UNIVERSITY OF AGDER

STATE-CIVIL SOCIETY SYNERGY AS A DEVELOPMENT STRATEGY: AN EXAMINATION OF THE IMPACT OF THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES PROGRAMME IN THE NSANFO COMMUNITY IN GHANA.

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This master's thesis is carried out as a part of the education at the University of Agder and is therefore approved such. However, this does not imply that the University answers for the methods that are used or the conclusions that are drawn.

University of Agder, 2014
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Abstract

The state in many developing countries has been the dominant provider of public goods and services with little involvement of civil society. Civil society in such context has often assumed the role of passive agents instead of being active participants in the country's developmental agenda. Contemporary development practitioners have criticised this conventional relationship and called for partnership between both entities in co-producing public goods and services. A major reason adduced by authors to support the necessity for such partnership is that, there are some functions better performed by the state and others better performed by civil society thus combining the resources of both the state and civil society will result in more effective performance.These theoretical foundations of state-civil society synergy manifest in the collaborative healthcare delivery in the Nsanfo community in Ghana. The absence of adequate and affordable public healthcare facilities and personnel in the community has necessitated the introduction of the Community-based Health Planning and Services (CHPS) programme as a strategy to improve healthcare delivery in the Nsanfo community. This CHPS is a community-based scheme which provides health services through partnerships between the Ghana Health Service and community volunteers. Under the programme, some community volunteers are trained in basic health care provision to enable them render emergency treatment services in households before referring patients to health care institutions if the need arises. This study, therefore, sought to examine the impact of this CHPS programme in the Nsanfo community, identify the nature of state-civil society synergy and threats to this synergy. The mixed methods strategy which combines both qualitative and quantitative techniques was adopted to achieve the objective of the study. The findings from the field indicate that even though the programme has greatly improved the healthcare conditions of the people of Nsanfo, there is less participation of the community members in maintaining the CHPS facility. This is due to suspicions of financial embezzlements on the part of the nurses working at the CHPS facility. Inadequate logistics and motivation for the volunteers also threatens the synergy in the CHPS programme.

ACKNOWLEDGEMENTS

My postgraduate studies on Quota scholarship in the University of Agder wouldn't have been possible without the contribution of some important personalities at one point in my life. This section is to briefly express my profound gratitude to these people.

First of all I would like to thank my family especially Hon. John Jagri Kokpah my father, for the tremendous role he has played in shaping my life till date. His constant words of encouragement,support and direction in my academic journey and personal development has greatly contributed to making me what I have become today and will eventually become. Words would not be enough to describe how grateful I am for your selfless support BABA. God bless you.

Secondly, I would like to express gratitude to Dr. Samuel Aikins of the Biological science department of KNUST and Coordinator of the quota scholarship scheme, KNUST, for giving me the opportunity and facilitating the process for me to take up the quota scholarship for my postgraduate studies in the University of Agder. This opportunity has been the turning point in my life and has immensely placed me in a position to face the future with unbridled confidence and hope.

I would also like to express profound gratitude to all my lecturers in the Development Management programme in University of Agder for the priceless training I have received in the two years of my post graduate studies. The quality of the training will go a long way in contributing to my personal development and make me a competent person in any professional environment I find myself. I will make you all proud someday.

Finally I would like to thank all the resource personnel who helped me in diverse way during my stay in Ghana for data collection. Special thanks go to Mr. Thomas Yeboah who was a great field assistant during my data collection in the Nsanfo village in central region. Special thanks also go to the interviewees especially the Mfantseman Municipal health Director, the Municipal CHPS Coordinator and the people of Nsanfo village who made time to respond to my questionnaires and also make time for the interviews. My entire postgraduate studies wouldn't have been a success without the role they played.

GOD BLESS YOU ALL

Dedication

I dedicate this work to my father Hon. John Jagri Kokpah and mother Mrs. Juliana Jagri, for the selfless sacrifices they have made for me to climb the academic ladder till this day. My achievements so far would not have been possible without those sacrifices. Thank you

Declaration by candidate

I, Francis Jagri, confirm that this work

"STATE-CIVIL SOCIETY SYNERGY AS A DEVELOPMENT STRATEGY: AN EXAMINATION OF THE IMPACT OF THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES PROGRAMME IN THE NSANFO COMMUNITY IN GHANA."

has not been previously submitted, either in whole or in part for a degree at this University or any other institution of higher learning. To the best of my knowledge the thesis is original and contains no materials previously published or written by any other persons except as acknowledged in the text and reference list.

..... Kristiansand, 4th June 2014.

Francis Jagri

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Abbreviations and acronyms

ACCORD – Austrian Centre for Country of Origin and Asylum Research and Documentation

AM-Alternative Medicine

CHAG - Christian Health Association of Ghana

CHC - Community Health Compounds

CHO - Community Health Officer

CHPS - Community-based Health Planning and Services

CHC- Community Health Committee

CSO - Civil Society Organization

DTAM- Department of Traditional and Alternative Medicine

EPN - Ecumenical Pharmaceutical Network

FH- Faith Healers

GHS - Ghana health service

GH- Government Hospitals

HC- Health centers

MBP- Mission-Based Providers

MDA's –Ministries Departments and Agencies

MDG'S - Millennium Development Goals

MHD - Municipal Health Directorate

NHIS- National Health Insurance Scheme

NGO's- Non- Governmental Organizations

PC- Poly clinics

PHMHB- Private Hospitals and Maternity Home Board

PMDP- Private Medical and Dental Practitioners

OPD - Out Patience Department

QGIH- Quasi Government Institutions hospitals

SFP - Self-Financed Providers

T HOPS- Teaching Hospitals

TMP-Traditional Medical Providers

UNICEF – United Nations Children's Fund

UNDP – United Nations Development Programme

WHO – World Health Organization

Clarification of concepts

- **State:** The concept state is used to refer to the formal government apparatus which includes public institutions, agencies and departments. The concept is thus used in the context of this study to refer to the Mfantseman Municipal health Directorate (MHD) and the Ghana health service (GHS).

- **Civil society**: UNDP(2012,p.3) defines civil society to encompass those *" diverse range of non-governmental organizations and actors engaged in not-for-profit activities, i.e., policy advocacy groups, transnational coalitions, non-governmental organizations (NGOs), indigenous peoples' organizations, faith-based groups, women's groups, social movements, volunteer involving associations, professional and media associations, academia, trade unions, and communities*").The specific type of civil society groups who are at the centre of this study is the community health volunteers in the *Nsanfo* community. This is the sense in which the term civil society is used in the context of this study

- **Collaboration/Synergy:** in the context of this study refers to the partnership between the Mfantseman Municipal Directorate and the health volunteers involved in the CHPS.

- **Sustainable development**: in the context of this study refers to that type of development intervention that is effective, efficient and stands the test of time.

CHAPTER ONE

1.0 Introduction

The debate about the relationship between the state and civil society in achieving the developmental agenda of countries has been a very interesting topic among development practitioners and policy makers in recent times. This is especially so in the case of developing countries where most are still confronted with the challenge of achieving sustainable development and meeting the developmental needs of their citizenry in particular. The state has been the lead agent of development in most of these countries (Bruce, 1994). One plausible explanation for the dominant role of the state in development has been that, since the state collects taxes from citizens, it is argued that the state should therefore be solely responsible for delivering expected public goods and services (Ostrom, 1996). Civil society participation in the development agenda of such countries has been largely insignificant. This conventional practice constructs state-civil society relationships on patron-client bases in which the patron (i.e. state) is expected to deliver public goods and services to its clients (i.e. civil society) from which it collects taxes. In this construct, it can be deduced that civil society assumes a passive and "backstage'' role in national development instead of playing an active role. In some extreme instances, the relationship between the state and civil society is even characterized by conflict and distrust as this situation positions the state and civil society as mutually exclusive entities with competing goals instead of being partners in development (Foley and Edwards, 1996).

In reality, however, evidence abound to show that the state in many countries has not been able to solely deliver the developmental needs of its increasing population (Bruce, 1994). This situation has given rise to further debate among development scholars and policy makers with the aim of finding more sustainable means of promoting human development. In that regard, the realm of civil society has been identified as the missing link necessary to partner the state in the provision of public goods and services and achieving sustainable human development in general (Ostrom, 1996 Evans, 1996). This new discussion is what has triggered the emerging phenomenon of state-civil society synergy for sustainable development in local, national and international development discourse. The concept is now largely touted as necessary for the broadening of the developmental framework of nations because such

synergy fosters complementarities and collective actions that can lead to sustainable developmental ends (Bruce, 1994). Contemporary development practitioners thus contend that both the state and civil society have some unique qualities on their own hence should partner to bring on board the best of both sides to achieve significant developmental goals. As Evans (1996, p. 1119) aptly puts it, *"state-civil society synergy can be a catalyst for development*" and that "*the combination of strong public institutions and organized communities is a powerful tool for development"* (Evans, 1996, p. 1130). The understanding is that since the state alone is incapacitated in delivering expected public goods and services, partnering with civil society would thus compensate for the limitations of the state.

This interesting debate among others is what motivated the researcher to study an example of state-civil society synergy in co-producing a public good which is rural healthcare in this case. The overall objective of the study was to find out how state-civil society partnerships could be adopted as a strategy for bringing healthcare services to the doorsteps of often marginalized rural dwellers in Ghana. This was done based on the examination of the impact of the collaborative Community-based Health Planning and Services (CHPS) programme in healthcare delivery in the *Nsanfo* community in the Mfantseman Municipal of Ghana. The ultimate aim was to identify possibilities for state-civil society synergy as well as constraints to such synergetic relationship using the CHPS case-study.

1.1 Problem statement

In economic terms, Ghana as a developing country can be described as making great strides in terms of development (Nicola et al., 2009). According to the World Bank (2011) between 2000 and 2006, the nation had recorded a 90% rate of progress in halving the number of people subsisting on less than $1.25 per day and with a significant improvement in other non-income related Millennium Development Goal (MDG) indicators such as gender equality, education and access to safe water. One sector that is however still grappling with major challenges is the healthcare delivery system especially in the rural communities. According to Makinen (2011), even though Ghana has been successful in relatively improving the welfare of her citizenry, inequality in healthcare remains a crucial policy concern. Van den Boom et al. (2004) reiterate this when they conclude after a study of healthcare delivery in Ghana that, the public health system in the country faces a variety of obstacles chiefly among them been

shortages of personnel, inadequate funding as well as unequal distribution of health workers in the country's regions.

Typical of developing countries, the government of Ghana has been the leading provider of healthcare complemented by some private healthcare facilities located in the urban areas. Healthcare delivery throughout the country is supervised by the Ghana Health Service (GHS) through its regional, district hospitals and public health centers (Ghana Health Service, n.d). According to IRIN (2008 as cited in ACCORD, 2009) as at 2008 when the population of Ghana stood at 23.5million, there were only 1,439 healthcare facilities. This translates to an average of one (1) healthcare facility to over 16,000 people clearly showing the deficits. Access to these facilities remains a problem as they are not evenly distributed across the country but concentrated in urban areas. Most of the rural communities in the country therefore lack basic health facilities and face challenges accessing healthcare (Van den Boom et al, 2004). There are also inadequate health personnel both in terms of quality and quantity especially in the rural areas. As a result maternal mortality in the rural areas of Ghana for example has been on the high in recent times (GHS, n.d). The Central Intelligence Agency (2013) as at 2013 ranks Ghana 41st on the world maternal mortality chart which translates to 350 deaths per 1000 live births.

Comparatively, this statistics can be described as an improvement from the past but much more needs to be done to significantly reduce this maternal mortality rate. This deplorable state of healthcare delivery in the country cannot be underestimated as it can have ripple effects on other sectors of development, the economic health of Ghana as a whole and indeed act as a constraint in the efforts towards meeting human development capabilities. Globally, Anno (2008) contends that progress towards achieving the 5th Millennium Development Goal is off track because only half of the world's women are giving birth assisted by a skilled professional. The problem compounded by large equity gaps between the rural-urban, poor-rich, uneducated and educated population in most developing countries and more specifically in Sub-Sahara Africa. This deplorable state of healthcare delivery, manifest in Ghana in general and in the *Nsanfo* community in the Mfantseman Municipal in the context of this study.

In order to make healthcare more accessible to the residents of rural communities and the *Nsanfo* community for that matter, the Ghana Health Service (GHS) through the Mfantseman

Municipal Health Directorate (MHD) in 2007 established the Community-Based Health Planning and Services (CHPS) programme which aims at increasing accessibility by bringing healthcare delivery to the doorsteps of the rural inhabitants (GNA, 2003). It is interesting to note that, it was the residents of the village that took the initiative to convert an old nursery school building into a community clinic and then appealed to the Ghana Health Service through the Mfantseman Municipal Assembly to post nurses to the community health centre and also provide them with the necessary logistics to run the facility. Their request was approved leading to the introduction of the CHPS programme in the community. In practice, CHPS is a community-based volunteer led programme which aims to provide health services through effective partnerships between the Ghana Health Service and community leaders and social groups (Ministry of Health, 2012). Under the programme, some community volunteers selected by the community members are trained in basic health care delivery to enable them render emergency treatment services before referring the patients to health care institutions if the need arises (GNA, 2003). These CHPS facilities are found in communities such as Nanaben, Narkwwa, Edumafa, Taido, Nsanfo, which are all located within the Mfantseman Municipal (Ghana Districts, 2006). The focus of this study is on the CHPS programme in the *Nsanfo* community.

This study therefore seeks to examine the impact of this CHPS programme in healthcare delivery of the *Nsanfo* community and ultimately the nature of state-civil society synergy in the programme and the constraints to the synergy. The healthcare situation in the *Nsanfo* community before the introduction of the CHPS programme will be investigated and compared to the healthcare situation after the introduction of the CHPS programme to determine the impact of the CHPS programme in healthcare delivery in the community.

1.2 JUSTIFICATION FOR THE STUDY

This study is relevant to development management because it bothers on issues of governance, sustainable development and specifically how the state and civil society can partner to effectively deliver public goods and services (healthcare in the case of this study). The choice of a case-study in the health sector is equally relevant as the healthcare delivery conditions of countries have shown to have ripple effects on the overall developmental aspirations of the nation. Indeed three out of the eight Millennium Development Goals (MDGs) all place emphasis on the relevance of quality healthcare in achieving sustainable

development. In particular, goals number four, five and six all talk about reduction in child mortality, improvement of maternal health, the combat of HIV/AIDS, malaria and other diseases respectively (UNDP,2013). The deplorable situation of rural healthcare delivery in Ghana justifies the necessity for this study to investigate possibilities for the state of Ghana to collaborate with civil society to improve upon rural healthcare delivery. Since government alone has shown to be unable to solely deliver healthcare, partnership with civil society is one plausible option. In justification, this study therefore aims to make a case for state-civil society synergy by examining the impact of this collaborative CHPS programme. The idea is to generate knowledge about how the state can positively partner civil society in its effort to achieve healthcare for all drawing lessons from the collaborative healthcare delivery in the *Nsanfo* community as a case study.

Moreover, a glance through previous research on rural healthcare delivery in Ghana reveals that even though some study has been done on improvement of healthcare in rural communities, not much empirical studies has been done on the specific case of state and community volunteers partnerships (i.e. CHPS programme) in healthcare provision in the rural areas of Ghana. This assertion is supported by the Ghana Health Service (2005) when they state that over the years, there has been over concentration on improving service delivery at the hospital and health centres by way of continuos construction of health facilities with the idea that such facilities will lead to an increase in uptake of health services. The reality according to the GHS however has been that, these envisaged objectives have not been achieved as there is little involvement of beneficiary communities in the decision making processes of their own healthcare. The GHS (2005) thus concedes that *"If the health sector is to achieve the health-related Millennium Development Goals' in Ghana, then there is the need for a drastic shift in the paradigm of service provision believing that the CHPS provides the Ghana health service with the vehicle for making this paradigm shift so as to deliver community level service by engaging communities in taking decisions concerning their own health"*

This study will therefore contribute in filling up the literature gap by examining the particular case of the impact of the CHPS programme in the study area which promotes community participation in their own healthcare delivery thus provide empirical evidence to support future prospects for similar state-civil society collaborations in other rural communities as envisaged by the Ghana Health Service and government.

1.3 Main objective

The main objective of the study was to examine how state-civil society partnership could be used as an effective strategy for improving rural healthcare delivery in Ghana. This was done based on empirical examination of the impact of the Community-based Health Planning and Services (CHPS) programme in the *Nsanfo* community in the Mfantseman Municipal of Ghana as a case study.

1.4 Specific objectives

The specific objectives were as follows

1. To investigate how, and the extent to which civil society within the *Nsanfo* community is integrated into the healthcare delivery structure of the CHPS programme.

2. To examine the extent to which community participation affects the operations of the CHPS programme in the *Nsanfo* community.

3. To compare and contrast the state of healthcare delivery in *Nsanfo* community before and after the introduction of the CHPS programme.

4. To identify the major threats to this collaboration between the Mfantseman Health Directorate and its civil society partners (*community health volunteers*) in the execution of the CHPS programme.

5. To inform and recommend best practices on how to ensure sustainability of the CHPS programme based on the lessons learned in the *Nsanfo* case study.

1.5 Research Questions

In order to achieve the above stated objectives, the following research questions were investigated in the course of the study.

1. How is civil society within the *Nsanfo* community integrated into the healthcare delivery scheme of CHPS?

2. How does community participation within the *Nsanfo* community affect the operations of the CHPS scheme?

3. In what ways has the CHPS programme impacted healthcare delivery within the *Nsanfo* community in the Mfantseman Municipal?

4. What are the threats to the synergetic relationship between the Mfantseman Municipal Health Directorate and their civil society partners in the CHPS programme?

5. What are the effective means of addressing these threats to the synergy and thus strengthen the CHPS to ensure sustainability.

1.6 Overview of the Study area

1.6.1 Geographical characteristics

The *Nsanfo* community is located within the *Anomabo* subdistrict of the Mfantseman Municipal. The Municipal lies along the Atlantic coastline of the central region of Ghana. Geographically , the Municipal "extends from latitudes 5* T to 5* 20' North of the Equator and longitudes 0* 44' to 1* 11' West of the Greenwich Meridian, stretching for about 21 kilometers along the coastline and for about 13 kilometers inland and constituting an area of 612 square kilometers" (Ghana Districts,2006). Examples of towns in the *Nsanfo* catchment area include Akraman, Fomena, Gyakuma, Nsaadze, Obontsir, Eshirow among others (Ghana districts.com, 2006).The Municipal capital is Saltpond. The Mfantseman Municipal is bounded to the East by Gomoa District, to the South by the Atlantic Ocean to and to the West by Abura-Asebu-Kwamankese District (Ghana Districts, 2006). In terms of climatic conditions, the vegetation profile of the Mfantseman Municipal is partitioned into a tropical rain forest with scattered reserve areas and dry coastal savanna which stretches about 15 km inland (Ghana Health Service, n.d).

1.6.2 Socio-economic characteristics

In terms of socio-economic characteristics, *Nsanfo* community is located relatively far away from the coast as such most of the residents are predominantly peasant farmers and petty traders. The Mfantseman Municipal where the town is located though also boasts of beaches which attracts tourists and generates some income for the region. Small-scale manufacturing in food-processing, ceramic wares, as well as soap industries also take place (Ghana Health Service, n.d). The indigenes of the area are predominantly Fante and Akan speakers but due to economic activities and intermarriages, the town is now characterized by several other Ghanaian languages.

1.6.3 Demographic characteristics

According to the latest national population census that was conducted in 2010, the total population of the Mfantseman Municipal stands at 211,915 people comprising 97,269 males and 114,646 females. This number reveals an increament of about 39.2% from the previous year 2000 national population census. This population is scattered in 168 settlements including the *Nsanfo* catchment area which is composed of an estimated population of 4,075. This population figure constitutes almost 7% of the Central region population and is estimated to have an annual growth rate of 2.8 %. It is estimated that some 37% of the populations of the Mfantseman live in areas classified as urban (Mfantseman Municipal Assembly, 2006). This means that a significant percentage of 63% of the inhabitants in the Municipality reside in rural areas like the *Nsanfo* community.

1.6.4 Health profile

The Mfantseman Municipal like many other districts and Municipalities within the central region is faced with many developmental challenges. Some of these major challenges include inadequate educational infrastructure, inadequate health amenities, inadequate accommodation for teachers posted to the town, bad road networks and inadequate electricity supply (Ghana Districts, 2006). With specific focus of the health statistics of the Municipal, the doctor- patient ratio is unfavorable. It is telling to note that,Global Medical Brigades, a healthcare NGO that works in the central region of Ghana reports that, the doctor-patient ratio in the Mfantseman Municipal stands at 1:48,029 (Global Brigades,2014). Such a huge disparity gives one an idea of quality of services that is offered in the community as a

result of constant pressure on limited medical officers. There is also the presence of quack doctors/ health practitioners, prevalence of communicable diseases like River blindness, Cholera, Malaria, Diarrhea, HIV/AIDS among others (Ghana Districts, 2006). As indicated earlier, these challenges have come about as a result of inadequate healthcare infrastructure and financial resources. These health-related characteristics and challenges is what has informed the collaboration between the Mfantseman Municipal health Directorate and community volunteers to introduce the CHPS programme in order to bring improved healthcare to the doorsteps of the residents of the Municipal and the *Nsanfo* community for that matter.

According to official statistics from the Ghana Health Service, the central region where the Nsanfo community is located in all has 220 health facilities comprising 108 public, 82 private and 14 mission/quasi and 16 community/NGO clinics (GHS Annual Report,2006). Typical of developing countries, most of these private institutions are however located in the district capitals and other urban areas. The distribution of health facilities, therefore, does not favour the large rural majority (63% of the population) including the *Nsanfo* community which is of interest in this study. In addition, there are 26 functional Community-based Health Planning Services (CHPS) compounds in six districts within the central region (GHS Annual Report, 2006). Some of these CHPS compounds are located in communities such as Nanaben, Narkwwa, Edumafa, Taido, Nsanfo, which are all located within the Mfantseman Municipal (Ghana Districts, 2006). The CHPS compound in *Nsanfo* is selected as the case-study.

Figure 1.Map of Southern Ghana depicting the Mfantseman Municipal where the Birwa town is located

Source: Google Maps

1.7 Study population

The relevant population that were identified for consultation as part of data gathering in the study included

- The Director of the Mfantseman Municipal Health Directorate.
- The Municipal CHPS Coordinator.
- The Community Health Officer at the Nsanfo CHPS compound.
- Community Health Volunteers involved in the Community Health and Planning Services (CHPS) programme.
- Sample of households within the Nsanfo community.

1.9 ORGANISATION OF THE STUDY

This study organized s as follows.

Chapter one comprises the introduction of the entire study, the problem statement of the study, the justification of the study and a brief description of the Nsanfo study area.

Chapter two of the study reviewed literature pertaining to the subject matter of the study. It extensively looked at scholarly works on state civil society synergy in development, the role of civil society in national healthcare delivery systems in general, narrows down to sub Saharan Africa and finally civil society and healthcare delivery in Ghana.

Chapter three of this study comprises the methodology aspect of the study. It detailed exactly how this study was carried out. The chapter showed how samples were selected in the course of the study, how the data were collected, and the instruments that were used to collect the data, how the data were presented and finally how the data were analyzed.

Chapter four of the study encompasses the presentations of data generated from the field. Both quantitative and qualitative data generated from the field through the administration of questionnaires and interviews are presented in this chapter.

Chapter five comprises the analysis of findings from the field.

Chapter six of the study comprises conclusions and recommendations of the study.

CHAPTER TWO

2.0 LITERATURE REVIEW

This chapter comprises the literature review aspect of the study. Among other things, the review explores a significant number of scholarly publications on state-civil society synergy and its relevance to promoting sustainable development. In general, it seeks to place the study within existing theoretical literature and empirical findings regarding the topic, how the concepts of state-civil society synergy became a mainstream topic in development planning and ultimately evaluate recent empirical study on the relevance of synergy in development thinking and implementation. As this study adopts the case of collaborative rural healthcare delivery in a community in Ghana, the review also briefly looks at healthcare delivery in developing countries, civil society involvement in national health systems and finally reviews publications on the healthcare delivery system in Ghana and how civil society has played a role within that context.

2.1 The role of state-civil society synergy in the sustainable development debate

The debate about state-civil society synergy as a more effective and efficient strategy for public policy implementation has attracted the attention of many political decision makers and development practitioners in recent times. This re-emerging consensus can be traced to the past failures of the state (i.e. governments) as the lead agency in single-handedly delivering the developmental needs of their respective countries (Bruce, 1994). This observation is supported by the UNDP (2012) when it argues that, civil society as a global phenomenon has seen a remarkable rise in recent years. At the global level, there is increasing recognition of the relevance of civil society organisations in implementing what is agreed on at the international level. This has manifested in calls for more grassroots participation in development programmes. At the national level too, there are increasing calls for greater emphasis on civic engagement in national development planning. The UNDP (n.d) describes civil society as the 3rd sector of society existing alongside and interacting with the state and profit-making organizations. Civil society has also been described as "*an arena of both collaboration and contention whose configurations may vary according to national setting*

and history". (UNDP, n.d, p. 2).This pre-supposes that the nature and characteristics of state-civil society relationships is not homogenous but vary in context from country to country.

According to Selsky and Parker (2005), collaborative engagements have become predominant in the developmental practice of nations over the decades culminating in a significant evolutionary change in conventional forms of governance. One of those significant collaborative engagements is the increasing partnerships between governments and civil society in addressing social issues such as affordable healthcare delivery. In explaining the concept, Nelson and Zadek (2000 as cited in Selsky and Parker, 2005, p. 850) on their part define state-civil society synergy as those *"voluntary collaborative efforts of actors from organizations in two or more sectors in a forum in which they cooperatively attempt to solve a problem or issue of mutual concern that is in some way identified with a public policy agenda item".* The phenomenon has become so popular that authors such as Prakash (2002) and O'Riain (2000) believe that such emerging collaborative relationships between governments and civil society organizations are increasingly blurring the boundaries between public and private spheres as they are increasingly becoming embedded in each other. This study agrees with the expositions of these authors as this phenomenon is increasingly becoming popular globally and manifest in various forms in countries including Ghana. A concept known as *hybrid governance* has now been coined by development scholars to describe the increasing collaboration between the state and civil society in coproducing public goods and services (Klitgaard & Treverton, 2003).

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2.2 Understanding the increasing popularity of state-civil society synergy phenomenon as a development strategy

According to Googins & Rochlin (2000, as cited in Selksy and Parker,2005), the increasing partnerships between public agencies and civil society to find solutions to societal challenges has grown very rapidly in recent years both in advanced and developing economies but remains a poorly understood phenomenon. Such cross-sector social-oriented partnerships vary in size, scope, and purpose and essentially aim to jointly address recurring challenges such as education, healthcare provision,poverty reduction and in some cases promoting environmental sustainability (Selsky and Parker, 2005). This assertion manifest in the case study of collaborative healthcare delivery adopted for this study where there is partnership

between the Ghana health service and community health volunteers in the Nsanfo community in the central region of Ghana.

Several reasons have been deduced to explain why this synergy phenomenon is becoming so popular. A dominant argument often cited to explain the necessity for such partnerships is that, both the state and civil society organizations collaborate because of their individual inadequacies (Child & Faulkner, 1998, Ostrom, 1996, Evans, 1996). Evidently, there is some degree of consensus within development literature that practically, the state on its own in terms of financial resources and capacity cannot deliver all the goods and services needed for quality standards of living. Civil society has therefore been identified as the credible partner for collaboration in the provision of these public goods and services. This assertion is corroborated by the UNDP (n.d. p. 2) when they contend that governments in developing countries can not on their own fulfill *"all the tasks required for sustainable human development. This goal requires the active participation and partnership of citizens and their organizations".*

A vibrant civil society is regarded as very instrumental in the expansion of human development because such civil society can affect norms that hitherto hindered human development through advocacy, social service provision, provoking policy change and ultimately champion social action that promotes quality human development (UNDP, 2012). In a critical examination of literature on synergy, one golden thread that runs through indicates that, there exist intrinsic developments enhancing values embedded in civil society of which the state as a matter of importance ought to tap in their developmental aspirations. It is believed that, in instances where such collaborations have taken place, sustainability of development interventions is relatively guaranteed. This study agrees with this school of thought based on some evidence from empirical works on synergy conducted by scholars such as Ostrom (1996) and Peter Evans (1996) in which such collaborations led to the effective execution of a sanitation project in Brazil.

Proponents of state-civil society synergy for development contend that apart from financial capital, other forms of capital such as social networks, community norms, and associational activities which are characteristic of civil society are crucial ingredients needed to promote social welfare and sustainable development in general (Evans,1996, Ostrom,1996). It has

therefore become necessary for the state to tap into these other forms of capital endowed with civil society to promote sustainable development.

Notwithstanding these positive attributes ascribed to state-civil society synergies, it is interesting to note that this synergetic partnership between the state and civil society has equally been criticized by some scholars as an attempt by governments to covertly distance itself from its traditional responsibilities of delivering public goods and services. Scholars such as Ashman (2000), Googins& Rochlin (2000) and Klitgaard & Treverton (2003) contend that governments are increasingly relying on civil society to deliver public goods and services because of the dwindling public confidence in governments. This study disagrees with this school of thought based on the belief that, government involvement of civil society in developmental projects is not a bad practice at all but rather is a manifestation of good governance that needs to be encouraged. The mere fact that governments recognizes and trust civil society enough to engage it in the governance process is a positive practice and should be encouraged. This stand is supported by the UNDP (2012, p.5) when they contend that, "*state-civil society partnership should not be considered as a separate domain as it is the tendency today, but rather as part of an overall approach to bring state and society together, which is intrinsic to human development"*. These interesting arguments and more is what has engaged development scholars, policymakers and development practitioners in increasingly paying attention to the ongoing debate about the potential of state-civil society synergy in enhancing sustainable development.

2.3 The realm of civil society

Even though the discussions about state-civil society synergy have been quiet insightful, there continues to be some lingering controversy about the exact role civil society contributes to national development. One valid deduction that can be made from the narratives on civil society is that most of the controversy arises from the conception or misconception of what constitutes civil society. This observation is shared by Wilson and Johnson (2000) when they argue that current discussions on the role of civil society in many development literatures continues to raise many conceptual and practical questions as to what constitutes civil society and what its role in development really is. Based on these conceptual problems and more, it is prudent for this study to briefly explore what constitutes civil society.

It is worth noting beforehand that there is no single definition to the concept. Several scholars have described it differently based on their own backgrounds and interest. Wilson and Johnson (2000) for example use the concept civil society to connote all those associational lives found outside the state and are typically highly fragmented in organization and action. They cite non-governmental organizations as examples of civil society organizations. This definition by Wilson and Johnson (2000) outlines one crucial characteristic that distinguishes civil society from other association in society which is that they are found outside the state. Other schools of thought narrow the definition of civil society to exclude profit making firms and enterprises (Skidmore, 2010). The UNDP(2012, p.3) on their part define the concept to encompass those *" diverse range of non-governmental organizations and actors engaged in not-for-profit activities, i.e., policy advocacy groups, transnational coalitions, non-governmental organizations (NGOs), indigenous peoples' organizations, faith-based groups, women's groups, social movements, volunteer involving associations, professional and media associations, academia, trade unions, and communities*". This definition aptly captures the mainstream description of civil society as such this study adopts this UNDP definition as the working definition of the concept in the context of the study.

2.4 Factors that promote effective state-civil society synergies for development

2.4.1. Regrime type

The ability of civil society to effectively engage the state in coproducing public goods and services depends on a number of factors. It is generally agreed among development scholars and practitioners that the effectiveness of state-civil society synergy depends on the larger politico-bureaucratic setting of a country. A fundamental variable is the type of political regime because it influences the nature of the state and its relationship with civil society (see Fisher, 1998; Frishtak, 1994; Rothchild, 1994; Salamon & Brinkerhoff, 1999). This factor cannot be underestimated. The point is well-reiterated by Evans (1996, p.1120) when he argues that "*effective states deliver rule-governed environments which strengthen and increase the efficiency of local organizations and institutions*". As a rule, democratic political systems have been identified to offer a more supportive enabling environment for state–civil

society partnerships than authoritarian or limited democratic forms of government (Diamond, 1994, Brinkerhoff, 1999). This study agrees with this argument. The simple reason being that; the rule of law (as against arbitrariness) which is a crucial condition for effective state-civil society relationships is effective in democratic regimes than in autocratic regimes. Democratic regimes tend to provide the political space for civil society operations without intimidation. Irrespective of these facts, it is crucial to also state that in as much as the character of the state can be instrumental in fostering an effective state civil society synergy for developmental ends, this same state character can also be the main obstacle to effective synergetic relationships.

This "anti-synergy" attitude of the state is demonstrated by a study done by Ostrom (1996) concerning primary education in Nigeria. In this particular instance, the character of the state was the main stumbling block in civil society's effort to contribute to primary education in the locality. The state did not contribute any tangible resources to primary healthcare provision in the locality.To make matters worse, Ostrom's (1996) study revealed that, the rigid and unstable bureaucratic regime on the side of the government left no room for innovation on the part of civil society in finding sustainable solutions to the provision of primary education in the locality. Such uncomplimentary attitude of the state in this case eliminates all possibilities for synergetic relationships with civil society. In the case of the collaborative healthcare delivery that this study seeks to examine, it can be deduced from the above argument that, such collaborations have been made possible largely because of the conducive political space in Ghana.This condition thus allows the state to freely partner with civil society in delivering rural healthcare.

2.4.2 Flexible legal framework

Closely related to the regime type is also the argument that for such synergies to be effective there ought to be the legal options available to allow for both the state and civil society to collaborate. Particularly, it is argued that the regulatory legal framework regarding the provision of a public good or service should be flexible enough to allow for innovation. Authors such as Brinkerhoff (1999) and Ostrom (1996) argue that just like the regime type being an influencing variable on state-civil society synergy, the legal environment can either be an impediment to such collaborations or a catalyst for same purposes. Ostrom (1996) in her

study of synergies in a sanitation project in Brazil theorized that, legal institutions encouraging both local and official initiatives was one major condition that encouraged trust and credible commitment from both citizens and government officials thus leading to the successful completion of the sanitation project. Such legal conditions can be as simple as the enforcement of contracts as expressed in any partnership between civil society and government officials. In the case of the CHPS programme that is adopted for this study, it can be inferred from this argument that, among other factors, the legal framework regulating the operations of the Ghana health service is what enabled the partnership with the community health volunteers to be possible in the first place. Such legal frameworks will determine the terms of operations in the contract between partners and also make any decision taken by the CHPS legitimate.

Proponents of this school of thought argue that non-democratic regimes often assume uncooperative attitudes towards civil society involvement in governance whiles the legal environment in democratic regimes often tends to accommodate and encourage civil society involvement in governance hence a likely partnership with the state. The potential of civil society to arouse the political consciousness of the citizenry for mass action is not a doubted issue. The seeming social bond and trust embedded within civil society can be harnessed for good developmental purposes and also used to incite sentiments against an unpopular government. It is this characteristic of civil society that usually attracts suspicion and mistrust from non-democratic regimes thus informing them to place legal impediments to stifle civil society. Such an uncooperative legal environment discourages any form of partnership between the state and civil society for developmental purposes. The relevance of legal framework in promote synergetic relationships is well summed up by the UNDP (2009) when they contend that

> "*A state's legal framework is one of many factors that affect how conducive the overall environment is towards civil society and its organizations. An enabling legal framework is certainly no guarantee of a vibrant civil society, and a disabling or restrictive legal framework is not necessarily an insurmountable barrier for civil society engagement and participation in public affairs. Nonetheless, the legal framework plays a pivotal role and an overall supportive legal framework can be considered a necessary, but not sufficient, condition for the development of a strong and sustainable civil society sector"*

2.4.3. Nature of public policy

Brinkerhoff (1999) argues that the potential for successful state–civil society partnerships is also influenced by the nature of the particular policy and social issue that the partnership deals with. There is no doubt that developmental policies differ in terms of the degree of technical expertise required, and the type of resources needed for their implementation. Such variations can influence the appropriate roles and responsibilities of the partners involved in a partnership thus the state and its civil society partners for that matter. Wilson and Johnson (2000) argue that development interventions are by nature characterized by activities which in practice reflect the social relations of which they are part. Thus assessing these projects or interventions can reveal the dynamics of state-civil society relations and also enhance the potential for partnership and participation to ensure sustainability. Ostrom (1996) illustrates this with the sanitation project in Brazil, where citizens had local information, skills, time and other local resources while the government complimented by providing capacities to construct public works and connecting the feeder lines to the trunk lines and treatment plants. This eventually led to a successful implementation of the sanitation project.

Moreover, because the civil society side of partnerships often involves voluntary collective action Brinkerhoff (1999, p.79) argues that "*successful policy implementation partnerships must pay attention to crafting an agenda and actions that solicit and hold the interests of the nonstate partners, whose contribution is usually non compulsory and non- remunerative*" . This point is very relevant in the case of healthcare provision in this study. The nature of healthcare provision is such that, some of the less technical responsibilities are be delegated to civil society (health volunteers) in the case of the CHPS programme whiles the Ghana health service (nurses) take care of the technical aspects of the CHPS programme.Because the services of the volunteers are also voluntary, the CHPS programme ought to have ways to sustaining the interest of the volunteers in continuing their non remunerated services.

2.5 The role of social capital in the synergy equation

Usually discussed alongside the debate on synergy is another important concept that has gained popularity among synergy literature. This is the concept of social capital. As Kumayov (n.d,) argues, this concept has attracted not just the attention of scholars, but also policy makers, donors and multinational development institutions. The narrative is that, this concept

of social capital is one of the crucial elements necessary for synergic relationships to emerge in the first place or to be sustained. The amount of social capital existing in any synergetic relationship can influence the sustainability or otherwise of any partnership between the state and civil society (Evans1996). According to Putnam (1993) social capital usually denotes those social networks established by associational engagement, such as voluntary organizations, family relations and collective norms and trust usually generated among citizens. Edwards (2009) argues that these concepts of civil society, social networks and social capital are arguably now regarded as the *missing link* in development. This implies that in order to make all other components of development such as economic and politics have a truly significant impact on the quality of life of a nation, such components should actively engage civil society in the development interventions (Harris, 2001). In order words, civil society and social capital engagement are now seen as the panacea to achieving sustainable development. This study strongly agrees with this assertion.

According to Evans (1996), the most basic issue to contend with when analyzing the origins of social capital in society is to examine whether such social capital already exist as an endowment in society or whether the synergy can be constructed. This assertion looks at whether the possibility of synergy depends primarily on certain socio-cultural endowments that must be tapped or whether such synergy can be constructed by applying certain imaginative organizational incentives (he *calls soft technologies)* to produce social capital in instances where such synergies are not naturally endowed. This constructibility may involve simple strategies such as just rethinking conventional ideas on how to build such synergies to suit local characteristics. These observations re-echo's' Ostrom's (1996) contention that, in instances where social capital and synergetic tendencies are absent, there ought to be certain incentives put on place in order to encourage synergetic tendencies. When these conditions are met, synergetic would be realized due to organizational innovation. These issues on social capital raised by the authors can be said to manifest in the CHPS programme operating in the study area. The fact that the programme was successfully conceived, collectively supported and implemented by the partners means that someway somehow, the social capital endowments of the community were adequately and effectively harnessed to achieve the purpose of collaborative healthcare provision in the community.

2.6 Healthcare delivery in developing countries: A manifestation of state-civil society synergy in practice

Access to quality and affordable healthcare remains a major challenge in most developing countries especially in sub-Saharan Africa. As a result of established correlations that exist between health, productivity and equitable development, healthcare improvements have become a key agendum of development countries. Indeed among other socio-economic priorities, healthcare is one of the dominant issues that is at the forefront of the Millennium Development Goals (MDGs), which most member countries including Ghana aim to achieve by 2015. The state in most countries especially in sub Saharan Africa has predominantly being the provider of healthcare services but this has been confronted with several challenges (Oghu and Gallagher, 1992). According to Robertson et al. (2009), developing countries are increasingly faced with the challenge of achieving sustainable healthcare for all citizens due to of challenges such as economic challenges, geopolitical constraints, transportation, limited healthcare workforce and infrastructural challenges to support qualitative healthcare delivery. In the Sub-Saharan African case for example, the International Financial Cooperation (n.d) argues that "*in spite of the billions of dollars of international aid dispensed, an astonishing 50 percent of Sub-Saiaran Africa's total health expenditure is financed by out-of-pocket payments from its largely impoverished population. In addition, the region lacks the infrastructure, facilities, and trained personnel necessary to provide and deliver even minimal levels of health services and goods*".

This rather uncomplimentary description of healthcare delivery in sub-Saharan Africa is not surprising. Given the complex and interconnected nature of healthcare delivery sector of any country, it is practically impossible for the countries in most developing countries as such to be posses all the resources, information and competence necessary to effectively deliver healthcare without assistance from any other sectors of the society (Centre for Global Development, 2009). It is in this regard that civil society especially private sector actors in most developing countries has intervened to compliment the efforts of governments in the provision of public goods such as healthcare. According to the Centre for Global Development (2009) "*by some estimates, more than one-half of all healthcare services to the poorest people is provided by private doctors, other health workers, drug sellers, and other non-state actors".* In this particular instance, it can be inferred that the definition of civil

society has been broadly extended to include non-governmental private healthcare providers and nonstate actors like health volunteers who are all involved in healthcare provision.

In supporting the increasing importance of the private sector in healthcare delivery, Burger et al. (2012,p.1) also argue that *"it is unlikely that any pragmatic solution to increase health care access can be achieved without active participation of both the private and public health care sector*". In such collaborations, civil society organizations act as either direct providers of healthcare services in oartnership with the state, contracted by the state, or they totally take over in areas where the state has ceased to operate (Loewenson, 2003). The former typology manifest in the CHPS programme which is the adopted for this study as it is based on collaboration between the state i.e. Ghana health service, and civil society in the form of community health volunteers. State-civil society relationship in healthcare provision could also manifest in the state given preferential incentives to private sector health providers in forms as subsidies for their cost of operations, special tax exemptions or even direct funding (Loeweson, 2003). Civil society organization's engagement in the health sector of such countries thus introduces new institutional, social, financial and other complementary resources to the healthcare systems.

According to Loewenson (2003), one important advantage of civil society involvement in healthcare delivery is that, they most often possess the ability to reach usually marginalized populations and poorly served remote communities. Access to quality healthcare in most developing countries is usually concentrated in urban areas largely neglecting rural and remote communities. In such instances, civil society intervenes to fill in the gaps where the state is absent. As the Centre for Global Development (2009) argues civil society and especially the private health sector often present significant opportunities to improve access to and coverage of services critically needed to reach the internationally acclaimed health-related Millennium Development Goals. On the macro level, in some extreme cases of political instability in some countries, CSOs have been found to replace the state as the major providers of healthcare services to the population of such collapsed states (Loewenson (2003). CSOs have also been identified to sometimes operate in difficult and high risk environments in their quest to provide healthcare services to remote and marginalized communities (Joseph et al, 1999). These reasons and more therefore make valid cases for the state to collaborate with civil society to fill in the gaps where the state is lacking.

2.7 Community participation in healthcare delivery

Usually discussed alongside civil society participation in health delivery in developing countries is the more general case of community participation in development interventions and healthcare delivery as an example. This phenomenon has been extensively discussed by healthcare practitioners and policy makers in the quest for universal primary healthcare delivery in most developing countries (Zakus and Lysack, 1998). However, it is important to note that there is no definite consensus among healthcare policy planners and professionals on what the exact contribution of community participation to health improvements are. Whereas some schools of thought completely dismiss its value altogether, others believe that community participation in healthcare delivery is the "magic bullet" that will ensure health improvements especially in the context of poverty alleviation (Rifkin, 2001). Despite this lack of consensus, community participation continues to receive support as a key to health development in most literature. The concept was championed by the 1978 WHO/UNICEF sponsored Alma Ata Declaration which identified community participation as a core principle of primary health care (Baatiema, Skovdal, Rifkin, and Campbell, 2013).

According to Zakus and Lysack (1999), the campaign promoting community participation in healthcare delivery emerged in the 1970's. This was especially in the global south when it became evident that public health agents alone were not capable of meeting the healthcare needs of citizenry hence the need to engage the communities in the provision of their own healthcare (Zakus and Lysack,1999). Preston, Waugh, Larkins and Taylor (2010) contend that, several case-studies have shown that, the results of community participation in healthcare delivery have been predominantly positive. This study examines this assertion in the case of the community based CHPS programme in the Nsanfo community of Ghana where community volunteers and members partner with the Ghana health service to coproduce healthcare.

The term community participation in any intervention generally denotes the practice of community members collectively assessing their needs and collectively diagnosing pragmatic solutions on how to meet those identified needs. (Zakus and Lysack 1998). One area of community participation in most countries both developed and developing is in healthcare delivery. The 1978 Declaration of Alma-Ata defined the concept of community participation in healthcare delivery as '*'the process by which individuals and families assume responsibility*

for their own health and welfare and for those of the community, and develop the capacity to contribute to their community's development" (World Health Organization, 1978). Such community participation in primary health care has been argued to enhance more acceptable and relevant healthcare provisions in addition improving its accessibility (National Rural Health Alliance 2002; Taylor et al., 2008). For example, according to Preston et al. (2010) in developed countries such as Australia, government's agents at both national and district levels have maintained and promoted community participation in healthcare delivery due to its manifest benefits. This proves the case that, the phenomenon is not exclusive to only poor or developing countries, but has become popular even among developed countries.

There is an appreciable amount of evidence to show that certain types of heath service delivery are better enhanced with the active participation of the communities they are intended for (Mike 2010 as cited by Abdulraheem et al., 2011). The reason for such positive assertions is that as end-users of the healthcare services, beneficiary communities have a duty in ensuring that such healthcare services are well delivered, and moreover, they are also well-positioned to monitor the quality of services. It is also contended that with the benefit of local information, communities can assess the specific obstacles facing facilities in providing healthcare services and also ensure that the right working conditions are available for the sustenance and success of healthcare interventions (Olapipo and Amodu.2011)

In the broader picture, several reasons have been enumerated to make a case for the promotion of participation and partnership in development planning and implementation. Wilson and Johnson (2000) for example identify three reasons why community participation in development interventions is necessary. According to the authors, apart from improving the effectiveness of development intervention, community participation as a sustainable development strategy also

- Leads to more effective interventions because in practice, it is an inclusive processes which engages all stakeholders in deliberating on the matters that concern their own welfare thus avoid problems of exclusion.
- Leads to more effective interventions because they reveal the complex social dynamics that surround them and thus enable interveners to take these into account when planning and implementing interventions.

- Specially improve cost effectiveness of social development as it brings on board civil society actors who positively assume ownership of developmental interventions and are an added resource in their implementation.

Even though the above argument by Wilson and Johnson (2000) are all important, this study would like to elaborate on their second argument. It is a widely known fact that local communities are endowed with some indigenous knowledge and social capital that can be very relevant to development interventions. Most of this local knowledge is time tested and passed down from generation to generation. A number of development literature have also revealed that the top-down approach to development interventions have most often than not collapsed or failed within a short period of time after implementation. One major factor that has often been cited to explain this phenomenon is the failure of such development implementers to investigate the peculiarities of the project areas. The practice has being to design projects from "outside" with the assumption that since such designs have worked in some situations, it can be directly replicated in order areas. Under such strategy, intended beneficiaries who are important stakeholders are not involved in the design and implementation of such projects. This situation creates cases where development interventions become white elephants as a result of either inappropriate design or inappropriate implementation in the areas where local stakeholders are not consulted or involved. This situation often breeds a non-cooperation and passive attitude on the part of the intended beneficiaries leading to boycott or eventual collapse of such projects due to inappropriate design and implementation.

To avoid the failure of such development interventions, Wilson and Johnson's (2000) suggestion of partnership and participation thus becomes a credible suggestion worth considering in sustainable development planning and implementation. Such locals are the repository of very crucial indigenous knowledge needed to ensure reveal the peculiarities and not easily observable characteristics of the project area to the implementers.

With regard to 3rd proposition, Wilson and Johnson (2000) claim that partnership improves the effectiveness of the provision of publics whiles making them cheaper. This study argues that in as much this claim can be true in some cases, it is worth stating that, that could be relative and not necessarily applicable to all situations. Partnership could enhance cheaper cost of projects but would not necessarily guarantee quality. Quality can be compromised

especially when the one party which is co-partnering in delivering the public good is not competent in the context of the project but only involved for the sake of participation. For example, project implementers can decide to rely on cheap labour in communities where projects are to be implemented in order to beat down on cost. Such labour might be cheap but can also compromise the quality of the project especially if the labour is unskilled. Thus, even though Wilson and Johnson's (2000) argue that partnership and participation delivers public goods are cheaper cost; this study believes that is relative and not necessarily automatic in all cases. The nature of the project should determine whether partnership/participation is necessary for its execution or not.

Another interesting issue Wilson and Johnson (2000) raise in their commentary on participation is that, "*it can lead to the empowerment of disadvantaged and hitherto invisible individuals and organizations"*. This point is very important because it brings to bare one of the often neglected dimensions of development interventions. Most people especially in rural communities are deprived as a result of several factors such as poverty and cultural norms. Such people are and often marginalized in decision making process in their communities. Amartya Sen (1999) in Development as Freedom states that the ability and opportunity for one to participate in decision making is a form of empowerment as such marginalizing people for whatever reason can be described as a form of disempowerment. The conventional top-down approach to development project implementation by which projects are designed from outside and transplanted into project areas has most often than not further deepened this form of marginalization. This is so because such top-down approach rarely seeks the opinion and contribution of locals to project design and implementation thereby depriving them of the opportunity to feel relevant and express their opinion about projects. In supporting the above argument, Oakley and Kahsey (n.d, as cited in Rifkin, 2001) argue that, the necessity for community participation in healthcare delivery for example is based on the belief that there is an indirect effect of empowerment due to the building of self esteem and sense of responsibility.

This study agrees with this point because through the opportunities for interactions and engagements with public health officials, community members are able to air their views and also speak on issues that matter to them. The feeling of recognition and the opportunity to contribute to the matters that concern the community could be a source of encouragement. Such opportunities will empower them to take up initiatives to participate in healthcare

interventions since they realize the efforts are crucial for the success or failure of a health intervention. Community participation thus breeds a sense of ownerships of the interventions thus empowers community members. Wilson and Johnson's (2000) claim that participation leads to empowerment of marginalized parties is thus in the right direction as it provides them with hitherto non-existing platforms to be heard at *least for once.* Such empowerment through participation inculcates a sense of project ownership and can go a long way ensure project sustainability.

In as much as civil society or community intervention in health care delivery is desirable and encouraged; Loewenson (2003) cogently argues that, civil societies in developing countries cannot on their own address some of the wider challenges impeding health service access and general public sector service provision for that matte. Community participation should not also be seen as a substitute for the state. In supporting same argument the Centre for Global Development (2009) also contend that "*the private sector is a not a replacement for effective public-sector action. In every setting, both sectors have roles to play in addressing the complex and difficult challenges faced by developing countries to expand access to high-priority health services to underserved populations*". This study strongly agrees with this argument thus adds that the relationship between the state and civil society should therefore be collaborative and complementary and not mutually exclusive in the quest to deliver healthcare for its citizenry.

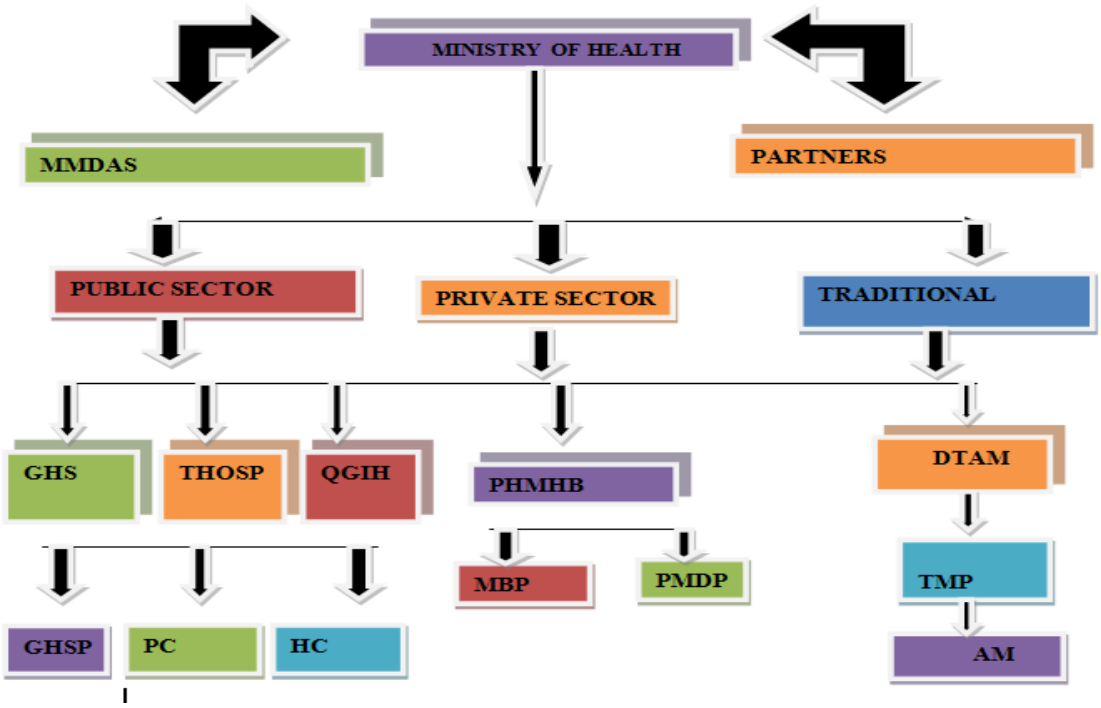
These benefits notwithstanding, Kilpatrick (2009) contends that even though it is often assumed that community participation in healthcare delivery will usually result in higher community satisfaction in the services and ultimately better health outcomes, evidence to support such assumptions is limited. This thus implies that there is the need for more empirical research into the impact of community participation in healthcare delivery thus justifies the need for this particular study. Since the main objective of this study is to examine how state-civil society partnership can be used as an effective strategy for improving rural healthcare delivery in Ghana, it is believed that, the findings at the end of the study will contribute in filling up this literature gap.

2.8 Primary healthcare delivery in Ghana

Attaining universal primary healthcare is no longer a developmental aspiration of just individual nation states but has become an international agendum as captured in the widely discussed Millennium Development Goals (MDG). Indeed the fourth goal of the MDGs is to reduce under-five mortality rate to two-thirds by 2015; the fifth goal is to reduce the maternal mortality ratio by three-quarters by 2015, and the sixth goal is aimed at reducing infection rates of HIV/AIDS, malaria, and other communicable diseases associated with hygiene and environment by 2015 (UNDP, n.d).Ghana as a developing nation aspires to achieve these international developmental ideals so far primary healthcare delivery is concerned as such the government of Ghana thus prioritizes health issues within the MDGs as part of its broader national developmental agenda (Ghana Health Service, n.d).

Ghana, since gaining independence in 1957 has implemented several policies aimed at improving the health status of its people (Van de boom et al, 2004). According to the WHO 2011 country report on Ghana, life expectancy at birth is now at 64 years, infant mortality rate as at 2011 stood at 78deaths per thousand live births and the maternal mortality ratio stood at 350 deaths per live 100,000 births (WHO, 2011). In statistical terms the country can be said to be doing relatively better when compared to previous rates and to that of other sub-Saharan countries but much more can be done especially with affordability and accessibility to primary healthcare especially among rural dwellers. Two government institutions define the public sector involvement in Ghana's health system: the Ministry of Health (MOH), which is responsible for policy making for the health sector and the Ghana Health Service (GHS), which is responsible for service delivery (Makenin, 2011). Healthcare delivery system in Ghana is organized into four main categories so far as its organizational structure is concerned. These are: public, private-for-profit, private-not-for-profit and traditional systems (ACCORD, 2009). Even though the former three represent the dominant practice of healthcare delivery in Ghana, there has been continuos efforts to integrate traditional medicine into the orthodox healthcare delivery system since 1995 (ACCORD, 2009). In a simple diagram, the healthcare structure of Ghana is organized thus:

Figure 2: STRUCTURE OF THE HEALTH SECTOR OF GHANA



LEGEND

MDAs –Ministries Departments and Agencies

GHS- Ghana Health Service

T HOPS- Teaching Hospitals

QGIH- Quasi Government institutions hospitals

PHMHB- Private Hospitals and Maternity Home Boards

DTAM- Department of Traditional and alternative Medicine

GH- Government Hospitals

PC- Poly clinics

HC- Health centers

MBP- Mission-Based Providers

PMDP- Private Medical and Dental Practitioners

TMP-Traditional Medical Providers

AM-Alternative medicine

FH- Faith Healers

Source: *Abor, P. A, Abekah-Nkrumah, G; Abor, J. (2008, as cited by ACCORD, 2009)*

From Figure 1, it can be deduced that, healthcare delivery in Ghana is not exclusive to the government. The private sector and civil society has been largely involved in the provision of

healthcare in the country. Such civil society organizations involved in healthcare delivery system in Ghana include the private hospitals and maternity home boards, the mission-based providers, private medical and dental practitioners and the faith healers among others.This situation reflects Ostrom's (1996) concept of coproduction in which she advocates the combination of resources by the state and civil society to collaboratively produce those public goods and services they hitherto produced single-handedly. This concept of coproduction appears to manifest in the case of healthcare deliver in Ghana. In most rural areas in Ghana, preventive and primary healthcare is predominantly provided by the community health posts under the CHPS programme but they are limited to just curative treatment due to the fact that they are mostly not staffed by doctors but by only nurses and sometimes midwifes (Ghana Health Service, n.d). In practice, community-based nurses and health workers provide emergency treatment at the health post stationed in communities and refer more complex cases to district hospitals, polyclinics, regional or tertiary hospitals, depending on the institution's proximity and the treatment required. In the case of urban areas, government hospitals and polyclinics are the first points of contact and main providers of curative secondary and tertiary health care respectively (ACCORD, 2009).

2.9 Administrative structure of health

The current operation of public healthcare delivery in Ghana is administered through the National Health Insurance Scheme (NHIS) which came into operation in 2004. The NHIS was established by parliamentary ACT 650 and LI 1809 (National Insurance Act) which was passed into law in August 2003 (Hepnet, 2007 as cited in ACCORD, 1999). With regards to legal regime establishing government responsibility in healthcare delivery in Ghana, article 36 clause 10 of the 1992 constitution of Ghana stipulates that, "*the state shall safeguard the health, safety and welfare of all persons in employment, and shall establish the basis for the full deployment of the creative potential of all Ghanaians"* (4th republican constitution of Ghana, 1992). This constitutional mandate to a large extent charges the state to spearhead the provision of healthcare within the country thus makes government the dominant actor and lead agent in healthcare provision. Ghana practices the centralized system of government with some degree of decentralization. The Ghana health hervice (GHS) is predominantly in charge of healthcare delivery in the country complemented by some private partners.

Politically the Ministry of Health is responsible for policy planning processes and information management, particularly concerning the areas of financing, human resources and infrastructure (Ministry of Health, 2008).In order to ensure efficient and effective administration, healthcare administration in Ghana is divided into three administrative levels: national, regional and districts levels which is further divided into sub district and community levels (Ghana Health Service, n.d). Healthcare at the rural areas is provided by community health compounds (CHC) which operate under the Community Health Planning System (CHPS). Traditional medicine in Ghana is very popular especially among rural community dwellers. Some reasons that could possibly explain the reliance on traditional medicine in most rural communities could be as a result of poverty and lack of access to healthcare facilities. As thoroughly discussed in the problem statement, proper healthcare facilities is heavily skewed in favour of urban communities largely marginalizing rural dwellers. Left with no option, most of the rural dwellers resort to traditional medicine as the dominant source of healthcare. The importance of traditional healthcare delivery in aiding government reach universal healthcare coverage in the country has been recognized and is continuosely being integrated into the heath sector reforms of governments of Ghana since independence.

2.10 Civil Society and healthcare delivery in Ghana

Civil society in Ghana has been a crucial partner in healthcare delivery for decades. According to Makenin et al (2011), "*the private health sector in Ghana is a large and important factor in the market for health-related goods and services. However, little has been documented concerning the size and configuration of private providers and their contribution to health sector outcomes".* This form of civil society has largely been privately owned health providers and Non-Governmental Organizations (NGOs) thus vary in nature from the type of civil society (health volunteers) adopted in the context of this study. Civil society participation in healthcare has been dominated by mission or faith based health providers who operate not for profit (Ghana Health Service, n.d). According to ACCROD (2009), a survey conducted in 2005 by the Ecumenical Pharmaceutical Network (EPN) found that faith-based health services in Ghana provide approximately 40% of the available health careThe other types of civil society healthcare providers are the Self-Financed Providers (SFP) who are profit driven and provide more than half (55%) of all services used by Ghanaian consumers. They include private hospitals, clinics, retail pharmacies, laboratories and chemical shops i.e., drugstores (Makenin, 2011).This statistics proves the important role the civil society is

playing in healthcare delivery in Ghana. It is worth noting that, if we are go by the narrow and strict definition of civil society adopted by WHO (2013) to refer to that social sphere separate from both the state and the market, then, these profit-driven private providers will not qualify as being part of civil society. But as indicated earlier on, in this particular case, the study adopts a broader definition of civil society to refer to refer to all those non-state organizations which are not affiliated to the state or government. On that base, it can therefore be deduced that, the mission-based healthcare providers and self-financed private providers, constitute the two major civil society bodies involved in healthcare delivery in Ghana.

According to EPN (n.d as cited in ACCORD,2009), of the large number of faith based private healthcare providers in Ghana, the Catholic church covers 27% share of healthcare provision, other Christian churches cover 11% whiles Muslim organizations cover between 1 to 2 % of the 40% faith-based health services in Ghana. This is corroborated by Makenin (2011, p. 43) when they argue that "aside from the Amadea Muslim Mission which contributes to roughly 2 percent of nonprofit service provision, the Christian Health Association of Ghana (CHAG) represents nearly all nonprofit civil society health care service provision in the country and usually target slum areas and hard-to-reach rural communities" . The Christian Health Association of Ghana (CHAG) member institutions are predominantly located in rural communities with the major aim of providing quality but affordable healthcare to the often marginalized and poor rural dwellers who lack access to proper healthcare services. They are mostly concerned with primary healthcare services such as immunization, family planning, maternal and child health services and health education (CHAG, 2003)

These Christian healthcare delivery organizations liaise with the Ministry of Health to ensure proper collaboration and complementation of the government efforts at providing for the health needs of Ghanaians (CHAG, 2003). Forty-five to sixty per cent of the total operational cost of these Christian faith-based health organizations comes from subsidies from the government (CHAG, n.d). This is a manifestation of Loewenson's (2003) observation that state-civil society relationship in healthcare provision could manifest in the form of the state giving preferential incentives to private sector health providers in forms as subsidies for their cost of operations. There are also privately owned healthcare facilities which operate for profit. These are usually located in the urban areas where private medical services can be afforded. According to Makenin (2011) "Private supply of services offers many choices to urban populations. However, rural areas are underserved by both self-financed providers and

Ghana healthcare service providers". This situation has thus necessitated the establishment of the CHPS program to engage community health volunteers as civil society partners in the provision of healthcare in rural communities. This CHPS programme is the focus of this study and is explored in as a sub-heading below.

Table 1: statistics of Christian institutions involved in healthcare delivery in Ghana

Denomination	Hospitals	Clinics /PHC	Schools	Total
Catholic	33	39	3N 3M	78
Presbyterian	4	15	2N	21
Evangelical Presbyterian	2	5		7
Anglican	-	8		8
Methodist	2	3		5
Salvation Army	0	8		8
Baptist	1	-		1
Assemblies of God	2	1		3
World Evangelical crusade	-	1		1
Seventh Day Adventist	7	2		9
Church of Pentecost	4	3		7
Church of God	0	1		1
Church of Christ	0	1		1
Siloam Gospel Mission	0	1		1
AME Zion Mission	1	-		1
Global	1	-		1

Evangelical Church of Ghana			
TOTAL	**56**	**89**	**152**

Key: N = Nursing Training School. M = Midwifery Training School. PHC= Public Health Centers

(Source: CHAG Annual Report June 2005 – May 2006)

This collaboration between these civil society organizations and the government of Ghana in healthcare delivery depicts an example of how state-civil society can form synergetic relationships in delivering a public good.

2.11 The Community Health Planning and Services programme (CHPS): A sustainable solution to rural healthcare delivery in Ghana?

Primary health care provision in Ghana is organized in such a way that it serves both rural and urban dwellers according to priority. The rural areas are however largely deprived of proper and permanent healthcare facilities and personnel (GHS, 2002). In order to bridge the heathcare accessibility gap between rural and urban communities, the Community Health Planning and Service (CHPS) programme was introduced since 2002 to address the deficeits (ACCORD, 2009). This CHPS strategy advocates the systematic planning and implementation of primary health care facilities and activities with active engagement of community members and traditional leaders (Baatiema, Skovdal, Rifkins and Campbell, 2013). In practice, this is usually achieved through the active mobilization and utilization of social networks as community leadership, decision making systems and local resources within defined catchment areas where a CHPS programme is to be implemented. This scheme had been inspired by the outcome of the 1978 Alma Ata declaration which was under the auspices of World Health Organization (WHO) and United Nations Children's Fund (UNICEF). The Declaration sought to redefine primary healthcare from the bureaucratic model of health service delivery to a closer to client model (Baatiema et al., 2013).

The Alma Ata conference advanced the idea that *" the mobilization of traditional Systems of leadership, resources, communication and governance had the potential of increasing health-care services accessibility, reducing child and maternal mortality whilst improving rural-population's overall health*" (Baatiema et al., 2013,p. 5). The outcome of these deliberations informed the Ghana Ministry of Health to introduce the CHPS strategy as a national programme to bridge the gap in healthcare access between rural and urban dwellers. Essentially CHPS reorients primary health care provision away from the conventional sub-district clinic-based mode of operation to a more comprehensive community-based model that integrates volunteers and other civil society agents (SPH, 2009). This scheme increases rural access to health care service while empowering local communities to take greater control over their health thus promoting community-driven health care services, with technical support from the Ghana Health Service (GHS, n.d, Baatiema et al., 2013). One of such CHPS programmes operates in the Nsanfo community in the Mfantseman Municipal of Ghana which is the study area. The picture below is the CHPS facility in Nsanfo.

Figure 3: The Nsanfo CHPS compound.

Photo : Author, Fieldwork, January 2014.

2.12 Brief history of CHPS programme

The introduction of the CHPS is in line with the national healthcare agenda of posting health nurses to every corner of Ghana with the ultimate aim of bringing healthcare to the doorstep of rural dwellers (Ghana Health Service, 2002). The CHPS implementation had become necessary when it became evident that years of experimenting with various'*health for all'* strategies rather revelaled that more than some 70% of the Ghanaian population still lived over 8 km from the nearest healthcare centre as at the 1990s. This slow progress thus necessitated the need to bring healthcare service closer to the rural dwellers (Ghana Ministry of Health, 1998). The CHPS programme was devised as the most appropriate solution after thorough pilot experimentation in a community known as Navrongo in the Upper East region of Ghana focusing on the mobilization of "*volunteerism, resources and cultural institutions for supporting community-based primary health care"* (Nyonator et al, 2005,p. 25).

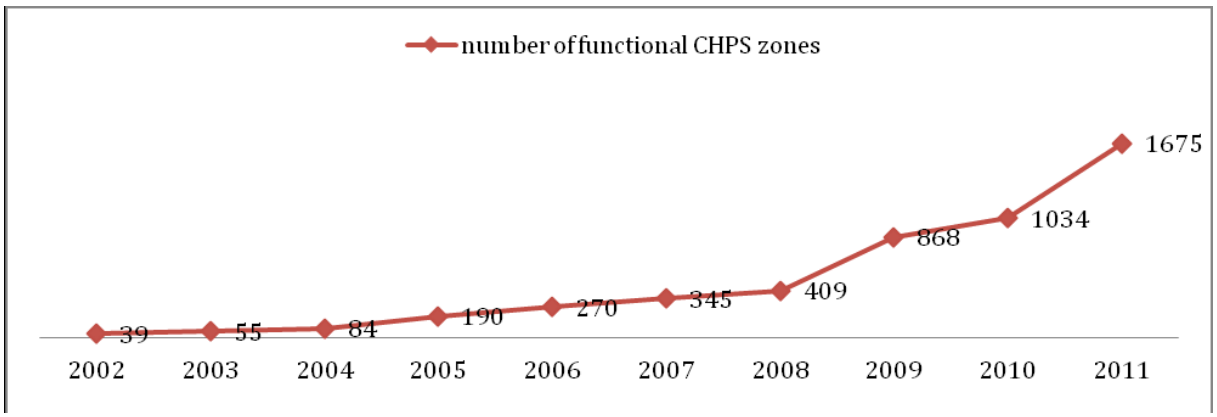
The prime motivation for the Navrongo experiment was based on the conviction of stakeholders at the time that, social resources such as community organization and pre-existing social networks had been underutilized and thus could be tapped to make volunteering services in healthcare provision more effective and sustainable. This pre-existing social networks is what Ostrom (1996) and Evans (1996) refer to as social capital that is described as the single most crucial resource needed for effective state-civil society synergy. The Navrongo experiment and subsequent nationwide implementation of the CHPS programme was therefore seen as finding a sustainable solution to healthcare deficits thus improve healthcare deficits throughout the country (Binka et al., 1995 as cited in Nyonator et al 2005). The programme thus reduces health inequalities by removing geographic barriers to health care. A key component of CHPS is that, it is a community-based, volunteer-led service delivery point that focuses on improved partnership between the Ghana health service on one hand and households, community leaders and social groups in a rural area on the other (SPH, 2009).

Among other things, the main objective of the CHPS is to transform clinic- based primary health care delivery and reproductive health-related services to community-based health agents (Ghana CHPS, 2009). The programme has now become of the core programmes of the

Ghana health service so far as rural healthcare is concerned and represents one of the health sector components of the national poverty reduction strategy (Nyonator et al., 2005).

In practice, CHPS is run by a community health nurse from the Ghana health service and community health volunteers who both participate in the provision of primary health care and family planning services through outreach programmes led by the health volunteers (Myjoyonline, 2013). A typical CHPS compound serves as community of not more than 3,000 residents and focus on such health services as, family planning, treatment of minor ailments, supervising child delivery, antenatal/postnatal care, immunization and health education (GHS,2008, Nyonator et al., 2005). The graph below shows how CHPS compounds across the country have increased over the years since its conception in 2002. As at 2011, the number stood at 1675 CHPS compounds scattered across rural communities in the country.

Figure 4: Number of CHPS compound established as at 2011



Source: Ghana Health Service Annual Report, 2011.

Establishing a CHPS programme like the one in Nsanfo requires six (6) processes according to the Ghana Health Service (2002). These procedures are based on lessons from the Navrongo experiment and are used in the nationwide implementation of the CHPS in rural communities.

In chorological order, the table below depicts these six procedures

Table: 2. Table depicting how CHPS are established

IMPLEMENTING ACTIVITY	TASK REQUIRED IN ESTABLISHIG A NEW CHPS IN A COMMUNITY
Planning	Community awareness building, outreach to traditional leadership
Community entry	Community mobilization and participation, involvement of traditional leadership through community gatherings and cultural diplomacy
Construction of community health compound	Community labour ad resource mobilization for construction of health compound. Idea is to instill sense of community ownership of primary service point.
Community health officer appointment	Mobilize providers to visit households' community and mass education on CHPS operations.
Procurement of essential equipments	Procurement of logistics as bicycles, motorbikes, health kits etc. motorbike riding training and maintenance capacity building.
Recruitment and deployment of volunteers	Selection of health volunteers by the community health committee in conjunction of traditional leaders. Training of volunteers in basic healthcare provision, family planning and the administration of first aid.

Source: Adopted from Ghana Health Service (2002)

This study specially takes notice of the third (3rd) and sixth (6th) milestone which involves the use of volunteer labour and community resources to construct the community health compounds and the recruitment and training of community health volunteers respectively. This last step in figure 4 above depicts the focus of this particular study which aims to assess state-civil society partnership in healthcare delivery in the Mfantseman Municipality. In the case of this CHPS scheme, the Ghana health service represents the state whiles these volunteers represent civil society.

Figure 5: An example of a CHPS community health volunteer at work

Source: Ghana Health Service, 2002.

2.13 Theoretical framework

An important theory that has been identified in the narratives regarding state-civil society partnerships in development is the role of social capital in nurturing effective synergies between state institutions and civil society. Indeed it is believed that social capital is one of the crucial elements necessary for synergic relationships to emerge in the first place or to be sustained. According to Brown and Ashman (1996), the cultivating and enhancement of social capital in the forms of local organizations and networks is an essential task in building state-civil society partnerships that taps local resources and energies for addressing developmental challenges. This social capital of a community has been defined in terms of those societal networks that are grounded in structures of voluntary association as family relations, norms of reciprocity and cooperation, and attitudes of social trust and respect shared by members of a community (Putnam, 1996). In a number of different synergy case studies conducted by authors such as Putnam (1996) Ostrom (1996) and Peter Evans (1996), they all theorize in their conclusions that high social capital endowments in a community had been found to be associated with cooperative social problem solving whiles low social capital endowment affects the sustainability and effectiveness of any state-civil society collaborations for problem solving. This study therefore adopted this concept as an underlining theoretical framework of the study.

With regards to this study, Nyonator et al. (2005) reveal that once the CHPS is launched in any district, the scheme is sustained by the social and political structures in the districts. The socio-political structures in this case could be referring to civil society made up of the traditional leaders, the volunteers as well as the residents of a said community. This argument by Nyonator et al. (2005) re-emphasizes the relevance of social capital which is extensively discussed by Ostrom (1996) and Peter Evans (1996) in ensuring the sustainability of such synergetic schemes as the CHPS. In similar vein, this study theorized that, the social capital endowments in the study area and how it is harnessed play a very important role in determining and analyzing the impact of the CHPS programme in the Nsanfo community.

Assessing the impact of cooperative programs as the CHPS is not a simple matter as the measurement of what constitutes a "success" or "failure" of the programme can be a thorny issue. According to Tendler (1989) and Uvin (1995) as cited in Brown and Ashman (1996), it

is practically difficult to calibrate the different impacts of such collaborative programmes but the capacity to affect large numbers of people is an important aspect of program effectiveness. The impact of the CHPS programme on healthcare delivery in this study was therefore analyzed based on yardsticks such as programme reach(in terms of people immediately affected by the activities of the CHPS as reflected in access of the sampled households of the community to the services provided by the community health compounds. Perception of households about the effectiveness and quality of the services rendered by the health volunteers and the community health compounds was also used in determining the success of the CHPS programme. The impact was also measured based on the review of official documents like the Ghana health report and also from the sample of households and residents that were interviewed and administered questionnaires in the field.

With regards to the role of the community health volunteers, Brinkerhoff (1999, p. 63) theorizes that, "*incentives are the essential lubricant that makes partnerships possible. Positive incentives provide the stimulus that impels partners on both the state and non-state sides of the equation to work together; negative ones discourage them from doing so*". This study in the course of data gathering thus looked out for this factor in the partnership between the MHD and the community health volunteers and how such incentives or its absence affected the execution of the CHPS programme in the Nsanfo community.

Uhoff and Colen (1980) in their article titled *word development* also provide a framework for analyzing community participation in healthcare delivery. According to the authors, "*community participation can best be analyzed by asking the critical questions of: Who participates? Why do they participate? How and where do they participate"?*. This particular framework appears simple but yet quite instructive. At best it traces how the state-civil society relationship within the community is constructed. This framework was thus adopted in the course of data gathering and analysis.

Finally the objective of the CHPS programme according to the Ghana Health Service (2005) is to

- Develop effective intersectoral collaboration.
- Improve efficiency and responsiveness to client needs.
- Improve equity in access to basic health services.

This study thus adopted these stated objectives and compared it with the empirical findings from the field. Such comparison helped the study do thorough analysis of the impact of the CHPS to see if they were actually achieving what they sought to achieve in their stated objective. Also the comparison also helped in further examining why the objectives had not been achieved based on data from the field. These issues were investigated based on interviews and the administration of questionnaires as part of data collection. A review of official health statistics of the Mfantseman Municipal also helped in the data analysis.

2.14 Conclusion

The review of literature reveals that civil society participation in healthcare delivery has largely been dominated by private sector healthcare providers and Non-Governmental Organizations some of whom are profit-motivated and others non-profit. The review also indicates that there is a literature gap so far as community volunteering and state partnership in healthcare delivery in Ghana is concerned. Even though community participation in healthcare is not an entirely new phenomenon; the review shows that less empirical study has been conducted on it. This study therefore helps fill in this literature gap by providing empirical evidence of community volunteer groups in healthcare delivery.

The knowledge and lessons generated at the end of this study is very significant so far as Ghana's developmental aspirations especially in rural healthcare delivery are concerned. This is especially so in this period in Ghana's developmental efforts where governments so far have been unable to single-handedly deliver expected public goods and services. Collaborating with civil society to coproduce and own these public goods and services is one of such pragmatic development alternatives. Investigating the impact of the collaboration between the MHD and civil society in healthcare delivery in the Nsanfo community, therefore, helps make a strong case for government to replicate such collaborations in other deprived rural communities in the provision of healthcare services as an alternative sustainable development strategy.

CHAPTER THREE

3.0 Methodology

Research methodology refers to the whole process of carrying out a study ranging from the research design to data collection techniques, presentation of data and interpretation (Myers, 2009). This study investigated the case of collaborative rural healthcare delivery in the Nsanfo community in the Mfantseman Municipal of Ghana. The aim was to examine the impact of the CHPS programme which is based on partnership between the Mfantseman Municipal health Directorate and health volunteers within the Nsanfo community. To achieve this objective, the study adopted the mixed methods strategy which combined qualitative and quantitative methods but with more focus more on the qualitative method. The quantitative aspect of the study was more of descriptive statistics. The reason for the adaptation of this mixed method was to get an in-depth understanding of the phenomenon studied. The adaptation of this mixed method is aptly supported by Yin (2003) when he argues that it is necessary to use both qualitative and quantitative methods in a case study if such mixed methods would enhance the strength of research findings. To Caruth (2013), the mixed methods offers richer insights into a case being examined and enables the capturing of some relevant information that might be missed by relying on only one research method. As this study adopted a case study research design, the mixed methods thus offered a better approach in achieving the objectives of the study. The inclusion of some quantitative data therefore helped make a stronger case for the findings backed by facts and figures.

It is worth noting however that, even though the study adopted a mixed methods strategy, the process predominantly assumed a qualitative approach while complemented by the quantitative process. This mixed method was operationalised right from the sampling stages through to data collection, presentation and analysis stage. Qualitative methods like semi-structured interviews and review of secondary documents were employed in data collection on the field while complemented by quantitative methods like administration of questionnaires.

3.1 Ontological and epistemological foundations of the study

The type of research strategy (i.e. research method and design) a researcher adopts for his study is most often informed by several factors chiefly among them being the ontological and epistemological foundations of the study (Bryman, 2008). These ontological and epistemological orientations essentially seek to explain the various ways of looking at the social environment or phenomena. These two paradigms play a significant role in directing how social research is conducted. Bryman (2008) explains that the epistemological paradigm concerns itself with what should be considered as acceptable and credible knowledge about society whiles the ontological paradigm is concerned with the nature of social reality as objective and existing independent of any external influence (Bryman,2000).

This epistemological and ontological orientation of research thus influences how social reality is perceived thus informing the most appropriate means to study such social reality. While some researchers perceive this social reality as socially constructed, dynamic and subject to human interpretation and actions (constructivism), others perceive this social reality as being objective, exclusive and existing outside and independent of any human influence (objectivism/positivism) (Bryman, 2008).One of such epistemological orientations of social reality is positivism which perceives social reality like as done in the natural sciences. The positivists believe that social reality is objective and exist independently of any external influence hence should be subjected to the strict dictates of the scientific process as done in the natural sciences . Thus to positivist, social reality should be studied objectively for what it is and not subjected to any interpretation of the researcher (Bryman, 2008). This positivist approach is usually the domain of quantitative study.

The antithesis to the positivist epistemological orientation is the interprativist approach which views social reality as highly subjective thus not eligible to be subjected to the strict dictates of the scientific process of the natural sciences as demanded by the positivist (Bryman, 2008). The main idea in the arguments put forward by interprativist is that, the subjects and objects of study in the natural sciences and social research are fundamentally different as such highly inappropriate to use the same process in studying social research. Interprativist school of thought contends that social phenomenon does not exist independently but interacts and is highly influenced by several external factors. In order to fully understand such social phenomenon therefore, the interprativist school of thought argues that social phenomenon

ought to be subjected to interpretations (Bryman, 2000). This epistemological orientation is the domain of qualitative study.

With the above issues in mind, this study was mainly inductive as it did not start out with a theory, but rather sought to utilize the collected data for analysis from which conclusions were drawn. The study was more interested in the process rather than outcome. The study sought to examine the impact of the CHPS programme in the Nsanfo community from the subject's point of view. The study was thus interested in meaning, and it was also descriptive in nature. This presupposes that, epistemologically, the study adopted a predominantly qualitative approach. Ontologically, the predominantly qualitative nature of the study implied that the data generated from the field were subject to interpretation (subjectivism).

The justification for this ontological and epistemological orientation of this study was because of the fact that qualitative research is normally preoccupied with interpreting words and behavior and understanding reality from the point of view of the entity being studied (Bryman, 2008). Emphasis was thus placed on the experience of the beneficiaries and actors in the CHPS programme within the Nsanfo community.

3.2 Research design

Research design provides information about how the actual research is going to be carried out after the research method has been identified. According to Yin (2003), the research design is the action plan of the whole research process that guides how the research is going to be executed to answer outlined research questions.

In the context of this particular research, the case study research design was employed. The motivation for adopting the case study research design was because it is particularly good for examining the "why" "how" and "what" aspects of research study (Yin, 2003). Bryman (2008) on his part argues that the case study as a research design attempts to explain a phenomenon on its own merits. This study sought to investigate the particular case of the impact of the CHPS programme in the Nsanfo community in the Mfantseman Municipal on its distinctive merit. The case study research design thus offered great opportunities for the researcher to have an understanding of the peculiar and unique social values and experiences of the participants under study within their natural environment.

In order to find answers to the research questions, both primary and secondary data were used. The data collection significantly involved the use of semi-structured interviews and questionnaires. It also involved the review of documents as secondary data obtained from the Mfantseman Municipal Health Information Officer. The reason for this multiple methods was to make it possible for triangulation of data. Meaning that one could cross-check what was being uttered by different respondents. For instance official information from as the Municipal Health Directorate, the Mfantseman CHPS Coordinator could be compared with the information from the Community Health Officer, health volunteers and the residents who are beneficiaries of the CHPS programme. By using several methods, the researcher developed greater confidence in the findings of the study as envisaged by Bryman (2008).

It is worth stating the fact that the synergy concept and its manifestations may be relative and dependant on several conditions such as the prevailing governance conditions (i.e. organizational arrangements of state institutions) and endowments of social capital (norms of trust and reciprocity) of a community among others. As such, this case study may not necessarily yield the same conclusions and findings as a similar case study in another social setting. Nevertheless, as Bryman (2008) observes, the purpose of a case study is not to make conclusive generalizations, but rather to generate an extensive and intensive examination of a particular case that the researcher adopts for study. The latter was the main objective of this study.

3.3 Semi-structured interviews

Bryman (2008) recommends that when conducting a qualitative study, the main methods for data collection may include focus group discussions, interviews (structured unstructured or semistructured), and ethnography or participant observation. Due to the predominantly qualitative nature of this particular study, the semi-structured interview technique was singled out for qualitative data collection. According to Bryman (2008, p. 436) "*interview is probably the most widely used method in qualitative research*". Some of the personnel identified for the study were thus interviewed using a semistructured interview guide. The choice of this instrument was because it was flexible and gave the interviewee a great deal of free hand in how to reply and also fairly cover the topics that the researcher wished to examine as suggested by Bryman (2008). More importantly, the semi structured interview gave the

researcher the opportunity to single out and probe further on some issues raised by the interviewees and were crucial to the study.

The relevant personnel that were interviewed included the Director of the Mfantseman Municipal Health Directorate (MHD), the Mfantseman Coordinator of CHPS, the health nurse at the Nsanfo community CHPS compound and 5 out of the 8 Nsanfo CHPS community health volunteers. The information gathered from these set of interviews were transcribed and triangulated to identify concurring and deviating themes and what they meant for the phenomenon under study.

Few notes were also taken while the interview session was audio-recorded with the verbal permission of all the respondents. All the recorded interviews were later transcribed and analyzed. Admittedly the process of transcribing all eight interviews was time consuming as the researcher had to keenly listen to the audio tapes in order to sift the relevant data from the irrelevant ones. The tape was repeated a large number of times to crosscheck what was actually said and what was transcribed in order to get the most credible transcription. The study took notice of the instances where the interview digressed to some interesting but unrelated conversations due to the semi-structured nature of the interview but this was minimized to the barest minimum by tactfully diverting the conversation to the interview guide.

Before the interview took place, prior arrangements and appointments were made with all potential interviewees and the interviews time where agreed upon in advance before the researcher moved to the field. Luckily enough, none of the interviewees disappointed on the scheduled appointments hence the interview sessions with the Mfantseman Municipal Health Director, the Municipal CHPS Coordinator, the community health nurse all went smoothly. Through the assistance of the community health nurse, 5 out of 8 of the health volunteers were contacted and met for their interview session despite the short notice. A pilot interview to test the efficacy of the interview questions was conducted before the real interviews took place. Through these strategies the interview sessions went smoothly thus helped find answers to the research objectives and questions.

3.4 Administration of questionnaires

This instrument represents the quantitative aspect of the study where the researcher sought to solicit quantitative information from some households within the Nsanfo community which are beneficiaries of the CHPS programme. A self-completion questionnaire was administered to one hundred and three (103) households and later processed into quantitative data for analysis using SPSS software. Interestingly, there was a 100% response rate to the questionnaires as households were eager to participate in the exercise. The purpose for the administration of questionnaires was to generate information from some subjects who are large in number thus practically making interviews impossible. In that regard, a sample of the residents was administered self-administered questionnaires to investigate their experience with the CHPS programme and the impacts it had so far had on their lives. Such quantitative information complemented the qualitative information generated from the other respondents via interviews and documents review thus made the findings of the study more credible.

3.5 Sampling techniques

With regards to the selection of samples, the snowballing sampling technique was employed in selecting the five (5) community health volunteers for interview as part of data collection. The technique was used in this instance as a matter of convenience and limited options. After one volunteer was identified and interviewed, they then referred and directed the researcher to the next volunteer to be also interviewed. Such technique was adopted otherwise it would have been difficult or even practically impossible for the researcher to readily identify which people are volunteers to interview. The snowball technique was also adopted based on the recommendation by Becker (1963) when he contends that such techniques become relevant when a researcher does not know the nature of the universe from which his sample is to be chosen for treatment.

With regards to the households, the convenience sampling technique was employed. The reason for adopting this sampling technique was time factor. Since majority of the residents in Nsanfo are farmers, most of them were already off to their farms by 6am long before the researcher arrived in the community to commence the household visitation and administration of questionnaires. This challenge was compounded by the fact that, the researcher lived in a

nearby community (Biriwa) which is about 5km from the study area. Since transportation was a challenge, by the time the researcher got a car to go to the study area, it was past 6am and the farmers had already left for their farms. Unfortunately nothing could be done to avoid this because commercial cars usually do not start operating earlier than 6am. There was no clear cut strategy as to which household to enter or otherwise as such the convenience sampling technique was therefore used to administer questionnaires to those adult members of households who were readily available at home and willing to participate in the exercise.

With regards to selecting the Mfantseman Municipal Health Director, Municipal CHPS Coordinator and community health nurse for interview, the purposive sampling method was used. This option was adopted because the study had purposely identified such people to be the exact people to solicit the information needed to answer the research questions. They were thus selected on purpose and interviewed accordingly as part of the data collection process.

3.6 Sampling frame

In summary, the list of personnel contacted in the entire duration of the data collection included

1. The Mfantseman Municipal health Director
2. The Mfantseman Municipal CHPS Coordinator
3. The Nsanfo CHPS community health nurse
4. Five volunteers in the Nsanfo CHPS programme.
5. The Mfantseman Municipal health Information Officer
6. 103 households

3.7 Review of documents

As indicated in the methodology, some secondary data was reviewed in the course of data collection especially at the analyses stage. These secondary data sought to complement the primary data gathered through the semi-structured interviews and administration of questionnaires in the field. Bryman (2008) argues that the unobtrusive nature of documents provides useful means for its usage in any qualitative study hence the justification for its application in this particular study. The documents reviewed mainly some annual Ghana

Health Service (GHS) Reports on the state of healthcare delivery in the central region prior to the introduction of the CHPS programme and the recorded impact of the programme after its introduction in the region. These were complemented by some statistical facts provided by kind courtesy of the Mfantseman Municipal Health Information Officer.

The other secondary documents reviewed included some few case studies on the CHPS programme conducted by other researchers in different parts of the country. In order to use these documents as credible secondary data, they were subjected to the four criteria of documents usage in qualitative research. Thus authenticity, meaning, credibility and representativeness (Bryman, 2008). The review of these documents was relevant because one of the objectives of this study was to compare and contrast the state of healthcare in the Nsanfo community in the Mfantseman Municipal before and after the introduction of the CHPS programme. The secondary documents therefore helped to allow for such inferences to be made.

3.8 Data presentation, interpretation,analysis and discussion of results

It is important to reiterate that, this study did not seek to make generalizations about its findings, but rather to investigate the specific local context of the impact of the CHPS programme in the Nsanfo community. As stated earlier, this study predominantly assumed a qualitative approach, thus epistemologically, the study adopted an Interprativist rather than positivist approach. Ontologically, the qualitative nature of the study implied that the data generated from the field that were subject to interpretation (subjectivism) to examine the phenomenon under study. The study was mainly inductive as it did not start out with a theory but rather sought to utilize the collected data for analysis from which conclusions were drawn. In the process of data analysis, this study mainly employed the 'thematic analysis' method. That is the study did not start with an initial hypothesis and result in a theory but rather sought out 'similarities and differences' in how the interviewees and households described different themes related to their experience with the CHPS programme. Furthermore, themes were identified by looking for 'theory-related material'. This means that the researcher used scientific theory and concepts from other similar works as a springboard for themes.

As Bryman (2008) indicates; the boundaries between thematic analysis and grounded theory are not solid hence the study had a touch of grounded theory as well. This was based on the

reality that the research was based on an initial hunch as such as several themes were derived from scientific theory, the distinctions between themes and concepts/categories became blurred allowing for some grounded theory to sought of emerge. Transcripts from interviews served as basis for coding (also known as indexing) (Bryman, 2008). The coding involved extracting key words, themes, attitudes or aspects from the transcriptions to help generate an index that assisted the researcher in the process of interpretation.

This particular research sought to identify recurring themes, which served as basis for subsequent interpretation and analysis. Indexing for instance was done based on respondent's attitude towards certain things some of which were positive others neutral and some negative towards the commitment and services of the health volunteers and the community health nurse. As these codes were made by the researcher, the study can thus be said to have adopted a subjectivist approach. That is, the study sought to understand and bring out the meaning of the respondents – a meaning that was sensitive to the context of the respondents (Bryman, 2008). Undoubtedly, typical of social science research some amount of personal biases might have influenced this process consciously or unconsciously but care was taken to mitigate these biases to its barest minimum by being objective throughout the entire process of the study.

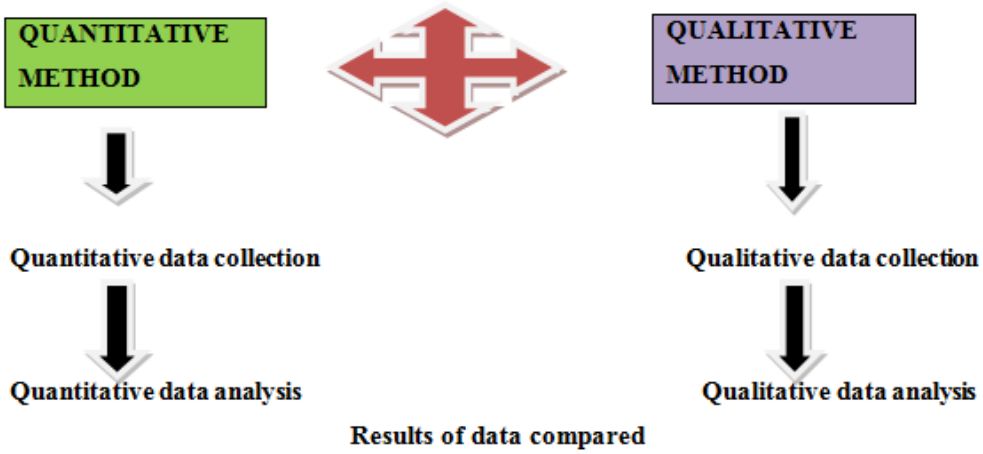
The actual analysis and interpretation was anchored in the research questions, recurring themes, and key findings. The final call on this matter was quiet clear enough during and after the actual data collection. A brief tentative indexing to check the theoretical saturation for the different tentative categories was done in the course of the data collection. This enabled the researcher to briefly see what tentative categories were well covered, and whether to slightly alter the focus of the research to fill all categories.

The quantitative data was analyzed using descriptive statistics with the help of the Statistical Package for Social Sciences (SPSS). The quantitative data generated from the field was coded and fed into SPSS to generate descriptive statistics. The use of SPSS enabled the information generated from the field to be presented in tables and figures to complement and enrich the qualitative data gathered. Typically, frequencies and percentages were used in interpreting the quantitative data.

3.9 Triangulation of data from the mixed methods

As the study adopted the mixed method approach, there was the triangulation of data upon collection of both quantitative and qualitative data from the field. At the presentation and interpretation stage, a concurrent triangulation exercise was conducted to integrate the results generated from the quantitative and qualitative data gathered. The basic aim of this triangulation was to determine instances of confirmation, corroboration, and cross-validation or otherwise of the results gathered from the field (Terrel, 2012). This triangulation ultimately helped strengthen the authenticity of the findings of the study.

Figure 6: Concurrent Triangulation Strategy



Source: Terrel ***(2012)***

3.10 Limitations of the study

One major limitation this study faced was with accommodation. The initial study area for the research work was Biriwa, which is a fishing community in the Mfantseman Municipal. Accommodation arrangements were thus made within the Biriwa community. Upon getting to the town, it became apparent that the CHPS programme which is the focus of this study was actually operating in a community called Nsanfo that is about 5km from the initial Biriwa

townships. All efforts to acquire a descent accommodation in the new study area proved futile as it was nonexistent. The researcher thus had to stay in the accommodation in Biriwa and commute to the Nsanfo community each morning to undertake the data collection. This came at an extra cost to the study as the bad road network to the Nsanfo village made almost all commercial drivers reluctant to go there. This was resolved by contracting one taxi driver to provide transportation for the entire duration of the data collection in the community for an agreed fee which was relatively very high.

Another limitation was with language barrier. The residents of Nsanfo community speak the Fante dialect and even though the researcher could communicate in some basic Fante, some of the vocabulary proved difficult to readily comprehend as such the study relied on the services of a translator who volunteered to serve as a liaison between the researcher, the health volunteers and the residents of Nsanfo. One challenge however encountered in relying on an interpretation was that the recorded interpretations had to be transcribed later and analyzed which was very time consuming. Some ‘’thank you’’ gifts were provided for the services of the interpreter raising some ethical issues.

One other significant limitation of this study is the fact that it only reports on the experiences of one CHPS community as a case study. Being a relatively small and predominantly qualitative study, the reality is that, the observations presented in the final report are based on the personal experiences and subjective views of only a few respondents (103 households) and not that of the whole community. It was therefore difficult for the researcher to generalize and comment on the CHPS programme as a whole but only limit it to the case study which is objective of this study.

A final limitation relates to reporting bias particularly by service providers as the Ghana health service who have an interest in reporting the programme in a positive light so as to appear good in the eyes of the researcher. Even though this study cannot challenge the evidence given by the Ghana health service, there is some possibility that the achievements may have been exaggerated or not.

3.11 Ethical consideration

In order for every researcher and his work to posses some appreciable level of integrity, there is the need for some ethical conventions to be followed before, during and after a research work. This is a major rule of thumb in the world of research. According to Oxfam (2012) "*any research must follow ethical principles and particular care must be taken when it involves people as participants or is likely to impact directly upon them*". Specifically it is argued that the researcher must recognize the capacity and rights of all individuals to make their own choices and decisions, and their right to be respected in the entire process. This means potential participants must:

- be free to choose whether or not to participate, without inducement
- have the relevant information about what the research is about
- give their consent, either written or verbal
- understand it, including the possible risks and benefits to themselves
- Have the right to withdraw from the research at any time.

Oxfam (2012)

This study took cognizance of these ethical issues and abided by them in the entire duration of the study. A number of ethical dilemmas were encountered in the course of carrying out this study.

One of such interesting ethical issues was with 'showing appreciation' to an opinion leader of the Nsanfo village whom the researcher had gone to greet and announce the reason his presence in the village as customs and conventions demanded. Upon listening to our mission in Nsanfo he took it upon himself to beat a "gongo" (town crier) throughout the entire village announcing the researcher's presence and urging the residents to give the researcher the needed cooperation in the exercise. Such an action proved to be very crucial as it opened doors to households the researcher visited. Had it not been for the kind action of the town elder, the researcher would have been treated as a stranger and perhaps received little cooperation from the residents. It must be emphasized however that, despite this announcement made by the town crier, it was made very clear to all the households visited that, the activity was very voluntary and they had the right to opt out of it anytime they wished. Such a move was duly informed by the Social Researchers Associations advice that researchers ought to inform participants in any research work about the right to opt out at anytime of the treatment process (Bryman, 2008).

It turned out that the residents were rather very happy to receive the researcher in their homes as it was brought them some sense of importance and pride to have 'people from abroad' visit their humble homes to engage them in the study. The researcher had the verbal consent of all respondents engaged in the treatment after explaining the study work and their role to them. The dilemma however was that, the town elder directly asked for *"something small"* for his services. The amount demanded was very little but it was very difficult for the researcher to give the money because it raised ethical issues. This was addressed by promising to "*see*" him when the data collection in the town was over. Fortunately or unfortunately, he was not around when the data collection ended and the researcher left the study area wondering whether the opinion leader would think he had been deceived by the researcher.

The second ethical issue encountered in the course of the study was with the reception received in the homes of some of the respondents. As they had been told to expect us in their homes for the data collection, some of them actually thought the researcher was a representative of an NGO who had come to witness the deplorable nature of the community and possibly provide them with some reliefs. This perception among the inhabitants was compounded by the fact that it been announced that the researcher was a student from Europe who had come all the way to Ghana and to their village to undertake the study. As such the recurring perception was that I was coming to see things for myself and go report back to my organisation in Europe to come to their aid. Since the researcher topic bothered on healthcare delivery in their community, they actually thought I had come to their aid hence asked me to tell my people to come provide them with a new clinic building since the one in their community was in deplorable shape. The researcher had to go through a great deal of time to explain to them that, the data collection was part of requirements for my masters degree and not necessarily to ''bring them immediate development''. This sought of proved an ethical dilemma to the researcher as it sort of dampened their spirit. In order not to totally dash their hopes, I however assured them that I will report my findings to the appropriate authorities specifically the Mfantseman Municipal health Directorate for them to take necessary actions on the recommendations of the study.

The third ethical issue the researcher had to deal with was deciding on whether to accept or humbly decline drinking water offered in some of the households. The major source of drinking water in the village was running water from a near river body whose cleanliness one could not readily confirm. Typical of societal conventions in most communities in Ghana, all

visitors to their homes ought to be served water before asking of their mission. It so happened that some five households offered the researcher some drinking water. Declining it would send a rather negative note on how the researcher perceived them and possibly jeopardize an intended questionnaire administration. In other to avoid sending such negative signals, the researcher had to accept and take a sip of the water offered out of courtesy. This was done with the full knowledge of the possible health implications but hoped that no health issues arise as a result of drinking the water.

Overall, some of the respondents wanted to remain anonymous for their own reasons. Such respondents were assured of their anonymity in the final write up.

CHAPTER FOUR: Data presentation and results of the study

4.0 Introduction

This chapter encompasses the findings of the data collection exercise that took place over a period of four weeks in the Nsanfo community. The mixed-method strategy which combines both qualitative and quantitative approaches is used in presenting the data gathered. The findings entail graphical presentation of responses to the questionnaires that were administered to some 103 households in the Nsanfo community. The results also includes relevant transcripts from the interview sessions with the Nsanfo CHPS community health nurse, five CHPS volunteers, the Mfantseman Municipal Health Director, the Mfantseman Municipal CHPS Coordinator and some Ghana health reports on the district obtained from the Mfantseman Municipal Health Information Officer as they relate to the objectives of the study. The results are presented in line with the overarching research questions that guided this study. Discussion and analysis of the findings is done in the next chapter.

The chapter starts with the presentation of the demographic characteristics of the respondents that were sampled during the study. Results on the extent of civil society integration in rural healthcare delivery are also presented. This is followed by the level of community participation in the CHPS programme. The next section then evaluates the impact of the CHPS programme on healthcare delivery in the rural communities while the last section presents the challenges besetting the partnership of the state and civil society in rural health care provision especially the operations of the CHPS programme**.**

4.1 Socio-demographic characteristics of respondents

A total sample of 111 participants were contacted during the fieldwork. Out of this sample, 103 constituted household members. The remaining 8 respondents included 5 volunteers (3 males,2 females) , the Community Health Officer, the Municipal CHPS Coordinator and the Director of Health in the Municipality. It is worth stating that the questionnaires received a 100% response rate, i.e all the 103 respondents provided relevant responses to the questions

that were designed. The demographic characteristics of the respondents covered aspects such as their sex, age, marital status, educational level, occupation and the number of years stayed in the community.

Table 3. Sex distribution of respondents

Valid	Frequency	Percentage
Male	36	35.0
Female	67	65.0
Total	103	103

Source: Field Survey, 2014

Table 3 displays the sex of the respondents that were administered questionnaires in their households. Out of the total sample selected, majority (67) representing 65% were females with the remaining 36(35%) being males. This statistic generally follows the country's sex ratio as females constitute about 52% of Ghana's population of about 24.3million (Ghana Statistical service,2010). The higher female representation in the study could be explained by the fact that the CHPS compound is mostly used by women especially mothers who frequently attend ante-natal and post-natal services. Mothers in this part of the world are typically responsible for care giving like taking sick children to the hospital due to the societal gender division of labour. Another reason that explains the female gender bias in the sampling was due to the fact that , most of the male members of households had already left the house for their farms very early in the morning leaving female household members at home to prepare the children for school. As such, the researcher increasingly met the absence of male members of households anytime the researcher visited homes each morning to administer questionnaires.

Another important demographic characteristic of the respondents relate to their age

Table 4. Age distribution of respondents

Age brackets	Frequency	Percentage
16-25	20	19.4
26-35	19	18.4
36-45	19	18.4
46-55	22	21.4
56 and above	23	22.3
Total	103	100.0

Source: Field Survey, 2014

The age distribution of the respondents as displayed in Table 4 suggests that the population of the community remains a youthful one. Although about 22.3% and 21.4% of the respondents were aged 56 years and above and 46-55years respectively, a cumulative total of 56.3% fell within the age bracket of 16-45years. This coalesces perfectly with the age distribution at the national level. Indeed, Ghana has a very youthful population with 36.5% of the population between (0–14) years of age, 60% between (15–64) years of age and only 3.6% of the population is 65 years or older(UNDP Ghana,2007). With regards to the volunteers, it is interesting to note that all five of those interviewed were above 40 years with the youngest (male) been 42 and the oldest (also male) been 63 years. This is interesting because one would have thought the youths (in their early 20's or even 30's) in the community would rather volunteer their time and energy in assisting in the CHPS programme but this was not so. An inferance this study deduces for this pattern could be that, such youth who are still very economically active would rather seek jobs that would earn them some good salaries than to volunteer their time and energy in the CHPS programme which is non-renumerative . As discussed in the latter parts of the data presentation, even though these older volunteers gave varied reasons for volunteering , it was impressive to note that even in their old age, they were relatively still economically active as they all engaged in farming yet still found time to volunteer for the good of the community.

Table 5. Marital status of respondents

Valid	Frequency	Percent
Single	19	18.4
Married	61	59.2
Divorced	7	6.8
Separated	12	11.7
Widow/Widower	4	3.9
Total	103	100.0

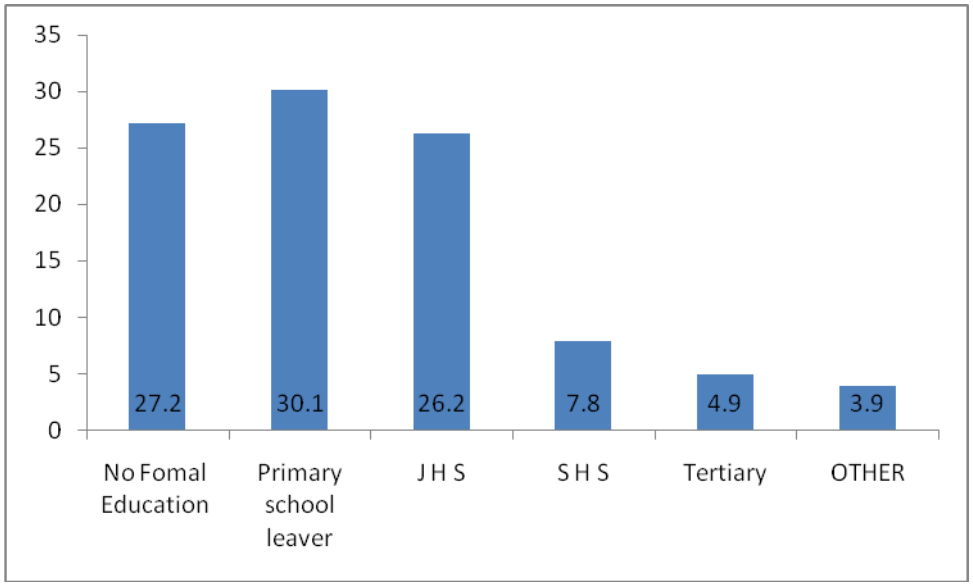
Source: Field Survey, 2014

With regards to marital status, a significant number (61) representing 59.2% were married, followed by 19(18.4%) who were single. About 11.7% were found to have married before but were divorced at the time of the survey. The remaining 6.8% and 3.9% were found to have been separated with their spouse and either the husband or wife was not alive respectively. It is instructive to recognise that, irrespective of the kind of marital status, each category with the exception of some of the singles had some dependant(s). About 41.8% of the sampled population indicated that they were having about 4-6 dependants. While 36.3% were found having 1-3 dependants, 22% were found to be having 7 dependants and above. Most of the dependants were mostly the children of the respondents. With regards to the voulnteers, two(*one male one female*) out of three were not married but all 5 indicated that they had some number of dependents ranging between 2 to 6. It was therefore impressive to know that even with such dependents and family to take care of, they still had enough time to volunteer for the good of the community. Reasons for their motivation to volunteer is discussed in the course of the data presentation.

Education has been recognised as a tool for national development as it provides the individual with requisite skills and wherewithal to support the productive sectors of an economy. It is also a tool for personal development. The educational level of the respondents displayed in figure 7 shows that majority of the respondents have not had the opportunity to attend higher level of formal education. Figure 7 indicates that majority of the respondents (30.1%) had attained primary school education. About 26.2% and 7.8% had attained Junior and Senior

High school education respectively. Only 4.9% indicated to have attained some level of tertiary education. The respondents in the other (3.9%) category were those who had attained various forms of technical and vocational training. More remarkably, about 27.2% had never had the opportunity to attend formal education. With regards to the educational background of the volunters, only two (all female) out of the five (5) volunteers had not had any form of education. The three (3) others who had had some form of education was up to the senior secondary school level. None of the five voulnteers had had the benefit of tertiary education. Interestingly all the two volunteers who had not had any formal education were all traditional birth attendants (TBAs) who had inherited their trade and training from their parents.

Figure 7: Educational attainment of respondents



Source: Field Survey, 2014

The reason for the generally low level of formal education attainment in the study community could be explained by the poor socio-economic circumstances that confront the inhabitants as it pertains in other rural areas of Ghana. The situation has been that, typical of developing countries, there are lack of educational opportunities in most rural areas in Ghana. The educational attainment of the study community also follows the national trend of education in the country. In Ghana, about 40-60% of the population have not acquired any formal education while majority of the youth who enter the junior and senior secondary education mostly do not get the opportunity to continue to the tertiary level (UNDP Ghana, 2007). The

educational attainment of the respondents when cross analyzed with their occupational status reveals some interesting patterns. The results are shown in Table 6.

Table 6. Occupation and level of education of respondents

	Level of education						
Occupation	**No formal education**	**Primary school lever**	**JHS**	**SHS**	**Tertiary**	**Other**	**Total**
Farmer	22	23	8	6	5	1	65
Fisherman	0	1	0	0	0	0	1
Petty trading	5	5	6	1	0	0	17
Not employed	1	1	5	0	0	1	7
Student	0	0	3	1	0	2	6
Other	0	0	3	1	0	2	6
Total	28	31	27	8	5	4	103

Source: Field Survey, 2014

Table 6 indicates that the major occupation of the people in the Nsanfo community is farming. Farming as an occupation as seen from the table remains an important source of livelihood in the community even for those who have attained tertiary level of education. The reason for this lack of economic opportunities and empowerment despite the relative high literacy level still lingers in the mind of the researcher and perhaps could be a topic for further studies in the future. Majority of the non-school attendants and primary school leavers together with even the 5 respondents who had acquired some level of tertiary education were engaged in farming. This also follows the situation in the country. In Ghana, it is estimated that agriculture (farming) employs about 60% of the economically active population (Asamoah et al, 2013).

Apart from farming, petty trading also constitutes an important source of economic activity for the people of Nsanfo.

Those in this category were found selling all sorts of food items. With regards to the volunteers, all five of them indicated they were also into subsistence farming. It is important to mention that, fishing is the main source of livelihood for the people of Mfantseman Municipality. However, this is not case in the Nsanfo community as people living there are very far from the sea and have less contact with it. This possibly explains the low number of respondents who are engaged in fishing. This finding has some policy implications for government. It is evident that farming continues to be the major source of livelihood for most rural dwellers as such if government is serious about its vision of eradicating rural poverty, then it is prudent they increase their support for rural farmers through logistical incentive (farming inputs, grants, ready markets for produce etc) for such famers to increase their productivity. Such support for increased productvity would ultimately increase their purchasing power and improve their standards of living and that of their immediate families. With such economic empowerment, this study believes there would be positive ripple effects on their healthcare conditions too.

4.2 Rural healthcare delivery: extent of civil society integration

The need for collaborative engagements has become a major preoccupation in the developmental agenda of many nations. One of those significant collaborative engagements is the increasing partnerships between governments and civil society in addressing social issues such as healthcare delivery. Indeed this state-civil society synergy in rural healthcare delivery represents a significant evolutionary change in conventional forms of governance. This section of the results presents the extent to which civil society (in this case the CHPS health volunteers) is integrated into the programme. To refreshen our minds, one of the foremost objectives of this study was "*to investigate how, and the extent to which civil society within the Nsanfo community is integrated into the healthcare delivery structure of the CHPS programme ''*.This section of the data presentationis therefore very crucial.

Due to the important role community health volunteers play in the operation of the CHPS programme, it is imperative to account for how they are recruited into the programme.

Interviews with some of the volunteers suggest that they willingly offered themselves to be volunteers with the aim of helping in the healthcare delivery in the community in which they have lived all their lives. As indicated earlier, only two out of the five volunteers were not married but all five had some number of dependents ranging between two and six. All five volunteers were also engaged in farming as their main occupation yet still found time to volunteer for the good of the community. The inference this study makes from this is that, it cannot be said that they offered themselves as volunteers because they were idle and had free time to volunteer. There were obviously other motivations and this study sought to find out what those motivations were. According to the volunteers, when announcements were made asking for volunteers during a community gathering to introduce the CHPS programme, they immediately had the conviction to offer their services as volunteers even though it was made clear that there was no remuneration for such volunteering services. Below are the responses from the volunteers when they were asked in the interviews how and why they offered themselves to become volunteers in the CHPS programme.

Volunteer 1	*Initially I was working as health insurance agent for an agency, so when the CHPS programme was introduced I realized I had the skill to help and that motivated me to join the volunteering work.*
Volunteer 2	*My mother's sister was a TBA(traditional birth attendant), so she decided to train me so that I will replace her when she dies. After her death, the community decided I should occupy that position and help with healthcare in the community especially with child delivery so I accepted to volunteer.*
Volunteer 3	*When Sesakawa (A Japanese NGO) came to this community,they needed volunteers but no one was willing to volunteer. That made me volunteer and since then i have been a volunteer even after the NGO left.*
Volunteer 4	*When the CHPS programme was introduced first, they were looking for volunteers and I decided to offer myself in order to help in the healthcare provision of our people. Moreover I was already volunteering as a TBA even before the programme started.*
Volunteer 5	*There were only two volunteers, one died and the other had travelled, there was no one to volunteer so when the nurses came for weighing, they asked for help from the community and I offered myself. I joined because some mothers do not have the strength to carry their children to hospital when sick, so I decided to assist to help in the health of our community.*

Source Field Survey, 2014

When the same question was as to how the volunteers were selected and integrated into the CHPS programme was posed to the Mfantseman Municipal Health Director and CHPS Coordinator, the information elicited suggested that before these volunteers were selected, there were extensive discussions with community leaders in order to know the right people who could help in ensuring the success of the CHPS. It was after these consultations and discussions that a Community Health Management Team (CHMT) was constituted to help identify potential volunteers. This is illustrated in the quote below by the Municipal CHPS Coordinator who is directly in charge of superintending all the activities and developments that evolve around every CHPS compound under the Municipal like the one in Nsanfo.

> *"The volunteers are selected with the help of the opinion leaders who are constituted into a Community Heath Committee. Since the town is relatively small, the chiefs and the opinion leaders know the right people who can be of assistance to our nurses in the CHPS compound"*

On the part of the Municipal Health Director, she also indicated:

> *"The Community Health Committee selects the volunteers who are then approved by the community members before the CHPS starts. After these volunteers were approved, we gave them some six weeks intensive training in preventive healthcare sensitisation and also on how to detect and report ailments from the homes that they visit in the community. They appeared very happy to be part of such a new programme that was coming to them"*

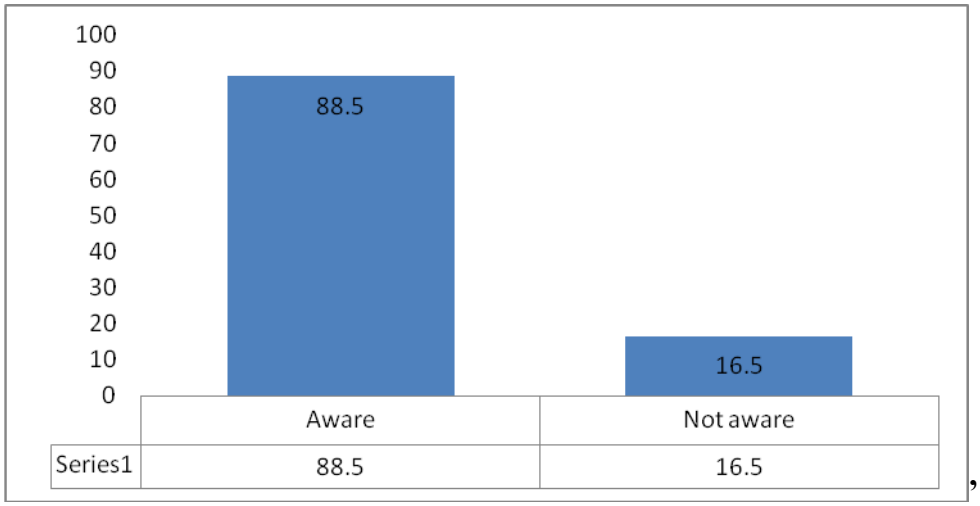
When pushed further for clarification as to why the newly recruited volunteers appeared happy been part of the CHPS programme, she responded thus

" aaahh !! you can imagine that to them, their involvement in the programme is a source of prestige to them, in a way they felt their social status had risen up especially when they go from home to home or are walking in the streets and people are calling them "maame (madam)nurse" or "papa nurse" and waving at them with smiles, it brings them some sort of joy"

The above quotes reveal some very interesting aspects of the CHPS programme that would be juxtaposed with existing literature and discussed in the next chapter of this study which discusses the results . Figure 8 displays the level of awareness of the local people regarding

the existence of volunteers in the study area. It can be deduced that there is high level of awareness of community volunteers among beneficiaries of the CHPS programme as 88.5% affirmed their awareness of the existence of the volunteers who partner with the health officials in rural healthcare delivery.

Figure 8 : Awareness of existence of community volunteers



Source: Field Survey, 2014

This high awareness level kind of vindicates the earlier allusion by the CHPS Coordinator and the Municipal Health Director when they indicated that the volunteers are selected by the community members themselves and also introduced to the whole community before the CHPS programme commences. Respondents were not only asked their awareness of existence of volunteers in the community but also whether they have been visited by a volunteer before and kind of services rendered by volunteers when they visit households. About 83.1% of the respondents indicated that they have been visited by community health volunteers either once or more times. The kinds of services rendered by the local volunteers remain essential in ensuring improvement of the health of the people. Table 7 gives a picture of the kinds of services undertaken by the community volunteers.

Table 7: Nature of services rendered by community volunteers

Services rendered by volunteers	*Frequency*	*Percentage*
Emergency treatment services	*55*	*53.4*
Given of information on healthcare	*20*	*19.4*
General Medical check up	*28*	*27.2*
Total	*103*	*100*

Source: Field survey, 2014

This finding also manifests the main objective that informed the establishment of the CHPS programme as a nationwide programme: to bring healthcare to the doorstep of hitherto marginalised groups and communities. As seen in Table 7, more than half of the respondents (55) representing 53.4% indicated that the major service rendered by the volunteers is emergency treatment services . Such emergency treatment services includes giving treatments to minor illnesses, immunisation and reporting of any major illness to health officials in the community. Aside emergency treatment services , the remaining 28 and 20 representing 19.4% and 27.2% respectively indicated that the volunteers are involved in general medical check up and giving of information on family planning and any other healthcare information from the nurses at the CHPS facility. By providing information on healthcare to the local people and also reporting illnesses back to health officials, it appears that the volunteers also serve as mediators who link the local people to the health officials by way of ensuring information flow for the mutual benefit of the two stakeholders.This can be illustrated in the quote below by the Municipal Coordinator for the CHPS programme:

"The experience has been that, when emergencies such as snake bite occur in the remote areas, community members run to the homes of the volunteers or send people to quickly call the volunteers.Due to the periodic training we give them, sometimes the volunteers are able to identify what the problem is and quickly administer emergency treatment. When it becomes critical, the patients are then rushed to the CHPS compounds for our nurses to properly attend to them. The volunteers frequently report to the community health nurses about people who are experiencing any disease and also give information from the health officials to the local people. "(In-depth Interview, 17th January, 2014)

This in effect provides an avenue for the smooth operation of the CHPS programme in the community. Interviews with volunteers are consistent with what the local people suggested. Aside general medical check-up and emergency treatment services , the volunteers further indicated that they frequently visit pregnant women and also educate parent on family planning. This finding thus manifests the main objective that informed the establishment of the CHPS programme as a nationwide programme which is to bring healthcare to the doorstep of hitherto marginalised groups and communities. Thus the integration of the volunteers in the CHPS remains essential in rural healthcare delivery and should be given the necessary support. The inferance this study makes of thus finding is that,it appears the volunteers are essential stakeholders in the functioning of the CHPS programme. In

vindicating this observation, when the volunteers were asked what their typical duties were when they visited homes in the community, they responded thus

Volunteer 1	***I attend to them always whether at night or day time especially in emergency cases. This has helped improve healthcare delivery in my area .***
Volunteer 2	***Due to the training we were giving by the health authorities, when I visit homes, I am able to educate mothers on how to ensure proper child health, nutrition for nursing mothers, family planning and education on general health issues.***
Volunteer 3	***I educate mothers on the need to take good care of their children by taking them to hospital when they are sick and also ensuring proper hygiene in their homes.***
Volunteer 4	***I visit pregnant women, educate parents on how to take care of their children and attend to any other health complaints they have in their homes.***
Volunteer 5	***I go from house to house to educate parents on good sanitary practices, how to take good care of their children, family planning and also remind them of weighing services(post natal services)***

(In-depth Interview, 17th January2014.

In order to find out from the beneficiaries of the CHPS programme what the impact of the programme in their healthcare need was, the respondents were asked to rate the performance of the health volunteers who had so far visited their homes on duty. Table 8 summarizes the views of the respondents regarding the quality of services rendered by the volunteers.

Table 8: Performance of community volunteers

	Frequency	*Percentage*
Excellent	*12*	*14.6*
Very satisfactory	*41*	*50*
Satisfactory	*29*	*35.4*
Total	*82*	*100*

Source: Field survey, 2014

The table reveals that majority of the respondents (41) representing 50% rated the performance of the volunteers as very satisfactory while 35.4% indicated the performance of the volunteers as satisfactory, the remaining 14.6% rated the performance of the volunteers as excellent.Some 21 respondents delined to rate the work of the volunteers. That notwithstandng, this high rating regarding the performance of the volunteers' is consistent with the information that was obtained from the health officials. In an interview as part of data collection, the Community Health Officer at the CHPS compound had this to say concerning the work of the volunteers.

> *"The volunteers provide education to the local people on the need to attend ante-natal and post-natal session at the clinic. Some of them who are also traditional birth attendants help women in labour to deliver at home when there is emergency or complications with the pregnancy. so we can say their services are really helping in healthcare delivery in this community"*

This assertion was confirmed by one of the volunteers who happens to be a traditional birth attendant. In stressing on the role she plays in the community, she revealed that

"*My duty as a TBA has helped many in this community. I visit pregnant women and educate them on their health. One time I visited a woman who was in labour as late as 1a.m to assist in her delivery and the delivery was successful by divine intervention. My role as a volunteer has really helped in improving maternal health in the community".*

Aside from rating the performance of the volunteers, respondents were also asked to describe the relationship that exists between the volunteers and the local community. Results from the study indicate that there is generally a cordial relationship between the volunteers, the

Mfantseman Health Directorate and the local people. In my interview, the Municipal Health Director professed:

> *"There is cordial relation between us and the volunteers. We invite them for immunisation programmes. They also call us for any identified health problem. Cases such as polio are reported by the volunteers to us through the health officials. "*

When the same question was posed to the Municipal CHPS Coordinator, she also reiterated that

> *"Our relationship with the community health volunteers is generally cordial due to the constant interaction we have with them. "*

These findings vindicate the whole argument that has been strongly made to promote state civil society synergy in development. This cordial relation is the social capital that Ostrom (1996) and Peter Evans (1996) argued to be relevant for the sustenance of such collaborative engagements between the state and civil society.

Table 9. Relationship between the community and volunteers

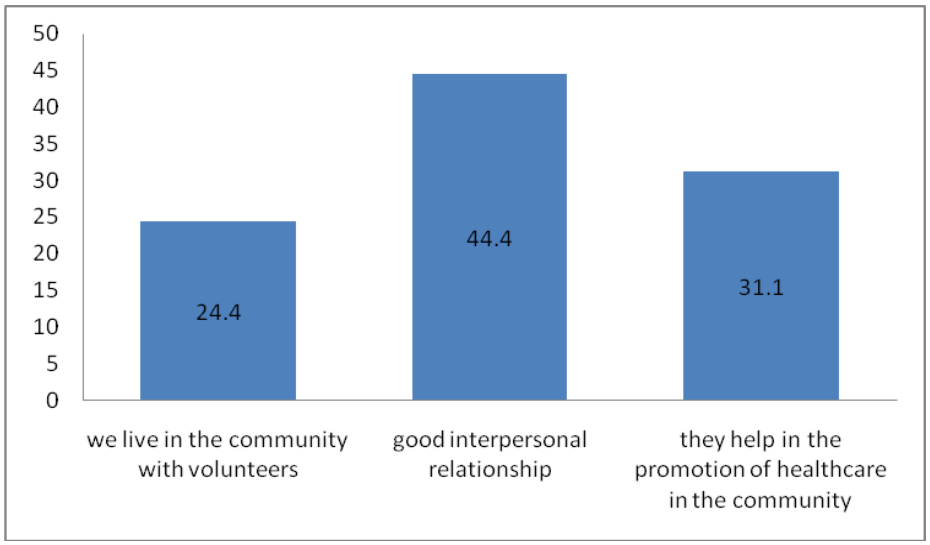
Valid	**Frequency**	**Percent**
Fair	8	7.8
Good	30	29.1
Very good	45	43.7
Bad	1	1.0
Total	84	81.6
Missing system	19	18.4
Total	103	100.0

Source: Field survey, 2014

Table 9 summarises the view of the respondents regarding the relationship between the local inhabitants and the community volunteers. Out of the 103 respondents, 84 responded to this question. Out of the 84 respondents, about 53.6% described the relationship between the community and the volunteers as very good. Those who rated the relationship as good scored 35.7% with about 9.5% describing the relationship as fair.

In order to measure why the respondents thought accounted for the prevailing cordial relationship between them and the volunteers, they were asked to give reasons. Several explanations were provided .

Figure 9: Reason for generally high cordial relationship



Source: Field Survey, 2014

Reasons cited for the cordial relationship that exist between the volunteers and the local community as seen in figure 10 indicate that good interpersonal relationship(44.4%), the fact that the volunteers assist in the promotion and delivery of healthcare(31.1%) and the fact the local people live in the community with the volunteers(24.4%) all explains this kind of relationship. The revelation of this cordiality is not farfetched as these volunteers live in the same community with the households they visit hence they are somehow familiar with the household members. The relatively small nature of the Nsanfo community could also mean that, "everyone knows everybody" through familial relationships, marriage or even occupation hence the cordiality in their relationships. Inspite of this positive relatioship between the volunteers and community memebers, this study contends that this cordiality is not automatic but dependant on some factors that ought to be in place as discussed in the literature review of this study. In effect the decision of the Mfantseman Municipal Health Directorate (GHS) to partner with the civil society(community health volunteers) have been

very useful in the study area as the volunteers are really helping in the sustainability and smooth progress of the CHPS programme. Beyond doubt, the volunteers remain essential stakeholders under this initiative; therefore, any attempt to bar them from the CHPS programme may be counter- productive and may lead to systemic failure of the CHPS programme.This observation was reiterated by the respondents when they were asked whether the volunteers should be removed from the CHPS programme or not. As depicted in the table below, a whooping 87.4% indicated that, the community health volunteers were crucial to their healthcare needs hence ought to be equipped properly and maintained. It is important to state that in as much the respondents rated the role of the volunteers very high, a possibility could be that, since they had no better alternative to the services run by the comunity health volunteers, it could be expected that they would find the work of the volunteers crucial and worthy to be maintained . Inferrably, they can be said to be relatively better off as prior to the commence of the CHPS programme, their access to healthcare was worse off so it is therefore not surprising that they find that the work of the volunteers relatively better hence the high ratings . This criticism of the seemingly high ratings is in no way doubting the evaluation of the respondents or undermining the credibility and comptence of the volunteers but rather, it only seeks to critically look at all possible reasons for some of the responses to questions gathered as part of data collection hence should be understood in that context.

Table 10. Opinion on maintaining volunteers on the programme

Valid	Frequency	Percent
Yes	90	87.4
No	13	12.6
Total	103	100.0

Source: Field survey, 2014

4.3 Community participation in the CHPS programme

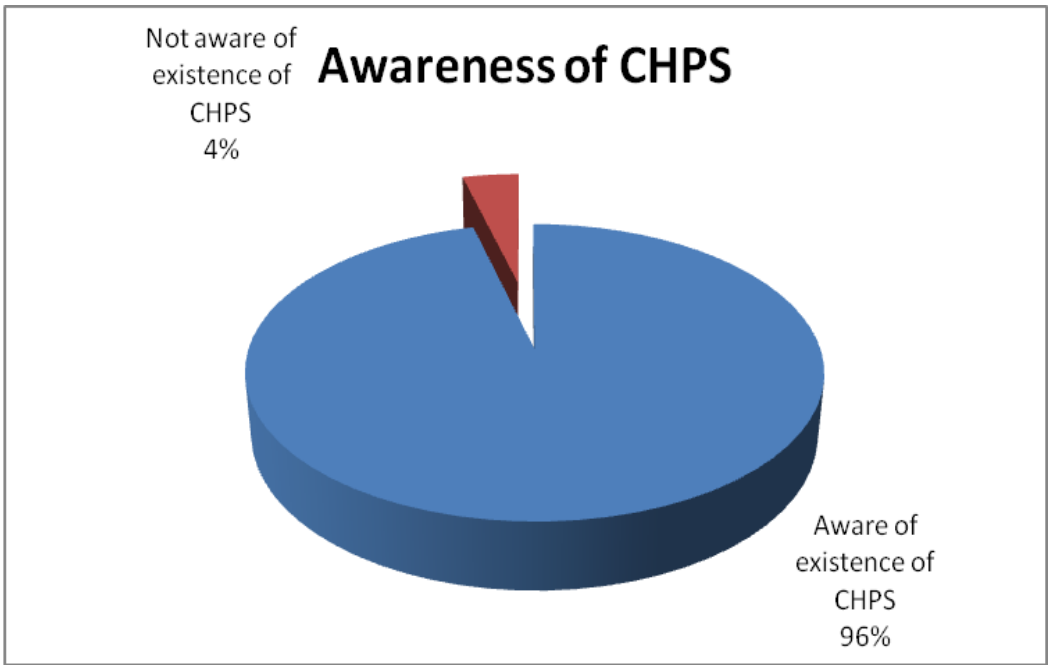
In recent times, high hopes have been vested in community participation in many social development interventions. In the field of health service, community participation has been a central aspect of the concept of primary healthcare. Although some completely dismiss the value that community participation brings, others forcefully argue that community involvement in healthcare delivery is the "magic bullet" that will ensure health improvements especially in the context of poverty alleviation while ensuring sustainability of community projects (Rifkin, 2001). In line with this, the present study sought to find out the extent and the diverse areas in which the local people are involved in the CHPS programme.

One aspect of community participation which is of relevance to the sustainability of development projects is consultation. Consultation connotes seeking the views of community members regarding an initiative as to whether they would support its implementation or otherwise. In that regard, respondents were asked as to whether prior to the establishment of the CHPS, a process of consultation was conducted to seek their views. Results show that almost all the respondents (95.6%) indicated that such a process was conducted by the Municipal Health Directorate in order to elicit their views regarding the establishment of the CHPS. This is consistent with what the researcher obtained from the Municipal Health Directorate. In an interview with the Municipal CHPS Coordinator, she professed:

"Before the programme was introduced, there were discussions with the community. The reason is that the community has a part to play for the CHPS programme to be successful. The Community Health Committee selecst the volunteers who are then approved by the community members before the CHPS starts. "(17th January, 2014)

The high level of community consultation partly explains the higher level of community awareness of the existence of the CHPS. Figure 10 displays the level of awareness of the CHPS programme in the study area.

Figure 10: Awareness of existence of CHPS programme



Source: Field Survey, 2014

A significant number of respondents (99) representing 96% affirmed the existence of CHPS programme while the remaining 4% stated otherwise. This high level of awareness could be attributed to the close ties that exist in the community. The reason is that, among the 99(96%) respondents who indicated to be aware of the existence of the CHPS, about 71(68.9%) suggested that their source of knowledge concerning the CHPS programme was through their familial relations and kin. Now this is the most startling revelation in the study. Although there is high level of awareness and patronage of the programme among the community, this did not translate into an exclusively high participation in terms of matters relating to maintaining the CHPS compound. The study acknowledges the logic that mere knowledge of the existence of the CHPS programme ordinarily should not necessarily translate to the desire to help in maintaining it. However, the reason why this study finds the situation to be the most startling revelation is the fact that the respondents are aware the CHPS health compound and to an extent the programme itself was the initiative of the community hence belongs to them yet they are lukewarm when it comes to maintaining their own facility. As discussed earlier, a huge majority indicated they that constantly used the services offered by the programme.

Moreover according to the policy framework establishing CHPS, community education on the programme should lead to the awakeness of the community members about their roles in the Initiative (GMHI, 2005). Also it was discovered that the current CHPS compound was constructed based on the iniaitiave of the Nsanfo community members themselves and then appealed to the Ghana Health Service to post nurses to their newly contructed health facility to run it. It is based on this information that the researcher finds their rather lukewarm attitude towards maintaining the facility quiet startling. Reasons the respondents gave for this rather ironic attitude is discussed in subsequent parts of the data presentation.

Table 11: Community participation in the CHPS programme

Areas of participation in the CHPS programme	Freq./Yes	%	Freq/No	%
Attend communal labour in building the compound	30	40.5	44	59.5
Involved in cleaning CHPS compound	19	25.7	55	74.3
Attend public gathering on health issues	66	88.0	9	12
Dissemination of information from volunteers and health personnel	35	46.7	40	53.3

Source: Field Survey, 2014

As illustrated in Table 11, matters relating to the CHPS programme seems not be a major priority of the community members. Apart from attending public gathering on health related issues organized by the health officials and other NGOs whose mission are consistent with improving rural healthcare delivery such as PLAN Ghana, all the other aspects received little community involvement. For instance, while more than half of the respondents(59.5%) did not attend communal labour in building the CHPS compound, a significant proportion(53.3%) are also not involved in the dissemination of information from volunteers and health personnel to other members of the community. More remarkably, about (74.3%) indicated not to be involved in cleaning up exercises which are organized by the community to maintain sanity within and around the CHPS compound.

This result on poor participation on the part of the community members in maintaining the facility is consistent with the information that was gathered from the Municipal Health

Directorate and the Community Health Officer. It is illustrative to note that although the community initiated the building of the health facility, health officials at the CHPS compound rated the participation of the community in the CHPS programme as very poor. In an interview, the community health nurse who runs the CHPS facility stated:

> '*The participation of the community in maintaining the CHPS compound is very bad. On one occasion, the Assembly man (Opinion leader) instructed the local people not to weed the CHPS compound when there was a communal mass cleaning exercise. And so the participation of the people is generally poor. There is no support from the community in maintaining the facility'.*

What further appears interesting is the revelation that the assembly man could go to the extent of instructing the local people during a cleanup exercise not to weed around a facility which belongs to the community. The deduction this study makes in all this is that, in this particular case study, community ownership of the CHPS programme does not necessarily influence their enthusiasm to maintain the facility. As it will be shown in the next section, it appears that the participation of the local people in the programme is limited just to the utilization or consumption of the services provided at the health facility and nothing else. Some opinion leaders in the community were asked for reasons for the generally poor participation of the community in maintaining the CHPS. One of them summarized the main reason for the non-cooperation:

"The nurses at the CHPS compound constantly fail to render accounts to us knowing very well that the clinic is for us. We want to know the financial state of our CHPS if not we won't have any obligation to maintain the facility since the nurses appear to have hijacked the facility withought accountability"

In order to put the above quotation in its proper perspective, it is prudent at this point to state a very interesting finding was made in the course of data collection. Results gathered from the field research show that the health officials (ie. Nurses posted by the Ghana health service to run the CHPS compound) constantly fail to render financial account to the community when they demand for it and that has significantly affected the level of commitment of the local people and leaders in participating in maintaining the CHPS compound. It is important to state that for patients who are registered with the National Health Insurance Scheme (NHIS), most of the treatment at the facility is free of charge but those patients within Nsanfo

and other surrounding towns who are not signed unto the insurance scheme are required to pay for the services they receive at the Nsanfo CHPS compound. This has been the major source of fund-generation at the facility and the bone of contention between the nurses and the community members. As shown in earlier sections, the fact that the community built the clinic on their own initiative using their own resources has given them (especially opinion leaders) some strong sense of entitlement and ownership of the health centre. It is based on this sense of entitlement that they feel empowered to demand financial accountability from the community nurses on all monies generated in the course of running the facility. This demand has been met with resistance from the Community Health Officers with the counter-argument that the Ghana Health Service policy regulation requires them to render financial accounts to only the Municipal Health Directorate on all financial matters related to the Nsanfo CHPS compound. The position of the community health nurse thus is that they are not under any obligation to render account to any opinion leader in the community. This is what has caused the tension and mistrust between the people of Nsanfo and the community health officers in the CHPS compound. This finding thus throws some light on the reason why despite the high patronage of the CHPS compound and its services, there is high apathy on the part of the inhabitants of Nsanfo when it comes to participating in activities to maintain the CHPS facility. The implication of this finding is discussed in the next chapter of the study. Clearly, there is a need to review this policy regulation on accountability.

4.4 Impact of CHPS programme on rural healthcare delivery

The main objective of this study was to explore how state partnership with civil society could serve as an important impetus in providing improved rural healthcare. In line with this, the study sought to find out how the CHPS programme is impacting on the health conditions of the people of Nsanfo. In order to achieve this objective, respondents were asked to provide the nature of healthcare delivery before and after the implementation of the CHPS programme, the effectiveness of the CHPS in improving community health and the various pathways through which the programme has improved their health conditions. Generally discussions and interviews with the local people suggest that, prior to the establishment of the CHPS compound, the health conditions of people was not something one could be proud of. Frequent injuries without treatment, occurrence of communicable and non-communicable diseases, maternal deaths, poor child health and insanitary living conditions are among some

the health challenges that the local people were confronted with prior to the establishment of the CHPS. Respondents were asked the main source of health treatment for ailment before the introduction of the CHPS in the local community. The results is displayed in table 12.

Table 12. Main sources for treatment prior to establishment of CHC

	Frequency	Percent
Mfantseman Hospital	4	3.9
Clinic in another village	96	93.2
Self medication	3	2.9
Total	103	100.0

Source: fieldwork, 2014

Results in table 12 indicate that majority of the people (96) representing 93.3% resorted to a a clinic is another village about 15km away from Nsanfo in their effort to treat their ailment. This clinic is in *Anomabo*, which is 15km from Nsanfo. This coalesces with information obtained from the Municipal Health Directorate. In an interview, the CHPS Coordinator argued:

> "*Almost all of the people of Nsanfo before the programme had to travel long distance to another community especially Anomabo to access healthcare. In instances where there were emergency cases, there was always a high likelihood of death especially maternal mortality. Most of the pregnant women died on their way to hospitals to deliver when there were emergencies. This was so as a result of the bad roads, you yourself am sure you have seen the nature of our roads as you travel to the community every day. The CHPS compound has drastically changed this situation."*

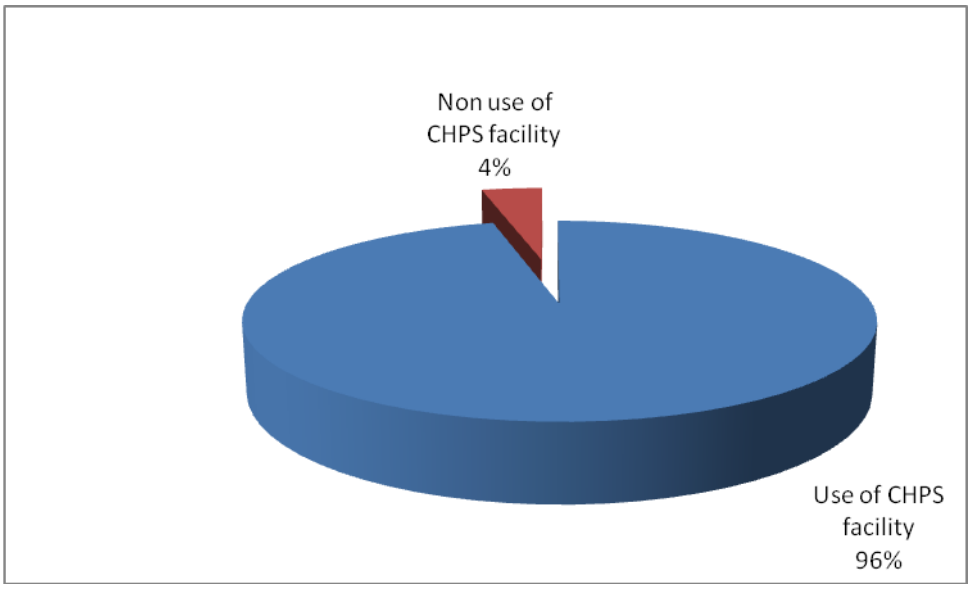
The decision of the GHS to partner with volunteers in providing rural healthcare is therefore justified by the issue of accessibility i.e long distance covered before accessing health facility. To compound the problem of long distance from Nsanfo to Anomabo, the poor nature of the road linking the two communities further affected the capacity of the people in attending the

clinic in Anomabo with some resorting to traditional medicine. The situation became more precarious when emergency health issues came up like transporting women who were in labour. Another factor that affected their capacity to seek proper healthcare in the adjourning village was the obvious high poverty levels. Majority of the inhabitants of Nsanfo are peasant farmers who cultivate farms purposely for subsistance. In instances where they are able to sell some of their farm produce to raise some money, the accrued money is usually spent on buying some items for the home and is barely enough for them to afford proper healthcare services in the Anomabo clinic due to the high cost of transportation.

The remaining 3.9% and 2.9% indicated that their source of treatment was the Mfantseman Municipal hospital and self medication respectively. Although self-medication seems not to be a major issue in the community, the act could further push the local people into even poorer health conditions. Overall, the state of healthcare delivery prior to the establishment of the CHPS was very poor as the local people could not easily access health services as and when needed. Thus the establishment of the CHPS has not only been beneficial in the treatment of ailment, but has also reduced transportation cost of getting to the next village to access health service.

Figure 11 displays the views of the respondents regarding the use of the CHPS in the study area.

Figure 11: Use of the CHPS facility



Results from figure 12 indicate a high level of use of the facility. As seen majority (99) of the respondents representing 96% indicated to be among those who use the CHPS compound when there is the need to seek for treatment of an ailment while only 4% affirmed otherwise. This finding further incites the interest of the researcher in the earlier finding regarding the rather low participation in the maintenance of the CHPS compound. From this particular statistics, is it not intriguing that a whopping 96% of the respondents use the CHPS as their main source of healthcare yet do not participate in taking care of the facility?. Even the 4% who indicated not to be using the facility suggested that the only reason they had not used it yet was the fact that, since the establishment of the clinic, they have not fallen ill yet however in the event that they needed healthcare services for treatment of an ailment, they will of course utilize the services provided at the CHPS compound.

Among those who used the health service, it was discovered that pregnant women represented a high proportion. The reason is that about 50% and 22% of those who use the health facility indicated that pre-natal and post-natal care is the major reason why they visit the health facility respectively. This revelation indicates that, the CHPS programme if properly resourced can go a long way in reducing maternal and infant mortality rates in the village and Ghana at large thus help achieve the 4^{th} and 5^{th} goals of the Millennium Development Goals and the national healthcare aspiration of zero maternal and infant mortality. The high level of patronage of the CHPS on the part of the respondents is consistent with information that was gathered from the Municipal Health Directorate. In an interview, the Municipal Health Director stressed:

"The community uses the CHPS facility for its purpose. There is high attendance rate."

On the same issue of utilisation of the facility, the Municipal CHPS Coordinator also had this to say:

"I will rate the patronage rate as 80-90%."

Results on how effective the CHPS has helped in improving healthcare delivery in the study area is shown in table 13

Table 13. Effectiveness of CHPS in improving healthcare delivery in community

	Frequency	Percent
Very effective	59	57.3
Effective	43	41.7
Not effective	1	1.0
Total	103	100.0

Table 13 reveals that generally the programme has been beneficial to the local people in terms of their health needs. Fifty nine (59) and 43 of the total sample of the respondents representing 57.3% and 41.7% indicated that the CHPS programme has been effective in improving the health needs of the Nsanfo community and even communities around it. The reason why the programme has been effective is that, it has radically aided the local people to have prompt access to healthcare service thus bringing affordable healthcare to their doorsteps as envisaged in the main objection for its establishment in the first place. Surrounding communities such as *Akraman, Fomena,Gyakuma, Nsaadze, Obontsir* and *Eshirow* all seek healthcare from the CHPS compound in the Nsanfo village as revealed by one of the community health nurses.

" As for this CHPS compound in nsanfo, I can say it came at the right time because it serves all the surrounding villages such as Akraman, Fomena,Gyakuma, Nsaadze, Obontsir and Eshirow which have an estimated popualtion of 4,075 and hitherto had to travel long distances to Anomabo for healthcare. All the nursing mothers and pregnant women from these villages all come to this CHPS compound for post-natal and ante-natal services ."

This has reduced the longer distance and high transportation cost which households had to bear in order to ensure access to health service in the villages. It is important at this juncture to state that not all types of ailments and health conditions are catered for at a typical CHPS compound including the one at Nsanfo. Specialised cases such as problem of the eye, kidney, ear and especially complicated delivery are not catered for by the community health officials under the CHPS programme. Thus cases beyond the control of the officials are transferred to larger hospitals in the municipal capital. This is a major principle underlying the CHPS programme. The inference that can therefore be made is that, had respondents been asked to evaluate the ability of the CHPS centre to trat all of these special cases,there is the high likelihood of generating contrary results. The CHPS facility in Nsanfo is therefore effective in

the fact that, it provides access to basic healthcare needs and not including specialised health conditions. Its relevance should therefore be evaluated against this background.

Results further indicate that, cases of maternal and child death, malaria and diarrhoea have also decreased due to the operations of the programme as volunteers constantly visit households and educate them on good sanitary practices. The table below depicts the services the Nsanfo CHPS programme now provides for the people of Nsanfo and surrounding villages. The table contains official Ghana Health Reprot statistics obtained from the Mfantseman Municipal Health Information Officer as part of data collection.

Table 14: Statistics of some basic services offerd by the CHPS programme in Nsanfo

Services	2013	2012	2011	2010	2009
Family planning (new registrants)	97	36	_	_	_
Child welfare services(no. of children attended to)	2,211	1431	1432	1084	1014
Immunisation for children between 0 to 11 months	2452	1192	760	962	1104
Integrated management of childhood illness(no. of cases reported by volunteers)	91	104	31	22	16
School health services by community health officials (no of children examined for health complications)	2449	2111	179	256	304
Vaccination(no. of people vaccinated)	26	1268	760	659	1104
Out Patients Department	849	752	_	_	_

Source: Mfansteman Municipal Health Directorate, Information Office, January 2014.

The statistics presented above reveals the very important roles that the CHPS programme is playing in the Nsanfo village . As can be seen, the numbers represent the annual record of beneficiaries that patronised the various services offered under the Nsanfo CHPS programme. Prior to the introduction of the CHPS compound, all these services as presented in the earlier discussions were received from the Anomabo clinic which is about 15km away from the Nsanfo community. The bad nature of the road and high cost of transportation further discouraged the inhabitants from travelling to seek medical attention even when the need

arose. Thanks to this CHPS compound, the residents are now relatively enjoying the above illustrated services ranging from immunisation of their children to child welfare services, family planning and vaccination within their backyard. It is important to state that the Integrated Management of Childhood Illness also known as IMCI is volunteer run. As explained earlier, the volunteers who form a crucial part of the CHPS programme are given some intensive training in early childhood illness detection courses in order for them to be able to detect such diseases when they visit homes in the course of their work as community health volunteers. So in general, it can be said that these services rendered by the Nsanfo CHPS compound has cumulatively improved the quality of healthcare of the people of Nsanfo through prompt access and reduction in the distance covered in order seek for health treatment.Indeed, healthcare is now delievered at the doorsteps of the Nsanfo people as envisaged by the Ghana Health Service .

The strategy is also crucial as it focuses on the preventive aspect of healthcare rather on the curative. This strategy is thus cost-effective as it is relatively cheaper to prevent ailments than curing them. This strategy resonates with the popular idiom that "*a stitch in time, saves nine*" meaning if households are given enough education on preventive healthcare, it can go a long way to prevent avoidable health conditions which if not properly treated can result in death and other serious ramifications for the victim and his or her immediate family.

4.5 Challenges associated with civil society-state partnership in healthcare provision

The preceeding sections have shown that the establishment of the CHPS programme in the study area has generally improved the health conditions of the people. This notwithstanding, the programme is beset with many challenges which hinder its smooth progress. These challenges were ascertained as part of the data collection process as it formed part of the objectives of the study. Results from the study points to some challenges currently facing the CHPS programme in the study community.

One major factor which poses a threat relates to volunteer-fatigue. Interviews with the Community Health Officer, the district CHPS programme Coordinator and the Municipal Health Director all show that the commitment of the volunteers is waning down**.** As already noted, the volunteers play a crucial role in the smooth operation of the CHPS programme

hence a loss of interest in the volunteering cannot be underestimated as it poses grave danger to the whole existence of the CHPS programme. The reason for this apathy on the part of the volunteers could be summed up in the words of the Municipal Health Director:

".....The commitment of the volunteers is dwindling. They sometimes demand monthly allowance for the work they are doing but that would defeat the whole purpose of the CHPS programme. Even if we were to give them some allowance for their work, such monies must come from the community because the CHPS compound and programme itself is for them. No such monthly allowance has been budgeted for in the annual budget ofthe Ministry of Health anf and the Ghana Health Service for that matter. Monthly allowance for volunteers was not factored into the original design of the whole CHPS concept so there is no way we can pay them such monies. However when there are isolated World Bank funded programmes like immunisation, we involve them so that they could receive some motivation/allowances as such World Bank projects come with funding ....."

This information from the Municipal Health Director raises quiet a number of salient issues. Arguably, civil society side of partnerships in the synergy equation often involves voluntary collective action hence Brinkerhoff (1999, p.79) argues that "*successful policy implementation partnerships must pay attention to crafting an agenda and actions that solicit and hold the interests of the nonstate partners, whose contribution is usually noncompulsory and non- remunerative*" . Now, as the CHPS concept does not make any componet to renumerate volunteers, it leaves the researcher wondering if the programme can stand the test of time. As volunteers form the backbone of the CHPS programme, if volunteer interest in this particular case study for example is dwindling, then it raises issues about how sustainable the CHPS programme would be in the Nsanfo community. The problem is worsened by the lack of adequate govenrment budgetary allocation to the Ministry of Health.

The inferance this study makes is that, in the absence of isolated programmes like the world Bank funded health projects, the Municiapl Health Directorate would not have the financial werewithal to sustain the CHPS programe in the Nsanfo community. The expectations that the community should bear the responsiblity of renumerating the volunteers too is not feasible as it was obvious from observation that they lack the economic power to shoulder such a responsibilty on a sustainable basis. In this regard, the government oughts to re-look at the CHPS concept and see if any financial incentive can be introduced to sustain the interest of the volunteers to ensure sustainablity. Information gathered from the volunteers confirm that

although the volunteering work under the CHPS programme attracts no financial reward, lack of motivation for the volunteers has also accounted for the current feeling of volunteer-fatigue. This prompted the researcher to enquire what he meant by ”motivation”. One of the volunteers shared his ordeal:

“Even the last time when we went for a programme, there was a promise of 10GHC (about $5) a month to cover cost of transportation and feeding for volunteers when they come for monthly weighing programmes. However they have not paid us that money for about 9months now since we have been going there. They keep re-assuring us that they will pay all the outstaning arreas but still have not as we speak now. so my brother, if we use our little savings for transportation and feeding at these programmes and they make these promise to re-imburse us and then fail for 9 months now, how do they expect us to continue to go round the village volunteering ?”

The above quote aptly re-echoes the sentiments most of the volunteers interviewed expressed. This promise of 10Ghc a month is different from the monthly allowance the volunteers are demanding. The promised monthly 10Ghc which is even in areas is far less than what the volunteersare demanding as monthly allowance and can only be received as and when a volunteer comes for the monthly weighing programmes organised by the Mfantseman Municipal health Directorate. What this implies is that, failure to attend such programmes means that the volunteer receives nothing at all. In all, the picutre that was painted was that, even though at the commencement of the CHPS programme it was made clear to the volunteers that they would not be paid for their work; most of the volunteers interviewed now feel at least they should be given ”*something small*” monthly for sacrificing their time to serve the community. In the words of one of the oldest volunteer(63 years old):

“My son, look at me, at my age I still felt it good to volunteer. I go round the village all the way to Akraman to do my job. Even if they will not pay us for our work, at least they can give us logistics like motorbikes or bicycle to help us in our work. Sometimes, you are sleeping and they call you to come and attend to an emergency situation in a nearby village. I have to walk all the way to Akraman in the night and even sometimes in the rain, it is not good at all, the authorities have to help us.”

This lack of adequate motivation and support is what has accounted for the dwindling interest of the volunteers in the operationalisation of the CHPS programme in the Nsanfo community.

Aside the lack of commitment on the part of the volunteers, another factor that threatens the very existence of the CHPS in the study area is the poor state of the CHPS clinic. Visits to the CHPS compound revealed that the building is in deplorable state as shown in the picture below and is near collapse. This was confirmed during interviews with the Health officials at the clinic. One of the health officials could not hide her feelings as seen in the quote below:

"My brother, you just take a look at our CHPS compound, it is in a deplorable and bad condition, how do you expect us to feel safe to give out our best under these conditions?"

FIGURE 12: Current state of the CHPS compound in Nsanfo

Photo : Author, Fieldwork, January 2014.

What is particularly worrying is that when it rains, the whole facility gets flooded and it considerably affects the day to day work of the health officials. The above issue was well echoed by the respondents when the researcher asked them what recommendation they would give to improve the CHPS programme in their community. A whopping 96% indicated that, they wanted a new community health because the current CHPS building is dilapidated.

Table 15. Recommendation on construction of new CHPS building

Recommendation on new building	**Frequency**	**Percentage**
Yes	99	96 %
No	4	4%
Total	103	100%

Source: Field survey, 2014

While this challenge particularly could lead to the collapse of the CHPS programme, it was discovered that there is currently no effort to help salvage the situation especially from the Municipal Health Directorate as seen in the words of the Municipal Health Director when she was asked whether any effort is being made to provide a decent health facility for the CHPS programme. The Municapal Health Director stressed:

> *"Infrastructure provision is outside the domain the of the Municipal Health Directorate , it is up to the community members to provide a proper CHPS compound and maintain it, that is the arrangement in the whole CHPS idea. Nonetheless we can appeal to the Government for support and see if something can be done about it."*

This response of the MHD re-echoes the failure of the Government of Ghana in living up to its expectations. The government among others is responsible for the provision of healthcare facilities for all citizens including the the people of Nsanfo as they pay tax. The arguement that infrasturcutre provision is outside the domain of the MHD leaves one wondering what then is the role of the government . As it was found out later, the only role the MHD plays in the operation of the CHPS programme is to post nurses to the facilities to run it and also periodically train volunteers. This study acknowledges the logic that, even though the idea behind encouraging communities to build their own CHPS compound is to instill a sense of ownership of the programme, the study nevertheless argues that, some provision should be

made in the budget of the Ministry of Health to cater for the repairs of some of the dilapidated CHPS compounds. Baatiema et al (2013, p. 12) aptly summarise this arguement when they contend that that "w*hilst it is important for community members to contribute with resources, engaging in a community-government partnership that bolsters community ownership needs to have a long-term strategy, with funding agencies committing to avail resources as and when required to sustain the health initiative*". This is so because, high levels of poverty in most rural communities like Nsanfo makes it unfeasible for the the inhabitants to bear the cost of building new a CHPS compound. The MHD just posting nurses to CHPS compound and undertaking periodic training of volunteers is not enough to ensure sustainability of the CHPS programme in the Nsanfo community.

There is also the problem of poor logistics and the lack facilities such hospital beds, essential drugs and other equipment that could aid the work of the health officials. This has undeniably affected their work. Additionally, accommodation for health officials and lack of constant flow of water in the facility and lack of security personnel to provide security for the health facility especially at night all serve as factors that affect the smooth running of the CHPS programme in the study area. This latter problem was highlighted by one of the health officers in the CHPS compound when she indicated in the course of her interview that

"We are sometimes scared for our lives because of threats of assault from some of the youth in the community. Sometime ago, some young men came to knock on my door in the middle of the night claiming there was an emergency in a nearby community, I didn't come out because I was afraid and they threatened to assault me anytime they meet me in town".

When probed further as to why she refused to attend to an emergency situation, she responded that she was afraid because around the same time, a chief had died and as custom demand, there were executioners from the chief's palace going out in the night to look for human beings to sacrifice as part of rituals to bury the chief. Her exact words were:

"My brother, how could I come out at that time of the night when it was all over town that the abrafu (executioners) were looking for human heads to bury the king with"

For clarification purposes, the researcher could understand the predicament of the health officer in refusing to answer the call to emergency in the middle of the night. There is a prevailing myth especially in rural communities that whenever a chief or king dies, custom demands that humans are sacrificed as part of the rituals to bury the king and bid him a final

farewell befitting of a king. In elusidating the above point,Ghanaian sociologist Ephirim-Donkor (2012) states that there is a belief among majority of the populace that traditional rulers especially in traditional socities are somehow asscoiated with human scarifice directly or with their tacit approval for various secret rituals. According to the author, when a king dies for example there is usually a widespread perception that executioners (Abrafo or adumfor) from the kings palace engage in an orgy of human sacrifice as part of burial rituals in order to transofrm the dead kings into deities. The supposed logic behind this alleged human sacrifice is that, as a king in his previous life, he would need people to escort and serve him when he finally arrives in the afterlife. Even though the researcher cannot independently ascertain or validate this myth, one cannot underestimate the claim by the community health officer because the myth is very popular especially in traditional communities. Her fears were therefore understood.

4.6 Conclusion

Overall, the decision of the Municipal Health Directorate to partner with the local people in establishing the CHPS compound with volunteers serving as "community doctors" have substantially helped improve child and maternal health, prompt access to and utilization of health service, reduction in transport cost in order to access healthcare and general improvement in community sanitation and hygiene. However challenges such as dwindling of commitment of community volunteers, deplorable condition of the CHPS compound, lack of logistics, lack of accountability to the local people by the health officials, security issues at the health facility together with accommodation problems all serve as major factors that threaten the sustainability of the CHPS programme in the study area.

CHAPTER FIVE: DISCUSSIONS, ANALYSIS AND IMPLICATIONS OF KEY FINDINGS.

5.0. INTRODUCTION

Preston, Waugh, Larkins and Taylor (2010) contend that, several case-studies have shown that, the results of community participation in healthcare delivery have been predominantly positive. In that regard this study aimed at examining how state-civil society partnership could serve as an important synergy in delivering rural healthcare in Ghana. The most significant results from this study demonstrate that, the collaboration between the state (Municipal Health Directorate) and the community volunteers (civil society) has largely yielded positive results in relation to improving access to and utilization of affordable basic healthcare in the Nsanfo community. The CHPS programme which was initiated by the community was perceived as a key intervention especially in effort towards bringing healthcare to the doorsteps of the local people although there still remain a number of challenges such as dwindling commitment of health volunteers, lack of logistics and deplorable condition of the CHPS facility among others. These identified challenges largely threaten the very existence and sustainability of the programme.

What should be noted however is that, even though there was the high tendency for the Ghana Health Service officials to exaggerate on the success of the programme in Nsanfo, this study independently ascertained the impact of the programme and can largely agree with the health officials on the relative success of the programme based on the data gathered from the field. In this section, the above findings together with other relevant results emerging from the study is discussed in line with similar empirical studies in the past in order to situate its broader implications for rural healthcare delivery and general healthcare planning in rural Ghana and in other developing countries that share similar healthcare challenges as Ghana. The chapter begins with a discussion of the role and the extent to which civil society (volunteers) have been integrated into the CHPS programme. This is followed by a discussion of the relevance of community participation, social capital and empowerment and the implications these have on the operation and sustainability of the CHPS programme. The last part provides a discussion of the effectiveness and challenges confronting the CHPS programme. All these discussing are done against the background of the stated research questions of the study.

5.1 Civil society integration in the CHPS programme : Implications for rural healthcare delivery in Ghana

Positive engagement of civil society in the provision of social services has been a major development strategy in many countries. As Zakus and Lysack (1998) indicate, this is based on the perception that untapped resources embedded in civil society agencies such as volunteerism can be of significant value in achieving sustainable social goals like healthcare. In Ghana, there is the active involvement of the civil groups in all aspects of development initiative such as advocacy, infrastructure provision, poverty reduction, environmental management and rural healthcare. In the case of the CHPS programme, community volunteers remain essential stakeholders in ensuring the delivery of healthcare at the door step of previously marginalized and vulnerable populations (Loewenson, 2003). Results from the Nsanfo study indicate that the community volunteer partners are selected with the knowledge of the local people, chiefs, elders and the community health committee. This buttresses the argumentation of Adongo et al (2013) who maintain that under the CHPS programme, community volunteers are mainly selected through a consultation process between the local communities(including chiefs, opinion leaders and households) and the Ghana health service.

The implication is that opinion leaders in the community and the local people in general play a crucial role in the choosing of health volunteers for the CHPS programme. Using thematic analysis of data from an extensive study of the CHPS programme in the Wa municipality of Ghana, Baatiema et al. (2013, p.1) discovered that community participation in the CHPS programme in their study area was sustained through the "*recognition and use of community resources, integration of the CHPS programme in pre-existing community structures and the alignment of the CHPS services with the community interest*". The involvement of these opinion leaders and community resources is very crucial in sustaining community interest in the CHPS programme.This is not surprising because customary practice in the country has vested much power in the hands of the traditional authorities in the performance of many social functions.

This notwithstanding, interviews with some volunteers suggest that they willingly offered themselves to be volunteers when the CHPS programme was introduced especially when they realised that people were reluctant to offer themselves as volunteers upon knowing that there

was no remuneration . The successful selection of the volunteers in Nsanfo and their subsequent integration into the CHPS programme in the study area therefore deserves commendation, as there remains no clear cut national guidelines in the selection, duration of service and how to sustain volunteer interest (Acquah et al, 2006). Additionally previous research conducted in other regions of the country reveals that some communities especially in the Volta regions have no volunteers in place as the volunteer groups and community health committees were still in the process of being formed (Nyonator et al., 2002). Lack of interest and commitment of community members are among the reasons that been adduced for lack of volunteers in those areas (Send Ghana, 2013). This is indication that the successful recruitment and integration of volunteers in the Nsanfo CHPS programme is no mean feat. Stakeholders in the Nsanfo community have done well in the area of being able to institute their health committee and volunteers to run the CHPS programme to its current state unlike other regions experimenting with the CHPS programme. Some lessons can be drawn from the Nsanfo experience especially in areas of volunteer recruitment.

Under the policy document guiding the implementation of the CHPS programme, the importance of community health volunteers have been well recognised. Their active involvement in the operation of the CHPS has been useful in terms of extending healthcare to local communities(GHS,2005). The Ghana health service operational policy (2005) on the CHPS programme envisages that, the decision to seek health care and which type of health care services household seek all depends on information available to the household. The volunteers in the Nsanfo community have proven to be relatively effective in making this crucial information available to households in the community. Results from the study indicate that the volunteers play essential role in information gathering and dissemination in addition to other crucial services. Table 7 shows that services rendered by the volunteers include emergency treatment services, visitation to households to provide general medical check and education of households on healthcare issues. Other services typically provided by the volunteers include health and family planning promotion, oral rehydration, periodic immunization and antenatal care, antipyretics for the care of children and vitamin supplementation for children (Awoonor-Williams et al., 2013). All these services have ultimately contributed to the current state of improved healthcare conditions in the Nsanfo community.

Moreover, community health volunteers were seen as the medium through which the local people communicated their health needs to the health clinic and at same time they also convey health related information from the health officials to the household members. Undeniably, by performing this responsibility, the volunteers serve as a medium that connect the health officials and the community members. This reinforces the argumentation of Adongo et al. (2013) that the realm of the community health volunteers in the operation of the CHPS is essential as they provide services in the area of community mobilization as well as participation, keeping records of all vital community health statistics while maintaining other requisite activities(Adongo et al, 2013). It can therefore be argued that per the services rendered by the volunteers, they act as partners to the health officials and the health committee in providing traditional governance structures for the implementation of the CHPS programme (Send Ghana, 2013).

The implication of all these findings is that, the Nsanfo case is another vindication of the argument that community health volunteers remain a pivotal force so far as improvement of rural access to healthcare is concerned. What this means is that, governments should pay critical attention to their efforts and support them to continue to play their essential roles they play. In the larger context, such volunteers act as the link in connecting rural dwellers to the overall national healthcare provision strategy. They significantly contribute to achieving the envisaged objectives of the CHPS according to the Ghana Health Service (2005) which are to

- Develop effective intersectoral collaboration
- Improve efficiency and responsiveness to client needs.
- Improve equity in access to basic health services.

Their role in the sustenance of the entire CHPS programme is therefore indispensable and resonates with the recommendation made by Kironde and Kahirimbanyi (2002,p.16) when they argue that "*health care planners should consider community participation as a viable way of ensuring accessibility and effectiveness in Primary healthcare programmes*". The Nsanfo case is a good reference point.

5.2 To what extent has the integration of health volunteers been successful in the provision of healthcare under the CHPS initiative?

Although not much validation has been provided by previous researchers, the little evidence emerging from literature review on the CHPS programme indicates that in areas where there exist properly functioning community health volunteers, such volunteers play active roles in improving the health conditions of local people. Results from this study indicate that half of respondents (50%) rated the performance of volunteers as very satisfactory while 35.4% indicated the performance of the volunteers as satisfactory; the remaining 14.6% rated the performance of the volunteers as excellent (See Table 6).

What should be borne in mind with this finding is that, the seemingly high ratings the respondents gave for the services rendered by the volunteers is based on treatments for less complicated ailments and general preventative healthcare education services the volunteers render. Complicated health conditions that cannot be treated by the health volunteers is immediately referred to the community health nurses at the CHPS zone who may also refer such complex cases to the main district hospital at Anomabo if the condition is beyond their capacity to deal with. The implication is that, even though the health volunteers seem to enjoy some higher levels of appreciation for their services, they are limited to the kind of medical services they can render due to their inadequate training in healthcare to render services in such complicated medical conditions . It can therefore be guessed that, had the respondents been asked to rate such volunteers on their ability to treat their complicated medical conditions, there is the likelihood of generating totally different ratings. Even if this had occurred, the volunteers cannot necessarily be blamed as the policy guidelines for the implementation of the CHPS does not stipulate for volunteers to deal with complex medical problems (GHS, 2005).

Notwithstanding this limitation, the high ratings the respondents gave for the volunteers are consistent with interviews with health officials and Municipal Health Directorate. The reasons for this is that the volunteers provide door to door services to households educating them on health issues such as taken good care of children and good sanitary practices, assist in weighing services, immunisation programmes and even attend to sick people in the community at odd hours. Results from this study on the performance of volunteers corroborate the findings of other studies. For instance, research findings from the Tampala in

the Jirapa District of the Upper West Region indicate that, through their activities, the community volunteers have helped in extending quality healthcare to hitherto scattered and very remote communities in the District (Send Ghana, 2013). In particular, it was further reported in the district that the volunteers had been effective in providing supportive services to the health officials in managing minor accidents, family planning promotion and mobilization of community members for health related seminars to discuss and educate people on living a healthy lifestyle (Send Ghana, 2013).

Although the findings from the Nsanfo study cannot necessary be generalised for the whole situation in country, the point that needs to made is that the active involvement of the volunteers especially by working together with community health officials have been beneficial in improving the health conditions of people of the Nsanfo study area. This largely supports the view of Loewenson (2003), who stresses that one important advantage of civil society involvement in healthcare delivery is its ability to reach usually marginalized populations and poorly served remote communities due to urban bias.

In all of these discussions, it is important to state that, in as much as civil society or community intervention in health care delivery is desirable and encouraged, this study cogently contends that civil societies in developing countries can not on their own address some of the broader challenges stagnating health service access and public sector service provision in general; neither should community participation be seen as a substitute for the responsibility of the state to make such health services available. It is within this framework that the limitations of the community health volunteers in the Nsanfo CHPS programme should be evaluated. Even though the CHPS programme in Nsanfo appears to be making some positive impact in the community, the government of Ghana cannot remove itself from the ultimate responsibility of providing better healthcare facilities for the people of Nsanfo and to an extent other rural communities. The government should therefore increase its budgetary allocations to the health sector in order to significantly improve access to healthcare by rural communities like Nsanfo. The Centre for Global Development (2009) aptly captures the position of this study on this matter when they cogently contend that that the private sector and volunteers for that matter is a not a replacement for effective public-sector action. At best, they can effectively serve as strategic partners in coproducing desirable social goods such as healthcare just like what the community volunteers are doing in the

Nsanfo CHPS programme. Much more commitment is thus expected from government in rural healthcare provision.

Figure 13: Interior of the Nsanfo CHPS compound.

Photo : Author, Fieldwork, January 2014.

5.3 Community participation, social capital and empowerment: Relevance for CHPS programme

Engaging communities in the design, implementation, monitoring and evaluation of development interventions including healthcare has been a major aspect of mainstream development orthodoxy (Chambers, 2005; Kyei, 2000). As thoroughly argued in the literature review, community participation has been celebrated in the international development arena, embraced virtually by most development thinkers as a means of ensuring successful implementation and sustainability of community level projects. This clarion call for community participation in healthcare delivery emerged in the 1970's especially in the global south when it became evident that public health agents alone were not capable of meeting the healthcare needs of citizenry hence the need to engage the communities in the provision of their own healthcare (Zakus and Lysack, 1999).

Preston, Waugh, Larkins and Taylor (2010) make the point that empirical case-studies on healthcare outcomes have shown positive outcomes especially where community participation is deployed. A DFID helpdesk report in supporting this school of thought argues that "*the input or contribution from the community itself is a crucial factor determining the outcome of a community health programme as community awareness and a sense of responsibility, expressed in the involvement of the people in the community health programme, gives the programme an impetus that results in continuing and accelerating movement*" (DFID, 2003, p.11).

In a study in Eritrea about community participation in a malaria control programme for example, WHO (2006) found out that, community participation reduced overall national mortality from malaria by a significant 60% in 2004. Moreover, 50% of malaria cases in the country were handled by communities through Community Health Agents (CHAs) (WHO, 2006). Findings from the current study largely point out the CHPS facility in Nsanfo community was initiated by the local people. It emerged in the course of data collection and interviews with officials that community mobilization of resources and labour was used in putting up the current community health clinic at Nsanfo. After which the community appealed to the Ghana health service to post nurses to the facility to run the CHPS programme. This represents an important initiative on the part of the community. What is significant to note is the fact that, the decision to establish a health facility was largely the initiative of the local people thus giving credence to the argument by Ostrom (1996) and Evans Peters (1996) on how social capital embedded in societal relations can be mobilized to undertake self-help projects like in this case. As argued in the theoretical framework of this study, indeed this social capital is believed to be one of the crucial elements necessary for synergic relationships to emerge in the first place and to be sustained.

This finding of the involvement of the Nsanfo community in putting up the CHPS compound corroborates with previous research works on the matter. In their evaluation of the CHPS programme in four regions including the Upper West, Upper East, Volta and Northern regions, SEND-Ghana (2013), a social development NGO noted that in villages where the programme has been implemented, communities contributed immensely in putting up the health facility. Community participation took the form of providing the construction materials such as iron sheet, stones and also their human labour in the construction of the clinic (Send Ghana, 2013). This suggests that CHPS programme largely emanates from local

people. The provision of the necessary building material and labour for the construction of the CHPS compound by the community in one way help to reduce the cost associated with the facility. In Nsanfo community, local materials and labour were used in the construction that helped reduce the financial burden on the community. This confirms the argumentation of Wilson and Johnson (2000) who opine that community participation has the merit of delivering public goods at cheaper cost as implementers have the option of relying on cheap and unskilled labor in communities where projects are to be implemented.

By implication, the participation of the community provides a sense of ownership of the health clinic and also empowers them to take their destiny into their own hands within the framework of their socio-economic realities (Wilson and Johnson, 2000). It is within this framework that one can appreciate the demand for financial accountability from the Nsanfo health officers by the community members. The implication of these findings is that the successful story of the Nsanfo people harnessing their social capital to put up the CHPS programme reiterates the point that, social capital embedded in communal relations and structures can become catalyst of self-help developmental goals if properly harnessed.

These notwithstanding, this study proceeds to argue that the ideals of community participation go beyond contributions aimed at establishing a facility to issues of maintenance and other matters relating to the operation and sustainability of projects. Although the community made an important decision to establish the CHPS, maintaining the facility did not matter most to community members. Apart from public gatherings on health issues, larger proportions of the respondents seem not to be interested in all other matters such attending of communal labour and involvement in cleaning up exercise around the CHPS facility. The reason for this development is discussed shortly. Under the CHPS initiative, communities have to be involved in the development of policies and plans as well as in monitoring, evaluation and maintenance of the health facility (GHS,2005, Nyonator, 2002).

However, results from the study indicate that community members and even some opinion leaders do not play an active role in the maintenance of the facility. As thoroughly discussed in the data presentation, this apathy has been largely due to community members suspicion of financial misappropriation of internally generated funds on the part of the nurses at the health facility. What is even worsening matters is the fact that, the nurses continousely resist any demand for accountability with the argument that the policy guidelines of the Ghana Health

Services requires them to only render account to only the Mfantseman Municipal Health Directorate and not community members. This has caused the tension and mistrust between the people of Nsanfo and the community health resulting in the community apathy. This was evident when health officials stressed the point that even during communal labour to clean up the whole community; the assemblyman instructed the community members not to weed around the CHPS compound and true to words indeed went past the CHPS compound to weed surrounding homes. This is incongruous given that the community owns the CHPS compound hence such high level of apathy towards maintaining their own initiative is rather unfortunate.

The above finding contradicts the major strands of opinion in the literature. Researchers such as Oakley and Kahsey (n.d, as cited in Rifkin, 2001) posit that the necessity for community participation in healthcare delivery is based on the premise that that there is an indirect effect of empowerment due to the building of self-esteem, ownership and sense of responsibility. However results from this study suggest that community empowerment and ownership of the facility did not necessarily translate into their enthusiasm to maintain the facility. The lack of the sense of personal responsibilities and ownership towards maintaining the facility could hinder the CHPS initiative from living up to its goals and purposes for which it was initiated (Akosa et al, 2003; Tierozie, 2011).

The implication of is that, community initiatives to undertake self-help projects is not an automatic guarantee that it would translate to same energy for maintaining the project. This notwithstanding, this study acknowledges the reality that, to an extent, the challenge of apathy facing the CHPS programme in the Nsanfo community cannot be blamed on the either the nurses or the inhabitants of Nsanfo. Having used their own resources to put up the CHPS compound, one can only agree that it is within the right of the opinion leaders of Nsanfo as stakeholders to demand accountability of whatever goes on at the facility. The nurses on the other hand at also appear to be in a dilemma as they are torn between flouting the code of conduct prescribed by the Ghana Health Services on matters of accountability and giving in to the demands of the Nsanfo people.

Interactions with the nurses indicate that they have absolutely nothing to hide as they have been financially disciplined and that the only reason they cannot divulge financial reports to the Nsanfo leaders is because it's against their code of conduct. Moreover, it was discovered that the responsibility of paying the health volunteers their transportation allowances during

training workshops is the responsibility of the Mfantseman Municipal Health Directorate and not the nurses at the CHPS compound. The volunteer thus unleashing their frustration on the nurses on the matter of non-payment of their arreas is therefore unfortunate. This study thus appreciates this dilemma they find themselves in and would argue that, perhaps it is time to relook at the Ghana health service regulations on financial accountability at CHPS compounds. A resolution of this challenge would go along way to increase trust between community members and nurses thus ensure the smooth operation of the programme. This conviction is based on some other cases studies on the CHPS programme in other areas where results showed that there was high community participation in maintaining their CHPS facility.

A case in hand is a research findings on CHPS from Northern Ghana where findings revealed that not only did communities such as Sabare contribute to building their CHPS facility,they also contributed to weeding around the CHPS and also provided the necessary support to the health officials in repair works of their CHPS compound (Send Ghana, 2013). This reiterates the argument by this study that among other things, if the identified challenges between the community members and the nurses concerning accountability are resolved, it would positively affect the commitment of the people to matters relating to the maintenance of the CHPS compound thus ensuring sustainability. Recommendations on how this can be done are discussed in the final chapter of this study.

5.4 Effectiveness and challenges of the CHPS programme in rural healthcare delivery

Bridging the rural-urban gap with regards to infrastructure development and access to social services especially healthcare has been on the policy agenda of successive governments in Ghana. Indeed the Government of Ghana envisages providing quality, affordable and equitable healthcare to all Ghanaians irrespective of their geographical location and socio-economic circumstances (NDPC, 2003). This ambition has however been stagnated by several obstacles ranging from the lack of adequate financial resources to the sheer lack of political will to make healthcare provision a topmost priority by successive governments that have ruled the country. To suffice, one major initiative that has been implemented to reduce health inequities between rural and urban areas and of advancing equity in health outcomes through

removing geographic barriers to healthcare service is the Community Health Planning and Service programme (GHS, 2002). The Ghana Poverty Reduction Strategy (GPRS) accordingly adopts the CHPS initiative as one if its major pro- poor health services intervention for the rural dwellers in Ghana (NDPC,2007).

Empirical studies focusing on access , utilization and outcomes of the CHPS programme has found that the programme represents an innovative approach of bringing healthcare to the door steps of hitherto marginalized. The CHPS initiative according to GHS (2007) is also reported to enhance improve child health, maternal mortality and treatment of basic diseases. Indeed, communities that have witnessed the implementation of the CHPS programme have seen a tremendous improvement in terms of access and health outcomes (Send Ghana, 2013). As argued in the theoretical framework of this study assessing the impact of cooperative programs as the CHPS is not a simple matter as the measurement of what constitutes a "success" or "failure" of the programme can be a thorny issue. According to Tendler (1989) and Uvin (1995) as cited in Brown and Ashman (1996), it is practically difficult to calibrate the different impacts of such collaborative programmes but the capacity to affect large numbers of people is an important aspect of program effectiveness. The Nsanfo case study further validates the above assertion.

Results from the current study indicate that prior to the establishment of the CHPS programme in the study area, about 93% of the respondents travelled to Anomabo which is about 15km in order to access healthcare services. However, after the implementation of the programme in Nsanfo, almost all the respondents (96%) do not travel to this Anomabo clinic anymore and therefore rely on the CHPS compound in meeting healthcare needs. This is consistent with other studies that have been conducted by other researchers and organizations in the country. In his impact assessment of the CHPS initiative in the Berekum Municipality in the Brong Ahafo Region of Ghana, Tierozie (2011) discovered that the programme largely enabled people in the municipality to have convenient access to health service in their community instead of travelling long distances in order to access healthcare. The implication is that the community-based CHPS programme has the merit of reducing the financial burden incurred by households in travelling to access health service. In the larger context, it contributes to poverty reduction by making access to healthcare more affordable.Fortunately for the people of Nsanfo, the implementation of the nationwide National Health Insurance Scheme (NHIS) in 2003 relieves them of any financial burden of paying for some common

health conditions which are all covered by the insurance scheme. Once a community member is registered with the insurance scheme, he or she does not pay for any of the services and medication captured under the scheme when they visit the CHPS health centre. The little funds residents accrue from sale of farm produce and petty trading could therefore be channelled into other productive activities by households thus increasing the purchasing power of households and their standards of living ultimately.

Additionally, Nyonator et al. (2002,p.24) in a similar study on CHPS in the Volta region of Ghana found out that " *emergency services are available 24 hours per day, seven days per week; ...community people appear to develop rapport with the community nurse and feel they are obtaining services from a caring individual are all indicators that the CHPS programme has been effective in rural healthcare in the Volta region of Ghana".* In as much as the case study Nyonator (2002) refers to seems to reflect the situation in the Nsanfo CHPS programme, this study acknowledges that the circumstances and characteristics in Nsanfo and the Volta region are not the same hence some other factors could account for the successes chalked by the CHPS programme in both communities hence both ought to be evaluated on their own merits. In further proving the crucial role the CHPS programme is rendering in rural communities, it was found out in one of the deprived districts i.e the Birim North, that about 54% of the inhabitants had access to healthcare within a radius of 15 kilometres prior to the establishment of CHPS compound. This has however reduced to about 6kilometres after the implementation of the programme.

The same could be said of the case of the CHPS programme in the Nsanfo community(Nyonator et al.,2002).. Residents hitherto had to travel about 15km to Anomabo to seek medical attention for the smallest illness but this has been drastically reduced to less than 2km(depending on ones proximity from the facility) with the establishment of the CHPS compound in Nsanfo.Residents can now just walk over to seek healthcare attention when the need arises. The volunteering component of the CHPS programme also brings healthcare services to the doorsteps of residents especially with special attention on preventive healthcare through their health education when they visit households thus improving their general healthcare conditions (Acquah et al 2006). Undoubtedly the decision to experiment and subsequently extend the implementation of the CHPS programme to various parts of the country has afforded many people the opportunity to access health care service. The implication is that this innovative synergy between the state and the civil society represents an

important strategy in addressing the development challenge of healthcare access especially to rural inhabitants in the country (Adjei et al 2002).

Not only has the CHPS programme significantly reduced the distance covered and improved access to healthcare. It has also resulted in actual utilization of health service as compared to self medication and traditional medicine in the past. Data from the current survey indicates that there is high patronage in terms of usage of the CHPS compound by the people in the study area in the treatment of all sought of illnesses. Figure 11 indicates that about 96% of the sampled population actually utilize the CHPS compound in the treatment of diseases and other purposes thus nursing mothers do not travel longer distance to seek ante-natal and post-natal service as they used to do prior to the establishment of the CHPS in the study community. This finding corroborate with district, regional and even countrywide level situation. Data from the Ghana Health Service (2011) suggest that between the periods of 2009 to 2011, the total population who were actually utilizing the various CHPS compound in the country increased from 16.8% to 21.8%. This is partly attributed to the substantial increase in the establishment of functional CHPS compound from 868 to about 1,675 over the same period (GHS, 2011). Currently, the programme has been extended and has become truly a national development strategy in rural development in the country (Nyonator, 2003).

Results further indicate that reported cases of illnesses by patients from the Nsanfo community and its catchment areas in the CHPS health compound increased from 752 in 2012 to 849 in 2013 as seen in Table 12, an indication of actual utilization of CHPS facilities as a means to seek treatment for illnesses. Earlier researches in the Upper East region where the CHPS programme was first experimented have highlighted comparable conclusions. It is estimated that the CHPS programme contributed to a rise in out-patient department (OPD) cases from 5% in 2009 to 13% in 2011 while supervised delivery also increased from 52.6% to 67.5 % over the same period. Indeed, the CHPS initiative serves as a means to bring to an end the vertical programmes through provided pathways and mechanisms for rendering healthcare services through a decentralized system. It thus involves processes of evidence-based organizational reorientation for extending the logic of the sector-wide approach at the community level (Nyonator, 2003).Therefore few will probably disagree that the CHPS strategy has been successful in helping solve the problem of long distance covered before accessing health facility, bridged the gap of health inequities in between rural and urban areas

and of promoting equity in health care access through removing spatial barriers in health system (Adjei et al.,2002).

5.5 Impact of health on productivity and poverty reduction : Policy implications

An indirect benefit of the CHPS programme in the Nsanfo community is that, it has the potential of impacting the economic conditions of households and beneficiaries thus help in poverty reduction. Improving the health of rural dwellers is crucial in the poverty reduction in any country given that ill-health is arguably a consequence and cause of poverty. Even though this could be speculative as this study did not directly or explicitly measure this economic impact as part of its objectives, it is still quiet valid to make this educated guess or inference based on some information gathered from the field. This assertion is also supported by arguments by scholars such as Tompa (2002) and Bloom and Canning (2005) that there is a direct correlation between the health condition of a people and their economic output.

The thesis is that the healthier people (the human capital of an economy) are, the greater their economic output in terms of productivity and less expenditure of scarce resource on healthcare vice versa. The lack of proper healthcare facility in the Nsanfo community meant that, residents had to spend scarce resources (money and time) to travel about 15km to Anomabo to seek healthcare for common diseases. Those who did not have money for transportation resorted to traditional medicine which was not always effective thus resulting in deaths from easily curable diseases. Arguably, the death of a breadwinner in a household has repercussions for the rest of household members as standards of living are affected. The establishment of the CHPS programme now means that, the health conditions of households is greatly improved as they have relatively easy access to treatment within their own community at virtually no cost. The economic implication of this CHPS programme thus is that, the people are relatively healthier to go about their occupations such as farming and petty trading. The other economic impact is that scarce resources such as money and time are no longer spent seeking healthcare services in Anomabo thus saving residents of Nsanfo time and money to take care of themselves and their households.

This conclusion is drawn based on the recurring statements the study gathered from respondents when they were asked questions on what the overall impact of the CHPS programme had had on their lives. The responses are summarised thus " *since the introduction of the CHPS programme in Nsanfo, our health conditions have being greatly improved as we now have our own clinic where we seek treatment for our illness. We are now healthy to go about our daily duties like going to the farm or going to the market to sell. Also we do not have to use our little earnings to take a car all the way to Anomabo to seek treatment for ourselves or our children, so the programme has really helped us*". It is based on these responses that this study makes the inference of the possible impact of the programme on the economic conditions of the Nsanfo people. It is therefore in the right direction that the government of Ghana sees affordable and accessible healthcare for all as a part of its poverty reduction stratgy. Government policies such as the CHPS initiative in this regard should therefore be pursued vigorously.

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5.6 The CHPS programme and attainment of goals number 4 and 5 of the Millenium Development Goals

Of particular relevance is the potential of the CHPS initiative to help accelerate progress towards achieving the health related Millennium Development Goals (MDGs). Specifically, goals number four and five which aims at reducing maternal mortality and infant mortality respectively. With only a year to reach the 2015 time bound globally accepted Millennium Development Goals, the synergy between the state and civil society represents an effective means of improving maternal and child health as well as of preventing and curing diseases such as malaria, cholera and other diseases. In Ghana, one of the major causes for high maternal death is the longer distance that pregnant women cover before accessing healthcare service (Van den Boom et al., 2004). This assertion is corroborated by the Ghana Health Service (2002) when they argue that geographic access still remains a major barrier to health care with excess childhood mortality still related to service inaccessibility.

The GHS (2002) estimates that some 70% of the population resides in communities that are over 5 kilometres from the nearest health facility thereby making childhood mortality in such communities about 40 percent higher than in communities located within 5 kilometres of health facilities. What makes this statistics rather unfortunate is the reality that, most of the diseases that cause death among people especially children are mostly preventable or curable if a proper diagnosis is made by simple primary healthcare procedures (GHS, 2005). The Nsanfo community used to suffer from such high maternal and infant mortality cases till the CHPS programme was introduced to relatively improve the healthcare situation. Unfortunately , attempts to seek official statistics on maternal and infant mortality in the Nsanfo community before and after the introduction of the CHPS programme did not yield positive results. The Municipal Health Information Officer indicated that they did not have such statistics for the Nsanfo community per say but only for the entire Anomabo sub-district where Nsanfo falls under. The study did not find it valid to make inference from the generalised Anomabo statistics as there was no specific statistics for Nsanfo but the aggregated total of statistics for the estimated 18 communities under the Anomabo sub-district. This reveals a larger problem of the typical challenge of records keeping and lack of development data in most developing countries including Ghana.

Nonetheless, empirical studies focusing on the impact of the programme has indicated that in areas where the CHPS have been properly managed and implemented there has been a reduction in cases of maternal death thus significantly contributing to meeting goal number 4 of the MDGs, (Ntsua, 2012; Nyonator, 2005). These empirical studies largely coalesce with results that were obtained from the study area. The improvement in maternal health can partly be attributed to the prompt access to healthcare by pregnant women. Moreover, women in Nsanfo are now able to attend both post-natal and ante-natal services within their own communities. Additionally, the programme has contributed immensely to improving the prevention of diseases such as malaria and diarrhea. This suggests that the programme has been successful in improving the lives of Nsanfo residents in the area of preventive healthcare and in efforts towards the actualising the health related MDGs.

5.7 Challenges of the programme

Notwithstanding these outcomes, a number of challenges still exist which threatens the very continuation of the programme. Results indicate that dwindling commitment of volunteers, deplorable state of the CHPS compound, lack of logistics, and better conditions of service for health officials are the major challenges associated with the programme in the study area. This finding largely corroborates with other studies on the matter (GHS, 2009; Tierozie, 2011). Of particular relevance among the challenges is the issue of logistics. In a study to assess the impact of the CHPS in four regions in the country by SEND-Ghana (2013), it was discovered that about 71% of the CHPS compound do not have basic logistics such as torch light (for attending to patients in the night when the lights are out), communication equipments and service delivery consumables. These in a way, could affect the work of the community health officials in the CHPS compound. Indeed, many of the CHPS facilities in the country continue to face the problem of logistics such as weighing scales, blood pressure apparatus and thermometers which to a large extent affect the extent to which health officials could diagnose ailment and provide the right prescription in relation to drugs (GHS, 2009). Additionally, results indicate that there is currently no midwife in the study community thus cases of emergency relating to birth are referred to the larger community clinics in the Municipality. This is attributed to the fact that the Community Health Officials have not received adequate training with regards to midwifery making them not able to sufficiently attend to pregnant women during emergency cases even though the policy guidelines require community health officials to receive some level of training in midwifery (GHS, 2009).

The implication is that the pregnant women at the eve of their birth may result to Traditional Birth Attendant's or larger health centers which come at a high cost due to longer distance to be covered. The deplorable state of the CHPS compound in the study area threatens the continual operation of the programme as health officials who are posted the community may not be willing to stay. Indeed,the absence of basic infrastructure such as television, decent water supply and solar fridges are all major difficulties that continue to demotivate health officials from accepting postings to rural communities. This situation ultimately threatens the continual survival of the collaborative health care programme by the state and civil society in rural healthcare delivery (GHS, 2009). The implications of all these identified challenges for the Nsanfo CHPS programme is that, there is the urgent need for the appropriate authorities to

retool the facility operate at its utmost best. The GHS policy of encouraging local communities to provide some of these equipments (with the aim of instilling high sense of community ownership) seems to be problematic due to high povert levels in most rural communities like Nsanfo.

Overall the CHPS programme has been effective in providing access to healthcare and improving maternal health and of preventing various kinds of diseases. However, the identified challenges confronting the programme could in the long run erode these benefits which could make the programme unsustainable. The implication of this findings for policy makers is that, whereas community and volunteer participation in healthcare delivery is critical and necessary , its participation alone is not sufficient to ensure improved healthcare for beneficiaries. Governments should therefore not relent in providing the necessary logistics needed to improve rural healthcare. Lack of basic logistics to make the programme function effectively could potentially affect the objectives set out under the programme. As the country envisages extending the programme to other remote areas and also improve the health of local communities, it will be essential to give pragmatic meanings to policy strategies and objectives. The mere establishment of CHPS compound in rural areas without providing the needed logistics and motivation to aid in the work health officials could in the long run be counter-productive.

5.8 Threats to the synergy

Kironde and Kahirimbanyi (2002, p.22) aptly raise a very crucial concerning the issue of volunteerism in such collaborative programmes. According to the authors, " *a major hindrance to community participation in developing countries is the desire for remuneration by the lay volunteers*" and that "*there is evidence to suggest that in the absence of appropriate incentives, attrition rates in lay worker programmes tend to be high after the initial novelty wears off*". This hypothesis by the authors was discovered in this particular study. Despite the active involvement and the crucial role being played by the volunteers in providing community access to affordable and quality healthcare under the CHPS programme, the realm of community volunteers are beset with a number of operational challenges which hinder their work. Brinkerhoff (1999, p. 63) theorizes *"incentives are the essential lubricant that makes partnerships possible. Positive incentives provide the stimulus that impels partners on both*

the state and non-state sides of the equation to work together; negative ones discourage them from doing so".

Results from the study area indicate that, there is generally lack of motivation and incentives for the volunteers to aid in the performance of their duty. This finding threatens the sustainability of volunteer partnership in the CHPS programme in the Nsanfo community.Results from this study together with previous study on the subject reveal that lack of motorbikes, torchlight, and raincoats remain the major challenges affecting the work of community volunteers in most CHPS zones nationwide (Tierozie, 2011; SEND-Ghana, 2013). This has the demerit of making the work of the volunteers more difficult and tiring especially in situations where they have to travel or walk longer distances to households in the performance of their duties. In the Nsanfo community, this situation has led to dwindling commitment and in some cases the withdrawal of some of them due to volunteer fatigue thus making the work of the health officials more difficult. In another context, it has been noted that volunteers start off enthusiastically but then their level of engagement falls off due to the lack of incentives (Acquah et al., 2006). This seems to have manifested in the Nsanfo case thus validating Brinkerhoff's (1999) theory on the role such incentives play in the synergy equation.

In further analysing the findings from the study, it has emerged that the lack of motivation for the volunteers contradicts what has been stipulated in the policy document regarding the incentives for the volunteers in the CHPS operation. According to the policy framework guiding the implementation of the CHPS nationwide, volunteers are supposed to be provided with a means of transportation like bicycles, tricycles and sometimes motorbikes since most of them travel longer distances in the performance of their duties (GHS, 2005). These are great incentives because they are dashed to the volunteers and become their personal property (and for private use) so long as they remain volunteers. It is only when one resigns from the volunteering on some intangible excuse that he or she is expected to return the bicycles or motorbikes. This study suggests that, the appropriate authorities pay critical attention to the challenges facing the volunteers in order to ensure the sustainability of the programme. It is evident that the CHPS programme has had some positive impacts and remains one of the cheapest means of improving rural healthcare. The least government can do is to address the challenges confronting the scheme. Even if authorities cannot meet the demands of the

volunteers, an acceptable compromise can be reached through dialogue and negotiations. This recommendation is further discussed in the final chapter of the study.

Despite this lack of incentives for the volunteers, it was discovered that the volunteers have all received some level of training regarding the work that they do. The training sessions cover basic primary healthcare issues, the concept of CHPS and community mobilisation, volunteerism and basic equipment use and the role of community health volunteers (Aquah et al., 2006). It is during these training programmes that the volunteers interviewed indicated that they were promised some financial incentives for attending such workshops but the promise had not been fulfilled for the past 9 months. Considering the extremely high cost of living in Ghana at the moment, the promised amount of 10 Ghana cedis for a meeting which is approximately $5 can be said to be barely enough to cater for their transportation and feeding per every workshop. Even with such meagre allowances promised them, the volunteers interviewed indicate they were yet to receive even that for the past nine months they have been attending workshops thereby demoralising them. One can thus understand some of the sources of their de-motivation.

In the midst of all these, this study contends that to an extent, the challenge of apathy facing the CHPS programme in the Nsanfo community cannot be blamed volunteers or their dwindling interest thereof. It is obvious that with the needed support and incentives, the volunteers would give off their best thus contribute to the sustainability of the programme. The main obstacle is the lack of consistent support from the appropriate authorities such as the MHD in resolving the challenges facing the CHPS programme in Nsanfo. The Ghana Health Service thus ought to step up their efforts in addressing such challenges to ensure sustainability of the programme given the important role that these volunteers play. This calls for urgent attention especially if the sustainability of the programme is to be achieved. Brinkerhoff (1999, p.79) argues that "*successful policy implementation partnerships must pay attention to crafting an agenda and actions that solicit and hold the interests of the non-state partners whose contribution is usually noncompulsory and non- remunerative*".

This study agrees with the author and further finds it hard to understand why there seem to be no strong commitment on the part of government in enesuring that this CHPS programme is supported to work effectively. Comparatively, the CHPS programme appears to be a cheaper way of providing rural healthcare to communities like Nsanfo. The least government can do is

to make enough budgetary allocation to support the CHPS programme in the meantime while measure are taken to build proper hospitals for rural communities. Government cannot turn a blind eye on the challenges the CHPS programme is facing in Nsanfo. The usual excuse of inadequate financial resources on the part of government is untenable as there are evidence to the contrary.

This study believes the solution to these challenges is a matter of political will by way of government prioritising healthcare and making more budgeatary allocation to the health sector and the CHPS programme to that extent. Much more commitment is expected from government to ensure the sustainability of the CHPS programme. As Kironde and Kahirimbanyi (2002) argues, the onus now lies with health planners and policy makers to devise appropriate and context-specific ways in which to achieve sustainability by keeping such volunteers motivated in community participation in health programmes while at the same time keeping in mind the limitations of cost-containment in such actions. Ostrom (1996) recommends introduction of institutional innovation such as rethinking of the problem in such instances to deal with issues emerging in such collaborative partnerships. This study perfectly agrees with Ostrom's recommendation. The next chapter concludes the study and provides some plausible recommendations aimed at ensuring that the CHPS programme continually leads to improving the health of communities while ensuring its sustainability.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

The purpose of this study was to assess how state-civil society collaboration could serve as an effective synergy in delivering healthcare to communities that are often marginalized in terms of benefitting from the modern healthcare system that exist in urban centres in Ghana. One resulting partnership of the state-civil society initiative in Ghana has been the implementation of the CHPS programme. Indeed, the stated objective in establishing the CHPS programme is to provide a mechanism that combines the orthodox healthcare delivery system with local structures and resources in the delivery of quality healthcare that is affordable to local beneficiaries.

In examining the case of the CHPS programme in the Nsanfo Community, the study revealed that the programme has been beneficial in terms of providing adequate access and utilization of affordable healthcare to the people of Nsanfo. The community before the programme had to cover longer distance to community (Anomabo) 15km away before accessing healthcare in the midst of challenges such as high transportation cost and uncertainty of being attended on time. The CHPS programme in Nsanfo has however contributed immensely to reducing the long distance covered by the community to access healthcare as access to healthcare is now at the doorstep of the people. Additionally the programme has enhanced the health conditions of the people through improvement in maternal and child health, prevention and curing of diseases such as malaria, diarrhea and minor injuries. Moreover pregnant mothers in the community are now able to attend ante- natal and post-natal health service at their own convenience.

The second conclusion drawn from this study indicates that, the involvement of the community members and the volunteers in the design, implementation and operation of the CHPS programme to a larger extent contributes to the success of the initiative. Community members contributed to the building of the clinic facility and donated some items such as beds, for the running of the programme. On the other hand the success of the programme in meeting the health needs of the people is also attributed work of the community volunteers. These volunteers serve as a link between the community health officers and local people

through exchange of information from one party to the other. Thus the volunteers provide education to the local people on health issues and report any incident of health problem among the community members to the health officials in the clinic. These services of the volunteers has therefore refocussed healthcare from the curative approach to preventive approach thus saving cost.

The study also identified a number of challenges confronting the operation of the CHPS in realising its fullest potential in rural healthcare delivery. Even though the community members initiated the building of the CHPS compound, there is the lack of support from the community in the maintenance of the facility as the local people constantly fail to clean the facility or provide any support in maintaining sanity in the facility. This has been attributed to the lack of financial accountability on the part of the health officials to the community although health officials indicated that they have no responsibility to render accounts to the community. The nurses contend that they are mandated by the regulatory framework to render accounts to only the Ghana Health Service. Additionally, challenges such as the deplorable state of the CHPS compound, lack of motivation for volunteers, inadequate logistics, security and lack of descent accommodation and other incentives for health officials all serve as a great deal of challenge with regards to the CHPS programme in the area. These identified challenges ultimately threaten the very existence and sustainability of the programme in the study community. These findings have relevance for policy design especially in efforts towards ensuring that the CHPS programme continues to function and lead to sustained health improvement of the local people.

Overall, in terms of implications of this case study for the broader debate on state civil society synergy, the findings further reiterate and reinforces the arguement that, such collaboration can be of essential benefits for coproducing public goods and services if properly designed and implemented. The ensuing section provides policy recommendation for the CHPS programme.

6.1 The way forward: Recommendations

Based on the findings emerging from this study, the following recommendations are proposed in order to help sustain the programme.

6.1.1 Community dialogue and transparency

It is evident from the findings of the study that the social capital endowments of Nsanfo have not been fully tapped by the Ghana Health Service to motivate effective community participation in maintaining the CHPS compound. If there is less community participation in maintaining the CHPS facility they built themselves due to suspicion of financial embezzlement, it can be said that the problem is not as a result of lack of social capital but rather the lack of transparency on the part of the Ghana Health Service. As thoroughly discussed already, the study revealed some level of tension between the local people and the community health officials especially surrounding the issue of accountability which has led to lack of community support in the maintenance of the CHPS facility. In order to resolve this, there is a need for an urgent and transparent community dialogue. This will bring together all stakeholders including the Municipal Health Directorate, Chiefs, Elders, community members, the Community Health Committee and the health officials in order to help discuss this very critical issue.

During such dialogue, a lasting solution must be provided in order to address the concerns of the community regarding the lack of financial accountability on the part of the health officers. The relevance of this transparency is supported by Zakus and Lysack (1998) when they also recommend that, in order to achieve community participation in such collaborative healthcare interventions, there ought to be mechanisms for transparency as well as an explicit statement on what the responsibilities and rights of both partners in the collaboration are. Such interparty dialogue will at least serve as a significant step towards re-energizing the commitment (social capital) of the community again in order to assist in the maintenance of the CHPS and other relevant activities.

6.1.2 Construction of a new CHPS compound: Need for government intervention

Even though the idea behind the introduction of CHPS programme in the Nsanfo community was to tap local resources and social capital to solve their own problems, this study believes that it has become necessary for the government (through the Mfantseman Municipal Assembly) to be directly involved in the construction of a new CHPS compound. The CHPS compound was noted to be in a very deplorable state as portions of the roof have been removed with cracks in the walls. Indeed when asked to provide any recommendation for the programme, over 97% of the respondents indicated that they wanted a new CHPS compound. Sadly, when it rains, the whole facility gets flooded and this affects the work of the health officials.

This study believes that the CHPS programme in Nsanfo will be greatly enhanced if the government is made directly responsible for the provision of the needed logistics and infrastructure. The study contends that health delivery at the community level is more of a developmental issue rather than a mere health concern thus for healthcare to be a central part of the national development agenda then government should have oversight responsibility for planning, financing and supervision of the CHPS initiative like the one at Nsanfo. A percentage of the annual District Assembly's Common Fund (DACF) should be allocated for maintaining all CHPS compounds in the Mfantseman Municipal including the one at Nsanfo. The fear that such government intervention would defeat the objective of CHPS which is to instil sense of ownership is untenable as there is a way around it. Government should provide the raw materials and finance and then use local labour to construct the new CHPS compound. This would ultimately instil the sense of community ownership that the CHPS concept envisages.

6.1.3 Provision of incentives for community volunteers and logistics for the CHPS compound

The community volunteers in Nsanfo have been an integral part of the success that the CHPS programme has witnessed so far in the community. However these volunteers lack the necessary incentive such as transportation means to help in their daily movements.

Government must as a matter of urgency resource the Mfantseman Municipal Health Directorate to come to the aid of the volunteers by providing them with the necessary equipments such as motorbikes, bicycles, torchlights, raincoats and other essentials that will aid in their work. Moreover as part of their contribution to the programme, the community could also set up a fund to reward their own community members who decide to work as volunteers annually, i.e a small end of year get together to celebrate and appreciate the volunteers for their work over the period. Additionally, the Municipal health Directorate must as a matter of urgency provide the necessary logistics such as weighing scales, hospital beds, thermometers, constant flow of water and security for the CHPS compound. This will ensure improvement in the work of the health officials. In furtherance to this, the community must also ensure the provision of decent accommodation in order to motivate the current and subsequent health officials who will be posted to the clinic.

6.1.4.More public education on referrals

It is important to reiterate that not all types of ailments and health conditions are catered for at a typical CHPS compound including the one at Nsanfo. Specialized cases such as problem of the eye, kidney, ear and especially complicated delivery are not catered for by the community health officials under the CHPS programme. Thus cases beyond the control of the officials are transferred to larger hospitals in the municipal capital. This is a major principle underlying the CHPS programme. However, it was discovered that local inhabitants mostly get irritated when they visited the CHPS compound and do not get treatment for some of these identified cases. Even though they indicated that they patronised the services at the CHPS facility, some of the respondents were quiet unhappy that the nurses sometimes referred them to the district hospital for some complicated health conditions. They summarily expressed their displeasure of having to travel at high cost to the municipal capital for such special medical conditions. Some of these patients refuse to go and resort to traditional medicine with its attendant problems. In all this, what the study discerned was that there appeared to be the lack of understanding of local beneficiaries concerning the kinds of services rendered by the CHPS programme as these local expected to get treated for all kinds of illness at their local CHPS compound. This study therefore recommends more public education in order to re-orient local people regarding the need for them to go to the larger clinics when they are referred by the nurses.

This master thesis concludes with an illustrative quotation from a DFID helpdesk report concerning community based healthcare programmes such as the CHPS programme. According to the report "*a community health programme is one form of care that can possibly provide the ideal answer to the problem of raising community health standards in particular and the quality of life in general. A community development programme —is aimed at creating possibilities for the poor and the suffering to live a life worthy of man, with a reinstatement of their human dignity and pride. This dignity and pride cannot be purchased with dollars from outside; man has to create them himself by his own actions"* DFID (2011,p. 6).

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APPENDICES

APPENDIX 1: SEMI-STRUCTURED INTERVIEW GUIDE

Interview Guide

My name is Francis Jagri. A Ghanaian national and currently a Quota scholar pursuing a postgraduate study in Msc. Development Management at the University of Agder, Norway. This questionnaire is part of requirements to obtain my masters degree in the above mentioned programme. My dissertation topic is "COLLABORATIVE RURAL HEALTH-CARE DELIVERY IN GHANA. A CASE STUDY OF THE IMPACT OF THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) PROGRAMME IN THE NSANFO COMMUNITY IN THE MFANTSIMAN MUNICIPAL OF GHANA. The main objective of the study is to examine how state (Ghana Health Service) and civil society (community volunteers) partnership can be used as an effective strategy for improving rural healthcare delivery in Ghana. I would therefore be grateful if you could spend some few minutes for the interview session. All answers provided are strictly for academic purposes and would be treated as confidential.

Data Collection Technique: Semi-structured Interview

Target: Mfantseman Municipal Health Director, Municipal CHPS Coordinator, Nsanfo CHPS Community Health Officer

Name of Interviewer:……. .
(Compulsory).

Name of Interviewee:……
(Optional)

Date: …… Interview Code…… Name of Community:……

1. How long have you served as in your position
2. When did the CHPS programme start in the Briwa Community?
3. How did the community receive the programme?
4. Were there any discussions with the community before the programme started?
5. What was the nature of the healthcare delivery in the Municipal before the introduction of the CHPS programme?
6. What necessitated the introduction of the programme in the Municipal

7. How would you rate the participation of the community in the programme?
8.- How were volunteers selected for the programme?
9.- How would you rate the performance of volunteers of the programme?
10. Are volunteers committed?
11. Do you engage volunteers in planning the health needs of the community?
12. In what ways do you engage them
13. How would you rate the co-operation you received from volunteers?
14. Has there been in any impact of this CHPS in the Municipal so far healthcare delivery is concerned?
15. Are these impacts positive or negative?
16. What are some of the impacts of the programme
17. In general, would you say the CHPS has been successful in achieving its aims?
18. What explains your answer?
19. How is the beneficiary community's reaction to the CHPS programme?
20. What explains this sort of reaction?
21. What informed the GHS to partner with community health volunteers in healthcare delivery
22. What is the nature of the relationship between the MHD and the community health volunteers so far executing the CHPS scheme is concerned?
23. Has the volunteer participation in the scheme had any impact on healthcare delivery in the Municipal?
24. In what ways have they impacted?
25. What is the beneficiary community reception to the health volunteers?
26. What explains this attitude towards the health volunteers?
27. What are the major threats to the CHPS programme?
28. Have there been any recorded challenges in the relationships between the MHD and the community health volunteers?
29. What are some of these threats to the relationship?
30. What is the MHD doing to mitigate these identified threats
31. How best can they be addressed?
32. Has the partnership with the community health volunteers been successful in achieving the stated objectives of the CHPS programme?
33. What accounts for this success or failure?

APPENDIX 2: Questionnaires for volunteers

My name is Francis Nyaja Jagri. A Ghanaian national and currently a Quota scholar pursuing a postgraduate study in Msc. Development Management at the University of Agder, Norway. This questionnaire is part of the requirements to obtain my masters degree in the above mentioned programme. My dissertation topic is "COLLABORATIVE RURAL HEALTH-CARE DELIVERY IN GHANA. A CASE STUDY OF THE IMPACT OF THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) PROGRAMME IN THE BIRIWA COMMUNITY IN THE MFANTSIMAN MUNICIPAL OF GHANA: The main objective of the study is to examine how state (Ghana Health Service) and civil society (community volunteers) partnership can be used as an effective strategy for improving rural healthcare delivery in Ghana. I would therefore be grateful if you could spend some few minutes to fill out the questionnaires. All answers provided are strictly for academic purposes and would be treated as confidential.

Demographic data

1. Sex

☐ Male ☐ female

2. Age

☐ 15-25 ☐ 26-35 ☐ 36 and above

3. **Level of educational attainment**

☐ Never went to formal school ☐ Completed Primary school

☐ Completed Senior High School ☐ Completed Tertiary

Any other, please specify .....

4. **Duration of stay in the community**

☐ 1-5

☐ 6-10

☐ 11-15

5. **Occupation**

☐ Farmer

☐ Fishermen

☐ Petty trading

☐ Not Employed

☐ 16 -20 Any other(s), please specify……..…

☐ 25 and above

Any other(s), please specify…….

6. How long have you served as a volunteer in the CHPS programme
   ☐ Less than on year

   ☐ 2-5 years

   ☐ Over 5 years

7. What motivated you to volunteer for the CHPS programme?
   ☐ Desire to serve the communitys health needs
   ☐ To gather some volunteering experience
   Any other? Please specify.....
   .....
   .....

8. How many households do you visit everyday?
   ☐ 1-5 households

   ☐ 5-10 hoseholds

   ☐ 10-15 households

   ☐ 15-20 households

   ☐ 20 and above

9. What kind of services do you render to the households in Biriwa as a volunteer?

   ☐ First Aid treatment for ailments

   ☐ Comunity education on family planning

   ☐ Disease prevention education

Any other, please specify
.....

.....
.....

10. How do the households you visit receive you ?

☐ Cordial

☐ Very Cordial

☐ Indifferent

☐ Unwelcoming

11. What explains this kind of reception ?

.....
.....
.....

12 Do you revieve any support from the Mfantseman Municipal Directorate ?

☐ Yes

☐ No

13. What kind of support do you receive from the Mfantseman Health Directorate?

☐ Field training in family planning

☐ Disease prevention training

☐ logistical support

Any other, please specify

.....
.....
.....

14. Is the support adequate ?

☐ Yes

☐ No

15. How would you rate the support you receive from MHD?

☐ Adequate

☐ Very adequate

☐ Moderate

☐ Not adequate

☐ Not adequate at all

16. Has there been any improvement in healthcare delivery in the community with the servicesof the health volunteers?

☐ Yes

☐ No

17. Can you give us some specific examples?

.....
.....
.....

18. Do you face any challenges in the course of carrying out your activities as a health volunteer in the community?

☐ Yes
No

☐ If yes what are some of these challenges.....
.....
.....

19. Have these challenges being addressed ?

☐ Yes

☐ No

If yes how were they addressed

.....
.....
.....

20. In brief, what do you think should be done to improve the services/operations of the CHPS programme in the community?

.....
.....
.....

21. Do you think your participation in the programme has improved the health delivery system in the community?

☐ Yes
☐ No

Give reason for choice of answer

.....
.....
.....

22. Do you participate in the planning of the health needs of the community?

☐ Yes

☐ No

23. Have you observed any improvement in the health conditions of the beneficiaries you serve?

☐ Yes

☐ No

24 If yes, what are some of these observed improvements ?

.....
.....
.....

24. Do you think there are certain things that demotivates you from being a volunteer in this CHPS programme?

☐ Yes

☐ No

If yes, what are they?

.....
.....

.....
.....

25. How best do you think the CHPS programme can be improved ?

.....
.....
.....
.....

APPENDIX 3: QUESTIONNAIRE FOR HOUSEHOLD

My name is Francis Nyaja Jagri. A Ghanaian national and currently a Quota scholar pursuing a postgraduate study in Msc. Development Management at the University of Agder, Norway. This questionnaire is part of the requirements to obtain my masters degree in the above mentioned programme. My dissertation topic is "COLLABORATIVE RURAL HEALTH-CARE DELIVERY IN GHANA. A CASE STUDY OF THE IMPACT OF THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) PROGRAMME IN THE NSNAFO COMMUNITY IN THE MFANTSIMAN MUNICIPAL OF GHANA: The main objective of the study is to examine how state (Ghana Health Service) and civil society (community volunteers) partnership can be used as an effective strategy for improving rural healthcare delivery in Ghana. I would therefore be grateful if you could spend some few minutes to fill out the questionnaires. All answers provided are strictly for academic purposes and would be treated as confidential.

Sampling Technique: Convenient sampling

Demographics

1. Location of Respondent…….

2. Sex

Male ☐

Female ☐

3. **Age**

16-25 ☐

26-35 ☐

36-45 ☐

46-55 ☐

56 and above ☐

4. Marital Status

Single ☐

Married ☐

Divorced ☐

Separated ☐

5. **Dependents**

Yes ☐

No ☐

6. If yes, number of dependents……

7. **Level of educational attainment**

☐ Never went to school ☐ Primary school leaver

☐ Senior High School leaver ☐ Completed Tertiary

Any other, please specify .....

8. **Duration of Stay in the community**

☐ 1-5

☐ 6-10

☐ 11-15

☐ 16 -20

☐ 25 and–Above

9. **Occupation**

☐ Farmer

☐ Fishermen

☐ Petty trading

☐ Not Employed

☐ Student

Any other(s), please specify……..…

ACCESS TO HEALTH-CARE

10. How many health centers are in your community?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 and above

11. **How often do you visit a health facility?**

☐ Once every month

☐ Twice every month

☐ Once every quarter

☐ It depends on when I feel ill.

12. **What is your main source of healthcare services?**

☐ The Mfantseman Municipal hospital

☐ The CHPS compound in Biriwa

☐ A private Health clinic in a nearby community

13. **Why do you prefer that particular type of health facility?**

☐ Because of its nearness to my home

☐ Because of the better quality of services rendered there

☐ Because of its affordability

☐ Because that is the only option

Any other reason: specify……

14 **Are you aware of the existence of a community Heath Compound in Biriwa?**

☐ Yes ☐ No

If yes where did you get to know about the programme

☐ From the District Assembly ☐ NGOs in the community ☐ Family ☐ Friend

Other specify……

15. **Prior to the establishment of the CHC, what was your main source of treatment for ailments?**

☐ The Mfantseman Municipal hospital

☐ A private health clinic in a nearby community

☐ A clinic in a nearby village

16. **Have you used the services of the CHPS compound before?**

☐ Yes ☐ No

17. **What was the nature of the service?**

☐ Treatment for an ailment

☐ Seeking of health related information

☐ Pre natal care sessions

☐ Post natal care sessions

☐ Medical check up

18. **How often did you use it?**

☐ Once in a month

☐ Twice in a month

☐ Depends on as and when I fall sick

19. **Did you receive the necessary services for which you visited the CHPS compound?**

☐ Yes ☐ No

20. **Was it effective in your opinion?**

Yes No

☐ ☐

. **If no why .**

……

……

……

……

EXPERIENCE WITH COMMUNITY HEALTH VOLUNTEERS

21. Are you aware of the existence of community health volunteers in Biriwa?

☐ Yes
☐ No

22.Have you ever been visited by a health volunteer?

☐ YES ☐ NO

23. **Have you used the services of the community health volunteers?**

☐ Yes ☐ No

24. **What was the nature of the volunteer services?**

☐ First Aid treatment for an illness

☐ Seeking information on healthcare related activities

☐ General Medical Check up

Any other, please specify……
……
……
……

25. **What was your impression about the quality of the services they rendered?**

☐ Excellent
☐ Very satisfactory
☐ Satisfactory
☐ Poor
☐ Very poor

26.. Do you think the involvement of volunteers can affect healthcare delivery in your community in a positive way ? ☐ YES ☐ NO ☐ I CAN'T SAY

Why your choice of answer?
.....
.....
.....

27..How is the relationship between you and the volunteers?

☐ FAIR, ☐ GOOD ☐ VERY GOOD ☐ BAD ☐ VERY BAD

☐ CAN'T TELL

28..Do you think the volunteers should be taken out of the programme?

☐ YES ☐ NO

37.. If yes why

.....

.....

.....

IMPACTS OF CHPS PROGRAMME

29.. Can you say the CHPS programme has positively affected you as an individual?

☐ YES ☐ NO ☐ NOT SURE

30. In what ways has it affected you as an individual?

☐ Access to quality healthcare within the community
☐ Significant improvement in healthcare needs
☐ Not immediate impact yet
☐ No benefit at all

31..Should the CHPS programme be continued? ☐ YES ☐ NO ☐ NOT SURE

32..Do health professionals from GHS orgamise periodic healthcare workshops for the community

☐ YES ☐ NO ☐ NOT SURE

33..How often does it take place.

☐ Weekly ☐ Monthly ☐ Quaterly ☐ Annually

34..Do you participate in the CHPS programme in your community?

☐ YES ☐ NO

35.In what ways do you contribute to meeting the health care needs of the community?

☐ Attend communal labour to build CHPS Compound

☐ Involved in cleaning the CHPS Compound

☐ Attend public gathering on health issues in the community

☐ Disseminate information on things learnt from volunteers and other health officers

36..Do health officials in the CHPS programme involve the community in planning their health needs?

☐ YES ☐ NO ☐ I DON'T KNOW

37. **In your opinion do you think the CHPS programme has improved access to healthcare delivery in the community?**

YES NO

☐ ☐

38. Over, how would you rate the effectiveness of the CHPS in improving healthcare delivery in this community?

a. Very effective b. effective c. not effective d. not at all

What explains your answer?

……
……
……
……
……

<u>CHALLENGES AND SOULTIONS OF THE CHPS PROGRAMME</u>

39. **Have you encountered any challenges in your interaction with the community health volunteers or the CHC?**

YES NO

☐ ☐

40. **What were these challenges?**

……
……
……
……

41. **What do you think can be done to address this challenge?**

……
……
……
……

42 **If you had the chance to make recommendations to the MHD about the CHPS programme what would it be?**

……
……
……
……
……....

APPENDIX 4: LETTER OF INTRODUCTION TO THE FIELD

UNIVERSITY OF AGDER

Date: 6 August, 2013

Visiting Address:
Gimlemoen 25
Phone: +47 38 14 16 20
Fax: +47 38 14 10 28

To Whom It May Concern.

FRANCIS JAGRI

This is to certify that Francis Jagri from Ghana is a student at University of Agder, Norway. He is pursuing our MSc degree in Development Management and is planning to conduct field work and data collection in Ghana in connection with his master's thesis. He is planning to do his data collection in Ghana from December 2013 to March 2014.

Field work in connection with the master's thesis is a compulsory part of the master programme. Mr. Jagri is a quota student and all quota students in our master programme conduct their field work in their home country. He is planning to graduate in June 2014.

With Best Wishes,
Yours Sincerely,

Jannik Stølen Timenes

Jannik Stølen Timenes
Academic Adviser
Department of Development Studies

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APPENDIX 5: EMAIL CORRESPONDENCE FROM GHS GRANTING PERMISSION FOR THE FIELDWORK.

PERMISSION TO CARRY OUT FIELDWORK ON THE CHPS PROGRAMME AT BIRIWA.

Actions
francis jagri

10/25/13
Documents

Outlook.com Active View

1 attachment (303.0 KB)

SCAN20130806141253.pdf
View online
Download as zip

Francis Nyaja Jagri
Msc. Development Management
Agder University
Norway
+47 96708474

"As a man thinketh of himself , so is he "
Actions
francis jagri
10/08/13

To: Mfantseman MHD

Hello Madam.
This is to acknowledge receipt of your reply. Thank you very much for your concern . I would keep in touch and re-contact you as soon as I arrive in Ghana.

Best regards

Francis Nyaja Jagri
Msc. Development Management
Agder University
Norway
+47 96708474

"As a man thinketh of himself , so is he "
Actions
Mfantseman MHD
10/08/13

Documents
To: francisjagri@hotmail.com

thanks for your mail and sorry for sending a late reply. you are very welcome to carry your study in the Biriwa community. i hope your findings will inform us on how to improve our

activities concerning CHIPS. we also hope to give you all the needed assistance you may require

---

On Thu, 10/3/13, francis jagri <francisjagri@hotmail.com> wrote:

Subject: PERMISSION TO CARRY OUT FIELDWORK ON THE CHPS PROGRAMME AT BIRIWA.
To: "gayhayfron@yahoo.com" <gayhayfron@yahoo.com>
Date: Thursday, October 3, 2013, 2:38 AM

Actions

francis jagri

10/03/13

Documents

Outlook.com Active View

1 attachment (310.9 KB)

SCAN20130806141253.pdf
View online
Download as zip

Hello Madam,

I trust this email finds you well.

My name is Francis Nyaja Jagri. A Ghanaian national and currently a Quota scholar pursuing a postgraduate study in Msc. Development Management at the University of Agder, Norway. As part of requirements to obtain my masters degree, I am required to submit a dissertation on a development related topic.I have accordingly chosen to do my research in Ghana so as to make my training in Msc. Development Management relevant to my home country. After a keen observation of the developmental challenges in Ghana, I decided to carry out a study on health-care delivery especially in rural areas. My dissertation topic as presented to my University is

"

COLLABORATIVE RURAL HEATH-CARE DELIVERY IN GHANA: A CASE STUDY OF THE IMPACT OF THE COMMUNITY-BASED HEALTH PLANNING AND SERVICES (CHPS) PROGRAMME IN THE BIRIWA COMMUNITY IN THE MFANTSIMAN MUNICIPAL OF GHANA:POSSIBILITIES AND CONSTRAINTS FOR A STATE-CIVIL SOCIETY SYNERGY "

The main objective of the study is to examine how state (Ghana Health Service) and civil society(community volunteers) partnership can be used as an effective strategy for improving rural healthcare delivery in Ghana. This will be down based on empirical examination of the impact of the Community-based health planning and services (CHPS) programme in the Biriwa community in the Mfantseman Municipal of Ghana.

As Director of the Mfantseman Health Directorate, I will therefore be glad if you could be of assistance to me in the study. I intend arriving in Ghana by November to carry out the fieldwork. Specifically, I would like to be extremely grateful if you could please grant me an interview session with you to discuss the state of Healthcare delivery in your Municipal as part of my data collection. My research also indicates that, there is a Director in charge of the CHPS programme in the Municipal or the central region. I would be grateful if you also provide me with their contact (email or phone contact) so as to arrange for interviews with him/her also as part of my data collection. I will like to state that, these interviews and indeed the entire study would be used for strictly academic exercise and the highest standards of academic ethics would be followed in all process. The integrity of your office shall be upheld at all times.

Please find attached an introductory letter from my University concerning my credibility so as far this academic exercise is concerned. Looking forward to hearing soon onthis humble request.

Thank you

Bestregards.

Francis Nyaja Jagri

Msc. Development Management
Agder University
Norway
+47 96708474

"As a man thinketh of himself , so is he