



## REDUCING MATERNAL MORTALITY THROUGH COMMUNITY PARTICIPATION: THE GBANKO EXAMPLE

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### Abstract

*Community Participation in health (CPIH) has been touted as the panacea to many health care delivery problems. For several decades, WHO and its allied agencies have churned out evidence of the efficacy of community participation in improving many health care outcomes across several countries. However, there is paucity of evidence with regards to its contribution in the reduction of maternal mortality in Sub-Saharan Africa. The paucity of information on the subject has necessitated the need for evidence-based research on the contribution of CPIH to maternal health outcomes within the context of MDG 5. This study examined the nature and level of Community Participation in maternal health issues in Gbanko, and the accompanying health outcomes using a qualitative case study approach. Data were collected from various key informants selected from a rural community setting and staff of the Ghana Health Service. Results indicate a high level of Community Participation in maternal and child health. Community Participation was in the form of active education campaigns, antenatal attendance, and skilled delivery at birth and post-natal attendance among others. These resulted in zero home delivery for the past 3 years, zero maternal deaths for 3 years in a row, over 90 % antenatal attendance, 100% skilled delivery at birth etc. Due to the impressive nature of the Gbanko maternal health situation, we recommend among other things that, communities should emulate this example. It is also recommended that every effort to sustain and build on the present gains should be made while eschewing complacency.*

**Key Words: Community, Participation, Maternal Health, MDGs, Gbanko**

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### Background of Study

Reducing maternal mortality has been a global priority for more than two decades now, and Millennium Development Goal 5 targets a 75% reduction in maternal mortality ratios between 1990 and 2015. While some countries in sub-Saharan Africa have shown modest success in lowering their maternal mortality ratios, overall progress in reducing maternal mortality in the region has been negligible (United Nations, 2008). In 2006, slightly more than half of all

maternal deaths occurred in Sub-Saharan Africa home to 12% of the world's population (WHO, 2007).

The vast majority of preventable maternal, newborn and child deaths, illnesses and disabilities continue to burden low and middle income countries (LMICs), particularly in sub-Saharan Africa. Within this region, nine countries (Ethiopia, Ghana, Mali, Malawi, Mozambique, Nigeria, Senegal, South Sudan, and Tanzania)

have amongst the lowest key maternal, newborn and child health (MNCH) indicators. For example maternal mortality ratios range between 350 and 840 maternal deaths per 100,000 live births (WHO, 2013).

In Ghana for instance, the maternal mortality ratio in 2013 was estimated at 380 maternal deaths per 100,000 live births (WHO, 2014). A Ghanaian woman's risk of dying from treatable or preventable complications of pregnancy and childbirth over the course of her lifetime is about 1 in 45, compared to 1 in 7,300 in the developed regions (Hatt, Chankova, & Sulzbach, 2009).

Increasing access to skilled birth attendance and emergency obstetric care is widely viewed as the key strategy for preventing maternal deaths. A variety of barriers impede this access: health systems constraints (shortages of skilled workers and health facilities, particularly in rural areas; poor quality care; lack of adequate transport systems), cultural barriers (lack of women's autonomy within the household, preferences for home-based births, traditional birth practices), and economic barriers (high out-of-pocket costs associated with facility-based deliveries and transportation), among others (Hatt, Chankova & Sulzbach, 2009). The majority of maternal and neonatal deaths could be prevented with early recognition and proper implementation of required skills and knowledge (Ray & Salihu, 2004).

### ***The Concept of Community Participation in Health***

Soon after the Alma-Ata Declaration, arguments for selective rather than comprehensive primary health care dominated and it was then recognised that community participation was important in supporting the provision of local health services and in delivering interventions at the community level (Rosato, *et al.*, 2008).

Community participation as a development strategy has a long history. It was central to the

“Health for All by the Year 2000” framework proposed in 1978 by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF), and adopted by 150 United Nations member states. Decades of prior experience using a medical service approach had not sufficiently improved health or alleviated health inequities. The “Health for All” strategy specified the potential for communities to be actively involved in health development to improve their health conditions (Sakeah, *et al.* 2014). Since then, the concept of community participation has been interpreted and applied in various ways by donors, governments, and nongovernmental organizations (NGOs).

Community participation is defined in the *Health Bulletin* as a process that increases a community’s capacity to identify and solve problems. Such participation can lead to equitable and sustainable improvements in health. The term 'community participation' is commonly understood as the collective involvement of local people in assessing their needs and organising strategies to meet those needs (Gryboscki, Yinger, Dios, Worley & Fikree, 2006)).

Rifkin (2006) asserts that over the years, community participation has evolved to include a variety of methods and approaches, some focusing on activities, others on processes. One set of “empowerment” approaches stems from the fundamental principles of community participation, and focuses on processes that enable intended program beneficiaries to define, implement, monitor, and evaluate programs that address self-defined needs (Rifkin, 2009).

### ***Role of Community Participation towards Improved Health Outcomes***

The relevance of community participation towards the improvement of health outcomes cannot be overemphasized. The importance of community participation in rural health service development is uncontested (Haricharan, 2011,

Rosato *et al*, 2008, Preston *et al*, 2010). Different philosophies and principles have been presented in support of the need for community members to take active part in health care planning, delivery and monitoring and evaluation.

The benefits of community participation include the fact that it can improve health outcomes, lead to more responsive care, facilitate people's involvement in treatment decisions and improve quality and safety (Galaa, 2012). In addition to better health outcomes community participation can help to reduce political risk, hold professionals and bureaucrats accountable, encourage clinical accountability, identify workforce issues and foster more responsive and equitable services.

Community participation in primary health care and rural health service development has been argued to result in more accessible, relevant and acceptable services (Taylor *et al*. 2008). When communities have this capacity, health programs may be more effective because solutions to health problems are based within that community's social structures, and accountability systems ensure that services are suited to the socio-cultural context (Gryboscki, *et al*. 2006).

Loewenson *et al* (2004) found, in a study in Zimbabwe, that community health committees improved both health outcomes and health services. Thus, clinics with health committees generally had more staff, expanded programmes, and better drug availability. Loewenson and colleagues also found that health committees were instrumental in finding successful solutions to problems. Baez and Barron (2006) noted that community involvement in Malawi had resulted in a more responsive health service.

Padarath and Friedman (2008) conclude that "community participation therefore provides an opportunity for community members and health care workers to become active partners in addressing local health needs and related health service delivery requirements. Community

participation also enables community members and other stakeholders to identify their own needs and how these should be addressed, fostering a sense of community ownership and responsibility" (Cited in Haricharan, 2011).

### ***Community Participation and Maternal Health***

Community participation has long been advocated to build links with improving maternal and child health. In spite of the popularity of the concept in policy frameworks and in practice, there is no equivalent commitment to measuring the outcomes of community participation as an intervention, or analysing the processes of community participation in order to improve those (Preston *et al*, 2010).

Several scholars have reviewed the benefits and challenges of community participation to health outcomes in general. These reviews have yielded varying findings and conclusions. While some scholars have concluded that the concept of community participation has been positive, others assert that nothing significant has been derived from it and still others remain neutral in their assessment. The promise of community participation to Primary Health Care is however undeniable (Rifkin, 2009). However, a critical review of the literature in the field sadly reveals that very little work has been done to ascertain the role of community participation in maternal and child health.

In fact since 1978 only a handful of studies in community participation has focused on MCH, the outstanding ones include Rifkin (2009), Rosato *et al*, (2008), Tripathy *et al* (2010), Bhutta, *et al* (2011). The much touted Community-based Health Planning and Services (CHPS) initiative is more or less a general health intervention and not specific to only maternal health. This situation makes it difficult to draw any firm conclusion on the effects of community participation on maternal health outcomes.

One may wonder whether community participation in health is the answer to the deplorable maternal health situation in Ghana and other Sub-Saharan countries. A plethora of interventions within community participation framework have been introduced in the country over the last three to four decades. These include: Primary Health Care (PHC), Medium Term Health Strategy (MTHS), Community-based Health Planning and Services (CHPS) initiative (Galaa, 2012). What has been the outcome of these interventions with regard to meeting the MDG five?

Are there any contributions community participation make on improved maternal health? In what ways and at what level do communities participate in improving maternal health? What challenges are encountered by communities in their quest to meaningfully participate in maternal health care? These are the key questions that inform the current study.

A significant contribution of this study is that it will fill the knowledge gap on how rural communities are participating (or not) towards reducing maternal mortality and improving maternal health. It hopes to bring to for issues of type, nature and level of participation that rural communities can and actually engage in at the grassroots level. It is envisaged that findings of this study will help clarify the numerous issues on the benefits of community participation, its methods and processes.

## **Study Methods**

### ***Study Site***

The study was carried out in the Gbanko Community in the Upper West Region of Ghana. The Community is found in the Nadowli-Kaleo District, 11 miles north of Wa, the regional capital. The community shares boundaries with Nyogloo to the East, Zambogo and Chaang to the North East, Guree and Sombo to the North, Papo

to the West and Kaleo to the South. The Sankana and Kaluri communities are to its South West.

Gbanko is predominantly a farming community with almost every adult person engaged in one form of agricultural activity or the other. It has a total population of about 1, 266 and like most Ghanaian villages has more females than males. The males are 480 while the female are 637. The community has six sections namely Jemaayiri, Mgeguyiri, Basumayiri, Tuomuniyiri, Peteryiri and Paaliyiri. The main language is Dagaare.

### ***Study Design***

The study utilized the exploratory case study approach. This design involved an attempt to study the issues of community participation using Gbanko as a case study. The reason for choosing Gbanko was that it is rural, had relatively homogenous population and the research team were quite familiar with the place due to some previous engagements they have had in that community. The study utilized mainly qualitative procedures to collect data.

Key informant interviews and FGDs were the main tools used to collect primary data. Secondary data was collected from records at the CHPS compound, District Health Directorate and Health Centres at Kaleo and Sombo. The respondents included personnel of the Ghana Health Service, Chief and elders as well as other opinion leaders of the Gbanko community. However, a critical component of the respondents was women in their fertility age (WIFA), and a few of their husbands. In all, a total of 130 respondents were sampled purposively. Three FGDS were conducted, one each for the Health Committee, the mother-to-mother support group, and the Community Health Officer (CHO) together with the health volunteers and the Traditional Birth Attendant (TBA). Key informant interviews were also conducted with a representative from the District Directorate of Health, the only TBA in the community, and the CHO.

## Results and Discussion

The following sections presents the results of the study beginning with the demographic

characteristics which included the sex, age, and education etc. of the respondents. It also includes issues on nature and level of participation, strategies for participation, benefits and challenges of participation.

Table 1: Demographic Characteristics of Respondents

Variable	Frequency	Percentage
Sex		
Male	48	37
Female	82	63
Total	130	100
Age		
14-19	3	2
20-29	24	19
30-39	60	46
40-49	20	15
50-59	17	13
60-69	6	5
Total	130	100
Education		
None	85	65
Basic	26	20
Secondary	14	11
Tertiary	5	4
Total	130	100
Occupation		
Farming and allied activities	87	67

Petty trading	26	20
Formal Sector	17	13
Total	130	100

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Birth Parity

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1-2	33	45
3-5	37	50
6-8	4	5
Total	74	100

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Source: Field Data, June 2014

The ages of all respondents ranged from 15-69 years. Specifically, women in their fertility age (WIFA) (who were the principal targets of the study) had ages that ranged from 16 to 45 years with a mean age of round 31 years. The majority (63%) of respondents were females. The larger representation of women in the study was purposively determined owing to the fact that they were directly involved in maternal health activities. Besides the 80 WIFA who were sampled from households, there were other key informants such as the CHO, the TBA and leaders of the Mother-to-Mother Support Group who were all women. The remaining 37% were male. About 35.4% of all respondents had a highest level of educational attainment ranging from the primary to the tertiary level. It means the majority (64.6%) of respondents had no formal education. About 67% of respondents reported that their major occupation was farming. This was expected considering that Gbanko is a typical rural setting in the Upper West Region and most of such communities are basically into farming. The remaining 33% of respondents were either into petty trading (20%) or formal sector work (13%). Data gleaned from the female respondents at the household level revealed the following on their

marital status and parity. Ten percent (10%) of respondents indicated they were single, 55 (68.8%) were married and living with their husbands, 7(8.7%) were divorced and the remaining 10 (12.5 %) are widowed. All respondents indicated they had accessed maternal health care (either ANC, skilled delivery or post natal care, or a combination of the three). Apart from a couple of the respondents who had never had children (but ever became pregnant), the rest of the respondents had a modal parity of 3-5.

### **The CHPS Initiative and Maternal Health in Gbanko**

In order to situate the study within a context, efforts were made to identify the specific maternal health programmes that were implemented in the community of which community participation was a prime element. Interactions with the various stakeholders in the community revealed that the CHPS initiative was the main programme with a maternal health component that took care of the maternal health needs of the community.

The CHPS programme is a process of health care provision in which health workers and community members are actively engaged as partners in the delivery of primary health care and family

planning services (Ghana Health Service, 2005). It involves the mobilization of community leadership, decision making systems and resources in a defined catchment area, the placement of reoriented frontline health staff [known as Community Health Officers (CHO)], with logistics support and community volunteer systems. Implicit in the responsibilities of the CHO is the provision of basic obstetric services to those who need them. These services include antenatal and post-natal services, and general reproductive health care services. The policy document on the operations of CHPS in Ghana specifically identifies some community-based structures which are integral to the initiative. Some of the community-based structures include Community-based volunteers, Community members, community health committees, mothers and children, Community/traditional health delivery personnel (native doctors, TBAs, herbalists, etc.).

### **Community Level Stakeholders of Maternal Health**

In an attempt to do a stakeholder analysis on participatory processes in maternal health it was imperative to identify the already existing community-based structures within the CHPS concept and those outside of it. The Community Health Committee and the Community Health Volunteers are the two most visible community-based structures that the CHPS initiative relies on in its attempt to involve the community in the implementation of the initiative. There were also instances where the CHO interacted with some identifiable groups such as the mother-to-mother support group whose major objective was to champion the welfare of women in the community and foster a positive relationship between women and other individuals or groups who had the

welfare of women at heart. As part of its contribution to maternal health, the mother-to-mother support group occasionally invites the community health nurse to their group meetings, where they engage in discussions relating to maternal health issues. The group also encourages pregnant women to pay particular attention to their health and seek regular medical attention including reproductive health, pre-natal, antenatal and post natal health services.

A respondent had this to say about the mother to mother support group.

*We in this community have a strong social bond with one another through this group. We formed this group to advise and guide our members to safe delivery. We hold weekly discussions with all pregnant and newly married ladies on how to keep yourself healthy when you are pregnant and how to have a safe delivery when the time comes* (A 45 year old Female Respondent)

The only recognized TBA in the community was also very instrumental in attending to the health needs of women. The TBA could best be described as playing an auxiliary role to that of the CHO in maternal health care. Although the traditional role of a TBA is to provide 'obstetric' services to women using traditional medical practices, her prime responsibility under GHS regulations was to identify pregnant women, register them and refer them to the CHO. The only time the TBA could provide direct assistance to a pregnant woman – whether at the prenatal, delivery, or post-natal periods - was during emergency situations. As a result of this, the TBA was given some training that equipped her to attend to such emergency situations.

A crosscheck with the TBA confirmed what was said by the CHO that she (TBA) for the past 24 months had not directly assisted any pregnant

woman during delivery and that all cases were referred to the CHO.

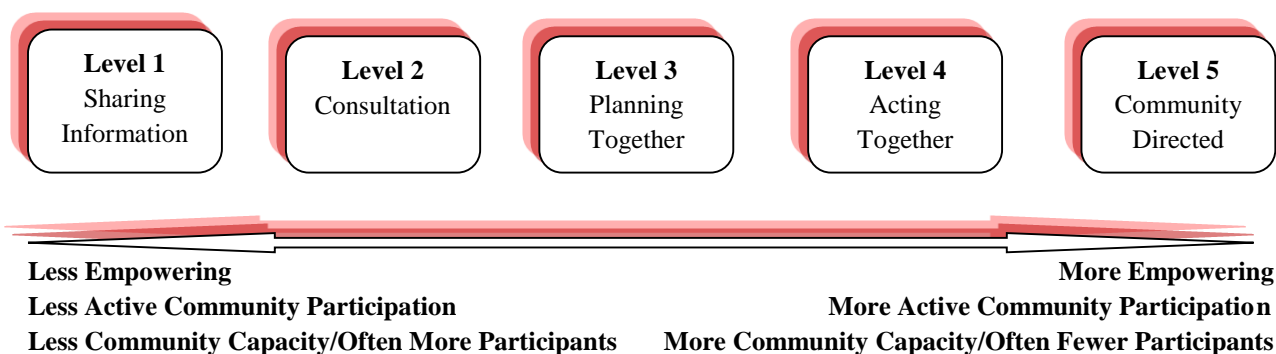
The Community Health Committee (CHC) and the Community Health Volunteers (CHVs) were two other groups who are particularly given recognition with specific responsibilities within CHPS. The Community Health Volunteers (CHVs) were reported to be trustworthy, hardworking, respected and capable individuals in the community who were recruited by the Ghana Health Service in collaboration with the CHC to assist the CHO with community activities in child health, family planning and other reproductive health services under the supervision of the CHC. The various discussions and interviews confirmed their presence and active involvement in the community. Some elders of the community also served as members of the committees. The committees and volunteers were found to be

active and functional in playing their assigned roles.

### **Level and Nature of Participation in Maternal Health Programmes in Gbanko**

Relying basically on the FSH Community Engagement Model, the research examined the level/degree at which the Gbanko Community was engaged in maternal health programmes. The aim was to establish the effectiveness and possible outcomes of any such involvement. The community engagement model comprises five levels of engagement on a continuum of community participation, empowerment, and community capacity. These levels are from bottom to top; 1) Information sharing, 2) Consultation, 3) Planning with the community, 4) Acting with the community, 5) Community taking control of decision making.

**Figure 1: Community Engagement Model**



**Source:** Adopted from Manitoba’s Department of Family Services and Housing (FSH)’ Engagement Model (2003)

Using these five levels, the study reveals that the majority of the people in the Gbanko community were actively engaged at level 1 activities where the CHO engaged the women in information sharing and advice. This ensued when women visited the clinic for antenatal and postnatal services and when the CHO undertook home-

visits and also at community health promotion durbars. This level is the least empowering and the participants need very minimal capacities to effectively participate.

There was also ample evidence to suggest that members of the community through the Health Committee, the Community Health Volunteers,



the mother-to-mother support group and the TBA were consulted on health issues and how they were to be carried out. Additionally, health planning with and for the community was also evident. On the evidence of the nature of relations with the community, one could draw the conclusion that the first four levels of community participation were present and involvement was particularly high.

One elder sums this up in the following quote:

*Before the Compound was built, we were consulted, our consent was sought when volunteers and committee members were recruited, we welcomed the nurse when she was introduced and since then we have been engaging in regular sharing of knowledge, educations and planning of health activities. Even the TBA has been helpful. In this community we believe in unity and that is our role in health care services. We will continue to do so and encourage active participation from all those who can and should (55 year old Community Elder and CHC member)*

Another important aspect of the levels of participation is that each successive level enables communities to be more active and empowered participants, having a greater voice and greater influence in decision-making. On the final level, where community members are expected to take control and make health decisions for themselves, evidence showed that this was not the case yet. Most of the major health decisions were still taken at the national, regional and district levels and not at the community level. Although according to the model, this was a setback, it did not necessarily affect the overall goal in engaging community members in health promotion and service delivery. Although the model presents the levels of participation as a continuum, it is not indicative that the highest level of participation is always the goal or the most desirable. Depending on the

resources available, the nature of activities to be implemented, the characteristics of the respondents, inter alia, the kind of level one wishes to rely on may vary.

Similar to the above model is what Schubert (1990) prefers to call intensity or depths of participation (cited in Galaa, 2012: 15). The four levels of Schubert's model of participation are; *Information sharing, consultation, taking decisions together* and *initiating action*. These represent levels 1, 2, 3 and 4 respectively. What Rifkin (1990) prefers to call the *levels of participation* which probably differ in 'body' but of the same 'spirit' with the above models was again cited by Galaa (2012: 14). At the first level of Rifkin's model, local people can participate in the benefits of health projects in the form of services or education. The second level involves support for programme activities in the form of cash or in kind. Level three involves implementation where local people assume managerial responsibilities including decision making. Level four concerns programme monitoring and evaluation whilst level five is where local people are offered the opportunity to take part in actual planning.

The study found that although the final level of participation (the community owning and deciding which programme they wanted) was absent, the remaining levels received some appreciable amount of participation. The activities which members of the community participated in included, provision of a CHPS compound and help in running it, health education and promotion, mother to mother support group, emergency delivery services, ANC and post natal attendance, etc.

### **What Strategies are employed in engaging the community?**

A representative of District Health Directorate and CHO indicated that the GHS tried as much as

possible to use the already established community leadership structure and other identifiable groups in promoting maternal health and involving the community. Basically through education, the CHO goes on home-visitations, meets with the health committee and volunteers and the mother-to-mother support group to share with them any issues concerning maternal health and how such groups of individuals could in turn, inform other members of the community. The community is always encouraged to take charge of the management of the CHPS facility through the community leadership and the health committee. All other individuals and groups who have the health of women/mothers at heart were identified and contacted to form an integrated whole.

Another interesting aspect of the participatory process in the community is the involvement of mothers-in-law and husbands. These two sets of individuals are seen as very instrumental in decisions concerning the wellbeing of married women in households. The case of the mother-in-law becomes critical when she lives with her son and her daughter-in-law. Although it was explained that mothers in-law and husbands were very supportive of women who needed medical care, the CHO stressed the need to involve them actively in maternal health programmes. As the CHO rightly put it:

*‘In this part of our world, the man is very instrumental in decisions concerning the health of his wife and children...but most important is the man’s mother...she is able to influence her son to take decisions that may or may not favour the wife’.*

The TBA also had similar sentiments when she said

*‘The mothers-in-law are always the problem...if they don’t like the daughters-in-law then nothing good comes out of them. Once they are also women, there is*

*the need to engage them so that they could take a central role in the health of the sons’ wives’.*

### **“We Participate Because of the Benefits we stand to gain” – Contribution of Community Participation to Maternal Health**

There is a popular saying that people will always be willing to participate in an event provided they stand the chance of benefiting either directly or indirectly from it. In assessing how the various stakeholders perceived the benefits or potential benefits of participating in the maternal health programmes, the study engaged the CHO and the District Director of Health as representatives of the Ghana Health Service, and the community members in a discussion. Apart from the improved ANC, delivery by a Skilled Attendant, and postnatal care (discussed later) which are very important measurable indicators, there were other benefits that were identified by the community and representatives of the GHS.

For GHS/Government, involving the community in maternal health activities has afforded them the opportunity to better identification and understanding of the local needs and issues of the community and helped them to prioritize services. The process has also led to the situation whereby the GHS appreciated the untapped community resources and energy that can be mobilized to enhance the health of women. In addition, community participation facilitates development of policies and programs that are better informed (provides a broader range of inputs to decisions or solutions to problems), more responsive to the community needs, and more likely to gain acceptance and achieve better outcomes. The GHS also identifies the issue of trust building and credibility with the community as one of the benefits of the participation strategy. This trust

building and credibility lends itself to accountability and openness.

On their part community members assessed the benefits they derived from participating in maternal health programmes as emanating from improved outcomes of maternal health as evidenced by ANC and skilled delivery outcomes. It came out clearly from focus group discussions and interviews that participation in the CHPS concept as a whole had many benefits.

*“Participation....Has enhanced our level of empowerment and self-worth through greater voice and input into planning and decision-making processes” (39 year old Male Respondent at an FGD)*

*The Health Committee oversees the day to day management of the CHPS compound, assists in the recruitment and supervision of health volunteers and helps in the*

*mobilization of the community for health programmes. Our involvement has enhanced our knowledge, experiences, ideas and insights within the community and with the Ghana Health Service. The broader aim is to empower us (community members) to reach our full potential and take charge of our own health (50 year old Elder and member of the Community Health Community).*

These views of the benefits of engaging the Gbanko community in health programmes were consistent with similar findings reported by the Canadian Policy Research Networks and Ascentum (2005), Government of Western Australia (2006), and Manitoba Family Services and Housing (2008).

### **Positive Maternal Health Indicators**

**Table 2: Maternal Health Trends in Gbanko**

Indicator	2010	2011	2012	2013	Mid 2014
ANC	58% (44%)	85% (66%)	90% (68%)	98% (74%)	99%
Skilled Delivery	68%	98%	100%	100%	100%
Maternal Death	2	0	0	0	0
Post Natal Care	60%	88%	93%	98%	98%

(Figures in parenthesis indicate % with minimum of at least 4 antenatal, visits)

Source: Field Work, June 2014.

From the table, one could infer that the concept of participation was a successful one. Of relevance to the study were fundamental maternal health indicators such as access/utilization to antenatal and post natal care and skilled delivery services and maternal mortality. Antenatal care provides good indicators of maternal health care worldwide. It indicates the proportion of women who were attended to at least once during pregnancy by skilled health personnel. This is critical as it allows women to identify and possibly correct potential problems in addition to receiving general health advice (UNICEF and Ghana's Ministry of Women and Children's Affairs [MOWAC], 2011).

Prior to the setting up of the CHPS compound in the community, most pregnant women hardly had access to ANC and those that could go to the nearest village for such services did that on irregular basis. With the inception of the CHPS programme in 2010, the proportion of women seen at least once by the CHO during pregnancy increased from 58% in 2010 to 99% by mid-2014. Also women who made at least four ANC visits during each pregnancy episode increased from 44% in 2010 to 74% in 2013 (2014 figures were yet to be calculated). This was indeed impressive since the national average for rural ANC was 67% (Sakeah, et al. 2014).

Another interesting phenomenon was the proportion of pregnant women who had access to skilled birth attendants. Although the CHO was not permitted to deliver women unless it was a case of emergency, 100% of all women who had at least one ANC visit delivered under the supervision of a skilled birth attendant either at the Sub-district health facility at Kaleo or at the Sombo clinic which are approximately 1.5km and 4km respectively from Gbanko. There has been a steady improvement from 68% in 2010 to 100% as at mid-2014. This means a zero home delivery for three years on a row. Again the figures are way

above the national average of 56% for rural areas (GHS, 2012).

The study also found that since 2011, no woman has died from pregnancy or child birth related causes. The total number of women who had access to post natal services also increased from 68% in 2010 to a current figure 98%. This means that women who are delivered by skilled health personnel have the opportunity to be attended to and given post natal services for at least the first few hours and days after delivery. This is a very good situation since it is believed that the first few hours after delivery possess the greatest danger to mothers and babies.

Overall, it is mind boggling, the near perfect maternal health indicators posted by the community. Although no statistical test were carried out to examine which factors were responsible for such impressive figures, it would not be farfetched to attribute this situation partially (at least) to the commitment of members of the community and the health workers to improved health care outcomes. Thus community participation had indeed contributed significantly to this impressive state of affairs. However, other positive contributory factors could be the accessibility and availability of transportation and good roads, coupled with the availability and nearness of health facilities that provide maternal services. Subsequent studies may explore these additional factors to measure their overall impact.

### **Factors which inhibit Community Participation**

Data revealed a number of challenges each of the participating partners encountered which had the potential of derailing the gains chalked so far. The following are some of the pressing challenges that need immediate attention.

One major issue that affects the level of community participation in Gbanko was

difficulties in meeting community members especially, the women during farming seasons, on market days, and on occasions such as funerals. This arose from the fact that the timing of home visitations conflicted with times where these community members had to go to their farms and also engage in other livelihood activities. There were also instances where some women prioritized their family and household responsibilities over their own health needs. This is not to say such women had any alternatives – such decisions often times came about as a result of pressure from her family or the community.

For instance, one married woman who was pregnant at the time of the study indicated that:

*Looking after my husband's informal business and cooking for his workers left me with limited time to go to the clinic” (A 27year old Female, Interview Respondent).*

*Timing is the greatest challenge we face in our outreach programmes especially during the farming season. It is heart breaking that I could ride through the community seeking to meet clients at their homes only to realize they are all out to farm or markets. It can really be frustrating especially for pregnant women whose husbands you want to meet at home to offer advice to both of them. Sometimes you meet the husband alone, sometimes the wife alone. It's very difficult to meet them all at once (CHO of Gbanko).*

Secondly, the Community was faced with inadequate skilled capacity to participate. Capacity implies the skill, knowledge and resources community members possessed and willing to use to improve health. Literacy rates

among adults of the community were relatively low hence health education and promotion campaigns were quite cumbersome to carry out. This is in line with findings of Galaa (2012), which states that inadequate capacity building programmes for community-based volunteers and actors was one major challenge of the participatory process. In Galaa's view, although training and refresher training programmes were organized in the form of workshops for health management staff and nurses, the same could not be said of community level auxiliary personnel such as some health committee members, the volunteers and the TBA. Inadequate funding and lack of logistics have been cited as reasons for that gap (Sakeah, 2014). In addition to this, the CHO, lacked midwifery training hence could not engage in obstetric care, except where there is an emergency.

Another challenge the research identified was how to meet the high expectations of the community with regards to financial motivation. Apart from the women who had the benefits of having access to quality health care, some health committee members, the volunteers and the TBA were very expectant on what they stood to gain (personally). In the words of the TBA

*“...my source of livelihood has been taken away from me and so far I have received any compensations...how do I survive?”(Gbanko, TBA, Interview)*

The sentiments expressed by the TBA arose from the fact that she has been asked not to assist women during delivery (which hitherto was her job) but rather, help the GHS identify such pregnant women, register them and refer them to skilled personnel. The issue of voluntarism, adequate motivation and participation must be considered seriously. Although as part of the requirements of the CHPS concept, the community itself must devise ways of motivating these volunteers that has not been seen to be

effective. The only instance where the community was seen to be very active in motivating a volunteer (the CHPS compound watchman) was when they used to contribute some money for him at the end of every month but that was converted to organizing communal assistance for him on his farm when the community could no longer sustain the monetary requirement. If what Galaa (2012) considers as 'secure base' is a true determinant of assessing how committed one will be in undertaking a voluntary work, then it will be very difficult for the TBA whose job has been 'taken' away, and the other volunteers who do not have a secure base (economically) to stay committed to their respective voluntary activities.

Inadequate husband involvement appeared to be a major concern which hampered participation. The society was still largely patriarchal and reproductive health decisions were largely within the purview of the man. Women who participated in health care issues did so at the discretion of their husbands and there were instances where their husbands forbade them to engage in certain discussions (Rifkin, 2009). Though most men did not interfere much with their wives seeking health care, their support in their regard was very minimal. Men were still authoritative in matters that had to do with family planning and this was a concern for the CHO. Decisions regarding the use of contraceptives were beyond the woman and men were the final says in such matters (Tripathy, 2010).

Complacency and misconceptions proved to be a key hindrance for adequate participation in maternal health. Illiteracy, ignorance and general misconceptions about pregnancy and child birth related issues be was found to be a serious problem in the community. For instance, the CHO lamented that

*ANC attendance is not 100% some women are too stubborn and complacent. The women who have had three or more*

*delivery felt they did not need to attend antenatal especially in their first two trimesters. They felt that they were 'experienced' enough to identify and take care of the danger signs (Gbanko CHO).*

When asked about this, a female respondent during the interview admitted this and said:

*It is true that women who have been mothers before feel like they know a lot so attending antenatal is not too important like it was in the early pregnancies. Once a woman told me that nothing has changed in antenatal clinics so she still aware of the danger signs as well as how to take care of herself during pregnancy. She added that she still has the knowledge taught during her first two pregnancies and will only attend ANC when she is more than six months pregnant. She kidded that besides, no woman in Gbanko has died due to child birth and pregnancy complications for the past three years (Narrative by Mother-to-Mother support group member).*

Due to ignorance of the reproductive system, some women also failed to detect pregnancies until the first trimester has elapsed. As a result some of the women reported that they usually detected they were pregnant after missing their "period" for two or three months. This phenomenon delays ANC attendance. According to Galaa (2012), level of education and literacy affects the effective participation of communities especially, the auxiliary personnel as it fosters ignorance and low awareness of the concept of participation.

## **Conclusion**

Engaging communities in the health of women has been seen by governments and international

agencies as one of the key areas in which to promote maternal health. Although promoting community participation at times is bedeviled with a number of challenges and requires different strategies, they are integrally related and there is the need to identify what form of participation will suite the specific characteristics of the participating teams. Though one cannot consider it as an ideal type of community participation in maternal health, the Gbanko story presents a good case for involving communities in the health of women. Under the present circumstances, the Ministry of Health/Ghana Health Service and their development partners consider community participation as one of the most viable strategic options to make themselves visible to communities and let these communities take ownership of health programmes.

The research findings are revealing and show great prospects of how communities can take charge of their own health. From the willingness of the community to participate, their commitment to the course of participation, the support of community leadership to the use of already existing community-based structures, there is ample evidence that if community participation is properly managed, it could be a viable strategic option to quality maternal health care delivery.

### **Recommendations**

The ensuing recommendations are aimed at assisting the Ministry of Health, the Ghana Health Service, Civil Society Organisations, the District Assemblies and communities to harness in a more realistic way the potentials of community participation and manage the inherent challenges. It is imperative that the Ghana Health Service or any Organisation that wish to involve communities in health programmes to pay particular attention to the building the capacities of the participating individuals and groups as that determines their levels of output. Regular

refresher programmes for Community Health Volunteers, the CHO, the TBAs and the Health Committee should be considered. There is also the need to equip the community with the necessary resources and logistics to make them more effective and efficient.

The role of husbands/men and mother in-laws is seen as very critical to the achievement of maternal health outcomes. Though the Gbanko CHPS compound has been able to harness this opportunity, much effort is still needed to let these individuals play a pivotal role in the health of their wives and daughters in-law respectively. The GHS, the MOH and the community must ensure this approach is improved and sustained.

As clearly presented in the Gbanko story, the timing of programme activities that involves communities must be such that it does not conflict with the livelihood activities of community members. Though that is a big challenge, it stands the chance of ensuring that majority of community members are available to take part in such activities.

ANC as well as post natal services should be modernized and encouraged. Complacency must be eschewed to ensure a sustained improvement of maternal health outcomes. Lessons learnt from Gbanko can also be replicated in similar rural setting to gauge it degree of success there too.

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