Health and decentralization

A study of the impact of decentralization on health services

in Ghana

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Thesis for the Degree of Master of Philosophy in Development

Geography

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University of Oslo

November
2010

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Preface

Health indicators in developing countries particularly those in sub Saharan Africa have been below standards. Some governments of these countries have implemented various policy reforms to arrest this situation. Notable among these is the decentralization of the public sector. The aim is to make development more participatory, with the hope that the outcomes of development will be quality in nature within the overall sector of the economy. Health sector decentralization is ongoing in Ghana with the aim that service providers and health facilities will be within the reach of users or the local people. This is to also foster a positive relationship between service providers and users who together will plan and execute health projects. In Ghana, health services and facilities are skewedly distributed. The north is characterized not only by high incidence of poverty but also of inadequate health facilities, high incidence of diseases such as malaria and guinea worm among others. However, the creation of districts coupled with the decentralization of the health sector resulted in the birth of the Ghana Health Service. This also led to the creation of District Health Units through out the country. This therefore calls for the need to evaluate the contributions of this process towards increasing community participation and local people's access to health services especially in the northern part of Ghana. The thesis thus seeks to assess the nature of community participation in the decentralized health units at the district and subdistrict levels and how this process has influenced people's decisions to use health services in their respective communities.

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Acknowledgement

I wish to express my profound gratitude to my supervisor Professor Jan Hesellberg for assisting me shape the thesis topic and guiding me through to the end of the research, but for him my ideas would have been locked up in my brain. I wish to thank Margot Igland Skarpeteig for contributing to laying the foundation of the thesis topic and supervising my work to some level before leaving for Ethiopia. I appreciate your efforts. I am also indebted to Dr Joseph Awetori Yaro for his mentorship, motivation and support with academic materials. I wish to also thank the District Health Director of the Central Gonja District, Amamata Sumani and her staff for making time to give me the necessary information needed for this thesis. The thesis would have been incomplete without the support of the people of the Kusawgu and Sankpala communities who organized themselves to share their unlimited views with me. I therefore say thank you, "playing mates". I wish to also thank Emmanuel John-Kwose, Timothy Akanpabadai and Razak Tiika for their support during the field work. My profound gratitude further goes to the Norwegian State Education Loan Fund (Lånekassen) for providing me with financial support for the two-year study programme in Norway. It gave me no room to worry over how to meet my living expenses. I wish to acknowledge the contributions of some workers at NORAD such as Ingvar Theo Olsen who shared with me general ideas on the thesis topic, and also directed me to other resource persons. My appreciation also goes to Einar Braathen and Siri Bjerkreim Hellevik all at NIBR for directing me on how to approach some key areas of the topic. To my family members, I say God bless you for your diverse contributions to making me who I am today.

Dedication

To my daughter Wesonno L. Jarawura for sacrificing to stay away from me at a tender age in order for me to come this far in life. Also, to my father Azuvugu J. Kwoyigah, for "sowing and nursing the seed of education in me". Most importantly, to the almighty God who is the giver of life.

Summary

The thesis with the title: "Health and decentralization, a study of the impact of decentralization on health services in Ghana", studied the nature of community participation and how the process has influenced the use of modern health facilities/services. The study was conducted in two communities of the Central Gonja District of the Northern Region in Ghana. The study revealed that local participation is weak. This is because local beneficiaries only participate actively in resource mobilization that is, making available community land for the construction of health centers and nurses' quarters, providing labour and other voluntary services. Other forms of participation such as needs assessment are narrow as people are sometimes involved in identifying their health needs. Management and leadership as forms of participation revealed that local participation is extremely weak. Issues of managing the day-to-day activities of the various health centers are seen as a sole responsibility of service providers and health workers. On access to health services, most of the people still find it difficult to pay for health services claiming that costs of treatment is high. The study showed that only ¼ of the population in the district is being able to register with the District Mutual Health Insurance Scheme. This, coupled with poor attitude of health workers, inadequate general health equipment and drugs, and the unfavourable operational hours of these health centers have made local users resort to alternative methods of treatment such as self medication and treatment by the traditional healers. However the physical presence of health workers and facilities/services provide some form of security to beneficiaries against emergency health cases.

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Content

Acronyms

BMC: Budget Management Centers

CHAG: Christian Health Association of Ghana

CHPS: Community based Health Services

DHMT: District Health Management Team

DHU: District Health Unit

GF: Global Fund

GHS: Ghana Health Services

GPRS: Ghana Poverty ReductionStrategy

MOH: Ministry of Health

NDC: National Democratic Congress

NGOS: Non Governmental Organization

NPP: New Patriotic Party

NHIS: National Health Insurance Sheme

OIC: Opportunity Industrialization Center

PHC: Primary Health Care

PNDC: Provisional National Defence Council

TBA: Traditional Birth Attendants

TH: Traditional Healers

UNICEF: United Nations Children Fund

WFP: World Food Programme

1   Introduction

The aim of the study is to discuss the contributions of decentralization towards increasing participation by beneficiary communities and improving local people's use of health services in the Kusawgu and Sankpala communities in the Central Gonja District of Ghana. Health standards in developing countries particularly those in sub Saharan African are falling as diseases such as malaria, HIV/AIDS, guinea worm among others are increasing. This is attributed to poverty, inadequate health services and facilities, high cost of treatment and a host of other factors. It is therefore not surprising that the Millennium Development Goals have received greater attention by various governments in these countries. Also, with the Alma Ata declaration of 1978 and the Bamako Initiative, which emphasize the need for local resources to be marshaled, with beneficiaries actively involved in every stage of health planning, policy makers in Africa have since seen the need to redesign policies that will integrate local people into every aspect of development. One of such policy strategies adopted by the Ghanaian government is the decentralization of the health sector. The study thus attempts to look at the performance of these local level structures in the form of District (subdistricts) Health Units, towards promoting local people's participation and use of health services.

1.1 Background of the study

The thesis seeks to investigate the forms of participation by local beneficiaries in providing health services/facilities and the degree to which district and sub district health systems have influence these beneficiaries use of health services. That is, looking at community participation and access to health services in two communities both located in the Kusawgu sub district of the Central Gonja District of the Northern Region. The Northern Region is one of the poorest regions in the country where seven out of ten people are considered poor (GPRS 1). However, poverty has an inverse relationship with access to health service (the so-called 'inverse care law'). The region is also one of those with less health facilities (Asante 2006), and a doctor patient ratio standing at 1:90000. The study district has no hospital; all that is available are clinics, health posts and community compounds. Cases of guinea worm are common and on an increase making the district records 62% of guinea worm cases out of the 288 cases nation wide. Malaria cases are leading in the district contributing to defining

the trend of mortality and morbidity in the district. On the other hand, the positive influence of decentralization on local level development is felt all over the country and can not be understated, as this led to the creation of the study district out of the West Gonja District in 2005. The rationale being that local level development is best promoted through an integrated approach where beneficiaries form part of the development process, which at the end enhances the quality and sustainability of development projects. It is for these reasons that the thesis chose to focus on such a topic and study communities.

To achieve the objective of the thesis, the following specific objectives shall guide the discussion.

> To identify the structure of the district and sub district health care system.

I will examine those characteristics that make up a district health system under decentralization. I will look at the composition of the District Health Management Team (DHMTs). The functions of the District Health Unit will be reviewed as stipulated in policy documents. This will then be compared with those functions actually decentralized so to identify the gap between the supposed functions and the actual functions decentralized. I will also look at the extent or degree of choice to which the unit has authority over regarding the execution of these. This information will enable me identify the challenges of the decentralized system towards promoting community participation and improving local people's access to health services and community participation.

> To identify the nature and extent of local level participation in health service delivery.

This specific objective is concerned with the form(s) that participation take at the community level in providing health services. It highlights the degree to which beneficiaries of health projects are allowed to be involved in the over all processes of health service delivery. Comparison of perceptions between community members and health care providers will be made. It is believed that efforts are being made to make the public sector participatory in nature; the thesis thus seeks to identify the degree to which this idea is observed within the health sector in particular.

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> To determine the relationship between the decentralized health sector and access to health service.

This objective looks at the efforts of the district health system towards addressing barriers that hinder local people from using health services. The essence of this objective is to examine in detail one of the dimensions of health service utilization. Access will be digested on the basis of different dimensions with views of community members forming the base line (depicting the real picture). Perceptions of district health personnel will add to community views, and further describe the measures that need to be put in place to tackle any associated challenges (if they so exist) regarding access to health services. This is to establish a relationship between decentralization and access to health services as whether negative or positive.

1.2 Structure of thesis

The thesis is divided into seven chapters. It starts with some background information on decentralization and health services in both developed and developing countries, the objectives of the thesis follows with highlights on the specific issues intended to be made known under each broad objective. Chapter two looks at the profile of the study district in general and the two study communities in particulars. Health issues in the district like diseases, malnutrition, sanitation, and water conditions are but some of the issues to be looked at since they all contribute to defining the general health conditions of the people of the communities.

In chapter three I shall look at the methodology used in gathering the data as well as other research issues observed during the data collection and analysis processes, for the methodology serves as the tool used in gathering and analyzing the data of the thesis. Chapter four looks at the existing literature on the thesis topic. It provides an overview of what decentralization in the world is about and narrowing it down to Ghana. Some few local government theories that support decentralization will be reviewed. Literature on health issues focusing on policy dimensions and local health structures shall also be discussed. The literature to be reviewed is to equip me with some information about what has happened else where. This creates room to identify differences and similarities of the thesis and other researches done else where. Chapter five looks at the features of the district and sub district health structure, functions of these local structures will be discussed in detailed. Community

participation will be examined under chapter six so to get a fair idea of the nature of participation observed in service provision. Also in this chapter I will present the impacts of decentralization on access to health services at the district. The last chapter looks at the conclusion of the thesis. I shall summarize the findings of the thesis and touching on the usefulness or weaknesses of the various theories/frameworks used in the thesis. I end the discussion on this chapter by making some recommendation by way of suggesting how the gaps identified can be filled.

2 Profile of the study area

This chapter examines the social characteristics of the Central Gonja District, with a specific focus on health. Major areas of concern include: the health situation of the people, the distribution of health facilities, the supply of portable water, sanitation, and nutrition. The purpose for focusing on these themes is that they have a direct bearing on the general wellbeing of the local people. The state of health of the people then determines their decisions to be made regarding seeking treatment and that is where access to local health services gains attention. For where these areas mentioned are deplorable, ill-health sets in, which then necessitates people to seek treatment.

2.1 Economic features

Agriculture is the main economic activity of the people. It provides the people with food, with some of the produce and animals sold to earn income. This is manifested in crop production and animal rearing. Crops produced includes, groundnut, cowpea, beans, millet and maize. Animals reared include, goats, cattle and sheep. Most of these animals are reared in sheds and with few large scale ranches for cattle mostly found in the bush. Mixed farming is the common practice of agriculture in the district. Fish cultivation is carried out on large scale in communities along the Volta Rivers.The district does not have large scale trading entreprises. However, commercial activities manifest in areas of fish, maize and yam trading around Tuluwe, Mpaha, and Boachipe. Markets at Buipe, Mpaha, and Sankpala get patronized as buying and selling of goods and services often take place.

Small scale industries are found in the following areas; cassava production and gaari processing, Shea butter production and Shea butter extraction, groundnut oil extraction, rice production and local soap making. Banking activities in the district are transacted by a branch of the Kintampo Rural Bank Limited at Buipe. However, some people of the district travel to Tamale to transact similar banking services. Generally, tertiary economic activities in the form of services such as insurance are not common in the district.

The annual average household income is estimated to be about 38 US dollars with about 80% of the people living below the national poverty line of about 62.5 US dollars[1]. The GPRS

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[1] www.ghanadisticts.com (downloaded on the 29-03/10)

explains that those below the line find it difficult to meet their barest minimums of food, clothing and shelter, with most of these people being rural folks who engage in agricultural production for their source of living.

2.2 Transportation system

The district can boast of only 310 km of motorable roads. Secondary roads such as the Fufulso Damongo road, Buipe Damongo, and Dameabra-Mpaha are the common ones. The only major road is the Tamale-Kintampo highways. The district is also characterized by 'overseas' areas (water logged areas not linked to some other places) of Tuluwe and Sheri where accessibility to such places become difficult particularly during the rainy season. This hinders movement of users of health facilities and the undertakings of some economic activities. Passenger transport services are mostly available and reliable on the Tamale-Kintampo highway.

Transport facilities within the district health unit are limited to 18 motor bikes with one vehicle at the District Health Directorate. The district has no ambulance for emergency cases; the only vehicle (Toyota pick-up) in the district is being used by the DHMT. Patients therefore bear the task of getting means of transports to referral points (nearest district hospital) which is mostly in Tamale. All these public health transport facilities in the districts have been provided by the central government through the Ghana Health Service.
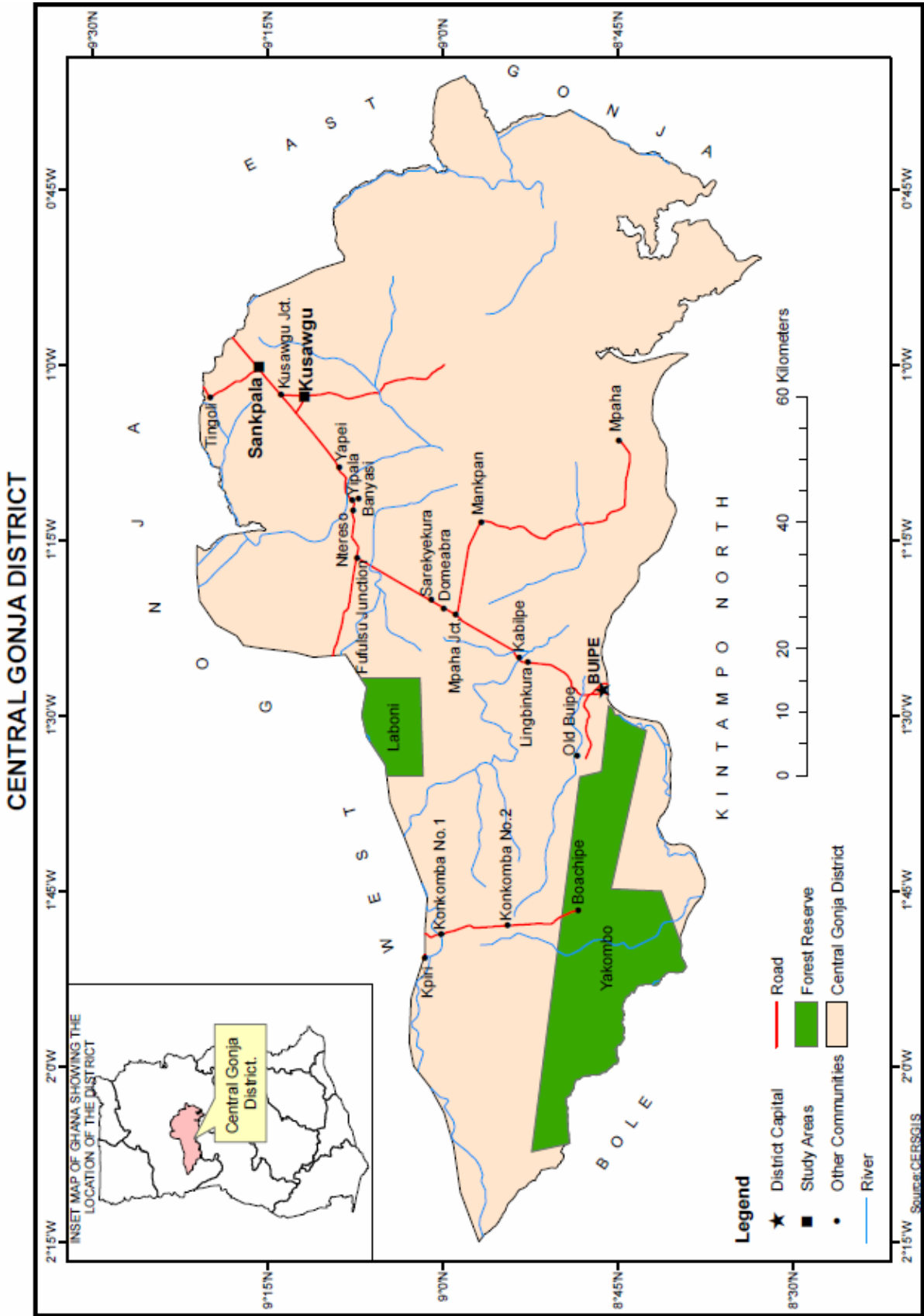
Figure 1. Map of the Central Gonja District showing the study communities.

2.3 Health infrastructure

The district generally has limited health infrastructure and personnel. It lacks a district hospital. As mentioned earlier, health facilities available include health centers at Buipe and Mpaha, and Health posts at Yapei and Kusawgu. There are also rural clinics at Sankpala and Chama. In the two study areas there are a number of drug stores with some drugs being sold at people's home. Sometimes too, mobile drug sellers also enter the communities to sell drugs and herbal medicine to the people. None of these drug sellers have the license to do so, as almost all of them also lack any training in pharmacy.

The health services provided at the district include medical care, antenatal and child welfare services. Others are immunization, post natal services, family planning services and guinea worm education.
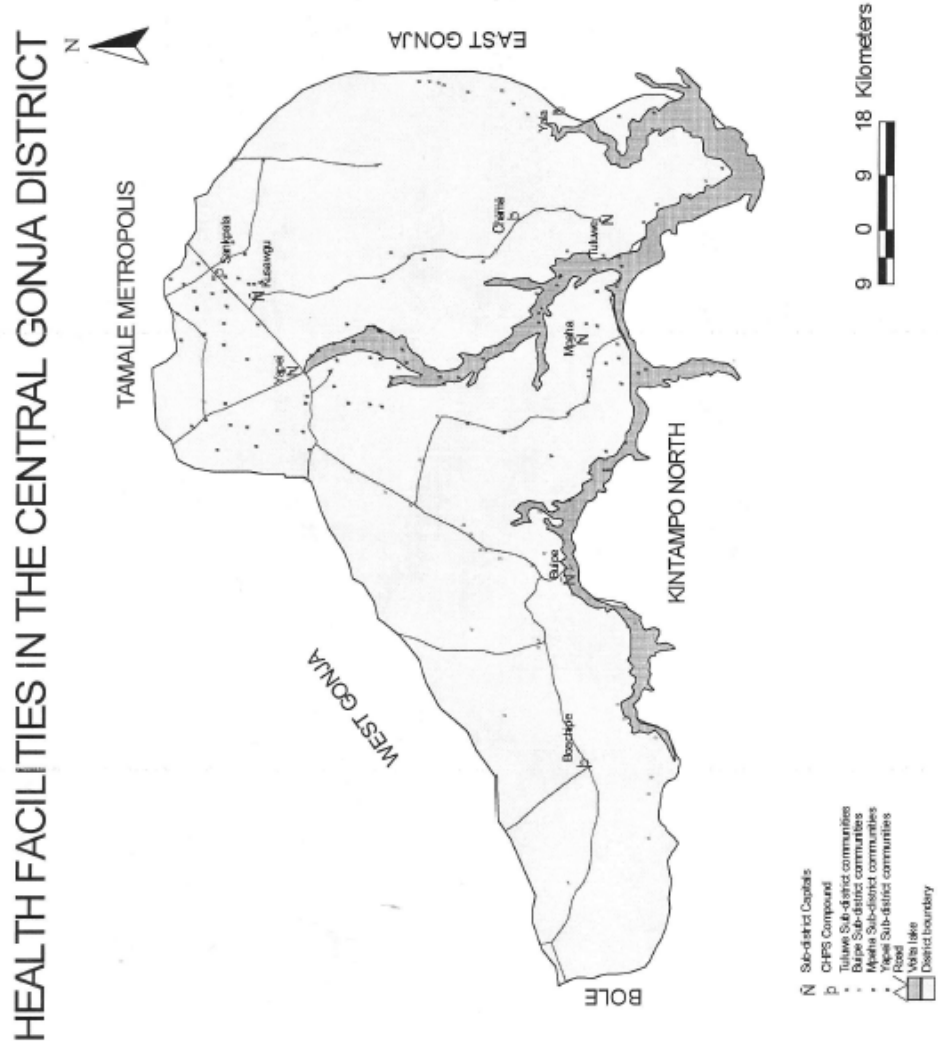
Figure 2. Map of health facilities in the Central Gonja District.

Source. Central Gonja District Health Unit.

2.4 Staffing

Staffing with regards to deployment of health personnel in the district is a challenge. Considering the poor nature of the district and the absence of some social services and facilities such as accommodation, educational and recreational facilities, some health personnel refuse postings to the district. The few who even do prefer staying in Tamale Metropolis whiles work at the district. It is therefore not surprising that users complain of non availability of health personnel at the various health facilities particularly during week ends as these personnel tend to enjoy their weekends at their various homes outside the district. The category of health personnel in the district includes medical assistants, nurses, disease control officers and auxiliary staffs. There is no single medical doctor in the district and this has implications for the general health situation of the people in the district.

2.5 Water and sanitation

Portable water supply in the district is not adequate since only a few rural communities have one or two boreholes serving the whole community (like Sankpala) with others having dried boreholes. Only 19% of the total population in the district has access to portable water. No community in the district has pipe borne water, the majority of the people relying on dug-out wells, rivers and dams. For instance Kusawgu, one of the sub-district and a study community has no single borehole with members of the community depending solely on a dam during the dry season and supplement this with rain water during the wet season. The inadequate potable water situation in the district makes guinea worm endemic, with the district recording the highest figure of guinea worm cases from January to June this year at Fufulso (Ghana News Agency, July 2009). The water situation in the district can be attributed largely to the geological conditions that prevail in some of these communities.

Further more, the sanitary conditions of some communities in the district is an eye sour. Only 4.4% of the total population in the district has access to sanitation facilities. No proper treatment of household waste as this was seen littered around houses, with open gutters allowing for the breeding of mosquitoes (defining the malaria cases in the district), bushes grow around buildings with limited places of convenience (toilet facilities) making people to defecate in the open. Although the people attribute the situation to poverty which makes them unable to put places of convenience, I would disagree and rather blame it on attitude. This is

because cheap local materials can be used to put up some of these facilities. However there are the activities of the Zoomlion Ghana workers who assist tidy up the communities of Sankpala and Kusawgu (Field Survey 2009).

2.6 Nutrition

Malnutrition is a serious issue in the district, Buipe sub district had the highest records of severe malnutrition in 2008 which is largely attributed to flood, poor harvest and inability to buy food. Cases of mild and moderate malnutrition were also reported at Kusawgu. It is thus realized that malnutrition increased in 2008 as compared to 2007. It must however be stated that the district is receiving support in the areas of intensive nutrition education and food support from Government of Ghana and World Food Programme. The district has since received three consignments of plump nuts to treat severe malnutrition in children below 60 months of age. Opportunity Industrialization Centre, an International Non Governmental Organization is providing assistance in the district in the form of food supplementation and training of community health agents on Health and Nutrition.

Some other supporting health structures found at the district is the Mutual Health Insurance Scheme which provides prepaid health mechanisms to the people in the district. It was realized that 30% of the population have been registered with the scheme. It is a nationwide policy but adopted and implemented in the various districts. This scheme takes directives from the National Health Insurance Authority with the headquarters at Accra. It is controlled at the district level by the scheme manager.

2.7 General health conditions

The health situation of the majority of the people in the district can be described as poor. This is attributed to the prevalence of diseases caused by poor nutrition, an issue attributed to floods, poor environmental sanitation and housing problems, and inadequate health facilities. Top ten ailments in the district are; malaria, upper respiratory tract infections, diarrhea, skin diseases, pneumonia, accidents and wounds, intestinal worms, dysentery, hypertension and acute eye infection. There are also reported cases of HIV/AIDS in the district. Malnutrition remains an issue with the Buipe sub-district recording the highest figure followed by Kusawgu, an incident attributed to poor harvest caused by floods in the district.

Summary

This chapter has looked at the distribution of health facilities/ services in the district where it is realized that health posts and CHPS compounds are the common types of facilities, as there is no district hospital. The category of health workers includes midwives, general nurses, community health workers, disease control officers and community health volunteers. Traditional healers and TBAs also exist in the district providing local health services to the people. Malaria is identified to be the number disease in the district. Malnutrition is also common with WFP stepping in to help. Sanitary conditions are poor with sources of drinking water being inadequate creating the opportunity for the local people to resort to drinking poor quality water (not treated) making guinea worm a common disease in the district.

3   Methodology

The discussion in this chapter is centered on the various methods that were used in collecting the data for the study. The reason for the choice of the study areas will also be justified as well as the procedures and guidelines that were observed before, during and after the fieldwork in these communities. Furthermore, the discussion will be focusing on the rationale for adopting a qualitative approach to the study (data collection and analysis).

3.1 Choice of the methodology

Kothari (2004) sees methodology as those steps that are followed in studying scientifically a research problem, and includes the research methods and techniques, as well as the reasons for the choice of such methods. The choice of the methodology therefore provides the foundation upon which the research rest and the lens through which the research problem is viewed. Bailey (2007) treats methodology as involving not only the techniques for data collection but includes the entire research, the decision of whether to approach the research qualitatively or quantitatively as well as issues of samplings. I decided to approach it from a qualitative perspective, employing qualitative techniques and methods in data gathering and analysis. Drawing from Kothari (2004) explanation of qualitative research, as one that is often suitable for the study of human behavior, I think it will allow me to identify those factors that influence people's choices in the use of a particular health facility as exemplified by the Aday and Andersen model (1974) on health utilization. Also Morse and Richards (2002) are of the view that qualitative methods when used, allow for the understanding of both sides of a controversial issue in a political or social situation, by simplifying the given situation without tempering with its complexity and context. It is realized that the concept decentralization is a complex one and vary from country to country. There is a debate also ongoing in Ghana that decentralization initially has no link with poverty reduction, but a precondition imposed later on developing countries by the World Bank to getting financial support. A situation of this sort calls for a qualitative approach through which every aspect of decentralization and its relationship with health care delivery can be digested.

3.2 The study area

The study covered two communities as its areas of focus, Kusawgu and Sankpala, located on the north eastern end of the Central Gonja District. They are about 8 km apart and share certain kinship relations. Politically, the chief of Sankpala is a divisional chief who pays allegiance to the chief of Kusawgu who is considered a sub-chief. Both communities belong to the Gonja ethnic group with the Yagbonwura as their paramount chief. Administratively Kusawgu is a sub district under which Sankpala lies. Their beliefs and practices are common, and with the inadequate health facilities, they experience high level of infant mortality. The two communities have also witnessed chronic cases of guinea worm. Geographically, Sankpala is also located along the Tamale-Kumasi road while Kusawgu is in the interior about 3km from these highways.

My choice of these two communities is influenced by the following: Firstly a base line study has already been conducted in these communities by the University for Development Studies of which I was a student and part of the team at one at of these communities, therefore with this datum line information (community profile, potentials and constraints of the Kusawgu community), a further and specific studies can be conducted. Further more, these communities exhibit the features needed for the study as they both have modern and traditional or local health care units. They also fall within the same decentralized health unit (Kuswagu subdistrict), and are besieged with numerous health problems. Contrasting the two communities, Kusawgu has a health post whilst Sankpala has a CHPS compound, and this comes with different level of service delivery. People within the catchment area of Sankpala prefer going to Kusawgu health post to going to the CHPS compound at Sankpala. Also whiles there is a trained TBA in Kusawgu, Sankpala does not have any. This differences will enable me identify some of the challenges that are associated with some facilities/services. The responses from the two communities will also bring out the divergence or similarities of people's views pertaining to the decentralized health system. The study could thus form the basis for generalization of health care in the district.

3.3 Data collection process

The research made use of informants who included; men, women, and the aged. Most of the individual interviews were conducted at the various health centers because it is the place where informants can easily be located. The interviews took place during the operational hours (working days) of the various health centers, as they are often closed during week ends. However it is realized during the interview process that the informants were mostly women at the health post, so to get the men and the aged, I visited some of the houses. At the health centers, respondents were self selected based on their volition. With the help of the health workers at the health centers, the objective of the study was explained to the users available. The workers then asked those who were less busy and willing to talk to wait for the interviews of which the informants obliged. The presence of the some of the health workers at the interview scenes made some of the respondents uneasy particularly discussing about the attitude of the health workers. I however managed to control the situation as I explained to these workers of the need to grant the informants the privacy to talk.

3.3.1 Sampling

> "Sampling is the science of systematically drawing a valid group of objects from a population reliably" (Stacks 2002, p. 3).

It is a well established fact that sampling is a common feature of both quantitative and qualitative research, and this makes it distinct from a census. No researcher can undertake a study without considering issues of sampling regarding the selection of the study area, choice and the size of informants, characteristics of informants and the type of information needed This is due to the fact that time and resource constraints would not allow every one in the population to be studied, as advanced by Jackson (1995). Moreover Conrad and Serlin (2006) argued that sampling strategy is a very important element of the research design being adopted, and that it clearly demarcates a boundary between qualitative and quantitative inquiries. It is against this background that the research identifies itself with qualitative sampling techniques. This is manifested in the following: Firstly the areas of study were deliberately selected based on their characteristics that each identifies with the topic understudy. The specific type of purposeful sampling technique used is criterion sampling (Bailey 2007). Both areas studied have inadequate modern health facilities; there is the presence of local health care providers, incidence of poverty and diseases being high, high

maternal and infant mortality rates and a host of features. The rationale for the choice of these two areas drawing from the field of qualitative inquiry is to allow for the wider understanding of the research topic with little regards for the systematic representation of the broader population and empirical generalization (Conrad and Serlin 2006) of the Central Gonja District. Since there was no designed list of informants with specific characteristics, for reasons that have to do with time (farming season), cost, logistics and willingness to participate, interviews were conducted at the various health centers. Group interviews particularly in the second round of the field work were conducted at the communities' squares

3.3.2 Gaining entry

The starting point of every field work when it comes to data collection is the issue of community entree. I defined it as the process of which the researcher makes a preliminary entry into the study area with the aim of establishing a positive and a sustained relationship that is crucial for the research. Bailey (2007) identified it as a complicated process, and the channel through which one uses to negotiate the entry which may affects the research outcome.

> "Knowing who has the power to open up or block off access, or who considers themselves and considered by others to have the authority to grant or refuse access is of course, an important aspect of sociology knowledge about the setting" (Hammersley and Atkinson 2009, p. 50).

Gatekeepers who may sometimes be multiple are often regarded as important when it comes to negotiating entry, and the relationship established with them has a long term effect on subsequent course of the research. The gatekeepers in my research includes the chiefs, elders and the assembly men of the two communities on whose land the health facilities are located and the users who they govern. In the public sector, the Regional Health Director became the major gatekeeper through who contacts with other health workers in the districts in general and the communities in particular were made.

Entry into the two communities was greeted with what Mohammad (2002) addressed as 'positionality'. It can be in terms of the differences and the similarities between the researcher and the researched. It is more appreciated with regards to the distribution of power between the researcher and the researched. I consider it important because it influenced the data collection process. For instance in these communities women are generally considered weak

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and seems to speak a little before men, this implied that during the interview process, male informants would wield power more than me and this could influence their level of contribution and co-operation during the interview process. To handle the situation I went with two male research assistants who interviewed the men and I once in a while chipped in. With the insider outsider myth, the reception at the two communities was with mix euphoria. Whiles in Kusawgu I was seen as an insider because I once stayed in that community for three years doing research in fulfillment of my Bachelor degree, I was treated as an outsider in Sankpala. I easily became accepted and identified with the former than the later; however I tried to manage the two situations carefully such that the outcome of the research is not being influenced by this outsider/insider myth (Styles in Hammersley and Atkinson 1995). Entry into the communities began with the calling on the chief and elders of the Kusawgu community with the assistance of a community teacher and the chief's spoke person, although the assembly man was the first person I tried to contact however he was absent at the time. Since my study is not ethnographic in nature, I made known my research intentions to the chief and his elders who then granted me the permission to interact with the people of the community. It must be noted that this community had just experienced a chieftaincy dispute before my field work in the community commenced. So our presence initially was treated with suspicion until the content of the research proved otherwise. In Sankpala, time did not allow us visit the chief, however the assembly man who seemed so influential received us and promised us of relaying our intentions to the chief. He quickly organized some people and the health workers at the compound and told them of our mission. We were also assisted to locate certain key people such as the Traditional Birth Attendants and traditional healers. When the research came to an end, the communities again were informed.

3.3.3 Methods of data collection

A research of this sort requires that various methods come in to play to arrive at what actually pertains on the ground. To arrive at first hand information the various data collections methods where used depending on the characteristics of informants, timing, convenience and the interview environment of the study areas.

Observation

Marshall and Rossman (2007) see observation as a basic and an essential method in qualitative research. They define observation as:

> "The systematic noting and recording of events, behavior and artifacts in the social setting chosen for a study" (p. 98).

This method was used to assess the physical conditions of the health facilities found in the community. From the observation, it is realized that the physical conditions of the modern health facilities and the general equipment found in them are comparatively better than those of the Traditional Birth Attendants and traditional healers who often use mud rooms in their homes for their activities, as these local people do not have the capacity to put up modern facilities. The use of mud houses is also inline with their beliefs and treatment practices. Observation was also used to assess the way patients are being handled at the various health centers by health workers, for instance the interactive relationship between patients-nurses, and the mood and attitude of health workers towards patients. It was also used at the various homes of the herbalists concerning the general treatment environment (herbs, objects and ways of treating various illnesses). This method was thus chosen to allow for the explorations of the general working environment (attitudes, mood and behavior) between patients and health workers, and the physical conditions (location, nature of buildings) of the health facilities. This allows for the accurate acquisition of information since all what was seen is what was recorded, no biases, for every thing relates to the present. It also saves time and resources since it was carried out independent of respondents' willingness to respond as shared by Kothari (2005). The observation process was covert, non participatory, it took place at the health center during working hours, and at the houses of the local health providers, and was not structure.

In-depth interviewing

Interviewing is 'a conversation with a purpose' (Kahn and Cannell 1957, quoted in Marshall and Rossman 2007). Questions were semi-structured and open ended. This was to give respondents enough time and freedom to decide on their choice of response to the topic. It constituted the major means through which data was gathered. It catered for the needs of local users who are illiterates. Categories of people here include users, health workers, traditional birth attendants, traditional healers and owners of community drug stores. The interview

process lasted for at least 30 minutes. Questions were self-administered by key informants or the major opinion leaders of the health service, who are considered literates. These people also needed an ample of time to be enable to respond to certain technical questions and who are also difficult to reach or access. They include the District Planning Officer and the District Coordinator of Health Services. The information gathered centered on issues of community participation in decision making, the demand and supply of health facilities, distributional criteria, contributions of other sectors to promoting health and the quality of health services within the district.

Group interviews

Group interviews were conducted to obtain more information about the topic. It was realized that the first information gathered was not enough to answer the research questions. However, it was revealed from the first data collection process that informants were willing to talk when put in groups. The second part of the field work thus adopted group interview methods as the means of getting informants express themselves well. This was because it was the farming season and informants were busy on farms and could only make time to talk in groups. Also it was realized during the first part of the research that when informants are put into groups, their fellow respondents help them express themselves which they find it challenging when interviewed alone. This is observed among the women. 8 people make up a group and this was based on sex. Each of the two communities had two group interviews, one for men and the other for women. Key informants such as workers at the health centers as well as the personnel at the district Health Directorate and the District Assembly were also contacted again for update of health information for the entire district.

3.4   Ethical considerations

Ethical considerations according to Bailey (2007) run through every aspect of the research, starting from topic selection to the publication of the research results. May (2001) sees decisions regarding ethics as those dependent of the researcher's values and that the communities, have the tendency of influencing negotiations between the researcher, sponsors, research participants and gatekeepers. He thus treats ethics as those codes and principles that are shaped around moral behavior. Whiles some researchers think that ethical considerations are paramount in research, others think otherwise, arguing that the context of the research should determine the need and not necessarily observing or violating rules in all situations.

With this background information, the research process (of the thesis) imbibed certain research principles .This was from the view point of the deontologists, one of the categories identified by Jackson (1995) and May (2001), as the process of conducting research where a set of principles are held in high esteem. Issues of informed consent, confidentiality, and privacy were observed during the research process. For instance, my identity as a researcher was made known to the study communities and the research topic explained. Participants were recruited on voluntary bases with their consent obtained. Background information about informants was asked but would not be presented in the analysis but to guide in cross checking responses, as issues of health to some degree are sensitive. Permission was sought before I could observe and take snapshots of the herbalist rooms for treatments (considered sacred, where gods are kept and rituals performed). The activities were carried out cautiously with time limit. At the Sankpala community, a TBA (not trained) declined to be interviewed until a detail explanation of the research topic was explained to her before she consented to it.

3.5 Validity and reliability

Validity and reliability are components of research works which researchers constantly strive to achieve. They serve as a check on research results so to ensure that researchers are not misinformed. Validity and reliability help define the strength of data, and also build the confidence that researchers place in what they have seen or heard. Wallen and Fraenkel (2001) see validity as how appropriate, useful and meaningful an inference of a researcher can be, based on the data collected, whiles reliability denotes the consistency of these inferences over time. Validity refers to the accuracy of an account in representing those features of phenomena that it intends to describe, explain or theorize (Ritchie and Lewis 2003). Field and Morse (2001) say validity has the goodness of an answer yielded by a particular study. Much as these concepts are vital in research, reliability has been criticized. As in Ritchie and Lewis (2003), reliability can never be achieved because no single reality can be achieved in a first instance so replication is an artificial goal. Also social phenomenon is complex and subject to dynamism.

However, I have chosen to identify myself with those researchers who see validity and reliability in research as important as seen in some of the above mentioned points. In carrying out the research I tried to observe those steps observed by Wallen and Fraenkel (2001). I used triangulation not only as a way of yielding large and quality data but also as a cross check on

some of the responses given by informants in my data collection process. These methods have been enumerated above. My data collection process also took two time periods; the first part did not yield enough data so I made a follow up. During the second part, the same questions that I asked in the first period were repeated in the second period even though additional questions were asked. Some of the informants noticed it and asked why I demanded for their response in questions which they answered in the first period. The importance of this exercise was to verify whether there would be variations in answers that same informants will provide to same questions at different time periods. Another strategy that I adopted was to note down some questions that informants asked me in the interview process and try to see the link with their responses. Since I do not speak or understand the language of informants, I tried to let them describe or explain things that they have mentioned but seems unclear to me. Even where responses are ambiguous, I encouraged them to explain. Certain times I asked different informants to describe same thing. This creates an opportunity for me to compare their answers to see how valid their answers are. I applied this strategy when interviewing the various traditional healers in the two communities on their mode of treatment. To validate the information on diseases, symptoms and treatment I encouraged informants to describe. Also some of informants were interviewed more than once. This was possible through the individual and group interviews. Some of those interviewed individually happened to be part of those groups interviewed. This allowed me cross check the responses made at the individual level and that of the group level. It was made possible by writing down the names of the informants though I decided not to reveal their identity in the data analysis process by Wallen and Fraenkel (2001). I therefore think that I have observed some validity and reliability strategies as suggested by Wallen and Fraenkel (2001) in my research process and therefore can conclude that the findings of the study population is valid and reliable.

3.6 Limitations of the research

- Security

The data collection period coincided with a period when there was a chieftaincy dispute between two gates in the community. This made our presence threatening, as some members thought we were spies in the community. Members were also uncomfortable to receive us at their homes and group meetings were not also encouraged. Informants were not comfortable

to talk as they were planning on what to do should anything happen. Others were not even seen. I was also scared and could not guide the interview process well.

➤ Language

The language of the study communities is Gonja, however it was noted during the interview process that some of them were Dagombas who could not speak Gonja. This means that I had to get additional interpreter although I understand neither of the languages. My inability to speak and understand the languages affected the originality of the data because, sometimes the interpreters find it difficult to get some exact words in English for some words in these languages, and this could have distorted the information. This interpretation was also delayed the process.

➤ Attitudes of some respondents (workers)

Members of the two communities cooperated with the process even though some were skeptical at the beginning. It was however disappointing that some officers at the District Assembly (the focal point of decentralization) were unwilling to answer the questionnaire. Their attitude towards giving me the necessary information was poor as some officers were not ready to respond to the questions at all. Others delayed the interview process by postponing the schedule all the time with the excuse that they are busy or are travelling. However officers at the health unit readily received me.

Table 1. List of informants.

Informant	Number
District Coordinating Director	1
District Director of Health	1
District Mutual Scheme Manager	1
District Health Budget Officer	1
Health Personnel at the two health centers.	4
Community informants	46

Source: Field Study.

Summary

This chapter has looked at the methodogical approaches that were employed in gathering and analyzing the data. It is realized that a combination of various methods such as individual and group interviews, and self administered questions served as the means of obtaining the primary data needed. This chapter also looked at the community entry and exit procedures, the strategies that were adopted to enhance the validity and reliability of the research. It further looked at the ethical considerations regarding informant's consent, privacy, and the use of rewards. The chapter again touched on the limitations that I encountered in the process of carrying out the research. Language was a major barrier to me and the insecure nature of the Kusawgu community culminating from chieftaincy disputes almost made me abandon the research.

4 Review of literature

This chapter examines in detail what the various concepts as mentioned in the topic are. It explores some arguments that underpin each of these concepts and provides frame works on access and community participation in health services which shall form the bases for analyzing the overall objectives of the thesis. It sheds light on the historical development of decentralization in Ghana. It also looks at the health and health policies in Ghana, touching on Primary Health Care in the country which is the focal point of the decentralized health structures within the country.

4.1 Decentralization

The concept decentralization is very complex and found itself in many disciplines such as political science, geography, management studies and organizational theory. Decentralization resists simple definition (O'Neill 2005). O'Neill was however quick to add that for decentralization to be effective, there must be autonomy and access to financial resources. It is often contested and hence lacks a clear definition (Peckham et al. 2007). Saltman et al. (2006) see it as an umbrella under which different but conflicting theories and approaches are sheltered.

With the ambiguity that comes with the concept, different definitions have been offered depending on the discipline and situation under which the concept is being examined. Some authors have also used the concept without clearly defining it as depicted in Mills et al. 1990. In the field of economics, it relates with public choice theory and fiscal federalism (Oates 1972). In political science and management studies, it represents the demarcation of political boundaries and administrative structures (Smith 1985). In defining it, Smith (1985), saw it as the demarcation of state's territorial boundaries into smaller areas with the stetting up of institutions to handle administrative and political affairs. This corresponds to the notion of local governance. It is a reform that comes with legal and administrative provisions for the transfer of authority, human and financial resources, accountability and rules from the central government to local entities (Olowu and Wunch 2004). Within Public Administration Rondinelli (1981) defined decentralization as:

> "....the transfer or delegation of legal and political authority to plan, make decisions and manage public functions from the central government and its agencies to field

organization of those agencies, subordinate units of government, semi autonomous public corporations, or regional development authorities, autonomous local governments or non governmental organizations" (p. 137).

Rondinelli used a four tier structure to elaborate the concept. These he listed as (1) devolution, (2) de-concentration, (3) delegation and lastly (4) privatization. Devolution involves the transfer of authority and responsibilities from central offices of a particular ministry to separate structures within the public administration. This takes the form of provinces, districts and municipalities. De-concentration is about shifting power from a central office to a peripheral office of the same administrative structure. Delegation transfers responsibility and authority to semi-autonomous agencies. Lastly Privatization refers to the transfer in ownership and operational responsibility to private providers. These concepts though sometimes used interchangeably to represent decentralization, Rondinelli justified that devolution stands tall among the others as it gives more autonomy to lower levels of government (Peckham et al. 2007). Some of the concepts however create room for discussions. For instance I see privatization as unfit to lie within decentralization because; it lacks that dependent relationship that binds the center and the periphery. Further, it can take place even within a centralized setting. Also some private entities may grow to wield power more than the central government which should not be the case. This is because the central governments often make arrangements to ensure that significant authority and power is usually retained at the center. The discussion of the thesis will however make use of Rondinelli's framework as some of these typologies such as delegation and de-concentration will be used to examine Ghana's situation.

Decentralization evolved from the Nordic Region and diffused into countries such as Spain, Italy, and the United Kingdom and in recent times Poland (Shah 2006). Historically, it is often tempting to conclude that in developed countries the concept evolved naturally, whilst being imposed on developing countries. In contrast, Oluwo and Wunsch (2004) argued that in countries of Africa particularly those in West Africa, some form of local governments existed before the ardent of colonialism. This they likened to the organization of states at the time through conquests and trade, resulting in the creation of empire states with conquered local areas responsible for their own development.

4.1.1 Arguments for decentralization in the world

Decentralization as a reform has been pursued for varied reasons depending on the conditions that prevail in a particular region or country. According to Mills et al. (1990), it provides a platform for local participation resulting in local self reliance and ensures accountability of government officials to people. It also serves as a way of addressing institutional, physical and administrative constraints on development. I think the opportunity for these benefits to be accrued depends largely on the motive for decentralizing and the extent to which it is being implemented. O'Neill (2005) in discussing decentralization in Latin America identified that, even though it was unevenly adopted across these countries, efficiency, democracy, neoliberal reforms, internal and international pressure and political crises were some of the reasons for decentralizing. From the perspective of Africa, Oluwo and Wunsch (2004) in discussing political decentralization, explained that the political and economic crises that swept across the continent in the 1980s coupled with pressure from donors for good governance are but some of the reasons for the implementation of decentralization policies. What baffles my mind is why donor agencies such as World Bank will advocate for decentralization when it is rather easier to deal with centralized states, may be to pursue policies with human face.

According to Saito (2008) as population increases and people's needs began to diversify governments found it difficult to meet popular demand. Moreover with the emergence of alternative service providers and the dawn of globalization where nation states became borderless, the state became less important. Most importantly the state is often blamed for being far removed from the realities of the local people. It thus became imperative to champion development within the domain of decentralized structures. Recently decentralization is pursued in developing countries as a way of reducing poverty and achieving the Millennium Development Goals (MDGs). Bossert (1998) added that decentralization as advocated stands the chance of promoting administrative efficiency and quality of services and also serves as a tool to usher in democracy and accountability at the local level. I think decentralization is pursued to meet goals of accountability in development , to improve the quality of public services (local governments know better the needs of the local communities and are more appropriate to comply with) and to enhance the participation of citizens to decision making. Cheema and Rondinelli in tracing the waves of decentralization noted that the concept evolved with time to expand the domain of governance.

4.1.2 Theoretical arguments underpinning decentralization

There existed bodies of literature that highlight the need for decentralization in the public sector. Most of these are concerned with the relationships that exist between the centre and local (periphery), or has to do with local governance. The perspectives center around reasons for decentralizing decision making to lower level structures and for the promotion of local government entities, with the aim of promoting accountability, efficiency, manageability and autonomy (Shah 2006). Arguments shall be drawn from some local government theories such as the Stigler's menu, and principles of subsidiary.

Stigler's menu

Stigler's efforts at contributing to discussions on central–local relationships took a dimension of two principles which are

- The closer a representative government is to the people, the better it works.

- People should have the right to vote for the kind and amount of public services they want.

These principles implied that the lowest levels of any political or administrative structure should constitute the arena for making decisions. Development programmes should be carried out based on needs assessment conducted at the grassroots level, with the people being part of the whole process. Also, to avoid duplication or waste of resources, energy and time, people's choice should be held supreme in deciding what kind of development to be pursued. Stigler's menu adds to the argument advanced by Rondinelli. Rondinelli argued that there should be the de-concentration of functions, responsibilities, resources and authority to local entities in the form of provinces and regions/districts for this encourages popular participation, efficiency and accountability in development.

Subsidiary principle

Subsidiary principle is among those arguments that call for the exercise of power and execution of responsibilities by lower level strata. The governing council of UNHABITAT treats the principle of subsidiary as the underlying motive for the process of decentralization. The principle is thus seen as one that has influenced the coming into being of local level governance. The principle is also identified with the social teachings of the Catholic Church

and has also been adopted as a fundamental principle by the European Union Law (Wikipedia 27-02/10). The principle states that concern of citizens should be handled by the lowest level of administration and governance and that where the lowest level cannot handle such, the next high level should intervene. As stated by Shah (2006), lower level governments should determine the means of revenue and define the parameters for spending such revenue as well regulate the processes. Central government should only intervene when there is the need. This principle intends to gain some independence for lower authority in relation to higher bodies. It also provides standards for evaluating local capacities. It further defines the types of roles of the state. It additionally recognizes power sharing relationship between various units. I think the principle intends to encourage self reliance, independent initiative and collective responsibility towards promoting local development. How ever this can be possible when local governments have the capacity in terms of personnel, finance and logistics to do so.

4.1.3 Decentralization in Ghana

Decentralization as used in the context of the thesis covers fiscal, political and administrative setups within the country. However, the arguments to be made will draw much literature from political decentralization as it is often the case in Ghana. This because political decentralization took precedence over any other type of public decentralization place in the country.

Decentralization as a process has been going on in the country since the pre- independence era. After independence, the process was characterized by local level elections and the passing of various legislations; however the reason for this propaganda was to rather condense power at the center (Ayee 1994, Olowu and Wunsch 2004). Decentralization in Ghana took a complete form only in the late 1980s through the efforts of the then Provisional National Defence Council government. The process was first introduced into the political system of the country where regions and districts were created with local political leaders being made to head such places. What triggered this reform was the implementation of the Structural Adjustment Programme of World Bank. This was also the party's ideology (then PNDC government) to bring power closer to the people (Oluwo and Wunsch 2004). These were the objectives of the decentralization reform; to promote participatory democracy by way of erecting local level institutions, and to empower local level governments to have control over revenue generating activities.

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Ayee in Saito (2007) added that Ghana decentralized its public sector as a result of the following; firstly with the economic and political upheavals which prevailed in the country at the time, the then PNDC government knocked on the doors of the World Bank for assistance, and the condition was that, for the country to be granted support, it must exhibit features of good governance by way of decentralizing. Secondly with the 'third wave of decentralization' that engulfed the globe to decentralize, the subsequent governments of the National Democratic Government (NDC) and the New Patriotic Party (NPP) refused to be left out of it, as it was further reinforced by the 1992 constitution. Lastly, to promote democratization and effective central administration, decentralization turns to be implemented to the later by the subsequent governments. It must however be noted that Ghana's efforts at decentralization (political) were stimulated by a top-down initiative, the opposite of what happened in some African countries like Sudan where citizens agitated for local governance.

Legal provision

Political decentralization in Ghana took effect with the passing of the local government law in 1988 (PNDC Law 207), which paved way for the creation of District Assemblies with the aim of making them the highest body in the district to perform legislative and executive functions. Other provisions include the chapter six of the 1992 constitution which has 'the directive principles of the state policy' (mandating government to be democratic by decentralizing), and legislative instruments (LI) like LI1514. This led to the creation of 10 regions and over 100 districts all pursuing the functions of local government. Decentralization in the manner is often equated to devolution.

Decentralization within the health sector

Health sector decentralization has drawn advocacy from various international organizations among which is the World Health Organization (WHO), requiring that certain health system functions be transferred to the local levels in order to meet the health needs of the people (WB 2005). A study of decentralization in Uganda by Hutchinson et al. (1999) showed that public sector decentralization paved the way for the health sector decentralization. According to Mills et al. (1990), health sector decentralization in developing countries have been central government initiatives with local areas playing a supportive role by providing village level health services. Decentralization within the health sector of Ghana seems unique from what is

generally known to be an integral part of public sector reform. The health sector has been largely isolated from the ongoing processes of local government reforms. It is also difficult to describe the type of decentralization that is taking place within the sector, as one sees traces of delegation and de-concentration all appearing at different stages of the process. Also the application of the tenets of decentralization within the health sector took its own pace and time period, and this makes the sector not to be well integrated into the local government system. According to Bossert and Thomas (2000), the health sector decentralization came in a separate context of civil services. The country's health sector saw the delegation of service delivery functions to the GHS, and the GHS in turn de-concentrated to the various Regional District and Sub-districts Health Management Teams. This process according to Bossert and Thomas is still not complete, as some supposed decentralized functions are still withheld by the Ministry of Health.

In Ghana, an effective decentralized health sector existed only after the passing of the Ghana Health Service and Teaching Hospital act in 1996 although efforts to do so dates back to the 1980s. This was to create an autonomous body to take up responsibility of health care delivery from the central Ministry of Health. Thus the Ghana Health Service was born with specific objectives as spelt out in Act 525. The aim of GHS was to set up a decentralized health system to provide access to basic health services to all persons as close as possible to where they live and work (Danso 2006). With the passing of act 525, the Ministry of Health was charged to policy making with health service delivery delegated to the Ghana Health service. A further analysis of the situation sees de-concentration to be taking place between the GHS and the local health management teams (at the regional, district and sub-districts levels). It must be noted here that the picture presented above is only in theory since there is still no complete delegation of power from the Ministry of Health to the GHS.

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4.1.4 Composition of health care delivery in Ghana after
   decentralization

According to Johnson and Stoskopf (2009), health care delivery system in the country falls into four categories: the public, private for profit, private not for profit and traditional systems. Services in the public health system is delivered through a chain of health facilities, with health centers and districts hospitals providing primary health care services, regional hospitals providing secondary health care and the three teaching hospitals providing tertiary health care. The private not for profit consists of the mission based providers. Within the traditional sector, we have the faith healers, traditional birth attendants and local healers or herbalists. Depending on the characteristics of a given rural community, the traditional sector tends to be very important in meeting people's health needs.

District level

In line with the scope of the thesis, health care at the district level will be examined substantially for it is the onus of any health system. The target of the district health service is to promote primary health care; it is responsible for the construction of health facilities in the form of hospitals, health centers and community health clinics (Johnson and Stoskopf 2009).

 Below the District structure is the sub-district level where there exist the health centers, health posts, and rural clinics. These facilities provide out patient services in the form of treating cuts and wounds, and make referrals to the districts hospitals in situations involving serious cases. They provide the first point of contact between the users and the health workers within the To boost access to health care in the country, a Community-based Health Planning and Services (CHPS) initiative is introduced lately based on a module carried out by the Navrongo Health Research Center. CHPS now a national health policy aims at overcoming geographical access to health services (Nyanotor et al. 2005). It involves the creation of health compound and subsequent deployment of a community health nurse and auxiliary health officers who provide mobile health services to a number of villages. The diagram in figure 1 depicts the structure of the Ghana Health Service at the district level. The arrows show the flow of functions and patients referrals within the decentralized system.

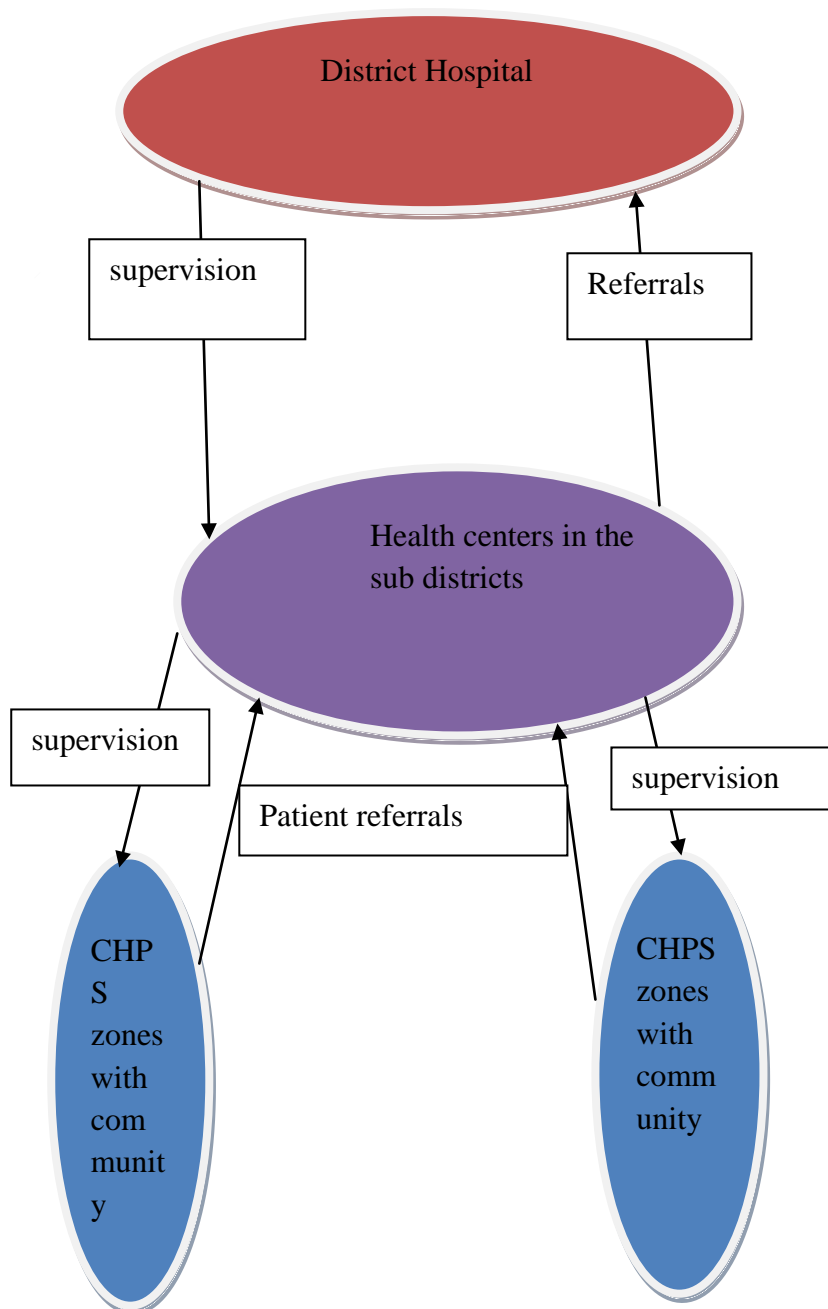Figure 3. Organizational structure of the District Health Care System.

Source. A simplified version of Heyen-Perschon (2005).

It is a fact that decentralization is widely implemented within the political system of the country, however certain key features within the health sector make it decentralized to some extent even though the process is still ongoing with the sector being in transition.

Firstly, at the national level, there is a delegation of service delivery functions, authority and resources from the MOH to the GHS. It is believed that the role of the central MOH is to be reduced to policy making with the GHS taking full responsibility of service delivery for the country (Bossert et al. 2000). The GHS in turn has also de-concentrated some functions resources and responsibilities to the regional, district, sub districts and health centers. Health personnel within the health sector are now controlled by the GHS and GHS will have the authority to decide over recruitment and dismissal of health worker. Health personnel will be part of the public service but not the civil service.

At the district level which is the focus of the thesis, there exist the DHMT a body responsible for monitoring and supervising the activities of the district and sub districts health activities. These include the monitoring and supervision of health personnel, resources movement and type or quality of services delivered at the various health points within the district. The various health units at the district also have the capacity within the decentralized system to plan their local activities but should be done within guidelines provided by the MOH and GHS.

4.1.5 Primary health care

Primary health care in Ghana originates from the Alma-Ata Declaration in 1978 by WHO but reinforced by the Dakar declaration. The declaration sees health as a fundamental human right; with health as a wide world goal which should be attained at it highest level as possible (Alma-Ata 1978). It covers areas such as preventive and control of locally endemic diseases; family planning; immunization against the major infectious diseases; appropriate treatment of common diseases and injuries, and provision of essential drugs. The declaration also sees the following as vital components of primary health care; promotion of food supply and proper nutrition, adequate supply of safe water and basic sanitation (Alma-Ata 1978). Primary health care in Ghana is handled by institutions such as community health centers and rural health centers as health needs are prioritized to meet both rural and urban places. The lack of permanent health facilities in rural areas in the country is addressed by a system called Community Health Planning Services. These institutions which are provided by government, mission, NGOs and philanthropies, serve as the first point of contact between health workers and patients. Workers at these places include community health officers and rural health workers, and the mode of reimbursement at these areas include NHIS, Cash and Carry, and

gratuitous. Maternity homes are also put up to handle cases related to reproductive health with the assistance of midwives (ACCORD 2009).

4.1.6 Poverty and health service utilization

Poverty and health have inverse relationships with the linkages being myriad. People who are considered poor can hardly afford a well balanced meal, are poorly sheltered and often have less access to good drinking water and sanitary facilities. Health facilities are often located far from where the poor dwell, and such areas stand the chance of being left out during health exercises such as immunization for common diseases. Gwatkin et al. (2006) noted that millions of people in the world's poorest regions suffer from preventable diseases just because they are poor. It is believed that poor people have less or no formal education, experience high birth rates and high mortality rates. Poor people are finding it difficult to meet the cost associated with health and this makes some of them to sometimes resort to alternative means of treatment. Where they find themselves in modern health centers, they are often detained for days at health for not being able to pay. According to Heyen-Perschon (2005) report on "The Current Health Situation in Ghana", limited access to financial resources forces people to stay in hospital until someone comes to their aid. Ashford, Gwatkin et al. (2006) study on the distribution of health services among the rich and the poor in 56 countries with the results being put into four wealth quintiles using more the 100 indicators for health status and health care, revealed that the lower a group's economic status is, the less it uses health services including basic services such as immunization, maternity care and family planning (Gwatkin et al. 2006). Even where health programmes are designed to meet the specific needs of the poor, the rich turns to benefit more. This could be attributed to lack of knowledge about the existence of these packages, inaccessibility of facilities, unresponsive health providers and cost of some services (Gwatkin et al. 2006).

4.1.7 The national health policy framework

Health service delivery in the country has been evolving through efforts of the government and development partners, aiming at raising health standards in the country. A national health policy that is currently underway is the Programme of Work which is put into phases. The first phase was from 1997-2001, followed by the second phase which was from the year 2002-2006. At present the health sector is in the third phase using a 5 year programme of work.

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This is augmented with the new health policy called "Creating wealth through health". The programme of work has spelt out the various priorities, strategies, target, resource and resource allocation criteria for the sector. Elements of policy documents like the Ghana Poverty Reduction Strategy, the Millennium Development Goals have been considered in coming out with the programme.

The policy framework of the country is geared towards addressing the major challenges associated with health care. These include access and equity to health service, and ensuring that health services contribute largely to reducing poverty in the country.

Its policy areas include the promotion of primary and emergency services through the tackling of geographical access by placing Health Points with community health officer in remote rural areas. CHPS zones shall be established (community based Health Planning and Services). It also aims at achieving financial access for the financially vulnerable; this is to be achieved through the NHIS and fee Exemption. These are discussed in detailed below.

4.2 Community participation in providing health services

Participation has become an essential ingredient of policy discourses both at the national and the local level in recent times. Regarding this, it's form, meaning and rationale has been changing. It is used in studies related to environmental resources, social works, children participation and citizen involvement. The thesis however chooses to identify itself with community participation. I intend to cover these areas of communities which include; the levels at which people participate, who initiate the process, control of participation and issues of power.

Community participation was first used by World Health Organization as a strategy to promoting health. It is often seen as the means through which community members can continuously   realize their full potentials through both individual and collective means.   It is recognized as a vital part of health programmes in developing countries (Bracht and Tsouros 1990, Rifkin 1991). In Ghana it is the medium through which the Ghana medium-term health strategy is to be achieved. However the value attached to community participation has been contentious, whilst some see it as a panacea to reducing poverty others think it is an illusion. I

think that when it is properly defined and implemented, it can promote development through community empowerment. Local people have begun to believe in themselves and feel that they know best what they want and how to do it. According to Bjårås et al. (1991), arguments for community participation has been posited by World Health Organization as: (1) the health service argument; which holds that beneficiaries under utilize health services because they played no role in providing such. (2) The economic argument; all communities have been naturally endowed with resources in various forms, and therefore should be harnessed towards providing health services. (3) The health promotion argument; it states that people should be at the center of addressing their own health issues and not medical interventions. (4) The social justice argument: participation in health decisions is the right and duty of all people particularly the poor and disadvantaged. This is clearly spelt out in article 4 of the Alma-Ata declaration as;

> "The people have the right and duty to participate individually and collectively in planning and in the implementation of their health care" (Alma-Ata Declaration 1978).

Bhuyan (2004) argued that failure of development efforts to improve lives of the majority of the people especially those in developing countries led to the redefinition of development process, thus community participation became the pivot around which development strategies revolve, so to make development people centered. Eckermann et al. (2005) states that;

> "Community participation is not just a component of primary health care but a life blood of the philosophy, and referred to is not just the involvement of or consensus with the community but active involvement of the ownership and control" (p. 158).

World Bank explained that community participation is being sought for because, local people based on experience and expertise can determine what works and why, can mobilize resources to support development and also become committed to such projects when involved (Rifkin 1991). Community participation is thus defined as a social process that allows people of a specific geographic location to be involved in identifying their needs (Rifkin 1986), Anderson and McFarlane 2008). The United Nation Economic and Social Council Report (UNESC 1956), defines community participation as the process by which the efforts of the people are united with those of the government authorities in order to improve the economic , social and cultural conditions of communities, with the view that such communities will be integrated thereby contributing fully to national progress. It is believed that bottom-up measures where ownership and decision-making and implementation power rest on members of the

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community, are being adopted. The United Nation Economic and Social Council Report has identified three dimensions of community participation: involvement of all those affected in decision making about what should be done and how it should be done; mass contribution to the development efforts, and sharing in the benefits of the programes. These dimensions have been expressed in similar ways as exemplified above by the World Bank Community participation involves information sharing, consultation, collaboration and empowerment.

4.2.1 Why should people participate in health care delivery?

There is a corpus of literature which argues that users should be involved in health care provisions. This is to encourage accountability of health services to users who are regarded tax payers, voters and consumers (Tritter and McCallum 2006). Drawing from countries' cases, The Netherlands is cited as an example that allows its users through legislation to influence decisions regarding treatment and service provision. In Denmark, patients and the public are involved through local democratic mechanisms, aside rights and complaint systems. Patient organizations also contribute to health debates and health service development (Tritter and McCallum 2006). It is argued that health services are funded by the taxpayer, and that there is the need for the justification of public spending (liberal ideology). The citizen is also a consumer and rational being whose consent must be sought. It is thus argued that users be involved so to serve as a mechanism for feedback on consumers views, needed for the proper functioning of the market. It must be noted that these theoretical underpins form the core of neoliberal approaches to health service provision.

4.2.2 Model of participation, Rifkin et al. (1988)

A number of models have been advanced to explain what participation is about. Among these are Arnstein 1969 model on citizen participation, which is often regarded as the earliest model of participation, Rifkin et al. (1988) model on participation, Roger Hart model (an application of the Arnstein model), Treseder model on children and adult initiated participation, and Burn et al. 1994 Ladder of citizen Empowerment.

Just as Rifkin (1991) stated, it is difficult to assess community participation as it is often equated to the number of people present at gatherings, but this does not necessarily means participation. Rifkin et al. in 1988 therefore came out with a diagram with five process indicators. It is often called a spidergram or pentagram where changes in the processes of

participation are described by plotting the situation along 5 continuums. Each is a critical factor in participation and all are joined in the middle to give a holistic view of the programme, these indicators include- a) needs assessment, b) leadership c) resource mobilization and d) management. By needs assessment, Arnstein meant the various ways by which communities' needs are being diagnosed, and the one who initiated the process, either as an external agent or the community itself. Leadership is examined in terms of the various health organizations in the community which represent the community, and work closely with the district assembly towards meeting local health needs. Resource mobilization is defined as those community contributions in terms of resources and information to providing health services. With management she meant the role the community plays in monitoring health activities of service providers, and also the degree to which community members are involved in the allocation of health resources. Organization represents the existent of local organizations that support health programmes. The pentagram has a scale for defining the various process indicators ranging from narrow where professional decide everything to wide where 'community' asks for programmes. A five-point scale is then used to rank these indicators. It must be noted that the diagram is used in studying programmes stretched over time. I however chose to use these indicators to determine the forms of local involvement in providing health services to ascertain the degree of each indicator as whether narrow or broad.

 These indicators shall constitute the parameters on which community participation in health care delivery in Kusawgu and Sankpala shall be assessed. The thesis does not intend to prioritize these indicators by attaching weight to each an every one of them, but interested in identifying the various ways by which community members partake in providing health services.
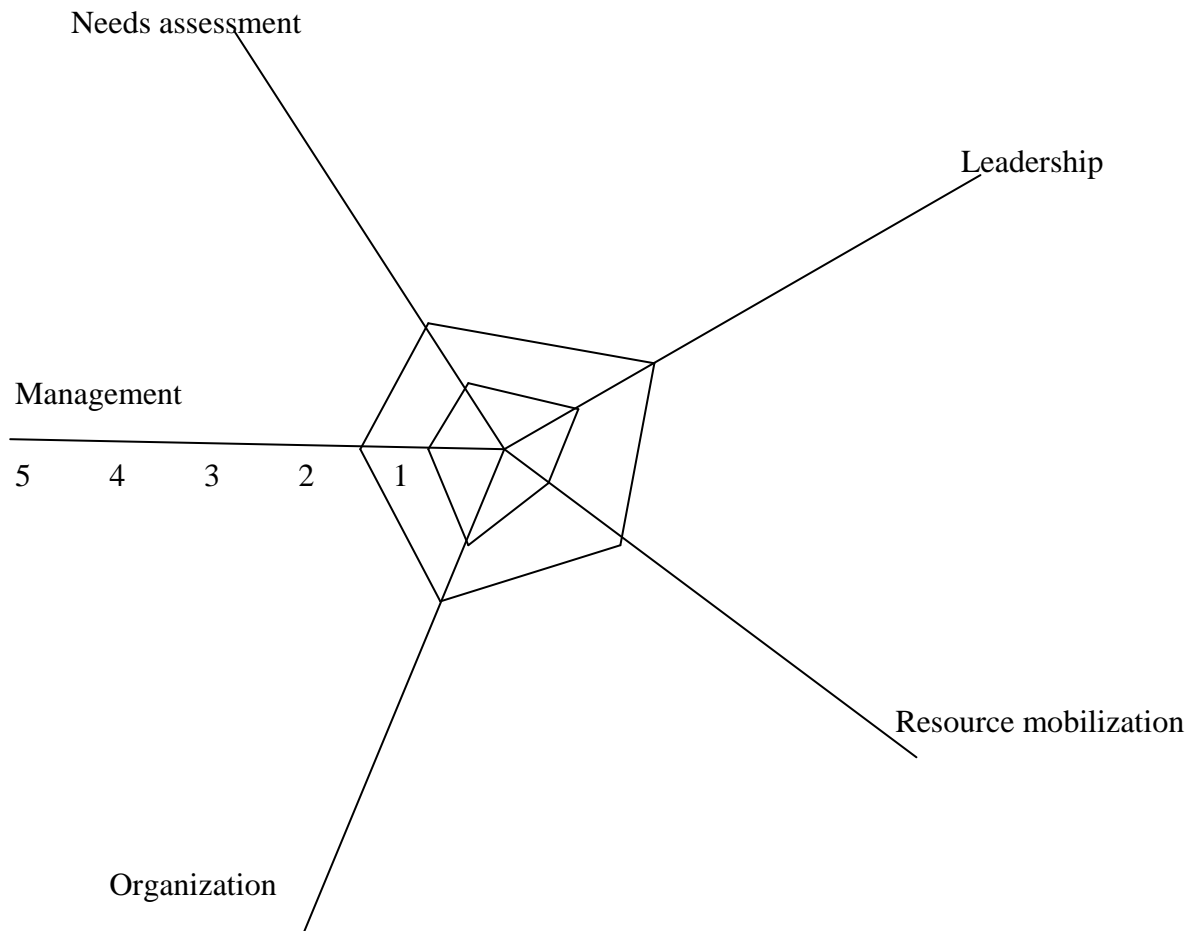
Figure 4. Participation viewed as a spidergram.

Source. Bjårås et al. 1991.

The spidergram above shows that there is some degree of participation already taking place within the given health system.

4.2.3 Ladder of participation, Arnstein (1969)

It is one of the pioneer models on participation. It is in a ladder form with 8 rungs. The essence of the ladder is to present the different levels of participation ranging from full participation to fake participation. The first two rungs are manipulation and Therapy which she described as levels of 'non-participation'. She added that these levels only allow stakeholders to 'educate' or 'cure' the participants. The next rungs, (3) informing and (4) consultation represent 'Tokenism' where participants are giving the opportunity to hear and a

have a voice. She added that though citizens are given the chance to make their opinions known, they lack the power to make their views heeded by the powerful. The next rung is (5) Placation, which is a higher level of tokenism, because it allows the have-not to advice but the powerful decides. The next rung is (6) partnership which allows power to be distributed between power holders and citizens. Here joint committees share planning and decision making responsibilities. (7) Delegated power and (8) Citizen Control are the highest levels and most desirable forms of participation. Citizens here exhibit greater power in both decision making and management.

The ladder of participation will be used to further identify whether the various forms of participation identified by the spidergram are forms of genuine participation or rather forms of non participation. The essence of this is to provide additional information on what is considered participation. It provides a critique to the spidergram.
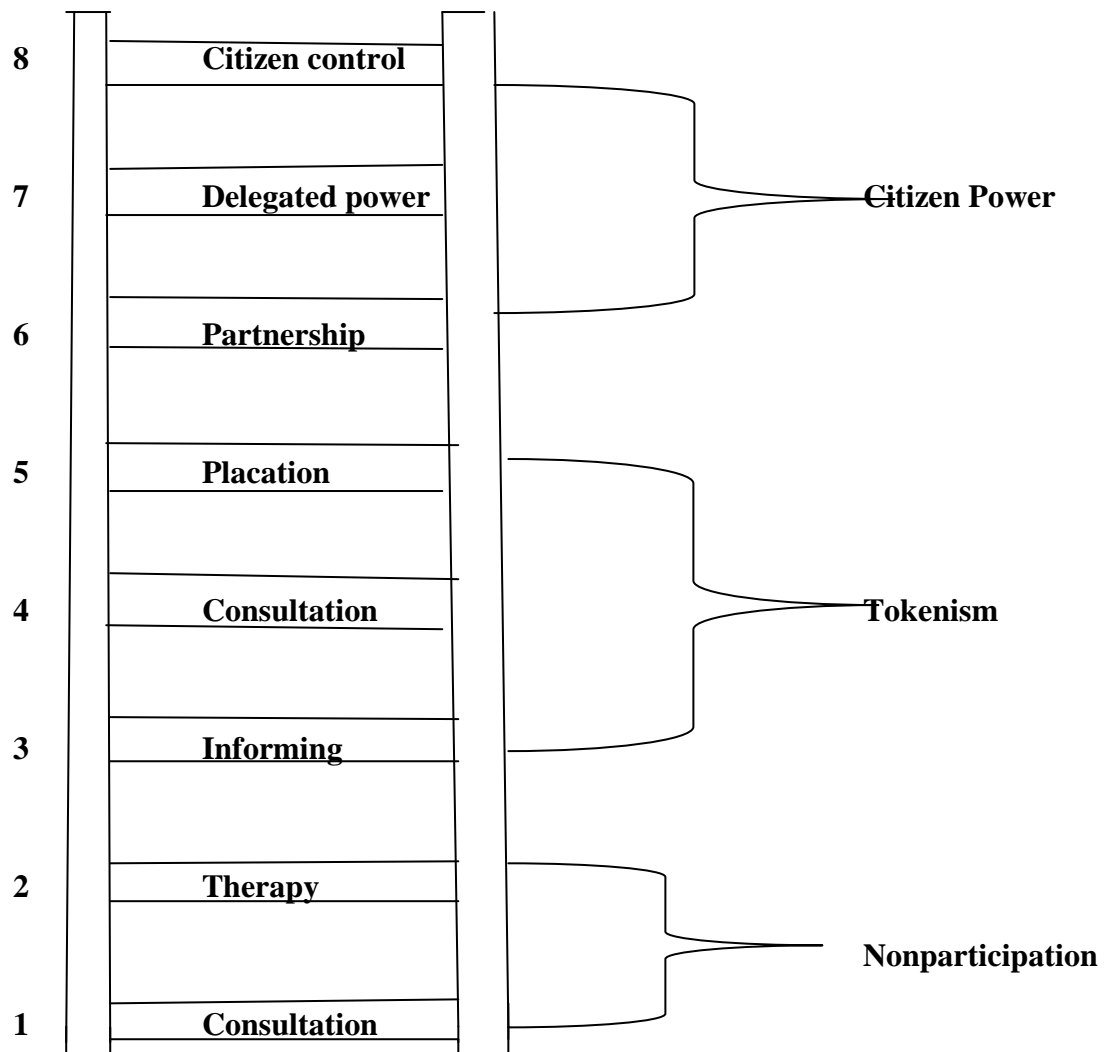
Figure 5. Ladder of Citizen Participation, Arnstein 1969.

Source. Arnstein in Flores 2005.

4.3 Access to health services.

Access is one of the themes of which the concept decentralization is evaluated against health care delivery in the thesis. It explores community members' views on what challenges they encounter in using given health care services. It further assesses performances of local health structures at the district level in mitigating the challenges that communities face in using these facilities.

What is access to health?

Access is a word which is often used without defined. It is difficult to define and finds itself in fields like health, and municipal and urban service delivery. It is widely used in discussions related to healthcare systems but generally accepted to be an ill-defined term (Penchansky and Thomas1981). Aday et al. (1980) see access as;

> "Those dimensions that describe the potential and actual entry of a given population to the health care delivery system" (p. 26).

 Penchasky and Thomas (1981) used taxonomy to define access which they argue provides a summary of the degree of fit between the patients and the health care systems. These they presented in five dimensions to include availability, accessibility, affordability, acceptability and accommodation. These dimensions shall be looked at in detail as they constitute the frame work for exploring local perceptions about access to health services. Availability describes the connection between the quantity and diversity of services provided and user's needs. Accessibility denotes both the physical location of services as well as patient mobility. Affordability refers to the ability of individuals to pay for the direct and indirect cost of health services; this includes medications and transport to the health facilities. Acceptability describes how providers' attitude and beliefs conform to users. Lastly, accommodation refers to the appropriateness of the provided service for clients. This includes hours of operation, wait time and office policies and protocol.

4.3.1 Why choose access to health service

Access to health services is one of the ways of identifying those barriers associated with health service utilization. As put in the words of Lewis (1977), access indirectly defines the

barriers needed to be overcome to obtain services such as health. Access determines the utilization rates of given health services (Obrist et al. 2007). Meade and Earickson (2000) explained that closeness to a doctor or facility is the major reason for the utilization of health services. The study areas happen to fall within the northern zone where only 15% of the rural communities live close to health facilities compared to 30% of their counterparts in the south (Danso 2006). This suggests that health facilities are inadequate in the north where the study areas are located. I therefore want to explore what the decentralized health structures have been able to do for the past one decade so to address the picture painted by Danso above. Aside availability, there are other factors that influence people's decisions to use health facilities, and one of this is cost. The dividing line between users and non users of health service is largely economic; those who use services are those who can afford them (Nyonator and Kutzin 1999). The country witnessed the introduction of neo liberal economic policies which made its health sector to adopt policy strategies like Cash and Cash, where people directly pay for health services. Asenso-Okyere et al. (1998) observed that the cost recovery strategy introduced in the health sector brought about a decline in the use of health facilities and increased self medications and other behaviors aimed at cost-saving. The Northern region where the study communities are located is declared one of the poorest regions. This therefore means that people here will have it difficult to pay for health services. I am again influenced by this inverse relationship between poverty and health service utilization and want to find out what the local health structures at the district level are doing to arrest the situation.

4.3.2 National policies aim at promoting access to health service

➢ Economic/Health insurance

It is realized that with the adoption of Structural Adjustment Programme by developing countries to leap out of economic crises, health sector financing took a cost-sharing formula as user fees were being charged with users of public facilities/services made to bear a greater cost. In the Ghanaian health sector, this was commonly referred to as the "Cash and Carry System", which meant that people pay out of pocket fee at point of service delivery and for drugs. This has been identified as a major barrier to health care particularly for the poor. A

study by Haddad and Fournier (2006) on health care reforms in Burkina Faso showed that although health facilities, staff and generic drugs had increased, access to these services declined as a result of people's inability to pay.

To absorb some of the cost associated with health care, the Ghanaian government embarked upon programmes for a National Health Insurance Scheme to replace the cash and carry system (Agyepong and Adjei 2008). According to Bour (2004), health insurance is the most important factor that influences health care utilization in many developing countries (Bour 2004). Nonetheless Malcom Gladwell (The Moral Hazard Myth) and other economists may disagree with Bour for reasons that have to do with Moral Hazard (a term economists often use to describe the change in behavior of people insured). I think there are reported cases in the country concerning how people began to abuse the system (reporting at the hospital when there is no serious illness), an indication of the moral hazard which Gladwell and others are talking about. He however suggested that people should consume health care the way they consume other consumer goods. I think that health insurance schemes in developing countries has comes as a relief particularly to the poor who find it difficult to pay even though the system itself faces some challenges. It will also make it possible for people to respond quickly to seeking treatment which would have otherwise been delayed hence aggravate health situation for reasons that have to do with cash payment. Moreover families can afford to channel their limited assets to other areas. The Central Gonja District can boast of a Mutual Health Insurance Scheme. It has chalked successes within one year (after it started operating), as 10,245 people have registered with the scheme out of a total population of 87,654 people in the district (The Statesman 18/04-08).

➢ The community-based Health Planning and Service (CHPS) initiative

As discussed above already, it is one of the lowest levels of health care provision. Based on a module carried out by the Navrongo Health Research Center, some districts have adopted it. With the yielding of positive results, government has adopted this initiative and making it a national policy aiming at bringing health services much more closely to the people.

> Traditional Birth Attendants (TBAs) and Traditional Healers (THs)

These are group of people who are mostly residents of the communities. Recognition have been given to this group of people following Alma-Ata declaration of 1978 which recommended that all resources to be put to use with TBAs and THs forming an integral part of the process, though in the Ghana the former is being recognized more by the government than the latter . This, it argued that health problems are numerous and with the limited resources available, meeting health needs may be difficult unless exhausting all available opportunities. A recent publication blames the government for the health sector problems of Ghana because it failed to incorporate indigenous medicine into the general health system which is easily accessible to many Ghanaians .

Traditional birth attendants occupy a high position regarding child deliveries in developing countries. It is believed that 2/3 of infants born in the world are delivered by TBAs (WHO 1979, Edwards et al. 1987). The role of TBAs was again reinforced by the Safe Motherhood Conference held in Nairobi in 1985. The training of TBAs in Ghana took a national dimension in 1989 with sponsorship from the United Nations International Children Emergency Fund, the United State Agency for International Development and the United Nations Population Fund (Smith et al. 2000). TBAs and THs are commonly found within the local environment, they are easily accessed geographically and economically as many Ghanaians believe that their services are cheaper. More so their practices are inline with the belief systems of the people making it easy to adapt. Traditional healers often rely on herbs for treating illness, and may involve the performance of some rituals. According to Ventevogel (1997) traditional medicines is more acceptable and widely recognized in Ghana but attracts a lukewarm attitude in neighboring francophone countries. He further noted that issues of traditional medicine in Ghana are controversial unlike TBAs who have become part of health policies. Traditional healers have received different reception from the various governments with no training for them at all even though they are willing to be trained and made part of the country's health system. However their works receive support from scholars like Oku Ampofo (director of the Center for Scientific Research into Plant Medicine, Mampong-Akwapim in Ghana) and Patrick A. Twumasi (a medical sociologist).

➢ Exemptions

One of the policies which aim at meeting the health needs of the poor and the vulnerable is the fee exemption policy introduced in the country by the various governments, following the financial challenges which confront some category of people in the country. It is presented above that some people particularly the rural folk cite cost as one of the reasons for the poor utilization of health facilities in the country. With the introduction of the cash and carry system where patients pay directly for cost of drugs, consultations, out patient cards and initial registration admissions gloves, gauze syringes and needles at health units, many particularly the vulnerable found it difficult to meet their health needs, the government thus introduced the exemption policy along aside the cash and carry system where some services are provided to all people without charge. The 1992 law reinforces the need for the poor and the vulnerable to be exempted. To illustrate this, the Ministry of health budget allocations comes with a sub-line called Refund of Medical Expenses, intending to reimburse health institutions for the care of the exempt patients. It should be mentioned that the criteria for the exempting people under this law is not defined and this allows health workers to use their discretion to decide who is poor and needy. This may pose the problems of error of inclusion or error of exclusion. It is also reported that the system was abused by health workers as they turned to give this privilege to their favorites. Another dimension of exemption policy is the delivery care introduced in 2003 the Ministry of Health. As noted earlier, the high level of unsupervised deliveries in rural Ghana is attributed to cost; the policy thus aims at improving financial and geographic access to delivery care services. Areas of deliveries include normal deliveries assisted deliveries including Caesarean section and the handling of medical and surgical complications arising out of deliveries. Deliveries at public, private and faith-based health facilities are covered (Ghana Medical Journal 2007).

Summary

This chapter looked at the existing literature on political decentralization in Ghana and decentralization within the health sector. It is established that political decentralization in the country began fully in 1988 and this received legal backing, as it is enshrined in the constitution of the country. The chapter also showed that decentralization within the health sector came in a separate context and not part of the public (political) system as may be the case of some countries. Health service organization at the local level takes the form of district

hospitals, health centers at the sub districts and CHPS compounds at the community or village level. Further more models of participation such as the Arnstein ladder of participation and the Rifkin et al.(1988) spidergram have been used to illustrate the degree or levels of participation that may occur in health service delivery.

5 Characteristics of the district health system

I am at looking the composition of the district and sub district health administration, the roles that these structures play. I will also examine those functions that are supposed to be decentralized and the actual functions decentralized. This information is to equip me with ideas on the gap (challenges) between the supposed and actual decentralized functions and how these are affecting the proper function of the local health unit.

As stimulated by law, the District Health Unit (DHU) is located at the district . It is the body responsible for the management and supervision of the sub districts (health centers and the CHPS compounds). The district Health Management Team (DHMTs) together with the public health unit provide public health services to the people of the district. Generally curative services in Ghana are provided by the district hospital, however, as indicated in chapter two, the district has no hospital, what exist are health posts and CHPS compounds in the various sub districts. At the sub district level, both curative and preventive services are provided by the health centers with outreach health services being provided by the Community based Health Planning and Services. Since the thesis is interested in activities of the DHMTs, it will review its composition as pertained in the central Gonja District.

According to the district health director, the team is made up of the following personnel; the district health director, the district public health nurse, district disease control officer, district nutrition officer, an administrator, pharmacist, the district store keeper, a psychiatry nurse and the health information officer. Some of these personnel are also found at the sub districts. The structure of the DHU places the director at the top who works with the district health committee. Below this category of people are the various sub units and personnel who provide services such as public health and clinical as indicated below.

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                    ┌─────────────────────────────────────────┐
                    │   Office of the District Director of     │
                    │                Health                    │
                    └─────────────────────────────────────────┘
                                      │
      ┌───────────────────────────┐   │
      │  District Health Committee│───┤
      └───────────────────────────┘   │
                                      │
   ┌──────────────┐      ┌────────────┴───┐      ┌──────────────┐
   │ Public Health│      │    Clinical    │      │ Sub-districts│
   │ Department   │      │                │      │              │
   └──────────────┘      └────────────────┘      └──────────────┘
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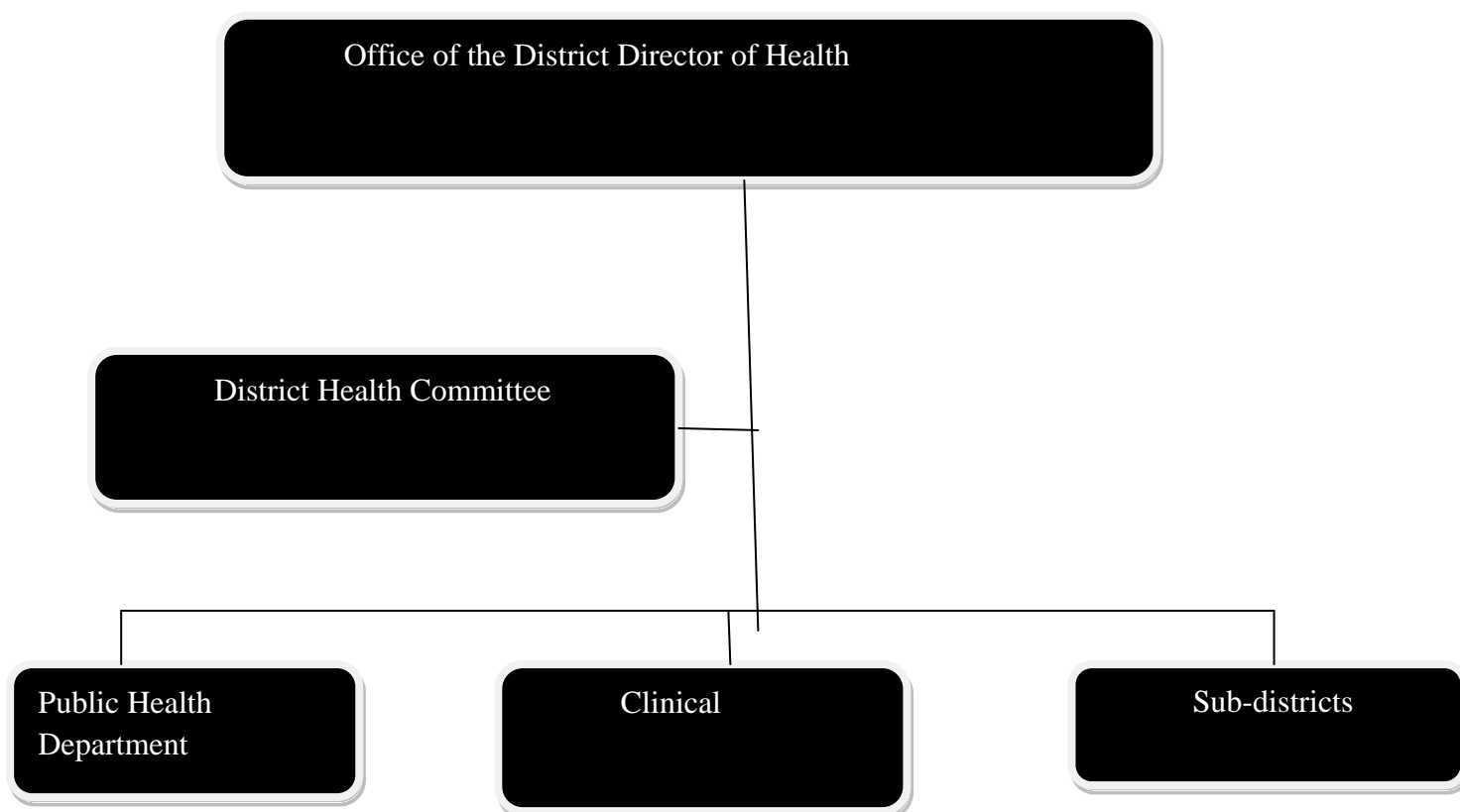
Figure 6. Ghana Health Service at the district level.

Source. Ghana Health Service (www.ghanahealthservice.org).

5.1 Functions

As stated by Mills et al. (1990), the type of a given decentralized system determines the extent to which functions are being decentralized. It is mentioned earlier that decentralization in the health sector did not take place within the context of the local government system but a separate process of civil service reform initiated in the late 1980s and early 1990s. The health sector of Ghana has features of de-concentration and delegation of administrative functions. Health sector decentralization is enshrined in the 1992 constitution where the Ghana Health Service created as an autonomous body is charged with service delivery whiles fiscal decentralization remains a function of the ministry of health. This process is still not complete and has received some criticisms from scholars (Bossert et al. 2000). This not withstanding;

the decentralized health structures at the district level perform the following functions of presented to be as follows;

1. The district health unit perform some financial functions. This according to Bossert et al. (2000), is done through the Budget Management Centers (BMCs) located at regional and district levels. These centers have the local responsibility of planning, managing funds and implementing an agreed programme of work within a given budget (World Bank 2003). The BMCs are given a budget ceiling by the MOH within which to operate. They also receive supervision by MOH officials. This implies that the BMCs are not actually decentralized structures but de-concentrated bodies of the MOH. Expenditure allocation is also an element of finance carried out by the DHA together with other local bodies. Based on facility reports, budgets are drawn within a given national budget ceiling to cater for local health needs. To boost local revenue, user fees serves as source of income to support the running of the district health facilities of which the DHA have a moderate control over.

Drawing from perceptions of district and sub district personnel, it is shown that Internally Generated Funds through the charges for services at the various health centers still remains a major source of income for supporting health care delivery. As established in the discussion on challenges of accessing health services in chapter six, some times health personnel demand for cash instead of the NHIS card for using health facilities as means of raising revenue particularly during the period when there is a delay in NHIS funds and other funds for the running of these services.

2. Another function decentralized to the district level is service organization. This has to do with hospital autonomy, which in Ghana's situation is centrally controlled and managed by health boards. Insurance functions are also performed at the district level with the creation of District Mutual Health Scheme, largely determined by the National Authority. Payment mechanisms at the various facilities are decided by the National Health Insurance Authority. Contract with private agencies is seen with the activities of the Christian Health Association of Ghana (CHAG). According to Bossert et al. (2000), apart from the contracting with private agencies the rest of the elements under service organization are narrowly influenced by the District health authorities.

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The absence of a district hospital at central Gonja district means that such functions of boards of a district hospital are non existent, but its absence has implications for the overall achievements of health in the district as will be examined in the ensuing chapters. The district health director mentioned that there are no CHAG facilities in the district. There are no private health facilities too. Therefore health service in the district is limited to activities of the central government, TBAS, and traditional healers. The Central Gonja District operates a Mutual Health Insurance Scheme (born of out the NHIS), which charges a premium of about 5 US dollars. Only ¼ of the total population of the district have registered as indicated by the scheme manger, the reasons for this low turnout will be discussed under access to health service in the subsequent chapters.

3. Human resource organization is also a function decentralized. It is concerned about salaries of health workers which are determined by the Ghana health service (GHS). It also looks at contracts with non permanent staff which is little or non existent in the GHS. With regards to civil service, the central GHS and MOH determine the hire and fire policies (Bossert et al. 2000).

Issues with regards to human resource at the district level are minimally controlled by the district health unit. Health officials however have the authority to recruit community health volunteers to assist health personnel at the sub district level. The data provided by the thesis however cannot justify how these volunteers are being motivated. The district health personnel also have the mandate to establish local health groups in the various communities of the district. Indirectly the District Assembly plays a role in human resources organization. This is done through the creation of scholarship package to assist students of the district and those outside it who are interested in undertaking courses related to health, and willing to serve in the district. To address the accommodation needs of the health personnel, the assembly has also constructed a number of nurses' quarters in some of the sub district to solve accommodation problems of health personnel.

4. Access rule is another function of the decentralized system. However; the District Health Unit has no authority over the definition of health service packages and targeting groups. It is done by the central MOH/GHS, which Bossert et al. (2000) saw to be narrow in terms of choice given to district health authorities.

With this function largely controlled by the central authority, problems peculiar with certain local districts cannot be met. Policies made like this are often general and implemented nationally, however the characteristics of the population and their resource endowment may vary from district to district. The weaknesses posed by this centrally controlled policy tendency is seen in the next chapter. This decision I think should have been done jointly with district health authorities, or better still, be made solely by the district health personnel. The mandate should be given to district level personnel to define their local parameters within which a person can be qualified as eligible for such a package.

> 5. Government rules is another function assigned to distinct health units. It takes into consideration local government that is the position of the District Assembly in health decisions of the district. Local government is seen to be largely excluded in health sector governance which has been criticized by administrators of District Assembly, for being contrary to Law 207. There are no district autonomous facility boards. The National Governing Council and the Director General of GHS are all presidential appointees. Community participation, a vital element of the general decentralization process is extremely weak. This is because the creation of community health committees at the grassroots level failed to put in place mechanisms that will allow these local institutions to be linked to health policy. Bossert et al. (2000) see these elements of governance to be narrow leaving district and sub district health structures with limited choices on decision making.

The nature of governance with regards to health service provision in the district will be discussed in detail under community participation in the ensuing chapters.

Functions supposed to be decentralized and the reality

As stated in this specific objective, I tried to identify those functions that according to policy documents are suppose to be decentralized and whether such functions have actually been decentralized.

The first anomaly identified with the process is about the administrative autonomy of the GHS. As noted earlier, the GHS has been created as a body supposed to have some administrative autonomy and flexibility than civil service department in service delivery, contracting, and cooperation with the private sector, how ever the process is yet to materialize

since there is still a greater influence and presence of the MOH at both the regional and district levels. In terms of human resource, the GHS has almost gained controlled from the MOH.

Another unique feature identified with the health sector decentralization is that the whole process is characterized by both centralization and decentralized. The idea of decentralization is about local governance and popular participation in every aspect of development. The nature of the Ghana Health Service has been criticized, as key positions or personnel are appointed by the president. These include the membership of the National Governing Council and, the Director General of the GHS (who also in turn appoint the various directors at the regional and district levels). These persons should have been elected. There is also low level of influence by the various District Assemblies over decision of health service delivery in the various districts. As stipulated in Law 207, the district level health sector is suppose to be subordinated to the district administration, however, this is non existent as the 1996 health sector reform refused to capture such provision. The role assigned to the DA is that of advisory which is considered minimal (Bossert et al. 2000). This reform is therefore at variance with the rest of the public sector, both legally and practically. Based on my observation, it is uncommon seeing the District Assembly and the District Health Unit share the same building, even their structures are often located far from each other. It is rather Water and Sanitation which is made part of the District Assembly Unit. When I tried to contact my informants at the district level, I thought I could find the personnel of the District Assembly at the same building with the District Health Administration. Surprisingly, this was not the case as the health unit is housed in a different building and far from the District Assembly. Their responsibilities and functions also seem parallel; they only coordinate in some areas. The district health unit seems more answerable to the Regional Health Unit than the District Assembly.

Funding, and financial management and administration is another issue of concern. Even though Budget Management Centers (BMC) have been created at both the national and local levels, since the MOH has not fully handed over service functions to the GHS, these BMC are still under the control of the MOH and those at the district level are being supervised by the MOH at the regional level and the process continuous to the national level. Quite apart from that, these BMCs operate without any flexibility as far as financial management is concerned. They are given a budget ceiling to work within and as at 1998, there had not yet been any

BMCs at the sub district level. The central government does not also intend to decentralize funding to the various health centers whose budgets will be managed at the sub district level. (Bossert et al. 2000). It means that funding (as a function) which is the engine of any service delivery system has been withheld deliberately at the central level with no efforts at all being put in place to shift part of this function to the district level. This is what makes the whole process of decentralization in Ghana and in the health sector ambiguous. The centralization of function of funding at the national level impacts greatly on the effective operations of the health centers at the district levels as funds turn to delay. This compels health workers to resort to demanding for cash for treatment in order to raise revenue to keep these centers functioning, which causes inconveniences to users and a disruption in use of the NHIS.

Another function that seems to be less decentralized is decision on who should make up a target group. Though it is a function supposed to be decentralized, it is completely centralized. No decentralized health unit has the mandate to define who should benefit from a given service package, and if the idea of decentralization is to bring service delivery much more closer to the local people, why then should identification of local beneficiary groups be a central decision? Just as I pointed out in chapter six, if target rules where made effective decentralized functions, the poor widow who shed tears for not being able to meet her children hospital bills would have had her needs captured (considered vulnerable), but because decisions makers regarding targets are far removed from the grassroots, the problem of omission may occur in defining such targets.

5.2 Challenges

With the type of functions and degree of choices made available to the district health unit, it would be prudent to assess how these arrangements are affecting general health delivery in the two communities studied. Some of these challenges may be local in nature but discussing them will contribute to understanding the reality on the ground. The relevance of this information is to guide in determining the level of success achieved by the decentralized structures.

Weak local management is one of the challenges facing the district health unit. This the Director Health Director attributed to lack of skilled labor. The district is among the last districts to be created in the region with low infrastructure development. The district is also

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noted for lacking a lot of amenities and services which deter many personnel from accepting postings to this area despite it strategic location. It is therefore common to see most of the government officials working the district but residing in Tamale, the nearest metropolis. Poor local management therefore affects the use of local resources and the meeting of health targets, and the over all health outcomes of the district.

Secondly there is the problem of inadequate and erratic flow of funds. This has been noted by both the District Director of Health and the manager of the Mutual Insurance Scheme. It is realized from above that fiscal policies on health are borne by the MOH located at Accra, with major decisions regarding funding being extremely centralized. However with the numerous tasks before the central government coupled with other factors that need to be considered, there is sometimes the delay in the disbursement of funds to the local health structures and this has the tendency of affecting the activities of health care providers. This challenge will be examined further under access to health services.

Further more, planning and implementation problems characterized the decentralized health system at the district level. It has been noted by Bossert et al. (2000) that separation of functions between the GHS and the MOH is still being implemented. Moreover, with the hierarchical nature of the decentralized system where certain functions, responsibilities and resources (particularly financial) are still determined at the top and implemented at the local level, it shows that independent planning cannot be done at the local level, and the bureaucracy may also delay the plans implementation as identified.

Aside these, the director noted that there is poor referral system of patients in the district. This is attributed to both the attitudes of the local people and traditional healers on one hand and the limited number of transport facilities on the other hand. Health personnel at the sub districts have complained of no referrals or delay in referrals of patients by healers to the various facilities with the situation appalling despite frantic efforts to get these educated on the importance of referrals. The modern facilities also lack transport facilities where ambulances for transporting emergency cases are lacking. Places for these referrals are even a problem due to the absence of a district hospital.

Poor health seeking behavior is also identified as one of the challenges facing health care delivery. This has to do with local people decision on where and to seek treatment when ill. As noted under access to health services, local people have various treatment points. The

modern health centers are mostly their last resort although the people admitted visiting these places. For reasons that have to do with cost, values and attitude, distance and availability, the people sometimes decide not to seek treatment at these facilities on time, as they often wait until a condition is serious before seeking care which is often too late.

Inadequate office and staff accommodation is one the challenges facing the district health unit. Government in general and the district assembly are doing less to address this problem. During the research in the district, I visited the district health unit. I was surprised to see the same building being used as a clinic and a district health administration at the same time. At the clinic, some patients were seen waiting under trees for their turn whiles others hang on anything in the sun. My visit to the Sankpala CHPS compound revealed that the staff there does not have accommodation. It therefore means that they either rent in the community or stay at nearby places.

Staffing is a challenge to the district. Though the central government has decentralized certain health functions and responsibilities to the district health unit, efforts have not been made to make available personnel to take up these responsibilities. It is a fact that the retention of health workers in rural areas in Ghana is a problem, as there is a general brain drain within the sector. However, if the decision on human resource were decentralized also to the local level, it would have helped instead of allowing the central GHS to decide. The District Health Director lamented that the district has no information officer as at the time of the field work, and this is hampering the effective functioning of the district health unit. The issue of staff inadequacy in the district will be discussed under access to health service in chapter six.

Not withstanding the benefits of decentralization, there are some local conditions which may not allow the process to be effective, with such instances demanding a centralized system of government. For instance, local factors like the chieftaincy disputes in Kusawgu and Buipe thwarts efforts of decentralized units at promote health service delivery. These disputes are not in small way affecting every aspect of the district life. Foe instance, during the research, I was scared of entering the Kusawgu community; I nearly dropped that community as one of the study areas. The disputes affect local resource mobilization as discussed in chapter six. Health education and campaigns within these communities were also disrupted. For instance a report from the district health unit showed that Guinea worm activities such as the distributions of water filters, abating of all suspected ponds/dams, health education, volunteer review meetings and house hold filter inspection/ demonstration on filter usage in these

communities were greatly affected . This is because, during such times, community gathering becomes difficult.

5.3 General achievements in health at the district

Despite the structural and general problems that bedeviled the decentralized system, the Central Gonja district has chalked some success in the general health outcome of the people.

Informants from both communities admitted that the decentralized system had created the opportunity for the local people to live in close proximity with health services and personnel, and has contributed largely to the control of epidemics particularly the guinea worm disease. Even though Kusawgu has no good source of drinking water, the presence of the health post and the personnel has contributed in terms of resources such as water filters and information on water hygiene which led to the eradication of the disease in the community.

There is also the improvement in health outcomes. With the creations of health groups such as the mother-to-mother support groups, mortality of mothers and children have been brought under control as mentioned by the health director. A report from the district Health Unit showed that in the year 2007, there were no maternal deaths, and in 2008, there were only few deaths. This success chalked is attributed to the creation of awareness on maternal mortality through durbars and the provision of anti- snake venom. It is realized that antenatal services were absent for pregnant women with no health personnel to assist in deliveries were non available. Delivery complications and maternal deaths were common, but the introduction of decentralization coupled with the free deliveries policies saw the deployment of health personnel to rural areas, where pregnant women and nursing mother can afford to enjoy free and accessible health services. This has contributed to saving the lives of women and children.

Furthermore the attitude and knowledge of community members with regards to general health had improved. Health education exercises and campaigns coupled carried out by health workers coupled with the existence of the community health groups had led to an increase on the general awareness about curative and preventive measures of some diseases. During my interaction with the information, I noticed that almost every person had a fair knowledge of HIV/AIDs as the people admitted knowing the symptoms and ways of preventing oneself from contracting the disease. The level of awareness guide people to take precautionary

measures towards certain illness. It also influences the people health seeking behavior should any of them fall a victim of some of the diseases.

Summary

It is realized in this chapter that some functions of health care delivery have been decentralized. These include service organization where district hospitals are suppose to be autonomous with health boards running them, which is not the case in Ghana. Rules regarding access to health service are decentralized but beneficiaries of such a package are determined by the MOH. As stipulated, some functions are yet (to be) or not fully decentralized, as BMCs are still supervised by MOH at the regional level and those at the regional level being supervised by the MOH at the national level. The lack of clear definition of decentralized functions coupled with failure of MOH to decentralize some functions created problems in areas of local management of health centers, funds, health personnel deployment and retention and some local conditions such as chieftaincy disputes all hamper the smooth operations of the decentralized system. The chapter has identified that despite these challenges, some successes have been chalked with regards to health outcomes in the district as infant and maternal mortality is declining, guinea worm disease also under control now with some improvement in the health seeking behavior of the people of community members.

6 Impacts of decentralization on health

6.1 Local people perceptions about participation: Community members versus health workers

This part looks at the nature of participation that users are experiencing in the provision of health services in the study communities. This stems from that fact health provision in recent times is greatly influenced by neoliberal market policies advocating for the decentralization of power and the call for grassroots participation. This, it is argued will make beneficiaries of target projects contribute (resource constraint theory) to providing these services thereby making beneficiaries identify with such projects. This theoretical proposition is attributed partly to the Bamako Initiative 1987, with its foundation laid by the Alma Ata declaration. Some countries in Africa that have chalked successful decentralization policies in Africa particularly with regards to the transfer of power to the local populace are Senegal and Botswana.

Ghana is noted to have decentralized its public sector in the 1980s, and its health sector decentralized largely in the 1990s. It will therefore be prudent to assess how the process has influenced community participation in health service provision. It is widely accepted that community participation has some benefits; however efforts to define and measure it still remain debatable, with little efforts being made to systematically evaluate the process (Willis and Khan 2009). This is because the process is dynamic and new things about participation keep emerging. Not with standing this, I choose to discuss the thesis using Rifkin et al. 1988 pentagram model to identify the degree of participation. The pentagram model describes the changes in participation from one period to another in implementing a health programme as in the literature; however the thesis is an ad hoc study which means that not much of the model will be used. It will be applied in identifying some forms of local participation in health provision. The thesis is not of interest (the pentagram) to neither attach values to the process indicators nor rank them. The results from the pentagram will then be presented on Arnstein

Ladder of Citizen Participation. It must be noted that some of the definition of levels or dimensions posed by these models may over lap, but one will be used at a time.

6.1.1 Degree of community participation in health services

The discussions make uses of five process indicators of the pentagram model. These are; resource mobilization needs assessment, leadership, organization and management.

> Needs assessment

Needs assessment provides a definition of a particular community's profile. It also involves the identification of that community's health needs. It is done through the creation of a platform which allows local people to voice out what they desire or demand of providers of a given service. It includes the identification of people's constraints, potentials, challenges and opportunities. It is often done by organizations that control most of the health care resources for a particular population. Needs assessment can be initiated locally or internally in communities where members seek self and independent development. Here, local people meet to decide on what they want, prioritize these needs and seek for support to implement them, without the process being necessarily initiated by project professionals.

Needs assessment is an essential ingredient of community participation as posited by Rifkin et al. 1988 because of the following; it creates the opportunity to address the unique needs of people. This supports the fact that people's needs are different and health service providers should not attempt to conclude that "what is good for the goose is good for the gander". Need assessment thus have the potential of making available the information needs of a particular group of people regarding health services. When done properly, cost is saved and performance enhanced, because an opportunity is created to define health objectives and the needed resources, and matching these together.

Health projects when carried out based on needs assessment instill sense of ownership in people, and accepted by target beneficiaries. This is because beneficiaries will not refuse to patronize such projects because such projects are not reflective of their felt needs. It is therefore not surprising that community participation has been advocated for, so to address the failures (attributed partly to lack of participation by target beneficiaries) of plans and projects in the past that characterized the provision of health services. Need assessment also

provides the opportunity to decide rationally on how to use resources to improve performance, and to also direct resources to those who have unmet needs or underserved.

Drawing from the views of health providers both at the district and community/facility levels, it was realized that the health needs of the two communities is initiated by health officials particularly those at the district and sub district levels. It is however a joint process where members of these communities are sometimes involved in discussions regarding their health needs. There are also instances where the traditional leaders and their elders in council represent the entire community in dialogue with health workers. The Assembly men of these two communities also represent their members in discussion of this sort. The unit committees in the two communities meet to deliberate on what is ought to be done regarding health service delivery, and through the Assembly men, their intentions are channeled to the health authorities concerned.

The various health groups in the communities sometimes also act on behalf of their community members in issues related to needs assessments. Aside DHMTS and sub DHMTs initiating needs assessment, the process is sometimes taken up by personnel of NGOs (in collaboration with the DHU). Specific examples of platforms used in carrying out needs assessment include durbars, fora and other social gatherings. Here local people are asked to forward their demands, and people come in turns to express what they want. At the end of the day their demands are harmonized and prioritized.

Another medium that equips health workers with community's needs is facility reports from the community's health facilities. These reports are reviewed periodically to get information about community's unmet needs. The weakness of this approach is however that community members are not involved directly to rank their needs and what may be decided by the health authorities may not necessarily be the needs of the people as a whole at that particular moment.

Community based surveillance workers also serve as a channel through which community's needs are made known to personnel at the various health centers. These surveillance workers interact with health personnel frequently, and they are also resident of the communities so it is easy for the local people to easily discuss their needs with them, who also relay them before health personnel. The district director of health added that rumors serves as another method through which community needs are made known to them. I however think that this method is

informal and there is no means of identifying the person(s) who made such demands, so this method may be misleading. There is also, no guarantee that such needs will be given attention as those that are even made formally are sometimes ignored by health service providers.

Regarding community members' views about the nature of health needs assessment in the communities (so to confirm or refute the presentation made by health workers), an informant from Kusawgu explains what she knows about the process as stated below;

> I am not aware of any forum that has been created by the health unit to promote the exchange of information between the community and the health professionals, and that if any exist then it is the Assembly Man of the Kusawgu Zonal Council who might have represented us at the district level.

An informant also at Kusawgu added,

> I am not aware of any forum or durbar being organized by the health unit. However, personnel at the health post sometimes meet some group of women and teach them on new practices of promoting good health, and those women in turn teach the rest of the women in the community on these new practices.

During the research period at Sankpala I met the district health workers on two occasions. At the CHPS compound, I was to interview the health personnel there, but when I got there I had to wait for more than 2hours. This was because there was a health discussion ongoing among the personnel of the compound, health workers at the district level, elders of the community, women and other opinion leaders of the community. Even though I did not know of the subject matter that was being discussed, I think that opportunities have been created to promote the exchange of information between health workers and community members, but the essence of the meetings might not always be well understood by some community members who might have happened to be my informants. It could also be that such informants at those moments were not qualified to be part of the discussion (the methods adopted for needs assessment) that is why some members of the community lack information about the process.

I saw the Assemblyman of Sankpala on another day with the health personnel at the district level in the community undertaking health exercise. I am however not saying that their presence was enough to constitute participation but their mere presence indicates to some extent that health workers recognize the importance of the local people. I think that needs

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assessment has been going on in these communities just that the community members are not well informed about the nature and essence of the exercise, which I think is a lapse on the part of the health workers.

Based on the above information about needs assessment from the perspectives of health service providers and community members, I see the level of participation to be low drawing from the pentagram model. This is because community members see themselves to be narrowly involved with health workers having a greater stake in community decisions. If health workers say that durbars and fora have been used as platforms for needs assessment, and some of the informants disagree with this then I think health workers are not revealing the reality on the ground because such gatherings always involve the entire community and there is no way that some members of the community will not be made aware. These communities have a very effective way of disseminating information through the (village) crier. I think probably that other methods have been used as some of the informants expressed and not durbars and fora (probably these were used for other health projects and not) for needs assessments. Further more, a health worker at one of the centers made a remark on why health workers feel reluctant to involve community members in some health exercise.

> Most of the local people are illiterate and do not easily grasp the content of health issues under discussion, so it is often good not to involve them since they can delay discussions.

So if this is a general opinion held and observed by most of the health workers, then I think the local people are right to feel that they are not participating enough. The truth about the real situation on the ground cannot however be ascertained by the thesis as I said it is an ad hoc exercise that would not allow me track the degree of participation, and with participation being dynamic and fluid time is required to actually measure it. What I observed and was told at that time is what is presented.

However there are some challenging issues that may affect need assessment within these communities. This information provides some explanation to the low level of participation in needs assessment. First is chieftaincy disputes characterizing Kusawgu. It must be borne in mind that the two communities are neighbors and most importantly the Sankpalawura (divisional chief) pays allegiance to the Kusawguwura (subchief) and what happens in one affects the other. There is an outstanding chieftaincy dispute in Kusawgu among the various gates to the throne. The situation affects the gathering of people for such exercise, and during

such times, outsiders (health officials) may be scared to move in to such communities for fear of being attacked. If this period coincides with the time when a particular health project is to be initiated in the community, it means that needs assessment can not be conducted.

The importance that community people also attach to health issues is another factor that may influence the process of needs assessment. This is manifested in their attitudes and behavior towards health meetings. Health personnel complained of the low turnouts of community members during meetings (even though number of people in attendance does not necessarily lead to participation in the process). Attendance has a motivating factor for health personnel and sense of commitment on the part of community members. Where attendance is poor, it creates the chance for some few people present to decide for the rest of the community. Their views may not be a reflection of what the entire community so desires. Moreover poor attendance to meetings gives an impression that local people are not interested in their own health issues, therefore health personnel can also ignore need assessment and decide at their level what they think is good for such communities which in the long run may not be desirable. When I was doing my field work in Kusawgu as part of my first degree, attempts were made to organize community forum to discuss the development needs of the community. Announcements were made through the various media, but the attendance was very poor. Some community members' turn out for meetings where they expect an immediate reward. This attitude of some members of the communities affects health discussions

Also the flow of information between health workers and community members may hamper the process. When health personnel fail to get the entire community informed of such exercise, turn out may be low (that is those willing to attend regardless of whether there is a reward or not). The district health director admitted that there is no information officer for the district, and this has the tendency of affecting information flow between health personnel and communities. It is therefore not surprising that community members accused health personnel of not making available enough information to them. I will say that needs assessment exist in the communities but the activity is weak (narrow).

➢ Resource mobilization

The shortage of resources continues to be a major setback for developing countries particularly those in Africa. The economic crises that have besieged the world, with the reduction in international assistance to countries have triggered the need for local resource mobilization. Resource mobilization when successfully carried out has the potentials of meeting current needs and deficiencies as well as maintain pace with demands for health development.

An example of resources include; space, funding, influence, expertise, supplies and materials, advocacy, local transport and volunteers. Resources can be financial and non financial. Non financial resources can take the form of labor, supplies, or space. However, these non financial resources are often regarded as without value but they are of great importance and every community is endowed with them (The Manager. Vol.11). Financial resources for health care delivery can also be harnessed with in communities through charges for the use of a facility, prepayment schemes and fundraising activities. It behooves health providers to identify the appropriate means of generating these resources from local people based on what they are endowed with.

The mobilization of resources at the local level is of unlimited importance. This can be seen in the following ways. Firstly local resource mobilization addresses ills of equity. This is because the poor will not be burdened by health financing strategies such as cost recovery, cost cutting or cost sharing but would contribute what is within their environment in the form of human resource and space. By doing this health promotion is responsive to the needs of the poor and a safety net is developed for all. Secondly, local resource mobilization is a way of maintaining a decentralized health structure. This is because most countries decentralize functions and responsibilities without corresponding transfer of resources; therefore the gap created can be bridged through local resource mobilization. Thirdly local resource mobilization allows beneficiaries and providers of health services (private and public) to develop partnership. It allows for the complement of resources, that is diversify a programme's source of support. Lastly local resource mobilization can leads to the sustainability of health projects. This is because local people become committed and involved in project maintenance (The Manager. Vol.11).

It can thus be said that resource mobilization is a vital element of community participation. Not only does it makes available resources but also instills in local people the sense of collective responsibility in the provision and maintenance of health facilities/services. Communities also feel satisfied for being able to make valuable contributions to improving the health of their people. The responses of the two communities show that local resource mobilization takes the following forms:

Beneficiaries that are residents of the study communities using the two health facilities provide land for free for the construction of health facilities. Community members admitted that access to land in the two communities either by residents or non residents is free; it does not connote any monetary value. An informant stated this on how to get land in the two communities

> One only needs permission from the chief and the Tindana.

It is also realized that community members offer free labor for any manual work and tidy up the surrounding of the health facilities. A male informant of the Kusawgu community stated their contribution to promoting health service delivery in the form of security.

> One of us from this Kusawgu community has volunteered to serve at the health post as a night security.

In addition to providing voluntary services, members of the community also help disseminate information pertaining to health to one another in the community. Also, the fee for services and the recent NHIS are means of generating resources to the community. As stated earlier, health personnel in order to get money to run health services will have to ignore the NHIS and charge community members directly. Beside these the communities do not provide any direct financial support in the form of donations to the health facilities. Therefore only funds earmarked for the various facilities, and Internally Generated Funds are what is being used to run the health post and the CHPS compound respectively.

Health personnel at Kusawgu health post describe the alternative means of supporting activities at the health centers.

> Sometimes we receive support from Non Governmental Organizations such as OIC which makes available food supplements to pregnant and nursing mothers [a support that does not only increase the nutritional level of the pregnant women and nursing mothers but also motivates them to come for ante natal and post natal care services].

Another form of contribution made by the community members is accommodation. Some members of the two communities provide accommodation for some of the personnel working at the health centers. This was evident in Kusawgu where the Disease Control Officer was being accommodated by a community member.

A female informant in Sankpala said that they do not support the compound in any way financially.

> We only pray for the workers to be fit all the time to go about their duties.

She made this statement because she does not know that the direct cash that she pays sometimes at the health post is a way of contributing financially to supporting health activities at the center. She thinks that cash donations are the only means of providing financial support.

Resources mobilization in the communities also takes the form of food items. As noted earlier, this is the resource within the environment of the people which the local people are comfortable to share with health workers. The group response from the men of Kusawgu revealed that sometimes during the farming season gifts or food stuff like yam, maize and eggs are being given to some health personnel.

It can be said that the communities contribute to resource mobilization through the provision of land or sites for building, free labor, security and accommodation of some health workers. Using Rifkin scale for the process indicators, I will assign resource mobilization as a form of community participation a fair or average value.

I tried to shed light on some conditions or situations that may sometimes hinder community resource mobilization. The essence of this information is to identify some of the internal or local challenges that need to be overcome before community resources can be fully harnessed.

Firstly as I mentioned earlier the chieftaincy disputes prevailing in the district in general and the Kusawgu community in particular for some time now serve also as threats to local resource mobilization. This is because people are living in perpetual fear and cannot undertake any productive venture that will boost their economic status to contribute to health care delivery. Moreover resources (contributions from both the district Assembly and communities) that would have been channeled to meeting health care delivery are used to maintain peace and order.

The dispute over who to provide traditional leadership also affects communal contributions to health service. For instance, if there is no recognized chief in the community, communal resource like land can not be made available for health purposes. Local people cannot also be mobilized to provide labor when they do not see an eye to eye.

The flooding of the district may also be a threat to resource mobilization for health projects. Not only does it displace people but also affect their farm output and income generating activities. It thus denies people of their income and other valuables which would have been used in some ways to meeting health needs. The little income obtained will be channeled to domestic food budget, and less priority given to health decisions.

> Leadership

Most societies in recent times strive to have some form of organized leadership, as the absence of leadership can result in anarchy or chaos since there would not be any orderliness and representation. Leadership involves influence and attainment of goals, and can be found at any level of society or organization. The type of environment determines the style of leadership as it can take the form of autocracy, democracy and laissez-faire.

A leader serves as a steering wheel that drives projects, he or she also become a liaison between the community/organization and development agencies. A leader also builds network by mobilizing, and promoting community's interest. A leader fosters change through information sharing, coaching and empowerment.

In health, leadership runs through the various strata particularly of the decentralized setting. At the district level, there exist the District Health Director and the DHMT (also made up various departments and agencies), we have the sub district DHMT. At the health facility level we have the nurses (midwives, general nurses, community nurses), the disease control officer and the auxiliary staff, with one of the nurses being their leader fondly called 'the-in charge'. For a smooth operation of health activities within these communities, some leadership must also come from the community. These will represent the entire community in matters that have to do with health and work closely with health personnel towards the attainment of goals and objectives of health in that community. The focus of the thesis is centered on the existence of health leadership at the community level.

Interviews with members of the two communities show that various kinds of health leadership and groups exist in the two communities. The most fundamental aspect of leadership in these communities is the chief and his council as well as other opinion leaders of the community, who represent the community's interest in health matters. For instance in creating a CHPS compound one of the stages is the Community Entry where community leaders are oriented and involved in health activities. This therefore allows leaders (of the community) to contribute to issues and have their demands considered. At Sankpala the response from the women (group) revealed the existence of the following groups; the guinea worm group, the Exclusive Breast Feeding group and the Red Cross group. A female informant in Sankpala stated the role(s) played by some of these groups.

These groups and their leadership sometimes meet with the nurses and discuss health issues pertinent to the community. For instance the nurses sometimes teach them on new methods of caring for children and when they comeback they also teach us.

The male group of Sankpala mentioned the health committee and the WATSAN (Water and Sanitation) groups. These groups are those that are also in existence at Kusawgu. The response of the women (group) at Kusawgu showed that "Mangazian" also plays a leadership role among the women when it comes to health matters. The "Mangazian" is a woman who wields enormous power by virtue of her experience, achievements (in religion), wealth and age. Another group of people who, though political in nature but committed to health is the Unit Committee headed by the Assembly man.

The district health director added to the above of the Community base Health Volunteers, Mother-to-Mother support groups, traditional healers and TBAs. The importance of these groups has been articulated below by her.

Their existence helps improve the utilization of health services, give local people the opportunity to acquire knowledge, attitude and skills from health staff. On a whole they are contributing to raising the health status of the community members as there is a reduction in morbidity, and mortality of mothers and children in the district.

She noted again that the formation of these groups was initiated by the health personnel and that members were chosen by the various communities voluntarily based on those group members' level of experience, commitment and sometimes level of literacy.

The thesis does not include the study of the performance and functions of these groups; however the mention of them by informants (from the communities and at the district level) shows that there is some leadership roles assigned to some community members by health services providers. There is also no information on the degree of participation of these groups in local health issues. I give a mean or fair value (using the pentagram scale) to Leadership as a process indicator in the sense that there is the polarization of various health groups in the communities responsible for certain health tasks. The attempt to create them which is mostly an initiative by health workers is an indication of their efforts towards promoting participation. It however does not imply that these groups are effective and consulted in every aspect of health decisions.

Touching on the challenges that may affect the importance of leadership to achieving community's interest, I think that leadership itself may be a threat to participation. This has to do with the composition of the groups and leaders. Where the groups are composed of people of the same affluence, interest or physical endowment, domineering attitudes over the rest of the community members cannot be ruled out. This is one major concern of decentralization which many scholars have written about, where some local elicits hijacking the process and pursuing their own self interest at the expense of the local people. I also observed that some of these groups do not have any representation from marginalized people particularly those with disabilities. I therefore doubt how the needs of such people are identified and integrated in health projects. I see it as a failure on the part of health professional (creators of these groups) for not creating an opportunity for this category of people to be part of the groups.

Where local leadership is also weak, there would not be a clear presentation of local health needs and a push through of these needs. The diagram below thus shows the various forms of participation felt by the people of the study communities. The local activities captured by the thesis have been sorted under these indicators.
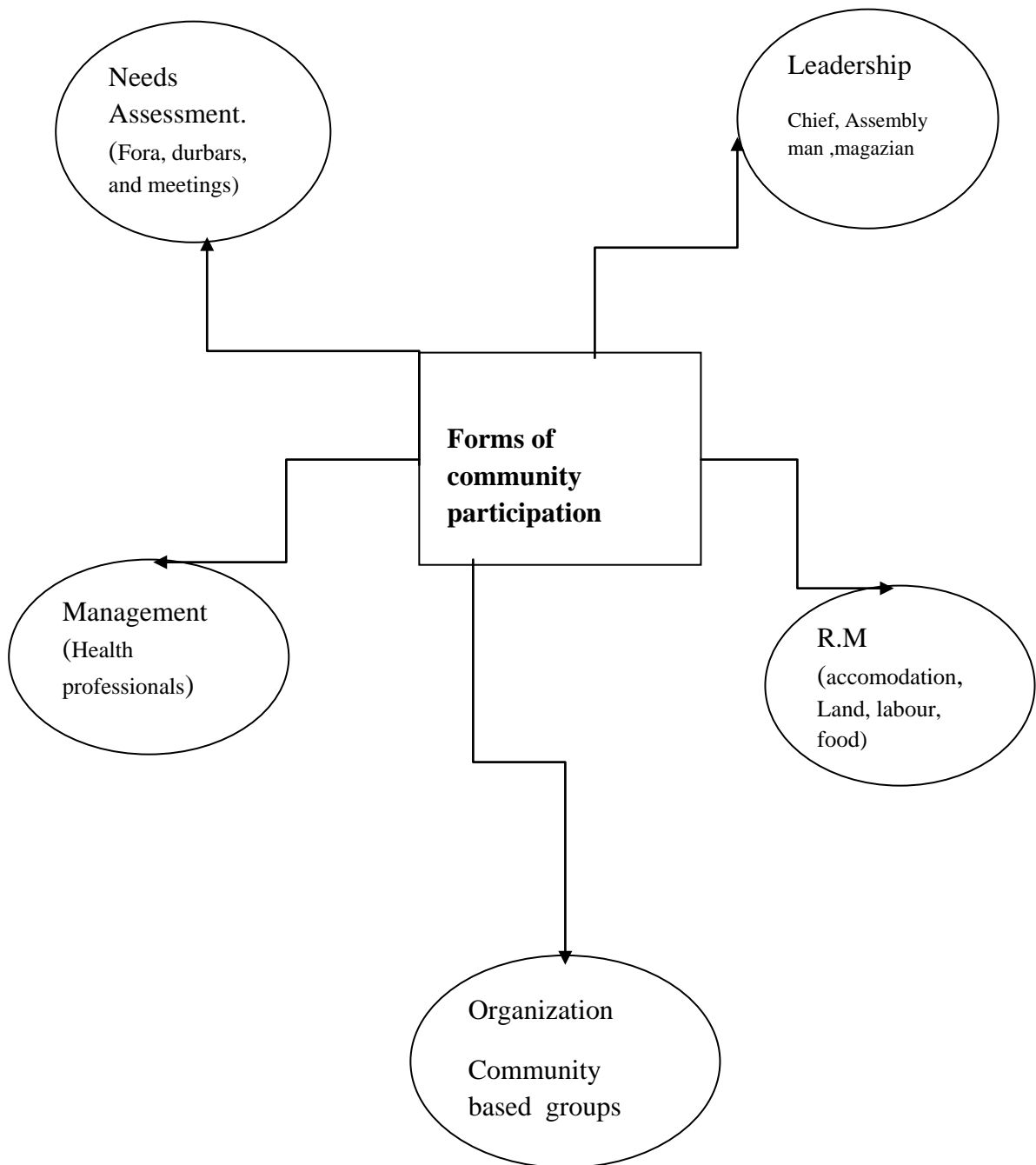
Figure 7. Forms of participation in health service delivery.

Source. The author.

➢ Management

Management composes of different groups of people occupying different levels in society who collectively decide and influence how a particular health system is being run. Management may also refer to a group of people who perform the functions of planning, organizing, leading or directing, controlling and staffing. Management plan by stating goals and objectives, setting targets and work to achieve them. They organize, by sub dividing the organization into units or structures, and coordinate or control the activities under each unit. Management also leads or direct by influencing people behavior through motivation, communication and leadership. They recruit personnel, hire, and train, evaluate and compensate. The last function of management is to control, that is measure and report actual performance, make comparisons and take corrective/preventive actions.

Drawing from the functions of managements posited above, it would be prudent to examine where community members are classified so to determine the nature of participation.

Firstly I think that the creation and functioning of health group in the two communities play management roles. This is because each of these groups has its goals and objectives, these groups also offer leadership services by representing the entire community, they also make available health information and teach some members on health issues, and this contributes to influencing behavior by way of directing. It is tempting to overlook this role being played by these groups, however, every contribution counts. The contribution should not be so huge or tangible before it is considered. According to the district director of health, community based volunteer system takes up surveillance of unusual events in their respective communities and report to the DHMTs or the sub-DHMTs. So there is coordination between health workers and local leaders.

Even though efforts have been made by health care providers to integrate local people in process, the process is incomplete as the day to day running of health centers remains a sole decision and responsibility of the district health units. This has to do with the utilization of resources, funds and personnel at the various facilities. Supervision of health workers is the sole responsibility of health officials who are far removed from health personnel. This is why health personnel at these places decide when to report at work and when to close from work. This also encourages absenteeism among health personnel at the various health facilities particularly during weekends. I think the communities should have been actively involved in

monitoring personnel movement, and given the authority to report any misconduct of any health personnel to the authorities at the district level. It can thus be said that the absence or little involvement of community members in monitoring health workers is what makes personnel at the various facilities conduct themselves unprofessionally sometimes as will be seen in the chapter six. Interaction with the community members showed that monitoring of these places is something they are yearning to do but not given the mandate.

The source and utilization of resources particularly financial resources at the various health facilities remains the responsibility of health personnel and professionals. No opportunities have been created to even inform community members on this. I am therefore of the opinion that participation in terms of Management by community members is extremely low. Community members are only consulted when health care providers deem it fit, it is not made a legal issue or mandatory. This allows health providers decide what they want and not what the community wants. The ultimate responsibility lies in the district health unit.

➢ Organization

I am discussing this with respect to non governmental groups that support health service delivery in the district and the two communities in particular as there are no locally based organizations in these communities. What exist as seen earlier are smaller health groups created by the district health personnel.

A number of organizations exist in the district alongside the DHMTS, supporting those health groups within the communities. Some of these organizations have also encouraged the formation of health groups within the two communities as mentioned already through which health information and services are made available to the rest of the people of the studied communities. An example of such organization is the Opportunity Industrialization Center (OIC). The OIC provides critical education and training to the communities in areas related to reproductive health, family planning and HIV/ AIDs. At the community level it encourages group formation and educating them on its three areas of focus and these groups in turn educate the rest of the community. A respondent in Kusawgu said this;

> There is an OIC group formed in the community that educates us on health.

In the year 2008 Performance Review of the district, the health director stated that the OIC is undertaking food rationing exercise in some communities and training some women as Community Health Agents.

Another organization that provides health services to the communities is the World Food Programme (WFP). In discussing the health profile of the district, it is realized that flooding has been occurring in the district and this often affect productivity resulting in food insecurity and malnutrition cases. WFP thus provide assistance in the form of cash donations and food items to flood victims in the district. During the interview process, I saw the sharing of food (cereals and grains) among nursing mothers and pregnant women. Asked on the importance of the exercise, the health workers at the Kusawgu health post admitted that the package encourages antenatal and post natal attendance, as beneficiaries often turn out on such days. The beneficiaries were happy about the package as expressed by some group of women that I met at the health post.

> The supplements make up for what we lack or have little at home. The money we would have used to buy maize will now be used to buy ingredients for soup and other things.

United Nations International Children's Fund (UNICEF) is another organization in the district that supports health services in the district. The flooding of the district sometimes in the year affects people's food levels, shelter, property and animals. The organization thus provides relief services in the form of food, clothing, drugs, detergents and mosquito nets to victims. It is also into other sectors of the economy within the district.

There also exist Global Fund (GF) in the district which focuses on Tuberculosis, Malaria and HIV/AIDS. It provides support in the form of grants and donations to facilitate activities geared towards achieving its goals. The absence of a community based organization to represent the community at the district level in health matters but NGOs shows that participation in this regard is low. The health groups initiated by the health unit lack the capacity and legal support to perform functions which they would have if they had evolved from the communities without any external stimuli.

The absence of community based organizations tailored at promoting local development implies that no direct collaboration can be built between the community and other community health organizations. This does not create the opportunity for community members to tap the

experience and ideas of these external bodies as well as the support to make certain demands at the district level. The absence of such organization puts additional pressure on health groups in the community since they are made to sometimes functions outside their scope. I think participation in terms of organization is therefore low or narrow in the two communities, which I see to be a failure or weakness on the part of the people of the two communities.

6.1.2 Placement of the process indicators on Arnstein ladder of participation

The information presented above about the process indictors will serve as a baseline for placing these on Arnstein ladder of participation. The essence of the discussion is to provide additional information on them using another framework. This is to diversify the approach to understanding community participation in order to get a clear understanding of what it stands for and how it is being interpreted by different people. It will further furnish me on any contrasting views between the two models regarding participation in health service.

➢ Needs assessment

From Rifkin et al. (1988) model, I concluded that the process indicator is moderate in that the process is carried out between health service providers and the beneficiary communities. This is based on the following as spelt out by the model: It is realized that needs assessment involves the identification of local people needs by professionals, jointly with community members or done solely by community member. Each of these defines a degree of participation as narrow, moderate and wide respectively.

Applying the features of the Ladder of Citizen Participation, I think needs assessment comes under consultation. This is because the datum line information obtained using the pentagram model revealed that needs assessment is done jointly with beneficiaries. This creates the platform for citizens to present their views or opinions and to also be informed of health issues pertaining to the community as posited by Arnstein. Drawing from her model, needs assessment which is seen as the efforts of local members combined with health professionals or health personnel is not enough to be considered genuine participation. This is because the

mere identification of needs together is not an end in itself but a means. However there is no opportunity created to ensure that what is decided by the people is implemented by health professionals. She thus argues that for needs assessment to be considered a genuine participation, mechanisms should be created to allow local people to make follow-ups for their needs to be inputted. In the discussion under Rifkin et al. (1988) model, it is established that the decision regarding health service delivery in the district rest largely on the DHMTs and the other sub district structures as well as the various health centers. This implies that local people do not have the right or legal backing to challenge certain health decisions or outcomes. So health professionals decide whether a given local need is feasible or not. I think the combination of the two models here helped to clarify or identify certain conditions that need to be upheld in making needs assessment a form of participation. The Arnstein ladder has helped point out the weakness of the pentagram in the sense that needs assessment can only be effective (considered participatory in nature) when there is the opportunity for beneficiaries to press for their desire needs, and not just about who identifies them. There is no guarantee (beneficiaries do not have the power) to hold health services providers (the powerful) to task for implementing what is not desired of the community. Arnstein added that consultation can be a legitimate step towards full participation but inputs of citizens' ideas should not be limited to this level else participation remains a window–dressing ritual. This goes to say that needs assessment done either jointly or solely by the community be encouraged with modalities put in place to allow local people confront services providers when they fail to provide projects or services of their choice. Consultation is thus a form of tokenism as put by Arnstein where the have not are heard and have a voice but lacks the power to change their status quo.

➢ Resource mobilization

Drawing from The Manager, which states that local people particularly the poor be made to contribute what they have easy access to within their environment and not necessarily cash as it puts additional burden on the poor, I think the two communities are doing well. As presented under the pentagram, resources like land, labor, accommodation and food are being contributed by the people in the process of providing health services. I therefore think that the Sankpala and Kusawgu communities are contributing resources to providing health services in their respective communities. Using the ladder of participation I represent resource

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mobilization at the rung of partnership. This is because land in Ghana is a valuable asset which is communally owned. The local people have the power over the land (stool land) and unless the chief and the "Tindana" are consulted, no body can have access to it. The local people also decide the size and the site allocated to health users. This means the local people have power over the resources that are endowed in their communities, and unless partnership is built to enable the sharing of functions and responsibilities, such resources cannot be made available for use. Therefore if the people own it and are ready to offer it free of charge as their contribution then I think it denotes genuine participation. I see that the nature of resources and the extent of the contribution shape the decision about whether to go into partnership or not. The skepticism here is about the decision on how financial resources are to be used. Since the management of the health centers excludes the local people, it is obvious that the decision regarding the use of community resources is what is made open but decisions regarding financial resources particularly those resources gathered by health providers is made by health professionals alone. This does not make resource mobilization in the communities a complete form of (partnership) participation. The partnership created is handicapped in that not much information is being shared between community members and health professionals. Health professionals deliberately shield financial information from the beneficiaries. With this, it is difficult to say that resource mobilization is a form of genuine participation or not, because of the context in which it is being approached here. However it has some elements of genuine participation.

> Leadership

There are myriads of health groups in the two communities, however the degree to which they are allowed to function or influence decisions determine whether there is genuine participation or not. From the ladder I place it at the rung of Informing. Arnstein sees this as the first step towards participation since it allows people to be informed of their rights, responsibilities and options. However, it is characterized by one way flow of information that is from the officials to beneficiaries with no channel for feed back and no power for negotiation. I place it in this rung because most local health groups are only informed of ways of arresting an epidemic situation like guinea worm, malaria and child and mother mortality. Unless there is a disease out break or a new method of addressing a particular health problem most of these groups are often left fallowing. They take no initiative of their

own, and if they do such initiatives have to be within the wimps and caprices of health service providers. The only opportunity created for feed back is on disease surveillance where leadership of such groups report to health officers about the effectiveness of a particular treatment method, disease break out and the number of cases in the community. Leadership of these groups are not given the power to negotiate for the methods (good health practices) that best work for them, every information from service providers is imposed on them. These groups by nature don't have any legal backing. Leadership of these groups is regarded "followers" of service providers.

> Management

From the discussion above, it is realized that management perform functions of planning, controlling, directing and organizing. It is realized that there is no room created for community members to contribute to monitoring of personnel effectiveness and efficiency. Since the community members live in close proximity with health personnel and interact with them frequently, the local people would have been the best people to monitor personnel attendance (even though it may come with challenges), reporting and closing from work. Even at the facility unit, no communication medium has been created for users to lodge immediate complaints about certain attitude of personnel or level of satisfaction about service delivery. For how long can people harbor their dissatisfaction about certain malpractices at the various health centers until durbars, meeting or other social gatherings are organized? In addition community members are not involved in the allocation of resource except those contributed by them as I noted earlier. Planning the activities of the various health centers excludes contributions of community members; this means that community inputs which may be relevant are left out. Health professionals take all major health decisions.

Using Arnstein ladder, I place management at the first rung of it. It denotes manipulation on the ladder. As Arnstein said, manipulation is a form of non participation. This is because the real objective is not to enable people participation in planning or conducting programmes but to enable power holders educate participants. I therefore think that the existence of the groups in connection with management of the health centers is to allow health professionals make available health information to community members via the groups. It is also a way of gaining

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community support through the groups to enable health professionals pursue their own interest under the guise of genuine participation.

Another group that I associate with this kind of non participation is the District Assembly. The assembly only plays an advisory role in matters pertaining to health. I think this is a function deliberately created and assigned to the assembly and many researchers on decentralization in the health sector of Ghana have noticed this problem. However it seems the District Assembly is content with its functions as the District Coordinating Officer mentioned that health service provision in the district should still remain a function of the Ghana Health Service. He however stated that the Assembly monitors the activities of the District Health Unit.

> We monitor their activities by periodic request for reports on the activities of the health unit.

But the effectiveness of the monitoring of health service providers in the districts is what is not certain, and the extent to which this activity affect or influence health service providers decisions, attitudes and behavior to health service provision in subsequent times. This is because, the District health Unit feels that it is responsible to the Regional Health Unit and not the District Assembly.

➢ Organization

As noted earlier, what exist in the two communities are local health groups created by the health professionals. As mentioned earlier, NGOs exist in the district and operate within these communities through coordination with health workers; however the nature of their operation and performance is not of interest to the thesis. By nature, the local health groups in the communities serve as a medium through which information from health professionals are passed onto community members. They did not evolve naturally within the community to press for participation in the process of providing health service to the communities. None of these health groups have the legitimate function or power. Health professionals use them to "prove" that people at the grassroots are involved in programmes. Some of these groups give their consent to health programmes without a deeper understanding of what it is about. Such

groups are not also given the opportunity to ask whether such programmes are desired of them.

I think Organization in the sense of the two communities is non participation. It is a form of Manipulation (according to the ladder) where smaller but local groups have been created by health officials in the name of participation. The nature of these groups has been described and elaborated upon above and this makes me think they constitute non participation.
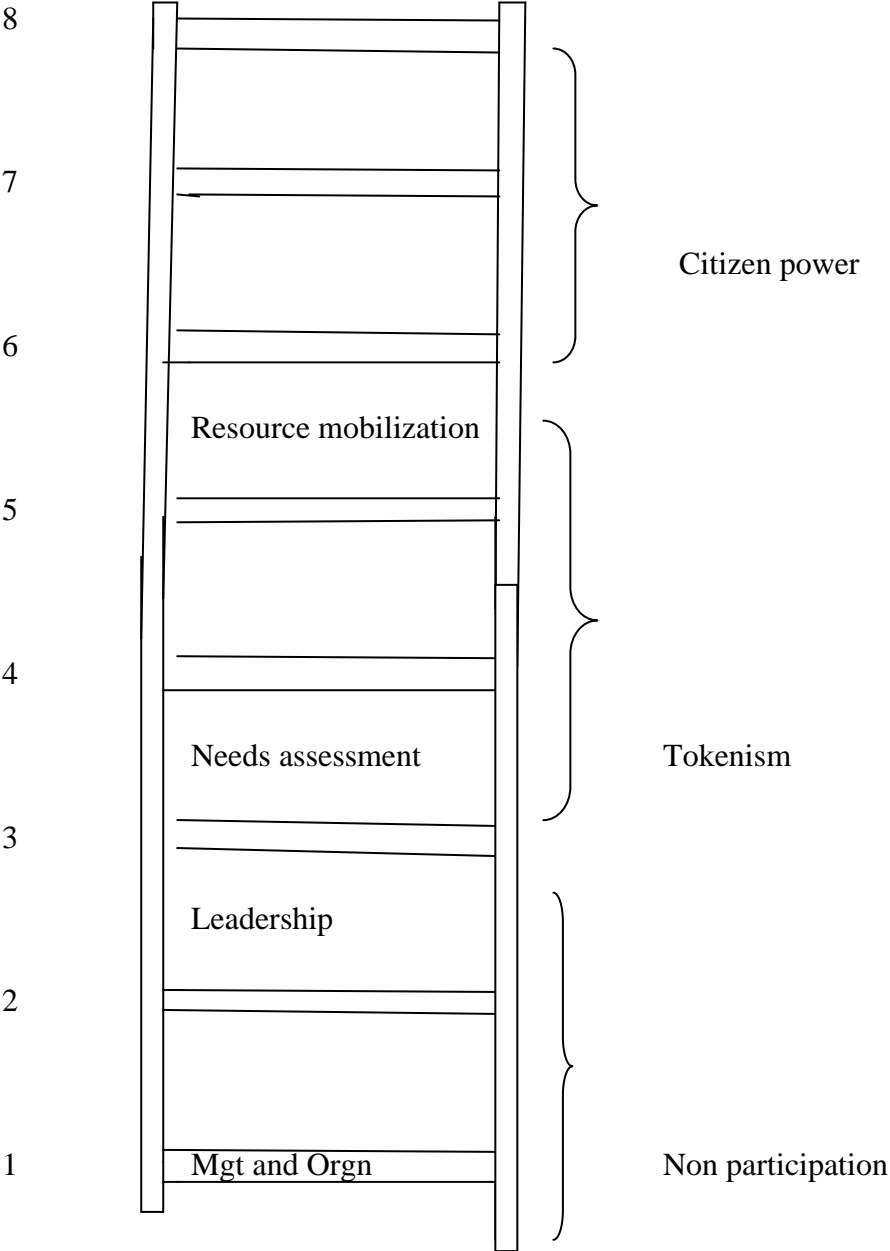

Figure 8. Results of local people's participation on Arnstein ladder of participation.

Source. The author

6.1.3 Discussing the relationship between Arnstein's model and Rondinelli's typologies of decentralization within the health sector of Ghana

In discussing the nature of decentralization within the health sector of Ghana, one sees the de-concentration of service functions from the central GHS to the local health structures like the district health unit. Placing it on the ladder, it is realized that participation is extremely weak because the central GHS only tries to decongest it activities but not authority and power. Viewing the de-concentration from the perspective of Arnstein model, it denotes non participation within the sector.

Delegation of service delivery functions in the country is in the process of being shifted to the GHS. It means that the GHS will have the mandate to provide health services for all Ghanaians. At the local level, delegation is manifested in the shifting of some responsibilities, functions and authority to the district and sub district units. For instance the DHMTs have the authority to supervise health personnel and monitor the activities of the various health centers. The health centers also have the authority to design their own action plans or plan of activities but need approval from the district Health unit. Discussing Delegation at the national level with regards to the GHS and the MOH, it is hopeful that the process when complete may represent Partnership between the two bodies, however this will be different from the kind of partnership that is advocated as ideal, as expected to exist between the central and local governments as proposed by local government theories.

The functions performed by the district health unit in relation to the central GHS on one hand and the community in relation to the District Health Unit and the central GHS on the other hand may all be termed Tokenism on the ladder. The only genuine form of participation would have been experienced in devolution where local jurisdictions take absolute control of service delivery as in the case of the Federal Republic of Nigeria.

Table 2. Comparing the relationship between decentralization and community participation in

Rondinelli (1981) typologies and Arnstein ladder of participation (1969) within the

health sector of Ghana

Decentralization as a process	Category of people involved/activities	The ladder of participation depicting the outcomes
De-concentration Implementation of policies and programmes designed by the central GHS and MOH (since there is still no complete separation of functions) by the local level health structures.	• The Regional Health Units, the district and sub-district health units. • The District Health Mutual Scheme • The people at the community level have no role to play • The building of health centers, local health offices and posting of health personnel to such areas (a way of bridging the gap between the central GHS and the local community)	Non-participation The local health structures are simply performing empty ritual of participation. No opportunity is given to these structures to question the nature of such policies. They only 'stamp on' governments predefined activities
Delegation Local level health structures though given policies and plans designed by GHS/MOH, they have. some discretion to be exercised over these. That is local level structures can alter the content of some of these policies to favor local situation. However changes made should not be in sharp contrast with what has been planned by the central authorities else it may be withdrawn by these authorities since they control the processes, and the results	• The GHS at the national level • The regional and district health structures. For instances DHMTS supervise and monitor health personnel and the activities of the various health centers within the district. • Community members are informed and consulted on health projects and the intended results. Community members are also tasked to contribute the kind of resources and services that are endowed in their communities • Community health groups act on behalf of health personnel in the community	Tokenism There is some participation by the local health authorities since they are allowed to influence policies to some extent; however policies that have strong political motivation cannot be altered locally. More over these local structures have limited power to push through certain demands. Beneficiaries (community members) are being represented by their various health groups or community leaders in diagnosing health problems, but these do not have the power to ensure that they are provided with what they demanded for.

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Devolution		Citizen control/ genuine participation
Local health authorizes have the power to make autonomous decisions regarding what kind of health services that are desired of the local people. These structures define the procedures and the expected results	• Not existing in the health sector, but to some extent in the local political set up where District Assemblies formulate by-laws, design local plans, define the methods of implementation, resources required and the expected outcomes.	This may be termed self development where the district health structures and the community members carry out local projects using local resources.

Analyzing the importance of the two models reveal that Rondinelli typologies are more useful at the national or broad level while the Arnstein model is useful for specific case studies which are local in nature.

6.2 Access to health services

The discussion starts with a look at the disease profile of the two communities, testing local knowledge on signs of these diseases, where they seek for treatment and why. It further describes the activities of health providers such as the activities of the modern health facilities, traditional birth attendants and herbalists. This is be followed by a discussion on issues around access to health services touching on each dimension of it in the two communities drawing from local perceptions.

The idea of throwing light on the disease of the two communities is to explore indigenous knowledge about diseases and the immediate decisions people take regarding where to seek treatment. I think with this information, interventions in local health could be made more acceptable.

All groups and individual informants were asked to list the diseases that are common in their communities, and identify the commonest as well as to state the one they fear most. A synthesis of their views showed the following as the common diseases of the two communities; malaria, guinea worm, cholera, convulsion, pneumonia, chicken pox, AIDS and Upper Respiratory Tract Infections, with malaria being the one they fear most. Some of the names of the diseases were mentioned in English whiles others were mentioned and described in the local language. I was careful here because it was not all diseases mentioned in the local

language that corresponded to those in English. So to understand it better, I asked them to describe how the disease or illness is like. Malaria was identified as the number one disease in the two communities.

In order to get an insight into some of the causes of some of the diseases, malaria they described to be caused by poor environmental and sanitary practices which allow for the breeding of mosquitoes which then bite them and cause malaria. Coupled with this was the inability of the local people to purchase treated mosquito nets, and refusal of some community members to use these treated nets. They therefore admitted that mosquito bites cause malaria. A woman mentioned that cholera is caused by the eating of contaminated food. Asked on the prevalence of guinea worm cases, all respondents attributed it to the drinking of contaminated water.

Testing their knowledge on symptoms of some of these diseases, the following present their perceptions; Malaria they explained to be showed by feverish conditions, high temperature, severe headache, cold and sometimes vomiting. They described cholera to be manifested when vomiting, stomach pains, running diarrhea and vomiting. With guinea worm, blisters are formed and when they burst, one sees a worm in a sour at the affected part

Nature and other social factors play roles in creating some of these diseases. Kusawgu and Sankpala are agrarian communities where the people rely on agriculture for livelihood and source of income. Farming is done around their homes and outside the community. Livestock in the form of cattle, goats and sheep are kept at home even though some cattle ranches are found in the bush. The mode of housing these is in smaller pens attached to their houses, with some of the livestock raised in the open close to the homes. Household waste is not given any proper treatment. Borrowed pits where sand was collected for building are seen not refilled. This implies that the immediate surrounding plays a role in defining some of these diseases.

Nature also plays a part because the study areas are found in the dry savannah which has high temperatures and other dry conditions. People at night are seen sleeping in their compounds because the heat does not allow them to sleep in their rooms. The warm environment has a connection with chicken pox. Aside the high temperature attributed to nature, drilling of boreholes in Kusawgu is not also yielding any results. Whilst I was staying in Kusawgu doing a research as part of my first degree, I witnessed the coming into the community of a

water drilling group. Days where spent in the community in efforts to drill boreholes but all efforts proved futile. This could be as a result of low technology.

The poor sanitary conditions coupled with the sleeping in the compounds without the use of treated mosquito nets explains the rationale for the high cases of malaria in the community. The existence of houseflies and odor also contaminates food leading to cholera cases. From the literature aspect of the thesis, malaria is identified as the number disease in the district. Some of the diseases mentioned coincided with those obtained from the district health unit as shown in the appendix; the secondary data on the disease profile has therefore been confirmed by the local knowledge of the people.

The cases of Guinea worm in the communities are attributed to poor quality of drinking water as the people in Kusawgu rely on rain water and a dam which they share with their livestock. Even though there is a borehole and an overhead tank which provides the Sankpala community with drinking water, some people still prefer drinking water from bad sources; this therefore has to do with attitude and beliefs. Even though quality drinking water is a challenge in Kusawgu, the people are adhering strictly to water treatment methods and this has lessened guinea worm cases in the community.

6.2.1 Treatment

During the interviews, respondents were asked to mention places that they go for treatment. According to respondents, the nature of the sickness and cost of treatment determine where to seek for treatment. Places like the health post, the CHPS compound, the drug stores, the herbalist and the TBAs were mentioned. A woman in Kusawgu stated that when she falls sick, regarding the symptoms, if she sees it to be malaria or other illnesses like cholera, she goes first to the health post for treatment and when she does not get better, she proceeds to Tamale Teaching Hospital since the district has no hospital. She added that when the sickness is perceived to be spiritual, she consults her pastor since she is a Christian. The women group in Kusawgu admitted that they seek health care at the health post for cases related to pregnancy and child birth since it is free. A male respondent also in Kusawgu who is a farmer and a security man said he relies on home-prepared herbs for treatment and when his condition fails to improve he goes to the herbalist. The male group at Kusawgu stated that some illnesses do not allow them visit the health post, but rather consult the herbalist. They explained that when they are bitten by snakes or experience bone dislocation or fracture they

go to the herbalist. This is because the local people feel that the herbalist is more efficient and does not amputate people arms or limbs (they see amputation of arms to be common with modern treatment, and it is something they do not want to experience). Informants further explained that the modern medicine is not able to remove the 'teeth' of the snake and this means a part of the snake is still in them. All informants admitted that they go to the health post or the CHPs compound for modern treatment. The information reveals that people make the decision on where to seek for treatment depending on the nature of the sickness, and conditions that have to do with access to health services which shall be discussed later.

6.2.2 Herbalist and herbal medicine.

The idea of decentralization is to champion local development by way of identifying those local potentials in the form of resources and services, and tailoring them towards addressing local challenges. Decentralized health services aim at working with community level health service providers to promote primary health care. This was why the Alma- Ata declaration emphasized that local resources should be marshaled and combined with that of government resources to promote health care delivery. The herbalist is a local health personnel who provides diverse treatment methods to the local people. With the shortage of modern health workers and health facilities coupled with limited government resources, it is realized that herbal medicine though given little attention in Ghana can contribute to alleviating the government's burden on public finance for health services. Also herbal medicine in Ghana is premised on local people's beliefs and accepted by all, with a greater percentage of the people regarding it as the only treatment option particularly in rural areas where health services are not available. Herbal treatment has less bureaucratic tendencies as any community members can easily visit the herbalist.

The thesis identified that by coincidence the herbalists interviewed are all men (there are also women too) who hail from the communities and residing in such communities. Those interviewed happened to be old and have no formal training on treatment. They think that they inherited the skills from their parents, adding that they also learned it from their fathers who were also herbalists. The herbalists feel that they had some apprenticeship in the herbal treatment. The herbalists also have children who assist them in the process and at the end of the day acquire the skills. During the interview process some herbalist invited their children to assist them (the herbalists) in answering some of the questions.

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One unique feature about herbal treatment is that it requires you to bring some items such as cola, a fowl and tobacco during the consultation and not money (seldom required). When one gets better and there is the need for some rituals to be performed, he or she buys the necessary things for it. The herbalists do not charge for consultation or treatment but where people want to show appreciation for effective treatment, the herbalists do not decline to receive such offers.

Another feature about the herbalist is that they hardly make referrals to modern health centers; they believe that they can cure all diseases and illnesses. They also prescribe one particular herb for treating more than one sickness or disease. They do not also keep patients at their homes unless one's case is peculiar. With regards to the source of herbs for treatment, the herbalist mentioned that some of the herbs are obtained from the nearby bush even though they sometimes travel miles in search of herbs. The herbalist is also always around to be consulted; he has no specific time schedule or working hours.

A distinguishing feature of the herbalist is also that he combine spiritual treatment with herbal treatment. According to a herbalist at Kusawgu, he relies on herbs for treatment. However when the sickness is perceived to be spiritual he sends the patient to the room where the gods are kept for revelation on causes of the patient's predicaments. He then gives advice on what to do like which god to pacify and what herbs to use.

Patronage of the herbalist is high in the two communities. This is because their mode of treatment is built on the local beliefs system and attitudes and this makes the people to easily identify themselves with the herbalist. They are also residing in the community and always ready to receive people for treatment. Treatment by a herbalist is "free" in the sense that they do not ask for money from patients, but the process also goes with rewards since patients after treatment offer gifts to the herbalist.

Many respondents praised herbal medicine for being cheap and available always. This may be good but the system has some challenges which I think need to be considered. Most of these herbalists are locally-based ones who do not have any equipment for testing some of the herbs that they use. The human being becomes their laboratory for testing the effectiveness and potency of these herbs. It therefore means that the chance of being healed by herbal medicine is uncertain even though some modern medicine may be the same.

There is a high level of risk associated with the use of herbs from these herbalists because no herb according to a herbalist has an expiring date. Secondly patients are in some cases treated at their homes, this therefore means that there is no close monitoring of the patient, and in case the patient needs an urgent attention at a particular moment he or she may not get it.

Also herbalist do not make referral to the health centers although they sometimes refer patients to other herbalists, this means that if one had the chance of surviving from modern treatment when referred, would not get the chance again. This problem was lamented so much by the health personnel at the various facilities.

Most of these herbalists are illiterate who cannot document any thing regarding treatment, it is not even part of their treatment system, every thing is kept in their heads and passed orally from generation to generation, this means that information on treatment may get distorted with time.

6.2.3 Traditional birth attendant

There are TBAs in both communities; however the one in Kusawgu is trained whilst her counterparts in Sankpala are untrained. They are mostly women who have given birth before. According to the trained TBA at Kusawgu, she inherited her skill from her mother and she is also training her daughter informally to become one. She is currently the only TBA in Kusawgu. However there are some experienced women in almost every compound who assist in deliveries. In Sankpala, almost every compound has a woman, experienced enough to handle delivery cases, and where they feel incapable they rush the person to the CHPS compound or the nearest health center.

According to the trained TBA at Kusawgu she was formally trained at Yapei during the early 1990s. After the training she was given a kit box and book for recording deliveries. In the box are soap, sponge, sponge dish and a towel. She was also assigned a secretary to keep records since she is not a literate. Nurses from the health post used to visit her concerning her job and to check records of deliveries in the book, however in recent times they do not visit her again and she is not also strong enough to walk to the health post. Ask on rewards, she stated that people usually give her gifts like soap, fowl or money. However she stated that she has no materials to work with. These materials include gloves to cover her hands since she always use her bare hands,

> The use of bare hands affects my appetite for food because of what I see and touch with my bare hands.

There are no cleaning detergents to use afterward. This means that she normally bear the cost of cleaning herself of delivery related dirt. Concerning attendance, she stated that the introduction of the Health Insurance has made it possible for many women to go to the health post to deliver so she does not receive many case again. With regards to referrals she said that where cases are beyond her she refers them to the health post. She advised that many women be trained to take over her place since she is old now.

Concerning the importance of TBAs in the community, an informant in Kusawgu made this comment;

> They are readily available, I prefer TBAs to nurses at the health post because they have time for pregnant women, full of experience and more qualified than nurses.

The roles of a TBA are helpful since she handles cases particularly during weekends when health personnel are away. However she is only one person in Kusawgu and this puts a lot of pressure on her. She is also weak physically considering her age, and this means more TBAs have to be trained. The case of Sankpala is serious because the whole community has no trained TBA and this means that untrained women assist in deliveries.

I further see a problem with the system because the training that these TBAs are given is not enough to play the role of midwives since they work with the support of simple objects.

6.2.4 The health post or CHPS compound

Kusawgu has a health post which serves the Kusawgu community and its surrounding villages. Sankpala has a CHPS compound which serves the Sankpala community and it surrounding communities too. All respondents in the communities identified these as where they go for modern treatment when they fall ill but it is not always their first places of treatment

Respondents from both communities had some ideas on cases which these facilities can handle. Cases like antenatal and postal natal, family planning, malaria treatment, convulsion, were mentioned by respondents. They added that not all diseases can be treated at these places and that health personnel sometimes make referrals to the Tamale Teaching Hospital (the

nearest hospital to the communities). Respondents also exhibited high level of knowledge of official opening and closing hours of these facilities; however they are sometimes opened late as some respondents observed. This implies that one has to spend more time waiting at the center and this affect their daily work schedule particularly work on farms. The women are very much aware of the exemption particularly of pregnant women and children under five years. For personnel at these places, respondents are much more familiar with them, as some of the communities render services in one way or the other to them.

Challenges of the health centers will be discussed under the dimensions of access to health services in the ensuing discussions.

6.2.5 The drug stores

Each of the study communities has a drug store. These play important roles as far as access to health services is concerned in these two communities. The stores generally have drugs for pain relief as well as ointment and balm. Most of the people even prefer visiting the drug stores to going to the health centers for cost and other reasons. The drug stores are opened always, and even at night, sellers are ready to offer services and this is one of the reasons for their high patronage. The sellers also offer drugs on credit, a service which is absent in the health centers. Patients do not also spend a lot of time here before they are being attended to.

However, these drug stores are by standards not fit to exist. They are not licensed. There are no equipments for storing drugs. They do not have sophisticated drugs since by nature they are not licensed. Sellers here are not trained and lack any pharmacy background yet they prescribe and sell drugs to people. There is therefore the possibility of wrong prescription of drugs, and selling of wrong drugs to patients who may suffer the consequences in the long run. Sometimes due to low demand, some drugs get expired, yet are being sold to the public. This is due to the cost element, and the lack of supervision of activities of these drug sellers. Also these sellers are basically profit driven so they may sell some drugs at higher prices compared to those at the hospitals.

6.2.6 Dimensions of access to health services

This is the onus of the thesis; arguments here will be used to evaluate the overall processes of decentralization in reducing barriers to health services. The discussion looks at the various dimensions of access from the perspective of community members. For easy analysis and clear understanding of the concept, the dimensions will be discussed in detail one after the other. It will provide a description of what each entails and the merits as well as the challenges imbedded.

Affordability

The aim of decentralization is to identify and make service delivery affordable to the local people. Due to lack of income, local people find it difficult to seek for treatment when ill particularly at health centers. The system thus tries to make the cost of treatment cheaper by allowing health personnel at the district level decide how much to charge for a given health service and to also bring on board local service delivery mechanisms (such as the service of the herbalist and TBAs) available in these communities and patronized by the people.

Affordability defines people's ability to pay for health services including the direct cost of services at the health facilities such as drugs, consultations, and OPD cards. The indirect cost involves transportation to and from these places. Community members see the direct cost to be important in defining affordability, that is the cost of drugs, consultation among others as they are willing to cover any number of kilometers to visit a medical officer. This implies that cash needed to pay for health services is what worries them most.

To ascertain their level of ability to afford these services at the health units, an individual informant in Sankpala stated that even though it is costly, when one has the health insurance card he or she is cushioned economically, not ruling out the challenges of the scheme itself. The women group in Kusawgu admitted that they seek health care at the health post for cases related to pregnancy and child birth since it is free. The male group in Kusawgu stated that, the ability to pay for health service depends on the nature of the illness, whether one is registered with the health insurance or not, and whether one's illness is covered by the health insurance scheme or not. This therefore means that, even with the health insurance scheme, people are still not certain on the decision of free health care. A male individual informant from the Kusawgu community admitted that even though they are able to pay, it is with

difficulty adding that some people particularly those without the insurance card contract treatment on credit (and are usually harassed by nurses to make payments), with some users denied treatment for being unable to pay. Another male informant [a security man] from the same community revealed that he cannot just afford his health bills. He cannot even register with the health insurance scheme; he therefore relies on home-prepared herbs, visits the herbalist or buys drugs from the chemical shop when he falls ill. Contrary to the views above an individual informant in Sankpala stated this;

> Health treatment cannot be expensive, because life cannot be bought, so no matter what, I try my best to pay.

This implies that affordability does not influence her decisions on treatment; the most important thing is for her to get treated regardless of the means of financing the cost. Some informants among the Sankpala women admitted that, even though they have not registered with the health insurance scheme, they are able to meet their hospital bills; however there are some people who really cannot pay for the services at the CHPS compound. The male informants from Kusawgu mentioned that sometimes the bills at the health post are so high that they find it difficult to pay. The women (group) informants from Kusawgu added that certain times one is not allowed to use the Health Insurance Card at the center, and at such instance they find it difficult to pay.

Concerning issues of external financial support to meet health costs, an informant in Kusawgu said, people who are favorites of the Member of Parliament (for that constituency) sometimes get support, besides that there is no support coming from anywhere. All group informants from the two communities stated that there is no support for those who cannot pay their bills from the community or outside the community. The following are words of an individual respondent at Kusawgu health post from Songnayile expressing the situation she is facing and what makes her incapable of meeting her family's health costs

> I am a single parent, my husband died on the 6th day I gave birth to our 6th child, this particular child falls sick all the time, is there any help I can get from any where?

Touched by her words, I gave her 1Ghana Cedi, an equivalent of 0.7 U. S dollars.

The views presented above show that majority of the people find it difficult to meet their hospital bills, as most of the people lamented about the direct cost of treatment. It is realized that those services with exemptions are well patronized (ante-natal), as pregnant women were

seen every where and those who are also exempted from paying bills such as the aged and children, also visit these places when they fall sick. From my observation at these centers, pregnant women, nursing mothers and the aged were in high attendance whiles young adults and adult males were just a few, even those male adults seen around had either brought their children for treatment or picked their pregnant wives to antenatal.

It is also observed from the interviews that the indirect cost which covers travelling to these areas is not mentioned by informants. It implies that it is not a challenge to them. The reason is partly because the people of Kusawgu and Sankpala are fortunate to have these facilities erected in their communities. All informants in these communities admitted that the cover less than a kilometer to get to these areas or spend less than 30 minutes walking to these places.

During the individual interviews at the two health centers, I met some patients from outside these communities. To have some ideas on the cost of health service delivery, they revealed that the direct cost of treatment at the centers is what bothers them, but they are willing to walk several kilometers to these areas. This implies that while they can avoid or dodge the cost of transport to these areas, paying for their bills is unavoidable (stating that bills are usually high). This reaffirms the argument in the literature that due to high cost of treatment at health centers people in Ghana resort to self-medication and the use of other cost saving methods which in this study refers to the use of herbalist, home prepared herbs and the buying of drugs from chemical shops

It is also realized that the NHIS is not an end it self. This is because it does not cover all sicknesses or illnesses such as surgery, and this means when one needs to undergo surgery, he or she fumbles regarding the cost of payment. This was why the male informants in Kusawgu admitted that, affordability depends on the nature of the sickness. These men often experience hernia from their work related activities and go for treatment, and this informed them that Surgery is not covered by the NHIS, with the cost being very high. The women could not reveal this because, surgery related to pregnancy or any cost associated with delivery is free as stated in the literature (the free deliveries policy).

Another point worth noting about the cost of treatment and the NHIS is that, the use of the NHIS cards is sometime deactivated and the Cash and Carry system reintroduced. This is partly due to the late disbursement of funds to these centers as stated by the district NHIS officer. Some of these centers during such period will have to rely on Internally Generated

Funds to run these areas, and the only way to achieve it is to abandon the NHIS and revisit the "Cash and Carry System" .

All informants admitted that poverty is the cause of their inability to pay for services, arguing that if not for it; no matter how high the charges are, they would have been able to pay. It would therefore be interesting to explore some the factors that render these people and unable to meet their health bills. This information contributes to defining the economic status of the people in these two communities, regarding the fact that people's income levels have a connection with their health decision.

To get some information about their wealth or income levels so to determine how that is affecting their health decisions, the following were their views. Informants explained that they are into agriculture that is the rearing of animals and farming. However, they experience low crop yield and low production in livestock. This they attributed to over reliance on rainfall for farming with erratic rain pattern. They are not also able to do dry season farming because of water shortage as this problem also affects their livestock breeding (no drinking water for animals), with no pasture for their livestock during the dry season. The low crop yield is attributed also to poor nature of soils with no financial support to purchase fertilizer to beef up the soil nutrients level. The technology used is also rudimentary and this does not increase production as hoes and cutlasses are still the main tools for farming. Natural disaster sometimes affect crop yield as the district some time in the year experience flooding. This affects their crops yield.

Poor health attributed to guinea worm disease and malaria also renders some of them unfit to work. When produce are sent also to the market they attract low prices and this altogether affect their household income making them poor, thus unable to pay for health services.

In conclusion, it can be said that the loud outcry about the cost of treatment in the health facilities is attributed to the poverty levels in these communities. According to the District Health Director, averagely the cost of treating malaria is about 4.5 US dollars, and it is about the same amount that people are required to register for the NHIS. The problem I think is that some people do not have the money at all to meet the cost and not that charges at the health centers are galloping, not also ignoring the fact other factors influence the people's decisions to use the modern health facilities. This implies that people's inability (caused by poverty) to raise any meaningful amount is what is forcing most of them to resort to herbal and self

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medication. However, there are also instances where one can say that poverty is not the cause of their inability to meet health costs. This is because at least majority of the people in these communities own assets like livestock that when sold can enable them register with the scheme or meet their health needs. I think without a detailed study of their wealth or financial strength, one cannot conclude as to whether it is poverty that denies them the ability to pay for their services or it is the level of cost charged at these areas. The question remains open since the data available cannot answer it.

Availability

Decentralization as a reform came as a way of addressing certain development inadequacies such as reducing poverty by making available social services that are crucial to the wellbeing of the people. It is believed that local people will pursue self development by mobilizing resources both within and outside the local environment to provide social services such as health facilities in areas where they are inadequate or lacking, it is to also encourage relevant but local or indigenous health practices to contribute to promoting primary health care. Availability here is about the physical presence of the facility, personnel and equipment whiles accessibility has to do with moving to these facilities to utilize them.

Availability also refers to the relationship between quantity and diversity of services provided and users' needs. From the perspective of the two communities, availability refers to those services found in their respective communities and those used by them at larger cities like Tamale where they are mostly referred to. Availability according to respondents also refers to the number of health staff at these points, their presence at the centers all times as well as equipments to handle cases. They added that it is not only about the presence of a health center in the community but the available services that they render.

An informant mentioned that she thinks the pharmacy is defunct (therefore no pharmacy) as health personnel often tell them that there are no drugs. There is no dentist too, as they are often referred to Tamale Teaching Hospital. It is realized from above that Kusawgu and Sankpala have a health post and a CHPS compound respectively, with these centers provided by the Ministry of Health via the Ghana Health Service. However the services rendered here are not sufficient to meet the people's health needs. There is no dentist, as they are often referred to Tamale Teaching Hospital. These are the words of a respondent;

> Whenever I get tooth ache, I have to content with painkillers to subside the pain until I see a doctor at Tamale.

I think regarding the types of services that these centers are supposed to provide, a dentist is not suppose to be there. The lack of knowledge by the local people on the supposed services to be provided makes them feel that they are deliberately denied of some of these services.

The presence of these centers also serve surrounding communities, for instance communities that use the Kusawgu health post include Bagiyile, Boaboso, Mamuyile, Alipe and Chaama. Communities that use the compound at Sankpala include; Bakpei, Dawunipei, and Kachirasea and many others. These communities according to respondents are far and the people here have to travel to Kusawgu to enjoy these services. This shows that there some communities in the district who lack health centers. The inadequate distribution of health of health services in the district according to the District Health Director is, due to resource constraints, however population and distance are the main criteria for distributing health facilities.

The women group in Kusawgu lamented that the absence of a district hospital with referrals made to the Tamale Teaching Hospital poses challenges. For instances patients and care takers have to board commercial vehicles which attract cost. These vehicles are not also reliable as one has to wait for long, for a vehicle that is not fully loaded to arrive as there are no vehicles plying the communities (sometimes there are vehicles from Sakpala but not regularly) to Tamale. It therefore means that when one is referred, he or she does not get any direct transport to Tamale from the health center, and the patient's situation may get deteriorated upon arrival. They women further explained that when you get to Tamale Teaching Hospital and the patient happens to be admitted, the care taker of the patient cannot be staying at home whiles assist the person and if they have no relations in Tamale town to shelter the care taker, he or she is left at the mercy of mosquito and snakes since he or she has to sleep outside the hospital wards (no accommodation for care takers). The caretakers are also separated from families which has some effects.

On the issue of personnel availability, a male informant from Kusawgu stated that personnel at the health post are not many as they (users) sometimes spent about 2 hours waiting to be attended to by these few personnel, and they spent less time in the consulting room so they sometimes do not feel satisfied as there is less interaction between they and the personnel.

The long waiting hours sometimes aggravates their health situations and even renders their day unproductive since they cannot go to the farm afterwards.

The male informants (group) at Kusawgu lamented about the absence of health personnel at the health post during weekends. They complained that when one falls sick during week ends, one has to content with alternative modes of treatment, since the personnel are always not available. The reasons for the absence of these personnel during weekends, according to an informant at Sankpala is attributed to accommodation problems, however their counterparts at Kusawgu attributed it to attitudinal problem since there is Nurses Quarters by the health post for health personnel.

A grey area identified during the research is means of communication. They two health centers do not have tele-communication facilities such as line phones and mobile phones to facilitate communication between users and health personnel. It comes as a surprise because there are a number of communications cables passing through these communities with private network towers erected. At Kusawgu junction one sees towers of Vodafone communication, MTN and Tigo yet these have not influenced the decisions by management of the Kusawgu health post to equip it with a telephone or mobile which will be made available for public use, This means when community members need any support from the health post then they have to walk there or if one is fortunate to know the private numbers of personnel (only if personnel are comfortable about it) then a call can be made. Even if personnel are willing to make available their lines for public use, it is not binding or makes them act quickly to such calls because the process has not been made formal. The two communities have full network coverage by the major private telecommunication operators. An individual respondent in Sankpala said she is not aware of the existence of these facilities at the CHPS compound. Information about other people providing alternative health services in the communities, showed the presence of the TBAs and Herbalists as mentioned by all informants. Informants also mentioned the availability of chemical shops (unlicensed) in the various communities.

Availability also becomes an issue when considering the general furnishing of these centers to meet patients comfort. The supply of drugs at the health centers received reaction from respondents. It sis realized that the dispensary at these areas do not have sufficient drugs to meet patients need. A respondent at Kusawgu expressed her disappointment with the quality of services being provided at the health post:

All the time the nurses tell you that there are no drugs, when will they ever have drugs?

Benches at OPD department were not enough to meet the ever increasing population. At the Kusawgu health post, some of the patients were seen sitting on the floor whiles others hung on short walls due to a few number of benches available.

The lack of testing kits and poor ventilation facilities such as fans and insufficient beds for in-patients were some of the inadequacies of the health centers which were brought to bear by respondents from the two communities.

I think on average informants from the study communities are satisfied with the type of health services present in their communities. By standards these communities are rural in nature and what befits them is what they have been given. The only problems are the inadequate staff, unavailable staff during weekends, the absence of a district hospital and the inadequacy of general equipments at the health centers.

Accessibility

Decentralization as advocated is intended to bring services and service delivery much closers to users. This is to reduce the number of kilometers and hours that users have to spend before reaching a given facility. This will also allow users to participate in the management, monitoring and supervision of activities at these centers to enhance the overall quality of services delivered and the general wellbeing of the people. Bureaucratic tendency that delay decisions in executing health plans will also be reduced as the local people begin to steer their own health affairs.

Accessibility refers to both the physical location of services, as well as patient mobility. It describes the ease with which or the challenges that patients encounter in their bid to utilize health services. In rural areas like the study communities where there is poor road network, travelling to health centers become problematic. The nature of roads determines whether vehicles will ply such communities or not. The district is characterized by places called overseers (waterlogged areas cut off from major towns) with no bridges connecting them. As an agrarian communities, some of the people have their farmlands far form home and found in the hinterlands, this therefore means that when one falls ill on the farm it becomes difficult to reach these facilities. Accessibility is also compromised because during rainy seasons, people

spend a lot of time on their farms and would have wanted to attend these centers either very early in the morning or in the evening, however the centers close during such time periods.

Accessibility to these areas by informants of the two communities is not a problem. This is because informants admitted spending less than 30 minutes walking to these service points except when they fall ill when outside the community (farms). Accessibility only becomes a major challenge to them when they are referred to Tamale or when one suddenly falls ill whiles on the farm. They cover more than ten kilometer in vehicles to Tamale Teaching Hospital (TTH) since there is no district hospital for referral. Means of transport from Kusawgu is unreliable as there are no vehicles from Tamale destined to the place except Sankpala. Patients form Kusawgu when referred to Tamale have to walk from the health center which is about 3kms to the Tamale -Kintampo high way. Any vehicles that are passing by and are not full will then stop and pick them. When one even boards such vehicles he or she is still not certain of the exact time of arrival as some of the vehicles stop on the way to pick passengers (time consuming) and others due to their bad nature break down on the way. Some patients die on their way to Tamale or get there with their situation worsen. It is common seeing patients being carried in tipper trucks or cargo trucks to Tamale on referrals due to lack of means of transport.

The distant communities listed above as also patronizing these various health centers face transportation challenges. Peoples from some of these listed communities that are interior (far from the Kintampo-Tamale high way) will have to cover about 5km walking to the health centers. With the harsh weather conditions such as the scorching sun and sometime rain, patients suffer to reach out for treatment. Some of these areas are characterized by water bodies like rives and streams and patients have to wade in the water exposing themselves to water borne diseases. During the interview process, members of these distant communities particularly the women complained of their inability to go for antenatal, and that sometimes they are compelled to deliver their babies at home without supervision from a medical officer.

Acceptability

Decentralization tries to capture the local characteristics of the people at the district and integrating these into efforts of the national government's aim at promoting development. In health care, decentralization tries to provide services that are inline with the local people's beliefs, norms and values. This is to boost local people's patronage of health services by the

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beneficiaries. Experience in the past showed that health planners failed to integrate local features and interests into development plans and projects and this led to rejections of such projects or poor patronage of such projects by target beneficiaries.

Acceptability describes the compatibility of attitudes and beliefs between health care providers and users. It outlines those socio-cultural factors that influence people decisions to use a particular health facility. Economically, health care providers are the producers and users are consumers, and for the demand of these services to take place, then providers have to exhibit certain qualities that are coherent with those of consumers. In the thesis it denotes the power, class and the economic status between health personnel and users. Acceptability in terms of attitude also comes from both sides, that is, from the patient and the health personnel. It therefore means that ideal attitudes are established at the meeting point of the two groups of people. For instance a bad attitude put up by health personnel can influence the attitude of users towards them and the vice versa. There is therefore the need for coherence in attitudes between the two groups. All informants from the two communities commented on the attitude of health personnel at the health centers. According to the Sankpala male group, the attitudes of the personnel sometimes keep them away from seeking treatment at the compound when they fall ill.

> The attitude of the senior nurse is very bad, she is not friendly.

The women group in Sankpala reinforced the above statement.

> The senior nurse is not friendly.

Response of the male group in Kusawgu shows that the attitude of the personnel at the health post is mixed.

> Some of the nurses are good and others disregard the community members.

The female group in Kusawgu seems to be satisfied with the attitude of the personnel professionally.

> The nurses handle us with care and they know how to go about their work

It is therefore interesting to note the contrasting views of informants. Whiles some informants are satisfied with the attitude of the health personnel others are not.

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To identify the reasons for the attitude being up by the personnel whom the users claim is not good, they explained that there is a power imbalance between health workers and users, and this has to do with money, and literacy. A woman in Kusawgu stated this;

> The nurses see us as dirty, illiterates, poor and villagers that is why the look down on us.

Another area which has to do with acceptability is the diversity of services provided at these centers. It is a known fact that orthodox medicine in Ghana excludes herbal treatment, even though efforts have been made to recognize herbal medicine through the creation of institutions like Center for Scientific Research into Plant Medicine. Allopathic treatment and herbal medicine in Ghana do not go hand in hand. This creates a vacuum, and boundary delineating many people who have been with herbal medicine all their lives from seeking treatment at health centers. Moreover most of these rural health centers do not provide services that cater for peoples psychological and spiritual needs. There are no counseling units. People seek counseling from their spiritual leaders.

A respondent in Kusawgu remarked,

> When I fall sick and perceive the sickness to be spiritual, I usually contact my pastor.

This is an indication that orthodox medicine failed to inculcate people's spiritual needs into it. It is not surprising that people combine both herbal treatments with modern treatment, because they feel that the modern system failed to capture their health needs holistically. I think this sometimes make some users to resort to alternative modes of treatment rather than orthodox. For instance the male group at Kusawgu stated that some illnesses do not allow them visit the health post, but rather consult the herbalist. They explained that when the get snake bites, or experience bone dislocation or fracture they go to the herbalist because they see him to be more efficient than the health post.

> With a snake bite, they herbalist can remove 'the teeth' which the health post cannot do. Even mental cases are first sent to the herbalist.

Another issue about acceptability is communication barrier. If the health workers are not able to understand the language of the local people, it becomes a problem. It means that some one who understands and can translate has to be available before consultation can commence. In

the study areas, the language of the people is Gonja even though some people speak Dagbane. However some of the personnel do not understand this language and this poses a communication barrier between users and personnel. It means that patients will have to rely on family members to translate their needs and symptoms to the health personnel and explain in return the diagnosis to them. The challenge with the process is that, it is time consuming and there may be misinterpretation. With this regard to this I observed that personnel at the various centers are trying to contain this challenge as they try to speak a number of languages with patients (to break the barrier) when there is a communication barrier between them.

Accommodation

Decentralization as a process aims at creating an enabling environment where beneficiaries of projects can use social services at any time of their convenience without being hindered. It tries to build positive attitude between providers of health services and users, to provide services that accurately meet the needs of users.

Accommodation denotes the ability of the operating system to address patients' needs appropriately. The working hours of the health center and the waiting time of patients count. It is realized that urban models of health delivery to some extend determine the provision of health services in non urban areas; however these models fail to capture the needs of these non urban people. Health centers are understaffed, health providers are only available during restricted times (Morgan et al. 2004). In the study communities work hours start at 9 a.m and end at 12 noon; however when patients are around at the time and not yet attended to, the working hours are extended. This also implies that when there are no patients and it is not up to closing hours, personnel also leave. In the study communities, the various health centers do not operate during weekends, as some of the personnel (Kusawgu) even leave the communities during weekends. This means that when people are ill during week ends they have to go for alternative treatment, to Tamale or wait till the week begins.

Patients also complained of long waiting hours. They stated that sometimes they personnel start to work after the official time; this means that they have spent long time waiting for personnel to report and start work and they (patients) again spend time in queues waiting to be consulted as a result of inadequate staff. To throw light on how the operation hours of health centers affect their decisions on treatment, an individual informant at Sankpala stated this;

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> Sometimes when the health personnel at the compound delay in coming and I realize that my condition or that of my child is deteriorating; I rush to the drug store and explain to the seller who prescribes and sells drugs to me or I take her to the herbalist since he is always at his home.

The view of this woman informs one of how attitude to work can force people to change their decisions on where to go for treatment.

The discussion above centered on the real situation of access that characterizes the people of Sankpala and Kusawgu in their efforts to seek for health services. The picture above provides a datum line with which measures to address the situation could be understood. Since the thesis attempts to assess the contributions of decentralization through the works of the District Assembly and the District Health Directorate, towards addressing problems of access to health services in the district the ensuing discussion will be centered on providers' perceptions.

6.2.7 Increasing access to health services; perceptions of health service providers

The discussion focuses on efforts of health service providers geared towards increasing access to health services. Each of the dimensions will be discussed, throwing light on what is being done to tackle some of the challenges identified under them. Issues that may lie outside the study objectives but relevant to the discussion will be included.

Availability

A lot of issues go into availability as used in health services. It is not just about the physical presence of the health centers but the necessary equipments, personnel and other supporting facilities that are required for the smooth running for a given health center. A synthesis of the views of informants expressed above shows that the physical presence of the health centers is meaningless unless these are well equipped with benches, beds, ventilation facilities and testing kits to meet patients' demands.

Concerning the non availability of these health facilities in some parts of the district and the distance that people (the distant communities) cover to use the facilities at Sankpala and Kusawgu, the District Health Director mentioned that more CHPS compounds are being

constructed in the district to meet the population demands. So in every community with a population between 3500 and 5000 people within a radius of 5kms, a health staff is re-oriented and relocated there.

Currently personnel at Kusawgu health post include; 2 community midwives, 4 community health nurses, 2 general nurses, 1disease control officer and 9 health aides. At the Sankpala CHPS compound, there is 1 general nurse, 1 community health nurse and 5 health extension workers. It must be noted that volunteers from the two communities are recruited and trained for specific health areas, and they assist personnel at the centers. An example of these volunteers includes the guinea worm volunteers in the two communities. Even though there was no available information to indicate the standard level at which a given heath center should be equipped with staff, it is widely accepted that there is inadequate staff at the various health centers. For instance the personnel at the Kusawgu health post admitted that the total number of nurses needed at the center is suppose to be 13 but they are only 6 (community health nurses, midwives and general nurses). At the Sankpala CHPS compound, health personnel revealed that there are only 2 nurses, however they are suppose to be 6. On measures to address the situation, the District Health Officer stated that there is a nationwide expansion of health training institutions in the country. She further stated that the District Assembly has made available a sponsorship package to interested candidates who want to pursue nursing and other health related courses

Considering the other inadequacies that characterized the various health centers, she added that they are working on them, however specific information regarding what is being done was not given.

As noted earlier, the general notion of decentralization is to improve service delivery both in quality and quality. Considering the nature of these communities (being rural), I think the right type of health facilities have been provided to the people except the inability of the district to build a hospital. However the strength of the health staff compared to the population need to be improved, so to avoid long queues and hours being spent at these centers. The scholarship package mentioned above as a motivational factor for students aspiring to go into nursing and other health institutions is laudable but to what extent can it produce and attract health workers to the district? This implies that some students may go in for the scholarship only to finish and refuse postings to such communities. Moreover, there is

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no specific information regarding how the inadequate health equipments are to be addressed. This means that these challenges can not be addressed immediately.

Affordability

This is the major challenge that most of the respondents face. That is the direct cost of paying for services. To get an insight on what is being done to ensure that community members are able to contain the cost of treatment; the District Health Director mentioned the NHIS as the only effort being put in place to support users of health facilities meet their cost of treatment. She added that vulnerable people like the aged, pregnant women and children are given free treatment. Regarding the potentials of the scheme, the District Mutual Health Scheme Manager mentioned that people who cannot afford their heath bills will be partially supported by the government to do so when one is registered, and children whose parents have registered will have free treatment. He further explained that one needs 7.2 Ghana Cedis (5 US dollars) to register. Information on the number of people in the district who have been able to register with the scheme revealed that only 45,000 people out of 194,000 in the district have registered. This implies that only about 1/4 of the total population in the district has been able to register.

It is realized therefore that the NHIS and the free treatment policy for pregnant women, children and the aged are the only ways by which users in these communities are supported to take care of their health needs although it is a fact that many majority of the people in the district still find it difficult to register. It must be noted that these are national policies, as the district lacks any local mechanisms in the form of community health insurance to address specific local health needs. There are no NGOs and philanthropies who support local people meet their cost of treatment.

With the number of people who have registered with the scheme, I can say that it is poverty that robs the people of their ability to pay for health services. This is because if the premium is about 5 US dollars almost at the level at which the GPRS defined people as poor, then it can said that it is not the amount charged for treatment that is the problem but the people's income level is low to meet the cost.

Accessibility

This is seen in terms of the number of kilometers or minutes spends to reach a given health facility. It also includes the transport facilities for conveying patients between their homes and the various health centers. As presented above, efforts are being made to construct CHPS compound at those areas within the radius of 5km with the required population. My worry about this population and distance criteria being used is that most settlement in the northern part of Ghana comprise of few but scattered houses. It is common to cover more than 5kms before one meets a community made of about15 houses with the total population not more than 500, and the pattern continues. I suggest that some other criteria be considered too, because the first two are not representative enough.

In terms of transport, not much has been done. Motor bikes still serve as the means of transportation for health personnel. Patients still handle their own transport needs when they need urgent services at the centers, and when referred to Tamale.

No efforts have also been made to ensure that the opening hours of the health centers have been adjusted to meet local needs. The system of service delivery is still rigid as it adopts urban conditions and imposed them on rural areas.

For instance during the rainy season informants admitted being busy on farms and only available in the morning or in the evening, however for these centers to change their time of operations to meet local conditions, they still go by what has been predefined in urban areas. This makes it difficult, for the coordination of community activities with that of the health centers activities. So this aspect of accessibility still remains unsolved.

Acceptability

Regarding acceptability to health service, it is realized that the nature of providing health services (community-based) to the communities allows for the participation of community members, and thus the opportunity for them to make decisions that are in line with their values and beliefs. The District Director of Health stated that, the system of providing health service through the CHPS initiative allows members of the community to jointly plan and implement health initiatives with health officials, and this conforms in some ways to their values. More so health personnel have been trained and still go for in-service training concerning how to handle users professionally so to make them feel welcome and

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comfortable. To tackle the language barriers, most of the personnel at the various health centers are able to speak at least one of dialects of the users, with provision made for translation (done by colleague health workers) for those who do not speak a common language with users.

Health personnel are also incentivized to accept their duties. This is done through salary increment and other additional duty allowances as stated by the Director of Health at the district. She further explained that community members are also sensitized on the need to use these health facilities through durbars, community meetings and fora.

Accommodation

Nothing has also been done to ensure that personnel at the health post remain in the community and discharge their duties during weekends. The thesis lacks information on what need to be done to keep them during week weekends. The director of health in the district stated that in service training programmes are periodically organized to update health personnel on current health practices in the country, as well as discussions on client patient relations. Trainee nurses are also given training on professional codes of conduct during their training. However, I doubt how these modalities are influencing behavioral patterns and professional conducts of health workers by way of establishing good rapport with patients so to make the latter feel comfortable. From the views of the local people, decentralization has failed in this regard to create the necessary conditions necessary that will keep health workers at post all time round by way of making services readily available. The District Health Unit is weak at designing specific but local measures that will propel health workers be at post all time. It has also failed to create the platform capable of harmonizing community members interests and values with that of health workers. The views of the District Director showed that attention is only focused on ways of improving the working ethics of health workers, without corresponding efforts to also get the local people to adjust or adapt to the modern health system. Moreover, the measures adopted to boost the skills levels of health workers are generally national health policies which may not be working in these local communities (not recognizing specific local conditions).

Summary

It is realized that community participation as envisaged in policy documents is extremely weak within the country's health sector as little opportunities are being created for local people to participate, particularly with the management of the various health centers. It revealed also that users are willing to make available resources that are found in their communities in providing health services. These include land and voluntary services like labour. The chapter further showed that access to health services is still low, as most of the people cannot meet the costs of treatment at these centers. The district health system however is doing a little to boost service delivery and increase the level of utilization of the existing health services by the local people as no local initiative has been put like ways of absorbing the people costs of treatment or assist them register with the NHIS. Health personnel at the various health centers also put up attitude which does not auger well with the local users. For instance nurses still abandon health centers and leave for cities during weekends. Patients still wait in long queues for consultations/treatment. Not withstanding the above mentioned challenges, it is realized that the health indicators of the two studied communities in particular and the district as a whole are improving as cases of guinea worm, maternal and infant deaths and poliomyelitis are on the decrease.

7 Findings of the research

The outcome of the research yielded mix results about the effectiveness of the decentralized health system in Ghana. The findings showed that local level participation in health service provision is extremely weak, as local people are much excluded from the process. This implies that Alma-Ata declaration in 1978 and the Bamako Initiative on participation in health service provision is yet to be fully observed in the Ghanaian Health Sector. The findings also indicate that not much have been achieved with regards to improving people's level of use of health services.

7.1 Decentralization and community participation

As mentioned earlier, participation in health service provision as envisaged in the Alma–Ata Declaration is still far from being achieved within the Ghana Health Sector. This is because the findings showed that the level or degree of local participation in health service provision is very minimal, with no efforts being made at the moment to address the situation. It showed that health workers and professionals are not willing to fully integrate local people into health decisions because they feel that they cannot contribute meaningfully to health decisions but rather drags the process.

The findings revealed that apart from the opportunity created to allow for the marshalling of resources endowed in these communities in the form of land, labour and other voluntary services, no other   efforts have been made to allow people at the community level to fully participate in health matters. Management of the various health centers is the sole responsibility of the district health unit and the DHMTs. Supervision of health workers is done by officials DMTS, with no opportunity created for the local people to contribute even though the local people interact more frequently with the health workers. Specific activities of the various health centers are planned by the personnel with approval from the DHMTs. Even movement of personnel and other resources is being monitored by the DHMTs. It was also realized that no medium has been created in the form of complaints boxes to allow users comment on the quality of services being provided by the personnel at the centers. The absence of these modalities to propel change in service delivery could account for the alternative modes of treatment being adopted by the local people as shown in chapter six.

On the other hand, the thesis has identified that no deliberate efforts have been made by the local people to promote participation. It is rather the health personnel who as part of formalities and to meet certain criteria such as donor support or advocacy groups invite the people into the process at certain stages of health decisions. Even though some local members have expressed the zeal to participate in health decisions, they have not been able to organize themselves to do so.

7.2 Decentralization and access to health services

A summary of the findings on the relationship between decentralization and the people's access to health services indicate the following;

Costs of treatment are a major determinant of people's decisions on where to seek treatment. The study showed that local people are zealous to use modern health services, however they often consider the amount of money needed to enjoy a given health service, and when such is not within their means, coupled with their inability to register with the NHIS, they resort to alternative methods of treatments. The study revealed that there is a high level of self-medication and other cost saving methods like the use of the herbalist in the two communities, a situation attributed to lack of money to meet health expenses.

Moreover the few who are able to afford treatment at these centers feel unsatisfied about the quality of services and the outcomes or results of treatments. Poor attitude of health personnel drive many users away from the various health centers as personnel behave unprofessionally towards users, for instance health workers report to work late or not turning up to work at all. On the quality of results, the local people have realized that the herbalist is best at treating certain illnesses such as the treatment of dislocation or bone fractures.

The inadequacies associated with the decentralized health system also made it to have little impact on people decisions towards using to health services. These inadequacies are manifested in the form of health staff, drugs and general medical equipments. The absence of a district hospital as a referral point for the rural clinics is a major challenge lamented by the majority of the people. The inadequate supply of drugs at the various health centers makes people feel reluctant to use some of these facilities but to go the community drugs stores to buy drugs. These problems make the local people to lose confidence and trust in the modern health system at their various communities in treating their illnesses and sicknesses.

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The findings further pointed out that transport and communication facilities are inadequate in the various health centers in the district, as many places within the district are inaccessible (are water logged areas without bridges to link such places to other towns), with people in such communities finding it difficult to reach the nearest health centers. Communication facilities in the form of telephones and mobile phones for public use are non existent and this impedes efforts to reach out for emergency health services. Ambulances for handling emergencies are lacking with no efforts being made to always assist patients to be transported to the nearest referral hospitals.

Not withstanding the above challenges of the decentralized health structures, it is established that decentralization has made available health services and facilities much more closely to the people. The physical existence of health structures and personnel has come as a relief to the local people. Their presence provides some security especially in times of emergencies. This also implies that the people now have a lot of choices at their disposal over where to seek treatment.

With regards to the relevance of theories in the thesis, it was realized that some of the theories or frameworks were to some extent useful in the discussion. For instance, the typologies of decentralization proposed by Rondinelli (1981) provided a general idea of the nature of decentralization in Ghana. It showed that there is public decentralization ongoing in the country especially within the domain of the political setting; however it presents a *mix picture* about the health sector. It was revealed that the health sector is still characterized largely by centralization where the Ministry of Health wields enormous power with regards to health service provision, with District Assemblies relegated to the background. The theory further highlighted that district health services are largely controlled by the central Ministry of Health particularly with budgeting and finance, with no efforts being made as at now to decentralize this function.

On the other hand, the theory became less useful in studying the relationship between the district health unit and the people at the community level. Even though decentralization argues for local participation, it failed to spell out the various ways by which local people could be involved in health service delivery. It also failed to recognize that *power* is a very vital element of participation, it only sees local level representation as the only means through which local people can participate in development. This therefore made the theory less useful and the need to look beyond it. Therefore in efforts to understand the nature of participation

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between the district health unit and the local people, Rifkin et al. (1981) model thus became important. This model defined some of the ways by which local people can contribute to health service delivery by way of participating aside electoral representation. The model thus helped the thesis to identify the nature and extent to which the people of Kusawgu and Sankpala contribute to health service delivery within their respective communities. However, the model only enumerated five process indicators through which local people can contribute. These indicators are not representative and reflective enough of the characteristics of the local people. For instance, direct health services provided by local healers are not recognized under the model, none the less their services remain the traditional and most accepted means of treatment to the local people. The model is thus built around only the modern health system. It therefore became less relevant in evaluating the contributions of traditional healers. The model assumed that when all the process indicators are observed in health service delivery, the needs of the local people will automatically be met. It failed to recognize the *power relations* (as being imbalanced) between health professionals and local people with the former wielding a lot of power and may decided not to provide what is needed by the latter. This made the thesis to move further in search of a framework that sees *power* as a vital component of participation, hence the adoption of the Ladder of Participation by Arnstein (1969). Although the ladder is old, it still remains relevant in studying participation in present days. The ladder made a dichotomy between what constitute non participation and genuine participation. It recognized power as an essential ingredient that local people ought to have to push through with their demands. The ladder guided the thesis to know that in actual fact there is no genuine participation within the health sector of Ghana because beneficiaries lack the power and the legal support to press for their needs, they only contend with what has been decided and provided by the central government. However the ladder became less useful because there are other factors which lie outside the staircase of the ladder and are crucial for participation. For instance questions like this posed by the thesis could not be answered by the ladder. Are the services of traditional healers an element of participation in health service delivery? If so where should they be placed on the ladder? The ladder thus limits itself to the study of modern health system and not a blend of traditional and modern health systems.

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7.3 Recommendations

The following provide suggestions on what can be done to improve local people use of health services in the Kusawgu and Sankpala communities in particular and the Central Gonja District as a whole. These recommendations are molded out of the challenges that the thesis identified to be impeding the full utilization of health services by the local people. The recommendations also touch on how participation should be carried out in the two communities to influence local people acceptance and patronage of health services.

7.3.1 Community participation

Health care providers should be educated on the importance of involving beneficiaries in planning and managing health care delivery. These providers can be sensitized during training, worships and seminars organized by policy makers, NGOs, and civil society groups. This is because, the health worker is the one close to the user and until he or she sees the need to encourage local level participation; national efforts aim at doing so will be thwarted.

Community participation in the whole public sector should be made official or legal, so that when beneficiaries are denied the opportunity to partake, they will have the power to challenge the operators of the given health delivery system. In the constitution of Ghana, it only gives the mandate for people to participate in the governance particularly of their local areas as enshrined in the decentralization article. However, this proposition has not been advanced to cover the health sector and some sectors of the public. I therefore suggest that in order for democracy and good governance to be observed fully in the country, parliament should enact a law on local level participation in service delivery in the country

Local people should also be enlightened on the importance of participation. Mass education exercise should be organized by bodies like the District Assembly, NGOs and advocates of local participation to create awareness in these people. By doing so, the local people will be equipped with knowledge and ideas on the nature of participation and their roles. This will eliminate the tendencies for local people to drag or hijack the process as complained by some of the health workers at the health centers. The education will also instill in local people the zeal to take the move to participate in service delivery rather than always waiting to be brought in my health professionals.

Government should make it a policy that participation as a process will cover all the spheres of health care delivery that is from policy making down to the implementation stage. The process should also be transparent to allow every aspect of service delivery to come under scrutiny by both community members and the health personnel. Accountability should be rendered at every stage of service planning, with a free flow of information between local people and health personnel. By this, local people will be motivated to participation and the outcomes of health programmes will be ideal.

The district health unit should map out local key service providers in the various communities and integrate them into the decision making process. These people include the herbalist, TBAs and sellers of drugs in the local communities. The health unit should partner with these people through education, training, and visits so to discuss with them ways of promoting good health practices. Since these people live much more closely to the people, it will be easier for the health unit to reach out to the local people if the modern health system is built around these local service providers. More so, all chemical shops in the communities should be licensed with a regularly monitoring of their activities. This is to avoid the sale of expired drugs. Drug sellers should also be educated on the dangers of selling drugs without prescription from the health centers, and they should desist from making prescription to the local people.

7.3.2 Access to health services

A district hospital should be built to serve as a referral point for the various rural clinics and to provide curative services to the people of the district. It can be done through the harmonization of efforts and contributions of the central government, the District Assembly, the GHS, local beneficiaries, NGOs and philanthropists.

The use of waivers should be encouraged. This is with the objective that the hard core poor who find it difficult to register with the NHIS and pay for treatment are cushioned by the government. Health professionals should define policies that are locally oriented to cover users such as poor widows and other poor people at the community level who find it difficult to meet the health expenses of their families. The waivers will serve as safety nets for those who find it difficult to pay for health services. A detailed study of these communities should be done to identify the eligibility of users for such a package. It will encourage the poor to

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also use modern health facilities, as the problems of cost associated with treatment will be absorbed by the central government.

Government should give full recognition to traditional medicine and if possible integrate it into the modern medicine as done in Japan, India and elsewhere. This will make modern medicine easily accepted by the local people as the system will be built around their beliefs and practices. The local governments should also strive to work with the traditional herbalists through the exchange of information and ideas on ways of treatment. The various herbalists interviewed expressed the desire to work with the District Unit; therefore the unit should work closely with these people by way of training them on modern methods of treatments, and should also in turn learn from these herbalists as some of them are of good knowledge and experience. Therefore, there should be some form of partnership between the herbalists and the local government; by-laws should also be made to protect these herbalists. In line with these, more TBAs should also be trained as they are of immersed importance to the community. The health personnel should visit regularly these TBAs to share with them current information on deliveries. The TBAs should once in a year be given a token by the DHMTs as a reward for their services rendered to their various communities.

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Appendix

INDIVIDUAL INTERVIEWS

Community members

Profile of diseases

1.	What are the common diseases found in the community?

2.	What is the number one disease found in the community?

3.	What do you think are the causes of these diseases?

4.	When your get any of these diseases, where do you go for treatment?

5.	In terms of modern treatment, where do you go for treatment?

6.	Do you feel satisfied or not about the health services provided at these health centers.

7.	What should be done to improve the quality of health care delivery if you are not satisfied?

8.	What makes you feel satisfied about the quality of services provided at the health care center?

Community participation

1.   In what ways does the community contributes to the running of the health center?

2.   What health groups are in the community that supports the running of the health center?

3.   Does the District Assembly plan with the community concerning how the health center should be run?

4.   Which other group of people within the community provide health services besides the health center?

5.   In what ways are traditional birth attendants and traditional herbalist helpful to the community?

6.   Are you able to pay for their services or not?

7.   In what ways does the community contributes to the running of the health center?

8.   What health groups are in the community that supports the running of the health center?

9.   Does the District Assembly plan with the community concerning how the health center should be run?

10.   Which other group of people within the community provide health services besides the health center?

11.   In what ways are traditional birth attendants and traditional herbalist helpful to the community?

12.   Are you able to pay for their services or not?

Access

1.   Is the treatment cheap or expensive?

2.   Are you able to pay for the health services or is it difficult to pay for?

3.   Are there people from the community or outside it who find it difficult to pay?

4.   Do they get support from elsewhere?

5.   For how long do you walk to the health service center?

6.   Are there users of the health center who walk for long before getting to the health center?

7.   In what ways is the presence of the health post important to the community?

8.   Is the health personnel fit to handle health issues at the center or not?

9. Do you think the health post is able to meet the health needs of the community adequately?

10. Do you think there is any reduction in the levels of diseases or not in the community?

11. If diseases have reduced, who should be given the credit?

12. Would you like to use a traditional herbalist, and what will make you like to use him/her?

The district chief executive

1. What type of health facilities are being provided by the District Assembly?

2. What is the total number in the district?

3. What criteria do you employ in allocating these health facilities to the beneficiary communities?

4. In what ways does the District Assembly support these facilities to ensure their sustainability?

5. What is the average fee charged at these health centers?

6. Geographically, how accessible is the service centers to the beneficiaries?

7. How adequate are the health facilities or services able to support the health needs of the community?

8. Are the personnel at these centers trained?

9. Describe the changes that decentralization brought to health care delivery.

10. In what ways is it supportive to improving quality health care delivery?

11. How does it also impede quality health care delivery?

12. In your own opinion, do you think the decentralized or centralized system is best for meeting the health needs of the people?

13. Women are considered marginalized, what is done to meet their health needs in the district?

14. What structures are put in place to promote the exchange of health information between the District Assembly and the beneficiary communities?

15. Who is responsible for the monitoring and evaluation of the activities of the health centers?

16. By what ways are the health needs of the Kusawgu and Sankpala communities identified?

17. Which category of the population receives more attention from the district in terms of health care?

18. Do you have traditional birth attendants and traditional herbalists in kusawgu?

19. In what ways are their services important to kusawgu and the district as a whole?

20. Does the District Assembly work with them? What ways.

21. In what ways does the District Assembly supports them?

22. Are they part of the health decision-making process within the district? What avenues are being created?

Traditional birth attendants (TBA)

1. How did you become a TBA?

2. What do you like about this job?

3. Does your job reward you financially to be able to earn a living?

4. Do you coordinate your activities with the health service center?

5. Do you coordinate your activities with the District Assembly or you do not?

6. Would you like to work with the District Assembly? In what ways?

7. What challenges do you face?

8. Have you ever been invited by the District Assembly to participate in health decisions?

9. What external support do you get to improve your quality of service delivery?

Traditional healers

1. How did you become a herbalist?

2. What illnesses/diseases do you treat?

3. What do you like about the job?

4. Can people pay or not for your service?

5. What type of facilities do you use?

6. Can they adequately meet the health needs of the people?

7. Have you been given any formal training or not to improve upon your skills?

8. Where is the location of your treatment center in the community?

9.   Has the district Assembly ever invited you to a discussion on health issues or not?

10.   Do you think participating in District Assembly's health discussion will help improve the quality of health care delivery in Kusawgu? How?

11.   What challenges do you face?

12.   Suggest ways of overcoming these challenges?

Nurses at health center

1.   What are the common diseases recorded in the health center?

2.   Which one has the highest figure?

3.   What is responsible for the diseases in the community?

4.   In what ways is the health center useful to the community?

5.   Is the health post adequately equipped to meet the health needs of the people?

6.   What are the challenges that it faces?

7.   What efforts is the District Assembly making to overcome these challenges?

8.   In what ways does the community contribute the upkeep of the health service center?

9.   Do you get the community involved in health decision making? Please explains those ways?

10.   Do you think TBAs and Traditional Herbalists are important at all?

11.   Do you work with them?

12.   What good things about them do you like?

13.   What weaknesses of them do you shun?

14.   Do you take decisions regarding maternal delivery with them?

The district health director

1.   What role do you play in promoting health care delivery in the district?

2.   What is your opinion about the quality of health care delivery in the district?

3.   What do you suggest should be done to elevate or sustain the health status of the district?

4.   What other bodies or teams in the district Assembly support health care delivery?

5.   Who participate in health care decision-making in the district?

6.   What platform is being created to promote this participation?

7.   Are you aware of the activities of TBAs and traditional herbalist?

8.   In what ways is their service important to the district?

9.   Does the District Assembly work with them? What ways.

INTERVIEW GUIDE FOR ADDITIONAL INFORMATION (MAY 2010)

TOPIC: HEALTH AND DECENTRALIZATION: A STUDY OF THE IMPACT OF

DECENTRALIZAITON ON HEALTH SERVICES IN GHANA

BY LYDIA KWOYIGA

UNIVERSITY OF OSLO, NORWAY

MPHIL IN DEVELOPMENT GEOGRAPHY

Community members

Community participation

1. In your opinion, what is community participation in health service delivery?

2. What features or elements do you consider necessary as part of community participation?

3. Who identifies your health needs?

4. Who initiate the participation process?

5. What type of health groups exist in the community?

6. Do these groups play active role in health decisions concerning the community?

7. What types of resources are being provided by the community towards meeting health goals?

8. Who decides the types of resources to be provided by the community?

9. What role does the local community play in managing the health service delivery?

10. Who decides on how resources should be put to use?

Access

1. How many kilometers do you cover before you reach the health center?

2. Are you able to pay for the services?

3. What will make you patronize the health center?

4. What is you opinion about the attitude of the nurses?

5. What resources would you like to have at the health center?

6. What is your level of satisfaction about the services?

7. Before decentralization (before 1996), describe the nature of health service provision?

8. How do you see health service provision now?

9. Between decentralization and before decentralization, which one of these periods do you think health service provision was satisfactory?

10. In your view, what ways would you want the community to participate in health matters?

11. What other things are not mention and are worth noting as far as health service delivery is concerned?

District Health Director

 Decentralization and its related issues

1. In your opinion, what is decentralization about?

2. What features make the health sector decentralized?

3. What are the reasons for the setting up of the district health directorate

4. what % of the local health spending is borne by the central government.

5. Who gives the mandate for the operation of the District Mutual Health Insurance Scheme?

6. What is done to ensure that there is adequacy of personnel?

7. Are the health services well equipped to be able to provide good health care?

8. In what ways does the health unit monitor and supervise the activities of the various health centers?

9. What are those health service centers that are being provided by the Christian based Health

Association (CHAG)?

10. Mention the various ways by which the district health unit support the activities of

    CHAG?

11. What is the composition of the District Health Management Team?

12. Describe the nature of health service delivery before decentralization was introduced?

13. What has changed in the delivery system under decentralization?

14. Between decentralization and before decentralization, which one of these time period has

    improved health service delivery?

15. What are the challenges of health service delivery under the decentralized system?

16. What do you propose should be done to mitigate some of the challenges?

17. What other issues do you consider important and should be discussed with regards to

    decentralization of the health sector?

Community participation

1. Who initiates community participation?

2. What are the ways by which community needs are assessed?

3. Who identify these needs

4. What category of health groups exist in the community?

5. What are the importance of getting these people involved in health matters?

6. What direct health services are being provided by the community to augment services

    provided by the modern health facilities?

7. What are the ways by which community members participate in the management of health

    services within the community?

8. Who are the various health facilities accountable to?

9. What platform is created to allow community members express their level of satisfaction

    or dissatisfaction of health services?

10. What type of resources are contributed by the community as a whole towards health

    service provision?

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11. Besides all these questions, what other health issues are considered vital and need to be brought out?

Access

1. What type of health facilities are found in the district?

2. What measures are being put in place by the district health unit and other lower structures to ensure that local people can pay for health services?

3. Who decides the amount of local fees charge at the various health post?

4. What is done by the district health unit to ensure that community members agree to use these health services?

5. What category of people are excluded from paying for services even if without health insurance?

6. What activities are ongoing to ensure that people can easily reach (not covering more than 5km) for health service?

7. Are people willing to use these health facilities at all?

The finance/budget officer

1. What are the sources of revenue to the health unit?

2. What is required of the various health centers before money is disbursed to these areas?

3. What criteria is used to allocate funds to the various health center?

4. Who are involved in the drawing of budget for the district health unit?

5. Who approves of the budget of the unit?

District Mutual Health Scheme manager

1. What is the district mutual health scheme about?

2. What is the minimum premium?

3. What is the purpose of setting up the scheme?

4. What are its importance?

6. How does the local people perceive it?

7. What is the turn out of people about the general registration?

9. How many people have registered with the scheme?

10. In what ways has the scheme affected the use of health services?

11. What are those areas of treatment that the scheme cover?

12. What are the challenges that the scheme faces?

13. who gives the mandate for the operation of the District Mutual Health Insurance Scheme?

District coordinating officer

1. What position does the district assembly occupy in health decision making?

2. What contributes in terms of resources does the district assembly give to the health unit?

3. In what ways is the assembly involved in the health issues of the district?

4. What are the various areas of which the assembly coordinates with the health unit?

5. In what ways does the district assembly monitor the activities of the district health unit?

6. What role does the district play to improving access to health service?

7. As the political head of the district, what is done by the district assembly to ensure that local people participate in health decisions?

8. Is the district health unit adequate enough to handle health issues of the district?

9. What functions would you recommend the health unit to have?

10. Would you recommend that health service provision be a complete responsibility of the District Assembly and not of Ghana Health Service?

Personnel at health post/CHPS compound

1. Is your number adequate enough to meet the community health needs?

2. Where do you make referral cases to?

3. Who supervises your activities?

4. What type of records do you keep regarding the functioning of the health centers?

5. How do you handle emergency cases?

6. What are the ways by which community members are involved in providing health

services to the community?