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Community Capacity To Participate In Health Programmes From The Lens Of Theory In Ghana

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Abstract
While primary health care programmes based on community participation are widely implemented in low- and middle- income settings, empirical evidence on whether and to what extent local people have the capacity to participate, support and drive such programmes scale up is scant in these countries. This paper assessed the level of community capacity to participate in one such programme – the Community-Based Health Planning and Service (CHPS) in Ghana. The capacity assessments were drawn from Chaskin who theorised indicators of community capacity with modifications to include: sense of community; community members commitment; community leadership commitment; problem solving mechanisms; and access to resources. These capacity measures guided the design of an interview guide used to collect data from community informants, frontline health providers (FLP) and district health managers. Key qualitative themes were built into a questionnaire administered to households selected through systematic sampling approach. Findings showed that growing individualism, low trust in neighbours and apathetic behaviours undermined the capacity of mutual support for CHPS. The capacity to support CHPS was high inlocal leadership and community social mobilisation groups who often dedicated time to working with FLP to promote maternal andreproductive health service use, and in advocating broader support for CHPS. Within the wider community,commitment to voluntarism was low as members perceived CHPS to be owned by, and run on government funds and resources.Poor voluntarism was compounded by poverty that crippled the capacity to provide needed resource support for CHPS. Findings have great implications for building strong capable communities for participation in community oriented health programmes.

Keywords: CHPS, Community Capacity, Participation, Voluntarism, Ghana

INTRODUCTION

In Low and Middle Income Countries where centrally controlled health programmes often fail to make significant impact, community participation is seen as the way to make health systems results oriented(Rifkin, 2014; Rosato *et al.*, 2008). Community participation although an age-old concept associated with the1978 Alma Ata proclamation of primary health care, has remained relevant in contemporary global health policy discourse(Draper *et al.*, 2010; Rosato *et al.*, 2008). Within the last decade, for example, community participation has been revitalised by a number of international health policy initiatives – the Millennium Development Goals, the Every Newborn Action Plan, the Integrated Management of Childhood Illnesses among others that strongly encourage strong community involvement in promoting health and well-being (Juma *et al.*, 2015; Rosato *et al.*, 2008).

Community participation has traditionally been viewed from the lens of utilitarian (participation as a means to an end)and empowerment (participation as an end in itself) in pursuing social change (Morgan, 2001; Pérez *et al.*, 2009). Central to both traditions of participation is that the community acts as an agent in defining, diagnosing and prioritising solutions to problems confronting health (McLeroy *et al.*, 2003).

Community capacity is has been defined as '…a community's human, organisational and social capital that can be leveraged to solve collective problems, and improve or maintain well-being; it may operate through informal social processes and/or organised efforts by individuals, groups, networks of associations and the broader system of which the community is part'(Chaskin, 2001).From this point of view, capacity is seen as the bedrock of a functional community participation as it determines the ability to mobilise, network and collectively solve health problems.

The capacity to participate in health is reported to have profound benefits. Notably, it motivates actions in addressing problems of programmes implementation(Hickey & Mohan, 2004; Mansuri & Rao, 2004), offsets cost of health delivery, increases broad-based support and health service use,thereby improving confidence in the health system(Alfonso *et*

al., 2008; Millar *et al.*, 2013).While knowledge on the importance of community capacity proliferates,empirical evidence on whether and to what extent local people have the capacity to participate and support community-based health programmes implementation is poorly documented. This has created room for multiplicity of assumptions regarding what a capable community is(Gibbon *et al.*, 2002; Goodman *et al.*, 1998; Wendel *et al.*, 2009), further comprising empirical endeavours of this important field. The knowledge vacuum is often a barrier to governments and health stakeholders' efforts at making informed decisions on building capable communities for participation in health programmes.

This study sought to contribute to the knowledge gap by drawing on theory to empirically assess the level of community capacity to participate in Ghana's community-based health planning and service (CHPS) programme implementation.CHPS is a national primary care programme modelled on the Alma Ata primary health care tenets – community participation, inter-sector partnership and use of cost effective local resources(Lawn *et al.*, 2008).

THEORETICAL FRAMEWORK

This study drew upon Chaskin (2001) theory of community capacity to assess the level of community capacity to participate in CHPS. Chaskin theorised four indicators of community capacity: *sense of community; commitment among community members; mechanisms of problem solving; and access to resources*. Sense of community describes the nature and quality of social ties for mutual benefits. It is determined by mutual concern for community issues, shared values as well as norms that propel common actions for participation in, and addressing problems of health programmes as a defined group (Wendel *et al.*, 2009).

Commitment of community members has to do with the ability of individuals, groups and leaders to invest time and resources in promoting general wellbeing and common good of the community Mechanisms of problem solvingentailformal and informal channels through which individuals or groups identify and solve problems or pursue collective goals(Chaskin, 2001). Such channels typically include but not limited to strong social networks, social organisations and coalition groups exhibiting prosocial behaviours to advance a course of action(Laverack, 2006).Access to economic and physical resources internal to the community is a crucial defining feature of community capacity.Prevailing economic opportunities, and access to assets and expertise are important enablers of community capacity to participate in health (Wendel *et al.*, 2009). Chaskin (2001) indicators of capacity were termed in this study as: 1) sense of community; 2) Community members commitment; 3)Community leadership commitment; 4) problem solving mechanisms; and5) access to resources. We theorised that these domains of capacity are a means to community participation in the CHPS programme. We define participation in this study as any form of involvement in CHPS activities: delivering health services, providing resource support, engaging in voluntarism, taking part in decisions and plans relating to CHPS or advocating for CHPS health service use.

METHODOLOGY

The study was conducted in 4 CHPS communitiesin2 districts of the Upper West Region(UWR) of Ghana using exploratory sequential mixed-methods: qualitative findings informed the design of quantitative methods (Creswell & Clark, 2011).

Qualitative Methods

Qualitative data were collected from 8 focus group discussions with key community stakeholders of CHPS such as traditional authorities,Assembly Members, Community Health Volunteers (CHV), and Community Health Management Committee Members (CHMC). In addition, 13 in-depth interviews were held with FLP and district health managers (Directors and CHPS Coordinators). Participants in the qualitative study totalled 74 and were selected purposively because they are key stakeholders in the CHPS implementation process.

Topic guides for the qualitative interviews included understanding of CHPS, social networks and community mobilisation, local leadership support for CHPS, sense of community and ownership of CHPS, socio-economic context, livelihood activities and commitment to voluntarism. The author and 3 field researchers collected all qualitative data in participants settings. Qualitative data was analysed thematically with the aid of Nvivo 11 software.

Quantitative Methods

Themes generated from the qualitative data were built into a structured questionnaire used for quantitative data collection.Statements about sense of community, community members' commitment, problem solving mechanisms and access to resources were assessed using a 5-point agreement/disagreement scale; while those pertaining to community leadership commitment were placed on high/low likert type scale. For each capacity indicator, respondents were asked to rate from a scale of 1 (being very low capacity) to 5 (being very high capacity), the overall level of community capacity for that indicator. A set of open-ended questions were also asked to determine frequency of participation in CHPS activities and howmuch money respondents contributed to support CHPS within 12 months to the time of the study. Random systematic sampling technique was used to selected 420 household heads for

interview. Data was analysed using descriptive statistics – means and standard deviations.Mean scores on questions measuring overall level of capacity were calculated and illustrated with a spider diagram developed from Origion2016 Software (Massachusetts, USA). The study obtained ethical approval from the Ghana Health Service Ethics Review Committee (Ethical approval ID No. GHS-ERC: 14/07/15).

RESULTS

Demographic Characteristics of Participants

Demographic characteristics of participants are shown in Table 1. Participants in the qualitative study were older (= 37) than those in the quantitative study (= 32). The majority of participants in both studies had no formal education and farming was the main occupation.

Table 1: Characteristics of participants in the qualitative and quantitative study

Characteristic	Description	Qualitative study (n = 74)	Quantitative study (n = 402)
		n (%)	n (%)
Sex	Male	44 (59.5)	132 (32.8)
	Female	30 (40.5)	270(67.2)
Education	None	27 (36.5)	227(56.5)
	Primary	22 (29.7)	120(29.9)
	Junior/senior higher	19 (25.7)	38 (9.5)
	Higher	6 (8.1)	16(4.2)
Occupation	Farming	41 (55.4)	200(49.8)
	Public sector worker	1 (1.4)	5 (1.2)
	Artisanal	21 (28.4)	147 (36.6)
	No work	11 (14.8)	50 (12.4)
Age	Mean (std. dev.)	41 (11.41)	35(12.33)
	Median	37	32
	Range	25 -79	19 – 75

COMMUNITY CAPACITY TO PARTICIPATE IN CHPS

This section presents findings of both the qualitative and quantitative data on the capacity to participate in CHPS applying Chaskin (2001) community capacity indicators: sense of community (shared values and social capital and their effect on participation, and perceived ownership of CHPS); community leadership commitment to providing necessary support systems; community members commitment to voluntarism; mechanisms of problem solving and access to resources (the capacity to provide financial support or undertake small scale project linked to CHPS). Salient points are illustrated by verbatim quotes from the focus group discussions (FGD) and in-depth interviews (IDI).

Shared Values and Social Capital

Participants expressed concern about declining shared values and the fact that individuals tended to enact and place their own values and interest above the common good of the community.This problem was more with the youth who faced social alienation,leaving themselves out of the loop and in critical decision taking as a result of adaption to city life.This adversely affected the capacity to converge, connect and thrash out issues pertaining to the common good of the community. In addition,it was found the capacity of social trust that can be leveraged to foster quality interactions in achieving specific ends in relation to CHPS was problematic.

> *"You know as a community we talk and greet each other, but I cannot trust that someone is thinking good about me or someone is talking nicely to me with good intentions…if you invite me to attend a function of the clinic [CHPS] and I don't trust you, I will not go".* (FGD, Male, CHMC)

Perspectives of the qualitative participants somewhat contrasted the quantitative findings where many respondents agreed that shared values among community members was strong (53%; = 3.98) and that there is positive social capital among members (52%). However, shared values did not translate into mutual support for CHPS by the majority of respondents (51%; = 4.10) and from this participant's perspective:

> *"I can say that as a community we share common values, cultures and maybe identity. Because of that we help each other during funerals and traditional events. But that is yet to reflect fully in CHPS which is not something that we grew up with".*(FGD, Male, CHV)

Perceived Ownership of CHPS

The low sense of community perhaps shaped perceptions around ownership of CHPS.About 55%(= 3.89) and 53% of the respondents respectfully agreed that the community own CHPS, and that CHPS is tied to the community's identity. To the contrary, most participants in the qualitative data did not feel the community owns CHPS, because its operations were rarely community driven.Additionally, and as demonstrated in the quote below, FLP explained sense of ownership was weak,as most community members were somewhat distanced from CHPS, because of perceptions that CHPS is government owned and the community is only used as a vehicle of enabling government achieve its objective.

> *"When you tell them to support CHPS because it's their own, some of them will reply that it is for the government…stop worrying us, tell the government to help".* (IDI, Female, FLP)

Community members' Commitment

Commitment to Voluntarism

Commitment to voluntarism, such as being part of a voluntary committee or altruistic initiatives to drive CHPS scale up was a challenge. Most respondents (69.2%) considered it needless providing active voluntary services and giving donations (67%);because of perceptions that CHPS already operate with government funds and resources.FLP were also perceived as doctors earning substantial salaries, and therefore in a capacity to better manage CHPS without the community's support. Consequently,voluntarism for CHPS was drifting towards pecuniary transactions.

> *"They want money not voluntarism. If you call people to assist do anything for CHPS without giving them money for transport or food, then don't expect to see them next time*." (IDI, Female, FLP).

All the communities were reportedly endowed with artisans including carpenters and masons, but they were rarely seen voluntarily providing maintenance services for the CHPS facility.It was revealed that parts of the walls, roofing and woodworks of the CHPS facilities were impaired, as for example: "the roof leaks when rain is falling"; "there are cracks all over the fence wall" and "some of the doors have problems", but local artisans did not commit themselves voluntarily to fix the problems. A FLP explained that community members preferred health authorities taking up maintenance of the facility because of weak community capacity to undertake such responsibilities.

> *"…instead of mobilising to work on the problems of the facility, they keep telling us to talk to Director [District Health Director]or the Assembly because they are not able to work on it".* (FGD, Female, FLP).

Poor commitment to voluntarism also reflected in poor participation in CHPS activities. Across all the communities,an average of 8 CHPS events in the form of meetings, durbars and health education among others were organised 9 months prior to this study. However, respondents participated in an average of 2.4 of the 8 events.Key reasons that accounted for poor participation were time – people working for long hours in farms and other occupations to feed their families, apathetic behaviours and the feeling that government and not the community can be of significant support to CHPS.

Serving in the Community Health Volunteer Programme

Not only was there weak broad-based interest to serve in the community health volunteer (CHV) programme (71.2% agreed interest for the CHV programme was low), but also, existing members of the committee expressed low self-interest and commitment to voluntarism. Members lamented about lack of incentives, transport and essential logistics to perform prescribed duties. And while obviously trying to cope with the sacrificial and prosocial motivation at CHPS implementation, the CHV were discouraged by additional distresses they endured from cross sections of community members.

"Whether farming season or not, we leave our personal work and run errands for the good of the clinic [CHPS]. But people don't see this.Sometimes if you tell a woman to come for ANC you get either insults or nonsense and that is discouraging to us." (FGD, Male, CHV).

Mechanisms of Problem Solving

Mechanisms of problem solving was demonstrated in the formation of gender-based social mobilisation groups known as *Mother-to-Mother-Support* (M-MSP) group for women and *Father-to-Father Support* (F-FSP) group for men, both actively diffusing information, soliciting support and using social events to attract broad-based support for, and participation in CHPS. The M-MSG was a platform where women network, share ideas and use meetings and other social events or fora to discuss mechanisms of supporting CHPS. The group also sought to empower women to gain control over health decisions and to collectively identify and solve maternal and child health problems confronting the communities as indicted by most respondents (77% (= 4.1).The M-MSG was also shown to be beneficial by this participant.

> *"The M-MSG is making our work easy. I can say most women now cooperate with us, they sleep under mosquito nets during pregnancy and they attend the child welfare clinics unlike the past".* (IDI, Female, CHPS Coordinator).

The F-FSP on the other hand aimed to increase men knowledge on health issues and participation in CHPS meetings, durbars and other programmes of scaling up. Its membership targeted adult men, but their approach to enabling broad-based participation differed from the M-MSG. Participants reported that the group members carried out education across to peers on the importance of family planning, use of contraceptives for birth spacing, allowing pregnant women make 4+ ANC visits and male involvement in family health. The group's activities were reported to be beneficial by a large proportion of the respondents (75%) and from this qualitative participant:

> *"In fact it is because of what they tell us that some of us now accept family planning. Sometimes we even try to go with our wives to the CHPS facility for the family planning injection."* (FGD, Male, CHV).

Community Leadership Commitment

There were mixed views regarding community leadership commitment to CHPS implementation. Over half of the respondents highly rated efforts of the leadership in promoting antenatal care use (56.6%; = 3.99) and inspiring others to participate in CHPS (52.4%; = 4.11). A high proportion, however, viewed leadership as putting minimal efforts in promoting use of CHPS family planning services (55.1%).In the qualitative data participants revealed that community leadership demonstrated the capacity to support CHPS by openly advocating use of antennal care (ANC) and child health services,but not family planning. Two of the Chiefs were credited for being able to work with FLP in designing sanctions against women who delivered at home, an action which participants said positively influenced ANC use and facility based deliveries to some extent.

> *"One thing I can say about the Chief is that he is doing his best for CHPS. He sometimes educates men not to allow their wives deliver at home and that people should use FP. Because of that some women are becoming conscious about delivering in the facility".* (FGD, Male, Assembly Member)

Access to Resources

Poverty appeared to have had crippling effect on the communities' capacity to invest resources, especially finances to support CHPS. Small scale farming and *pito* (local beer) brewing constituted the primary local economic activities, which according to participants brought in adequate income to adequately support livelihood. As a result, the majority of respondents (54%) said community members lacked capacity to offer financial support for CHPS implementation.

When respondents were asked to state how much money they contributed to CHPS activities within the past 12 months preceding this study, only 67 (16.7%)out of the 402 provided figures (mean: GH¢ 7.73; range 1–65; exchange rate: GH¢4.85 to US$1 as of November 2018). personnel. Limited economic power also prevented the communities from implementing their own CHPS related action plans.

Overall Community Capacity Assessment

To determine the overall level of community capacity to participate in CHPS, respondents were asked to rate each indicator on a scale from 1-5. The average rating for all the capacity indicators was 3, which is an indication that overall capacity was fairly high. Ratings ranged between 2 and 5 – low and very high capacity respectively. Capacity rating was low for community members' commitment to CHPS (rated 2) and access to resources (rated 2), but moderate for sense of community (rated 3) and community leadership commitment (rated 3). Only mechanisms of problem solving was rated very high (5), which is understandable giving the commitment and synergy with which the social mobilisation groups demonstrated towards CHPS. Figure 1is a spider diagram illustrating the ratings for each capacity indicator.

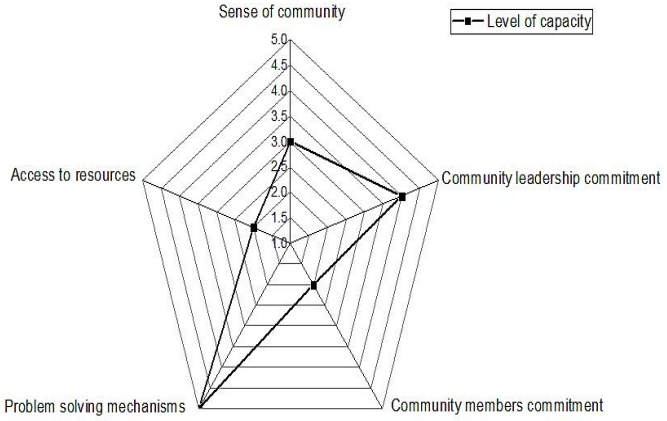

Figure 1: Spider diagramofoverall capacity rating of each indicator

DISCUSSION AND CONCLUSION

CHPS is more than just a medium of health service delivery. It encompasses community participation, mobilisation and social support systems in reducing cost of care delivery and promoting social accountability mechanisms in health governance at the micro level(Nyonator *et al.*, 2005). As participation is paramount to sustainable CHPS implementation in achieving target objectives, this study sought to determine whether and how local people have the capacity to participate in it, with the ultimate aim of identifying gaps to be used as target points for strengthening scale up. Since capacity as a concept has not been explicitly theorised and widely applied with differential meanings in health programmes context, we situated our analytical approaches within Chaskin's (2001) theory of community capacity.

Our quantitative findings of the level of capacity to participate as illustrated in Figure 2 demonstrates how the communities were fairly weak in all the capacity dimensions except problem solving mechanisms grounded in the formation of gender-based social network groups. Consistent with earlier studies(Agongo, 2014; Ministry of Health, 2009), social structures of the communities that could be leveraged to support implementation were weakened by growing sense of individualism, apathetic behaviours and weak communal ties. More fundamentally, a more intense close-knit culture which according to Woolcock (2001)is an essential fibre and can be deployed to get by and promote social discourse within and across community members was challenged

by the spread of urbanisation and the experience of it. The youth who represent a more promising force and whose synergies can be harnessed to support CHPS implementation,were loosely bonded with the community,owing to cognitive and perhaps, socio-psychological responses to city life. Such orientations posed great barriers to inclusive participation and socio-affective behaviours to CHPS.

Policy makers seeking strategies to strengthen CHPS implementation can benefits from the study's findings in a number of ways. First, since social capital is important for building and sustaining community values towards mutual beneficial relationship(Woolcock, 2001), we suggest the initiation of strong community networking programmes that will allow for formal and informal meetings and promotion of horizontal collective action. Brune and Bossert (2009) noted how such networks helped build trust and social capital leading to restoration of strong ties among community members in post-conflict communities.

The scale of social networking held by the social organisations can be leveraged to harness social cohesion and diversity for CHPS scale up. For example, when they are encouraged to strengthen vertical and horizontal membership, or inclusion of people from a range of professions and backgrounds, diversity increases so that individuals are more likely to see themselves as working together to promote CHPS. State and non-state institutions can intervene and craft appropriate strategies within which to maximise support for CHPS from the social organisations, while at the same time challenging them to go higher.Findings about declining voluntarism, generally within the larger population, and specifically within the volunteer cohorts, suggest exploiting strategies internal and external to the community.Internally, local leadership taking up frontline roles in volunteerism, or encouraging hearts, and in acknowledging volunteers' efforts, critical roles, initiatives and routine sacrifice to a large extent can stimulate broad-based altruistic behaviours. Externally, minimal compensations in the form of allowances for upkeep, as well as for field and transportation can be introduced by government to spur up voluntarism among the CHVs.

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