high on public agenda for health authorities and other agencies. Some of the best known examples of such relatively current developments include Health 21, Local Agenda 21 and Healthy Cities Initiative.

Health 21 is a revised strategy of Health for all in the 21st century advocated by the World Health Organization (WHO) in the 1978 Alma Ata Declaration on primary health care and endorsed by all 189 member states. The Health 21 policy has an overarching goal of achieving full health potential for all and includes a fundamental commitment to community participation. It identifies three basic values which form the ethical foundation for participation. These are, (i) health as a fundamental human right, (ii) equity in health and solidarity in action between countries, between groups of people within countries and between genders and (iii) participation by and accountability of individuals, groups and communities and of institutions, organizations and sectors in health development. The above values of participation are further buttressed by perspectives formed within the Ottawa Charter for Health Promotion (WHO, 2001) and the Jakarta Declaration on leading health promotion into the 21st century (WHO, 1997). Whilst the Ottawa Charter recognizes that health promotion works through concrete and

effective community action, the Jakarta Declaration reiterates the necessity to give priority to community capacity-building and individual empowerment as means of enhancing participation

Agenda 21 refers to the United Nations action program for sustainable development into the 21st century, an outcome of the UN Conference on Environment and Development in Rio de Janeiro on the 1992 Earth Summit. Central to Agenda 21 is the proposition that urban development will not be environmentally, economically, or socially sustainable without the active participation of communities. This is because many of the problems and solutions being addressed by Agenda 21 have their roots in local activities, thus the participation and cooperation of local authorities and communities are a determining factor in fulfilling its objectives. Local authorities have since the 1992 Earth summit been enjoined to undertake consultative and consensus-building processes with citizens and local organizations in formulating their own sustainable development strategies – Local Agenda 21. The principles of the Rio Declaration on Environment and Development therefore, reinforce the increased commitment of various governments to community participation, giving prominence to increased involvement of women, youth, indigenous people, nongovernmental organizations, workers and communities in decision-making and action (United Nations, 1992)

Another factor that gives impetus to community participation in health delivery in recent times is the WHO Healthy Cities Initiative. It was designed to engage communities in visioning a healthy city and taking action to achieve it. Established by the WHO Regional Office for Europe in 1986, the Healthy Cities program aimed at drawing together the principles of Health for All and the strategic guidance of the Ottawa Charter for health promotion into a framework that could be applied in the local urban context (WHO, 2001). As stated earlier, community participation is core to the Ottawa Charter for health promotion; consequently, the concept of public participation and intersectoral collaboration underpinned the Healthy Cities program throughout its implementation phases. The above international policy declarations which underscore the centrality of community participation in health care delivery have influenced national health policies and programs. The Ghana health policy for instance offers a comprehensive framework that highlights the importance of involving communities actively in identifying needs, defining priorities, taking action, evaluating programs and monitoring progress towards health and sustainable development (GHS Policy document No 20, 2005).

1.6 Levels of community participation

Community participation can operate at several different levels. Rifkin (1990) explains participation in the area of health by differentiating the various levels of participation. In the view of Rifkin, community members can participate on a minimal scale or passively in the benefits of health interventions in the form of services of education. They can participate in health interventions at the second level by supporting health facilities such as in-kind or cash contributions as well as taking up roles and responsibilities as health providers. At the third level, community members take up managerial responsibilities and decision-making on managing activities. The fourth level involves monitoring and evaluation of programs whilst the fifth level of participation offers the opportunity for community members to plan and translate their own felt needs into true grassroots development. According to Rifkin, participation at the fifth level represents higher community participation as community members actually decide the health activities they think should be undertaken and ask for assistance from health authorities or government to facilitate implementation. The ability of the community to initiate development projects on sustained basis is a demonstration of their maturity in participation.

Similarly, it is important to recognize the different degrees or levels of participation as described by Brager & Specht (1973) in their ladders or continuums. The continuum is a lengthy and dynamic process, which helps communities to take greater responsibilities for health care. Communities, according to Brager & Specht (1973) must attempt to move away from the unsustainable position of being mere recipients of services, resources and development interventions towards being active partners, or owners of the interventions. Achieving long-term self-reliance is not a single action, but an ongoing process that develops through several stages, all requiring time and resources.

1.7 Forms of participation

Pretty (1995) identifies seven forms of participation. These range from **passive participation** or tokenism where people participate by being told what is going to happen or has already happened to **self-mobilization** where people participate by taking initiatives independent of external institutions to change the system. The second form according to Pretty's typology is **participation in information giving** where people participate by answering questions posed by extractive researchers. People do not have the opportunity to influence proceedings as findings of the research are neither shared nor checked for accuracy. The third is **participation by consultation**. Under this type people participate by being consulted by external agents who listen to their views. These external agents define both problems and solutions and may modify them in the light of people's responses. Such consultative process however, does not grant any share in decision-making and professionals are not obliged to take on board people's views. The fourth type is **participation for material incentives**. Under this form, people participate by providing resources such as labour in return for food, cash, or other material incentives. Many programs on education, agriculture, environment and health fall under this category. It is very common to hear this being called participation, yet the people have no stake in prolonging activities when the incentives end. The fifth form is **functional participation** where people participate by forming groups to meet predetermined objectives related to a project which may involve the promotion of externally initiated social organization, whilst the sixth type is **interactive participation** where people participate in joint analysis which leads to action plans and the formation of new local institutions or strengthening of existing ones. From the above discussion, it can be said that the type of people who are likely to become involved in community mobilization efforts and the motives for such participation largely influence the form of participation.

1.8 Importance of community participation in health service delivery

Community participation according to WHO (1998) is a fundamental principle of both Local Agenda 21 and Healthy Cities. It is important for many reasons and offers many different benefits for individuals, communities, organizations and society at large.

From the communities and citizens perspective, participation is relevant because they have a right to be involved in decisions that affect their lives, they know more about where they live, what they want and what is best for them than outsiders, they want to be actively involved and have an influence due to the diminished confidence in policies made solely by health experts, professionals and politicians. Professionals working in health authorities and other organizations also advance range of arguments to the effect that;

- Community participation can help target resources more effectively and efficiently.

- Involving people in planning and delivering services allows them to become more responsive to need and therefore increase uptake.
- Community participation methods can help develop skills and build competencies and capacities within communities.
- Involving communities in decision-making leads to better decisions being made, which are more appropriate and more sustainable because they are owned by the people themselves.
- Community participation is a way of extending the democratic process of opening up governance and of redressing inequality in power.
- Community participation offers new opportunities for creative thinking and innovative planning and development.

In sum, community participation from the view point of citizens and professionals provide a convincing argument for giving it priority as an active two-way process that can be initiated and sustained by communities and health authorities. It can increase democracy, empower people, mobilize resources and energy, develop holistic and integrated approaches, achieve better decisions and more effective services and ensure the ownership and sustainability of programs.

1.9 Obstacles to community participation in health

The apparent gap between the promise of enhanced participation on one hand, and the everyday realities of participatory health delivery processes on the other, suggest the need to understand more fully the obstacles and dynamics to participation in health service delivery. Zakus & Lysack (1998) present a real problem to facilitators of community-based health programs. According to them, the manner in which community participation is expressed varies considerably with the context in which it is implemented. This makes comparison of projects and their evaluations highly problematic. A related difficulty in their opinion is determining the unique contribution of community participation to improvements in health. For Zakus & Lysack (1998) disaggregating the effects of local participation from other effects is a complicated procedure.

Secondly, community participation has proven difficult not only to define but also to practically initiate and sustain. This is due to the fact that health initiatives reliant on public participation often place additional burden on the already disadvantaged individuals and groups. There are important costs involved in participatory activities including personal cost expenditures, training cost and information compilation and dissemination cost. Unless these are taken into account, only the most privileged segments of society will participate, thereby excluding lower income citizens (Zakus & Lysack, 1998).

Related to the above point is the compelling case made by the United Nations (1981) that people in rural communities in economically “backward state” are unlikely to participate in mobilization efforts because, to some extent, it is difficult to arouse the poor from their apathy and indifference to development issues. This rather paradoxical statement has been supported by the findings of Stone (1986) which state that the poor and disadvantaged may have little interest in being involved in participatory processes and instead prefer professional handling of community health matters because they are used to being bypassed or at most condescendingly solicited and then ignored. According to UN (1976) and WHO/UNICEF (1971), several

international organizations that have initiated and implemented community-based projects in which poor people were motivated to get involved in efforts to establish squatter settlements and improve their living conditions, have found through program evaluation to have short life span or required considerable external assistance to survive. Thus, insufficient financial resources at the local levels constitute a critical barrier to community participation in health.

Another obstacle to community participation in health service delivery according to Zakus & Lysack, (1998) is the fear harbored by community members that participation may provide an excuse for government to eliminate the local health centers and reduce funding for public health activities. Others fear that any gains made through community participation approach work against their larger purpose of advocating to the national government to increase both the quantity and quality of government health care.

Fourthly, the UNDP/World Bank/WHO study group on Onchocerciasis identifies the lack of understanding of participatory processes by health workers and managers as barriers to effective community participation. As progress is made from lower to higher levels of participation (information, consultation, decision-making and managerial), participatory processes become more complex and demand different types of skills, knowledge, and experience and leadership capabilities. Several studies reviewed identify the problem of weak participatory skills at different levels of participation. Zakus & Lysack (1998) recommend an investment in the training of new members of community organizations in the domains of health planning and other managerial tasks. According to them, competency in community organization, problem solving, priority setting, health information collection and analysis, health intervention planning and delivery and finally program evaluation are required for enhancing community participation. The individuals, who participate, for Zakus & Lysack, also require on-going education and support.

The fifth obstacle relates to the nature of communities. Communities in the view of Zakus & Lysack are very heterogeneous entities in their demographic composition, interest and concerns. The lack of homogeneity creates a problem in locating health facilities and determining the legitimate representatives of the community in the process of selecting individuals to constitute community health boards. Zakus & Lysack further argue that those individuals who have the energy, time and motivation to become involved in program activities may not be in fact supported by the general public and instead be considered as elites. Where this is the case the dominant minority may dictate the health agenda with little or no meaningful input from those targeted for the community-based health intervention. Many segments of the population can also be isolated from mainstream political and social structures including the organizational structures of the health system; hence some groups within the so called community will find it hard to break into the system. This has been observed in the disability context where negative attitudes toward people with disabilities, low levels of education and other historical biases have prevented disabled people from participating and holding substantial political power. The critical issue for advocates of community participation is to examine more carefully who it is that is included in the community (and thus community participation) and who is not. Laverack & Wallerstein (2001) however, indicate that heterogeneous groups and individuals can actually become more of a “community” through the process of program planning to the extent that program aims and objectives reflect in part shared interest and needs of heterogeneous members. Individual, family or clan-based differences may then give way to cooperation as program participants create community identity around the tightly focused program objectives.

Additionally, Wallerstein (1992) observes that the conceptualization of community empowerment and participation in health leaves much to be desired. Wallerstein asks questions such as, who exactly is empowered:

the community or individuals? Does empowerment mean that some individuals or groups gain at the expense of others? There is the question of whether communities have the interest and capacity to contribute to community participation. Is it not possible that other priorities displace health on the community's agenda? Do the structures and traditions of the formal health system not often present obstacles to meaningful involvement in health promotion activities? Empowerment and health promotion efforts have been criticized for failing to adequately address equity and social justice concerns. Riger (1993) further argues that health promotion and empowerment strategies emphasize on the acquisition of new skills in advocacy and social activism which encourage autonomy and conflict. But the essence of community is cooperation, communion and connectedness. Thus situations which foster assertive self-determination (health promotion and empowerment) may work contrary to those which promote community cohesion and participation.

Furthermore, Zakus & Lysack (1998) have identified an obstacle which may be disturbing to advocates of community empowerment, health promotion and community participation. This has to do with the dilemma of seeking to facilitate enhancement in the health of disadvantaged groups without diminishing their inherent right to self-determination. Many community-based health projects are confronted with this dilemma. Zakus & Lysack argue that while control by powerful interests is not the ideal for community participation, there are occasions when supports are crucial. Citing experiences in Mexico, they have shown that government financial support to fledgling community organizations and official recognition of these groups is essential in legitimizing and enhancing citizen participation.

Finally, Network for Sustainable Development-NSD (2008) a local NGO implementing the community mobilization component of GHS/JICA project on Community Based Health Planning and Services (CHPS) in the Upper West Region of Ghana reported that inadequate knowledge and understanding of the CHPS concept by beneficiary communities constitute a daunting challenge to effective community mobilization and participation in the CHPS program. According to the reports, community members consider the CHPS facility a clinic and they expect the CHO to be stationary at the CHPS compound and provide treatment to patients. This is contrary to the objectives of the CHPS concept. Community members also do not understand why they should support the Community Health Volunteers (CHVs) on their farms because they are members of the community and also benefit from the Health facility. They feel offended and wrongly think that the Community Health Officers (CHOs) are spying on them when they go on home visits to give them education on hygiene and preventive care. These misunderstandings in the view of NSD are due to fact that community members are not adequately sensitized on the CHPS concept at the initial stages of the program to enable them properly understand their roles and responsibilities

In sum, Qingwen Xu, (2007) observes that various personal characteristics such as gender, educational and income levels, occupation, ethnicity, living arrangements and membership of certain types of groups constitute critical distinguishing factors of people who participate in community affairs from those who remained uninvolved.

The obstacles to community participation include power relations between community actors and local health authorities, the competency level of health workers in facilitating participatory approaches, fears harbored by citizens of possible decrease in government support should they involve deeply in health services delivery, the negative conceptualization of community empowerment and participation in health promotion and finally inadequate knowledge and understanding by beneficiary community members of the health program being implemented in partnership with them.

1.10 Enhancing community participation in health

The concept of “enhancement” in this study refers to “strengthening” or “improving” community participation in health service delivery system. The World Bank learning group on participation defined participation as a process through which stakeholders influence and share control over development initiatives and other decisions and resources which affect them (World Bank, 1995). From this perspective, participation is seen in the level of consultation or decision-making in all phases of a project from needs assessment to appraisal, implementation, monitoring and evaluation. This conception of participation represents an ideal form of participation which can be located at the highest level in Brager & Specht ladder of participation at which every organization aspires.

In reality however, community participation in health service delivery is still a mere tokenism. Zakus & Lysack (1998) attribute this to the tendency of health authorities to set the health agenda for the communities by selecting the programs requiring participation and the cost of participation in terms of time and resources. Akosa (2005) asserts that there is no community participation in health decision making. He calls for a drastic paradigm shift in the provision of service within the health sector in order for Ghana to achieve its health Millennium Development Goals. These amply demonstrate the need to explore more innovative strategies of enhancing or improving community participation in health service delivery.

1.11 Methods of community participation

Community participation methodologies refer to the various techniques and approaches employed to elicit citizens’ involvement in the community development activities and decision-making processes. Many techniques and methods have been developed to enhance high degrees of community participation within work related to the Local Agenda 21 and Healthy Cities. These methods and techniques are categorized according to the action planning model comprising of five stages: assessing needs and assets, agreeing on a vision, generating ideas and plans for action, enabling action and monitoring and evaluating (WHO, 2002). At the needs and assets assessment stage techniques such as community profiles and appraisals, community mapping and rapid participatory appraisals are recommended. Guided visualization is employed at the second stage of agreeing on a vision. The third stage which is generating ideas and plans for action use techniques like modeling and simulation. Community network and story-dialogue methods are used at the fourth and fifth stages respectively which include enabling action and monitoring and evaluating.

The USAID/GAIT project ‘Citizen Participation in Local Government’ training manual (2003) identifies and uses some innovative techniques for enhancing citizen participation in local governance which are also relevant to health promotion. They are Lafi Raga (that is, health services in the market), Town Meetings (TMs) and Question & Answer Meetings (QAMs)

Lafi Raga is an innovative approach to reach out to patients and potential ones with medical care and information as they go about their trading activities on regular village market days. The Cooperative League of USA (CLUSA) has used this methodology in West African countries including Ghana, Burkina Fasso and Benin with resounding success. The Lafi Raga concept is based on the fact that many rural folk do not visit the health care providers/clinics as a result of economic pressures. They keep on postponing their visit to the health center in favor of their economic activities and by the time they get there their health situations are diagnosed to be

beyond help. Besides, the regular weekly or bi-weekly market in most rural communities in Ghana is not only an economic event but also a major social event for the exchange of farm related information, social gossip and interaction. It is usually an occasion where the rural folks visit the “town” to experience new life through the information grapevine. Therefore since participation in health service delivery requires that information gets to the community through education and effective communication, the Lafi Raga approach ensures that health information and education are disseminated to a large and mobile audience for it to be carried to places beyond the confines of the market place.

Town hall meetings are gathering of stakeholders in a particular community with the same interest to deliberate on issues hindering their health and development with the view to finding solutions to them. The main objectives of a town hall meeting are to provide a platform for citizens to see, know and interact with their public health officials, provide an opportunity for health officials to know at first hand some of the problems bothering the community, enable clarification on topical issues of common interests and to afford citizens the opportunity to be heard. The features of town hall meetings include the involvement of the whole community, it is non-partisan, non-religious and non-sectarian in nature, devoid of personal attacks; public officials are not under compulsion to answer all questions on the spot and it encourages suggestions and proposals for improvements. The town hall meetings are therefore effective methods of ensuring broad based participation in community health decision-making processes.

Question and Answer meetings are forums organized to bring public officials face to face with citizens to answer questions on specific issues related to their stewardship. For instance managers of the National Health Insurance Scheme (NHIS), utility providers, and local government officials provide answers to pertinent issues raised by citizens relating to their services at a community platform. A distinguishing feature of Question and Answer meetings is that specific departments are invited, ideally 2 to 3 at a time, to ensure exhaustive deliberation of the issues.

2.0 Research methodology

This research is an explorative and descriptive study of how the level of community participation in the CHPS program can be influenced by the CHOs’ understanding of the CHPS concept and approaches in facilitating community engagement process. The survey used a cross-sectional design approach in which data was sought from a research questionnaire conceived on a typical CHPS implementation processes. A total of 102 sample units constituted the sample size. The breakdown is as follows; 28 CHC members, 28 CHVs, 28 selected community opinion leaders and 18 health staff which included 10 CHOs and 8 SDHT In-charges. This approach allowed the use of the CHPS implementation processes as the logical frame for the investigation of the level of community participation at the various stages of the CHPS program using the CHOs, SDHT In-charges, CHVs, CHCs and selected community opinion leaders as units of analysis.

2.1 Research Location

The study was conducted in the Nadowli district of the Upper West Region of Ghana. The district covers a total land area of 2,742.50km² with about twenty (20) main towns. Nadowli district has a population of 82,716 (2000 population and housing census), of which 43,341 are women representing 52%. The district has localities with population size of about 2000 implying that the district is a typical rural one. There are three (3) main religious groups in the districts namely Christianity (59%), Islam (18%) and Traditional religion (23%). The seemingly

homogeneous nature of the ethnic and religious groupings of the population presents a great potential for the dissemination of information, education and mobilization of resources for development in the district.

Nadowli is one of the deprived districts in the Upper West Region where absolute poverty is very prevalent. Agriculture is the mainstay of the district economy employing about 90 % of the population. The agricultural sector is however, faced with myriad of challenges such as erratic and inadequate rains, high cost of farm inputs, lack of access to farm credit, poor storage facilities resulting in post harvest losses. The above problems result in low output levels of agricultural productivity giving rise to common problems associated with poverty such as low income, malnutrition, food insecurity, migration and poor participation in health and other development activities.

Access to education is inadequate especially in the outlying rural areas of the district. About 35% of the district population cannot have access to primary education within 4-5km distance; the effect of the above is prevalence of high illiteracy levels within the district which influences citizens' level of understanding on issues and participation in the district decision-making processes.

In the health sector, the DHMT collaborates with SDHTs and CHPS zones to implement and manage national and regional health policies in the district. The district health administration also works with relevant stakeholders such as the District Assembly and NGOs to ensure participation and maximum utilization of resources in the delivery of health services. With regard to health facilities, available District Health records indicated that there are two hospitals in the district. The District Hospital and a private one (Ahmadiyya Moslem Hospital) located in Nadowli, the district capital, and Kaleo respectively. There are thirteen (13) Sub district health centres and fourteen (14) Community-based Health Planning and Services (CHPS) zones. Even though the average distance to a health facility in the district according to district health reports has reduced from 16km to about 9km, this still lags behind the national target of 5km maximum distance in accessing health services. Access to health service in the district is challenged by inadequate patient and staff accommodation to meet current demands as well as inadequate nurses with limited capacity. In addition, the district has 2 Cuban doctors who are not permanent, 1 psychiatric nurse, 1 Public Health nurse, 1 medical assistant, 1 pharmacist, 12 midwives, 25 Community Health Officers (CHOs), 65 Community Health Nurses, 6 State Registered Nurses and 60 Health Extension Workers. Furthermore, the district has 167 Community Health Surveillance Volunteers (CHSVs), 371 Community Based Agents (CBAs), 86 Growth promoters, 70 Community Health Committee members and 159 trained Traditional Birth Attendants (TBAs) providing support services in health delivery at the community level. The disease pattern in the district reflects the national trend of disease prevalence with malaria taking the first position of the top ten causes of OPD attendance (District Health reports, 2009).

3.0 Findings and analysis

3.1 Knowledge of CHOs and SDHT In-charges of the CHPS concept.

One of the objectives of the study was to find out whether CHOs who are the frontline staff of Ghana Health service in the implementation of the CHPS program and their immediate supervisors at the Sub-district level have good understanding of the CHPS concept and how that could influence community participation. Ten CHO-knowledge testing statements extracted from the CHPS policy document were considered in this section. Respondents were asked to indicate their level of agreement as "strongly disagree" which was scored 1, disagree =2, uncertain= 3, agree= 4 and strongly agree= 5.

Table 1 shows the statements and the percentage distribution of the respondents' level of agreement or disagreement with these statements. Items 1-7 are statements which are true of the CHPS concept therefore responses on "strongly disagree", "disagree" and "uncertain" depict poor understanding of the concept whilst "agree" and "strongly agree" responses demonstrate good understanding of the concept. Items 8-10 on the other hand are false statements about CHPS thus respondents who indicated their agreement or uncertainty about them demonstrated poor understanding whilst those who disagreed with them showed good understanding of the concept. The table below distributes CHOs and SDHT In-charges according to their agreement or disagreement with statements about the concept of CHPS.

In the table 1 the statement whether "CHPS is "close-to-client" service delivery system" constitutes a basic definitional element of CHPS (CHPS policy document, 2005). In response to this statement 33% and 61% of CHOs and SDHT In-charges collectively agreed or strongly agreed with it representing 94% endorsement of the statement which constitutes good understanding of the concept. One (1) CHO representing 6% however disagreed with the statement which portrayed poor understanding of the CHPS concept.

Secondly, the statements that "CHPS recognizes the households as primary producers of health" and "Planning with the community (community participation)" received 100% agreement. However, the statement that the CHPS implementation process recognizes the community as social capital received mixed responses. Social capital according to Putnam (2000) refers to the collective value of all "social networks". That is who people know and the inclination that arise from these networks to do things for each other [the norms of social reciprocity]. This is a fundamental concept in the social mobilization processes of CHPS. To this statement, 28% of the respondents disagreed with it demonstrating poor understanding of the concept while majority 72% agreed with the statement indicating good knowledge of the CHPS concept

Furthermore, responses to the following statement namely "service delivery is not based on the principles of primary health care (PHC)", "mobilizing community leadership" and that "CHPS operate at level C of the 3-tiered structure of health service delivery within the district" revealed poor understanding of the concept. The statement that service delivery is not based on the principles of primary health care (PHC) is a false one. In fact CHPS is basically about providing primary health care (PHC) services at the door steps of the hard-to-reach rural communities. But 72% of the respondents agreed to the false statement whilst 28% extricated themselves from the trap. Again, mobilizing community leadership in support of the CHPS program is one of the key implementation activities. However, 84% of the respondents demonstrated poor knowledge in responding to this statement by indicating their disagreement. Finally, the statement whether "CHPS operate at level C of the 3-tiered structure of health service delivery within the district" received 83% agreement from respondents. Fig.1 provides an illustration of the 3-tiered structure of health service delivery where CHPS operate at level A at the community level. The District Health Management Team (DHMT) operates at level C. The high endorsement of this statement gives the impression that the CHOs who are the frontline staff of the Ghana Health Service in the implementation of CHPS and their immediate supervisors (the Sub-district In-charges) do not clearly understand their direction within the structure in which they operate. Shared vision as the saying goes drives participation. The implication may be that there is low involvement of the frontline staff in major programmatic decision-making process within the structure of Ghana Health Service. Where there is poor internal participation within the implementing Agency, such values may be replicated at the community level by the CHOs in their engagement processes with the community members. The findings present a general picture of mixed understanding of the CHPS concept among CHOs and Sub-district In-charges in the Nadowli district which may have implications on enhancing community participation in the program.

3.2 Methods usually employed by CHOs to engage community members CHPS

The UNDP/World Bank/WHO study group on Onchocerciasis found out that lack of understanding of participatory processes by health workers and managers constitute a barrier to effective community participation. This view was buttressed by Zakus & Lysack (1998) who asserted that competency of health staff in community organization, problem solving, priority setting, health information collection and analysis, health intervention planning and delivery as well as evaluation are required for enhancing community participation. Against this backdrop, respondents were asked to mention their most frequently used approaches/methods of involving community members in the CHPS processes.

The data analyzed revealed that “durbars” 33% and “community meetings” 33% are commonly used methods by CHOs and Sub-district In-charges in facilitating community participation in CHPS. It was also observed that, home visits” 11% “, Antenatal clinic (ANC) sessions”6% and education during Child Welfare Canters (CWCs) 11% are methods which mostly target women and empower them to take active part in community health promotion activities are employed by majority of the respondents. It is however, pertinent to note that women in the Nadowli district are culturally not major house hold and community decision makers. Therefore, if about half of the activities for eliciting participation are targeted at women, this may have implications on participation in CHPS.

3.3 Level of community participation in CHPS decision-making processes

The level of community participation in the CHPS implementation processes was investigated. Community Health Volunteers (CHVs) and Community Health Committees (CHCs) and community opinion leaders were asked to indicate their level of participation in these processes from “1” (never), “2” (sometimes) and “3” (always) on a 3-point Likert-type scale for ten cases. Besides, the CHVs, CHC and community opinion leaders were asked to indicate their understanding of who takes decisions on the CHPS implementation activities. This approach allowed for cross-examination of responses in the analysis to ascertain the level of involvement of community members in the CHPS decision-making and implementation processes.

In responding to the statement that beneficiary CHPS communities “participate in deciding whether CHPS is a priority need of the area”, 11% respondents said that community members never took part in such decisions, 32% indicated that they participated in the discussions and arrived at a collective decision on CHPS as their priority choice. Majority 57% of the respondents indicated that their participation in such decision-making process is not regular. When respondents were asked about “who takes the decision on CHPS as the priority development need of the community”, 35% indicated that the process is usually a collaborative effort between the health authorities and the community members. Majority 48% of the respondents however, added that the decision-making process involves the entire CHPS communities. The seemingly low level of community participation in CHPS in the Nadowli District reflects ground reality. Community members hardly identify health as a priority issue and invest time and money for quality health service. More importantly, this situation is exacerbated by the adverse impacts of the changing climate which make food security a top most priority of the people. In discussing about factors affecting community participation in health Wallerstein (1992) asked whether it is not possible for other priorities of the community to displace health on the community’s agenda. This implies that if health is identified by the community members as their priority need, the level of community participation in CHPS activities is likely to be high. But the findings indicate that 57% of community members do not regularly participate in the community needs prioritization processes. Beside, Health authorities do not

provide innovative alternatives or complementary development initiatives to CHPS such as facilitating linkages of community health actors such as CHCs, mother-to mother support groups to micro-financial institutions to enhance livelihood and incomes for improved health access. Consequently, CHPS becomes a need identified by the health authorities and imposed on the beneficiary communities which has serious implications on participation.

Secondly, respondents were also asked whether all the beneficiary CHPS communities in the CHPS zone are represented at forums that discuss and build consensus regarding the location of the CHPS compound. To this, 11% of the respondents indicated none involvement, 57% indicated that sometimes all the communities are represented at the discussions and 32% indicated that all the CHPS communities always take part in deciding on the site of the CHPS facility. Again, in response to the question “who takes the decision on where the CHPS compound should be located?” 48% and 36% of the respondents indicated that the entire CHPS community and both the community and Health authorities respectively usually decide on the location of the CHPS compound. 12% did not know who take such decisions and 4% said that only the Health authorities decide on where the CHPS compound should be sited. The CHPS compound for a zone is jointly owned and supported by all the beneficiary cluster communities who may all be interested in having the CHPS facility located in their individual communities. The process of locating the CHPS facility could sow a seed of disunity and rivalry among hitherto cordial neighboring communities. This means that to enhance community participation in the CHPS activities an effective dialogue and consensus building among all the beneficiary CHPS communities regarding the location of the CHPS facility must be facilitated to arrive at terms acceptable to all. The findings suggest that participation of the CHPS communities in deciding on the site of the CHPS facility is fairly good. This implies that there may be quite a good number of communities who harbor the feeling of marginalization in determining the site of their CHPS compound and that is likely to adversely affect their participation in the CHPS activities.

Furthermore, the participation of beneficiary CHPS community members in developing budget estimates for the construction of the CHPS compound was examined. Nearly all 98% the respondents indicated that the community members do not take part in budgetary decisions regarding the construction of the CHPS compound. 1% of the respondents indicated that community members sometimes take part whilst another 1% said that community members always take part in developing budget estimates for the building of CHPS compounds. The results give an indication that beneficiary CHPS communities are not involved in determining the budgets for building the CHPS facilities. These findings agree with Zakus & Lysack (1998) who found out that the difficulty in initiating and sustaining community participation lies in the tendency of health authorities to set the health agenda for the communities by selecting the programs requiring participation. Participatory development process requires the total involvement of stakeholders at all stages of the project life cycle. The community members see themselves actually partnering with the health authorities in the CHPS activities if they as well take part in the financial decisions and the provision of communal labor in the building of the CHPS compounds. This process gives the community people a clear picture of what role to play in the CHPS program implementation and motivates them to commit resources to the program hence, enhancing participation, ownership and sustainability.

3.4 Obstacles to effective community participation in CHPS

Respondents (community members and health officials) were asked to indicate the extent to which they agreed or disagreed with statements in their opinion on factors that are perceived to have adverse effects on community participation in CHPS processes. These results are displayed on table 4.0 and 4.1. Responding to the statement whether “Inadequate consultation of community members in the process of demarcating a CHPS zone”

constitutes an obstacle to participation, majority, 33% of health officials strongly agree while majority 37% of community members disagrees. Whilst the health staffs think their inability to adequately consult with community members in the CHPS processes might hinder participation, the results from the community members suggest that such consultative processes have no impact on their decision to participate in the program or not. These findings agree with Stone (1986) who argued that the poor and disadvantaged may have little interest in being involved in participatory processes and instead prefer professional handling of community health matters because they are used to being bypassed or at most condescendingly solicited and then ignored. This means that health authorities' consultative processes with CHPS beneficiary communities must be seen as genuine and sustainable and not just mere tokenism.

Secondly, in response to the statement whether "Participating in CHPS is burdensome and inconveniencing in terms of time and resources" hence constitute an obstacle, 72% of health staff and 75% of CHVs/CHC and community opinion leaders agreed. In other words the health authorities appreciate the fact that rural community members sacrifice a lot of their time and resources in order to support and sustain CHPS hence any attempt to overstretch them will result in noninvolvement. The study agrees with the findings of Zakus & Lysack (1998) that community participation has proven difficult to practically initiate and sustain due to the fact that health initiatives reliant on public participation often place additional burden on the already disadvantaged individuals and groups and unless these are taken into account, only the most privileged segments of society will participate, thereby excluding lower income citizens. This implies that community members are unlikely to participate in CHPS activities unless Government considers any additional burden CHPS places on beneficiary communities who are invariably the disadvantaged in society.

Thirdly, the statement whether "Negative attitude and disrespectful behaviors of some health workers towards community members" as an obstacle to community participation in CHPS was examined. To this, 56% of health staff and 43% of community members agreed. On the flip side of the coin, 38% and 46% of health staff and community members respectively disagreed with the statement. This means that while health staffs think their negative attitudes and behaviors towards community members may affect the morale of community members hence their low participation in health activities, community members on the contrary disregard such attitudes and behaviors of health staff as concerns serious enough to hinder their participation in CHPS.

As regards the statement whether "Heterogeneity of the CHPS communities" affects community participation in CHPS activities minority 22% of the health staff (CHOs and SDHT In-charges) disagreed whilst majority 50% of them agreed with the statement. In response to the same statement majority 67% of the CHVs, CHC and community opinion leaders disagreed and 28% agreed with the statement. In other words whilst the CHPS communities see themselves as homogenous people with similar beliefs system, values, cultural practices and common development interest, the health staff seem to consider them as different entities with competing interest. The findings suggest that the health staff (CHOs and Sub district In-charges) may not have adequate understanding of the concept of "community" which is critical for effective community mobilization for CHPS. The findings disagree with the view of Zakus & Lysack (1998) that lack of homogeneity creates a problem in locating health facilities and determining the legitimate representatives of the community in the process of selecting individuals to constitute community health boards. The results above further underscores the value of dialogue and promotion of working together processes during the initiation of new CHPS zones for the beneficiary communities. This means that the CHPS communities must be oriented through facilitation processes at the CHPS inception phase to agree to work together. They must also be supported to identify health as a common interest and development priority which they desire to collectively achieve. In these circumstances

heterogeneity of the CHPS communities may not constitute an obstacle to participation.

Furthermore, majority 72% of the health staff agreed with the statement that “Uncooperative and difficult nature of community members” constitute an obstacle to enhancing community participation in CHPS. While 22% disagreed. The uncooperative posture of community members has implications. This could be attributed to the CHOs inadequate skill in facilitating community engagement processes that are in tune with the socio-cultural context of the people. Besides, the non-involvement of community members in the budgetary decisions for the construction of the CHPS compounds may raise issues of transparency, mistrust and lack of community interest in the CHPS activities. Additionally, the data indicates that stakeholder analysis which aim at harmonizing divergent community interests and addressing some anticipated fears prior to the demarcation of the CHPS zones were not conducted and sometimes beneficiary CHPS communities were also not involved in the CHPS zoning process. These poor initial community entry and engagement processes could subsequently result in non-cooperation of community members in the CHPS implementation processes. Again when respondents were asked whether “Inadequate skills and knowledge of CHVs/CHC members in CHPS processes” constitute an obstacle to community participation, majority 77% of the health staff disagreed whilst majority 64% of the CHVs/CHC and community opinion leaders agreed to the statement. In other words whilst the health staff believe that the CHVs and CHC members are adequately empowered to perform their roles and responsibilities the latter think that is not enough. This means that there is the need to conduct periodic capacity needs assessment on the CHVs and CHC members and provide them with refresher training if found to lack some skills.

The assertion that “Fears of possible reduction in government support for community health care activities” serves as an obstacle to community participation was investigated. Majority 50% of the health staff disagreed with the statement and 44% agreed with it. On the part of CHVs/CHC and community members 45% disagreed, 40% agreed and 15% was not certain. This means that the idea of possible reduction in government support for CHPS as a result of community support of the program does not constitute a serious obstacle to community participation in CHPS. Though Zakus & Lysack, (1998) have shown that community members fear to participate in health promotion activities because participation may provide an excuse for government to eliminate the local health centers and reduce funding for public health activities, this study disagreed with that view.

Furthermore, 68% of respondents indicated that “Inadequate understanding of the concept of CHPS by community members” constitutes an obstacle to participation in CHPS, 15% disagreed and 11% was not certain. Qingwen Xu, (2007) observed that personal characteristics such as gender and educational levels constitute critical distinguishing factors of people who participate in community affairs from those who remained uninvolved. Similarly, Zakus & Lysack (1998) showed that negative attitudes toward people with low levels of education have prevented them from participating and holding substantial political power. Data on the educational levels of CHVs/CHC and community members revealed that 44% received no formal education, 13% had only primary education, 38% received formal education up to middle/JSS level and 5% received secondary education. One may conclude that low levels of education among the community members affect their level of understanding the CHPS concept. This means that in order to curtail the spread of misconceptions on CHPS owing to poor understanding of the concept which in turn has adverse implications on participation, health staff will have to go an extra mile in sensitizing community members for them to grasp the concept.

In addition, a key principle in community participation is that it must result in tangible benefits (Annual report, CLUSA/GAIT II, 2005). In other words community members are motivated to participate in programs if their

participation in such programs yields results. Consequently, the level of satisfaction by community members of the services rendered under CHPS by CHOs was examined. 45% disagreed with the statement that “Unsatisfactory service delivery by health staff” constitutes an obstacle to participation, 35% agreed and 20% was uncertain. This means that other variables other than satisfactory service delivery by CHOs motivate community members to participate in CHPS activities.

Finally community members were asked to indicate their agreement or not whether “Weak support for CHPS by traditional leaders (Chiefs)” adversely affects community involvement in the CHPS activities. Again 49% of the respondents agreed with the statement, 47% disagreed and 4% was uncertain. The traditional authorities in the rural communities play pivotal role in community self-help initiatives. They are the hub of the community hence their acceptance and commitment to a course of action is likely to be supported by their subjects and the vice versa. The study found out that support in CHPS by traditional authorities in the Nadowli district is weak. This could be due to the high level of illiteracy, inadequate understanding of the CHPS concept and the difficulty in sacrificing time and community resources for CHPS. This implies that community participation in CHPS generally in the district is likely to be low.

3.5 Overcoming obstacles of community participation in CHPS

Information on actions which enhance community participation was based on documented best practices and strategies employed by NGOs and some Governmental bodies in facilitating citizen participation in public service delivery. Table 5.0 presents the distribution of respondents (Community Health Officers (CHOs) and Sub-district In-charges (SDHTs) by level of agreement with selected actions perceived to enhance community participation in CHPS whilst Table 5.1 distributes Community Health Volunteers (CHVs), Community Health Committees (CHC)s and community opinion leaders according to their agreement or disagreement on these actions.

The study revealed that almost all the respondents agreed with the actions for enhancing community participation in CHPS. However, with regard to the action whether “DHMTs should encourage and support community health initiatives rather than initiating CHPS for the communities and soliciting their cooperation” 28% of CHOs and SDHT In-charges disagreed, 11% harbored some reservations while 61% agreed with the statement. In response to the same statement, 50% of the community members disagreed with the statement, 41% agreed and 9% was not certain. The rejection of this action by community members could mean a re-affirmation of their conviction that “Fears of possible reduction in government support for community health care activities” do not pose a threat to community participation. This implies that Government for that matter DHMT can continue to play a facilitative leadership role in the provision of CHPS facilities.

4.0 Conclusion

First, the findings on the level of understanding of the CHPS concept by CHOs were mixed. Durbars and community meetings were found to be the most commonly used approaches in facilitating community participation in CHPS activities. This means that CHOs need to improve upon their understanding of the CHPS concept and acquire more skills in participatory approaches beyond durbars and community meetings.

The findings indicated a generally low level of community involvement at the various stages of the CHPS implementation processes. Key activities such as setting the communities health priorities, demarcation of the

CHPS zones, determining of budget estimates for the construction of the CHPS compounds received poor participation by beneficiary communities. The level of community participation in the CHPS process matches neatly with Pretty's (1995) passive form of participation where people participate by being told what is going to happen or has already happened. This means that community members depend largely on health staff for information and major decisions affecting CHPS in their zones.

Finally, the findings indicated that heterogeneity of the communities does not constitute an obstacle to community participation especially in the case of Nadowli district which is fairly homogeneous in socio-demographic composition. The study disagreed with the view of Zakus & Lysack that lack of homogeneity creates a problem in locating health facilities and determining the legitimate representatives of the community in the process of selecting individuals to constitute community health boards and hence may impair participation.

5.0 Recommendation

Based on the literature reviewed and the findings of the study the following recommendations are made for enhancing the implementation of CHPS.

1. For better understanding of the CHPS concept by CHOs, periodic refresher training should be organized for existing CHOs in the system as an interim measure. In the long term however, a review of the Community Health Nursing training curriculum is recommended to include topics on the concept of CHPS and participatory approaches.
2. Participatory development takes place at all stages of a project life cycle. Besides, effective citizen participation revolves on the wheels of transparency and accountability. In the light of the above it is recommended that all beneficiary CHPS communities be genuinely involved in all the processes right from initiation to the launch of the CHPS facility. Also, since the community members provide support system for the CHO, CHVs the CHPS compound security to facilitate their work it is recommended that these community level actors periodically organize community feedback sessions to account to community members of their performance to justify the community's continuous support and participation in CHPS activities.
3. One major obstacle to community participation in CHPS identified by the study was the additional burden the program places on the already poor and disadvantaged beneficiaries. It is recommended for Government to review the CHPS policy to lighten the level of burden of the community members so as to sustain their interest and enhance participation in the CHPS program.
4. Periodic refresher training is recommended for CHVs and CHCs who assist the CHOs in their work. Also the community members should continuously be sensitized on the concept of CHPS using varying participatory methodologies and
5. Ghana Health Service (GHS) should create Community Participation Units (CPUs) at the District Health Management Teams (DHMTs) or re-train all district CHPS Coordinators as community participation experts to effectively provide the needed backstopping to CHOs.
6. The house hold and community health agendas are being displaced by economic realities. Community members hardly get good yield from their agricultural activities. Agricultural infrastructure such as irrigation

dams, road network to market centres, access to agro-inputs and micro finances become the priority issues in the community development agenda. Community Health Officers (CHOs) should thus, become more innovative in their health promotion strategies by introducing micro-financing packages such as Village Savings and Loan Associations (VSLAs) to CHVs/CHCs and mother-to-mother support groups. These will not only constitute a sustainable support system for the community health actors but also platforms for community health education.

7. Even though women are seemingly more responsive to household health issues, care should be taken to avoid over-targeting them for community health promotion activities in patriarchal settlements as found in the Nadowli district. The use of citizen engagement methods such as CHO home visits, Antenatal Care (ANC), Child Wealth Centres (CWCs), and mother-to-mother support meetings are seen to be more women-centred. Engaging with father-to-father support groups in CHPS promotion will lead to the emergence of male gender champions who can advocate and break the cultural barriers that impede women's full participation in household and community health decision making.

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Table1: Distribution of CHOs and SDHT In-charges by agreement or disagreement with statement about the concept of CHPS

Statements about the concept of CHPS		CHOs and Sub-district In-charges perceived level of understanding of the CHPS concept				
		Strongly disagree	Disagree	Uncertain	agree	Strongly agree
		%	%	%	%	%
1	It is “close-to-client” service delivery system	-	6	-	33	61
2	It recognizes the households as primary producers of health	-	-	-	56	44
3	It recognizes the community as social capital	6	11	11	44	28
4	Planning with the community (community participation)	-	-	-	33	67
5	Service delivery with the community (client focused)	-	6	-	39	56
6	Mobilizing community leadership	6	22	56	16	-
7	It is an innovative strategy of delivering PHC services to community members	6	-	-	56	39
8	Service delivery is not based on the principles of primary health care (PHC)	5	39	28	11	17
9	The selection and incentives for the CHVs are under the direct control of the CHO	28	28	11	27	5
10	CHPS operate at level C of the 3-tiered structure of health service delivery within the district	6	11	28	33	22

Source: Survey Data, 2009

Table 2: Distribution of respondents (CHVs, CHCs and Community members) by level of participation in the CHPS implementation processes.

Participation in decision making in the CHPS implementation processes		Never		Sometimes		Always	
		F	%	F	%	F	%
1	Participate in deciding whether CHPS is a priority need of the area	9	11	48	57	27	32
2	Participation of all the beneficiary CHPS communities in deciding on the location of the CHPS compound	22	6	43	51	19	23
3	Determining the criteria for selecting CHVs and CHC members	36	43	33	39	15	18

4	Selecting CHVs and CHC representatives in the CHPS zone	4	5	33	39	47	56
5	Determining the support system for CHO, CHVs and the CHPS compound security	11	13	42	50	32	38
6	Deciding on the respective roles and responsibilities of the health authorities and community members in the CHPS program	51	61	27	32	6	7
7	Developing budget estimates for the construction of the CHPS compound	82	98	1	1	1	1
8	Deciding community's contribution in the construction of the CHPS compound	23	27	43	51	18	21
9	Deciding on the maintenance of the CHPS compound (weeding round it, cleaning, transplanting trees etc)	12	14	42	50	30	36
10	Deciding on women participation in the CHPS processes.	2	2	33	39	49	58

Source: Survey Data, 2009

Table 3: Distribution of CHVs/CHC and Community opinion leaders according to their understanding of who takes decisions on the CHPS implementation activities

Who takes decisions on the CHPS implementation activities?		Don't know		Community & Health authorities		Entire Community		Only community leaders		Only Health authorities	
		F	%	F	%	F	%	F	%	F	%
1	Decision on CHPS as the priority development need of your community	9	11	29	35	40	48	5	6	1	1
2	decision where the CHPS compound should be located	17	20	10	12	35	42	19	23	3	4
3	Determination of the CHVs & CHCs selection criteria	28	33	12	14	20	24	22	26	2	2
4	Selection of the CHVs & CHC members	1	1	2	2	57	68	23	27	1	1
5	Decision on the community support system for the CHO, CHVs & the compound security	11	13	22	26	45	54	4	5	2	2

6	Determination of the respective roles of the health authorities and the community members in the CHPS program	36	43	34	40	1	1	0	0	13	15
7	Decision on the budget for the construction of the CHPS compound	58	69	2	2	0	0	0	0	24	29
8	Decision on community members contribution in the construction of the CHPS compound	12	14	39	46	15	18	3	4	15	18
9	Decision on the maintenance of the CHPS compound	13	15	16	19	50	60	3	4	2	2
10	Decision on the participation of women in community health decision-making process	3	4	18	21	58	69	3	4	2	2

Source: Survey Data, 2009

Table 4.0: Distribution of respondents (CHOs & SDHTs) according to agreement or disagreement with factors perceived as obstacles to community participation in CHPS

Factors perceived as obstacles to community participation in CHPS		Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
		%	%	%	%	%
1	Inadequate consultation of community members in the demarcation of CHPS zones	11	17	17	22	33
2	Heterogeneity of the CHPS communities	22	-	28	33	17
3	Fears of possible reduction in government support for community health care activities (That is government pushing its social responsibilities on the communities)	6	44	6	22	22
4	Lack of skill and understanding of participatory methods by health workers	22	61	-	17	-

5	Inadequate understanding of the concept of “community” by CHOs	17	33	-	39	11
6	Tendency of health authorities to set the health agenda for the communities by selecting the programs requiring participation	22	28	17	22	11
7	Unsatisfactory service delivery by health staff, eg poor handling of referred cases at the referral point	28	39	16	17	-
8	Participating in CHPS is burdensome and inconveniencing in terms of time and resources (e.g providing support system for CHVs, CHO and CHPS compound security)	17	11	-	44	28
9	Inadequate skills and knowledge of CHVs/CHC members in CHPS processes	44	33	6	17	-
10	Inadequate knowledge of the CHPS concept by CHOs	44	33	6	17	-
11	Uncooperative and difficult nature of community members	11	11	6	22	50
12	Negative attitude and disrespectful behaviors of some health workers towards community members	6	32	6	39	17

Source: Survey Data, 2009

Table 4.1: Distribution of respondents (CHVs, CHCs & Community leaders) according to agreement or disagreement on factors perceived as obstacles to community participation in CHPS

Factors perceived as obstacles to community	Strongly	Disagree	Uncertain	Agree	Strongly
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participation in CHPS		disagree				agree
		%	%	%	%	%
1	Inadequate consultation of community members in the demarcation of CHPS zones	24	37	4	18	17
2	Heterogeneity of the CHPS communities	21	46	5	20	8
3	Fears of possible reduction in government support for community health care activities (That is government pushing its social responsibilities on the communities)	18	27	15	30	10
4	Inadequate understanding of the concept of CHPS by community members	4	17	11	51	17
5	Unsatisfactory service delivery by health staff, eg poor handling of referred cases at the referral point	18	27	20	29	6
6	Participating in CHPS is burdensome and inconveniencing in terms time and resources (e.g providing support system for CHVs, CHO and CHPS compound security and CHPS activities conflicting with farm activities)	7	18	-	40	35
7	Inadequate skills and knowledge of CHVs/CHC members in CHPS processes	10	14	12	56	8
8	Negative attitude and disrespectful					

	behaviors of some health workers towards community members	4	42	11	30	13
9	Weak support for CHPS by traditional leaders (Chiefs)	15	32	4	34	15

Source: Survey Data, 2009

Table 5.0: Distribution of respondents (CHOs and Sub-district In-charges) by level of agreement with selected actions perceived to enhance community participation in CHPS

Actions that enhance community participation in CHPS		Strongly disagree		Disagree		Uncertain		Agree		Strongly agree	
		F	%	F	%	F	%	F	%	F	%
1	Identify and conduct stakeholders analysis prior to the demarcation of the CHPS zones	0	-	0	-	3	16	5	28	10	56
2	DHMTs should encourage and support community health initiatives rather than initiating CHPS for the communities and soliciting their cooperation	0	-	5	28	2	11	5	28	6	33
3	Involve all beneficiary CHPS communities in the zoning processes	0	-	0	-	1	6	7	39	10	56
4	Promote working together processes among heterogeneous communities	0	-	0	-	1	6	7	39	10	56
5	Empower communities through continuous education on CHPS and health promotion	0	-	0	-	1	6	7	39	10	56
6	Provide skill training on participatory approaches for CHOs	0	-	0	-	0	-	9	50	9	50
7	Promote community accountability and transparency through stakeholders' feedback mechanisms	0	-	0	-	0	-	11	61	7	39
8	Build capacities of community	0	-	0	-	2	11	9	50	7	39

level actors in CHPS (CHVs/CHC) through periodic just-on-time training programs					
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Source: Survey Data, 2009

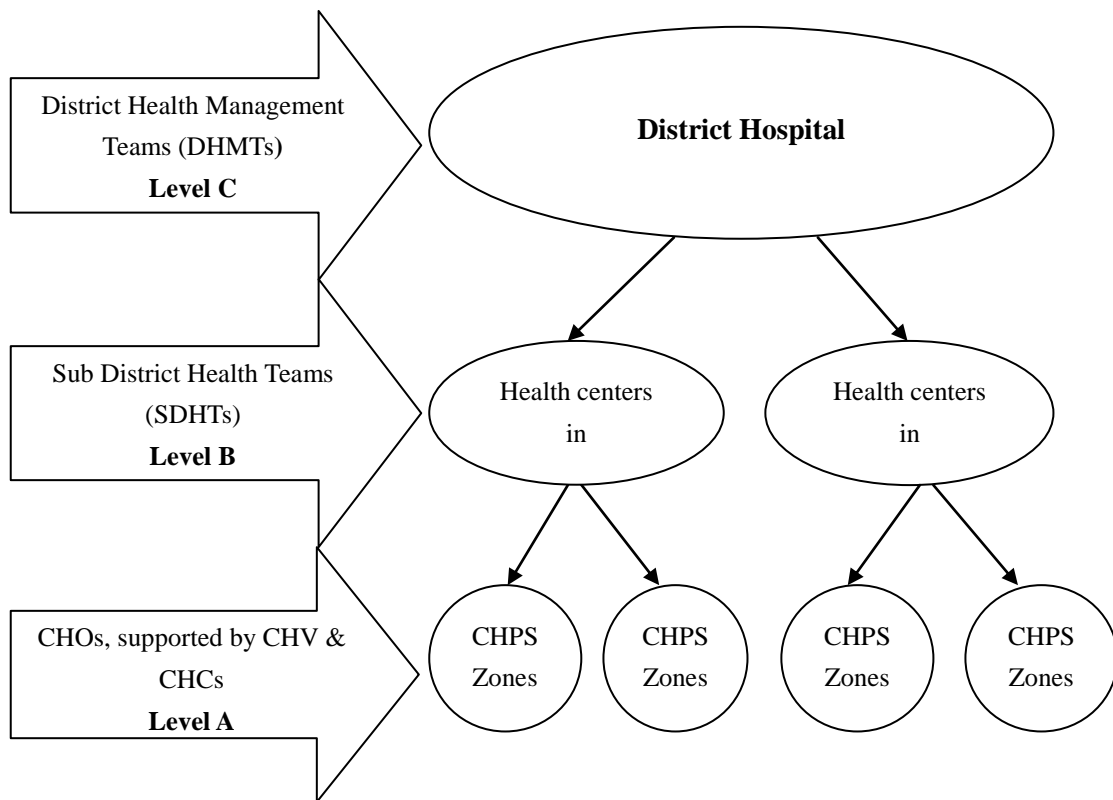
Table 5.1: Distribution of respondents (CHVs & CHC and Community opinion leaders) by level of agreement with selected actions perceived to enhance community participation in CHPS

Actions that enhance community participation in CHPS		Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
		%	%	%	%	%
1	Identify and conduct stakeholders analysis prior to the demarcation of the CHPS zones	-	27	1	45	27
2	DHMTs should encourage and support community health initiatives rather than initiating CHPS for the communities and soliciting their cooperation	4	46	9	30	11
3	Involve all beneficiary CHPS communities in the zoning processes	-	17	-	63	20
4	Promote working together processes among heterogeneous communities	-	7	6	74	13
5	Empower communities through continuous education on CHPS and health promotion	-	-	1	77	22
6	Promote community accountability and transparency through stakeholders' feedback mechanisms	-	1	-	47	52
7	Establish referral desks at the referral points and give special attention to referred cases.	-	5	20	43	32
8	Build capacities of community level actors in CHPS (CHVs/CHC) through periodic in-service training	-	-	1	61	38

programs					
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Source: Survey Data, 2009

Fig. 1 The organizational structure of CHPS.



Source: adapted from the CHPS policy document.

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