GHANA INSTITUTE OF JOURNALISM

EXAMINING THE LINKAGES BETWEEN COMMUNITY PARTICIPATION AND MATERNAL MORTALITY REDUCTION IN THE LA-DADE KOTOPON MUNICIPAL ASSEMBLY.

BY

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Declaration

We hereby declare that, except a reference to other people's work, which has duly been acknowledged, this dissertation is the result of our original research and that no part of it has been presented for another degree in this university or elsewhere.

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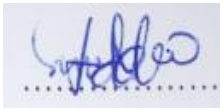
SARAH ADJORKOR ADDO MADC19113		01/10/2020

Supervisor's Declaration

I hereby declare that I supervised the preparation and presentation of this project work in accordance to the guidelines laid down by Ghana Institute of Journalism.

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Dedication

The piece of work is dedicated to God Almighty. I also dedicate this work to our lovely families, handsome and adorable children, for their prayers, encouragement, love and support throughout the study.

Acknowledgement

I give praise, honour and thanks to the Almighty God for His grace in seeing us through to the completion of our programme.

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I am equally grateful to the respondents who partook in the study for granting interviews and responding to our questionnaires to the successful completion of this project.

Abstract

Community participation in health is seen as a very effective but challenging implementation approach to health service delivery and has been of great interest among health care policy planners and implementers. It is a system approach that aims at enhancing accessibility and the utilization of health services at the community level. Whilst the beginning of the idea and conceptual development of community participation are fundamentally attributed to large multinational health institutions, particularly the World Health Organization (WHO), its implementation is the ultimate responsibility of local health programme initiators. This study examining the links between community participation and maternal mortality reduction in the la-dade kotopon municipal assembly.

Both quantitative and Qualitative data were collected from personnel of the municipal health directorate and residents' in-depth interviews, two focus group discussions and a community conversation with all the major actors at the community. The various actors collectively evaluated community participation in the maternal health program.

The findings from the thematic analysis show that the community participated in some stages of the planning and implementation process. However, majority of the informants indicated that they were not consulted about their specific health needs before the facility was established. The study found a positive effect of community participation on maternal health reduction.

The study concludes that communities should be capacitated and encouraged to participate in health interventions at the community level.

Contents

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

1.0 Introduction

A global estimation of 800 women die daily from pregnancy and childbirth-related complications, with 99% of these occurring in low middle-income countries (Nour, 2008; Pathmanathan et al, 2003; Koblinsky, 2003). South Asian and sub-Saharan African countries bear the highest burden of maternal death (World Health Organization, 2019). A situation requiring critical and effective mitigating strategies. This chapter presents the introduction to the project topic "examining the links between community participation and maternal mortality reduction in the La-Dade Kotopon Municipal Assembly". The chapter proceeds to state the background of the study, problem statement, research objectives as well as research questions, the purpose of the project, and the significance of the project.

1.1 Background to the Study

A target of the Millennium Development Goals (2001–2015) adopted by the United Nations General Assembly in 2000 aimed to improve maternal health, committing to reduce the global maternal mortality rate by three-quarters between 1990 and 2015. Achieving equity and universal coverage of maternal healthcare delivery remains crucial to efforts toward poverty reduction, gender equality and women's empowerment. To this end, the successor to the MDGs, the sustainable development goals (SDGs), re-emphasizes the commitment to reducing maternal mortality through universal coverage of maternal healthcare delivery. Access and utilization of healthcare services during pregnancy and childbirth are crucial to safe motherhood. The use of prenatal health services enables the early detection and management of pregnancy-related

complications and provides opportunities for health promotion (Joshiet al., 2014). The provision of timely and quality maternal healthcare services is essential to the health of mothers and newborns (Noonanet al., 2013).

The World Health Organization (WHO), and United Nation Children's Fund (UNICEF) The Maternal Mortality Ratio (MMR) as "the annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes)". The MMR includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year. Globally, according to UN inter-agency estimates, maternal mortality ratio declined by 38 per cent – from 342 deaths to 211 deaths per 100,000 live births, from 2000 to 2017. This translates into an average annual rate of reduction of 2.9 per cent. In Ghana, the maternal mortality ratio is estimated to range from 214 to 700 per 100,000 live births. These figures have persisted for some time despite various policies and initiatives including an Antenatal Care policy and the Safe Motherhood Initiative African (2006). In recent years, Ghana's MMR decreased from 580 deaths out of 100,000 live births in 2007 to 485 deaths in 2010, and further reduced to 308 deaths/100,000 live births in 2017 (GMHS, 2007; PHC, 2010, MOH 2019).

Furthermore, the Government of Ghana (GOG) in consultation with various stakeholders instituted policies such as the national health insurance scheme, free maternal health care policy etc. to help minimize MMR. Some of these policies have helped most of the rural communities as far as maternal health is a concern and those who could not afford some medical services. The rural areas which are mostly deprived of permanent health infrastructure have been prioritized with programs such as community health planning service (CHPS), which aims to transform clinic-based primary health care and reproductive health services to community-based primary health services. Most

CHPS workers are mobile and move from community to community to educate community members on preventive practices as well as administer curative services (Ghana CHPS,2009a), as cited in Abdallah Salisu and Vanessa Prinz (2009) health care in Ghana.

In an attempt to improve maternal mortality, WHO undertook several interventions. Chief amongst them is effective adoption of community participation, which occasioned the 2003 publication of "Working with Individuals, Families and Communities to Improve Maternal and Newborn Health", (1) the IFC framework that promotes integrating the health promotion approach set out in the Ottawa Charter (2) into National Maternal and Newborn Health (MNH) strategies. The IFC Framework was developed in response to analysis and global statements indicating that as well as strengthening services, MNH strategies need to improve the capacity of individuals, families and communities to provide appropriate care for pregnant women, mothers, and newborns in the home.

Community participation is a social process in which specific groups with shared needs living in a defined geographical area actively pursue identification of their needs and take decisions and establish mechanisms to meet them (Bichmann et al., 1989). This means individuals and groups, exercise their right to play an active role in the development of appropriate health services. Community participation in health development (CPHD) is a process by which partnership is established between the government and local communities in the planning, implementation and utilization of health activities (Rifkin, 1990). Community participation in health development (CPHD) ensures conditions for sustained improved health and supports empowerment of communities for health development. Consequently, CPHD Increases coverage, efficiency, effectiveness, and equity of health services provision and promotes self-reliance in the community (Oakely, 1989).

Partnerships between community and institutions at all levels allow for sharing of experiences, expertise and resources necessary for the attainment of 'Health for All'. Community's direct and indirect participation in the promotion and maintenance of their health and that of their families lies at the core of community centered approaches to development. Such approaches require the implementation of sustainable development programs based on self-reliance and are managed and owned by the community. Increased commitment by all is urgently needed to ensure full implementation (WHO, 1997).

Therefore, community participation is essential for effective maternal education and policy implementation. Hence the need for more studies in this discipline to expand its academic frontiers.

1.2 Problem Statement

The conceptual gap between communities and health planners or health service providers has always led to the failure of many health development projects or programs. Invariably the success of any health program depends very much on the extent to which the community participates. Thus knowing how broad or narrow community participation is in programs is very useful to planners or health managers. In light of these maternal and child health challenges, many countries in Africa, including Ghana, have increasingly emphasized the need for bottom-up community engagement in the planning and implementation of healthcare services. This approach has the potential to promote utilization of safer maternal and child healthcare services.

In Ghana, attempts have been made at promoting community participation or involvement in Primary Health Care. These include the Brong Ahafo Rural Integrated Development Program - BARIDEP (Beausoleil, et al, 1978), Danfa Rural Health Project (DANFA, 1979) and several

mission-initiated PHC programs notably the Ashanti-Akim Rural Health Program (1979). The conclusions of all these projects indicated that the progressive involvement of the community in the provision of essential health care led to the solution of numerous health problems at the local level (Letsa et al. 1992).

The CHPS program, an initiative of the Ghana Health Services launched in 2000, was designed to increase access to health care and family planning services in rural areas of Ghana (Nyonator et al, 2005). A CHPS zone has a population of 3,000 to 4,500 people–covering two to three unit committees of the District Assembly (Ghana Health Service,2005). From its inception, community participation was a significant component of the program. Local communities provided land and labor for building CHPS compounds and community health volunteers undertook health education and management of minor ailments. midwives partnered with traditional birth attendants (TBAs), community health volunteers and other community members to provide skilled delivery in rural areas. As the program seeks to ensure that all women in remote villages have access to skilled attendants during and after delivery, strong partnership between TBAs and health professionals and between all community members and the midwives are essential (Nyonator et al, 2005).

There are replete of community participation studies from the public health and development communications perspective in Ghana (Bougangue & Ling, 2017; Craymah et al, 2017; Adu et al, 2018; Sakeah et al, 2018). Most of these studies focused on the three northern regions of Ghana (Alhassan et al, 2019; Sakeah et al, 2018; Johnson et al, 2015). This study broadens the scope by investigating community participation in the La-Dade Kotopon Municipality.

1.3 Research Objectives

The main objective is to investigate the relationship between effective community participation and maternal mortality reduction within the La-Dade Kotopon municipality. The specific goals are;

1. To assess the factors that influence community participation interventions for maternal health.
2. To evaluate the effectiveness of community participation interventions for maternal health.
3. To assess the synergies between community participation and safe reproductive health practices.
4. To identify the barriers and facilitators to effective community participation.

1.4 Research Questions

1. What are the factors that influence community participation interventions for maternal health?
2. How effective is community participation interventions for maternal health?
3. What are the synergies between community participation and safe reproductive health practices?
4. What are the barriers and facilitators to effective community participation?

1.5 Significance of the Study

The study hopes to encourage stakeholders in the health sector to participate fully in maternal health care delivery in the La Dade Kotopon Municipality. Furthermore, the findings will serve as a source of information to parents, health professionals and authorities, traditional rulers and other stakeholders. NGOs, Parents and other groups working to promote community participation will be fully aware of the kind of support required of them to make maternal health delivery a success. The findings of this study will help health officers of the La Dade Kotopone municipal health Directorate to play their expected roles to develop effective community campaigns in the municipality. Furthermore, the findings envisage informing the community members on the need to join hands with the government in the provision of maternal health care in their locality. The findings of this study will also add to the existing body of knowledge about community participation in healthcare delivery in Ghana and how this concept is being implemented around the country.

1.6 Research Methodology

The study is a descriptive survey which focuses on gaining in-depth knowledge of events happening at a particular jurisdiction. It also employs quantitative and qualitative methods to analyse data in order to arrive at a conclusion. Both primary and secondary data will be used in this study. Primary data will be collected through questionnaire and interviews, whilst articles from the internet, journals, and direct information from respondents will be gathered as the secondary data. The study's population comprise of the district directorate of health, health facilities and female residents in the municipality. they are the right respondents who can give more relevant

and valuable information for the research as possible. Descriptive analysis is beneficial to researchers since it helps one to gain a more accurate and precise profile of the event, the person or the situation. Excel Spreadsheet will be used to analyse the data. Findings will be presented descriptively in tables, frequencies and percentages.

1.7 Scope/limitation of the Study

The study will be conducted in the La Dade Kotopon Municipality in Greater Accra region. it will be limited to the district directorate of health, health facilities and female residents in the municipality. It, will also cover the recognizable female associations and groupings within the municipality. The study will be completed within 6 months. Therefore, the conclusion and generalization may not be readily applicable to other institutions.

1.8 Organization of the Study

The whole study consists of five (5) sections, chapter one is devoted to the study background, discussion of research problems, general and specific objectives of the study, research questions to be answered, study significance and scope, finally, methodology and the structure of the study. Chapter two deals with the evaluation of the literature and examine distinct literature by distinct writers. The research methodology is discussed in Chapter 3. The study outcomes and analysis will be focused on in Chapter 4. The results, conclusions and suggestions will be covered in Chapter 5.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter contains a review of the literature about the concept of community participation and maternal mortality issues. This section also reviews theories and approaches on community participation and maternal mortality in order to understand the theoretical underpinnings of these concepts. The second part deals with concepts of community participation, maternal mortality and other emerging issues. The third aspect looks at empirical evidence and finally a conceptual framework that show the linkages between the main concepts of the study.

2.1 Theoretical Review

2.1.1 The Theory of Margin

The theory of margin, a theory of participative behaviour has been propounded by Howard McClusky since 1970 and is very different from the aforementioned theory. He defines margin as a "function of the relationship of load to the power". Load is defined as the “self and social demands by a person to maintain a minimum level of autonomy" and power is described as "resources such as abilities, possessions, position, allies, etc. which a person can command in coping with the load" (McClusky,1970p 340). The greater the power in relationship to the load, the more margins will be available. Surplus power provides a margin or cushion to handle load requirements. Margin can be increased by reducing load or increasing power.

From this characterisation of load and power, Lupanga (1988) derived a hypothesis to explain the lack of people's participation in development activities in the Third World. He hypothesised that the majority of rural people in most of the Third World have a heavy load and little power to cope

therewith and hence they are too preoccupied with mere survival to participate meaningfully in development activities. Meaning the higher the margin between load and power, the lesser the participation in development activities. Should the hypothesis be true, a logical conclusion is that efforts to mobilise such marginal masses to participate in development activities must of necessity, include the reduction of load or rising of their power or both.

Though the hypothesis could explain the lack of people's participation in development activities, it cannot explain why the same people who do not participate in some development activities take part in some other development activities. There are many cases of poor people in developing countries participating in some programmes or adopting some technologies and not participating in some other programmes or rejecting some other technologies. Therefore, there must be some programme-specific or technology-specific factors that affect people's participation.

The hypothesis of the theory of margin assumes that majority of the people have heavy load and little power to cope therewith and hence they are too preoccupied with mere survival to participate meaningfully in development activities. It therefore suggests that efforts to mobilize marginal masses to participate in development activities must, of necessity, include the reduction of power or raising their power or both. The ‘power’ is seen by the study as empowerment. Beneficiaries must be empowered to participate so that they can initiate actions on their own and thus influence the processes and outcomes of development (maternal health).

2.1.2 Gender Equity Theory

Gender equity theories are rooted in the pursuit of justice and equality between genders, in health, social, nutrition, economic, and power relationships between males and females (Afsana et al, 2007; Gill et al, 2007). The concept of equality is divided into formal (de jure) equality and substantive (de facto) equality, which is grounded in the law. De jure equality has roots in John

Locke's philosophy of liberal individualism and may provide "gender-neutrality" and "sameness of diagnosis and treatment" (Fineman, 2008). However, it does not take into consideration that discrimination may still occur based upon the substantive or de facto equality notions and does little to address the social and economic disparities among vulnerable populations, which are linked to allocations of resources and power (Fineman, 2008).

Substantive equality is result-oriented and identifies and considers circumstances, need and disadvantaged groups (Fineman, 2008). For instance, women bear children, have different social norms and roles in current society, which may influence the substantive "equality" that women need to promote gender equity.

The Convention on the Elimination of all forms of Discrimination against Women (CEDAW), an "International United Nations Human Rights Treaty that guarantees substantive equality and non-discrimination for women", has set out two approaches to equality including: equality of opportunity and equality of results (CEDAW, 1981). "Equality of opportunity" refers to the rights of women to access resources within a country with laws to protect this equal access. "Equality of results" refers to the real change that is recorded that pertains to access and opportunity for women (CEDAW, 1981). While the term "gender inequality" describes the differences between genders with respect to health, "gender inequity" describes those differences that are deemed unjust and are the focus of this review. In working with vulnerable populations, Fineman (2008) suggests being concerned with privilege and favour as well as discrimination issues.

In Africa, gender roles influence reproductive and maternal health seeking behaviors because of paternalistic cultural influences (Moran, Winch, Sultana, Kalim, Afzal, & Koblinsky, 2007). It has been suggested that intimate partner violence in women from the Subcontinent plays a role in lessening a woman's ability to seek any healthcare, including prenatal and postpartum care

(McCloskey, Williams, Lichter, Gerber, Ganz, and Sege, 2007). Attitudes of women themselves have often become a barrier to obtaining gender equity, with reports from the International Institute for Population Sciences and Macro International (2007), showing 54% of married women in Africa "believe it is acceptable for a husband to beat his wife". Women's empowerment and autonomy, two provisions of gender equity, includes health care decision and

Health equity has been an ongoing goal for several decades within developing countries (Ostlin, Sen, and George, 2004). Although there has been some growth in the social, educational, and health sector regarding gender equity in Africa, there continues to be a large health disparity, particularly with maternal health and particularly among the rural and poor communities (Sidney, 2002). This failure to grow, despite goals, has been linked to a lack of follow-up policies and programs linked to reducing health care disparities (Ostlin et al, 2004).

Thus, given improving maternal health, education and knowledge transfer are critical. Community participation is the design of maternal healthcare policies also plays a critical role in knowledge transfer and acceptability of maternal health policies.

2.2 Conceptual Review

2.2.1 Definition of Community Participation

First and foremost, community participation is made up of two terms, "community" and "participation". As such, a comprehensive clarification of the concepts of the words „community" and „participation" as individual entities would give more insight into the term „community participation".

Community

Many writers define the term community in various ways. For example, Wates (2000) defines a community as “a group of people sharing common interests and living within a geographically defined area.” Hamdi (1991), on his part, points out that the term community has both “social and spatial dimensions” and that generally the people within a community come together to achieve a common objective, even if they have certain differences. The concept of a community holds the ancient view that efforts of a group of people are more forceful than that of an individual. The saying that there is strength in unity is true in that a group of people can achieve more in their work than an individual. Similarly, disregarded individuals who may not have been listened to could have voices easily heard when they join groups. On the contrary, some scholars are of the view that the definition of the concept of community must not always be that of a people as a collective and a united entity. For example, Hamdi (1991) contested that communities may not necessarily be together and assume a singular social identity. In some cases, therefore, involvement of communities in community projects may only occur at the tail end of the projects‟ execution when such organized people do not exist. In such circumstances, the purpose of bringing such “scattered” people together during project execution is to build among them the sense of communal living.

Participation

The term participation has also severally been defined. Westergaard (1986) defined participation as “collective efforts to increase and exercise control over resources and institutions on the part of groups and movements of those hitherto excluded from control.” The World Bank‟s Learning Group on Participatory Development (1995) defines participation as “a process through which stakeholders‟ influence and share control over development initiatives, and the decisions and resources which affect them.” A cursory definition of participation would mean engagement of a

set of people in performance of an activity that will result in the improvement of their welfare is such areas of their lives as their income, security, or self- esteem (Chowdhury, 1996).

According to Habraken (1986), participation has two definitions with opposite meanings. By this definition, two key stakeholders are important, thus the users and the professionals. In the first instance, participation occurs when certain salient duties are given to the users to perform, where they share the decision-making responsibility with the professionals. This type of definition portrays the community as participating in decision making from the initial and the planning stage of the project to be executed. The other type of participation is where there is no shift of responsibilities between the users and professionals but instead only the opinion of the user is considered while making decisions. The term participation is often modified with adjectives, resulting in terms such as community participation, citizen participation, people's participation, public participation, and popular participation (Sharma, 2000).

Community participation

Community participation has been given much discussion and publication in recent times. The concept connotes the idea of a group of people having the same needs and aspiration getting themselves involved in working towards those ends.

According to the United Nations Centre for Human Settlements (UNCHS) (1991), indicates that there is a great deal of misunderstanding with regards to the term "community participation" means in practice. This agency defines community participation to mean the "voluntary involvement" of a group of people from the decision-making stage of a project to its execution stage. These kinds of projects are those that directly impact the well-being of the people especially in low-income areas of society. The concept of community participation is not a new phenomenon. It is only given

a new impetus as a result of rapid urbanization in developing countries which is now drawing the attention of the international community. It is as a result of this new level of attention that there are disputations on the concepts and their practices. Oakley and Marsden (1984) also defined community participation as the process by which individuals, families, or communities assume responsibility for their own welfare and develop a capacity to contribute to their own and the community's development. In the context of development, community participation refers to an active process whereby beneficiaries influence the direction and execution of development projects rather than merely receive a share of project benefits.

Another definition that is worth noting is that of Makgoba and Ababio (2004). These authors note that the concept of community participation in one instance explains how the local government and the community relate to each other. In another instant, it deals with the extent to which the community impacts decisions that affect their wellbeing. Community participation entails the involvement of the community in the planning process of the municipality to ensure that such participation results in a meeting of their human needs. Similarly, Fox and Meyer (1995) corroborated this assertion and indicate that community participation may be looked at as "the involvement of citizens in a wide range of administrative policy-making activities including the determination of levels of service, budget priorities, and the acceptability of physical construction projects in order to orient government programmes toward community needs, build public support and encourage a sense of cohesiveness within society".

Oakley et al (1991) seem to provide a summary of what community participation looks like by positing out that it should be a means of empowering people by facilitating the development of their skills and abilities, thus enabling them to negotiate with the development delivery system and or equipping them to make their own decisions in terms of their development, needs and reality.

From this conceptualization, it can be concluded that community participation involves the establishment of decision making bodies that are represented by and accessible to the local communities.

2.2.2 Levels of Community Participation

There are various levels of community participation. The suggestion is that these levels should be built in from the start of a project to the end of the project cycle. These levels can enhance any project and should be considered as part of all activities, from learning programmes, interpretation and events, to the conservation and management of heritage assets, including historic buildings and parks. From the perspective of Taragon and McTiernan (2010), they outline five levels in which people within a community could participate in a project. The five levels offer increasing degrees of influence or control to the people involved. The levels are informing, consulting, deciding together, acting together and supporting others to take the lead.

The first level of community participation according to Taragon and McTiernan is informing. This level involves telling the people (beneficiaries) about the project to be undertaken. This might be one of the first things development practitioners do which should be viewed as preparation for more active involvement. This level is the starting point for any intervention. Informing the people who are the beneficiaries of any development project is an appropriate way of involving them. Informing the people can also be used as an introduction to consultation and more active participation as they feel valued. It is imperative to start informing the people at the planning stage of any project and give regular updates so that the people may know what is happening at each stage of the project and understand changes to the original plans.

The second stage is consulting, where the people are given choices about what will happen in the project and a chance to shape it. The first two levels of informing and consulting are important

steps in any project. They are however passive ways to involving people in any project which does not fully meet the aim of participation if it only includes the first two levels. The aims of participation include informing and consulting activities alongside more substantial participation. Real participation is active and gives people a meaningful personal stake in a project. The consultation stage is when the project offers beneficiaries some say on what they are going to do. At the basic level, one might seek opinion on a limited number of options for one element of a project and at a more in-depth level one might be asking for new ideas and options by involving local communities in planning projects.

It is important that as programme planners consult, they listen to the opinions given and redraft the plans or make decisions based on the views of the beneficiaries. Beneficiaries should be consulted early enough particularly where decisions need to be made that will have an impact on the community. The benefits of effective and timely consultation play vital roles where the people feel they have a say and have been heard. Consultation also reduces the risks of conflict with people later in the project, provide avenue for the people to learn new information and ideas or gaining advice that will improve the project.

The next stage is deciding together and creating opportunities for people to make decisions about and influence the direction of projects. At this level, the people are to be involved in managing and organising the project and making decisions about what and how things happen throughout the project. The people can take part in a number of ways, for example, by becoming a Trustee of the organisation (with the associated legal responsibilities) or by becoming a member of a working or advisory group for the project, which is a more specific and time-limited commitment. For small community groups, this type of participation will be core to their organisation and for a community- based project, most of the management will be done by members of the local

community. Larger organisations may have to make changes to their governance to involve community representatives.

The benefits of deciding together are enormous as local people know their community best, and how decisions will affect the community. One significant benefit of involving beneficiaries in development interventions is that it brings new skills and experience to the management of the project and organisation. Including a wider range of communities and more diversity brings different points of view and new ways of looking at issues. Community participation in management is more likely to implant the project within the community, helping its future success and increasing the likelihood of getting more local support.

The fourth stage is acting together which creates opportunities for people to develop and deliver project while taking a role in heritage conservation and or learning activities. At this level of participation, the people contribute to the delivery of the project in practical hands-on ways. It involves deciding together and then working together to carry out the activities planned. Taragon and McTiernan (2010) term it as collaboration, coproduction or co-creation. Acting together transforms people from audiences or consumers of heritage to partners in the development and delivery of heritage activities. Deciding together makes participants bring knowledge, ideas and insight to projects of how people's experience of heritage could be improved. Acting together further blurs the distinction between professionals that maintain and interpret heritage and users that learn from and enjoy it.

The benefits of acting together leads to participants increased commitment to projects. Working together brings additional resources such as time and expertise. Furthermore, new ideas and different approaches to delivering activities can motivate and inspire existing staff and volunteers and increase the success of projects. The people involved can engage directly with the target

audiences, helping to build their trust, attract first timers and ensure that they have a good experience. The community also becomes a visible part of the project, generate wider interest from media and other local and or community organizations and participants build the knowledge and skills to maintain and share their heritage.

Finally, Taragon and McTiernan, (2010) give the last level of community participation as supporting others to take the lead. The purpose is to empower the people to take ownership of the project, make final decisions and deliver activities with some independence. At this level, the balance of control tips giving a greater degree of influence to the community based organizations or people involved. This is about supporting participants to take ownership of the project or a specific part of it. The purpose is to help the people develop and carry out their own plans. As much as possible, decision making and delivery are undertaken independently, while mentoring and professional assistance are provided where it is needed.

2.2.3 Purpose of Community Participation

The purpose of community participation in development programmes at local communities is very significant. The reason is that it provides avenues that allow the poor to be active participants in development with external agents acting mainly as facilitator and financiers. Arguments for participatory development as advocated by Chambers (1997) have led to the inclusion of participation as a crucial means of allowing the poor to have control over decisions. Furthermore, there is an emerging understanding within the development literature of the less formal institutions that operate often at the local and community levels to shape livelihoods and outcomes (Pieterse, 2001). Also, the inclusion of participatory elements in large scale development assistance came quickly at the World Bank, in Social Investment Funds (SIF) and other forms of assistance (Anyidoho, 2010).

The literature on community participation provides evidence that it leads to development projects that are more responsive to the needs of the poor. It is also responsive to government projects and better delivery of public goods and services. According to Khwaja (2004), the concept leads to better maintained community assets and a more informed and involved citizenry. An obvious aspect highlighted in these benefits is the role of participation as a means of providing and accessing information. When a community participates, it provides information about its preferences and gains information that may influence its optimal choice which are likely to lead to increased welfare for the community and better development projects (Khwaja, 2004).

According to Olukotun (2008), communities that are the beneficiaries of the projects should not be seen as targets of poverty reduction efforts but assets and partners in the development process. Olukotun reiterates that experience has shown that given clear rules of the game, access to information and appropriate support, poor communities can effectively organize to provide goods and services that meet their immediate priorities. This is because communities have considerable capacity to plan and implement programmes when empowered to decide and negotiate. Taragon and McTiernan (2010) also talks of transferring skills and experience which individuals gain through community participation. Other benefits include strengthening local pride, sense of community and increased quality of life.

One essential reason is that community members having enjoyed so much working and living together, having enjoyed each other's confidence and relationships, having sat together to jointly take decisions for their common goals and benefits, it is logical and reasonable to think that any attempt at breaking this bond would be minimally resisted or maximally broken and destroyed. No wonder the failure of many projects that have no element of consultation from the local people (Olukotun, 2008). The indication is that community participation can help provide positive results

which will eventually lead to sustainability of development interventions due to the long standing bond that had existed among local people.

In conclusion, community participation creates prosperity and project sustainability. It also empowers the communities to shape their future by giving them resources and authority. The concept according to Olukotun (2008) is a new vision that seeks to put the rural people in the driver seat with a new set of powers, rights and obligations. One significant reason is that when communities are involved in project formulation, design and implementation, they are likely to be sustained and more cost effective as a result of equitable distribution of project benefit which leads to better designed projects.

2.3 Empirical Review

A study by Phologane (2014) in South Africa, aimed to evaluate community participation in development projects in Mokgalwaneng Village. The study focused on the nature and extent of community participation in developmental projects implemented in the Mokgalwaneng Village. The methodology used was mixed method (qualitative and quantitative) employing an evaluative study design. Five projects were selected and respondents were sampled purposively, ten from the community and two project officials for each project. Questionnaires were used in data collection. Descriptive statistics was used to analyse the quantitative data while the qualitative data was organized into themes.

The study revealed that the majority of the respondents did not participate in the initiation and planning stages of the projects. The study further revealed that no income and low-income, politics, favoritism, long working hours, illiteracy, low self-esteem, lack of training, lack of resources, lack of communication, lack of information and transparency about the projects are the challenges of

participation. It is therefore recommended that; the government should support the community at all levels to ensure a strong commitment to development projects.

Maraga, Kibwage, and Oindo (2010) conducted a study to critically analyse community participation in the project cycle of afforestation projects in River Nyanab Basin, Kenya. The study employed the mixed method using structured questionnaires, interview guide and focus group discussion guide for data collection. 150 respondents were sampled from a population of 1,928 households using systematic random sampling technique. Data was analysed using both quantitative and qualitative techniques. The study concluded that there was low community participation in the project identification, planning and monitoring and evaluation stages of the afforestation projects. High community participation was only observed in the project implementation stage

A study was conducted by Chifamba (2013) to assess the level of community involvement in rural project cycles. The problem identified was that despite two decades of tireless effort and the adoption of several approaches to raise the development and economic growth of rural areas in Zimbabwe by integrating the rural population, who were largely peasants, into mainstream rural development (through community involvement and participation in rural development projects), the living conditions of the rural poor were still deteriorating.

The mixed method study which employed the exploratory survey study design sought specifically to assess the level of community involvement in rural project cycles; examine the factors that promote and hinder community participation; and to recommend strategies through which effective community participation could be facilitated in rural development process. Eight projects whose nature demanded the local people's participation were randomly selected and data was

collected from 254 respondents using structured questionnaires. 25 key informants were purposively selected and interviewed.

The study revealed that there was relatively low degree of community influence or control over organizations in which community members

participated, especially given that the services were usually controlled by people who were not poor or recipients of services. Community members are usually going through an empty ritual of participation; hence they had no real power needed to affect the outcome of rural development process. The study recommended that community participation should be centered on the role of the community as primary actors who should be allowed and enabled to influence and share the responsibility (and possibly costs) of rural development process.

In their study of reducing poverty through community participation: the case of national poverty reduction programme in the Dangme-West district of Ghana, Osei-Kufuor and Koomson (2014) found that community participation is more effective and has the potential to result in empowerment when the primacy is on training and building the capacity of beneficiaries. The study further found out that there was a significant relationship between beneficiary participation in training and capacity building programmes and the level of participation in poverty reduction programmes. Also, the intensity of beneficiary participation among the sampled communities was found to be high.

The study sought to examine the instrumental use of community participation in the National Poverty Reduction Programme in the Dangme West district, Ghana to promote participation and reduce poverty. The mixed method study using multi-stage sampling sampled 210 respondents consisting of project beneficiaries and staff of the facilitating NGO, ProNet. Data was collected

using interview schedule. Data was analysed using the computer software Statistical Package for the Social Sciences (SPSS) and result was presented using descriptive statistics. The study recommends that for poverty reduction projects to meet their potential for alleviating poverty, more attention must be focused on periodic skills training and capacity building programmes. Husseini, Kendie, and Agbesinyale (2016) conducted a study to examine the nature of community participation in the management of forest reserve in the Northern Region of Ghana. Though the forest reserves are said to be managed collaboratively, fringe communities are supposedly involved only in maintenance activities of the reserve boundaries and seedling planting in plantation programmes. For some years now the forest reserves have been threatened by illegal activities and encroachment from the very communities supposed to be helping in managing the reserves. The study therefore sought to;

(i) establish the stakeholders in the National Forest Plantation Programme in the Northern Region of Ghana; (ii) determine the forest management practices in the reserves and (iii) establish the nature of community participation in the management of forest reserves.

The study used the mixed method research design combing survey, in-depth interviews and focus group discussion. Two reserves were randomly selected from each of the four forest districts. Proportionate sampling was then used to get sample of fringe communities per reserve. Using the Krejcie and Morgan theory, 370 respondents was randomly selected. 87 key informants were purposively selected making a total sample size of 457. The quantitative data was analysed using Statistical Product for Service Solution (SPSS) version 16 software. The data from the in-depth interviews and the focused group discussions were categorized into appropriate themes and analysed through discourse analysis.

It was revealed just like the other studies reviewed that participation of forest fringe communities in the management of forest reserves ranges from passive to tokenism, meaning that fringe communities have no control over access to resources and management. Their participation is limited to boundary cleaning and providing labour on plantations. The study recommended that Forest Service Division (FSD) is to initiate a formal collaborative agreement with all the user groups: chiefs, assembly persons, farmers, herbalist, women groups, hunters, cattle herders, charcoal, and firewood producers.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter describes the techniques and procedures used to obtain important data for the study. The chapter explains the research design and approach adopted, the population, sample and sampling techniques, instrument used, data collection procedure and data analysis.

3.1 Methodology Approach

Designing a research plan calls for a decision on the research approaches, research instruments, sampling plan, data sources and contact methods' (Kotler and Keller 2006). Furthermore, Yin (2007) defines research design as the logical sequence that connects the empirical data to the study's initial research questions, and ultimately, to its conclusions. This research employed a descriptive type of research. Descriptive research states how the research looks like and summarizes the general nature of the data obtained (Saunders et al, 2003).

In terms of approach to data collection, the study adopted a qualitative approach. A survey was conducted to obtain information about the target population. The qualitative approach was adopted to present an in-depth understanding to the phenomenon amongst respondents. The survey strategy enables a large amount of data to be collected in a highly economic way from a sizeable population (Sanders et al., 2000). The design has an advantage of producing a good amount of responses from the selected respondents.

3.2 Population of the Study

Fig 3.1 Map of La Dade Kotopon Municipal

Ghana Statistical Service, 2015

The population of La-Dade Kotopon Municipality, according to the 2010 Population and Housing Census, is 183,528 with females constituting 52.7 percent while males formed 47.3 percent. The Municipality is entirely urban (100%) and has a sex ratio of 90 which is lower than that of the region (93.6). It also has a youthful population (children under 15 years) (44.3%) depicting a broad

base population pyramid which tapers off with a small number of elderly persons (60+ years) constituting 5.8percent. The total age dependency ratio for the Municipality is 50.1percent, the child dependency ratio is higher (44.3%) than that of old age dependency ratio (5.8).

La Dade-Kotopon has a Total Fertility Rate of 2.0which is the lowest in the Region. The General Fertility Rate is 61.0births per 1000 women aged 15-49 years and is lower than the regional average of 75.7. The Crude Birth Rate (CBR)is 18.9per 1000 population is also lower than the Regional average of 22.7. The crude death rate for the district is 4.4per 1000which is slightly higher than the regional average (4.3). The death rate for males is highest for age 70 and above representing about 40deaths per 1000 population while for the females, the highest death rate of about 30deaths per 1000 population also for ages 70 and above. The Municipality has a total of73,423 migrants representing about 40.0 percent. It is observed that persons born outside the Greater Accra region but resident in the Municipality were mostly from the Eastern Region (27.4%) while those from the Upper West region were the least (1.8%)

3.2.1 Target Population of the Study

The population of a study is basically the total number of items or units that are under investigation of which all the other possible observation is made (Kumekpor, 2002). It is the mass or the totality of all members or units from which information could be obtained (Rubin and Babbie, 2001). The target population of the study consist of all La-Dade La Dade Kotopon Municipal Health Directorate Staff and female residents of age 18 and above.

3.5 Sampling Technique and Size

The sample population is a subset of the entire population, and inferential statistics is to generalize from the sample to the population (Furlong et. al, 2000). In conducting a research, it is often impracticable to collect data from all the entire population. Hence a smaller sample is often chosen to represent the whole population. 70 participants were chosen for the study. Purposive and convenience sampling was used to select the participants. The researcher conducted interviews with 10 sampled staff of the municipal health directorate and engaged in 3 separate focused group discussions, with each session comprising 20 participants. Homogeneity of the participants in the focus groups was maintained in terms of education, socio-economic status, and area of residence. However, diversity in terms of parity and other socio-demographic characteristics was maintained while selecting FGD participants. The convenience sampling methods were used in the study because they presented an unbiased representation of the respondents and essential for gathering relevant information needed for the research within a short time within the constraints of limited resources at the researcher's disposal.

3.6 Source of Data

In conducting this research, the researcher recognizes that a qualitative study of this nature cannot be carried out without first looking into data sources. According to (Saunders, Lewis et al. 2009) data is a fact, opinion and statistics that have been collected and recorded together for reference or for analysis. Primary data refer to information gathered for a precise purpose at hand. For this study, primary data were used to get information. The benefits of using primary data are that a more reliable and exact information needed is obtained.

3.7 Data Collection Methods

The data collection instrument mainly used for the study was questionnaire and focused group discussions. The information was collected from the sampled population by means of a structured questionnaire administered to respondents where appropriate boxes were/ were ticked base on the unbiased judgment. The questionnaires had both closed questions to allow for varied responses. The purpose of the chosen method was due to time constraints as well as cost. The questionnaire aimed at obtaining relevant and supplementary information through further probing of the respondents and by evaluating relevant research publications of related firms in the sector. Moreover,

3.8 Validity and Reliability

The validity of a research instrument determines the extent to which the instrument reflects the objectives being examined (Macnee et al., 2007). The reliability of the instrument, on the other hand, concerns the extent to which the instrument yields the same repeated trials. Although unreliability is always present to a certain extent, there will be a good deal of consistency in the results of a quality instrument (Zeller, 2002). This consistency is what is termed as reliability. The questionnaire was given to the supervisor to check whether it will be measuring what it needed to collect. Questions will be structured in a way that made respondents provide more accurate and precise answers to the items on the data collection instrument. The validity of the study will be ensured by carefully and thoroughly reading over the questionnaires. Reliability will be ensured by being vigilant to see the consistency of the instrument. Also, the questionnaires will be pre-tested to ensure validity.

3.9 Data Analysis

The analysis done was quantitative in nature. The study used the Statistical Package for Social Sciences Version 21.0 to aid in data analysis. Frequency distributions, as well as tables, were used to present the data. Cronbach alpha was used in assessing the reliability of data used. Discussion of findings and analysis were given through the use of means and standard deviation, percentages, correlation and regression analysis tools.

3.10 Ethical Consideration

Moral and ethical issues set the rules and guidelines which distinguishes between what is right or wrong in research. To encourage ethical behaviour during the research, the researcher set the following guidelines. Thus information that could be embarrassing to the respondent when made public must be protected. As part of an effort to protect any such information, the researcher did not include the names of the respondents on the questionnaires.

The researcher had a duty to keep all information volunteered by respondents out of the public domain and used the information only for the purpose it was collected. The researcher had to sign an undertaking to abide by the confidentiality clause. Before the researcher engaged a respondent, the respondent was asked whether or not he/she would like to participate in the study. If the respondent refused after the researcher had made his/her purpose known the researcher discontinued the research process.

CHAPTER FOUR

FINDINGS AND ANALYSIS

4.0 Introduction

This chapter presents the results of the study. It describes the socio-demographic characteristic of the respondents, motivation for business and business practices adopted by respondents. The descriptive statistics were used in the analysis. It provides simple summaries about the sample and the measures. The results are presented in the form of graphs and charts to indicate the responses to the following key areas of the study: demographic analysis, analysis of the objectives and other essential thematic areas relevant to the objectives of the study.

4.2 Demographic of Respondents

Table 4.1 demographic Analysis of Health Workers

RESPONSE	FREQUENCY	PERCENT
	GENDER	
Male	14	36.8
Female	24	63.2
Total	**38**	**100%**
	Years of Service	
1- 5 years	27	71.1
6-10 years	6	15.7
11-15 years	5	13.2
16 years+	0	0
Total	**38**	**100%**
	LEVEL OF EDUCATION	
Senior High School	0	0
Diploma		

First Degree	12	31.6
Masters	26	68.4
Professional		
Total	**38**	**100%**
	EMPLOYMENT STATUS	
Full time	23	60.5
Contract	15	39.5
Total	**38**	**100%**
	DESIGNATION	
Community health Assistant	2	5.3
General Nurse	20	52.6
Administrative Staff	16	42.1
Medical Staff		

Source: Field Data, 2020

Table 4.1 above illustrates the gender distribution of respondents for the survey. Respondents from La-Dade Kotopon Municipal Health Directorate are categorized into 14 males and 24 females. This is significant for the study as it gives an almost balanced representation of both genders in expressing their respective opinions to reduce any bias in the responses of the respondents.

The table further shows the breakdown according to the educational background of respondents who took part in the study. A total of 38% which represent a greater number of respondents were staff who had Diploma, while 8% of the respondents were staff who had master's qualification. Respondents with Degree and Secondary level educational qualification formed 19% and 29% respectively. 6% of respondents had a professional qualification from accredited professional institutes. This is significant for the study as it provides a balanced representation of both the decision makers and those who are directly affected by such decisions.

Table 4.1 presents the employment status of the respondents. This is important to note that majority fulltime staff form the core of the institutions and this has an indication on investing into training and development of the staff. It is clear that an overwhelming majority of the staff are full time or permanent staff (60.5%). It was found that those in the part-time category worked in other government and private organizations however they provided special services to these institutions which were (39.5%) respectively. For example, some respondents were retired but contracted to work on weekends while some facilitators from Non-Governmental Organizations (NGO's) were performing various functions in the hospitals for their respective organizations.

the years of service of respondents in both institutions. Cumulatively, it shows that fifteen percent (15 %) of the respondents have been employed between 1- 5 years; forty percent (40%) have been working for 6-10 years; and thirty-seven percent (37%) for those who have been engaged for 11-15 years. Finally, eight percent (8%) of the respondents have been working for both institutions for 16 years and above. This implies that more than half of respondents have worked for more than 5 years. The reason is that most employees refuse to be transferred from the district capital to other rural areas. The district capital is the most urbanized with good access to telecommunication and internet access.

Table 4.2 above represent the profession of respondents within the health delivery system. The study revealed that 8 respondents representing 6% of sample size were medical doctors. Administrative staffs which include, finance and accounts, human resource, administration, IT department and procurement department totalled 35% of sample size. Midwives and clinical nurses were (24%) and community nurses were 35% of the sample size. This outcome is very

significant as it will assist the researcher better appreciate issues raised and put them within their proper context.

Table 4.2 Demographic Analysis of Respondents

Demography	***Characteristics***	***Frequency***	***Frequency %***
Marital Status of	Single	6	20%
Respondents	Married	7	23.3%
	Divorced	4	13.3%
	Cohabiting	13	43.3%
	N	**30**	**100%**
Age Of Respondents	18-25 Years	10	33.3%
	26-30 Years	15	50%
	31-40 Years	5	16.7%
	40-50 Years	-	-
	50+ Years	-	-
	N	**30**	**100%**
Educational	No Formal Education	4	13.3%
Qualification	Primary School	5	16.7%
	Junior High School	10	33.3%
	Senior High School	8	26.7%
	Tertiary	1	3.3%
	Other	2	6.7%
	N	**30**	**100%**
	Trader	17	56.7%
Occupation Of	House wife	4	13.3%
Respondents	Hairdresser	3	10.0%
	Seamstress	3	10.0%
	Teacher	2	6.7%
	Health Professional	1	3.3%
	N	**30**	**100%**

Religion of Respondents	Christian	21	70.0%
	Muslim	8	26.7%
	Traditional	1	3.3%
	None	-	-
	N	**30**	**100%**
Average Monthly	100-300Ghs	11	36.7%
Income	301-500Ghs	12	40.0%
	501-1000Ghs	5	16.7%
	1000Ghs +	2	6.7%
	N	**30**	**100%**

Source: Field Data, 2020

Table 4.2 presents a detailed breakdown of respondents' demographic data. It was found that the majority of respondents were living together with their partners. 23.3% were married whiles 43.3% were not legally married but cohabited with their partners. Marital status shows the proportion of women who are exposed to the risk of pregnancy and childbearing. Married women may be influenced by the knowledge, perception and attitudes of spouses, in-laws and other family members regarding caesarean session. 13.3% were divorced whereas 20% are single.

From the table, 33.3% of respondents were aged between 18-25yrs. Respondents aged between 26-30yrs constituted 50% while 16.7% fell between age range 31-40yrs. This implies all respondents exceed the legal age requirement of 16 years to be married and get pregnant. It also implies all respondents were within the age range 18-40 which is considered the most fertile period and medically accepted period to conceive. Furthermore, this outcome indicates respondents are matured to decide to respond to the study questionnaire without coercion.

The Table also gives a breakdown of the respondents' level of education. Respondents with no formal education constituted 13.3%. Both respondents with a Primary school certificate and a Junior High School (JHS) certificate were 16.7% and 33.3% respectively. 26.7% of respondents

were Senior High School graduates, 3.3% having Tertiary Education and 6.7% being through vocational education. This trend is an indication that the majority of respondents had attained some basic educated and understood the questions of the study to provide satisfactory responses. Furthermore, it is expected that mothers with higher education will have a better understanding of delivery process and types of delivery.

Table 4.1 further presents findings of respondents' occupation. The results show that traders constituted the majority (56.7%) of respondents followed by housewives and seamstresses constituting 13.3% and 10 % respectively. Likewise, teachers and health professionals formed the least, constituting 3.3 % and 6.7 % respectively. Finally, 10% of respondents were hair stylists. This means a significant number of respondents engage in economic activities to fend for themselves or supplement their partners and are better placed to provide accurate and relevant data for the study.

Also, the majority (70%) of respondents are Christians, followed by 26.7% Muslims and 3.3% traditional believers. Similarly, 46% of respondents averagely earned 301-500Ghs monthly, 1% earned above 1000Ghs, 11% earned 501-100Ghs and 42% earned 100-300Ghs. It is obvious over 80% majority of respondents' monthly earnings does not exceed 500Ghs.

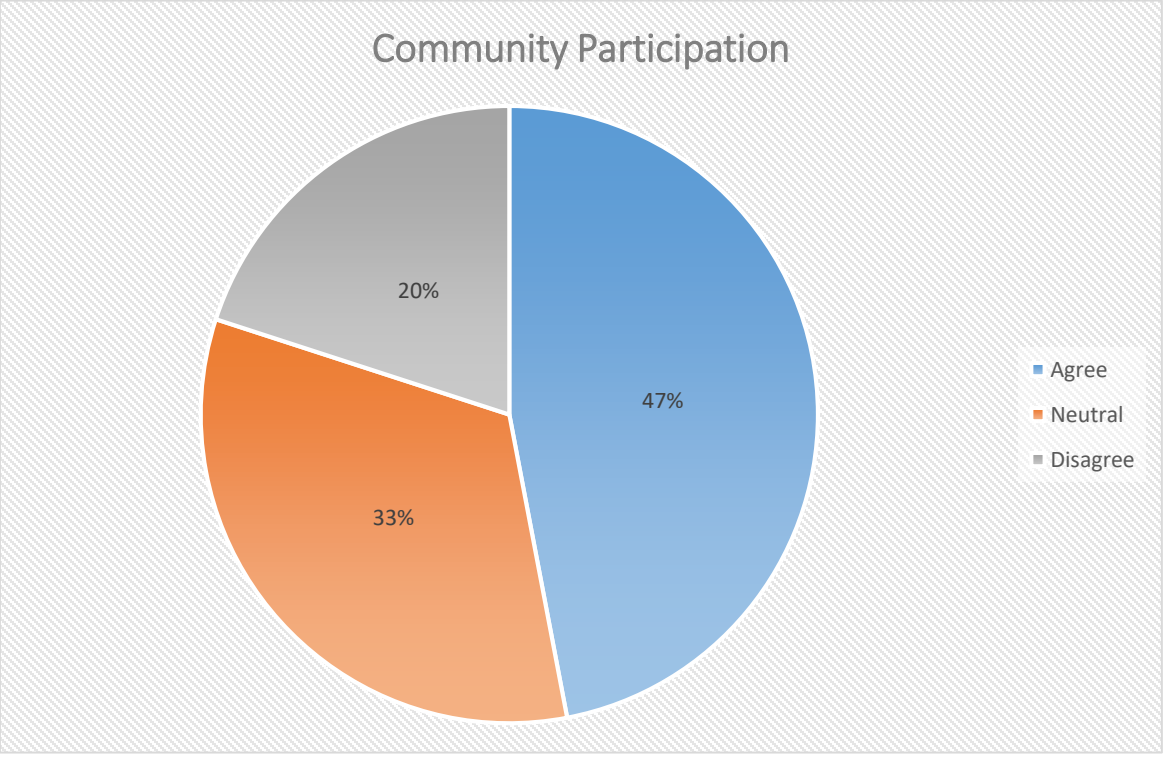
4.2 Community Participation Interventions for Maternal Health.

4.2.1 Practice of Community Participation

The study sought to determine the operationalization of community participation by the La Dade Kotokpon Municipal Health Directorate. The results revealed 47% strongly agreed the Municipal Health Directorate conducts community participation on maternal health. They acknowledge the

existence of public affairs department mandated to undertake stakeholder engagements on health related issues with various stakeholders at least every quarter of the year. 33% respondents neither agree no disagreed the hospital undertook public health education. Similarly, 20% of respondents also disagreed public health education was embarked on by the hospital. The findings are inconsistent with Ghana's Primary healthcare policy with the aim of eradicating preventable diseases through health education. The primary health care policy designed by MOH (2015) stipulates at least quarterly health education being organized for community members on preventive health care.

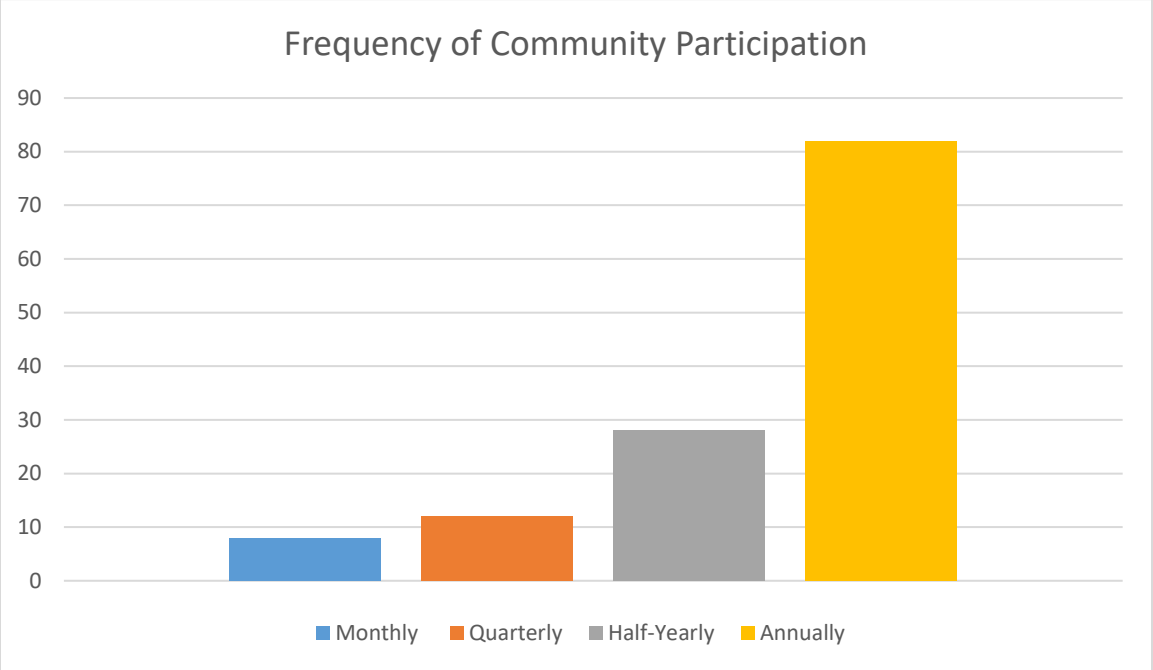
Fig 4.1 Practice of Community Participation



Source: Field Data, 2020

4.2.2 Frequency of Community Participation

Fig 4.2: Community Participation Frequency



Source: Field Survey, 2020

The frequency of public health education conducted by the hospitals was assessed. 6% of respondents stated community participation activities were conducted monthly. 11% believed the health directorate under took community participation activities every quarter. 20% responded half-yearly and the majority 63% of respondents believed community participation activities were conducted on the yearly basis. The study furthers probed the answers of respondents to ascertain the reasons behind. Some respondents indicated that community participation is not widely patronised by the community. Answering to this during the interview, a respondent asserts the participation of the community in the operations of the health directorate is not encouraging. Other reasons accounting for the yearly engagement was financial resources weakening the effective organization of such educational programmes. Some interviewees further indicated the directorate couldn't undertake public health education frequently due to lack of requsite manpower. It was

revealed that, on occasions where such programmes were organized, health professional worked for 12 hours instead of 8-hour shift.

4.2.2 Nature of Community Participation

Needs Assessment

The view expressed by all participants from the interviews was that the community was not involved in deciding their maternal health needs or planning the maternal health programs. According to the participants, the program was designed by health authorities from the municipal health directorate without the community's involvement. In spite of this, the evidence showed community members embraced and aided the program because it partly reflected their health needs. The quote below is a participant's opinion on this.

„*.... We were not asked what kind of services we expected from the clinic. They don't provide some important services here. They are not taking health insurance here. It is our major problem. Even though this is good, we wanted a Clinic but it is good that we have been given this because it helps small'* (service user in the Focus Group Discussion)

Averse to the overriding opinion that their needs had been pre-determined by the health expert, a minority of participants indicated there were indeed community consultations about the maternal health program before it was brought to them. This was further emphasized by interview from the Municipal Health Director. The director reported they held two meetings with the community on issues of implementation and these were discussed and agreed by the chief and the elders who represented the people of the community before the implementation of the Maternal health programs. Below is an excerpt from the committee secretary in this regard.

'The System for Health people, the district people, committee members together with chief and elders of the community met two times to discuss how maternal health implementation will be done and the roles we were to play. After that there was a durbar organized for the community members to tell all the people. (Municipal Health director in individual interview)

Health caregivers and some beneficiaries appeared to be more acquainted with benefits of participation as compared to other service users. However, service users scored their participation in needs assessment at point-1 on the spider-gram demonstrating very low level of participation.

Resource Mobilisation

The interviews demonstrated that the communities contributed in kind to support the program. Contributions in kind took the form of provision of land, water, weeding of site, providing security among others for the construction of CHPS to provide Antenatal services, as well as labour. Apart from the above stated, all other cost was borne by USAID Systems for Health and other development agencies.

'Our chief gave them the land free of charge. We the women fetched water, swept the compound after the place was cleared of weeds by the men, we cleaned the place after the construction, we really did a lot. The men also helped carrying mortar' (Female service user in individual interview)

The study revealed that decisions on communal labour were exclusively taken by the community health committee. However, community members shared the view that their contribution toward the programme has given them a say over the programme. The data collected from the in-depth interviews, the two focus groups discussions agreed that their contribution toward the implementation of the CHPS has been great.

Management

The findings showed that the role of the community health management committee was limited to the maintenance of the CHPS facility and does not include the determination of the kind and quality of service delivery. This is largely determined by the health experts. Some service beneficiaries in the interviews also registered their concerns about the kind of services rendered at the CHPS facility and the fact that the Community Health Management Committee was unable to get the authorities to provide them with the much desired services.

This is demonstrated in the participants‟ quote below:

'…No! They didn't ask us for exactly what we need. See, if you are in labour and you come to deliver, it is only the male nurse who is there to attend to you. He is not even a midwife but he is doing well. Some people are not comfortable with male nurse during labour. They don't take insurance here. They will only write the medicine for you to go and buy, they don't always have medicine. Sometimes when you are seriously sick, they will tell you to go to Lekmma Hospital.' (Female service user in focus group discussion).

……We have complained to the committee to let them take health insurance but till nothing is happening.' (female respondent in focus group discussion)

Additionally, the interviews showed that final managerial decisions were taken by the Municipal health authority.

'Hmmm… we have written some letters to the district for them to include some services but we have not heard or seen anything about that. Our mothers are complaining that they don't get drip

when they come to deliver. You have to buy all the medicines except para [Medication]. *They have to do something about this'*. (Female respondent in individual interview)

Organization

The study revealed that the primary health programme successfully created all the necessary structures for the establishment of the CHPS. The structures included the presence of a Community Health Officer, Community Health Management Committee and Community Health Volunteers. The study established that all the community structures were properly carried out according to the primary health policy guidelines in order to avert any confusion. In throwing more light on the degree of organization of the community structures, a member of the health committee said the following:

'The chief called for a durbar and asked for a representative from each of the clans in the community and I was chosen by my people and introduced to the community during the meeting. After that, we went for a one-week training in Teshie concerning our responsibilities as committee members'. (Respondent in individual interview)

4.3 Effectiveness of Community Participation Interventions for Maternal Health

Table 4.3 Maternal Mortality Rate

Year	Mortality Rate
2015	5
2016	5
2017	4
2018	3

Source: Field Data, 2020

From the respondent's viewpoint, 51% agree their institution is achieving maternal mortality targets. 10% neither agreed nor disagreed though 39% disagreed. The study carefully observed 2015 to 2018 annual report of municipal health directorate under review submitted to the Ministry of Health. Of every 100 births, La Dade Kotokpon Municipality recorded 5 maternal mortality cases in 2015, the same figure was recorded in 2016. Nevertheless, 2017 saw a decline to 4 and subsequent decline to 3 in 2018. Ghana's Millennium Development Goals (MDGs) on maternal health is 54 per 1000 births (MOH, 2015). Ghana Health Service (2009) stated clearly, one main objective of the primary health care policy was to reduce maternal mortality rate significantly nationwide.

The analysis above shows a reduction in maternal mortality cases at La Dade Kotokpon and hence could be attributed to the community particpation and engagements.

4.4 Synergies Between Community Participation and Safe Reproductive Health Practices.

	Mean	Std Dev
Community participation leads to effective and efficient use of resources	4.79	0.92
Community support helps beneficiaries with materials for reproductive health learning.	4.88	0.76
Community participation deepens the relationship between beneficiaries and community health professionals	4.25	0.93
Community participation has impacted positively on unsafe abortion practices parents	4.56	0.94
Community participation has enlightened community members on birth controls and family planning.	4.58	1.25
Community participation has eroded negative perception on family planning	3.50	1.50

Community participation has improved on regular antenatal and postal visitations	4.50	1.35

Source: Field Data, 2020

This objective sought to know how respondents perceived the importance of their participation in Maternal Health delivery in their area. it can be observed that, the majority of the respondents are in general consensus or agreement that their participation is essential in improving Maternal Health delivery in the area. For instance, with mean of 4.79, majority of respondents hold the view that Community participation leads to effective and efficient use of health resources. This agrees with the thoughts of Cariño and Valismo, (1994) that community participation helps to identify specific health needs confronting the people and direct resources towards them. This eliminates issues of wastage. This implies that to a greater extent community participation can help to curb the problem of health resource misapplication. Similarly, respondents believe that Community support helps beneficiaries with materials for reproductive health learning. This confirms the assertion by Cornwall (2008) that when communities help to improve the health delivery with reproductive health educative material, more children learn better and are well prepared for the changing world. Thus, by inference, one could argue that greater and proper community engagement may result in more teenage girls avoiding unwanted pregnancies.

On statement "Community participation deepens the relationship between beneficiaries and community health professionals" obtained a mean score of 4.25. This finding is in line with WHO, 1992 report which suggested among other things that community participation in Maternal Health delivery can contribute to promoting girls' improved relationship between health professionals and community memebers. The report established a positive link between community participation and access to maternal health in most local communities. Policy measures aimed at improving access

in the local communities must target the local community members to ensure success and sustainability.

The general consensus among respondents on the relevance of their participation in health delivery in their area is in agreement with the views of Jimenez and Sawada, (1999) [in, Mansuri & Rao, 2004]. In advocating for the community development concept in the field of education, they reported that community managed schools in El Salvador had fewer absentees than centrally managed schools. This also confirms Wandersman and Florin (1990) assertions that community development efforts have positive impacts in various communities. In the same vein Shaw (1971) recognizes the value found in group processes such as the capability of groups to produce more and better solutions than those working alone and that groups learn faster than individuals.

4.5 Barriers and Facilitators to Effective Community Participation.

	Mean	**Std Dev**
Lack of communication between health staff and community members	3.99	1.35
Poor understanding of maternal health issues by community members.	3.94	1.34
Inadequate resources to support the community participation	3.92	1.31
Discouragement from external family members and other community members.	3.81	1.39
Ineffective medium of communication at meeting.	3.60	1.37
Health staffs lack skills in working with community members	3.99	1.35

Source: Field Data, 2020

The pattern in this chart reflects varying patterns in the responses about their agreement with a sample of factors that affect the participation of communities in the delivery of basic health. The analysis reveals that health stakeholders (respondents) agree generally with the first four (4) factors in the chart, which boarder on community members' inadequacies in terms of, resources and time. In terms of ranking (in descending order), the three most important factors affecting community participation are: inadequacy of community members' resources to support health programs, community members' poor understanding of health issues, and community members' thoughts of not having time.

There seem to be a divergence in the view of respondents on whether a communication gap exists between health authorities and community members, and whether this affects the delivery of basic health care. The same divergence in opinion is found concerning whether the medium of communication and lack of trust are factors that affect community members' participation in basic health delivery. The analysis shows on the half-right of the chart that respondents generally disagree on issues that relate to inadequacies or inefficiencies on their part. For instance, the various stakeholders gave higher negative

Low knowledge level and or poor understanding were discovered as a great challenge. This confirms the findings of Hrriet, Anin, and Yussif (2013) when they reported that low knowledge level and poor flow of information account for the low involvement and participation of stakeholders at the local level. Poor communication gap and bad-timing of meetings also came out as a significant challenge in the area. These are in accordance with views expressed by Baku and Agyemang (2002) that the main problem inhabiting community participation in education delivery in our local communities included among other things poor timing of meetings

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of Findings

In view of earlier assertions regarding the negative implication of low or no community participation in the implementation of maternal health programme (Derso et al., 2014), the study set out to assess the effect of community participation in reducing maternal health in Ghana using the social psychological understanding of participation. The study has been able to highlight a range of factors impacting optimal and empowering community participation. Some of the factors facilitating community participation included successful establishment of CHPS structures, community mobilisation of local resources to support CHPS (communities made significant „in kind" contributions to support the program), and representativeness of community interests.

External interference from health professionals, top-down approach to program design, are some of the factors hindering community participation as shown by the study. The study revealed that management and the final decision making structures were vested under the authority of the municipal health directorate who made decisions without full community members" engagement, an arrangement which does not strengthen community participation.

The study results indicate that the programme was largely imposed on the community by health experts without recourse to the specific health needs of the community, a situation which will not enhance optimal community empowerment (Laverack & Wallerstein, 2001; Rappaport, Reischl, & Seidman, 1987; Wallerstein, 1992).

The use of social psychological understanding of participation (Campbell & Jovchelovitch, 2000) enabled the study to identify the factors that impede community participation in implementation in a manner that enhance community empowerment. These impediments showed an expert conceptualization of participation by community members resulting in unilateral decision-making by district health experts.

The study's findings substantiate the claim by Goodman et al., (1998) and Rifkin, (2009) which assert that; "the structure of community leadership is often historically or culturally determined to exclude marginalised groups including women, young people and marginalised men, with such social exclusion being widely regarded as a contributor to the health inequalities often suffered by such groups" (WHO, 2008).

In order to ensure effective and all-inclusive health care delivery, there is the need for health policy makers and planners to involve community members in discussions about service provision, where the community's opinion is taken as seriously as expert knowledge. Whilst health experts have particular expertise that can augment participation, such proficiency must include knowledge requiring community participation (e.g., gender, culture, power relation and resources). The study also reveals how failure to involve the community in planning, challenges the alignment of health care delivery with realities in the community and runs the risk of reproducing health services according to the status quo of experts" definition.

The study also revealed limited participation of community members in the maternal health programme. They were only asked to contribute in kind to maintain the maternal health programs which reflects the utilitarian value of community members in health programme implementation. They perceived service package as one imposed on them as they played no role in determining the kind of health services to be provided at the health facility. Health care providers on the other hand

asserted that the community members were properly included before the start of the programme. There were opposing views of how community participation was carried out which arguably are rooted in the unwillingness of some actors to let go their control and the quest of members of community to be more involved in decisions that directly affect their welfare. In addition, health care providers being experts are positioned in a place of power which complicates genuine power sharing in participatory health interventions.

Against the backdrop of the importance for community members to contribute with resources for the building and maintenance of the ANC compound, demonstrating their utilitarian value which reinforces community ownership, there is the need for a lasting blueprint, with health agencies committing to provide all the necessary resources when required to support the health initiative and by developing the capacity of communities and groups so as to enable them maintain the programme and seek other avenues of funding. The lack of a sustainable source of funding for the programme runs the danger of creating a situation where failure of poor communities to contribute to the health initiative could result in them being denied access to health care.

5.2 Conclusions

In conclusion, the study has revealed that community participation in the improvement of Maternal Health is not a new thing in the La Dade Kotokpon. People acknowledged and viewed as important their obligation to participate in health needs but are not well informed on their specific roles they need to play, in terms of, provision of infrastructures and learning materials. Generally, there was a low level of involvement in the various activities community members are engaged in their quest to improving marternal delivery. The study has also highlighted the main challenges confronting community members in their quest to helping improve health delivery including low knowledge level and lack of communication. It has also brought out vividly ways of improving the practice

through the use of the local language at meetings, good communication links established between the school and communities and providing continual updates on events happening in the school to get them well informed on their specific roles they need to play.

5.3 Recommendations

The health Directorate should seek sponsorship from the numerous mining firms operating within the Municipality. As part of their Corporate Social Responsibilities, the firms could support the directorate financially to enhance community participation medical.

The management of in unification with the traditional authorities and religious bodies should set up volunteering groups who will be trained and equipped to provide house-to-house public health education.

The Ministry of Health through the Ghana Health Service together with donor partners to come out with a long-term strategy to sustain the health initiative by building the capacity of community members and groups, enabling them to develop the programme and seek alternative sources of funding.

The Ministry of Health must as matter of urgency grant financial clearance for the recruitment of health professionals to supplement the shortfall of staff in the directorate. The recruitment process should be hastened and the Ministry in collaboration with the district Assemblies organize training programs at least once a year.

The National Health Insurance Authority should pre-finance healthcare institutions to make funds readily available to the municipality. Availability of funds to the hospitals will positively impact the operations of the hospitals in providing quality health care.

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Appendix

Questionnaire for Health Directorate Staff

Dear Respondent,

I am a postgraduate student in the, collecting data for a dissertation on ***Examining the Links Between Community Participation and Maternal Mortality Reduction in The La-Dade Kotopon Municipal Assembly***. I would be most grateful if you could take time off your busy schedule to permit me to engage you to provide answers to the questions below. The information is solely for academic purposes and the information provided will be treated confidential

Thank You

Part 1: General Profile of Respondent

This section collects information about you. *Please answer all questions by ticking the appropriate box* [√]

1. Gender: [ ] Male [ ] Female
2. Age [ ] 20-29 years [ ] 30-39years [ ] 40-49yeras [ ] 50 years above
3. What is your highest education *(Please indicate highest level achieved)* [ ] Diploma/HND Holder [ ] First degree [ ] Second degree [ ] Others *(please specify):* ……
Years in Service: [ ] 1-5 years [ ] 4-6 years [ ] 7-10 years [ ] 11yrs +
Designation Community health Assistant [ ] General Nurse [ ] administrative Staff [ ] Medical Staff [ ]

Part 2: Factors That Influence Community Participation Interventions for Maternal Health.

1.Our outfit undertake community Engagements On marternal health?

[ ] Strongly Agree [ ] Agree [ ] Neutral [ ] Disagree [ ] Strongly Disagree

2. How Often does your outfit undertake community engagements on Maternal Health?

[ ] monthly [ ] quarterly [ ] Semi-annual [ ] Annually

3. Who are the target participants of maternal health community engagement?

[ ] women groups [ ] adolescent females [ ] religious organizations [ ] Schools

[ ] all the above

4. What is the nature of community Participation your outfit undertakes?

……

……

……

5. Why do your outfit undertake community engagement on Maternal Health?

……

……

……

Part 3: Synergies Between Community Participation and Safe Reproductive Health Practices.

Please tick to rate the following statements using a scale of 1 to 5 where 1 is Strongly Disagree, 2 is Disagree, 3 is neither Agree or Disagree, 4 is Agree and 5 is Strongly Agree.

	1	2	3	4	5
1. Community participation leads to effective and efficient use of resources					
2. Community support helps beneficiaries with materials for reproductive health learning.					
3. Community participation deepens the relationship between beneficiaries and community health professionals					
4. Community participation has impacted positively on unsafe abortion practices parents					
5. Community participation has enlightened community members on birth controls and family planning.					
6. Community participation has eroded negative perception on family planning among beneficiaries					
7. Community participation has impacted positively on regular antenatal and postal visitations					

Part 4: Barriers to Effective Community Participation.

Please tick to rate the following statements using a scale of 1 to 5 where 1 is Strongly Disagree, 2 is Disagree, 3 is neither Agree or Disagree, 4 is Agree and 5 is Strongly Agree.

	1	2	3	4	5
1. Lack of communication between health staff and community members					
2. Poor understanding of maternal health issues by community members.					
3. Inadequate resources to support the community pariticipation					
4. Discouragement from external family members and other community members.					
5. Ineffective medium of communication at meeting.					
6. Health staffs lack skills in working with community members					

Interview Guide for Municipal Health Directorate

Dear Respondent,

I am a postgraduate student in the, collecting data for a dissertation on ***Examining the Links Between Community Participation and Maternal Mortality Reduction in The La-Dade Kotopon Municipal Assembly***. I would be most grateful if you could take time off your busy schedule to permit me to engage you to provide answers to the questions below. The information is solely for academic purposes and the information provided will be treated confidential

Thank You

1. Do your outfit undertake community engagements on Maternal health?
2. How often do your outfit undertake Community engagements?
3. What are the roles that community members play?
4. In what ways are community members involved in the planning of the maternal health engagement Programme?
5. In what ways are community members' parts of the implementation of maternal health Program?
6. How do community members engage in monitoring and evaluation of the programme?
7. What are the benefits of beneficiaries' involvement in the maternal health sensitizations?
8. What are the plans put in place towards the long term sustenance of the programme?
9. What else can be done to improve and sustain the maternal health Programme at the community level?
10. In your opinion, how has community members contributed to the success of the programme?

FOCUS GROUP DISCUSSION GUIDE

Dear Respondent,

I am a postgraduate student in the, collecting data for a dissertation on ***Examining the Links Between Community Participation and Maternal Mortality Reduction in The La-Dade Kotopon Municipal Assembly***. I would be most grateful if you could take time off your busy schedule to permit me to engage you to provide answers to the questions below. The information is solely for academic purposes and the information provided will be treated confidential

Thank You

1. Religion……
2. Education ……
3. Occupation …….
4. Family Income……..
5. How long have you stayed in this community? ……..
6. What do you understand by the meaning of community participation maternal health?
7. In your view, do you think community participation is important?
8. Have you been involved in any maternal health sensitization program?
9. If yes, what role did the local people play?
10. How were the local people involved in the decision-making process?
7. What kind of support do the local people give to maternal health sensitization program?
8. What has been some of the limitations towards effective community participation of local people?
9. What do you think can be done to improve effective participation?