COMMUNITY PARTICIPATION IN HEALTH DELIVERY AND MANAGEMENT IN GHANA
Lessons from Selected Districts in Northern Ghana

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ABSTRACT

This paper discusses an investigation on a common and yet illusive phenomenon in development management – community participation. It seeks to explicate the nature and forms of community participation in the public health sector in order to uncover the modes through which communities participate in health care delivery and management. Using case studies of community participation programmes the study concentrates on the three northern regions of Ghana. The findings show that community participation in the public health sector of Ghana is more a means - geared towards the improvement of the health status of communities - rather than for confidence building and empowerment purposes. One key factor limiting community participation in Ghana has been the "inward" looking policies of the Ghana Ministry of Health, which has been pro public sector health to the neglect of non-allopathic and the private-for-profit sectors, for some time now. However, for community participation in health to be genuine and empowering, a Coalition for Participation and Partnerships model together with the strategies for its implementation is proposed.

KEY DESCRIPTORS: Community Participation in Public Health, Health Development Organizations, Coalition for Participation and Partnerships in Health (CPPIH), Health Development Approaches.

BACKGROUND AND NATURE OF THE PROBLEM

In Ghana, a series of policies and programmes outlining strategies for community participation in health have been implemented since the Alma Ata Declaration of 1978. The three main programmes or strategies facilitating the process are the Primary Health Care (PHC), the Medium Term Health Strategy (MTHS) document and the Community Based Health Planning and Services (CHPS) (WHO, 1978; MOH, 1996; MOH, 1999). The PHC system and its global programmes and strategies shaped community participation in public health care in Ghana in the late 1970s and 1980s in three broad areas:

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- Community Involvement in Health (CIH);
- Intersectoral Collaboration in Health (ISC H); and
- Introduction of Tier-System of Health Care Delivery.

Community Involvement in Health under the PHC was interpreted in the health sector to mean three things: participation in service delivery by auxiliary staff and village level health workers, decision-making and management of health care by members of the community as well as their active involvement in proactive and preventive health development programmes. The emergence of the paradigm of CIH was influenced by the realization that doctors and health workers alone might not be able to "cure" health problems without the active involvement of the patient and larger public in the treatment process. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care [Alma- Ata declaration 1V]. The PHC "requires and promotes maximum community and individual self reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education, the abilities of communities to participate" (WHO, 1978: 3).

Intersectoral Collaboration in Health, which was also one of the strategies of the PHC, sought to integrate vertical programmes that permeated health care management and delivery. District and sub-district initiatives were pursued as part of this strategy to realign vertical programmes and to promote integrated services delivery. The strategy further sought to foster collaboration between the public health sector and traditional and private sectors on the one hand and those other sectors whose activities directly impact on health on the other - in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication.

The MTHPS and the CHPS have re-echoed ISCH based on the understanding that multiple factors contribute to health and disease and hence the need for stakeholders to work together. The various programmes under the PHC such as the District and Sub-district Initiatives and the Bamako Initiative introduced the tier system of health delivery. Management systems and programmes for building the capacity of the new institutions created to support community participation were established.

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

Oakley (1989: 9) made a similar point when he observed that " although there would appear to be widespread agreement on the importance of community participation for bringing about the desired redistribution of the benefits of health, there is less of a consensus on the nature and content of the participation process." It appears that participation in health means different things to different people and it is not just shades of disagreement over particular aspects of interpretation or implementation of Community Involvement in Health (CIH), but as a result of fundamentally opposed views regarding what the process should mean in practice (Oakley, 1991). Uphoff (1986) refers to a state of 'pseudo participation' in health programmes and argues that in many projects participation is stronger in rhetoric than in practical reality. The widespread confusion about the nature and content of community participation in health prompts a question about how communities and stakeholders have participated in public sector health in Ghana. It also raises the question of not only the factors that influence the process of participation in Ghana but also the nature and content of participation that has emerged as a result of the pursuance of community and stakeholder participation programmes in the public health sector over two decades and half or so.

This paper attempts to synchronize the specific experiences of community participation in Ghana in the search for the evolving forms, nature and content of community participation in health management in Ghana in general and northern Ghana in particular. This is intended to stimulate process-oriented and integrated approaches to participation in the health sector that aim at generating process-oriented data on how best and in what ways community participation in health fare and/or can be sustained.

COMMUNITY PARTICIPATION CONCEPTUALIZED

Definitions of Participation

Stone (1992) notes that no development concept has been thoroughly, consistently and fervently advocated than that of participation since the 1970s. On his part, Oakley (1999) describes participation as an umbrella term that defies one single definition. Community or public participation in health, sometimes called citizen, consumer or people's involvement, may be defined as the process by which members of the community, either individually or collectively and with varying levels of commitment; work to:

- develop the capability to assume greater responsibility for assessing their health needs and problems;
- plan and then act to implement their solutions; (c) create and maintain organisations in support of these efforts; and
- evaluate the effects and bring about necessary adjustments in goals and programmes on an ongoing basis (WHO, 1978; Vuori, 1986).

Rifkin (1988) summarized the definition of participation to characterize activeness, choice, and the possibility of the choice being effected. She also defined community participation as a " social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanism to meet these needs" (Rifkin, 1988: 933). Similarly, a WHO study group (1991) suggests that participation is interpreted in three different ways: participation as contribution, as organization, and as empowerment. Although Oakley (1999) also identified three interpretations of participation - as collaboration, in benefits for those previously excluded and as empowerment, he indicated that participation could be broadly categorized into two: participation as a means and participation as an end. Participation as a means refers to a process of ensuring local cooperation and collaboration in externally introduced projects or programmes while participation as an end, is a process where participation is a goal in itself and expressed in terms of empowerment through the acquisition of skills, knowledge and experience to take responsibility in programmes/projects.

Levels of Participation

Rifkin (1990) clarifies what participation can mean in the field of health by distinguishing among the differing levels of participation. According to Rifkin, local people can participate minimally or most passively in the benefits of health projects in the form of services or education. At the second level, local people can participate in programme activities such as support for health facilities through in-kind or cash contributions and assuming roles as health providers or workers.

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

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

In a bid to "seek clarity through specificity," Cohen and Uphoff (Macdonald, 1993: 89] developed a taxonomy of types of participation and the four most important in their view being, participation in implementation, in benefits, in evaluation and decision making. This framework, though a useful analytical tool, is not devoid of problems concerning how to operationalize the terms - evaluation and decision-making - on the ground.

Intensity or Depths of Participation

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

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

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

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

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

- Information: Solicited from intended beneficiaries
- Preferences/Judgment: Opportunities for intended beneficiaries
- Lobbying/Advocacy: Opportunities for intended beneficiaries.

B. Participation in Actual Decision Making

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

Broadly, the model presents two types of participation in the decision-making process in a continuum of intensity: influencing decision making and taking decisions, which are qualitatively different, with the latter being participation at a higher level. Model A1-3 represents degrees of consultation aimed at influencing decisions as one moves from 1 to 3 while B1-3 represents increasing opportunities for initiating and enforcing decisions.

Thus, Schubert's (1990) four-level intensity model on participation is reduced to three, when one puts the two types of decision making together with initiating action. Schubert uses the term functional participation to cover non-decision making participation. The distinction is useful in conceptualizing participation in both decision making and non-decision making terms although fraught with similar problems as Uphoff's et. al. such as the problem of how to categorize non-functional activities that do not involve choices or decision-making.

Forms of Participation

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

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

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

Table 1: Taxonomy ff Forms Of Participation

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

Source: White (1996)

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

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

- The options in the interests, functions and forms are internally diverse and tension ridden over which elements or combination of elements will predominate at any given time. This means that participation is not static but changes over time;
- Forms and functions of participation is site of conflict;
- Forms and functions of participation are shaped through the constellation of interests and they in turn, act as feedback into the constitution of interest; and
- Interests reflect power relations, sometimes external to the participation process itself.

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

Similarly United Nations Research Institute for Social Development (UNRISD) (1979; 20) makes a useful distinction between 'systems-maintaining' and systems-transforming participation. On one hand, 'systems maintaining' is similar to nominal instrumental and representative types of participation where people are responsive to development policies of authorities. Systems-transforming participation, on the other hand, is about empowerment and ownership where there are concerns for structural change and genuine democratic transfer of power to marginalized groups. Viewed this way, the Human Development Report defines participation in terms of people having constant "access to decision-making and power, as well as in terms of economic participation "(UNDP, 1992). The UNRISD (1981) was also quite clear about the power dimension of people's participation when it defined participation as the organized effort to increase control over resources and regulative institutions on the part of groups and movements hitherto excluded from such control.

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

The power dimension of participation permeates all levels of decision making in the health system and the larger community including international relationships between developed and developing countries, relationships between agencies such as WHO and UNICEF, on the one hand and, between local Governments, inter-relationships between governments and health ministries, and so on down to the level of health committees, community health workers and rural communities, on the other. These different groups represent interest categories in the participation process[9]. At each level, there are struggles for control over health decisions and benefits.

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

METHODOLOGY

The data were collected between years 2000 and 2002. A case study approach was adopted for the selection of community participation programmes and respondents. Case studies do not only identify what people do, but how they make sense of what they do. A systematic series of case studies can reveal a lot about the processes of social reproduction and transformation, and how human agents play an active role in this process (Leedy, 2001). Four community participation programmes, namely surveillance programmes, disease control/prevention, primary health workers programme and community health management programmes were selected using purposive sampling techniques such as availability of on-going project activities on participation and geographical spread of activities and structures for participation across sample districts and communities.

A district was selected from each of the three regions covered by the study. These are Yendi for Northern Region, Builsa for the Upper East Region and Lawra for Upper West Region. These districts were selected because of their long-standing involvement in community based health development programmes, facilitated by UNICEF under the Primary Health Care Programme since 1985. Nine sub districts: three each from each of the sample districts were selected for the study. Two communities from each of the sub districts were selected on the basis of the nature of participation in public health issues-active or inactive with the support of members of the district and sub district health management teams.

Health sector specific institutional data were collected from the various levels of the health sector: MOH, GHS- national, regional, district and sub-district levels. Data

[9] For more information about sets of persons and levels of decision-making in participation see Uphoff (1986)

collected covered issues relating health sector reforms, emerging structure and function of programmes such as the National Traditional Birth Attendants (NTBA), Primary health training for indigenous Healers PRHETIH, Community Health Workers Programme (CHWP) and other institutions such as health management boards, social services committee, health teams and committees. Data were also collected on issues of programmes implementation, organisation and management. Directors from the regional health administration down to the sub-district directors provided such information. The information was supplemented and validated by that from management team members in charge of specific programmes in disease control, maternal and child health, nutrition and so on. The data collected also covered aspects of district/sub-district-community relations. Key informants' interviews were largely employed in the collection of institutional based data. The other type of data had to do with inter-sectoral relationships, collaboration or partnerships and partnership management and problem solving. These data came from sectors and agencies fostering collaborations with MOH. These agencies and organisations include Catholic Relief Services (CRS), Christian Health Association of Ghana (CHAG) traditional practitioner, private health practitioners, District Assemblies, UNICEF and so on.

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

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

The data collected were mainly qualitative and analysed manually according to the core themes of this paper: nature mechanisms and forms of community participation in the public health sector of Ghana.

KEY FINDINGS

Nature, Mechanisms and Forms of Community Participation

Nature of participation

Communities participate in broad scope of activities in the public health sector of Ghana. These activities cover community entry and preparation, information, education and communication, social mobilization to aspects of programme planning and implementation - where communities make contribution in ideas, material and financial resources. However, community participation in needs assessments and programme planning issues was reported to be limited. This is because even though communities are involved in data collection through surveillance and growth monitoring programmes, actual use of the data in community problem assessment is rarely done. Furthermore, the CBDP and FACS, which offer communities the opportunity to engage in project or programme planning through the VAP and Village Health Committee systems respectively, are limited to seven districts covering about one hundred and fifty communities in the three northern regions (UNICEF and CRS project districts). What is more, the participation process still requires facilitation in order to cultivate the desired effect.

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

The case studies show that participation in curative health services by community auxiliary staff is the most contentious and public health professionals are divided on this aspect of participation because of the inability of the public health sector to effectively monitor the participation of auxiliary staff in curative services delivery. Thus, although a wide-range of public health activities/services is open to the participation of communities, actual participation, as shown above may be limited from one community to another as a result of the varying infrastructure of the communities involved, nature of the district or sub-district health programmes or the specific health provider involved. Consequently, community participation in public health issues vary across communities, health sub-districts and districts, and among the different health providers engaged in modern health care delivery. These variations are the source of the confusion about community participation in the public health sector.

Mechanisms of Community Participation

Communities participate in health in various ways: through individuals selected and trained or health experts in traditional healing equipped with enhanced skills to en-

able them improved their expertise in specific aspects of their practice for instance delivery. Members of communities may also be given new skills to enable them play assigned roles in specific areas in care delivery. Communities also participate through forms of representation, normally in-groups, teams and committees either formed or already existing in the community. The findings also show that group and team forms of participation serve as platform or umbrella for bringing together members involved in the first two forms of participation for purposes of problem solving. As indicated by the case studies, community level health workers are often encouraged to attend group/committee/team meetings. The skills, orientation and motivation of participating individuals, determine the success of the first type of participation. In the case of the other two, group dynamics are key to success. Group forms of participation as expressed in institutions such as Community Health Committees and Institutional Management Committees have been found to be less active as they easily become dormant. In the case of the first two forms, participation is targeted at individuals who have skills to bring to bear on the process of health care delivery and management. Finally, communities participate as a whole (village assemblies) in specific health assignments or project activities and in selecting members to represent them.

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

Forms of Community Participation

Needs and Interests Oriented

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

Although the above continues to influence public health sector policy on participation, participation under the MTHST and the Community-Based Health Planning and Services (CHPS) seeks to ensure that public health services are tailored to the needs of the communities so as to increase the patronage of services and legitimize projects. Emphasis is no longer placed on the extension of the coverage of services alone but also on their acceptance and utilization. Thus, participation in the public health sector plays an instrumental role – a means of making health services available, effi-

cient and accessible socio-culturally. Because participation is geared towards improving the coverage and quality of health services, the outcome of participation is normally measured using service output indicators and not process indictors.

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

The case studies also show that community participation in health is more a means rather than an end process - geared towards improvement of the health status of communities rather than confidence building and empowerment. Although the "means" type of participation has its own capacity building agenda, it is more geared towards creating and improving services and not changing power relations. It is within this context that Rifkin's (1996) classification of participation as target oriented and as empowerment is more appropriate. In the target oriented framework, participation is characterized by the following: a way of mobilizing community resources to supplement health services; a means to an end; passive, responding to professional direction; and best evaluated by quantitative methods. The empowerment participation on the other hand, is a means of giving people power over their health choices; active and based on community initiative; a process whereby communities are strengthened in their capacity to control their own lives and make decisions without the direction of professional authority; and best evaluated by qualitative method.

Participation through Collaboration and Partnerships

The case studies point to community participation through partnership and collaborative arrangements. The collaboration of the public health sector with private health sector providers is progressing slowly in the three northern regions. In the Lawra and Builsa districts in particular, private non-profit sector providers are allocated designated health sub-districts to concentrate their operation in order for their services to make the desired effect. There are also support mechanisms provided to the private-non-profit sector and sub-district staff of these agencies to benefit from training and workshops aimed at capacity building. Personnel of the private-non-profit sector are also involved in decision-making at the sub-district and district through representation on sub-district and district management teams. In the districts where Church

Based Health Providers operate in selected sub-district, they are represented on sub-district and district teams. Guidelines are however, required to formalize the relationship.

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

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

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

Constraints to Participation

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

The institutional restructuring for community level participation has also fallen short of a clear-cut institutional arrangement for aligning and coordinating the services at the community level. The status of the Health Committee System for planning at community level and problem solving in health remains unclear. It is now uncertain what constitutes the acceptable institutional arrangement for community level care within MOH for all community service providers. The absence of such broad based institutions or structures isolates community level health workers making them unable to come together to plan or take health decisions affecting their communities or for purposes of problem solving. Similarly, the lack of such structures creates problems about health sector care policing and the provision of technical backstopping to community level auxiliary staff.

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

Proposed Model of Community Participation

As revealed by the discussions above, the type of participation being pursued in the public health sector of Ghana is not far reaching enough. It has failed to allow broader participation in public health sector planning, decision-making and services delivery by communities, civil society organisations and the private sector. Participation in the public health sector is meant to mobilize the economic and social resources of communities

to achieve predetermined health targets. The results of participation as determined by the targets are considered to be more important than the acts or processes of participation. Furthermore, the means-type–participation under review has succeeded in developing wide range of health services structures but lacks adequate health development structures to facilitate and co-ordinate collaborative and partnership arrangements among health providers and stakeholders.

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

The CPPIH Model

Nature/Purpose

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

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

Institutional Framework

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

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

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

Services Delivery and Community Mobilization

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

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

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

CONCLUSION

One important limiting factor to community participations has been the inward looking policies of the Ministry of Health of Ghana, which for some time now, has been pro-public sector health to the neglect of the private-for-profit and traditional medicine. The de-linking of the MOH policy function from its service delivery function by the creation of the Ghana Health Service (GHS) is therefore in the right direction towards ensuring broad-based stakeholder participation in public health sector in Ghana. However, for participation in the public health sector to be genuine and empowering, a Coalition for Participation and Partnerships model together with the strategies for its implementation is proposed.

CPPIH proposes a framework for broadening participatory planning and decision-making involving all distinct key health providers engaged in the health sector of Ghana. This framework is different from the traditional working of the public health sector. The model replicates the Village Level Action Planning Process (VAP) that engages community representatives and technical line agencies in the planning process together. The framework seeks to reposition community participation in health as a health development issue and not just a service delivery programme.

CPPIHS also provides a framework for integrated and holistic health care delivery by all key health care providers through zoning and contractual arrangements modeled on the principle of partnership based on horizontal and vertical integration to ensure the provision of plural, holistic services within defined geographical areas. The model replicates the benefits of network and collaborative programmes in the health sector and at the same time ensuring that services are holistic and not in bit and pieces as being done now.

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