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UNIVERSITY OF SOUTHAMPTON
FACULTY OF SOCIAL AND HUMAN SCIENCES
DIVISION OF SOCIOLOGY AND SOCIAL POLICY

**MALARIA CONTROL POLICIES AND STRATEGIES IN GHANA:
THE LEVEL OF COMMUNITY PARTICIPATION IN THE INTERSECTORAL COLLABORATION**

BY

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THESIS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

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JULY 2011

Dedication

I dedicate this thesis to my wife Rachel Van Acker whose belief in the value of education gave me this opportunity to undertake this PhD study. For all the years I was away, I knew she suffered for she was on her own keeping things together. Nonetheless, she never stopped supporting me in any situation that I found myself in. She was always there for me whenever I needed her. Simply, she was the “wind beneath my wing” and I would forever be grateful to her and the children: Mieke, Jan and Jacqy.

DECLARATION OF AUTHORSHIP

I, Nicodemus Osei OWUSU declare that the thesis entitled:

**MALARIA CONTROL POLICIES AND STRATEGIES IN GHANA:
THE LEVEL OF COMMUNITY PARTICIPATION IN THE INTERSECTORAL COLLABORATION**

and the work presented in the thesis are both my own, and have been generated by me as a result of my own original research. I hereby confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this university;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;

Signed:

Date:

Acknowledgements

In going through an academic life, we are often bound to go through the hands of various teachers, lecturers, mentors and supervisors and each of these individuals plays a part in our success and we need to be grateful to all of them. However, out of these good people, I am specially and enormously more grateful to two: my PhD supervisors, John Mohan and Nyovani Madise. Without these two, the success of my PhD could not have been possible. I thank both of them for sharing their expertise and knowledge with me during the whole process that I went through. I personally think at times, I overstretched their patience and taking me as their student might have been one of the biggest challenges in their professional lives. To them I say many thanks for your guidance, support and patience which did take me through the tough times.

Also I would like to thank all those who have shared their knowledge on the subject when I was in the field in Ghana. Their time and narratives contributed immensely to the richness of the content of this thesis. I would also like to thank Egbert and his wife Lianna as well as Wiggert and his wife Winny who have been there for me in all kinds of situations. Their support in this my journey has been unswerving. Friendship and encouragement from friends like Fiifi Amoako Johnson, Sharon Holder, Mohammad Amidu, Bernard Baffour and Nicki Elvins, the secretary to my supervisor who made me learn that often a little bit of smile to a person who keeps your file has a positive reward in the end. She and all the others have been very helpful in various ways and many thanks to you all for being there for me when I was in need.

Finally, my heartfelt thanks to my family including: my wife, my daughter Jacqueline and the entire family of Van Acker for their love, support and patience. I am also thankful to my parents for the love they showed to me by sending me to school. Not many Africa children could get such an opportunity and although they did not live long to see this day, I will be forever grateful to them.

Abstract

For more than a century now, malaria has been a major public health problem in Ghana which consequently has been one of the country's sources of underdevelopment due to economic losses, high rate of morbidity and mortality. Faced with this problem, the last ten years has seen a commitment from the Ghanaian government to address the issue by establishing a policy that would transform the way the disease is prevented and controlled. The transformation of the management of the disease by the use of intersectoral collaboration strategy (ISC) was to ensure the inclusion of the grass root community members who were hitherto excluded from participating in policymaking process of the national malaria control programme (NMCP) activities. The idea was that by allowing the communities to participate, members would be empowered to have ownership of programme activities, could accept the challenges associated with the control of the disease, and above all contribute more effectively to the success of the policy goal of minimising the persistence of malaria in Ghana.

However, over ten years now, no systematic study has been done to assess the extent to which this policy goal has been rhetoric or a reality. This thesis therefore seeks to examine this vision by investigating the extent to which the community members are allowed by the health authorities to participate in this policy strategy. Drawing on the case studies in the rural and urban districts in Ghana, the practical reality of the degree of community participation in ISC has been explored. In addition, the roles played by the community members in malaria control programme activities were examined with the aim of understanding the importance of communities in malaria control efforts. Finally, the barriers to participation as well as the extent of the institutional involvement in ISC and its possibility to facilitate community participation have also been examined.

Overall, the evidence from the study findings demonstrated that the established strategy of ISC has not significantly promoted community participation in the NMCP activities. While the communities were consulted on malaria issues, they were often excluded from the final decision-making on issues that needed to be acted upon. Consequently, the communities have no guarantee that their views will be considered during the final deliberation in which they have little or no part to play. In spite of this, the study found that through various ways, the community members had been playing a number of significant roles in the control activities. These roles included: supporting health staff in their outreach services, contributing in managing the environment, providing assistance in the monitoring and evaluation of malaria programmes and finally assisting victims to cope with the disease. The findings also indicated that without a

number of barriers, certain existing contextual factors (e.g. good level of horizontal integration and political structures and social-cultural institutions) potentially could have contributed to the community participation. From the views of health officials, these barriers were the powers of central bureaucratic structures and lack of resources whilst the community members perceived poverty, lack of support from the local health authorities, the precarious nature of their livelihood and traditional culture as those factors that have undermined participation. These barriers were structural and as such tackling any one barrier in isolation was not likely to solve the malaria problem. Besides, no one government sector, on its own, through participation, could make it possible for the community members to have a full ownership of the control programme activities as well as develop a culture of malaria prevention and control.

Thus in the context of the study sites, the study concluded that although there is no evidence to suggest that ISC has enhanced full community participation, the strategy should be commended. In reality, the finding indicated that through ISC strategy many sectors including the community have become more aware of malaria problem and communicate more to solve the problem together. In the light of this, the study finds joint action in the form of ISC across many government sectors as a potential solution if these barriers are to be dealt with in a more strategic way rather than a piecemeal manner.

In conclusion, it has been argued that with such a complex problem like malaria, ISC with community participation in policy making process is both a necessary and sufficient condition in reducing malaria persistence in the study sites. The health sector must work collaboratively with other related sectors and it is with such collaborative efforts that can change the attitudes of the community members. Changes in behavioural attitudes are paramount if communities' activities that affect the environment and promote breeding of mosquitoes are to be minimised. Thus with ISC strategy, what is further needed are: proper control planning that will ensure better coordination amongst sectors, adequate resources and behavioural change by the community members themselves. Each of these factors, I believe should not work in isolation, rather must work together otherwise malaria persistence in Ghana will not go away anytime soon.

ABBREVIATIONS

AAS	Ahafo Ano South
BIDS,	Bath Information and Data Services
CAM	Complementary and alternative medicine
CHERG	Child Health Epidemiology Reference Group
CHIM	Centre for Health Information Management
CWIQ	Core Welfare Indicators Questionnaire
DCE,	District Chief Executive
DDT	Dichlor-diphenyl-trichlorethylene
DHS	Demographic and Health Surveys
FCUBE	Free Compulsory Universal Basic Education
FGDs	Focus Group Discussions
GDP	Gross Domestic Product
GER	Gross enrolment ratio
GHS	Ghana Health Services,
GMEP	Global Malaria Eradication Program
HIV/AIDS	Human immunodeficiency virus /Acquired immunodeficiency syndrome
HFA	Health For All
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Net
ISC	Intersectoral Collaboration
JAMA	American Journal of Public Health
JSS	Junior Secondary School
KMA	Kumasi Metropolitan Assembly
MAM	Mobilize Against Malaria
MOH	Ministry of health
NDC	National Democratic Convention
NGOs	Non-Governmental Organizations

NHIS	National Health Insurance Scheme
NHIA	National Health Insurance Authority
NMCP	National Malaria Control Programme
NPP	National Patriotic Party
OPD	Outpatient Department
PHC	Primary Health Care
PMI	President's Malaria Initiative
POW	Programme of Work
PPAG	Planned Parenthood Association of Ghana
PPME	Policy Planning Monitoring and Evaluation
RBM	Roll Back Malaria
RCC	Regional Co-ordinating Council
SSA	Sub-Saharan Africa
SES	Socio-economic Status
TB	Tuberculosis
UNDP	United Nations Development Fund
UNICEF	United Nations Children's fund
USAID	United States Agency for International Development
WHO	World Health Organisation

TABLE OF CONTENT

DECLARATION OF AUTHORSHIP	III
CHAPTER ONE	1
1.1 Introduction	1
1.2 Problem statement	1
1.3 Background to the study	3
1.3.1 Malaria situation in Ghana compared with other West Africa countries	4
1.3.2 The significance of community participation in malaria control strategy of ISC	10
1.3.3. ISC with community participation in Ghana compared with other countries	15
1.4 Research questions	18
1.5 The contributions of the study	20
1.6 The Structure of the thesis	21
CHAPTER TWO	24
THE HISTORY OF MALARIA CONTROL IN GHANA	24
2.1 Introduction	24
2.2 Vertical programme delivery approach in controlling malaria in Ghana (Pre & Post independence - 1977)	25
2.2.1 Pre-independence	28
2.2.2 Post-independence (1957-1977)	30
2.2.3 Summary	32
2.3 Horizontal (integrated) approach of malaria control (1978-2010)	33
2.3.1 The start of comprehensive approach period (1978-1989)	36
2.3.2 The beginning of global partnership initiatives (1990-1999)	38
2.3.3 Ghana intersectoral strategy initiative 2000-2010	42
2.3.4 Summary	47
2.4 Conclusion	48
CHAPTER THREE	51
LITERATURE REVIEW	51
3.1 Introduction	51
3.2 Literature search	51

3.3 Malaria and malarious community	53
3.3.1 Malaria and potential factors contributing to the increase risk of communities' exposure	53
3.3.2 Summary	58
3.4 Community Participation	59
3.4.1 The concept of Community	59
3.4.2 The concept of Participation	61
3.4.2 The Significance of Community Participation	63
3.4.3 Arnstein's (1969) "Ladder of Citizen Participation"	66
3.4.4 Barriers to community participation	68
3.4.5 Critical factors that facilitate community participation	72
3.4.6 Summary	74
3.5 Policy of Intersectoral collaboration	75
3.5.1 The concept of Policy	76
3.5.2 Intersectoral collaboration	77
3.6 Literature Gap: Community Participation in Decision Making Process	80
3.6.1 Policy Triangle as a framework for policy analysis	81
3.6.2 Alford's 'structural interests' framework	92
3.7 Other theoretical frameworks and their potential relevance	96
3.7.1 Structuration Theory	97
3.7.2 Policy Network approach	102
3.6.3 Summary	105
 CHAPTER FOUR	 107
 RESEARCH METHODOLOGY AND METHODS	 107
4.1 Introduction	107
4.2 Research Methodology	107
4.3 Methods	110
4.3.1 Qualitative method	110
4.3.2 Quantitative (Survey) method	121
4.3.3 Non-participant Observation	122
4.4 Data Sources	123
4.4.1 Target Population (malaria control policy actors)	123
4.5 The study context	125
4.5.1 Urban and Rural districts' communities within the study region	126
4.6 Field work procedure, data collection and analysis	131
4.6.1. Questionnaire and its pre-testing	131
4.6.2 Actual data collection	132
4.6.3 Processing the in-depth interviews (<i>data analysis</i>)	134
4.7 Data quality	142
4.8 Response Rate	146

4.9 Research Ethics	147
4.9.1 Informed consent	147
4.9.2 Confidentiality	148
4.9.3 Research and ethical approval	149
4.10 Summary of the chapter	149
CHAPTER FIVE	150
MALARIA PROBLEM AND THE CONTROL POLICY MAKING PROCESSES OF INTERSECTORAL COLLABORATION IN GHANA	150
5.1 Introduction	150
5.2 Malaria situation in Ghana	150
5.2.1 Malaria compared with other diseases in Ghana	153
5.3 Contextual factors undermining government’s efforts	157
5.3.1 The geography and ecology of Ghana	157
5.3.2 Socio-Economic Context	160
5.3.3 Organisational structure and malaria control management	162
5.3.4 Cultural Context	165
5.3.5 Education (high illiteracy rate)	166
5.3.6 Summary	167
5.4 Factors contributing to the minimisation of malaria deaths	168
5.4.1 Global and Regional Context	170
5.4.2 National Context	172
5.4.3 Summary	173
5.5 Malaria Control Policymaking Processes	174
5.5.1 Policy Planning and Formulation (Priority Setting)	175
5.5.2 Malaria Control Policy Implementation	180
5.5.3 Evaluation of malaria control	183
5.5.4 Summary	184
5.6 Policy Actors	185
5.7 Conclusion	188
CHAPTER SIX	191
THE ROLES OF THE COMMUNITY AND THE EXTENT OF ITS PARTICIPATION IN THE POLICYMAKING PROCESS	191
6.1 Introduction	191
6.2 The socio-demographic characteristics of the participants	192
6.3 The perceived roles of the community members within the NMCP	194
6.3.1 The community’s perceived roles in outreach services	197

6.3.2 Perceived community roles in monitoring and evaluating malaria control programme activities	205
6.3.3 Helping victims to cope with the disease	210
6.3.4: Managing the environmental issues	217
6.3.5 Summary	222
6.4 Community participation in malaria control policy process.	224
6.4.1 Participant's views on the planning stage at the national level	224
6.4.2 Summary	230
6.5 Local residents' views on the extent of participation in the policy making process at the district level	232
6.6 Community participation as perceived by local health officials	236
6.7 Conclusion	237
CHAPTER SEVEN	239
BARRIERS AND THE EXTENT OF INSTITUTIONAL INVOLVEMENT IN INTERSECTORAL COLLABORATION	239
7.1 Introduction	239
7.2 Barriers from the perspectives of the health officials	239
7.2.1 The powers of central bureaucracies caused by the typology of a decentralised system of approach	239
7.2.2 Lack of resources	247
7.3 Barriers as perceived by the community members	251
7.3.1 Disillusionment among community interests	251
7.3.2 Culture	259
7.3.3 Poverty	265
7.3.4 Summary	270
7.5 Potential Facilitating Factors to Community participation found in the study sites	273
7.5.1 The extent of institutional involvement in ISC and its impact on community participation	273
7.5.2 The existence of political structures within the communities	282
7.5.3 Socio-cultural institutions within the communities	284
7.5.4 Summary	288
7.6 Conclusion	289
CHAPTER EIGHT	291
DISCUSSION AND CONCLUSIONS	291
8.1 Introduction	291
8.2 The study methods and their strengths and weaknesses	292
8.2.1 The strengths of the study	294
8.2.2 Limitations of the study	295

8.3 The relevance of the study frameworks	296
8.3.1 Alford's theory analysis of participation in NMCP	296
8.3.2 Measuring participation using the framework of Arnstein (1969)	299
8.3.3 Health Policy Triangle Framework of Walt and Gilson (1994)	301
8.3.4 Structuration Theory	303
8.3.5 Policy Network Approach	305
8.4 The roles of the community members and the extent of their participation in the NMCP policy strategy of ISC	306
8.5 Conclusions and implications of the key findings	307
8.6 Policy and practical recommendations	314
8.7 Conclusion	320
8.8 Recommendations for future research	321
References	324
APPENDICES	377
Appendix 1: The periodisation of malaria control policy strategies in Ghana before and after independence until 2010	377
Appendix 2A: Health Officials' Interview Guide	379
Appendix 2B: Community members' Interview Guide	380
Appendix 3: Questions about the interviewees' backgrounds relating to socio-demographic characteristics	381
Appendix 4: The Degree of Integration amongst sectors at the local level on malaria control	382
Appendix 5A, B and C: Samples of an Interview Transcript on Roles, Barriers and potential Enablers	383
Appendix 6: List of interviewees who were to be quoted	399
Appendix 7A: Information Sheet	401
Appendix 7B: Consent form document	402
Appendix 8: Letter of approval from School Research Ethics Committee	404

List of Figures

Fig 1.1: No. of malaria cases in Ghana compared with other West Africa countries	6
Fig 1.2: No. of reported deaths caused by malaria in Ghana compared with other West Africa	7
Fig 3.1: Arnstein (1969) ladder of participation	67
Fig 3.3: Framework for health policy analysis	82
Fig 4.1: Targeted groups of stakeholders/actors	124
Fig 4.2: Map of the AAS area and its sub-sub-districts	128
Fig 4.3: Map of the KMA area and sub-sub-districts	130
Fig 4.4: The most important role(s) perceived to be played by community members	139
Fig 4.5: Barriers that undermine community participation	140
Fig 4.6: Potential Facilitating Factors to Community participation	141
Fig 5.1: Trends in malaria cases (in millions) in Ghana between 1990 and 2009	151
Fig 5.2 Top Ten Causes of Death for All Ages in Ghana (2005)	155
Fig 5.3 Top Ten Causes of Deaths for Children Under 5 Years - National (2005)	155
Fig 5.4: Ghana and its regions	158
Fig 5.5: Organizational structure of the health sector in Ghana	163
Fig 5.6 The organisational structure of NMCP	165
Fig 5.7: Estimated malaria deaths in children from 1 to 59 months old prevented by vector control scale-up from 2001-2010	169
Fig 5.8: Estimated under-five child lives saved by malaria prevention in pregnancy scale-up from 2001-2010	170

List of Tables

Table 1.1 Scores for community participation process indicators	17
Table 4.1 Interviewed Actors involved in Malaria Policy Processes at various levels in Ghana	125
Table 4.2 Population Distribution per Sub-district Health Areas – 2008	127
Table 4.3: Population Distribution per Sub-Metro Health Areas – 2008	129
Table 4.4 Timeline for field activities	131
Table 4.5 Final Interview results and response rate	147
Table 5.1 Top Ten Causes of Admission for All Ages & under-five children (2004)	154
Table 5.2 Various actors involved in malaria control programme	188
Table 6.1 Socio-demographic profile of the survey participants in rural and urban districts in Ghana	193
Table 6.2 The various roles played by rural and communities in NMCP activities	195
Table 7.1 Level of integration among institutions participating in malaria control programmes in the Kumasi Metropolitan Assembly	276
Table 7.2 Level of integration among institutions participating in malaria control programmes in the Ahafo Ano-South District	277

List of photos

Photo 4.1: A pit meant to contain bath-water at the rural areas	142
Photo 4.2: A broken bridge which has ended up being mosquitoes breeding site	143
Photo 5.1: An example of the situation of deforestation in Ghanaian communities	161
Photo 5.2: Creating awareness of malaria problem in Ghana	182

Chapter one

1.1 Introduction

1.2 Problem statement

Malaria has been a major public health problem in Ghana for many years now. Despite government's efforts to control the disease, malaria has increasingly had a huge impact on the country (Dugbartey et al., 1998; Asante and Asenso-Okyere, 2003). For example, it has been estimated that between 3.1 and 3.5 million cases of clinical malaria, which represents about 44% of all outpatient illnesses are reported in public health facilities each year. Also malaria accounts for 36% of all hospital admissions and 22% of all deaths in children under-five years every year. Moreover, between 2000 and 2007, the percentage number of deaths attributable to malaria in the Ghana for all children of five years accounts for between one-fifth and one-quarter of child deaths (National Malaria Control Programme (NMCP) Annual Report, 2008; Owusu-Agyei et al. 2007) . Among pregnant women, it has been emphasised that over 13.8% are infected with the disease and 9.4% of all deaths are attributed to it (GHS, 2008; Antwi et al. 1998). According to Ghana's NMCPAR (2008) this is only a small fraction of the actual number of infected cases that are reported. Studies from Ghana and elsewhere in SSA have shown that the ratio of reported to unreported cases of malaria is 1:4 or 1:5. The reason for these high unreported cases is that most of the cases are treated at home (Breman et al. 2004; Buabeng et al. 2007).

It has also been noted that malaria is not only a health problem but also a developmental problem in Ghana with huge amount of financial burdens placed on both households and the economy (Asante and Asenso-Okyere, 2003). From the study of Asante and Asenso-Okyere (2003), it was revealed that a single episode of malaria in a household resulted in an estimated average cost of almost 134, 000 old Ghana cedis (US\$ 15.79).

With regards to economic impact on the country as a whole, the estimated annual loss of Gross Domestic Product (GDP) is approximately between 1-2 per cent (World Malaria report 2003; World Health Organisation (WHO/Roll Back Malaria (RBM) 2005). For example, in 2008, the Ministry of Health estimated that the annual economic cost of reported malaria cases in Ghana was US\$772.4 million dollars. With National Gross Domestic Product (GDP) of US\$59.4 billion dollars, this figure represents around US\$32.65 dollars per person (MOH 2008). From the macroeconomic perspective, it has also been found that one percentage increase in the malaria morbidity rate often slows down the rate of real GDP growth by 0.41% (Asante and Asenso-Okyere, 2003).

These problems caused by malaria have raised major concerns within the health communities in Ghana with respect to the policy strategy that will determine the future direction of malaria control in the country. It has generally been accepted that the past conventional (top-down) approach to malaria control has failed to produce the desired results (Shiff, 2004; Breman et al. 2004). As a result, there has been growing recognition that in order to address the complexities involved in controlling malaria and to facilitate healthy and sustainable community development more effectively, a gradual adoption of more systematic, integrated, and participatory approaches to governance and decision-making is needed (WHO, 2002).

Against this background, since 2000, donors and multilateral organizations have provided extensive technical assistance and significant funding to the government of Ghana to support efforts to control malaria. The end result has been an adoption of the policy of Inter-Sectoral Collaboration (ISC) which seeks to view and address the malaria problem systematically and holistically (Shiff, 2002; Baird, 2000). This implies a shift from the traditional compartmentalized and top-down approaches to decision-making, towards a more participatory approach that is able to know and deal with the influence of complex local environmental, political and social-economic factors on community health. Thus, shifting from “eradication” to “control”, the current approaches are more

horizontal with malaria control integrated into the primary health care (PHC) system. This approach relies, to a greater extent, upon increased participation of the local people (Dunn 2005) and subsequently has become central to malaria control policy arenas over the last ten years (Bank Report, 2007; WHO/RBM, 2005; MOH, 2008).

However, until now, there has been limited knowledge about how local communities in the various districts have responded to this policy strategy in terms of their levels of participations (Chaki et al. 2011). Moreover, the transformation of such a policy into specific programmes has long been recognized by scholars and practitioners as fraught with implementation difficulties that are not easily remedied (Kai, 2009). This study, therefore, focuses on the following principal research problem:

“How have the local communities participated in the policy making processes of malaria control programmes and what challenges do the various districts’ decision-makers face in moving ahead with the ISC approach in Ghana”?

By choosing this key research problem I intend to investigate the policy making process of malaria control and the extent of community’s participation in the process of making and implementing the control policy strategy in the various districts in Ghana. Thus in the context of this innovative a “bottom-up” ISC approach my purpose is to find out the extent of community members’ participation in malaria control programmes policy making process. Furthermore, I intend to have deeper understanding about the roles of the community members in malaria control programme activities as well as the challenges faced by local health authorities in advancing this ISC policy strategy.

1.3 Background to the study

In this section, three main issues will be discussed. The first part of the section compares malaria situation in Ghana with other West Africa countries. The second part looks at the importance of community participation and its emergence by placing it in the

historical context of primary health care. The last part of this section provides a comparative picture regarding intersectoral collaboration (ISC) and community participation in Ghana with other countries.

1.3.1 Malaria situation in Ghana compared with other West Africa countries

While malaria has been a major health concern in Ghana almost all the countries in sub-Saharan Africa are also faced with such a predicament. Trends in Ghana must therefore be compared with those of its more immediate neighbouring countries. Comparing some of the reported numbers of malaria cases¹ and deaths in Ghana with those in other Western Africa countries (see Figures 1.1 and 1.2) enable the trends in morbidity and mortality² in Ghana to be better understood.

The main sources of information on these two main indicators are the disease surveillance systems operated by various ministries of health in these countries.

However, these data often have certain defects based on the fact that:

(i) not all health facilities report each month, and so changes in case numbers may be a sign of fluctuations in the number of health facilities reporting rather than a variation in underlying disease incidence; (ii) even if all are reported regularly, reporting systems usually do not take into account patients attending private clinics or morbidity treated at home. As a result, trends in disease (e.g. malaria) in health facilities may not reflect the general trends in the entire community; and finally (iii) not all malaria cases reported are confirmed by microscopy or rapid diagnosis test (RDT) and as such some of

¹The working definition of a case of malaria is considered to be “fever with parasites”. Many medical commentators have argued that these cases are the number of identified persons with suspected malaria but have not yet been medically tested to diagnose the real presence of a parasite in the blood. Case of malaria is often defined as a patient seeking medical attention with fever over 38°C and no signs of acute respiratory infection, urinary infection, measles or abscesses or any other diseases (Gomez-Elipe et al. 2007).

² Morbidity rates, like disease incidence (number of new disease cases within a certain period) and mortality rates such as disease prevalence (current stock of diseased at a certain point in time), are usually the main indicators of public health and health care needs of a population. In addition, incidence and prevalence rates are also vital inputs for burden of disease studies (Michaud et al. 2001; Lopez et al. 2006)

the cases reported as malaria may be other febrile illnesses (WHO, 2010; Steketee and Campbell, 2010).

Despite all these limitations, it is worth using such international data on malaria cases to compare the performance of Ghana with other countries since this is the only credible source of comparable information on the disease (WHO, 2010). In arriving at the values for morbidity and mortality rates (MRs) per 100,000 in both Figures 1.1 and 1.2, between 2001 and 2009, the indicators of MRs were calculated as;

$$MR = (D/PY) * 100,000 \text{ for morbidity};$$

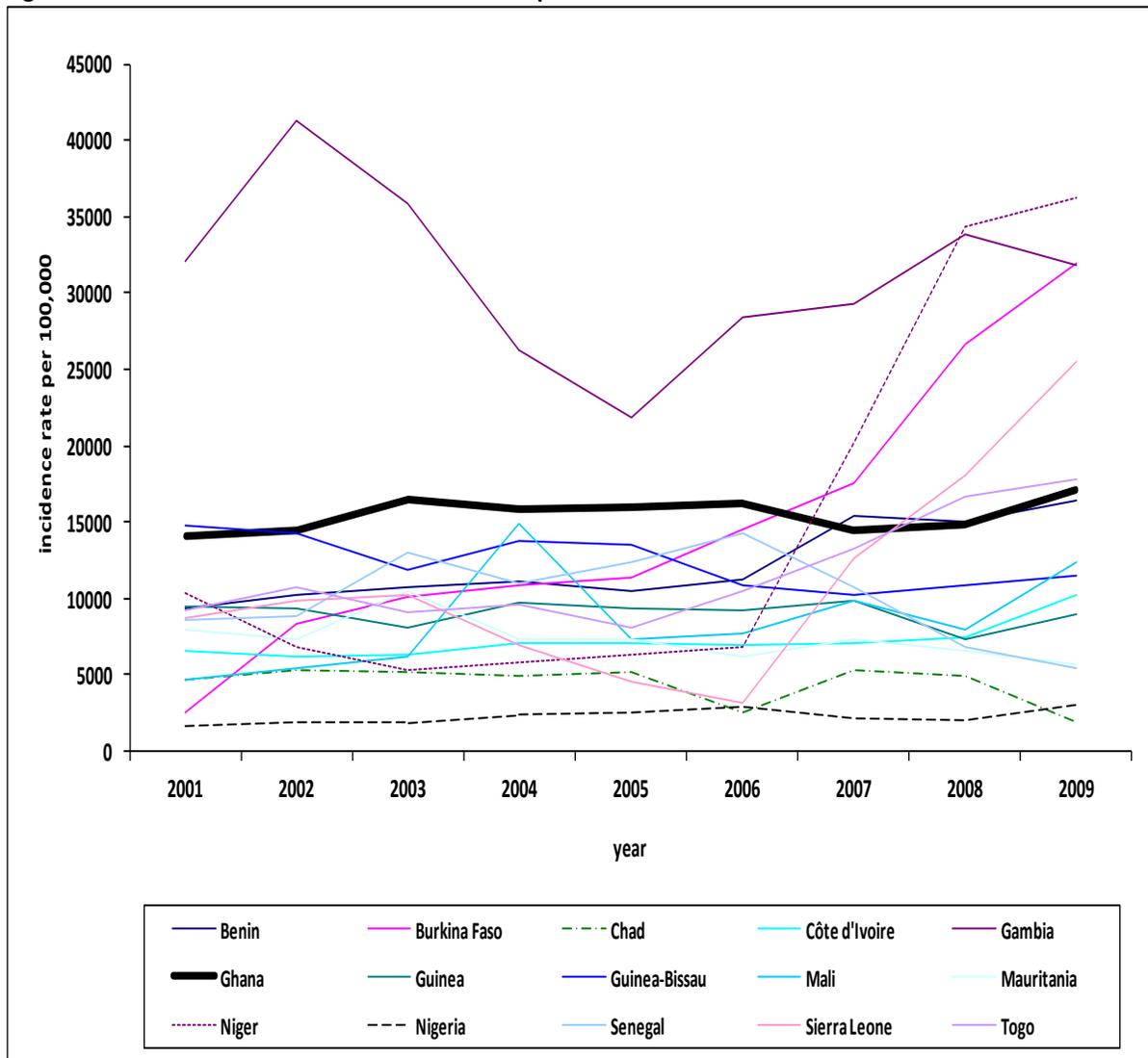
where **D** is number of all suspected malaria related cases during the eight-year period and **PY** is the total population as at 2005 for the country. For the malaria mortality rate, **D** was replaced with the confirmed number of all malaria-related deaths with the same 100,000. Using the countries' population in a single year as a denominator was meant to standardise the rates amongst all the countries involved.

Overall, Figure 1.1 graphically provides an idea about incidence trends of Ghana (black line) compared with other West African countries between 2001 and 2009.

From Figure 1.1, it is clear that amongst all the Western Africa countries facing the problem of malaria within the region, although Gambia was the country that has consistently had the highest level of incidence rate, Ghana has been the second highest country with malaria incidence rate between 2001 and 2006. For Ghana, since 2001, for every 100,000 people, at least 14,000 or more were suspected of having malaria in each year until 2006. With a start of 14,070 suspected cases of malaria for every 100,000 people in 2001, by 2006, the country has got to its peak of 16,227 cases. However, between 2007 and 2009, in contrast with other countries in the region such as Niger, Burkina Faso and Sierra Leone, Ghana experienced a fall in incidence rates. In spite of this fall, by 2009, Ghana was still amongst the sixth countries with the highest malaria incidence rates and even though Guinea Bissau started slightly higher than Ghana,

(14,794 and 14,070 respectively) by 2009, it had lower incidence rates than Ghana, (e.g. while Guinea Bissau had 11,450 cases per every 100,000 people Ghana had 17,073).

Figure 1.1: Number of malaria cases in Ghana compared with other West Africa countries

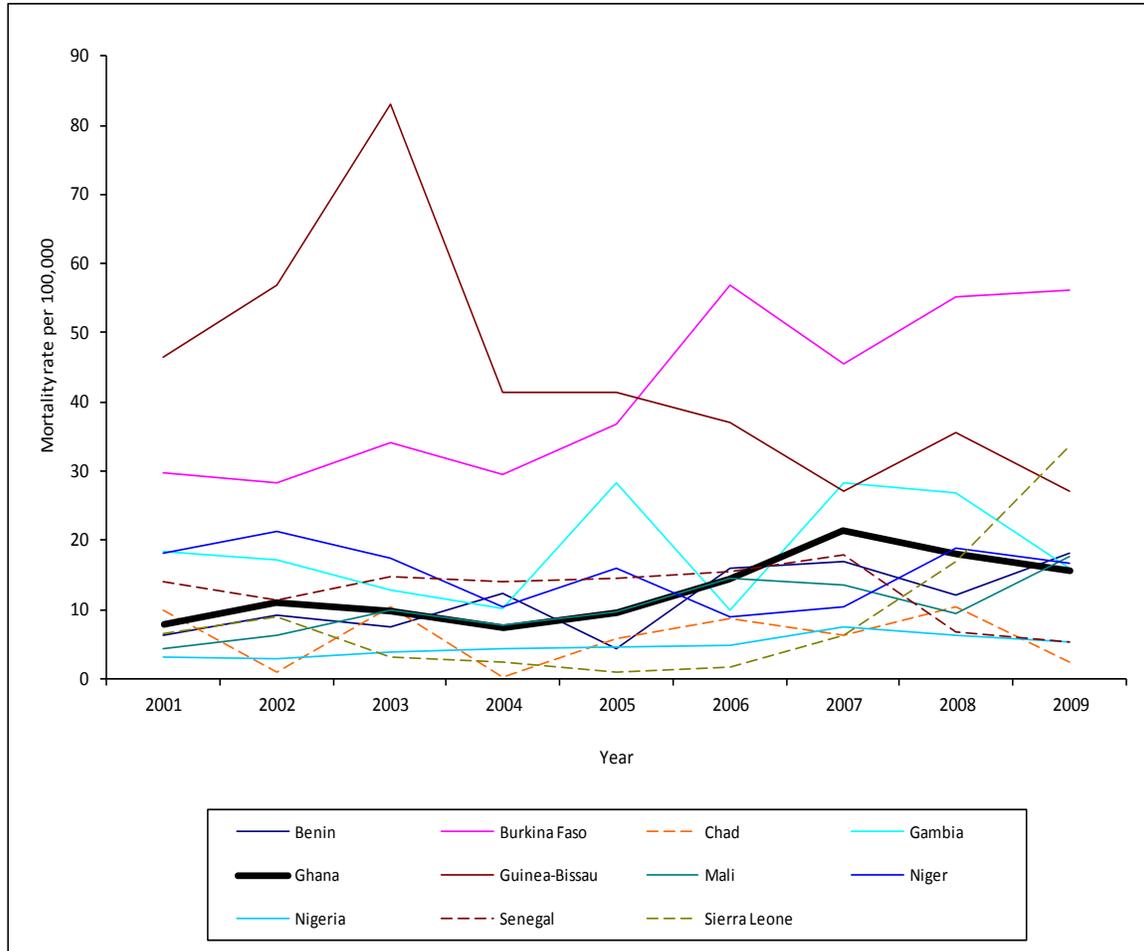


Source: WHO 2010. World Malaria Report on trends of suspected malaria cases

In general, for all these West Africa countries, it is clear that with the exception of some few countries like Nigeria and Cote d'Ivoire (which is difficult to explain why it has been so low in these two countries) the rates for incidence have been high. The implication here is that most of these countries including Ghana might have put less emphasis on the preventive measures and therefore making the population more vulnerable to the

disease. However, whilst it may be true that many of these countries have focused less on prevention, some of these countries have paid more attention on curative strategies which leaves a big gap between the rates of morbidity and mortality in these countries as Figure 1.2 depicts.

Figure 1.2: Number of reported deaths caused by malaria in Ghana compared with other West Africa countries



Source: World Malaria Report, WHO, 2010. Reported Death caused by Malaria

From Figure 1.2, it is evident that in contrast to morbidity rates, in terms of mortality Ghana is relatively better than most of its neighbouring countries. For example, although Guinea Bissau and Burkina Faso were lower than Ghana in terms of rates of morbidity between 2001 and 2006, both of these countries had the highest levels of

malaria mortality rates throughout the entire eight years. In the case of Ghana, in comparison with countries like Guinea Bissau, Burkina Faso, Gambia, Niger and Senegal, which started in 2001 with high mortality rates (46, 30, 18, 18, 14 respectively) Ghana with 1407 suspected malaria cases had only 8 malaria-related deaths for every 100,000 people in that year. Although this figure has fluctuated, until 2006 Ghana was able to contain the death rate to the extent that it never went beyond 11 malaria-related deaths per 100,000 people.

Generally, on the basis of the available evidence in Ghana, it can be said that at best mortality is static and at worst rising starting from 2005 and reaching its peak in 2007 of about 21 malaria-related deaths per 100,000 people. In addition, there is an indication that Ghana is not particularly doing well compared to other countries, (e.g. Nigeria and Sierra Leone), although it is very hard to determine whether this is just a result of better diagnosis in other countries. For example, in 2001 the mortality rate in Nigeria was 3 as against 8 per 100, 000 malaria-related deaths and by the year 2009, Nigeria still had the lowest rate of mortality of 5 whilst Ghana had 16. In the case of Sierra Leone, it was until 2009 when the mortality rate became twice as Ghana (33 and 16 respectively). Throughout this period, (2001-2008), Sierra Leone did better than Ghana and even during the period that Ghana enjoyed its lowest mortality rate (which was 7 in 2004), Sierra Leone had only 2 per 100,000 people.

However, despite these comparative trends, it has to be said that there is a need for caution in generalising these results from the various national data. This is because available evidence has shown that malaria varies greatly amongst countries in terms of data collection, the level of intensity, the vectors that transmit it and the species causing the disease. For example, in presenting a comprehensive review of studies that assessed the impact of irrigation and dam building on malaria incidence or prevalence stratified by the 14 WHO sub-regions of the world, Keiser et al. (2005) cautioned that:

“there might be subtle differences in ecologic, epidemiologic, and socioeconomic features; thus, resulting in different transmission characteristics, even in neighbouring villages” (Keiser et al. 2005, p.400)

In addition, these countries differ in the amount of resources available to fight the disease and all these factors affect the fight against malaria and consequently the level of malaria morbidity and mortality rates (WHO/RBM, 2005; Breman, 2002). For example, using SSA Human Development Index (HDI)³, of 0.463 today, Ghana is placed above the regional average of 0.467 for Africa. Amongst the Africa countries Ghana is ranked the 17th country whilst countries like Burkina Faso and Guinea Bissau are ranked 42 and 45 with HDI of 0.305 and 0.289 respectively (UNDP Report, 2010). In addition, differences in governance and culture with regards to political commitment to community participation can contribute to the differences in morbidity and mortality outcomes (Agyepong and Kangeya-Kayonda, 2004). For example, a comparative study of Ghana with other countries in Africa including Burkina Faso by Chilka (2005) indicates that Ghana’s political commitment⁴ to community participation process is twice as much as that of Burkina Faso (scores of 3 and 1.5 respectively). Thus differences in observed mortality rates from nationally generated data could be a reflection of differences in national health policies and programmes caused by differences in resources in these countries including the challenges facing them. Most of these countries are relatively poor and therefore can not afford to implement life-saving programmes like village-based health services or NHIS and insecticide-treated bed nets which could have positive impact on malaria reduction (Ndugwa, 2008).

In conclusion, it can be said that with malaria morbidity and mortality rates still relatively high in Ghana, there is the need for a better understanding of the strategies which could offer better outcomes than the ones that until now have focused on bio-

³ The HDI represents a push for a broader definition of well-being and provides a composite measure of three basic dimensions of human development: health, education and income

⁴ This means that Ghana has in place, structures and systems that can translate the political pledges into active participation by the community members. Such systems include decentralised government and administrative machinery, as well as health sector reforms in favour of district care services (WHO, 2003).

medical models. Thus whilst the burden of malaria continue to be borne by the poor within the communities due to lack of accessibility to health facilities in SSA (Breman, 2004) it is imperative that studies that take into account all the political, socio-economic and cultural factors are conducted at the local levels. The results of such studies will reflect on the true circumstances of an area within a country which can potentially help in dealing with the problem of high rates of malaria incidence in Africa and for that matter Ghana.

1.3.2 The significance of community participation in malaria control strategy of ISC

Until the beginning of this century, the control of the disease was characterized by top-down approach (Mills et al. 2008; Breman et al. 2004). With this policy, goals were defined by the bureaucrats at the highest level of the government, with ideas that implementing control policy change was about getting people to do what they were told. The authorities had the belief that developing a programme of control without community involvement could lessen social conflict as well as minimising deviation from the goals set by the authorities (Dunsire, 1990; Pressman et al 1973). However, little attention was paid to the fact that for successful malaria control efforts to be sustained, control efforts should be an integral part of national health development and community action efforts, supported by intersectoral collaboration at all levels must be put in place (WHO, 2002). According to Sharma et al. (1986):

“for successful malaria control, whether today or tomorrow, people's participation is absolutely essential, and in the future, much will depend on the 'community-will’” (p.844).

Community involvement is therefore crucial as Nichter (1984) suggests a "community diagnosis" must be executed using a participatory approach before any health or economic development interventions can be effectively planned. The argument for a community-based (bottom-up) strategy is that community members are vital for the success of malaria prevention and control. This is because not only can they contribute to vector control and epidemiological surveillance but also they can help local planners

to have access to information necessary to make better informed planning decisions on the disease (Heggenhougen et al, 2003). This implies that for programmes to be sustainable planners must engage the community members so that they can have interests in them.

However, although there has been a realisation of the need to pay attention to the social aspects of people's experiences of malaria, evidence to date has shown that the community members are still not involved in the decision-making process (Mlozi et al., 2006). For this reason, one suggestion has been that rather than different organisations fighting the disease individually, various actors must fight against malaria in unison. The consequence has been the adoption of ISC policy strategy (Teklehaimanot et al. 2007; WHO, 2003; Sambo et al. 2011). This involves not only government agencies but also local communities, non-governmental organisations, and all private enterprises that are involved in combating the disease. According to Heggenhougen et al, (2003), such an approach:

“ will lead to a better understanding of communities and facilitate establishment of the necessary and most appropriate collaboration through which an alliance of mutually respectful partners will work together to successfully control malaria”. (p. 143).

The impetus for this emphasis on ISC and more local participation can be traced to multiple factors. First, in 1978 when the Declaration of *Alma Ata* was made, it was argued that PHC was the key to attaining health for all and therefore the Declaration called on governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of *“comprehensive national health system development and in coordination with other sectors”* (Forsberg 2001, p.10). This approach is usually referred to as, Intersectoral Action for Health (IAH) (WHO 1998a). Moreover, following the publication of *“OUR COMMON FUTURE”* in the 1980s the argument over the need for establishing co-operative structures between different policy sectors also came to the fore (Brundtland 1987). The report argued that the only possibility of overcoming the problems with our natural world, whose destruction would facilitate the spread of malaria, is by the active involvement of those who cause and are

mostly affected by these problems. The report invented the phrase “sustainable development” and started a political debate which has continued until now, affecting many sectors, such as health.

In respect to malaria control the WHO (2000) acknowledges that:

“the failure of past efforts is due, to a large extent, to inadequate collaboration of malaria control programmes with non-health sectors and insufficient attention paid to the political, economic and social aspects of people’s experiences of malaria”

This emphasis on intersectoral collaboration is also central to health promotion initiatives which place a strong emphasis on creating processes which allow people to have control over and improve their own health. Citizen participation⁵ is considered to be amongst the five key pillars of primary health care and allows health care organizations to be able to quickly react to the needs of their communities, as well as helping citizens to play a part in the decision-making process (WHO, 1986).

Furthermore, stakeholder participation in policymaking has been promoted by both international organizations and domestic institutions, especially the rise of democracy and the emergence of civil society organizations. For those African countries like Ghana that were accepted as part of the Bretton Woods Heavily Indebted Poor Countries (HIPC) Initiative, the process of crafting the poverty reduction strategy papers (PRSPs) accorded high priority to participation by key country stakeholders (Resnick and Birner 2008). All major international donors now highlight the importance of participatory and transparent processes in a majority of their projects. The World Bank, for example, has a *“Participation and Civic Engagement Group”* to make sure that governments, civil society groups, and its own staff incorporate the citizens of developing countries in the making and implementing policies and programmes (World Bank. 2003). Many

⁵ Community participation encompasses a range of activities from information sharing and pursuing participant feedback, to joint planning and organizing for health at the local level. Community participation is a two way process that can be performed by local citizens/communities and a variety of organizations

commentators have argued that the launching of World Bank- and IMF-sponsored PRSPs as part of the HIPC Initiative symbolized one of the most publicized endeavours to promote participation. In effect, this was supposed to be an indicative of a new course for development agencies that stressed a shift from top-down programmes. It is also seen as an alternative which supported an implementation of country-owned strategies through a national dialogue between governments and their citizens (Booth 2003; McGee, et al. 2002).

Another key factor contributing to the importance of participatory approaches was the growing prominence given to health sector reforms through decentralization during the 1990s. In general, the late 1980s and early 1990s witnessed a “wave” of democratization in much of SSA and Ghana was no exception. In the early 1990s, through decentralisation, Ghana made significant efforts by shifting responsibilities for service provision away from the centralized state to local governments, with the expectation that the local citizens could more effectively channel their demands to authorities. It was intended that this would boost government accountability and local ownership of development projects and disease control programmes (Ayee, 1994; Afenyadu, 1996; Johnson, 1997).

Thus, health policy-makers now acknowledge the need for participation of the local citizens and cooperation with other sectors not only at the national levels, but also at the regional, district and sub-district levels, (WHO, 2001). Viewed from a governance perspective, this signifies a move from ‘stand alone working’ to a more integrated policy approach (MOH, 2006; 2008; NMCP, 2008). The latter approach relies on a multidimensional and integrated way of working where intersectoral relationship is negotiated in an ongoing communicative process and does not, in principle, depend on hierarchical mechanisms of control (Heide, 1994; Milne et al., 1996). Implicitly, one could argue that the exclusion of the local people from decision-making processes in the control of malaria appeared to have come to an end.

However, evidence in most Africa countries has shown that the national policy actors including donors as well as national governments have failed to promote community participation (de-Graft et al. 2010; Mubyazi and Hutton, 2003). For example, in analysing the crafting of PRSPs among a set of African countries Booth (2003) found that stakeholder participation did not include most civil societies within these countries. In addition, critics have argued that development institutions have used the idea of participation to their own advantage, thereby sacrificing its true realization for a weaker alternative (Resnick and Birner 2008). For example, Leal (2007) argues that development organisations and national governments have used the idea and discourse of “participation” as a facade for promoting policies and practices that are decidedly neoliberal. Finally, some critics believe that donors as well as governments do not acknowledge the inherently political nature of participatory processes, especially when it comes to decision making on issues that are relevant to the citizens. For instance, based on her research on water resource management, Cleaver (1999) observes that a technocratic emphasis on participatory methods obscures the role of power relations in the development process and ignores the potentially exclusionary nature of participation.

Thus there is a need for understanding the extent to which community participation is encouraged in this novel policy strategy of ISC in Ghana. Moreover it has to be said that ISC is a new policy field and therefore a less-resourced country like Ghana has to tread carefully. There is therefore the need for research into the challenges and opportunities that are involved in ISC approach so as to understand how feasible and effective these relatively fresh policy strategies can be translated into prevention and control programmes and services in the various districts. To date although community participation has become very significant in health policy debate in recent times, there is a lack of empirical analysis of the participation that occurs, particularly in the developing countries (Veitch, et al 1999; Zakus and Lysack, 1998). The reason is that researchers have focused on outcomes rather than the process of controlling the disease (WHO,

2006), thereby paying much attention to actors like the government and the private and neglecting communities (Ndiaye et al. 2001). Furthermore, the various roles that communities may play in control programme activities are not well understood and are therefore largely unexplored (Freudenberg et al., 1992; Asthana et al., 1996; Paul, 1988; Taylor, 2003). Consequently, the wealth of evidence to support community participation in health-related activities (e.g. malaria) is lacking (Baum 1995a; Labonte, 1994, Legge et al., 1996). Moreover, there is limited knowledge in rural health policies that are related to controlling diseases like malaria and little is also known empirically about the dynamics of community participation in prevention and control policymaking process (McCarthy et al. 2010; Dolea et al. 2010; Joan, 2009).

1.3.3. ISC with community participation in Ghana compared with other countries

In the last two decades, the strategy of intersectoral collaboration (ISC) with community participation has remained a guiding principle in controlling tropical diseases. The strategy has been credited with some of the successes of control and elimination campaigns in a number of developing countries (WHO, 2004; Atkinson, et al. 2011). Within most of the countries in the developing world there has been greater recognition of the importance of public sector having partnership with local communities with the aim of encouraging their participation in interventions (Stone, 1992; Zakus and Lysack 1998). Examples include: Kafiriri et al (2003) in Uganda, Deressa (2005) in Ethiopia; Kroeger et al., (2002) in Colombia; Bryan et al. (1994) in Bolivia and Brazil; Lloyd et al. 1994 in Mexico and Ramaiah et al. (2001) in India.

However, comparative studies of community participation in ISC are almost totally absent from the literature (Atkinson, et al. 2011). For example, in Ghana, although the government's support for participatory approaches has always been emphasised as far back as 1980s when decentralisation was introduced, there was no international comparative study in the country until 2002. This was Bossert and Beauvais's (2002)

study of comparing Ghana with three other countries including Zambia, Uganda and Philippines in terms of decentralised system of government with community participation in policy making process. The results showed that while Ghana has made significant efforts in ensuring community participation, the extent of it is limited. In line with its general nature of “decentralised centralism”, (Bossert and Beauvais, 2002, p. 17), the Ghanaian health system previously offered little or no mechanism for popular participation in health sector decision-making. There has been little local governance and the District Administrations have been somewhat undemocratic and local authorities do not have any crucial role to play in health sector governance (Herbst, 1993; Aryee 1996; Mohan 1996). There was little or inadequate involvement of other government ministries, NGOs and other private institutions in ISC strategy (Bossert and Beauvais 2002). This was in contrast to all the countries studied like Philippines, Zambia and Uganda which had stronger ISC with not only NGO but also community participations through both elected local government and representative sectoral institutions (Bossert and Beauvais, 2002).

Apart from the above study, from the literature reviewed including the findings of Atkinson et al. (2011) systematic review of 60 years of literature, it was noted that the only other recent and relevant comparative study was Chilaka (2005). This study covered the period 1998–2001 and it was on the programme of the RBM initiative (Atkinson et al. 2011). It was a quantitative study and the parameters used in scoring the countries for success in malaria control were malaria outpatient attendance (%) and malaria admissions (%). These parameters were obtained from the WHO Africa malaria report for 2003 (WHO, 2003) and were selected because they appeared to provide a better picture of the malaria situation in the countries in terms of morbidity (Atkinson et al. 2011).

From this study, it was found that although community participation was present, amongst the studied countries, there were discrepancies in the extent of participation in

these different countries as Table 1.1 indicates. The computed participation value (Cp) for the five countries under consideration varied: Uganda (12.5), Ghana (10.5), Tanzania (10.0), Nigeria (9.5) and Burkina Faso (8.0). In a whole, taking into account a maximum attainable Cp of 25, it can be inferred that the level of community participation in the RBM initiative is still generally low in these studied countries although with varying degrees of levels of participation amongst these countries.

Table 1.1 Scores for community participation process indicators

Process Indicators	Scores					
	Ghana	B/Faso	Nigeria	Tanzania	Uganda	Average scores
Needs Assessment	2	1	2	1	2.5	1.7
Community Organisation	1.5	1.5	1.5	2.5	3	2
Programme Management	2	2	1	1	2	1.6
Resource Mobilisation	2	2	3	2	2	2.2
Political Commitment	3	1.5	2	3.5	3	2.6
Total Scores (Cp values)	10.5	8	9.5	10	12.5	10.1

Source: Chilaka, 2005

Amongst these countries, apart from Uganda with a total score of participation 12.5, Ghana can be seen as a country with a highest level of community participation with a score of 10.5. From this result, one is tempted to conclude that Ghana has done relatively well however, considering the scores for process indicators, Ghana's score compared with other countries reveals different results. For example, when it comes to the involvement of local communities, NGOs and civil society organisations, as well as the private sector, Ghana was among the countries with the lowest scores (1.5). Compared with Uganda which was the country with the highest level of community organisation, Ghana was two times lower than this Eastern Africa country (1.5 and 3 respectively). This means that the communities of countries like Uganda and in many respects Tanzania have more been taking part in identifying their needs, prior to the initiation of a development programme than Ghana.

In addition, in terms of needs assessment, Ghana was again found to be lagging behind Uganda (2 and 2.5 respectively). Although countries like Burkina Faso and Tanzania had scores (one each), and were lower than Ghana, the situation implies that prior to the introduction of a development programme, Ghana had been less effective in completing a situational analysis of malaria control in all its districts compared with a country like Uganda. In essence, Uganda has the structures that are more likely to strengthen the role of the communities in malaria control activities compared with Ghana (WHO/RBM, 2003; Chilaka, 2005).

In sum, amongst all the process indicators, it is only when it comes to political commitment that Ghana is seen to be doing well with a value of 3. This factor reflects the existence of support systems and structures which can help in translating the level of commitments to community participation into practical realities (Chilaka, 2005). However, while Chilaka (2005) international comparative study shows a positive result for Ghana, there is a need for caution in the interpretations of the results (Atkinson et al. 2011). The fundamental reason is that these countries have inherent differences in their interventions, designs, implementations as well as their outcome evaluations of the policy strategy of ISC with community participation. These variations are the result of various factors including: political context, socio-economic conditions, resource availability, technological environment and geographic location as well as the impact of the disease on the community (Atkinson, et al. 2011; Impoinvila et al.2007). This therefore highlights the need to investigate into the degree of community participation at the local level rather than across countries hence this study.

1.4 Research questions

On the basis of the above analysis, the aim of this study is to investigate the extent of local communities' participation in the policymaking processes of malaria control programmes in the current Intersectoral policy strategy. With this aim, the questions that I will try to answer will include:

1. What is the extent of malaria problem and what are the key contextual factors contributing to government inability to effectively control the disease in Ghana?
2. How do the malaria control policy making processes of ISC take place in Ghana what is the position of the community members in the process?
3. What roles do the communities play in malaria control policy process in Ghana?
4. How far do local communities participate in the malaria control policy strategy of ISC policymaking processes in Ghana?
5. What are the factors (barriers) that have undermined the successful working of community participation at the local levels (both rural and urban) in solving malaria problems?
6. What is the extent of the intersectoral collaboration amongst the various sectors/institutions involved in NMCP and what factors could potentially facilitate community participation?

These questions are asked for the purpose of analysing the different perceptions amongst actors from communities to national government on community participation in the ISC policy strategy. Actors and participants at several levels in this study are considered to be significant in terms of policy formulation and implementation, particularly those operating within the case study context of rural and urban Ghana. In such an environment, it will be worthwhile understanding the actors' perceptions on the effectiveness of local community participation within the collaborative efforts. It will also be relevant to gain greater insight into the challenges and opportunities facing local health policy implementing agents in regards to advancing such an approach to malaria control.

1.5 The contributions of the study

As result of the interdisciplinary character of this study, there are several contributions that the study could make. First and foremost, from theoretical perspectives, the study could potentially be valuable to a number of academic fields of investigation, including community health and development, public health research and practice and public health management/administration.

Secondly, on the basis of the available empirical evidence, it has been noted that very few research studies have currently been conducted in Ghana on the issue of malaria persistence. This thesis is believed to be the first study of malaria control through ISC which looks at question of participation and power of different groups at various levels. As such the findings address the some of the gaps in the literature around how policy process takes place and the extent to which the community members are involved in the health policy strategy of ISC or partnership process. The study also examines one of the major non-biological pathways to malaria persistence in SSA, (i.e., control policy making process in Ghana and the inherent implementation challenges), and thus contributes to better understanding of control policy challenges. By investigating and identifying areas needed for the local government to promote community participation in decision making of malaria control, the study will be relevant to civil society and non-governmental organizations by providing insight into the opportunities for building community capacity and coordinated policy.

In the context of social sciences, this research can be considered as part of the ongoing efforts aimed at providing some answers to the long standing issues surrounding malaria's persistence in SSA. Ghana was the first country under British rule to gain independence (in 1957) in SSA, and yet after all these years of self-governing, Ghana is still faced with a disease that undermines its independent development (Ahorlu, 2005). Thus, by using Ghana as the case study, with the aim of offering a set of descriptive and prescriptive recommendations for understanding and responding to complex problems

like malaria, the study could contribute in finding solutions to some of the underlying factors to the country's under-development.

1.6 The Structure of the thesis

The main aim of this study is to investigate the extent of community participation in the policy making process of ISC of malaria control programme. Chapter 1 has introduced the main focus of the study including the rationale and the contribution of the study.

■ Chapter 2 provides historical accounts of the development of malaria control policies in Ghana. The chapter looks at the development of policy towards malaria control in the post-independence period. Discussion in chapter is centred on both the past and current policy strategies which include vertical (top-down, 'non-integrated') and horizontal (bottom-up, integrated) approach. The underlying idea is that at first there was an emphasis largely on biomedical policy driven from the top down, but a number of criticisms became apparent. In particular the emphasis was largely on curative type of policy which gave little attention to the potential benefits of a preventive approach. In addition, there was limited effort devoted to community engagement and intersectoral collaboration. Finally the previous strategy gave little scope for the involvement of non-governmental and civil society organisations. The chapter concludes with the emergence of (bottom-up approach) the policy of intersectoral collaboration.

■ Chapter 3 focuses on the literature review. The chapter begins with a discussion on how ISC is understood in the health policy literature, the arguments put forward for its use as an incentive mechanism for controlling diseases like malaria and some of its problems. The second section discusses community participation and relates it to the current ISC policy making processes and focusing on the factors that contribute to the success or failures of this strategy. The chapter then concludes with a discussion on the framework that will guide the analysis of the study.

■ Chapter 4 discusses the methodology and methods of the research. In general, the chapter emphasizes on interpretative approach as a methodology for empirically studying community participation in ISC policy processes. In terms of methods, although the study combines both quantitative and qualitative methods, the study relies more on the latter. As a result most of the traditions methods associated with qualitative are discussed which include: indepth interviews, case studies, snow-balling, focus group discussions, policy documentary review and non-participant observation. Thus the chapter focuses on the selection of case studies and the various methods used in gathering the data as well as the data analysis issues. The chapter ends with some ethical issues.

■ Chapter 5 provides answers to the first two research questions by discussing the general policy environment within which integrated malaria control policy strategy in Ghana has taken place. It begins with the extent of malaria in Ghana, which will then be followed by the analysis of the contextual factors that have limited the country's ability to respond effectively to the challenges of malaria control. This is concluded by a description of the policy making processes of malaria control in Ghana

■ Chapter 6 provides answers to the research question three and four
The chapter begins with the examination of the community's roles and their positions in the policy process as perceived amongst the actors themselves.
This chapter requires an interdisciplinary, multi-level approach towards the case study of the ISC. This allows me to study ISC at local level in Ghana (the micro level) and integrate it with an understanding of the meso (regional) and macro (national) levels' programme policy processes. These are important because they can potentially influence the level of community participation at the micro level.

■ Chapter 7 examines the policy strategy challenges facing implementers at the local level. It answers research questions 5 and 6 which include the barriers and the extent to which the sectors are involved in the collaborative efforts and its impact on community participation. The chapter ends with the factors that potentially could have contributed in enhancing community participation.

■ The final chapter presents an integrated overview of the main findings as well as the main conclusions of this research study, including an analysis of the strong and weak points of the study. It ends with recommendations for malaria prevention and control policy in Ghana and lessons for future research.

Chapter Two

The history of malaria control in Ghana

2.1 Introduction

For decades now malaria had a unique place in the history of Ghana because its control requires a special response from the government of Ghana which until recently appears to have eluded the country. Until the beginning of the 21st century, while malaria control activities in Ghana have been under the management of the Ministry of Health (MOH), these activities similar to most SSA countries had often been conducted to the exclusion of other stakeholders (de-Graft Aikins, 2007). Different groups and organizations involved were working separately from each other and little or no regard was paid as to whether or not the local communities were interested in participating in such activities (Espino et al. 2004). Consequently, malaria control efforts have been fragmented and uncoordinated, rather than synergistic (RBM 2010). In order to understand the control activities that have been carried out over the past years, this chapter aims at providing a historical account of malaria control in Ghana since its independence in 1957.

Like the control of many diseases, the history of malaria control efforts to improve health, according to Mills et al, (2006) can be divided into a number of periods, with the pendulum swinging between focused, disease-specific support and broader health service support. On the basis of this categorisation, the chapter addresses the issues by dividing it into two policy periods: vertical and horizontal. Each of these periods reflects on the significant events that took place with regards to the efforts made by the country and the international organisational bodies to control the disease including pre-independence period (see appendix 1 for a summary of this periodisation). The first section discusses the vertical model of malaria control. This will be followed by periodisation with discussion on each demonstrating the main events that took place in

each period. The second section focuses on horizontal (integrated) model of malaria control before discussions on periodisation.

2.2 Vertical programme delivery approach in controlling malaria in Ghana (Pre & Post independence - 1977)

Historically, the method of organising programmes to control malaria has been considered as vertical (also known as categorical). This method of control, according to WHO (1996) was basically disease-specific emphasising only on short-term results by focusing on 'product' like cure rates rather than 'process' (e.g. the production of health). This approach to malaria control often fails to take into account the deep-seated social and economic conditions which potentially explain the presence of malaria (Atkinson et al. 2011). For example, resources that needed to be accessible to the very poor communities in order to be able to organise themselves were ignored and their willingness to take a unselfish approach to disease control were rarely considered. Moreover, there was little interest in ensuring better relationship between other stakeholders and community programme officers. Developed disease programmes were planned without any consultation with specific communities (Espino et al. 2004; Atkinson et al. 2011).

Thus programmes were conducted mainly without any regards to the local contextual factors such as behaviour and the belief systems of the affected populations (Porter et al. 2003). Programmes within this vertical mode of malaria control were centrally organized and implemented with dedicated staff and had little or no attention paid to community participation (Cairncross et al.1997; Pronyk 1997). This approach had a developed 'gold standard' of interventions such as house spraying which were applied nationally without modification or adaptation to local context (Krodstad 1996; WHO 1992; Alonso 1991). Being target-driven, the objective had often been to create epidemiological change or, more specifically, to meet specific cure and coverage rates.

The word 'eradication' therefore became the well known drive and focus for malaria control programmes with an inherent promise of permanency and eventual achievement (Henderson 1998). However, it later became clear that the aim of eradication was hard to be achieved considering the conditions in SSA countries (Porter, et al. 2003). Furthermore, it was realised that such short term goals like 'elimination' (or eradication) only forced the policy agenda rather than allowing the creation of a process which was favourable to local contexts (Atkinson et al. 2011; Packard, 2007). In effect, there were several disadvantages associated with this type of approach. Arguments made against vertical programmes are that, they:

■ *Create duplication*

The underlying cause for this problem is that vertical programmes often have different staffs, infrastructure, logistical and procurement systems that provide and support services. Even where services are integrated at the lower levels including the sub-districts, the programmes still maintain their own exclusive administrative systems. These include: management, supervision, reporting and support structures with the aim of advancing the progress of the programmes without any coordination amongst the rest of the sectors (WHO, 2002; Cairncross et al.1997).

■ *Are less cost effective and are inimical to decentralised health delivery.*

Many commentators have also asserted that high technical skills associated with this approach coupled with different implementation and management arrangements with out any intersectoral coordination give rise to high costs. Moreover, vertical programmes are, by nature, top-down in design and implementation and therefore alienates the communities as well as the various institutions at the local levels. Ultimately, it has been argued, such paternalistic approach of imposing interventions on communities and inducing them to participate for the greater good cause behavioural

resistance that can put at risk health programmes, especially in a place where the communities give low priority to the disease (Manderson, 1992). These common features of vertical programmes are in contrast to the practice of decentralisation which emphasises responsiveness to local circumstances (WHO, 2002; Oliveira-Cruz et al. 2003).

■ *Undermine government capacity to improve other aspects of public sector service delivery*

In this respect, in the first place, it has been noted that vertical programmes potentially take government attention from the rest of other needs and responsibility within the communities. Often, with vertical programmes, there is a tendency for the government to devote much resources including health workers' time on a limited range of problems. Very little attention is given to the development of comprehensive health systems which addresses the communities' health problem holistically.

Secondly, many commentators have argued that vertical programmes leads to funding competition and fragmented system of grant allocation to various diseases which do not augur well to the development and safeguarding of an integrated, long-term plan for population health (Pronyk 1997; Oliveira-Cruz et al. 2001; Soderlund et al. 1999). Additionally, where government are not involved in vertical programmes, the more technical and able staffs are often led away from government service or from key central roles to donor funded projects due to better terms and conditions of work (WHO, 2002; Oliveira-Cruz et al. 2001; Soderlund et al. 1999; Brown, 2001; Porter, et al. 2003).

However, while vertical approach has been viewed negatively by others, many experts also see it as adjunct to the wider health service rather than a substitute for it. From the perspective of the huge increased coverage of a considerable number of interventions,

it can be argued that there are a number of advantages related to vertical programmes which include the fact that:

- Operational planning is simple and realistic;
- Funding can be mobilised and used easily, consistently and swiftly;
- Major health interventions are safe-guarded and therefore their priority can be guaranteed even without strong government backing;
- Monitoring is often holistic and thorough, and the results are easily linked to identification and resolution of problems;
- There is a clear problem-focused by targeting areas where other health provision is sparse or ineffective
- Technical quality of services is good which helps in solving the problems of limited capacity within health systems. Logistically, there is efficiency in planning as well as better coordination in implementation of large scale, disease selective, national programmes (Brown, 2001; Agyepong, 1999; WHO, 1999; Atkinson et al. 2011)

On the basis of these merits of vertical programmes, one could argue that it was not surprising that the pre and immediate post independence of Ghana had malaria control under this system. In reality, all attempts to control malaria were in line with vertical mode of control which reflected the mainstream international public health thinking in the past about the best way of controlling the disease (Atkinson et al. 2011). The discussions below further illustrate this assertion.

2.2.1 Pre-independence

In the history of Ghana, the control of malaria dates back many years, starting when the country was still under colonial rule of the Western powers, including the Danish, Dutch and the British (Twumasi,1986). The discussion on the pre-independence period is relevant since the policies in this period could have influence on the implemented strategies which followed after independence (Martin et al. 2004).

Prior to independence in 1957, the country was faced with traditional (informal) and formal methods of reducing the burden of malaria. The former was practised by the local communities whilst the latter was introduced by the colonial. With regards to the formal method, it has been noted that there were two types of approaches adopted. In the first place, there was an introduction of the use of an antimalarial drug called quinine to treat victims of malaria (Dwuma-Badu, et al. 1978). Secondly, there was a realisation that, it was the local ecology and vector dynamics that put the populations at-risk and as such there was the use of environmental management⁶ interventions for vector control. This environmental management was about eliminating the breeding sites and to ensure that opportunities for vectors to exploit were reduced to a minimum. Also, non-pesticidal personal protection strategies for malaria prevention were practised, particularly by locating houses away from breeding sites like the dams and water pools to reduce the human-vector contact (WHO, 1982; Twumasi,1986; Walker, 2002).

However, such method proved technically difficult, ineffective and very costly for reducing the number of mosquitoes although environmental management has been found to be significant for the reduction of other vector-borne diseases. As a result, more emphasis was laid on the use of chloroquine as the main intervention adopted by the government at that time to treat all infected people, and for individual prophylaxis of non-immune populations (Twumasi, 1971; 1986). In a way, there was universal focus on biomedical interventions which often failed to give consideration to the influence of socio-cultural and politico-economic conditions existing within the communities. The implication was that there was a greater emphasise on individual exposure patterns and

⁶ Environmental management is defined by the WHO as »the planning, organisation, carrying out and monitoring of activities for the modification and/or manipulation of environmental factors or their interaction with man with a view to preventing or minimizing vector propagation and reducing man-vector pathogen contact. There are three types namely Environmental modification (e.g. land levelling); Environmental manipulation (e.g. intermittent irrigation) and Personal protection (e.g. house improvement or bednets (WHO, 2006)

risk-factors within populations, with little or no attention paid to the community as a whole (Pronyk 1997; WHO 1996).

As far as the informal (traditional) approach was concerned, according to Twumasi (1986), the communities relied on their own methods of keeping mosquitoes away from biting them in the night. One such method was, for example, by burning dried peels of oranges in their rooms before going to bed. In addition, the communities had often to rely on traditional herbalists for treatment. The implication here is that the current system of most local parents treating their malaria infected children at home before seeking treatment in hospitals has its roots in the past. As it was, before the formal introduction of bio-medical malaria control in Ghana, the local communities had an idea of protecting themselves against the mosquitoes, (Twumasi, 1986; Dwuma-Badu, et al. 1978).

2.2.2 Post-independence (1957-1977)

After independence in 1957 till the end of 1960s, Ghana adopted the inherited health care systems modelled after the systems in the industrialised world. Consequently, the government efforts at controlling malaria were intensified and these included environmental management, the use of anti-malaria drug of chloroquine, and the use of mosquito nets and by 1961 there was the creation of national health services including malaria control (Twumasi, 1986; Warren, 1986; Konadu, 2008). Along side with the promotion of modern method of bio-medical method of treating malaria was also the endorsement of the use of traditional medicine and this was reflected in the first President Kwame Nkrumah's campaign to create a national identity and to promote local initiatives. As a result, the first association of traditional healers, the Ghana Psychic and Traditional Healers Association was established in 1961 to improve and encourage the study of traditional health system, as well as research into herbal medicine in Ghana (MOH, 2007). Subsequently, the President established traditional medical system and officially professionalized it in 1969 (Maclean et al, 1986).

Ghana also adopted the Global Malaria Eradication Programme which had been initiated by World Health Organisation globally in 1955 and concentrated its attention on eradicating the disease through the continuous use of dichlorodiphenyltrichloroethane (DDT) (Anto et al. 2009). The most significant reason for concentrating on the fact that DDT was considered to be cost-effective. This was reflected in the WHO Expert Committee's claim on malaria:

“at last a method of controlling malaria in many areas at costs within the economic means of the people” (WHO 1947).

Besides indoor spraying chloroquine was the main antimalaria drug used and it was sold in most Post Offices (Ghana Malaria Action Alert, Vol 1. 2007; Agyepong, 2002). However, the programme of spraying had to be discontinued in 1967 due to technical and financial constraints (Ahorlu, 2005).

During this period, the idea was that the initial vertical approach could be developed into a mainstream public health (horizontal approach) as the incidence of malaria fell. In effect, vertical approach was perceived to be a 'quick-fix' method. Although these combined efforts achieved some successes in the area of mortality, they had little or no effect on the overall transmission of the disease (Packard, 2007). The authorities at that time became aware that eradication was only possible where there were sufficient resources to undertake the process. Moreover, the approach was short-term intervention which had no long term planning purposes (Twumasi, 1986). It is therefore fair to argue that rather than the communities or society-wide mechanisms, the past strategy has been using a biomedical approach which seeks to expose linear, direct causal factors for illness and the disease like malaria. With this strategy, it can be said that the health promotion strategy in the past targeted individuals (i.e. policies were simply curative, based on delivering treatments to individual victims) whose influence on health enabling environments or living conditions were not strong enough for

individuals and families to secure and maintain their own good health (Kickbusch 1989; 1999) This implies that the past policy strategy revealed the country's inability to perceive and address health problems of malaria holistically since social dimensions of the disease and the impacts of economic systems and cultural values were often disregarded from the diagnostic analysis, or therapeutic activities (Coburn, 2004). Consequently, health policy, research and resource investments became very reactive focusing on providing cures and interventions during periods of illness, as opposed to giving priorities to investment in strategies and facilitating environments such as educational campaign that would help to enhance and maintain health (Kickbusch, 1989).

Also during the 1970s there was a continuation of most of the activities in the 60s which included indoor residual house spraying and the use of chloroquine for malaria treatment. Additionally, the use of chloroquine was intensified at all health facilities in Ghana and bed nets use was also more promoted. Most people both in the rural and urban alike, who could afford using mosquito repellent measures, including aerosol insecticides and mosquito coils continued to use them. However, those who could not afford these, particularly those in rural areas, continued to use more traditional preventive measures, such as burning of leaves or dried orange peels as well as malaria treatment from the traditional herbalists. In effect, multiple interventions were more deployed in the vector control component of the programme although most of the measures' efficacies such as traditional methods of burning leaves or dried orange were doubtful as there were no scientific evidence to demonstrate their effectiveness (Mills et al. 2005; Ahorlu, 1997).

2.2.3 Summary

Conceptually, the discussion has centred on vertical (top-down) approach which involves more centralised development of programme objectives and actions plans by health experts and or professionals. This approach was adopted prior to the

independence and was continued after the independence until the end of 1970s. Thus traditionally, the malaria control in Ghana has largely based on this approach with the biological and medical interventions as the central focus. With regards to collaboration, concern was raised about the fact that this approach turned to exclude the communities and not much attention was paid to the socio-cultural and behavioural aspects of malaria control. There was no emphasis on the importance of having participants from the target communities to be involved in the planning and implementation phase of any malaria control effort. By adopting the approach, it has been noted that, it provides easy planning and implementation, helps in addressing problem of lack of resources, enhances technical know-how and ensures efficiency in planning as well as better coordination in implementation of large scale activities.

However, the discussion also revealed that this approach is without its limitations. Amongst them include: cost ineffectiveness; unfavourable to decentralised health delivery, detrimental to government capacity to improve other aspects of public sector service deliver, causes funding competition and fragmented system of grant allocation as well as duplication of efforts and waste. Thus as much as this approach has its opponents, it has its own supporters. However, over time, vertically organised malaria control programmes had to give way to a more horizontal/integrated, primary health care programmes, especially after the Alma Ata Conference in 1978 as discussed below.

2.3 Horizontal (integrated) approach of malaria control (1978-2010)

The World Health Organization (WHO) defines integration of health services as:

"the process of bringing together common functions within and between organisations to solve common problems, developing a commitment to shared vision and goals, using common technologies and resources to achieve these goals." (WHO 1996).

This definition is related to the development of primary health care at the level of district health services, which involves multipurpose staff and integrated programme

planning with many objectives. Logistically, it ultimately involves removing control from separate programme management arrangements and putting it in national systems (Brown, 2001). In the context of horizontal model of malaria control, this includes integration of similar levels of health services and other sectors. These can be generally divided into the following three categories which are in line with the categorisation proposed by the WHO (1996):

- Integration of service tasks within a given setting, where the service provided is coherent from the user's perspective;
- Integration at the level of planning, management and support functions; and
- Integration of different institutional and organisational components across sectors

The horizontal approach (bottom-up) approach to community participation puts emphasis on the need to engage and support communities in identifying and prioritizing their own health needs. This is to help them to democratically make decisions about the way local resource will be allocated with the support of the health professionals and local authorities (Rifkin, 1996). In essence, this approach seeks to address the over-all health problems on a broader scale and on a long-term basis through the creation of a system of permanent institutions which could allow staffs to work collaboratively together with the communities so as to achieve a common goal (Stephens, 1997). Primary health care (PHC) is a typical example of an integrated-holistic horizontal approach to health as it has been seen by most international commentators as the only viable way of addressing the health problems of poor countries. In contrast to the technical approach of vertical programmes, PHC has a package which is considered to include all aspects of personal health services, such as maternal and child health, family planning, nutrition, environmental health, health promotion, disease surveillance and crucial links with other sectors such as agriculture and education. It also stresses intersectoral activities, community participation, appropriate technology, and essential use of drugs (Mills, 1982; WHO, 2002; Hanson, 2000a; Magnussen et al. 2004).

The integration of health services in these periods therefore aims at promoting health services and ensures preventive and curative services through multidisciplinary and intersectoral collaboration. Many see this period as an era of working across disciplines to bring multiple academic, social and historical perspectives to bear and developing approaches that address the root causes of malaria (Porter et al. 2003; WHO, 1993). It is during this period that all resources in every sector that is involved in public health activities are productively put together for the purpose of collaboratively achieving a common goal. This is after realisation that each an every sector's exceptional and useful roles in controlling disease like malaria could be productive to various communities, if they work in collaboration with each other. By doing this, it is expected that rather than pursuing malaria control in terms of one specific interventions, working together on the same level will draw attention to the:

“social, cultural, economic and political dimensions of health, will lead to the creation of effective multidisciplinary teams, and to the development of interventions which work across social sectors “(Porter et al. 2003, p.326).

It is also argued that through this process of integration and cooperation, the whole sectors within the community will be able to make a longer term commitment to malaria control. This will help the community to put the disease within the broader context of historical, social, ecological, cultural and political relationships which often increase the risk of community members to the disease. Eventually, this integrated approach is expected to sustain malaria control and be responsive to local needs, ensure quality of care, and cost-effectiveness (Agyepong, 1999; Mills, 1983; WHO, 1983).

However, while this approach is popular, it often lacks the institutional roots to be able to generate adequate resources to support each community's objectives (Kaseje and Sempebwa, 1989). Furthermore, this approach has less capacity for rapid national scale-up of programmes and inappropriate for selective disease control or elimination

agendas, especially those funded primarily through external donor agencies (Nsabagasani et al. 2007)

In all, the integration of vertical programmes to the main health care system was one of the health sector reform strategies which took place over the last three decades. However, in the context of this study, these changes were dynamic and evolved over three periods (1978-89; 1990-1999; 2000-2010) with each period having its features as explained below

2.3.1 The start of comprehensive approach period (1978-1989)

Following the failure of vertical malaria control programs to achieve eradication during the 1960s and 1970s and with malaria eradication campaign beginning to lose grounds, many began to call for the integration of malaria control campaigns into the general health services (WHO, 1993; MOH 2005). As a result, after the Alma Ata Declaration of 1978, Ghana, like most SSA countries, adopted an approach (comprehensive) that emphasized prevention and managed health problems in not only in the bio-medical perspectives but also others such as socio-economic and political as well (Magnussen et al. 2004; Mills et al. 2005; Molyneux, et al. 2004). Malaria was to be controlled through mass education by the staff of health services although there were some elements of vertical approaches in its efforts (Packard, 2007). This was not surprising considering the fact that most advocates in international health policy had opted for selective approach⁷ within the comprehensive system in order to be cost efficient and effective (Walsh et al. 1980; WHO 2005). Thus, it aims at targeting particular disease, (e.g. malaria), according to the local environmental situation, expenditure involved and where there is documented evidence that it can be successful. However, many have criticised this approach arguing that it deprived communities of their ultimate responsibility to decide what problems their health system should solve (Newell 1988; Walsh et al. 1979;

⁷ Selective approach was proposed as a new perspective of addressing the main disease problems of poor countries. It emphasised on an integrated package of low cost technical interventions perceived to be economically efficient and effective, (Walsh, et al. 1979).

Magnussen et al. 2004). Nonetheless, even today, the country still adopts specific disease-focused international programmes which are illuminated in the current Global Fund for AIDS, Tuberculosis, and Malaria (Mills et al. 2006).

In addition, it was this period that the country embarked on a more vigorous campaign against the environmental filth after general acceptance that it could cause malaria. As a result, good sanitary environment was more widely pursued than previously considered through the provision of clean water supplies as well as effective sewerage and drainage and the removal of nuisances, such as refuse from all streets and gutters. The problem with this preventive approach was that it specifically targeted the few cities in the country to the neglect of other town and rural centres (Twumasi, 1986). In spite of this criticism, it could be argued that this was a sensible strategy because:

“bio-environmental and socio-economic influences on local transmission need to be understood by communities if they are to be empowered to effectively participate in programme planning and implementation” (Atkinson et al..2011, p.7)

However, it could be argued that although all these attempts might have led to some level of containments, there were many challenges which led to lower than expected outcome of malaria reduction. The underlying reason for this low performance was that the country lacked technical and financial resources to embark on large scale implementation of such programme (de-Graft Aikins, 2007). Also, it was reported that the Village Health Committees that was set up to improve service responsiveness to communities' needs, for example, played little or no role in the planning and evaluation of the health system and the communities had little opportunity to express their own perceived health needs (Ahorlu, et al. 2005).

Thus little attention was given to the importance of democratic process and community engagement. Besides, these periods were also characterised by the “closed” character of public health departments with no meaningful cooperation amongst the various sectors. During these times, there was no or little attention paid to health issues or

initiatives which lay outside the sector and there had been few opportunities for inter-sectoral collaboration. Activities remained compartmentalised at the national, regional and districts levels and no attempt was made to coordinate any activity with regards to disease control (e.g. malaria) (Senah, 2001). Accordingly, sectoral communication barriers existed which led to poor information exchange (Senah, 2001; Baidoo 2009; Twumasi, 1986).

However, one significant event which took place at this period was initiation of legislative reform, the Local Government Law (PNDC Law 207) which began in 1988, when the then Peoples' National Democratic Congress (PNDC) government led by Jerry John Rawlings was in power. It was a key piece of legislative reform with stated aim of the law:

“to promote popular participation and ownership of the machinery of government... by devolving power, competence and resource/means to the district level” (Map Consult of Ghana, 2002, p.35).

In spite of this well defined aim of encouraging community participation, Quaye (2001) argues that this decentralisation exercise was *“largely introduced to satisfy donor demands”* (p.36). On the other hand Ayee (1994) claims that the main reason for the PNDC's decentralisation policy was an attempt to increase their legitimacy in the country. Irrespective of the criticism levelled against this political move, it can be argued that it had significant influence on the health sector reforms that took place later in the 1990s.

2.3.2 The beginning of global partnership initiatives (1990-1999)

This period could aptly be described as the period when the seed of the current global malaria control strategy of Intersectoral collaboration (ISC) or partnership was sowed (Panicker and Dhanda, 1992; Riji, 1992). Although at the beginning of 1990s, many sectors within countries in SSA including Ghana had been working collaboratively, it

generally started in 1992 in Amsterdam when ministers of health from 102 countries convened to discuss ways of responding to the global resurgence of malaria. The end result was the Global Strategy for Malaria Control which laid emphasis on the need to shift from highly prescriptive, centralised programmes to flexible, cost-effective, and sustainable programmes adapted to local conditions and responsive to local needs (Packard, 2007; WHO 1993). Subsequently, the new malaria control efforts were to be integrated into existing health services rather than being 'stand-alone' programmes. An equally important part of the new Global Strategy was the call for a multisectoral approach to malaria control. The strategy paper noted:

“ Malaria control is not the isolated concern of the health worker. It requires partnership of community membersMalaria control must be an integral part of national health development and health concerns must be an integral part of national development programmes” (WHO, 1993).

The strategy had also to provide early diagnosis and prompt treatment to plan and implement selective and sustainable preventive measures, including containment or prevention of epidemics. Secondly, it had to strengthen local capacities in basic and applied research to permit the regular assessment of country's malaria situation in particular the ecological, social and economic determinants of disease (Packard, 2007; WHO, 1993)

In addition, it was during this period that Programme of Work I (POW) (1997-2001), a partnership between MOH and Development Partners was established around the principles of a sector-wide approach (SWAp) (PMI, 2007). With this system, in 1997, a Donor Pooled Fund (DPF), also known as “The Health Fund”, was launched. The system still exists and it involves contributing partners making an annual commitment to the fund by paying in regular contributions at the start of each quarter. Once paid, Funds are held in the Donor Pooled Account to which MOH and the Controller and Accountant General are signatories. Based on the sufficient in-flow of donor funds, the fund is allocated on a quarterly basis to the various levels of Budget and Management Centres

(BMCs) namely: national level, tertiary, regional and district. The main advantage of the Health Fund to date has been the level of independence and flexibility which it has given to BMCs to plan and deliver services (Addai and Geare, 2000).

Apart from “pooled funds”, there are other funds which are not channelled via the Health Fund and are known as “earmarked” funds. These are considered as falling into two categories which include:

- “MoH managed” earmarked funds, which are regarded as those funds devoted to specific programmes or projects but are channelled through MOH. As part of the financing and budgeting system, an “Aid Pool Account” (separate from the donor pooled fund) was set up and all donors are asked to channel all funds to the sector through this central account in the first instance. In practice, individuals donors are not obliged to contribute to this account and as such this central account which is related to Aid-pooled account is only partially observed or not at all by some of the donors in the sector. Also, it is worth point out that the term “MOH managed” does not necessarily denote MOH control of how funds are programmed, rather as a vehicle through which funds can be released (Addai and Gaere 2000).

- “Donor direct” earmarked funds which are considered as all other funds spent directly by donors in support of projects. These are not channelled through MOH and may or may not be in line with the PoW/SWAp.

In terms of its relevance, SWAp approach did help in supporting integrated systems at district level which also provided a framework for further facilitating a more cohesive approach to the planning and implementation of complex malaria interventions by means of inter-sectoral working (MOH, 2006; PMI, 2007).

Additionally, in 1999, the Ghana Health Service (GHS) was also instituted to assume responsibility for operations or implementation of malaria policies. It was also in this period that the National Malaria Control Programme (NMCP) Unit was set up to work in collaboration with GHS to be responsible for ensuring the implementation of malaria control strategies (MOH, 2000; NMCP, 2006).

Finally, in 1999 the RBM Partnership⁸ began and this marked a clear departure from the earlier Malaria Eradication Programme (MEP) of which the former recognised both the risks and difficulties of promising the total elimination of malaria (Packard, 2007). With this partnership, Ghana adopted the following from RBM's Global Strategy:

- Improve case management through capacity building for health practitioners and caregivers at home (Home-based care)
- Adopt multi prevention strategies, including ITNs, intermittent preventive treatment (IPT) in pregnancy and environmental management
- Make malaria a priority for all sectors, not just health and to promote close collaboration with other institutions (WHO/RBM, 2005; MOH, 2006; NMCP, 2007)

The main principle of the RBM initiative was therefore to turn malaria control into a truly developmental issue and enhance participation in malaria control by getting the major stakeholders to work together in a concerted effort based on their comparative strengths. The aim was to halve the world's malaria burden by 2010 and to reduce it by 75% by 2015. Consequently the country drew up a 'Medium Term Strategic Plan for Malaria Control in Ghana' (1998-2002), which sought to improve the coverage of malaria control activity by adopting an inter-sectoral (ISC) approach involving other government sectors and partnership with the private sector and the community (MOH, 1998).

⁸ Roll back malaria is based on partners working together to an agreed plan; intense action against malaria at the community level based on good evidence and focused on results; high level political backing leading to substantial increases in resources for health development; and strategic investments in better tools (RMB, 2010)

In general, until 2000, one could argue that the strategies adopted to control malaria since independence were not mutually exclusive from each other. If there was any difference at all, it was that while the 1960s and 70s strategies were more individualistic and focused more on curative, the 80s and 90s were both curative and preventive with more focus on communities. Furthermore, the organisation of the past strategies allowed limited scope for the inclusion of the non-governmental and civil society organizations in the policy making process. The problem was that these organisations were often competing against each other by lobbying the government for political recognition and limited financial resources (Twumasi, 1986; Warren, 1986). Thus, although many of these NGOs and other civil society groups work towards common objectives like improving communities' health, there was poor integration of them into the overall effort to improve coverage and quality of care (Mackenzie, 1992; Warren, 1986; Van der Geest 1997).

2.3.3 Ghana intersectoral strategy initiative 2000-2010

During this period, Ghana's perception of the principles of RBM as being in consonance with the overall goals of its Vision 2020 developmental plan was strengthened. Consequently, the country initiated a Medium Term Health Strategy with the aim of: increasing access, improving quality and efficiency in service delivery and building partnership/collaboration in the context of overall sector-wide development (MOH, 2002).

The starting point was when in 2000, African heads of states met in a historic summit in Abuja, Nigeria to commit to tackling malaria and to set targets (Abuja Targets) for key malaria control interventions so as to reduce malaria disease. It was generally recognised that the use of insecticide treated bed nets (ITNs) was a low-cost and highly effective way of reducing malaria particularly among pregnant women and children Under 5 years who sleep under them. The Abuja targets therefore aimed at raising ITN usage levels from less than 20% in 2000 to more than 60% by 2005. In the same year,

2000, Ghana adopted the Abuja Targets and removed the import duty on nets (WHO/RBM, 2005).

Another development during this era was the establishment of The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in 2002, which gave malaria-endemic countries like Ghana access to additional external funding for malaria control. It has also been noted that following the application to the Enhanced Highly Indebted Poor Country (HIPC) facility in 2001, the government formulated the Ghana Poverty Reduction Strategy (GPRS I), which was implemented over the period 2003-2005. The main objective was to improve the conditions for implementation of sectoral policies designed to promote sustainable economic growth and reduce the high incidence of poverty in the country. The strategy also focused on that component of human development which targeted measures designed to improve access of Ghana's population to basic needs and essential services. These programmes which included basic education, safe water and improved health and environmental sanitation added some impetus to the control of the disease. This was because although, the GPRSI had a macroeconomic objective, it was expected that the decrease in poverty could subsequently reduce poverty related diseases like malaria (United Nations Education & Social Council, 2007).

Also, in 2003, Ghana increased access to basic health services by passing the National Health Insurance Law (Act 650, 2003) that instituted a National Health Insurance Scheme (NHIS). This was to secure the provision of basic healthcare services to persons resident in the country through mutual and private health insurance schemes. Currently malaria treatment is covered under the NHIS (MOH, 2004; WHO, 2010; Sarpong et al. 2010). In order to support malaria control activities at the district level, the government also gave directive that 1% of the District Assembly Common Fund was to be used for the control activities.

In addition, in 2003, Ghana approved Intermittent Preventive Treatment in Pregnancy (IPTp) with Sulphadoxine- Pyrimethamine (SP) as a strategy to prevent malaria in pregnancy. IPTp has been implemented by the Reproductive Health Division in collaboration with the NMCP in all public health facilities, Faith-Based Organizations (FBOs) and private maternity homes. It is reported that in 2003, only 20 selected districts benefited from this strategy, but in 2005, it was scaled up nationwide to all 138 districts (NMCP Report, 2008). Additionally, there has been a decentralised system of microscopic screening of malaria at the districts' clinics as well as rapid test of malaria cases in the blood at the sub-district/community levels. This has reduced the costs of transporting slides to a central or regional laboratory, and has enhanced early diagnosis and prompt treatment (NMCP Report, 2008; MOH, 2009; PMI, 2008).

Furthermore, in order to encourage home management of malaria, pre-packed Artesunate-Amodiaquine was introduced and this was found to be effective in improving compliance (Yeboah-Antwi et al. 2001). Another strategy currently implemented has been the scaling up of the Community Health Planning Service (CHPS) or Community Based Health Service Initiative (CBHSI) (NMCP, 2008). This involves placing trained community health officers (CHOs) in communities or trained community health nurses or similar cadres on government payroll in communities (with accommodation) provided in partnership with the communities to provide them with certain essential health services. The aim has been bringing first contact close to the household through creation of single person health clinics at community level. Despite the fact that this strategy is at its initial stage, evidence has shown that the project has improved coverage and accessibility for basic services (NMCP, 2008; RBM, 2010; Nguyen et al. 2011).

The government has also promoted a Community-Based Surveillance system, using community volunteers to detect and report abnormal events or to alert health care sub-district team about possible cases of disease like malaria within their locality in a timely

fashion (NMCP Report, 2009). The main concern has been that the infection of malaria is inescapable, particularly in the rural areas where accessibility of health care services has been difficult. The government has therefore found it necessary to ensure that caretakers are able to recognize symptoms and signs of malaria and respond appropriately. Community surveillance also brings agents in daily contact with the community. In a way, it can be concluded that if surveillance for other diseases is executed in the same way as the malaria control programme, there is potential for malaria control programme to offer a platform, from which an intervention programme for other parasitic diseases could be initiated (Hashizume et al. 2006; Bloland et al. 2003)

With malaria parasites becoming resistant to chloroquine, in April 2004, Ghana changed its anti-malaria drug policy from Chloroquine which was first-line drug for uncomplicated malaria to be replaced by Artesunate-Amodiaquine (AS+AQ). At the moment, not only has there been free provision of Long Lasting Insecticide Treated Nets (LLINs) but also free treatment for vulnerable groups (pregnant women and children). Although some parasites are developing resistant to these nets, residual insecticide-impregnated bed nets remain the best prevention strategy against malaria (Koram et al. 2003; Binka, et al. 1996). However, Browne et al. (2001) argue that impregnated bed nets do not provide significant protection for pregnant women in terms of malaria, anemia, and low birth weight.

In order to promote the use and easy availability of Insecticides Treated Materials (ITMs), the government since 2003 had also involved a well-developed commercial sector of manufacturers and distributors who were interested in expanding their product lines to include materials that could help in controlling malaria. These include not only mosquito net manufacturers and suppliers but also manufacturers and distributors of other anti mosquito products. Thus, the main strategy to create demand for ITMs has been through the private-public partnership (WHO/RBM, 2011). However, despite the fact that biological control can be used to control mosquitoes, stimulating interest in

microbial insecticides in Ghana has not attracted much attention from investors. This seems to be due to large amount of investment involved in funding such biological control measures and the difficulty in developing microbial insecticide product that can easily be sold at the market (Obeng-Ofori, 1997).

In the case of indoor residual spraying, although the previous strategic plan for it had been discontinued due to financial and technical constraints, recent evidence has indicated that indoor spraying has been adopted by some districts that could afford it. For example, AngloGold Ashanti (a private mining company) initiated IRS activities with efficacious insecticide, within the Obuasi Municipal Assembly Area as part of its comprehensive Integrated Malaria Control Program. This is not surprising since the company has enough financial resources to undertake such exercise. To-date, result shows over 74% reduction in malaria cases within a period of 2 years in the intervention area which comprises urban and rural communities (PMI, 2008; NMCP, 2009). Furthermore, the Public Health Departments of the Metropolitan and Municipal Assemblies have been equipped with manual and motorised spraying pumps for aerial spraying. Focal spraying is normally undertaken in slums, swampy areas, areas around man-made “ponds” created by building/construction and mining activities etc. However, there has been a realisation that these focal spraying activities are largely not adequate enough as a result of lack of personnel, equipment, training, funds and more significantly lack of appropriate laws and bye-laws for prosecuting public or private sanitary and environmental offenders. Besides many not all communities can also afford them (NMCP, 2009; MOH, 2008)

In terms of environment management, it is worth noting that until the beginning of the last decade, Ghana did not have a Public Health Act or an Environmental Health Policy as legal provisions for public health were scattered in a number of laws, acts and ordinances dating back to the colonial era (Attipoe, 2001). However, by the beginning of 2000, the Government had promulgated an Environmental Sanitation Policy aimed at

developing and maintaining a clean, safe and pleasant environment in all human settlements. Besides this Ghana has specific policies that relate to specific areas of environmental management such as the National Environmental Action Plan. Consequently, Expanded Sanitary Inspection and Compliance Enforcement (ESICOME) programme was implemented and the MOH as at the beginning of 2007 has prioritized Environmental Sanitation and has re-launched the ESICOME programme aiming at vigorous inspections and law enforcement (Magala et. 2009; Government of Ghana-MOLG, 2007 Report).

2.3.4 Summary

In sum, the introduction of the horizontal integrated system of malaria control ushered Ghana into a new dawn of malaria control after 1978. From the late 1970s till now, there has been general realisation that battle against malaria control could not be won with vertical mode of control with only health sector as the only sector in the battle front fighting the disease alone. At least, the authorities have come to know that each an every sector has its unique and helpful role to play in solving this problem of malaria and as such there is a need for intersectoral collaboration. Consequently, various measures have been taken since 1980s till to date. These include: changing of anti-malaria drug policy from Chloroquine, which was first-line drug for uncomplicated malaria, to Artesunate-Amodiaquine (AS+AQ); free provision of Long Lasting Insecticide Treated Nets (LLINs) as well as free treatment for vulnerable groups (pregnant women and children). There has also been the promulgation of an Environmental Sanitation Policy aimed at developing and maintaining clean, safe and pleasant environment in all human settlements. In addition, the country has implemented ESICOME programme in order to ensure environmental sanitation as well as vigorous inspections and law enforcement. These measures in one way or the other have had certain degree of success although one can argue that a lot still needs to be done.

2.4 Conclusion

This chapter has traced the history of malaria control policy strategies starting from the period before independence in 1957 to this date. For the purpose of the different modes of malaria control, the discussion was divided into two parts with the first section focusing on vertical programmes' delivery while the second emphasises on horizontal (integrated) approach.

From the discussion of the previous approach it was noted that there was no integrated approach to both programme planning and implementation and donor inputs were limited to certain discrete time-based projects and activities. In effect, there were poor community, intersectoral and private sector linkage in the earlier policy strategies (MOH, 1996; WHO/RBM, 2011; Beir et al. 2008). In spite of this, the approach has its own merits which include: simple and realistic operational planning; easy mobilisation, quick and effective use of funds; holistic monitoring; a clear problem-focused by targeting areas where other health provision is ineffective and good quality of technical services.

Despite these merits, during this 21st Century (2000-2010), this approach was changed into horizontal integrated mode of malaria control. This new approach to malaria control has been implemented in the form of RBM which embraces a more systemic and collaborative efforts to solving multifaceted problem like malaria. In many respect, one can argue that unlike the past eradication programme, RBM has not been organised around a single intervention applied in a "one size fits all" manner. Instead there has been a combined approach which included the use of a range of approaches which had the potential to be adapted to local conditions.

Moreover, there are some social elements in the RBM interventions which is reflected in the parts that the community members have to play by altering their behaviours. For instance, in order for RBM to be successful, individuals within the community have to

obtain and to appropriately use and maintain ITNs. Pregnant women need to get ante-natal care and observe preventive regimens. Parents and or caretakers have to learn to be familiar with the symptoms of malaria and to be able to recognise the disease so as to promptly acquire medical care when a child develops a fever. Accordingly, the pendulum has swung unequivocally towards more on non-biomedical approaches aimed at minimising if not eliminating the causes of the disease which ultimately will lead to effective controlling malaria. At the moment, malaria has become a multisectoral problem that needs to be addressed on multiple fronts (Packard, 2007). This is reflected in 1992 Global Malaria Strategy, upon which the Roll Back Malaria Partnership was based, which is worth quoting:

“Malaria control is not the isolated concern of the health worker. It requires partnership of community members and the involvement of those involved in education, the environment in general, and water supply, sanitation and community development in particular. Malaria control must be an integral part of national health development and health concerns must be an integral part of national development programmes” (WHO, 1993)

Although national efforts have been focusing on integration, it is worth understanding that there are no perfect systems since both modes of malaria control (vertical and horizontal control programmes) have advantages and disadvantages. The decision with regards to integration of a vertical control programme into a primary health care system must therefore involve balancing the advantages and disadvantages of the two strategies to obtain the most efficient and effective balance. In the case of horizontal integration, it has been argued that many actors are often involved in decision making which makes it hard for decisions to be taken quickly. It also demands community participation since community participation is the basis for sustaining and improving successful rural health programmes (WHO, 1991). Community participation in rural health programmes’ development has been found to result in more accessible and satisfactory services delivery (Taylor et al. 2008; Kilpatrick, 2009). Thus, participation of communities in deciding their own health priorities must be pursued, yet evidence to

support this claim is limited (Kilpatrick, 2009; WHO, 1996). This study therefore focuses on the extent to which the community does indeed play its part in the decision making process of malaria control policy making which is discussed in the later chapters.

Chapter Three

Literature Review

3.1 Introduction

The literature on malaria control is extensive and a focussed search was therefore necessary. There are three issues that have been focused in this chapter. The first section focuses on the potential factors that contribute to the increase risks of communities' exposure to malaria in SSA and for that matter Ghana. The purpose here is to provide an understanding of some of the major factors that contribute to local communities' vulnerability to the disease. The second section concentrates on community participation: What it comprises; significance, forms, barriers and enabling factors that could facilitate it. The final section dwells mainly on the health policy strategy of intersectoral collaboration (ISC). The section concludes with the identification of the literature gap and the discussions of the frameworks that will be used in the study.

3.2 Literature search

I started by carrying out a literature search with the aim of finding out the existing literature particularly international and national peer reviewed published literature, about community participation and health programmes on disease control. 'Community participation' was selected as the main search term. However, based on the fact that terms can be used interchangeably, certain terms like 'community involvement' and 'community engagement' 'citizen participation' were also used. Other words/phrases including community development, empowerment, and health improvement programmes were also used to search databases such as Bath Information and Data Services (BIDS), Medline, and PubMed, Science Direct, ESTOR and EMBASE (which hold

details of a wide variety of journals) for publications in English published between 1990 and 2010. In addition, Medical and Social Science Journals (1990-2008) including Journal of Development Effectiveness, Malaria Journal , Health Affairs, Tropical Medicine and International Health , Health Policy, International Journal of Health Planning and Management; British Medical Council Journal; Journal of International Development, Lancet; International Journal of Integrated Care, International Journal for Equity in Health and International Journal of Infectious Diseases were used.

Although the review was fundamentally limited to journal articles, through 'snowball technique' references to chapters from books, as well as archival materials from unpublished documents of government, non-government agencies and workshop/seminar presentations relevant to the study that were found through other sources were also used. In addition, the literature was reviewed from the following websites of aid agencies, foundations, professional associations, and governmental and non-governmental agencies which promote community participation: the World Bank, the WHO Organization, the Centres for Disease Control and Prevention, and UNICEF.

This initial literature search around community development, participation and empowerment was immense with initial results of almost 3550. In addition, the National papers and reports yielded 56 documents and the on-line Journal of Rural and or Urban Health (<http://www.rrh.org.au>) yielded 30 essential documents. The World Health Organization website was also searched and 18 important documents were identified. In total 3,636 papers formed the initial basis of the review which were considered to be potentially pertinent to the study aim. I therefore had to revise the initial search terms and focus on the literature around: participation; forms of community participation, facilitators and barriers to community participation; vertical and horizontal disease control policy programmes; community vulnerability to disease.

Articles were selected for review if they represented a clear definition of the search terms and present evidence but excluded if they focused exclusively on theory or if they

did not seek to link community participation and health policy programme initiatives. The review drew on detailed case study evidence to explore the issues under considerations. This step yielded roughly 1500 articles of which 180 papers were considered for further examination. Further analysis was carried out with 'rural' and 'urban' added to the criteria for search terms as places where participation actually happened. However, the latter criterion of 'urban' did not include those in developed countries as the definition was found to be far more different from those developing countries. Ultimately, there were 76 publications that met all the criteria that were used and these included: community participation process mechanisms, the roles of the community, barriers and facilitators to community participation, malaria and the policy process of its programme activities.

3.3 Malaria and malarious community

This section explains what malaria is and the underlying reasons why communities in SSA are vulnerable to the disease. It focuses on four main parasites which makes malaria one of the most deadly diseases. With regards to the reasons for communities' vulnerabilities to the disease, while there may be several factors, this section will emphasise on four main factors namely: ecological conditions, increasing pervasiveness of socio-economic inequalities, cultural and location and housing types as discussed below

3.3.1 Malaria and potential factors contributing to the increase risk of communities' exposure

Malaria is a disease of the blood that is caused by a parasite transmitted from person to person by certain types of mosquitoes. According to experts there are four main species of human malaria parasites: *Plasmodium falciparum*, *Plasmodium vivax*, *Plasmodium malariae*, and *Plasmodium ovale*. Out of these four species, the species that causes the greatest illness and death especially in Africa is *P. falciparum* while the others are

usually not fatal though they may be seriously debilitating, (Gallup and Sachs. 2001; Hay et al. 2004; WHO 1998). Sachs and Malaney (2002) argue that the remarkably high transmission rates in SSA reflect the particular capacity of Africa's main vector mosquitoes, the *Anopheles gambiae* complex of species, with their remarkable tendency towards human biting

Generally, it is often said that "malaria is a disease of place", implying that transmission is very well reliant on the local geography (Myers et al. 2009). This implies that malaria transmission is closely related to ecological conditions as well as on the nature of human host, settlements and human control efforts. The major ecological conditions that are favourable to malaria to occur are: the presence of a human being acting as a host for the mosquito to feed on, the presence of a parasite, ambient temperature and precipitation (as a determinant of breeding sites for the mosquitoes) as well as the species of *Anopheles* mosquito (Kiszewski and Tekelhimanot, 2004; Strickland, 1992; Prothero, 1995).

Tropical Africa harbours all the contributing factors for severe malaria transmission such as high ambient temperatures all year round; enough rainfall to support year round, or near year round breeding; and nearly complete human biters (that is, almost all the species found in SSA feed on human blood) (Packard, 2007). Although these conditions do not explain all the recent increases in malaria cases, by virtue of its ecology, the continent is in an exceptional situation, with the world's worst malaria transmission, (Kiszewski et al. 2004; Sachs et al. 2004).

However, besides its ecological conditions there are other factors which contribute to the severe malaria cases in SSA. Amongst them are:

(i) Increasing pervasiveness of socio-economic inequalities

The linkages between poverty and poor health outcomes are widely acknowledged and the connections between malaria and poverty are manifold and multifaceted, (Gollin and Zimmerman, 2007; Sen, 1998). Despite the fact that malaria could make communities poor, poverty often makes communities vulnerable to the disease in so many ways. These include: lack of access to health facilities, lack of proper nutrition intake, lack of better education which prevent them from accessing information on the disease, and finally inability to have proper material goods like bed nets which could protect them against mosquitoes (Sachs and Malaney, 2002; Chuma et al, 2006; Onwujekwe et al. 2000). For example, Teklehaimanot and Meija (2008) found that as a result of poverty, those who were poor could not afford a complex house that will provide them some protection against mosquitoes' bites nor can they afford relatively cheap preventive items like insecticide-treated bed nets.

Also, Rashed et al. (2000) indicated that the differences in ITN possession in Benin were due to differences in education which in turn had been caused by differences in poverty. In this study, it was noted that men who finished secondary education were more likely to make higher use of ITN than those who have finished education up to primary level. The implication here is that for education to have any significant impact on take up of interventions there is a need for a threshold level of education which is often only available to the rich (Gallup and Sachs, 2001; Sachs and Malaney. 2002; Worrall et al. 2004).

(ii) Cultural factors

In general, cultural factors affect communities' perceptions of causes and modes of transmission of the disease, health seeking behaviour and practices of malaria prevention measures (Ahorlu et al. 2005). There is increasing evidence that the success

of malaria control in SSA communities depends on an understanding of these cultural factors (Comoro et al. 2003; Tarimo et al. 2000). Studies have shown that due to lack of general term or illness concept that approximates malaria, any illness with symptoms like malaria is often considered as malaria. For example, McCombie, (1996) found that the Dangla of Ghana, used the term *asra* to mean malaria while at the same time it is used for other illness conditions. Also, in a study conducted in Kibaha district in Tanzania, Comoro et al. (2003) found that severe malaria is often referred to as *degedege* and most of the mothers avoided mentioning it because there was a cultural belief that it was a bad omen. Consequently they refused to seek for appropriate treatment and simply referred to it as childhood disease whose cause was perceived to be associated with three things of which the most significant one was the *shetani* (evil spirits). This imprecision is significant in the sense that communities ultimately do not often have a clear understanding of how to seek treatment, (Oguonu et al 2005; Ahorlu et al. 2005).

In addition, in many communities in SSA, gender norms and values could have some roles to play in the accessibility of malaria treatment, care, and the use of preventative measures such as mosquito nets, (Reuben, 1993). These norms and values can bring about variations in patterns of exposure to mosquitoes for both sexes, especially where women always have to demand permission from their husbands in order to access treatment for themselves and/or their children (Ahoru et al. 2006). It is therefore not uncommon to find the literature arguing that gender related issues like treatment seeking behaviour, decision-making, resource allocation and financial authority within households are determinant factors in guaranteeing successful malaria control programmes and individuals' vulnerabilities to malaria (WHO, 2007; Rashed et al. 1999; Tanner and Vlasshof., 1998; Tolhurst and Nyonator, 2006). For example, Asenso-Okyere and Dzator (1997) found that women in Ghana often had to ask for the opinion of the male head of the household about treating a child because of the anticipation that he would have to provide money for the payment of the treatment. The study implied that if the male head was not around at the time of the sickness, there would be fatal delays

in accessing any health facility especially among pregnant women and the children putting them at a greater risk of severe malaria infection (Korenromp et al. 2003; Tin-Oo et al., 2001; Steketee, et al. 2001).

In all, one can argue that understanding the local communities' culture will improve communities' potentials to prevent and control village-based malaria incidence through the implementation of the appropriate interventions (Deressa et al. 2007; Launiala and Kulmala, 2006).

(iii) Location and housing type

In SSA, available evidence has shown that the probability of a person's being vulnerable to malaria incidence depends greatly on where the person lives (Chima et al. 2003). For example, in Malawi, Holtz et al. (2002) found that rural residence had higher risk factor for parasitaemia in children less than five years of age than urban residence, even after controlling for bed net use. Between the same villages within the same locality, Kreuels et al. (2008) found in Ghana that the incidence of malaria was surprisingly diverse. There was significant linear rate of reduction in the risk of malaria with increasing distance between children's households and the fringe of the forest. Thus the more one lives farther from the forest the less likely one becomes vulnerable to malaria.

Aside with the site or location of a house, the housing type also plays a significant contributory factor to the exposure of individuals to malaria. For example, in the North West of Burkina Faso, Yé et al. (2006) after adjusting for age, sex, use of bed net and housing conditions, found that children living in houses with mud roofs had significantly higher risk of getting *P. falciparum* infection compared to those living in iron-sheet roofed houses. Thus, poor housing construction also largely determines the extent to which one can be exposed to the risk of malaria and as far as SSA is concerned poor housing is common path way for their vulnerability to malaria (Krefis et al. 2010). Implicitly, the implications of all these findings demonstrate that those in the city are potentially less likely to be vulnerable to the disease than those at the rural areas since

the former has less forest in their surroundings and at the same time are less likely to live in mud houses.

3.3.2 Summary

In this section, it has been revealed that malaria is a blood disease with four main parasites of which *P. falciparum* is the main cause of morbidity and mortality. The literature has also revealed that although increased exposure to the risk of malaria in SSA can partially be attributed to ecological factors, there are several other factors that can cause community defencelessness against the disease. These factors include socio-economic inequalities, cultural behaviour as well as sex and gender role, location and housing type. It is hard to judge as to which of these factors are the main contributing factor to the communities' vulnerability. On one hand, if one sees malaria as a behavioural problem then it is fair to say that the socio-cultural factors are the most dominant factors which contribute more to the communities' susceptibility (Ahorlu et al. 2005). On the other hand, if one considers malaria problem as a poverty problem then, it can be argued that the socio-economic factors are the actual cause of their vulnerability (Sachs and Malaney, 2002). Considering all these perspectives, it has to be concluded that all these factors are interwoven and it is difficult to identify which of them is the main cause of all the woes of the communities' malaria problems in SSA. This makes it more important to have communities to be involved in policy making process so that their needs can be incorporated into the design and implementation of the policy (Myers, et al. 2009; Espino et al. 2004; Panicker and Dhanda, 1992).

Such inconclusiveness about the factors that contribute to communities' vulnerability to malaria raises major concerns with regard to how the various communities could minimise these vulnerabilities to the disease. The literature has indicated that community participation in the decision making processes is important for enabling citizens to voice their contextually based concerns, and contribute their local knowledge and skills. According to Boland and Williams (2003) :

“malaria prevention must go hand in hand with community participation” (p.93).

In spite of this importance, little is known about community participation in malaria control efforts (Muller et al, 2004). The next section will therefore discuss the concept of community participation and the factors that undermine or facilitate it.

3.4 Community Participation

This section reviews the concept of community participation in policy making process. In doing so concepts such as community and participation including the significance of community participation will be discussed. This will be followed by, forms of community participation using Anstein’s (1969) ladder of citizen participation framework as well as barriers and facilitators to community participation will also be explored.

3.4.1 The concept of Community

As much as the concept of community has commonly been used in the current health sector policy debate, its definition by and large, has exposed the level of discrepancy that exists amongst scholars on the concept. While some authors associate community with a geographical area, others identify community as a group of people with common life that are associated with shared common attributes such as religious beliefs, occupation or ethnic origin other than place (Hogget, 1997). For example, Agudelo (1983) has defined *“community”* as a group of people living in a particular area with similar values, cultural patterns, and social problems. This also includes a group awareness which make it easier for the residents to interact more deeply with each other than those from outside. With Agudelo’s definition, location and culture are significant factors that determine community. In support of this, Cohen and Syme (1985) have the view that ‘community’ has to be defined based on its use and role in people’s experience, according to what the members have in common with each other and how they symbolically differentiate themselves from others. For Rifkin (1986), community refers to ‘at risk’ groups or target populations whose identity is based on the features they share and experience in common with each other. Despite these apparent

differences, it can be argued that there is a common theme that can be derived from these definitions. In general, these writers argue that 'community' must be understood as a phenomenological concept, which articulates more the members' combined interests than their geographical location. Hawe (1994) epitomises the whole argument by describing a community as a social system, which has a:

".. Capacity to work towards solutions to its own community identified problems." (p. 201).

Thus community can be understood as the existence of people with common interest and ties which induce individuals to act for the communal gains (Anderson, 1991). Community in this study is therefore considered as a group of people living in a particular place as grassroots members who have been hitherto excluded from policymaking process but are united by one common interest (e.g. controlling malaria). It is this common interest that has brought them together with the aim of collectively finding a solution to the problem such as malaria. This definition excludes residents who have affiliations to the government or to private organisation, such as public-sector workers like nurses, doctors, and teachers and private-sector salaried workers like Doctors, Mid-wives and Drug sellers, although they may live in the same community. The significance of these differentiations is that although these 'resident professionals' could be seen as parents, malaria victims, health service users and simply as community members, yet when it comes to decision making in addressing certain problems affecting the community, they often face the problem of role conflict. While they can take decisions with the government for the grassroots citizens, when a specific problem under consideration affects their organizational or sectoral interests they represent, instead of fighting for the community, they are likely to switch to their professional community (Kegler et al 2008b).

3.4.2 The concept of Participation

According to Marsland (2006), although the concept of “participation” has become very ubiquitous, like the term community, there is an inherent ambiguity of this concept. Labonte (1997) considers participation as a process of trying to ensure the coming together of stakeholders of diverse background whose aim is to make a decision that will help them solve a problem. Similar view is also shared by Zakus (1998) who also argues that the concept of participation can be viewed as a process by which community members, either individually or collectively:

“develop the capability to assume greater responsibility for determining and assessing their own health needs and problems; Plan and decide on solutions; Become actively engaged in implementing the solution; Create and maintain organisations in support of these efforts; and evaluate the effects and bring about necessary adjustments in goals, targets and programs on an ongoing basis” (p. 481)

This definition of Zakus makes it clear what participation should achieve and offers explanations as to how community members are to participate so as to ensure progress in their health status. The process of participation according to Campbell et al (2000) provides a platform for dialogue amongst participants who can express, reaffirm and renegotiate what concern them. Thus in the context of decision making, according to Parry et al. (1992), participation must involve:

“taking part in the process of formulation, passage, and implementation of public policies [through] action by citizens which is aimed at influencing decisions which are, in most cases, ultimately taken by public representatives and officials” (p 16).

The underlying idea in this definition is that the success and sustainability of community participation in health and development projects depends on the degree to which community ownership and empowerment are realised (Kaseje and Sempebwa, 1989). Many commentators believe that for success to be achieved there must be a process by which communities are engaged to participate in problem identification, priority setting, programme design, implementation, monitoring and evaluation (Kaseje DC, Sempebwa, 1989; Toledo et al. 2007; Perez et al. 2007). For example, a study in Zaire examined the

impact of community participation in planning and implementation of malaria treatment delivery compared to standard treatment delivery through health centres. The results showed remarkable reductions in the mean malaria incidence when the communities were actively involved in planning and implementation. This was in contrast to being passive recipients of treatment through health centres (Delacollette et al. 1996). However, such an engagement, according to Morgan (1983), provides two contrasting but useful definitions of community participation which include: "participation as a means" and "participation as an end" (Nelson et al. 1995, p.1). The former sees participation as a tool which is considered by powerful organisations, such as governments or statutory agencies, who are looking for involvement in top-down initiatives as a way of utilizing community resources such as the labour and or local knowledge to ensure programme effectiveness. On the other hand, participation can be seen as end because through participation communities are able to recognise their own local issues and needs and develop their own method of solving them (Morgan, 2001). In effect, the rationale for participation is either to create an enabling environment for effective disease control (means) or ensuring the empowerment of the communities themselves (end itself) so as to realise the PHC philosophy of the right to 'Health for All' (Espino et al. 2004; Perez et al. 2007; Walley et al, 2008). The problem associated with the latter is that such participation can be a device for those community members who are involved to get power (Nelson et al.1995). In general, though, these two perspectives are not mutually exclusive.

These arguments are consistent with Arnstein's (1969) ideas on citizen participation; a process by which involves:

"the redistribution of power that enables the have-not citizens to be deliberately included in the future. It is the means by which they can induce significant social reform which enables them to share in the benefits of the affluent society" (p. 216).

In general, it can be said that the concept of participation has variously been defined by used by many commentators, and at the same time been given a number of meanings, ranging from information giving to consultation to substantial support for community-

led initiatives to it. This spectrum of activities identified as community participation has been generally been recognized and accepted (Arnstein, 1969; Smithies and Webster, 1998; Brown, 2000). However, irrespective of how community participation is defined, the essence of community is that something is “shared” and community participation can be considered as a process along a continuum which helps communities to make the most of their potentials and progress from individual action to collective social and political change (Butterfoss, 2006; LaBonte, 1997).

As far as this study is concerned, community participation should not only be seen to allow community members to be part of the problem identification but also creating an enabling environment by the authorities for the community members to directly develop a change of behaviour that will help in preventing malaria. This means going beyond simple consultation to a shared responsibility for resolving problems within the community. Thus, community participation is considered to have taken place where grassroots community members are given the chance to work together to develop and implement policy programmes in disease control (e.g. malaria).

In summary one can argue that community participation is a dynamic concept which cannot be seen as a stand-alone strategy, but it is part of a comprehensive approach, which helps policy-makers to promote structural or legal changes to support community empowerment (Speer and Hughey 1995). It is clear from the literature reviewed that community participation can be promising in its ability to bring about better health outcomes. Ultimately, the concept focuses on the idea that involving the members in decision-making about their communities and broader social issues has important social, economic and political benefits as discussed below.

3.4.2 The Significance of Community Participation

Participation by the communities has often been seen both as an end in itself and a means towards an end, (Oakley, 1989). Considering as an end in itself, many

commentators have concluded that community participation helps people to acquire the skills which also helps to promote higher significant level of local knowledge and experience which complements that of technical experts. This can contribute to the community members taking more responsibility over their own development leading to a better outcome in policy implementations and evaluations (Goldstein et al., 2000). For example, in Cairo, Saldana and Dubois (2006) found that through community participation a better health and sanitation environment throughout relatively marginalized group of Coptic Christians community's settlements were developed. In simple way, through community participation, members' ability to identify, mobilize and address social and public health problems (capacity) is improved (Goodman et al. 1998).

Community participation is also associated with collaborative capacity in that as members actively participate in the life of their community through leadership, social networks, and access to power they learn to cooperate and collaborate. In addition, they learn to identify their own problems and needs, arrive at a working consensus on objectives and priorities, and agree on the methods to implement common goals (Eng and Parker, 1994; Geyer 1997; Minkler and Wallerstein 2005). Furthermore, most supporters of community participation have the opinion that it can build trust in government, in the legitimacy, integrity, as well as increasing the acceptability of making some (un)favourable decisions (Folk, 1991; Rowe and Frewer, 2000).

Moreover, the WHO also argues that community participation provides an opportunity to the members to question and change proposed ideas,(WHO, 1997). What is more, other advocates also see community participation as a basic human right and therefore grassroots members should be given the right to exercise it (Rifkin 2003; WHO, 1997a; 1999). For example, Silkin (1998) study on WaterAid's work with communities around Hitosa in Ethiopia illustrates some of the benefits from community participating in the development and management of programmes. Silkin found that community participation motivated community members to use the water supplied rather than

traditional sources and led to a change in habits such as cooking practices, latrine usage and keeping the areas near standpipes clean. Thus, community participation is an active two way process which could be instigated by both individuals and organisations within communities and local health authorities (WHO, 1999).

It has also been pointed out that by the development of democratic involvement in decision making community participation collectively empowers people to have more control over their health and their lives (Atkinson and Cope,1997)

This is more significant because in SSA countries it is the communities that shape behaviour by means of exchange and persuasion. Furthermore, considering the fact that part of the problem with malaria are to do with behaviour, through participation, communities themselves can be mobilised to act as change agents (Mwenesi 2003; Govere et al. 2000; Macheso et al. 1994). This was exemplified in Rwanda where through community participation as a result of decentralisation, communities were able to mobilise themselves to bring change in their attitudes in terms of trust towards government officials and their programmes. Ultimately, community participation was seen as the most significant factor that contributed to programme effectiveness and sustainability (Dalal-Clayten et al, 2003; Mwenesi, 2003)

In summary, communities are the bridge between the government and private sector and as such community participation helps to make optimal use of their knowledge and enhances programme ownership. It therefore reduces dependency and promotes self-help. Also, involving community members can help pre-test new programmes for feasibility and acceptability. It also provides a mechanism for (re)building trust and accountability and encourages cooperation (Ngulube et al. 2004; Klugman, 2004; Bracht and Trouso,1990; Butterfoss 2006).

3.4.3 Arnstein's (1969) "Ladder of Citizen Participation"

From the literature reviewed, it has been noted that there are different forms of participation. Among them are those proposed by Arnstein, (1969) who provided an analytical visualisation of power in community participation as a ladder of eight rungs, ranging from 'degrees of non-participation' through to 'degrees of citizen power'.

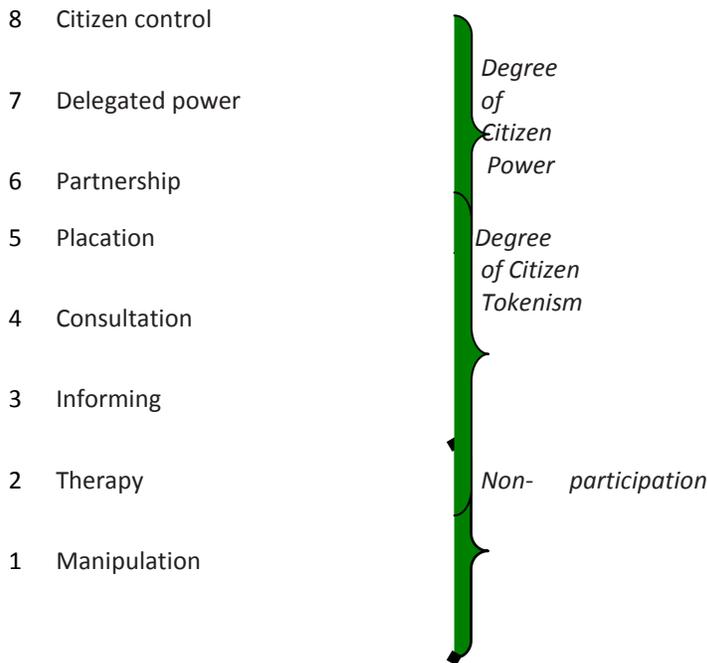
Arnstein (1969) argues that:

" . . . citizen participation is a categorical term for citizen power. It is the redistribution of power that enables the have not citizens, presently excluded from the political and economic processes, to be deliberately included in the future . . . it is the strategy by which the 'have- nots' join in determining how information is shared, goals and policies are set, programmes are operated and benefits ...are parcelled out... participation without redistribution of power is an empty and frustrating process of the powerless" (p. 216).

With Arnstein's (1969) "Ladder of Citizen Participation", (see Figure 3.1) the bottom part of this ladder has been that of informing people, while the top part is about communities having full amount and direct control over the decision making. In the mid-way, there is partnership that begins to develop, and the degree of participation moves from mere tokenism to degrees of citizen power (Arnstein, 1969). The main idea behind her argument is that there are gradations of participation in terms of the degree of control that participants can exercise in an attempt to influence the outcome of the participation process (Smithies and Webster, 1998). Taking into consideration the first levels, the model argues that whenever there is participation, there should be power equalisation between governments and citizens since decision-making power which is often in the hands of policymakers will ultimately be handed over to the participants. The real significance of this framework stems from the general recognition that there are various levels of participation ranging from manipulation or therapy of citizens through to consultation to what has been considered as genuine participation (that is, the level of partnership and citizen control).

As a whole the only factor that is taken into account is power in the participatory dynamic between citizen participants and organizations. Moreover Arnstein (1989) framework has been criticised for assuming communities and project participants to be homogeneous in their participation, while in actual fact, participants within communities are often heterogeneous (Wiebe et al. 1998; Smithies and Webster, 1998). In spite of these criticisms, I still find this framework appealing since it focuses solely on policy process and in the context of Ghana communities are mostly tight and therefore regarded as homogenous (Twumasi, 1986). The study therefore uses this framework to measure the extent of community participation.

Figure 3.1: Arnstein (1969) ladder of participation



Source: Arnstein, 1969

From Figure 3.1 it can be deduced that in the definition of participation, Arnstein (1969) *ladder* or typology of citizen participation has eight levels which shows degree of power distribution. Each rung of the ladder symbolises special degree of participation and the higher up the ladder the larger the extent of participatory activity. The two remaining lowest levels on this ladder, signifies that participation or non-participation may take the form of providing endorsement to decisions already taken by those with power. In

contrast, the three degrees of tokenism include asking for participation and ideas from members of the public without assuring them that their proposals or opinions will be considered. Here participation becomes nothing more than, as Balloch et al. (2001) argue

"a tool of the established system for incorporation "(p. 285)

Partnership, delegated power and citizen control all represent degrees of citizen power in which members of the community have the ability to influence decision making. This in turn has been categorised into three groups relative to true citizen participation. While the lowest category represents manipulative participation, the highest level of category indicates degree of citizen power. The middle category signifies degree of citizen tokenism. However, considering the fact that "participation is about power" (Morgan 2001, p.222), it can be argued that a higher degree of participation is desirable and it is relevant that participants get increasing degrees of power with each rung of the ladder (Lupton et al.1998).

In all these above-mentioned forms, it is worth stating that, there are many ways through which the government/authorities can use to get the communities to participate in the process or get the communities informed or involved on issues that concern them. These include Public hearings, workshop, Mass media, committee meetings and public meetings (Brown, 2003; Atkinson 1992; Shiel, 1999; Adams, 2001). However, despite these numerous avenues which the government can use to allow communities to participate there are various factors that could inhibit real participation. The discussions that follow focus on these barriers.

3.4.4 Barriers to community participation

Fakade (1994) identified two main categories of barriers namely: Structural barriers which consist of socio-cultural, economic and political barriers and Non-structural

barriers including lack of communication, and the attitudes and values held by the authorities

(i) Socio-Cultural and economic Barriers:

Beliefs and norms have considerable influence on participation especially in SSA where differences in ethnicity, religion, gender and status are predominant within the society. These generate variations in the response to participation (Dukeshire and Thurlow 2002; Woelk, 1992; Ndiaye et al. 2003; Klugman 2004). It is also found that the nature of gender relations is an obstacle to participation especially in a male dominated culture where women are preferred to be seen and not heard. This is summarised by Matembe (2009) who commented on the plight of Africa women by saying:

“culturally, women are not perceived to have a role to play in politics. They are expected to be home-makers and to stay in their homes. This being the case, women are frequently marginalised when it comes to debating and being listened to because they are considered to be women with not much to offer” (p.7).

Thus, traditions and cultures as well as religions very often hinder women's access to power since they are not given equal participation in decision making.

Another barrier is when the people themselves do not see the community as very important as was found by Werbner (1991) amongst the Bango people of Botswana. In a way, for community participation to be successful members of the community must become aware of the need to work for the community and the significance of collectively working towards achieving better living conditions.

Poverty can also be a source of exclusion from participating in communal issues especially if most members are far away from the place where meetings are held. In most of these rural areas, cost of transportation is high and members have to stop going to their farms for food to feed their families. Without any sources of income, poor

people can not often afford to travel (Woelk, 1992; Hoddinott, et al. 2006; Imoh, et al. 2009). It is therefore often not possible for people who have no financial backing to be part of the decision making for the whole community.

(ii) Political Barriers

This factor is the most significant basis for determining framework for the members to participate in the decision making. For example, in highly centralised systems, the state is likely to be unsympathetic to participatory processes and least accountable to its citizenry. In such a situation, decision making has top down approach with lack of community representatives to participate in decision making. Even if the country adopts a decentralised system, the extent of participation depends on the kind of system adopted. Unlike devolution Hardy et al. (2000) argue that decentralised system of deconcentration and delegation⁹ may not be favourable for community participation. The main reason is that the authorities to whom or which the responsibilities are given are not elected and therefore will not promote participation since they report to the central authority rather than to the community (Bronfman, 1998). For example, in most SSA countries, recent assessments by the World Bank, (2006) have revealed that there are still notable challenges linking the government's decentralization processes with community participation. Problems often identified included an insufficient flow of information to families and lack of consultation of community members on issues that affect them. Thus, where political ideology of a country does not promote opinions and diffusion of ideas, no genuine participation can be achieved (Dukeshire and Thurlow 2002).

⁹ Deconcentration, is often considered to be the weakest form of decentralization, since it does not involve any transfer of real power to local governments. Delegation is somewhat perceived as a more extensive form of decentralization, while devolution represents administrative decentralization that underlies most political decentralization (Rondinelli 1999)

(iii) Lack of communication

Lack of effective communication between government officials and the communities often results in people feeling that their needs are not being addressed and therefore they do not see any need to participate in decision making (Valaitis, 2002; Campbell et al. 2001). More specifically, when there are no feedbacks about the communities' identified needs, community members feel neglected since they do not have information on whether their concerns are being received and considered (Leach 2000).

The literature has also revealed that the attitude of government officials can also be a barrier. Most professionals have ideologies which often ignore the important role of indigenous knowledge (e.g., the idea that traditional herbalists must be included in deciding the kind of drug or treatment that must be given to malaria victims could be unacceptable to Western-trained medical doctors). Thus, there are often unequal power dynamics causing difficulties in motivating the marginalized populations to be involved in collective action for the betterment of the whole community. Many commentators attribute this to high levels of illiteracy at the community level. It is argued that illiteracy could limit members' understanding of the policy process as well as capacity to become involved in policymaking (Asthana and Oostvogel, 1996; Campbell et al. 2002; Valaitis, 2002; Campbell et al. 2001). It has been argued that the government representatives believe that because people at the grassroots level mostly can neither read nor write, they do not have knowledge on how government structures function and this makes it the government officials see community members as information providers, instead of considering them as real participants (Klugman 2004).

In conclusion, while the community members may be interested in participating in the policy making processes, in order to be successful in public health planning programmes and their implementation requires overcoming a number of barriers. However, in spite

of these barriers, there are critical factors that can facilitate community participation as discussed below.

3.4.5 Critical factors that facilitate community participation

While there are many obstacles in ensuring community participation, the literature has also revealed that there are certain essential factors that could contribute to community participation. This part of section two therefore discusses these factors and among those to be discussed includes: the nature of political climate in the country and availability of structural factors that enhance participation.

(i) The nature of political environment in the country

The general political environment is also critical in ensuring effective community participation (WHO, 1991; Yassi et al. 2003; Sleight et al. 1998). This is particularly the case when there is a political system that makes the government support and commit itself to community participation and to put in place a health organisational care structure that is receptive to local involvement (Boyce, 2001; Woelk, 1992). For example, in a community health project in South Africa, it was reported that only passive participation was achieved due to lack of political support in the country for community participation at the time of apartheid (Rifkin 1987). In contrast, in Rwanda, it was reported that the government promoted community participation through widespread decentralization in the years after the genocide and the return of refugees after 1997 (World Bank 2006). As part of community participation approach, the Parents and Teachers Associations (PTAs) were given the mandate to take over the management of schools working with the head teachers. Recent evaluations have indicated that the new PTAs and head teacher joint management arrangements have been successful in engaging parents in the management tasks (World Bank 2006).

In essence, the nature of political systems and the authorities and communities' willingness to promote and response respectively to internal power relations in certain political contexts can bring about the progress of participation in community decision-making (Campbell et al. 2002; Tandon, 1988).

(ii) Structural factors

It has also been noted that proper mechanisms through which community participation is to be generated and expressed could be a contributory factor for either strengthening or weakening community participation (Woelk, 1992). Morgan (2001) notes that:

“Participation can be sustainable only as long as the relevant actors remain committed and the socio-political and economic environments remain conducive, to the process” (p. 223).

The idea here is that the opportunity for communities to participate in health programmes, for example, will depend on, in the words of Kingdon (1995) discrete policy windows. According to Kingdon (1995) there are three streams of factors (problem, policy and politics) which need to come together in order to create change and allow a policy window to open. In the case of community participation in disease (e.g. malaria) control policy making process, it can be argued that one of the facilitating factors (.i.e. for the policy window to open), must be a universal recognition by both government and local agencies that there is a problem, and there is a practicable and feasible policy initiative of which participation is a necessary mechanism to be used to address the identified problems. In effect, participation must be consistent with the values of the government and local agencies.

In most SSA countries, community leaders and community health workers (CHWs) are supposed to be structures which represent the interests of the community. The involvement of chiefs and opinion leaders in some cases helps keep community members focused and make them willing to offer their time and energy to get involved

in project preparation and management (Kapadja, 1996; Piven and Cloward 1977). Goodman and Proudley et al. (2008) have argued that effective traditional leadership that promote participatory decision-making is potentially the most important factor to enhance community participation. For example, a study in North-West Cameroon, a Family Planning programme that had the support and participation of community leaders (all of the men) was able to increase the use of contraceptives in the community (Rosen and Conly1998). The authors noted that full community participation was achieved as a result of a continuous involvement by chiefs and elders' influence over reproductive decision-making. Also, in Botswana, Moumakwa, (2010) reported that due to a good institutional structure for policy making called *kgotla*, there was often a forum for community discussions. Through *kgotla* community could be present at the *kgotla* meeting without fear or favour and they express their ideas freely. They also make suggestions to all the ministries' civil servants who at times present and defend government policies. The implication here is that where there are group leaders who have very little interests in promoting community participation, developing effective community participation can become difficult (Woelk, 1992; Boyce, 2001).

In all, it can be concluded that factors that support community participation include the presence of proper mechanisms such as the structures which represent the interests of the community and there should also be favourable political environment which promotes inclusiveness or participation. Community members must also perceive that participatory actions are meaningful and lead to prompt, visible improvements.

3.4.6 Summary

Community and participation are complex concepts. It has been noted that over time definitions of community have shifted from an emphasis on tangible aspects such as geographical location to consideration of the more dynamic and complex interrelationships, process elements, diversity and identity. One common theme which is the value of shared interest amongst the community members.

The literature has also brought to light the significance of community participation. Potential benefits of this more participatory approach include: community capacity and competence and ensuring local ownership and maintenance of programmes. This review focussed on model of Arnstein's (1969) ladder of participation. Finally the barriers and facilitators of community participation have also been discussed. Among the factors relating to the former are: Social-cultural and economic; political and lack of communication while the latter includes: the nature of political environment and the presence of proper mechanisms.

Accordingly, understanding these barriers and challenges is a necessary condition for government to be able to get a community organized for or involved in policy activity. However, from the literature review, evidence has shown that although community participation can be a significant step in ensuring improvement in communities' health, little research is done on the subject with regards to policy making process particularly disease (e.g. malaria) control programme. As a result, the last section of the chapter discusses the concept of policy making process and its frame work which will form the basis for the empirical analysis of this study.

Having reviewed the literature around community participation, it seems appropriate to discuss an additional issue of significance to this study, intersectoral collaboration (ISC). With this study aiming at investigating a policy strategy of ISC in practice, it is a way of looking into the policy issue of ISC's implementation. Accordingly, a brief overview of the literature in relation to the concept of ISC policy which is relevant to the study will now be considered in the next section.

3.5 Policy of Intersectoral collaboration

The third part of this review centres on the policy of intersectoral collaboration (ISC). The section starts with discussions of the concept of policy as well as ISC and it ends with the identification of the literature gap and the frameworks which underpin the

study. With regards to policy making process, Walt and Gilson (1994) framework of policy triangle analysis which is made up of context, contents, actors and processes will be used. In addition, Alford's theory of structural interests will be used as a framework to highlight the positions of the various actors involved in malaria control policy making in Ghana.

3.5.1 The concept of Policy

The term "*policy*" is generally understood to refer to expressions of general purpose, decisions, practices, statements, purposive course of actions, regulations and laws made through consensus in addressing a problem or issue of concern. In its simplest sense, 'policy' means a broad statement that reflects future directions of government's goals and aspirations with guidelines provided for implementing those goals (Anderson 1975; Barker 1996, Hogwood and Gunn, 1984). In this way, it can be said that whenever a government takes a decision or chooses a course of action with the aim of solving a social problem, the particular strategy that it adopts for its planning and implementation, can be considered as public policy and this must be conceived in terms of a process (Anderson 1975; 1978; Jenkins, 1978, Rose, 1976). The reason is that policy decisions are not:

"something confined to one level of organization at the top, or at one stage at the outset, but rather something fluid and ever changing" (Gilliat, 1984:p.345).

Rose (1969) also made a comparable argument when he said:

"policy making is best conveyed by describing it as a process, rather than as a single, once-for-all act" (p.11).

By implication, it can be said that policy is socially constructed, wrapped up in and influenced by the meanings various actors attribute to policy content or goals (Fischer 2003). As a result, according to Gilson, and Raphaely, (2008), bringing about effective policy change does not simply require good technical design or using evidence to generate policy. Rather clear attention must be paid to the processes by which change is

brought about, including concern for the values and interests of the actors with potential to block or subvert policy development and implementation, and for the discussions surrounding policy change processes. These processes must often involve negotiation, bargaining, compromise and accommodation of many different interests, which ultimately offers it a political flavour. In essence, 'policy making' is not a simple instead a complex dynamic process involving series of actions and inactions of different groups with all kinds of interests at different stages (Walt and Gilson, 1994). The working together of these many actors are often influenced by the social, political, economic and historical context in which policy is formed and put into practice, (Walt and Gilson, 1994; Barker 1996, Anderson 2006). Thus, in reality, a policy is likely to be more than only one decision.

However, there are situations when the government makes a choice of doing nothing. In that case, it is "policy by inaction". This may happen when the authorities stand to lose or gain little or nothing from supporting the implementation of a certain policy. In the light of this, policy can not be seen only about explicit decisions but could also be viewed as whatever a government chooses to do or not to do (Dye, 2011; Dovers, 2005; Jones, 1994).

3.5.2 Intersectoral collaboration

Collaboration has often been regarded as the process of working together in a group, organization, or community so as to plan, create, solve problems, and make decisions (Strause, 2002). However, according to, John-Steiner et al., (1998) collaboration is not only to work together, but also involves:

"a commitment to shared resources, power, and talent" with no single individual or organization's point of view dominating (p.776).

In essence, by engaging in collaborative efforts implies that decision-making authority and task delegation are to be managed within the group with the results of these decisions and responsibilities reflecting the blending of participants' contributions

(Keast et al. 2004). Within the context of this study, this is important because with different groups of participants, each group and individual often have different levels of interest, skills, accessibility to resource and decision making power. The implication is that collaboration may involve the bringing together of diverse sectors in ways that secure a simultaneous realization of the goals of each in a single policy, or programme intervention. This ideal integrationist conception supposes that all noticeable differences can be solved by accomplishing an underlying unity of purpose (Thomas, 2003; Axelrod, 1984; Nicol1998).

In policy making, these participants can be considered as stakeholders and may be individuals or organizations. These are likely to be drawn from the following categories: Citizens (community members), Governments and Interest Groups (private sector). These categories are not mutually exclusive as for example, a community member can also be a part of a government agency or interest group. Thus ISC is seen as the coming together of different but separate actors from diverse sectoral backgrounds to achieve an outcome that addresses the needs of all parties through compromise which is needed to advance the policy objectives efficiently (Vigoda 2002; Huxham et al 2000; Straus, 2002).

Besides, it can be argued that ISC is about the organization of cross-cutting issues in policy-making that go beyond the boundaries of established policy fields, which usually do not demand individual department's traditional responsibilities (Meijers and Stead 2004). The collaboration therefore can take place on different levels from local to national and across sectors. Explicitly, ISC policy-making refers to both horizontal sectoral collaboration (between different departments and/or professions in public authorities on the same levels) and vertical intergovernmental collaboration in policy-making (between different spheres of government), or combinations of both (Briassoulis, 2005; Bramwell and Lane 2000)

Within this perspective of different degree of collaboration, it has been argued that ISC has changed the priorities in the health care sector, shifting from a health perspective that was originally disease-oriented and curative to a perspective that focused on prevention of ill health, removal of health risks and promotion of health (WHO1986b). It has been suggested that the greatest potential for ISC is at the community level (Kreisel et al.1998). The authors argue that it is here that sectoral barriers can be broken down as the community sees development as an amalgamated whole in which the activities of various sectors are interdependent and contribute together to its well-being. Kreisel et al (1998) write that intersectoral action for health had contributed many outstanding examples of infrastructure development, institutional reforms, sustainability of health actions, empowerment of people, health gains and reduction of health inequities at global, national and local levels.

In sum, it has become obvious that throughout the last decades, the idea that a national government is the centre of governance has been challenged. Actors who were previously not part of the traditional policy making system, particularly health actors, have more and more become engaged in the policy making process and with this:

“the boundaries of the public sphere are being redrawn” (Newman 2005, p. 2).

Policy making has become a process distributed among a variety of actors with different skills and interests. It has become a multilateral process of shaping and re-framing perspectives, of consensus formation within competing interests and uneven power structures (Scherer and Palazzo 2011: 900). Policy making is now often executed in a collaborative environment which relies on:

“neither market nor hierarchical mechanisms of control (...) but is instead negotiated in an ongoing communicative process” (Phillips et al. 1999, p. 481).

This means that various actors often do actively shape and negotiate the rules of the game within which the policy outcomes are crafted (Hajer and Wagenaar 2003; Wagenaar and Cook 2003; Loeber, et al. 2005; Hajer 2009). However, evidence has

shown that the survival and the success of this policy strategy (i.e. best outcome of this policy strategy of ISC) depend not only on the production of more than a sense of solidarity among members, but also the extent of community participation especially at the local level (Butterfoss, et al.1996a; Goodman and Proudley, 1996).

3.6 Literature Gap: Community Participation in Decision Making Process

From the literature review, it has become clear that community participation is relevant and it has now become so significant that its presence is a precondition

“for all policy documents and project proposals both from the international donors and implementing agencies” (Dudley, 1993 p.7).

This argument is true about national policy in Ghana where participation has been institutionalised in every aspects of governments’ policy making (Sakyi, 2010). Many commentators see it as a means of bringing the most marginalised members of society back into the mainstream politics (Taylor, 1999; Klein, 1984). Thus in theory at least, participation in health programmes’ decision making is clearly promoted. However, in practice the extent of influence that communities have upon the decisions taken can be viewed to be patchy (Sakyi, 2009). Based on the review, evidence has shown that although community participation can be significant step in ensuring improvement in communities’ health, little research is done on community participation in policy making process particularly disease (e.g. malaria) control programme (Atkinson et al (2011). In a sense, whilst the literature is vast on participation and the need to empower community members and to help them build their capacity and to be able to participate has been well discussed in the literature, very little attention has been given to the extent of their participation, (e.g. malaria programmes policymaking processes). In particular I found no study reporting exclusively on the specific role of a community as well as the factors that contribute or undermine communities’ participations in malaria control programmes in Ghana. This can be considered as unhelpful to both the communities and the

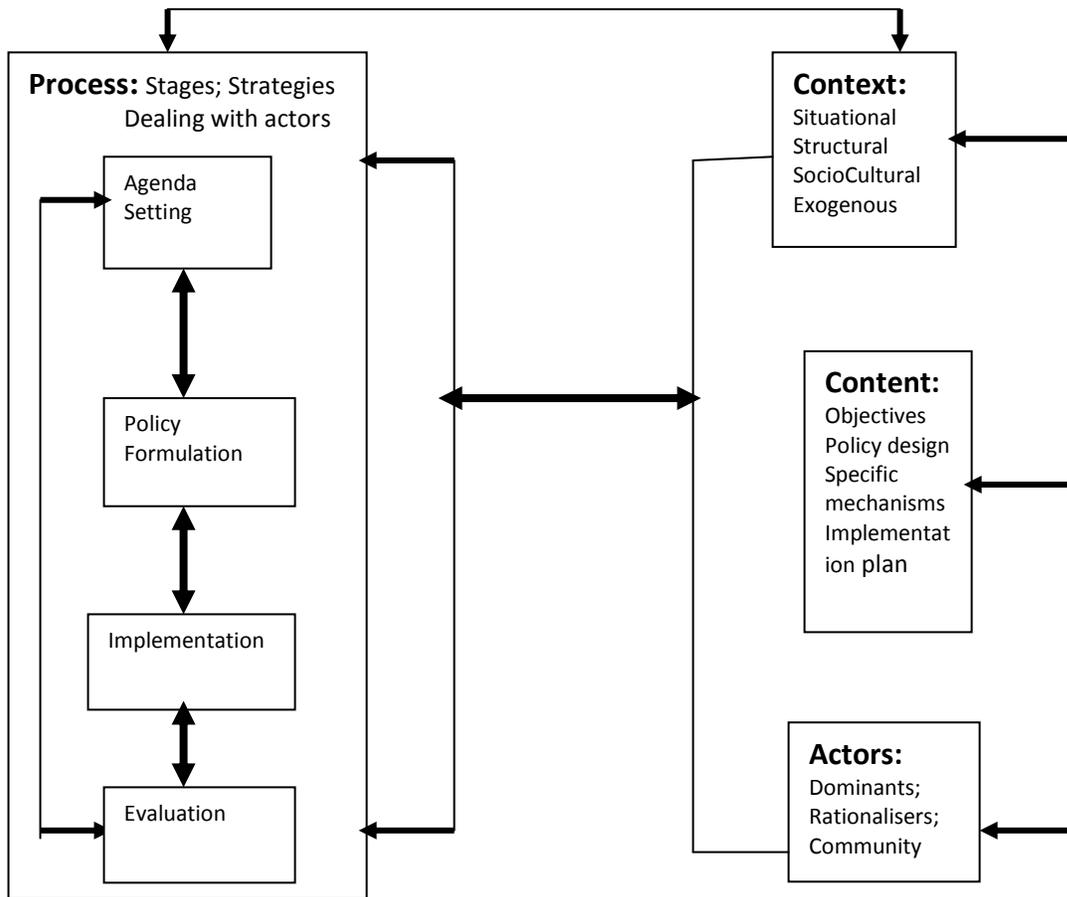
government taking into account the fact that if health programmes are to be sustainable, participation needs to be developed at the level of local policy-making and planning. As a publicly funded programme services, this will increase the democratic accountability of local health programmes (Litva et al, 2002; Milewa et al., 1998).

Through the case study, this study will try to contribute in filling the literature gap by exploring the degree of community participation in the policy making process of malaria control in Ghana. The study also aims at investigating into the role of the communities and the factors that facilitate and or undermine participation. The main frameworks underpinning this study are discussed below.

3.6.1 Policy Triangle as a framework for policy analysis

This study uses Walt and Gilson (1994) policy analysis framework (policy triangle) which describes health policy analysis by using four elements: content, context, actors and process will be used in this study. The relationships amongst these elements are illustrated in Figure 3.2.

Figure 3.2: Framework for health policy analysis



Source: Based on Walt & Gilson, (1994)

Figure 3.2 above is a simplified model for analysing a difficult set of interacting factors that are connected with health policy. Walt and Gilson (1994) have argued that research and analysis on health policy traditionally laid emphases on the content of policies and neglected the contextual factors, actors and processes which also influence policy development. This neglect has the tendency to limit analysis of policy making which often could lead to ineffective implementation, with expected outcomes not being achieved. By using the model of policy analysis, Walt & Gilson (1994) believe that

“Policy-makers and researchers will be able to understand better the process of health policy reform and to plan for more effective implementation” (p.354).

In effect, the model is used in this study because it offers a good “descriptive map” of the policy process (Walt, 1994) within which I will be able to discuss the study results of community participation in the process. This enables me to examine the stages in which grassroots communities participate in the policy making process of malaria control in Ghana. Overall, using this framework provides a good basis for analyses which helps in providing insights into the policy making process.

The framework shows all the four elements of Walt and Gilson (1994) model. From the literature it is noted that rather than a straight line, the stages are often viewed as an interactive ‘cycle’ where the evaluation stage overlaps with the problem identification stage as policies are altered, ended, or new ones are implemented (Porter 1998). However, the *context* in which health policy is developed can potentially have a remarkable influence at various stages in the life of a policy. A detailed explanation of these stages is given below.

(i) Contextual elements

In describing the contextual element of their proposed framework, Walt and Gilson (1994) examined the necessity of understanding the situational, structural, socio-cultural and exogenous factors that might have influenced policy development. In this arena, the authors talked about the need to know whether the government play a vital role or marginal role in policy making and what socio-cultural factors critically influence health policy. Situational factors such as major politico-economic and organisational changes could also have impact on the functions of the government and its ability to put into practice health policy or to amend it (Walt and Gilson, 1994).

(ii) Policy content

With regards to the policy content, the issue of policy objectives, design, specific mechanisms and implementation as well as evaluation plans are examined. The analysis of it is often considered to be by a method known as “policy document analysis” (Humphrey et al. 2003, p.103): In this study, “policy documents” include any publications of the government and or non-government (e.g. policy frameworks, service guidelines, strategic plans, programmes implementation, and legislation) which have had, or have the possibility to have a considerable influence on the future direction of malaria control programmes’ developments. Policy analysis can either lay more emphasis on policy details or can emphasis less on policy detail, but rather on the general content and policy trends. In this way, the main themes will be inductively identified and disclosed the course of the policy that has been pursued by government (Humphrey et al. 2003; Walt 1994).

(iii) Policy process

Policy process describes the real processes of policy development and the actors involved at each stage. Various authors have identified different stages in the policy making processes and have described them as “disjointed”, “messy” and “conflict-ridden” (Barker 1996, Walt 1994, Collins et al. 1999). Walt and Gilson (1994) suggest that policy processes do not exist in isolation but instead dependent on actors who provide each stage an expression. Thus, the analysis of the policy processes can not be made without the examination of the actors involved since they are all interwoven. In general, there are four steps in the policy process: (1) agenda setting, (2) policy formulation, (3) policy implementation, and (4) policy evaluation as depicted in the Figure 3.2 above (Walt, 1994; Brewer and Leon, 1999; Buse et al., 2005)

(a) Agenda setting

The word “agenda” may have different meanings in various contexts but generally, Buse et al. (2005) see it as a problem identification and issue recognition. According to Kingdon (1984), the term includes a number of problems to which government authorities and non-government officials directly related to those policy fields of concern pay much attention at any given period. Many commentators have revealed how and why authorities pay much more attention to some issues than others. Hall et al, (1975), in particular, have argued that some of the underlying reasons are legitimacy, feasibility and support. However, it is generally acknowledged that policy making does not take place at one point in time, instead it is basically incremental or corrective, and concentrates on small modification to existing policies. This is because it is noted that there is little within policy making that is ground-breaking, rather most activities are corrective measures taken before implementation takes place (Walt 1994; Collins, 1989)

(b) Policy formulation

Policy formulation is the stage in which decisions on what is to be done as a response to the identified problem by the government takes place (Roux 2006). This stage involves designing plans around the action that has been decided upon by the authorities. This usually includes the action’s goals and objectives the prioritisation of objectives and ultimately the development of potential policy options needed to address the problem (de Coning et al 2006; Roux 2006). This process, according to Howlett et al. (2009), involves “assessing possible solutions to policy problems” (p. 143) with the aim of attaining the best feasible policy choice to solve the problem at stake.

Overall, it can be argued that this stage of policy making process has a number of decisions to be made. In the light of this, Brynard (2006) claims that while policy formulation and decision-making are different from all accounts the latter plays a

significant role in the former. From the author's point of view, policy formulation begins "with a decision and it concludes with a final policy decision" (p.165).

At this level, Innes and Gruber (2005) argue that in order to have a more collaborative system of planning or an optimal dialogue, there are a number of conditions that should be fulfilled. In this study the most important ones are that: (1) there must be full involvement of all interested; (2) everyone in the discussion must be equally informed, equally listened to and thus empowered as members of the collaborative discussion; and (3) agreements must only be reached when there is a general consensus amongst the vast majority of participants and the interests of all players satisfied.

Furthermore, at this stage of planning and policy formulation, Fung et al. (2003) argue that the most important obstacle for participatory planning to become fair and effective lies in the problem of elite domination. In collaborative planning processes, there is potential for elites and experts to easily dictate the proceedings which can result in good programme failures as a result of the wrong presentation of local community interest by elites (Cernea, 1993; Forester 1999). Many commentators see this as form of "covert privatisation" which can potentially lead to centralised control causing lack of motivation on the part of the community members (Anderson, 2000; Ribot, 1996; Margerum, 2002).

(c) Policy implementation

Implementation, as seen by many authors, is the most significant key feature of the policy process since the nature and success of a policy initiative is dependent on it which in turn reliant on the relative power of supporting and opposing groups (Walt, 1994; Parsons, 1995; Birkland 2001). Policy implementation literature has identified implementation into three models: (i) top down models, (Pressman and Wildavsky1973);

(ii) bottom-up Models, (Lipsky, 1980); and (iii) integrated models (Sabatier and Jenkins-Smith, 1993). These models will further be discussed.

■ **Top-down approach**

The top-down perspective of the policy implementation process, according to Walt (1994) can be likened to a linear model. The author argues:

“In the case of health policy, decisions by politicians and bureaucrats within the ministry of health are communicated to planners in the health planning unit (they may or many not have been involved in policy formulation), who operationalise policies by designing appropriate programmes, with guidelines, rules and monitoring systems. These are then transferred to local health authorities (at provincial or district level) or to health care institutions (hospitals, health centres) to be put into practice” (p.153)

Therefore, the top-down approach is mainly centred on the analysis of the relationship between the authorising statute or order, the nature of the problem and the central actors in the implementation process (Sabatier, 1999). It actually embraces the centralised policy control issues and usually can comprehensively be seen to describe the process. The model sees policy implementation as different from policy making because policy can be made in one administrative level and at the same time implemented in another level (Pressman and Wildavsky 1973). The whole idea is that implementation of policy becomes like getting people to do what the central government is meant to do as well as initiating a programme of control according to wishes of those at the national level. The adoption of this method is justified based on the fact that it reduces conflict and prevents those at the lower level from moving away from the original goals set by the central government (Dunsire, 1990; Pressman and Wildavsky 1973).

■ ***Bottom-up Approach***

Conversely, bottom-up approaches focus on actors at the local, or operational, level with particular emphasis on the influence that these actors have on policy at implementation stage (Hjern, 1992; Lipsky 1980; Sabatier, 1993). The proponent of the bottom-up approach considers policy as being implemented by individuals within organisations who usually have substantial judgment over the means by which the policy can be implemented (Lipsky, 1971; 1980). Implementation process can be consensus building amongst implementers. In the words of Lipsky (1980), this is “street level bureaucrats” (p.19) approach. These bureaucrats include doctors, nurses, health administrators and others who play major parts in ensuring the full execution of policies at the local levels where most affected policy’s target population are.

This approach is often perceived as “backward mapping” in which the implementation process and the essential associations are traced backwards, from the final implementer to the topmost policy makers (Lipsky 1971; 1980). This is on the premise that unlike the central bureaucrats, actors at an operational level or at the point of service delivery have better understanding of what is happening on the ground than the people at the central level. The importance of this approach is that it offers various opportunities for actors at lower levels to make decisions on their own. This suggests that bottom-up strategies are directly associated with community participation in health policy-making strategies and it is therefore important to consider how much power is handed over to the community in policy-making and how much policy is imposed from the central government. Explicitly, if more power is devolved to the locals, they can effectively transform policies during the implementation phase and therefore have the chance to influence the outcomes (Lipsky, 1971; Dunleavy, 1982).

■ ***Integrated approach***

The proponents of this model argue that neither the top-down nor the bottom-up approach can be regarded adequate enough to explain policy implementation (Oyugi

2000: Sabatier 1986). The underlying reason is that there are certain conditions in which both national policy makers and local policy implementers have significant impact on the way the ultimate policy has to be executed. It is therefore important that both top-down and bottom-up approaches are integrated, hence an integrated approach of implementation (Sabatier 1986; Sabatier et al.1993).

Overall, when it comes to implementation, there is nothing like perfect implementation, because there is often the possibility of having 'implementation gap' (Hogwood and Gunn, 1984). The main reason for this implementation gap is that while those at the higher level may have control over policy making, those at the lower level could also have control over policy implementation at the lower level. This implies that it is not often the case that what is planned is what is implemented. Eventually the difference between what is expected to be implemented and not implemented is what gives rise to "implementation gap". Often, it is the 'street-level bureaucrats' who have the discretion in reinterpreting national policy directives according to local organisational and individual priorities and attitudes (Lipsky, 1980). The idea of local agencies having potential influence on policy implementation is a crucial issue for this study. For example, while the national policy in Ghana indicates that the communities must be allowed to be involved in disease control programmes like malaria, the final willpower to find the right strategies for ensuring community participation are left to the good judgment of local policy actors.

In order to avoid this, Walt (1994) claims that policy making must be an interactive with a constant loop between formulation and implementation elements. Implicitly, it has to be said that the top-down approach and the bottom-up approach can not be viewed separately since the various actors, both at the national and local levels can act collaboratively irrespective of the approach adopted by any level to influence policy outcome (Grindle and Thomas, 1991). However, for policy implementation to succeed, certain factors must be in place. These include: availability of adequate time and

sufficient resources, good communication and coordination amongst actors involved in the implementations and good involvement of all the affected actors (Dunsire, 1978; Hogwood et al, 1984)

(d) Evaluation

Policy evaluation is regarded as the final stage of the policy process (Walt 1994) and it is often aimed at helping the authorities to have at least a general view of the programme activities. It is usually when such an evaluation exercise is conducted that the authorities can make a decision as to whether to continue or terminate programme activities or establish the basis on which programmes can be changed to achieve better results (Weiss 1999; Walt, 1994; Pawson and Tilley, 1997). In effect, an effective summative and or formative programme evaluation can be seen as a way of improving and justifying public health actions by involving procedures that are practical, precise and fair. Many commentators consider it as a driving force not only for planning effective public health strategies, but to enhance existing programmes as well as indicating the outcomes of resource investment in areas such as health programmes (Love, 1991; Ovretveit, 1998; Weiss 1999).

There are two kinds of evaluation: formative and summative. The former involves the collection of data during the active life of a programme, with the aim of improving it. On the other hand, the latter involves collecting data about the active (or terminated) organisation or programme with the aim of deciding whether it should be continued or repeated (e.g. a health promotion activity) (Fitzpatrick, et al. 2004; Patton, 2002). The suggestion here is that the practice of evaluation often complements programme management by gathering necessary information.

Many commentators have argued that evaluation must involve not just evaluation experts but also all programme staff and stakeholders including grassroots members' views. The main reason for this all-inclusion idea is based on the realisation that

evaluation does not concern only those involved in programme operations (e.g., sponsors, collaborators, coalition partners, funding officials, administrators, managers, and staff); rather those served or affected by the programme (e.g., family members, neighborhood organizations, even skeptics and critics of the programme); and primary users of the evaluation (Ovretveit, 1998; Patton, 2002). Thus, involving all stakeholders ensures that all those concerned views are understood and considered which brings about fairness and legitimacy in making judgments on feedback and refining programme operations (Love, 1991). In effect, without the involvement of all stakeholders, it can be argued that an evaluation is likely to fail to deal with the most crucial elements of programmes' objectives, operations, and outcomes. Consequently, the findings of evaluation could be invalid and subjected to criticisms (Weiss 1998; Rossi, et al. 2004).

(iv) Actors

The term 'actor' is used by Walt and Gilson (1994) to represent anyone who has the power to influence the policy-making process. Broadly speaking, policy actors in the area of health include:

- Government who has the crucial responsibility in making policy decisions;
- Health service bureaucrats, for the significant role they play in policy development and implementation; and
- Interest groups or societal actors such as community members, business groups and other professional organisations

However, amongst the participating organisations (i.e. Government officials, Private and Communities), an argument can be made that although power is widely distributed amongst these policy actors it is not the same (Barker, 1996; Ham, 1999; Clegg, 1989). This is true with those who are involved in ISC policy on malaria control programme in Ghana. It is noted that power is not evenly distributed during the policy making process and such differential distribution of power has a number of implications in terms of interest and influence in the policy making field (Sakyi, 2010). In the health policy field,

each of these actors have its own interests and power (Ham, 1999). Mitchell et al. (1997) have also noted that policy actors could either have more power or less power as well as more or less interest in a policy.

3.6.2 Alford's 'structural interests' framework

In order to have an insight into the different interests amongst the actors, in particular the community, in the decision-making process of malaria control programme as well as the amount of influence taking into consideration the power structures, my study uses Alford's structural interests theory. This model will be used to investigate whether the structures introduced under ISC policy within the context of decentralisation actually represents the interests of communities. In other words, as part of community health improvement programmes such as malaria control, the theory is used as a basis to investigate whether the repressed interests of the 'community population' are served by allowing population to have a certain degree of the influence in the decision making process.

The basic reasons for using this framework are that although Alford's (1975) case study of health system reform in the United States was conducted some 40 years ago, to date the use of such structural interests typology in his study has still great significance as a basis for evaluating the extent to which communities interests could become more important. Alford's structural interest theory has some relevance in this my study because in the first instance, the framework was developed using the findings from a local case study of the role of interests and interest groups in health care decision-making in one locality - New York and although in different settings, it is in line with my study aim.

In addition, similar to Alford I also intent to understand the changing balance of actors who are involved in the policy strategy of ISC and their respective influences as well as how far the community's interest is repressed. Also, in the context of socio-political environment, Ghanaian society today can be said to be fundamentally pluralist. The

decentralised political structure of the country has produced different sources of powers and has consequently shaped a 'pluralist' political society starting from the sub-local to national levels. Moreover, there have been less powerful group of people in the society and this situation has contributed in making the professionals exceptionally dominant in the health arena (Koranteng and Larbi, 2008). Besides, the recent market economy has created "corporate rationales" in the form of capitalist context. Private health agencies are competing with each other as well as with the public in the control activities (e.g. sales of ITN) to accomplish their goals (MOH, 2008).

From Alford (1975) model, structural interest can be seen as the embedded interests maintained by the existing structure of social, economic and political institutions within health care politics (North et al, 2001). While there are many interest groups in a complex social system, they are not all of equal power and this often defines political processes within the health services (Reich,, 2002). In health care politics Alford (1975) identified three groups—the professional monopolisers, the corporate rationalisers and the community—reflecting in turn dominant, challenging and repressed interests in health care, who provided a succinct representation of the key stakeholders.

This theory of Alford (1975) considers the entire health care system as interconnected individuals with different structural interests. The significance of this theory is that it makes it clear which group within the structure has the most power, their level of interest and the level of their interdependency amongst themselves. With the use of term 'structural interests', Alford (1975) has argued that there are many interests which are gained or lost from the nature of association of health services and the simple reason is that power is not equally shared amongst the actors involved. On the basis of this Alford suggests three different types of structural interests which include: dominant interests, challenging interests and repressed interests.

(i) Dominant Interests

Within this group, the medical profession are seen by Alford (1975) as the 'dominant structural interest' in health care policy. The author argues those in the medical profession are often the dominant actors with special and monopolistic situation within the health sector. These professionals are often represented by different kinds of professionals include physicians, and those in other health occupations holding or seeking professional privileges and status. In the context of this study, nurses could be considered to be amongst them, even though "physicians are the most important interest group representing professional monopoly" (p.194).

Alford (1975) asserts that the position of those in this group is effectively well-established and their legitimation so well protected by socio-political institutions that they "do not continually have to organise and act to defend their interests; other institutions do that for them....(p.14). He further argues that although " all of these groups have different interests and are related to the health system in different ways,they share an interest in maintaining autonomy and control over the conditions of their work, and professional interest groups will— when that autonomy is challenged— act together in defence of that interest' (p.192).

(ii) Challenging Interests

These are the groups of people whose positions have been of great importance to the health care sector as a result of "the changing technology and division of labour in health care production and distribution" (p.15). According to Alford, the production of goods and services within health service is usually managed by large scale organizations or corporations like hospitals, public health agencies at all governmental levels and health planning agencies. These large-scale organisations represent an increasingly powerful structural interest, which Alford calls 'corporate rationalisation' (p.191). These

groups of people occupy the top positions in large scale health organisations and in principle are responsible for improving the efficiency and effectiveness of health services. In doing so, they tend to pose a challenge to the fundamental interests of professional monopolisers such as the medical profession (Alford, 1975). Examples of these groups include: hospital administrators, government health planners or bureaucrats, politicians, manufacturers of health products and health related pharmaceuticals, media and institutions or organisations created purposely to stand for the economic or professional interests of particular groups and Alford calls their interests as 'challenging interests' (p.192).

(iii) Repressed Interests

The third category, that of repressed structural interests, are those who are medically impoverished and could either not afford health care or have been neglected by patterns of provision favouring more affluent members within the society. Alford, (1975) prefers to call those in this group as the 'voiceless' whose grievances are not heard because "no social institution or political mechanisms . . . insure that these interests are served" (p. 15).

According to Alford (1975), the 'repressed interests' or 'negative structural interests', are not homogeneous, rather diverse in terms of their health needs, ability to pay, and ability to organise their needs into effective demands. The interests of the community population have often been considered as 'repressed interests' since there are disorganised compared to the other interest groups. Nonetheless, they share a common interest "in maximising the responsiveness of health professionals and organisations to their concerns for accessible high quality health care" (p.192).

The overall main theme of Alford is that those in the repressed group have limited access to health services. In the context of this study, the theory helps to comprehend the changing balance of influence within the policy group of interconnectedness by

examining to what extent have the community interests remained repressed in the malaria control policy making field?

3.7 Other theoretical frameworks and their potential relevance

In this section two other theoretical frameworks will be discussed. The discussion is based on the research questions which concern how policy making process of malaria control policy strategy of ISC takes place amongst various actors and the challenges facing the communities in their efforts to participate in it. More specifically, I wish to discuss (1) Structuration Theory (Giddens, 1984) and (2) Policy Networks (Kickert et al., 1997). The primary reason for discussing these two frameworks is that I regard them to be potentially relevant in answering some aspects of the research questions in this study. For example, the Giddens's framework has the possibility of helping me to understand the research questions: *"what are the barriers and potential enablers to community participation"?*, whilst the second theory could also contribute in understanding the research questions: *"Who are the actors involved in the malaria control policy making process; what roles do the community as an actor play in control programmes and to what extent are the various actors involved in the ISC strategy at the micro level"?*

In effect, the theory of Giddens (1984) could first be used to explain and understand the way malaria control policy process is shaped by institutional/structural arrangements in the country. In other words, the theory can potentially help to understand the extent to which the institutional structures pose as a barrier or potential enabler to community participation in the policy process. In respect to the theory of Policy Networks, not only has it got the possibility of enhancing my understanding of the extent of the various actors' involvement in the ISC policy strategy but also the roles that the individual sectors/actors (in the case of this study, the communities) play at the local levels (Mayntz 2003, Streeck & Schmitter 1985). Based on this potential significance, these two theoretical frameworks are discussed briefly below.

3.7.1 Structuration Theory

Given the pervasiveness of malaria in human life in Ghana, many experts have suggested that there is the need for community empowerment through participation in decision making process (WHO, 2006; Binka et al. 1994; Aryeetey et al. 1999). The reason behind this argument is that participation has been seen to be successful in disease control and elimination campaigns in many developing countries (Artkinson et al. 2011; Hickey & Mohan, 2004). However, the motivation to community participation is said to depend on the social structures (.e.g. programme activities and the rules governing interaction) that exist within the organisation or sector since the structures can serve to oppress or liberate the people (Freire, 1972). However, in the process of participation, through the interactions and actions between the communities and the health authorities (.i.e. active agents), the existing social structures can be restructured to have a new meaning (Sinwell, 2008). Thus, human actions particularly the actions of the formal authority (e.g. MOH) that control operations in the health sector, can policy process and determine the extent to which other community members will be motivated to participate in the it.

Against this background, my interests is to understand how the interactions between the agents (communities and the malaria control decision makers) and the structures at the micro level shape the control policy making process as well as the extent to which social structures can play a role in acting as a barrier or enabler to participation. It is on the basis of achieving these objectives that make me find the use of Giddens's (1984) theory of 'structuration' potentially attractive.

The starting point of the theory of Structuration can be summarised in a short phrase by Marx stating:

“Men make their own history, but they do not make it as they please; they do not make it under self-selected circumstances, but under circumstances existing already, given and transmitted from the past (Marx and Engels 1962, p. 399) (see also Giddens, 1984: xxi).

The structuration theory was developed by Anthony Giddens (1984) as a general theory of social systems which was an effort to find a solution to the fundamental division in the social sciences between *Voluntaristic* and *Structural* theories. The former focuses on the individual within a society as the primary influence on social change. These theorists see individual actions as important to the building or rebuilding of society. This is possible because active human agents are not passive objects but subjects that react to the structural conditions around them and as such can influence social structures by their actions (Freire, 1972; Sinwell, 2008). In contrast, the latter group puts emphasis on the role of societal structures, as the primary influences on the changes that take place within the society. In effect, while voluntaristic theories consider the role of the individual in social change, they tend to underrate the impact of societal structures. Accordingly, these two theories do not offer any broader explanations of the entire nature of societal change (Wolfel, 2001).

Contrary to previous assertions made about the nature of agency by many other theorists Giddens claims that agency can be the result of either intentional or unintentional action, since:

“Agency concerns events of which an individual is the perpetrator, in the sense that the individual could, at any phase in a given sequence of conduct, have acted differently” (1984: 9)

In reality, according to Giddens (1984) both the people and the structures of society are important in influencing all the changes that occur in the society. As Giddens (1991) describes:

‘In seeking to come to grips with problems of action and structure, structuration theory offers a conceptual scheme that allows one to understand how actors are at the same time the creators of social systems, yet created by them ... It is an attempt to provide the

conceptual means of analysing the often delicate and subtle interlacing of reflexively organized action and institutional constraint' (p. 204).

Thus Giddens' attempt to correct this shortcoming in his theory of Structuration provides a different view of social phenomena that incorporates both. In this light it has been argued that Structuration theory is:

"an approach to social theory concerned with the intersection between knowledgeable and capable social agents and the wider social systems and structures in which they are implicated" (Gregory, 1994: 600).

In essence, the agent knows what and why s/he is doing it and therefore is the element that recreates the social structure and proposes social change (Craib, 1992). However, although, the agent is a "knowledgeable and capable subject" (Cloke, 1991: 97), this does not mean that they are in complete control of their actions. Implicitly, there are conditions and unintended consequences of action that are not known (Jones, 1998). Structuration Theory therefore reflects Giddens thoughts on the complex relationship between structure and agency in society (i.e., macro versus micro perspectives). Thus while the actions of individuals are constrained by structures these same actions may also serve to recreate those structures over time (Langley (1999). To Giddens, these two (i.e. structure and human agents) are inextricably intertwined and therefore structure alone can not be viewed as a constraining factor which impacts upon human action. Thus structures are internal and encoded within the knowledge of individual agents which do not force an outcome, but serve the purpose of guiding individual decisions (Valadez, 2008). Giddens regards this interplay as the '*duality of structure and agency*', which means that structure and agency cannot be separated. In Giddens' own words,

"By the duality of structure I mean that social structures are both constituted by human agency, and yet at the same time they are the very medium of this constitution (Giddens, 1976: 121).

In other words, instead of considering social practices wholly in terms of *either* structures *or* agents, the concept of the duality of structure sees the connection between the two as being dialectical, so that none of them can be understood without

making any allusion to the other. In a whole, while other theories regard structures as determinants of human behaviour, structuration theory sees structural 'rules and resources' to have significant impact on agents in a different way. It is noted that although structuration theory accepts that some aspects of social systems are likely to go "beyond the control of any individual actors", it, at the same time, focuses on the positive aspects of rules and resources. According to Giddens (1984):

"Structure is not to be equated with constraint but is always both constraining and enabling "(p. 25).

The most important issue here is that human actions can not be understood outside the structures and as such these structures can be a source of both an impediment and facilitating to human actions. Giddens (1984) points out that human actor is the element that helps in building or rebuilding the structure of the society by means of invented values and norms which are reinforced through social acceptance. However, it has been said that this is not an attempt to "marry" structuralism and humanistic social theories, but an attempt to resolve their limitations through an understanding that both the agent and structure interact to bring about social change, implying both the societal structures and human agents are equally important (Wolfel 2004).

This theory has its appealing sides for me and therefore will consider using some of its ideas in this thesis. For example, the health sector can be considered as consisting of a set of structures which constrain and facilitate the participation of other agents (i.e. communities) related to the malaria control policy making process within the sector. From this perspective, the theory can be used to understand structures that pose as forces of enablement as well as constraint in the community participation. However, in the context of Ghana, despite the potential significance of this framework, it has its own flaws in applying to the policy making process within the health sector. For example, although using the Structuration theory as an investigative framework has the potential to help me understand how malaria control policy processes is shaped by

institutional/structural pressures (both at macro and micro levels), in the case of Ghana, its significance is limited. One reason is that due to scarcity of financial resources in developing countries like Ghana, many donor agencies have become a dominant policy actor. Health systems of Ghana are significantly dependent on foreign aid, which influences policy priority, allocation of resources and creates scope to the donor agencies to emerge as important policy actors (MOH, 2007; Collier P and Gunning, J.W., 1999). This makes the local health structure (i.e. organizational rules, resources, and consequences) less effective since decisions are not influenced by the local existing structures. Thus there appears to be no duality between decision-making processes and the social forces that influence and constrain or enable decisions that are made at the macro level. In reality, there is a gap between the socio-cultural structures at the local level influence the process of decision making and the agents that make the decision on malaria control in Ghana. The decision that is made is based on guidelines and suggestions given to them by the national actors (Sakyi, 2009), hence little or no effective interactive relationship between local structures and the policy making agencies.

Related to the above reason is based on the realisation that:

“despite two decades of macroeconomic liberalization in Ghana..... Ministries of Health remained relatively centralized bureaucratic organizations that continued to perform traditional direct service delivery roles” (Russell et al.1999, p.767).

This implies that although there is decentralisation, the decision making in Ghana is highly centralised with the central body assuming the key role in policy making (Bossert and Beauvais, 2002). The Central government remains responsible for governance and this trend consequently reduces the power of local people and the societal forces get lesser scope to voice their demand (Sakyi, 2009; Bossert and Beauvais, 2002). Ultimately, at the micro level, the powers of the local agents to shape or reshape the existing structures are often restricted (Agyepong, 2005).

The last problem of this theory is that it focuses more on prediction of outcomes of policy process. However, in this study, I am not interested in outcomes prediction of the policy, rather the policy process. Thus although the theory has the potentials for understanding how the social structures pose as a barrier or enabler at the micro level structural constraints do not guide the behaviour of policy actors at the national level.

On the basis of the above given reasons, and considering the other study objectives, although I am interested in this theory as one of the investigative frameworks, I still consider it to be inadequate in helping me understand the policy making process and the extent of community participation. There is therefore the need to use other frameworks which can better help in answering the other aspects of the research questions.

3.7.2 Policy Network approach

This approach emphasises on a set of relatively stable relationships amongst many actors who share certain common interests with regard to a policy and therefore exchange resources to pursue these shared interests. This is based on the acknowledgement that co-operation is the best way to achieve such general goals. The existing relationships linking these different actors are usually non-hierarchical and interdependent in nature (Börzel, 1997). In effect, policy networks are:

“.....stable patterns of social relations between interdependent actors, which take shape around policy problems and/or policy programmes” (Kickert et al., 1997, p. 31).

The core idea underlying this approach is that all actors in a policy field recognise that they cannot attain their own interests and goals without others' support. The policy network through ISC strategy is necessitated by the fact that the health sector which is the public agency can not possibly provide a solution to the problem of malaria on its own and neither the private sector is also prepared to offer its service alone to deal with

the problem at a level which will be acceptable to the public. There is therefore the need to have interdependency and sharing of resources. Besides, within the public sector, the need for assistance from other sectors becomes essential because there are other resources and a combination of different ideas which, for example, the health sector alone either does not have or do not completely own (Sabatier and Jenkins-Smith, 1993). Implicitly, some actors need more resources owned by different actors to accomplish their policy goals and objectives (Adam and Kriesi, 2006). Often most groups of actors have interests in a given policy sector, and the capacity to help determine policy success or failure (Marsh 1998; Kickert, et al. 1997). This is particularly in relation to policy issues like malaria control that are complex and cannot often be managed within the traditional sectoral or organizational borders (Mandell, 2000). There is therefore a mutual dependence in solving policy problem and this stresses the significance of understanding interactions between the diverse actors. This also brings to the fore the importance of understanding of power and domination between actors in a policy-network (Adam & Kriesi, 2006). In general, it has been recognised that during the policy process, the wish amongst these actors to solve policy problems and interact in multi-centric rather than centralized ways necessitates the use of communication and coordination mechanisms.

In principle, from the viewpoint of decision-making, policy networks are non-hierarchical because it is expected that all actors will have to take part out of their own free will and no actor has formal rights to decide over others. Non-hierarchical forms of governance through policy networks have some visible advantages, especially in complex social environments. They have the potential to produce more effective solutions because they are able to process more appropriate information, to take a greater variety of values into consideration thereby increasing the acceptance of decisions by stakeholders (Scharpf 1993). However, in reality, the distribution of power within a network can be asymmetrical due to the discrepancies in the access to main resources

or other forms of power (e.g. social, political, organizational or technical power) (Mandell, 2000; Rhodes, 1990; Illeris and Jakobsen, 1990; Marsh, 1992).

In the context of this study, the use of this theory could help me in understanding various actors involved in intersectoral policy strategy as well as the extent of integration amongst the sectors (actors). Also, with the malaria control policy making process characterised by multi-level governance at various levels of policy-making (local, regional, and national) the roles of the sectors (actors) at the local levels could also be understood (Mayntz 2003, Streeck & Schmitter 1985).

Nonetheless, this approach still falls short of certain characteristics which can help me in answering all the research questions. For example, the three main ideas inherent in Policy network approach are under the assumptions that: modern governance is frequently non-hierarchical; few policy solutions are simply imposed by public authorities and governance involves mutuality and interdependence between public and nonpublic actors, as well as between different kinds of public actor (Kassim 1993; Peters 1998; Dowding 1995; 2001; Le Galès and Thatcher 1995). However this is not the case in relation to policy making process in Ghana where policy making is centralised (Bossert and Beauvais, 2002). In the case of Ghana, individual local actors are weak in terms of resources and rely heavily on central government for assistance and expertise. The effect is the blurring of the distinction between policy making at the local and national levels and consequently hierarchical in nature.

Additionally, actors at the policy-making field in Ghana is characterised by frequent political appointees and there also is still a fragmentation among different ministries. The latter has resulted to a situation where there is a more vertical loyalty amongst employees than at the horizontal level. These two combined have made policy network with capacity to manage the decentralisation process very fragile (Koranteng and Larbi, 2008) and the major actors involved in the policy making process not to cooperate and

coordinate (Sakyi, 2009). This therefore puts the utility of policy network approach into question in a situation where there is rapid change in both institutions and actors (Peterson, 2003). Thus, although policy network may be formed, its formation is on *ad hoc* basis and as such once formed, networks quickly disintegrate. In fact, that underlye this approach One This is because, in the first place, the can not be applied to Ghana Given such fluidity surrounding policy network in Ghana, I did not find this approach appealing as a major investigative framework which will help me to have access to all the necessary data to answer all the research questions. Finally, although this approach provides a description of how policy decision processes are organised, it fails to offer any explanation of why they are organized in that way (Hill, 2005:74).

In sum, the policy network as understood in the context of Western literature can not easily be applied in Ghana due to socio-economic and political conditions of the country. The issue is, on the practical level, there are a number of constraints that have to be overcome. Also, this framework does not provide a simple” descriptive map” of the policy process, which can point to the stages, that I find most relevant in relation to my research questions, which are the stages of *agenda setting, policy formulation and implementation*. I therefore do not find this approach powerful enough to help me answer all the research questions, hence the need to use other frameworks in addition to the above discussed ones.

3.6.3 Summary

This section has discussed the concept of policy. The literature has revealed that there is no one common agreement regarding the definition of the policy concept. A general definition of health policy in the context of malaria control has been used for this study. This implies that while several forms may be recognized and each would point towards some government intention, at the same time, the absence of policy activity can be viewed as government policy on health issue, more specifically on malaria control.

In the context of this study, ISC was identified as a policy strategy to control malaria. It was noted that ISC is the process through which people work together in a group, and organization, or community plan and make decisions to solve a particular problem. Although this was considered to be very important approach to allow the grassroots community members to be part of the decision making process, data supporting this argument has been lacking in the literature.

The later part of this section therefore identified the literature gap which relates to lack of evaluation on community participation within the ISC policy strategy that has been suggested to control malaria. Lack of studies examining exclusively the extent to which community participation has been happening within health policy of ISC is the inspiration for the present study.

Walt and Gilson's framework as a model for analysing health policies was introduced as model that will guide the evaluation of the policy process in the last part of this section. This involves analysing research variables of policy process which include; content, context, process and actors. In relation to Actors, Alford's structural interest model has further been proposed as a framework to understand the kind of influence communities have on policy making process in Ghana.

In all, it is worth stating that the review of the literature has offered me the context and the frame of reference within which to review my own study results on the challenges and dilemmas faced by those involved in ensuring that communities get the opportunities to participate in disease like malaria policy process. In addition, the literature review enables me to have an informed direction of the empirical research. The next chapter will however, discuss the methods employed within the case study before moving on to examine the malaria control policy making process in Ghana.

Chapter Four

Research Methodology and Methods

4.1 Introduction

This chapter describes both the research strategy and approach including the details of how these two have been applied. In general, while the study is more qualitative in nature, a quantitative method (questionnaires) has not been excluded. Thus, this study has adopted a mixed method approach with different sources of data collection which is meant to allow for triangulation and the exploration of issues and contexts from a range of different perspectives.

The chapter begins by summarizing the methodology of this study. The next section focuses on the explanation of the logic of enquiry used in this study taking into account the significance of certain major strategies of qualitative research. The use of methods is explained in details, including a description of the data source with emphasis on the participants and the study context, followed by a description of the data collection and data analysis procedures. Finally, I provide an explanation for the establishment of the reliability of the findings as well as the ethical issues involved in this study.

4.2 Research Methodology

The study adopted interpretive approach. This approach involves the systematic way of interpreting socially meaningful action of people in their natural settings in order to arrive at an understanding of how they build and maintain their social world (Neuman, 1997). It has been argued that knowledge on social world issues is often limited and there is no single truth about social issues. Rather, there are multiple realities which are socially constructed by the members themselves who live within these communities which can be misleading when examined superficially. Context is therefore vital in

making sense of individuals and groups actions (Mason, 2002; Neuman, 1997). It is therefore imperative for me as a researcher to be near to social issues that are created and maintained by the people. This will help me to understand the circumstances under which they find themselves and to get grip of the details of the data on them (Tichen and Hobson, 2005; Mason, 2002; Neuman, 1997; Easterby-Smith et al. 1999).

Thus the underlying reason for adopting the interpretive approach is based on the fact that basically, this research is mainly qualitative with a case study strategy. The study's main aim is to find out, from the perspectives of the various policy actors how malaria control policy making takes place and the extent of community members' participation in the process. With these 'how' and 'why' questions, it is obvious that the study is grounded in a philosophical position that is broadly 'interpretivist' (Mason, 2002). In other words, the study is concerned with how the social world is "interpreted, understood, experimented with, produced or constituted" by the actors involved (Mason, 2002, p.3). From the point of view of interpretivists, human beings are unique and accept that people have different subjectivities, which is built on how the world is seen in terms of where we stand. In this sense, the notion of participation in this study is understood as the participation interpreted and experienced by the communities under investigation within the context of malaria control policy making process. However, research needs to recognise that respondents may attach different meanings to participation.

In essence I needed a methodology which would allow me to interpret different point of views expressed by different groups of people. The use of the interpretive research approach has been helpful in assisting me to 'get close' to participants; to penetrate their internal logic and interpret their subjective understanding of reality (Shaw, 1999). Implicitly, in order to comprehend the viewpoints of the study subjects, I have to adopt an empathetic stance by seeing their opinions from the context they are sharing with me (Saunders et al, 2007). Employing this approach (interpretive) is therefore most

suitable for exploring issues concerning policy process and by the use of this approach, research questions that can be generated can be addressed with real cases (Hopper and Powell, 1985). Through the way participants construe and the meaning they give to social issues, this approach relatively makes it easier to have a better understanding of issues pertaining to the study. Also, the experiences of communities and those working within the communities could be better understood through more in-depth interviews (Bryman et al., 2011; Irving and Gaffikin, 2006).

All in all, it is fair to say that the adopted interpretive research approach is more appropriate in the sense that in terms of analysis, the approach is similar to the main method of analysis, which is inductive approach, used for this study. The point I would like to make here is that although I combined both deductive (because I gathered the data with various objectives or themes such as community roles, barriers and potential enablers, in mind) and inductive approaches, the use of the latter approach played a central role in my analysis. This implies that I allowed the data to mostly 'talk for itself' with little or no interference from preconceived notions and thoughts during the literature review and the data collection process (Bryman, 1988; Easterby-Smith et al. 1999). In this way, by using this approach, I can allow the flow and direction of this study to take its course and follow leads as and where the results become available so as to gain an in-depth understanding of the situation. This is essential in the sense that there is often the interplay between the observations of realities and the formation of concepts, as well as between perception and explanation that often takes place during the research process (Blumer, 1982). Ultimately, the approach is capable of helping me understand and see the problem under investigation from the viewpoints of the actors involved in malaria control programmes namely: communities, health officials and private individuals (Hannabuss, 1993; Baum 1995; Attree, 2004; Mays and Pope 1995).

4.3 Methods

The following section describes the multiple methods that were used for data collection and analysis, which primarily includes both the qualitative and quantitative. However, while the study combined both approaches, the study relied more on a qualitative approach. The basic reason is that quantitative approach such as surveys (questionnaires) used in this study does often provide a snapshot of a problem and easily fails to present the entire picture of a social event. This failure does not help me as a researcher to understand social events “*in terms of social actors’ motives and accounts*” (Blaikie, 2000, p.101). This is in contrast to qualitative method which, irrespective of the time horizon, can still be suitable for capturing the whole process that I as a researcher intend to understand (Yin, 2003; Bryman, 1988; Mason, 2002; Denzin and Lincoln, 2005). The quantitative method was therefore only used to assess the demographic status of the interviewees as well as the extent of actors’ involvement in the ISC. Nonetheless, using the two methods (i.e. triangulation,) helps to combine both the strengths of alternative methods for overcoming another’s weaknesses (Gill and Johnson, 2002). In general, most parts of the study were based on qualitative methods and the various strategies and approaches involved in these methods are discussed below.

4.3.1 Qualitative method

In view of the fact that this study is largely qualitative, the many traditions of its research were used and this included: case studies (Yin 1994; 2003), in-depth interviews (Glaser and Strauss 1967; McCracken 1988; Patton 2002; Quinn 2005), focus group discussions (Krueger and Casey 2000; Stake 1995, 2000), and nonparticipant observations (Spradley 1980).

(i) A Case study as a research strategy

I used case study as a strategy following the advice of Yin (2003) who suggested that a case study is appropriate for questions about 'how' or 'why' a phenomenon occurs (Yin, 2003). Such questions call for a 'depth' investigation of the particular circumstances of a case, rather than a 'breadth' investigation which is often served by a survey approach (Yin, 2003). In other words, research that focuses wholly or partly on process is well appropriate to case studies as it: "*allows investigators to retain the holistic and meaningful characteristics of real-life events*" (Yin, 2003, p. 2). By using a case study, I hope to be able to empirically make an inquiry which can help me explore the problem under study and to bring out the details from the perspectives of interviewees involved in the study. Also, I will be able to use multiple of data sources (Leonard-Barton, 1990; Yin 2003) and by having multiple sources of evidence helps to further ensure a study's construct validity (Yin, 2003).

The case study focuses on two separate districts with the first being the agriculturally-based rural district of Ahafo-Ano North (AAN) while the second is the commercially viable urban district of Kumasi Metropolitan Assembly (KMA) (See section 4.4 for more information on the case context, and Figures for the various maps of districts). Although selecting these two different districts as the case study sites was a complex task, with the research question primarily focusing on rural and urban differences in community participation in ISC policy making process, AAS and KMA districts proved to be rational choice since they are the least and most developed districts respectively in the region (Regional Annual Report, 2008).

(ii) In-depth interviews as a form of data collection

In this study, the main form of data collection was by using interviews with malaria control policy actors. However, despite the fact that the interviews could best be described as in-depth, they were also 'semi-structured' in the sense that the interviews I

conducted included a flexible set of questions which were often handled in a certain order (Weiss, 1994; Mason, 2002; Robson, 2002). This helped me establish a quick rapport with respondents which contributed to in-depth and open conversations about interviewees' understandings of their participation in malaria control programmes. I was flexible because according to Weiss (1994), there is always the need to take into consideration the needs of the interviewees' ability to express themselves with ease and in a manner that is suitable for them. Practically, from what I saw, such flexibility also helped the interviewees to expand on their own views (Oppenheim, 1992; Stake 1995).

However, it has to be stated that the development of the interview questions was informed by the literature review. For both health officers and community members the lists of the interview questions were made from the research questions. The preparation of the semi-structured questions was guided by the advice of many experts on qualitative interviewing (Weiss, 1994; Kvale, 1996; Mason, 2002) by linking research questions with interview questions. (See appendix 2A and 2B for the questions or interview guide for the health officials and community members respectively).

Amongst all the forms of data collections, it was the key informant interviews which offered the richest and most elaborated information on the case. This data collection procedure contributed to the in-depth and detailed understanding of the policy context, concerns about communities on malaria policy planning, community as well as management responses to the extent of community participations in control strategy of ISC and finally their responses to the challenges facing the communities in their participation.

Interviewees were purposively selected and it was not only those health professionals knowledgeable (i.e. experts) about the health policy making process, but also others from the communities as well. In general, the selection criteria included ordinary community members, those officials involved in local government administration, the

local health unit and malaria control programme, community-based agencies or NGOs concerned with the malaria control and community health and well-being as well as all those involved in the sectors related to malaria control programme.

All the interviews were conducted on one-on-one and face-to-face. Such interviews *“offer the possibility of modifying one's line of enquiry, following up interesting responses and investigating underlying motives”* (Robson, 1998; p. 229) and as such are preferable to telephone interviews. During the semi-structured interviews the participants were first asked to describe their experience with malaria control activities with the health officials. This allowed them to tell their story in their own way and became comfortable with me (Stake 1995). I also had an understanding of the malaria control policy making process through the literature including the themes around which the questions were to be asked. For example, I had prepared my questions on themes like the roles the communities perceived themselves playing, the level of community participation and the barriers/facilitators to the participations. This knowledge was useful when I was following up with questions and I made sure the questions were related directly to themes. The communities were also able to answer most of the questions out of their own experiences.

In effect, the interview was structured in such a way that the interviewees would be motivated and would have the highest level of confidence, by starting with a ‘story’ question: For example, I started by saying ‘help me to understand your level of community participation in malaria control policy making process” or Can you tell me more about the role you or any other member in this community play in malaria control activities”? This way of asking the questions helped the interviewees to feel comfortable narrating the story in the way they perceived it had happened (Weiss, 1994). The style of questioning was very straight forward and direct and I used such methods to conduct the interview because it seemed the most honest way of dealing with an interviewee, which also prevent any trick or deception (Mason, 2002). While expecting the interviewees to be honest about their own answers, I tried to keep away from asking

questions that would make the interviewees to be vulnerable to deceit. For example, I tried to avoid asking many historical questions that would demand the interviewees to recollect an event in the distant past. In general, at the end of the interview, the interviewees would often be asked a 'theory' question. For example, I would ask: "People think that decentralisation has helped the communities to be more involved in policy making process like malaria. What is your opinion on this claim?" This technique comes from Pawson (1996), who emphasises the need to be open in discussing theory in the interview context and advises taking a direct approach to bring out theories from interviewees. By and large, I saw the interviews very positive with most interviewees providing answers along the themes with certain level of mood which seemed to demonstrate the joy they have had in such interviews, an experience that is familiar in qualitative research, (Kvale, 1996).

Although the interviewees did occasionally digress from the standardized questions, it did not change the outcomes as the findings did incorporate those unforeseen information of relevance. (e.g. I found out that poverty prevention did not only enhance accessibility to health facilities but also community participation in policy making as well). However, the disadvantages were that the interviews were time-consuming, coding was difficult and more efforts were demanded from the interviewees (Oppenheim (1992)). Also my presence, as a researcher during the interview was seen as a problem because it potentially created uneasiness on the part of most of the participants, who felt shy to answer some of the questions. As a researcher who comes from such background I was not surprised since it was part of their culture to be polite to strangers. I therefore had to be friendly to interviewees and let them know that I was also part of them, born and bred there. In this way, most of them felt at ease with themselves and also felt confident in responding to the interviews.

In a nutshell, the semi-structured interviews fit well with the character of this study and in this context, interviewing was understood not merely as a technique for collecting

“objective knowledge” from respondents, but as an activity that involved interactions. In other words, interviews were seen as social encounters (Dingwall and Miller, 1997; Silvermann 2000) in which both interviewer and interviewees were active and knowledge was constructed by their joint collaboration (Holstein and Gubum, 1995; Dupuis 1999). In such a social situation, I became aware of the existence of a triangular relationship between the type of information that I was seeking, the type of respondent with the information, and me as an interviewer asking for the information. As a result, I had to follow the advice of most experts who suggested that the best possible way that could be used to minimise some of the problems that were likely to crop up in the course of the interviews was to remain as a listener and not a contributor in the process (Creswell, 2007; Stake, 1995).

(iii) Policy Document Review

In addition to the qualitative interviews, background materials were also used. This was found to be important because in modern western society, documentation is part of *“the fabric of everyday social life”* (Atkinson and Coffey, 1997, p. 45) and as such I could not afford to ignore paperwork, in the form of annual reports, research on malaria, conferences and other documents. However, although these documents often create certain kinds of representations with their own conventions, I was aware that they should not be used as substitutes for other kinds of data. For example, it is generally known that while learning through records alone can help individuals to know how an organization actually operates everyday, these records can not be considered as strong “official” proof of what they really report (Atkinson and Coffey, 1997, p. 47). This is because words and their meanings can be altered when written down. This is possible because written text is an artifact, *“capable of transmission, manipulation, and alteration, used and discarded, reused and recycled”* (Hodder, 1994, p. 394). Nonetheless, documents provide one view of reality, occasionally designed to put forward a case, validate a position, or present a picture. These documents usually are

nameless which perhaps offer them a greater authority or perception as a factual account, than most articles that are often associated with specific authors (Atkinson and Coffey, 1997). I therefore took almost all the information I had from the policy document reviews seriously and where necessary used it to support my arguments.

The policy document review involved looking into appropriate national, regional and local health reports particularly on malaria control, publications made by the MOH and other International bodies related to malaria control programme. Many of these documents were obtained personally at offices at all levels or via internet. In most cases key informants were asked for these relevant documentary materials which otherwise would have been hard to access publicly.

Policy documents were selected on the basis of their significance in offering information on the essential socio-economic and political contexts not only of the country but also the districts to be used as case studies as well. Examples of information obtained included: both districts' Health Annual Reports between 2005 and 2009; MOH Policy Report between 2005 and 2009; NMCP Annual Reports, between 2005 and 2009; Global Fund Report, 2008; Independent Reports on malaria by Private organisations like USAID, World Bank and WHO Country Reports between 2006 and 2009 (excluding the ones obtained from the Web-sites). However, what was disappointing was the fact that there was no concrete information on the expenditure on malaria alone. It was also difficult to have access to well-documented information on policy process at the district levels, apart from what the participants told me. Nevertheless, the data obtained served not only to complement the empirical analyses and allowed for triangulation, but also provided information about the period before the collective memory of the respondents. Furthermore, the policy document analysis contributed to gaining a better insight of the health context, socioeconomic situations of the country including the community members at the study sites, and finally the situation of malaria in the country including the districts under study. Also, some of the major health management players,

organisations and agencies involved in dealing with malaria problems were identified through the review. Thus, although other methods were used, the documents examined validated the information obtained from the actual informant interviews and also helped me as interviewer to discover the right person to contact at the beginning of the interview.

(iv) Snowball-method

Having identified the majority of the interviewees through literature or document reviews, a snowball technique was also used to identify other potential interviewees (Babbie, 1989). This is usually regarded as chain referral sampling in the sense that participants or informants with whom contact has already been made use their knowledge within the field under research or social network to recommend persons they know to the researcher. These individuals are normally perceived to be those who could potentially contribute to the study. It is a good method for having access to groups of people that are not easily accessible to researchers through other sampling strategies (Bernard, 1995; Denzil and Lincoln 2000; Pope and May 2000)

With the snow-balling method my interviewees were asked during the interview if they could provide the names of additional useful respondents. Later, at the end of the interview the interviewees were asked to indicate any other persons who would be able to contribute to this research. Through this, a few extra participants were recruited based on suggestions made by other key informant interviewees. In theory, this process should have been continued until no new names came up. In practice, however, it was impossible to interview all those mentioned and only the most frequently mentioned actors were selected for interview, due mostly to financial and time constraints

The inclusion criterion applied in this study, was that interviewees should, in one way or another, be involved in or have an insight or opinion on the process of setting, implementing and evaluating the malaria control policy strategy including the extent of

community participation in the process. As a result, those interviewed included respondents perceived as typical health sector members as well as respondents coming from other sectors which were not part of health sector (e.g. education, agriculture etc) but whose activities influence the policy process. On the part of the community members, they were those who are mostly affected by the policy and as such any of them could potentially be a target for an interview depending on the person's time.

Also, certain participants were selected based on their relationship with the control policy or their departments' collaborations with the malaria programme or their roles as malaria victims' care providers such as doctors/nurses. In addition, private-not-for-profit representatives' views were also obtained.

(v) Focus Groups

Focus Group Discussions (FGDs) method was also used as a research strategy to obtain information. Those who were selected included adult community members between the ages of 18 and over years and they comprised both men and women. All participants were from the community and were permanent residents with good knowledge of the area. The selection of participants was done through the help of the community leaders. Often an appointment was made with the leaders and once I had met the local leader, the task of selecting the participants would be assisted by the community leaders.

During the FGDs, the number of participants per group was between 6 and 8. These figures were ideal for the study because it helped the author to manage the group (Bryman, 2001). However, since most of these discussions took place in public places and participants' homes, there was often a snow ball effect. That is, there were often more participants up to 12-15 people in the groups because of the nature of the African social lives where interactions with individuals are open and unlimited. As an interviewer, even though I saw these numbers rising I could not stop the individuals joining the group for the discussion. Doing so, to the community, would be seen as

disrespect. In any case, the inclusion of these 'uninvited' individuals often did not disrupt the process, rather contributed positively to the discussion. From my observation, the more people joined in the more the discussion became lively as malaria was seen as an important health problem not only for some people within the community to be concerned about, but also for all the community members. These methods were employed to derive the various experiences of the interviewees and to have a better understanding of the complexities involved in policy process.

Generally, prior to the interview, the participants were made to be aware of the reason for conducting the research. Explicitly, the discussion often started by explaining what the meeting was all about and how long it would take. Also, the participants' voluntary participation was first further explained including the confidentiality issues involved. The groups were told about their rights of which among them was that if they chose not to participate, they had the right to stop and they could withdraw from the study at any time. In this way, the group would be told, taking part in the study was to be considered as voluntary. Furthermore, the participants were assured of their confidentiality and the questionnaires were only identified by study numbers. Throughout the group process some ground rules were initiated. For example, participants were asked to be polite to each other and the groups were told that each participant was free to contribute equally. This allowed me to cope with any member who began to dominate the exchange. The members were questioned on challenges facing the community with regards to their participation in the control policy making process.

During the discussion, all the questions were related to the prepared themes on three main issues associated with malaria control activities and these included: community members' roles; the level of their participation, and barriers and potential enablers to participation. In most cases, where interviewees talked about general issues on any of these, (e.g. barriers) I asked them to give a precise example to elicit the accurate nature of what they intended to put across (Weiss, 1994; Kvale, 1996). For example, one

interviewee argued that one of the problems of lack of community participation was the tradition, which to me was too broad to understand. However, when she was further asked to be specific, she then talked about the traditional role of men as decision makers give the women less chance to participate. Besides, I also adopted what Kvale (1996) calls 'interpreting as you go' questions (p.14) especially in the later interviews. This means I tried to ask the interviewees' questions like '*so just to clarify, what you just said is ...?*'. I also used a technique of 'markers': which means returning to particular feelings that were brought out in one instance to elaborate another (Weiss, 1994). For example, there was a discussion on the roles played in outreach services, and in the course of that one interviewee talked about the role the community played in environmental cleanliness. Here I had to ask the participant to hold that view until we finished the discussion on outreach services. After that I came back to him to bring that issue again and then asked the rest of the group if they could comment on that role.

Over all, I found the FGD to be important because it provided a chance for community members themselves to probe each other's reasons for holding a certain view (Bryman, 2001; Stewart et al. 2007). This was in contrast to the normal individual interview where the interviewees could have a particular view without any challenges. During the FGDs, individuals could answer in certain way, but as they paid attention to others' answers, they often either agreed with them or disagreed with their views. Through this approach of allowing individuals to argue with each other, a more realistic account of what the participants thought about the problem was achieved. Hence the FGD did provide more valuable data and corroborated the perceptions of individual interviewees which consequently made the quality of the information that was collected richer.

In addition, through the FGDs, I was able to have access to information relating to issues which the participants considered to be essential (Bryman, 2001). In most cases, I had never expected some of these issues. For example, it was in this FGD that I realised how much the government's policy of National Health Insurance Scheme had discouraged

most community members from going to hospitals. They explained that because most hospitals were either not paid by the government or delayed the hospitals' payments, the health workers often preferred to treat those without insurance because they paid directly after treatment. This issue was not envisaged to have been a factor but in the end was shown to have significant implications for the research objective: community participation. To these interviewees, it served as disappointment to most community members which also impacted on their motivation to participate in health issues like malaria.

In short, despite the fact that FGDs method has been criticised on the grounds that it: "*tends to create a forum for collective conversations which reinforce consensus rather than allow space for more diverse or contradictory truths to be expressed*" (Neal and Walters, 2008, p. 291), this was not the case throughout the discussion in this study. Each person's view was quite different, and I never lost some of that difference to the group consensus or the loudest people. The simplicity and the straight forward nature of the questions proved very significant and I never influenced nor was aware of the influence of the group on the individual's answers provided.

In bringing the FGDs to a close, even though no incentives were provided at the beginning, in several instances, at the end of the discussion, participants were given a bottle of soft drink like coke. The buying of these soft drinks was just an appreciation for their time spent to answer the questions and it was often done at the end of the interview so as not to appear as an incentive to participate in the study. The respondents were made to be aware that it was an initiative taken by the author (interviewer) but not an obligation which had to be done.

4.3.2 Quantitative (Survey) method

With regards to the quantitative method, the survey was conducted using face-to-face interview method between November 2009 and Jan 2010. The respondents were the community members, government workers and non-governmental (private) sector

workers. In the study area, as a result of practically the absence of individual's postal mailing addresses or system, coupled with low levels of literacy amongst most of the community members, there was a need for an interview-administered procedure for collecting the data. Therefore I had to read the questions to the respondents and accordingly completed the survey based on verbal responses. The use of this approach did help me to finish the whole survey within the three months schedule. Moreover, not only did it allow me as an interviewer to judge the respondents' reaction, commitment and trustfulness in participation, but it also gave me the chance to make certain questions clearer to the respondent in the survey.

The survey questions of the study were on the participants' opinions on the level of integration amongst the various institutions involved in malaria control programme activities. Also, the socio-demographic characteristics of the respondents, such as age, gender, education, and occupation were also included in the survey (See Appendix 3 for the questionnaires relating to socio-demographic characteristics of the interviewees). With regards to the involvement, individual institutions were asked to rate their level of involvement in the malaria control strategy of inter-sectoral collaboration on a scale of 0 (not at all aware) to 5 (full) collaboration. (See Appendix 4 for the sample of the questions relating to the extent of integration amongst actors involved in malaria control)

4.3.3 Non-participant Observation

Another method used to have access to data was non-participant observation. This kind of method involved attending and actively participating in work group meetings, forums, seminars or workshops where a number of discussions were held, contributed very usefully to getting insights into process or 'observations'. For example, while in Ghana for data collection, I had the chance to be part of one-week national health summit between 16th Nov- 21st under the theme: '*Going beyond strategy to action*' organized by the Ministry of Health. The summit included not only seminar lectures given by

officials from both government, NGOs and International Agencies, but also group discussions. In addition, in the same week, I attended Global Fund Five-year Evaluation study under the theme: *'The impact of collective efforts on the reduction of the disease burden of AIDS, TB and Malaria'*, organised by the Global Fund. In participating in these seminars, recordings were made on all the speeches made by the experts and notes were also taken. Although I was not one of the actual participants, I took the opportunity to have a lot of discussions with some of the presenters as well as participants who shared very valuable information on the issue of malaria.

In summary, the source of the information and data were varied but the main sources could be grouped into three namely: (1) interviewees (2) non-participant observation, and (3) policy documentary review. Among the interview groups were: (i) International agencies/donors (ii) NGO leaders or staff; (iii) Government institutions officials and other knowledgeable experts on the subject, such as academics/researchers, and (iv) Communities.

4.4 Data Sources

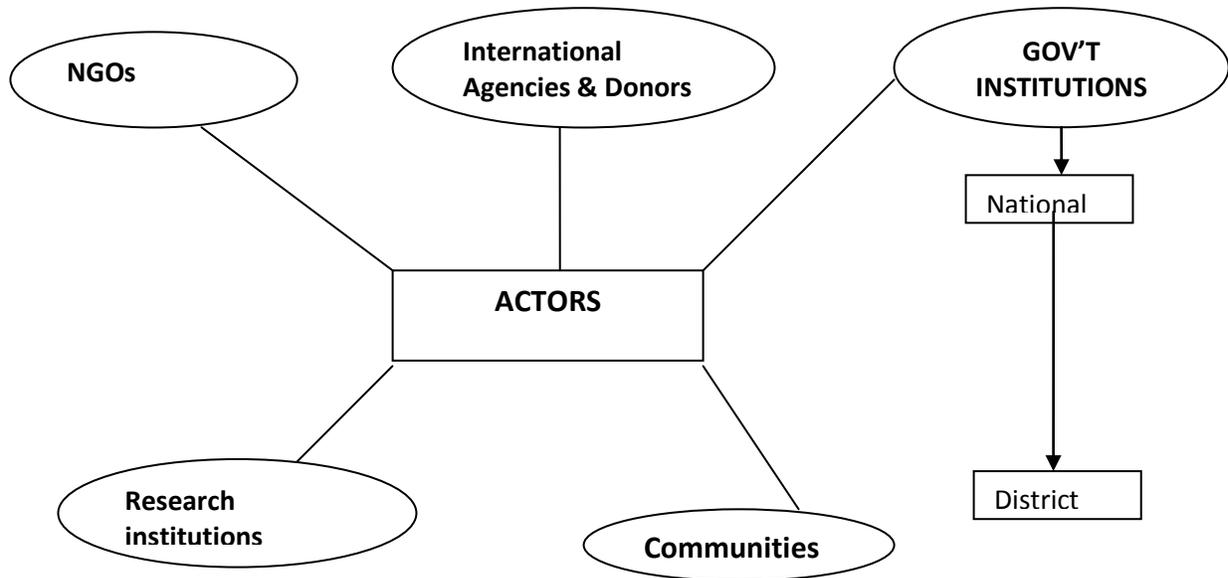
4.4.1 Target Population (malaria control policy actors)

The target population in this study is the policy stakeholders (actors). These stakeholder/actors are individuals and/or groups who are engaged in malaria control activities and have different responsibilities throughout different stages of the policy process. By virtue of their positions and their roles either within the government institutions or non-government institutions as well as local communities these individuals can influence the general policy environment on malaria control in either positive or negative ways. These actors included:

Government institutions; International agencies and donors such as the United States Agency for International Development (USAID), United Nations International Children's Emergency Fund (UNICEF) and World Health Organization (WHO), Non-Governmental Organizations (NGOs) such as Planned Parenthood Association of Ghana PPAG and

Mobilize Against Malaria (MAM), Research Institutions and the local Communities. The composition of the study population can be summarized in the Figure 4.1.

Figure 4.1: Targeted groups of policy stakeholders/actors



Source: Author's own design

The above figure illustrates the composition of the various actors/stakeholders involved in the malaria control. The government institutions comprise the national, regional, district and sub-district stakeholders who are officially under the control of the government. The communities include the people at the local levels working with the other stakeholders. They live within the influence of the policy of malaria control and are likely to be affected by management decisions or actions. The foreign agencies and donors provide substantial funding and technical assistance towards combating malaria, while NGOs could play a critical part in developing and implementing malaria control programmes, including a role in identifying "natural" community leaders (religious, social, and educational) and developing local health committees. Research Institutions

provide the critical scientific base for the development of intervention tools such as drugs, insecticides, vaccines, and diagnostics for malarial control in the country (MOH, 2005). The next section identifies and discusses the different communities involved in the study.

The total number interviewed were 110 excluding 55 members of the communities who took part in the focus group discussion on the challenges facing the communities.

Table 4.1: Interviewed Actors involved in Malaria Policy Processes at various levels in Ghana

	Frequency	Percent (%)
Policy Makers	14	12.7
Rep of Int Health Agency	3	2.7
Rep of NGOs	5	4.5
Civil Servants	43	39.1
Field Officers	17	15.5
Rep of Professional Association	14	12.7
Elected Community Members	14	12.7
Total	110	100.0

Source: Author's analysis of Qualitative In-depth Interview Data, 2010

Table 4.1 shows the interviewees including policy makers, civil servants, field officers, NGOs, representatives of the professional associations, representatives of international health organizations and elected representatives. The interviewed international actors included: the officials of WHO, USAID and UNICEF. The next phase of the data collection includes different community participants (e.g., community members)

4.5 The study context

The study region, the Ashanti, is one of the ten regions in the Republic of Ghana. It is worth mentioning that the choice of Ashanti region was for practical purpose. In fact, while all the regions in Ghana are malaria endemic regions and therefore any of them could have been chosen, the selection of Ashanti was based on various reasons. These

include practical considerations, such as availability of background information, familiarity with the local language, an available research network and opportunities for cooperation from the policy actors.

4.5.1 Urban and Rural districts' communities within the study region

The fact that this study focuses on both rural and urban settings for comparison means that there is a need to explain what these settings mean in the context of sub-Saharan Africa (SSA). According to Silimperi (1995), in SSA, the categorisation of urban environments is by no means consistent. While certain countries may define urban communities by physical borders and population size, others may define them based on geographic limits connected with administrative roles or governance. However, in this study, the urban community is defined according to the census or statistical definition of an urban centre in Ghana which is any settlement with a population of 5,000 or more persons. Currently, it has been noted that more than four out of every ten Ghanaians live in a city or town of more than 5,000 people and “if current trends continue, by the year 2020 more than half of all Ghanaians will live in urban areas” (Nabila, 1988, p. 1). Whereas only 9.4% of the total population lived in urban settlements in 1931, this population has grown to be 43.9% in 2000, (Songsore, 2003a).

In the case of the definition of a small rural community, it can be defined as a population of less than 3,500 people. Based on this definition, it was appropriate to choose rural and urban districts as case study areas in Ghana. With the rural district, Ahafo Ano South district, (see figure 4.2 below for the area map) which is one of the least developed districts in the region (MOH Regional Report, 2008) was selected. The population is made up of mostly farmers who, in addition to subsistence incomes from cash crops, often have to depend on remittances from close relatives working in the nearby urban centres. The district occupies a total land area of 124km square and its capital is Mankranso. It is sub-divided into six districts as figure 4.2 in the next page illustrates. (see also Table 4.2 below). Table 4.2 shows the population distribution in the

district. It has a total of 174,612 but with an adult population of approximately 100,000. According to the district’s annual report (2008), the adult literacy rate is 41.1% with only 24.8% of the population having secondary school education and 80.9% of its population having a primary school education. To put it into national context, the district literacy rate of 41.1% is below the national literacy average rate of 57.9% (Demographic Health Survey, (DHS) 2003)

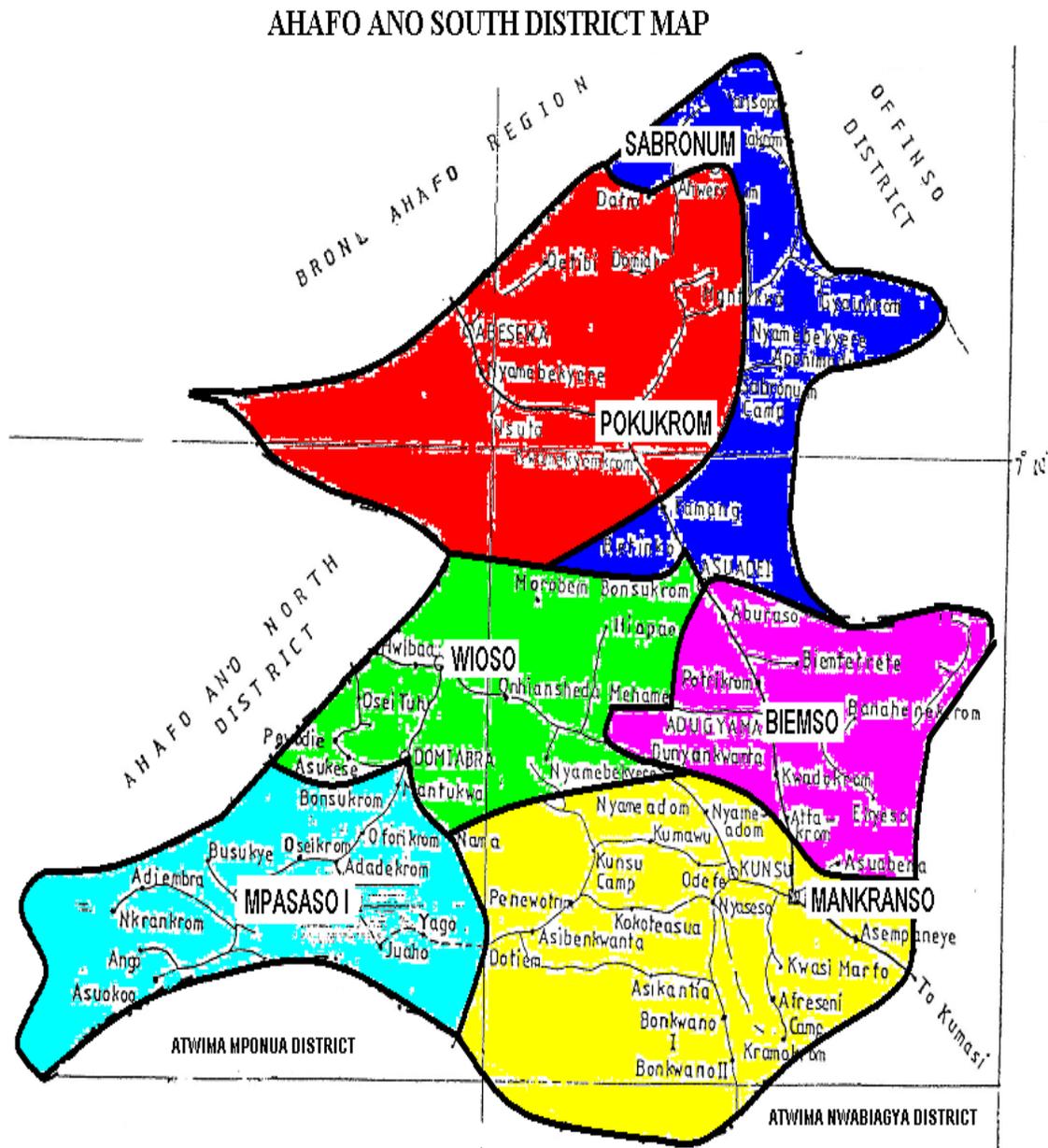
Table 4.2: Population Distribution per Sub-district Health Areas – 2008

Sub-Districts	Population
Mankranso	35,621
Pokukrom	32,129
Mpasaso	31,430
Wioso	30,033
Sabronum	25,319
Biemso	20,080
Total	174,612

Source: District’s annual report (2009)

In terms of occupation, about 80% are farmers as against 56% of the national labour force that is engaged in farming such as cocoa, vegetables, plantain and maize farming. It has been noted that the rest of the community are made up of petty traders, chain saw operators and civil servants, (Annual Report, Ahafo Ano South district, 2009).

Figure 4.2: Map of the AAS area and its sub-sub-districts where the study was conducted.



Source: Ahafo Ano District Annual Report, 2008

The selected urban district was Kumasi Metropolitan Assembly/District (KMA). According to the District Annual Report, (2009), the city is 150 square kilometres in size. In terms of population, it is the largest of the 27 districts in the Ashanti Region. It has an estimated population of 1,529,151 and the adult population is 750,000 (Annual report,

KMA, 2009). Kumasi is a cosmopolitan city with trading being the main occupation of the inhabitants. There are six sub-districts with 213 communities in Kumasi as Figure 4.3 illustrates (see table 4.3 below).

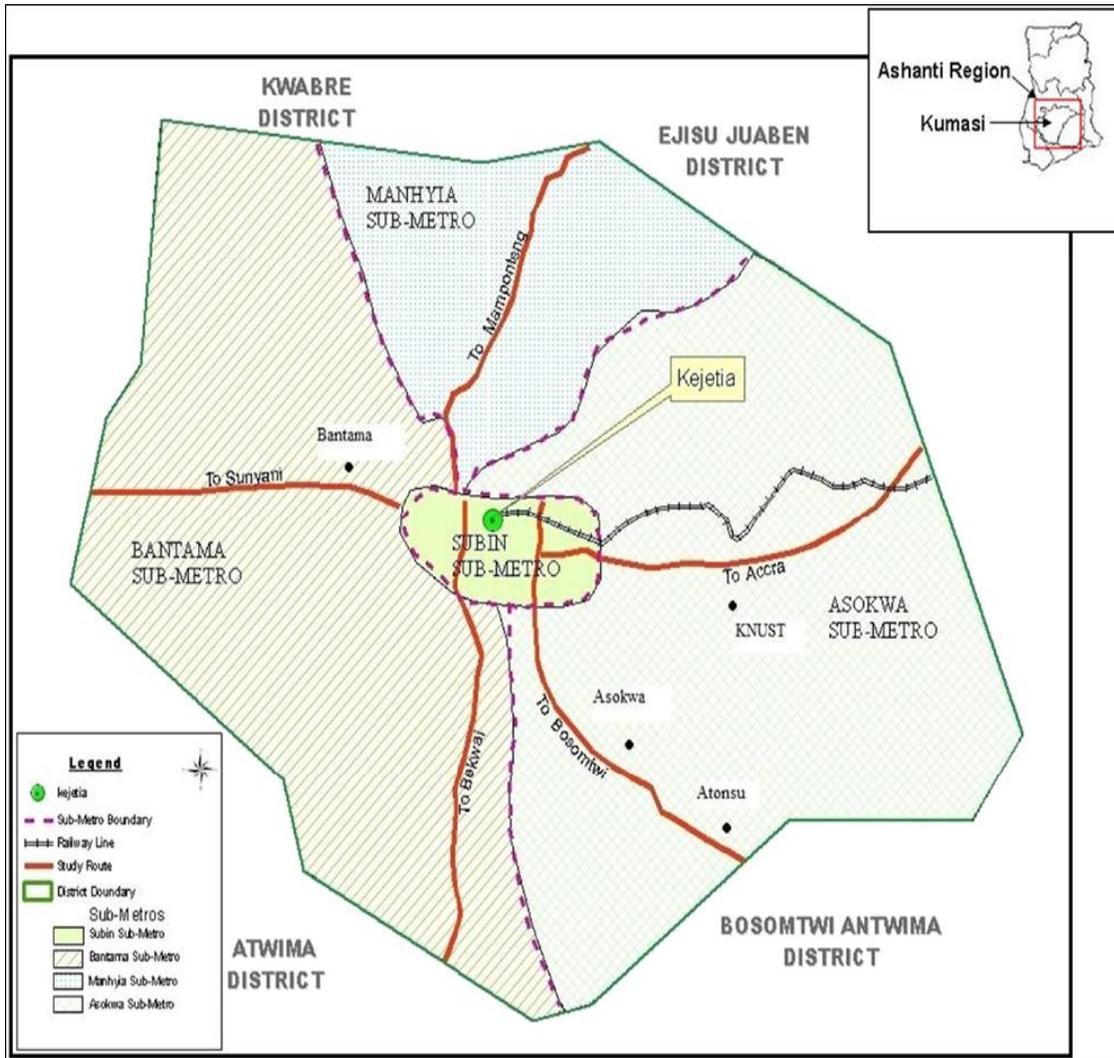
Table 4.3: Population Distribution per Sub-Metro Health Areas – 2008

Districts	population	% of the population	Nr of Communities
Asokwa	463,333	30.3	56
Bantama	370,055	24.2	50
Manhyia South	284,422	18.6	59
Manhyia North	244,664	16.0	25
Subin	166,677	10.9	23
Metro	1,529,151	100	213

Source: KMA annual reports, 2009

The number of inhabitants with formal education includes: 26.1% for primary; 44.4% for middle or Junior Secondary School (JSS), 23.5% for Senior Sec School (SSS)/Vocational or Technical or Post SSS and 4.4% for Tertiary (District's Annual Report, 2009)

Figure 4.3: Map of the KMA area and sub-sub-districts where the study was conducted



Source: KMA Annual Report, 2008

4.6 Field work procedure, data collection and analysis

The field preparation and data collection processing covered a period of 12 months from March 2009 to March 2010. The timeline of the main field activities is presented in Table 4.4

Table 4.4: Timeline for field activities

Time	Duration	Major activity
April – August 2009	4 months	Field preparation and design of questionnaires
September -October	1 month	Application for ethical approval
November 2009-Jan 2010	3 months	Data collection (both qualitative and quantitative) including 1 day pre-test of questionnaire
Feb 2010- June 2010	4 months	Data entry and editing and transcription of interviews

4.6.1. Questionnaire and its pre-testing

The questionnaire contained both personal interviews and surveys concerning the extent of community participation in the process and the challenges involved.

Before the questionnaire was implemented in the field, a pre-test was carried out to test the content for consistency and validity. This was done with the aim of knowing if respondents “comprehend questions as intended...and whether questions can be answered accurately” (Dillman 2000, p.142). It was also to test how long it would take each participant to answer the questions, especially in their own language and it also afforded the opportunity to become more familiar with the questionnaire and to be able to know which area needed improvement during the interview. The pre-test was done with 10 participants and it took place in communities which shared relatively almost the same socio-economic characteristics (i.e., education and occupation) as the ones that had been chosen.

The pre-test exercise revealed two unanticipated problems associated with certain questions' wording. For example, one question asked respondents to indicate their age and all participants indicated that this would be difficult to answer and would therefore be left blank since most of them did not know exactly when they were born. They suggested that asking an age range would be more useful so the wording of the question was changed to that effect. Moreover, two participants who took part in the pre-testing exercise also made mention of some of the wordings used in the questionnaire. Among these were "infrastructure" and "information technology". They all thought they should be simplified to avoid relatively lower educated members of the community from being 'scared away' by such unfamiliar words which might appear too technical for them. As a result the wordings were changed to "road net works, transport and internet. It was after these pre-test interviews that the actual data collection began. However, it is worth stating that I did not include the results from the pre-test with the results of post-test interviews.

4.6.2 Actual data collection

The sample size for this study population comprised of both the rural and urban. There were a total of 165 participants with 85 from urban of (KMA) and 80 participants from rural (AAS). The allocation of the sample size of 165 was considered to be financially practicable and it was also based on the amount of time available.

All the interviews were conducted at either the respondents' home, office or in a public place/community's gathering centres depending upon where the respondent wanted it to take place. The language used during the interviews, depending upon the respondent's level of education, was either English or Akan, but it was mostly the local language, Akan. This is the most commonly spoken language in the country (almost 90% people can speak and understand Akan). Therefore, interviews with the community members were conducted in their own language. This prevented misunderstanding of the questions, and also encouraged all the participants to speak freely and convincingly.

Prior to all these interviews, appointments were made with the interviewees so as to make it convenient for the participants and to maximize response rate. In the rural communities, for example, because the participants were mainly farmers, some interviews were held late in the evening and at times the days that they did not need to work. These times were often chosen by the participants and I often accepted them as long as it did not compromise the author's and the interviewees' interests and security (e.g, night time). In one community, the day was Tuesday, while the other day was Saturday. These days, as traditionally believed, used to be the holydays for their gods and therefore every community member has to be home without any work on the land. On the other hand, in the urban centre, it was hard to get their cooperation during the week since almost everybody in the community was busy buying and selling things. It was therefore only on Sundays that the community members could be reached both at home and at public places. Thus, I had to work throughout the week in order to enhance the chances of reaching all the targeted groups. In this way, while Monday to Friday was scheduled to meet people who work in the offices as well as meeting some communities in the late hours, the week-ends were seen as primetime for doing interviews in some communities. However, survey was not the only method used in conducting the study.

The field interviews were conducted by the author, with the help of one local man who has just finished his senior secondary school (SSS). Although he had not enough experience in qualitative research, the assistant did not require extensive training in being part of the research process during the qualitative interviews. The task of this person was to help with additional notes taking during the interview which helped me in better interpreting some of the most difficult words of the local language. The respondents were located with the help of community leaders and almost all the interview took place in respondents' office, community centres or home with the exception of five that were conducted in the respondents' business premises which were also not far from respondents' houses.

Topics covered in the interview guide of formal interviews were, in line with my overarching research questions:

1. *What is the extent of malaria problem and what are the key contextual factors contributing to government inability to effectively control the disease in Ghana?*
2. *How do the malaria control policy making processes of ISC take place in Ghana?*
3. *What roles do the communities play in malaria control programme activities in Ghana?*
4. *To what extent are the local communities allowed to participate in the malaria control policy strategy of ISC policymaking processes in Ghana?*
5. *What are the factors (barriers/enablers) that have undermined or potentially facilitated the successful working of community participation at the local levels (both rural and urban) in malaria control programme activities?*

All the interviews were audio-taped with the exception of six individuals' interviews. These interviews were not audio-taped because the respondents refused to the interview being recorded, even though they did not disagree to notes being taken. Most of the interviews were conducted in Akan, the local language, with the exception of 8 interviews where the interviewees felt at ease having the interview in English. This occurred in cases where the interviewee preferred to speak English rather than the local dialect because either the respondent did not properly understand the general local language of Akan, or did not feel comfortable to speak the local dialect. Thus, the interview process was completed within the allocated time schedule which led to the next phase of the data collection, the focus groups

4.6.3 Processing the in-depth interviews (*data analysis*)

Having obtained all the data, the processes and procedures of shifting from the qualitative data that have been collected into some form of explanation, understanding or interpretation of the people and situations under examination started (Gibbs, 2002;

Babbie, 2003). This implies getting grasp of the importance and figurative content of qualitative data (Somekh and Lewin, 2005).

The analysis of the data began in the same period as the collection of the data till the time that the data had been finally collected and collated. This was possible because each time I completed an interview as well as the FGDs, I would write down my impressions and reflections in my research note book. In this sense, it can be stated that during the field work, reviews of data took place on a daily or weekly basis depending on when the next schedule of interviews would take place. Often, at the end my fieldwork, I would transcribe interviews conducted and compiled the initial categories or list of important 'concepts' that emerged from the data. This was done because I wanted to ascertain and validate some of the main issues while still in the process of data collection. In reality, identifying the main themes was less problematic in this study because, on the basis of the study objectives, I had all the themes such as roles, the barriers and potential facilitators around which the questions were asked. As I transcribed, I would also go through my notes and if I found the need to follow leads, I would do so without delay.

In analysing, I mostly used an inductive approach whereby, as stated in the third section of this chapter, I allowed the data to emerge from the interviews without any interference from me. This approach, in taking a traditional, non-computerised approach to data analysis, helped me to immerse myself in the data while frequently going through the transcripts and field notes. This approach gave me an in-depth knowledge of the data. In general, I analysed the qualitative data manually because I wanted to be more involved in the analysis and get 'closer' to the data, becoming used to the participants' words and ideas. Thus, I did not use computer analysis in this study because I wanted to avoid losing any contextual underpinnings of the study findings. This was more important considering the fact that most of the transcribed interviews

were more understandable in the cultural context of some of the Ghanaian communities.

Overall, I followed the guidance of Ritchie and Spencer, (1994) inherent in the 'Framework' approach¹⁰, which is systematic and has a well-defined procedure. In using this framework, I found it flexible during the analysis process because it allowed me to combine both data collection and data analysis during the collection process, although I could have finished collecting all the data before coding (Ritchie & Spencer, 1994). I also chose this approach, rather than the full, grounded approach as developed by Glaser and Strauss (1967), because I had no intention to develop any theory out of this research.

(i) Data Coding

The coding started with each of the transcribed interview's documents having community type/name and the selected theme in addition to an interviewee's number. These were put against the document. For example 'AASR1' would be used for an interviewee number 1 on 'Role' question from 'Ahafo Ano South' district. The number was allocated sequentially starting from the first interview transcribed. Also, in coding, two matrices were devised often on two separate sheets, one for the health officials and the other for the communities' interviews in urban district and the same applies to the rural district. On each matrix, comprising numerous squares, the interviewees' pseudonyms (false names or in my case, numbers) were inscribed vertically, and the abbreviated version of the interviewees' answers to the questions was recorded in the

¹⁰The 'Framework' approach has a five-step process of data analysis. The analysis begins with familiarisation with the data set (the interview transcripts, field notes and documents collected) followed by the identification of a thematic framework or development of an initial coding system. Indexing of the data collected then takes place using this framework after which the data is charted by a process of abstraction and synthesis that leads to "[searches] for structure rather than a multiplicity of evidence" (Ritchie and Spencer, 1994: 186). Finally, mapping and interpretation occurs. This method emphasises the interaction that occurs between the researcher and the data in order that the nuanced and complex nature of the data is emphasised.

corresponding squares horizontally (See Appendix 5A, 5B and C for examples). Coding it this way was helpful because it helped in providing an instantaneous inter-interviewee and intra-interviewee comparisons and contrasts (Bradley et al. 2005; 2007).

In spite of the fact that many commentators have recommended a number of readings of the data with an emphasis on different types of code (Coffey and Atkinson, 1996; Strauss and Corbin, 1998; Mason, 2002; Richards, 2005), in this study, the central focus was on content and analytical coding. This means that I was frequently interested in *“what sorts of things the people are talking about”?* and secondly *“what is the significance of what the people are saying”?* In all these, I considered not only the frequency of the phrases referring to a particular theme (e.g. barriers) but also their association or links with the theme. This is because according to D'Andrade, (1991) *“ anyone who has listened to long stretches of talk, whether generated by a friend, spouse, workmate, informant, or patient, knows how frequently people circle through the same network of ideas” (p.287).*

In addition the directional views of the interviewee on the issue under discussion (i.e., positive, negative, or indifferent) as well as the interviewee's characteristics such as age and gender were taken into consideration. Each of these had its own colour for highlighting the statement. In all, I usually regarded more than two phrases with similar meaning that frequently appeared on an issue or theme to be a salient point in the minds of interviewees (Strauss, 1992) and therefore needed consideration. However, it must be said that the knowledge of the communities on certain themes varied and therefore there were themes that had more phrases than others. In that case, the frequencies of phrases were put into their context. For example, on the issue of barriers, a lot of people considered poverty as the main barrier and therefore more phrases frequently indicated that while relatively few talked about disillusionment.

Each interview was coded at least twice, with the first reading focusing more on the content of the interview and as I became more used to the interview materials, I then

paid attention to the analytical coding during the second reading. I also used the second reading to make sure I did not miss any important code in the first time reading. In coding, although I might have had a set of a priori themes, I saw the need to maintain an open mind and therefore did not force the data to fit the a priori themes (Ritchie & Spencer, 1994). Rather, with the emerging categories, I tried to find out about their meaning, their significance and importance of issues as well as about direct or indirect relations amongst ideas. In all, I made sure that the original research questions were being fully addressed.

Initially, when the two matrices that classified data from officials and communities each district (rural and urban) were examined together, a number of categories and sub-categories with regards to the roles, barriers and potential enablers to participation were identified. However, as the transcripts, summaries and the matrices were studied again further links were found amongst the various categories and sub-categories. Such links led to a reduction of a number of the various categories and sub-categories as they were thus consolidated to result in 4 and 10 (under roles); 5 and 11 (under barriers); 3 and 3 (under enablers) categories and sub-categories respectively. A spider diagram was produced at this stage to make sense of the links between the themes (see figures 4.4; 4.5 and 4.6 respectively).

At this point, the transcripts were perused one more time and illuminative quotations were highlighted and coded using the categories and sub-categories that had been identified. A number of these quotations were chosen to be used in subsequent writings. Overall, I did not have any specific expectations for the data before the analysis started. Rather, I expected that categories and sub-categories related to initial themes would emerge from the interview materials through inductive content analysis and the constant comparative method. Ultimately, through the coding, I was able to gain an understanding of the inquiry issue, how interviewees perceived malaria control policy

process, their roles, the extent of their participation as well as the barriers and potential enablers to participation.

Fig. 4.4: The most important role(s) perceived to be played by community members

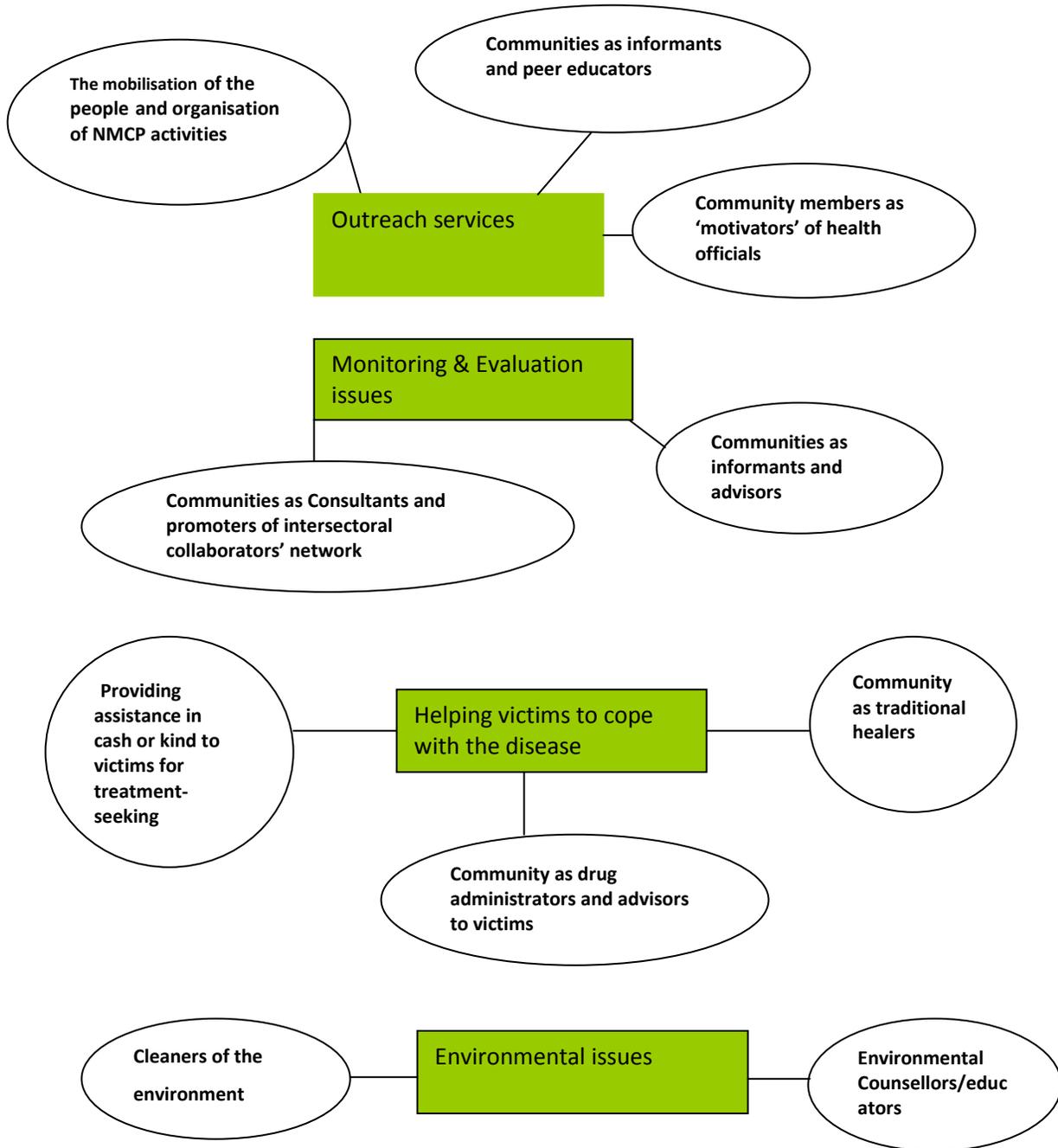
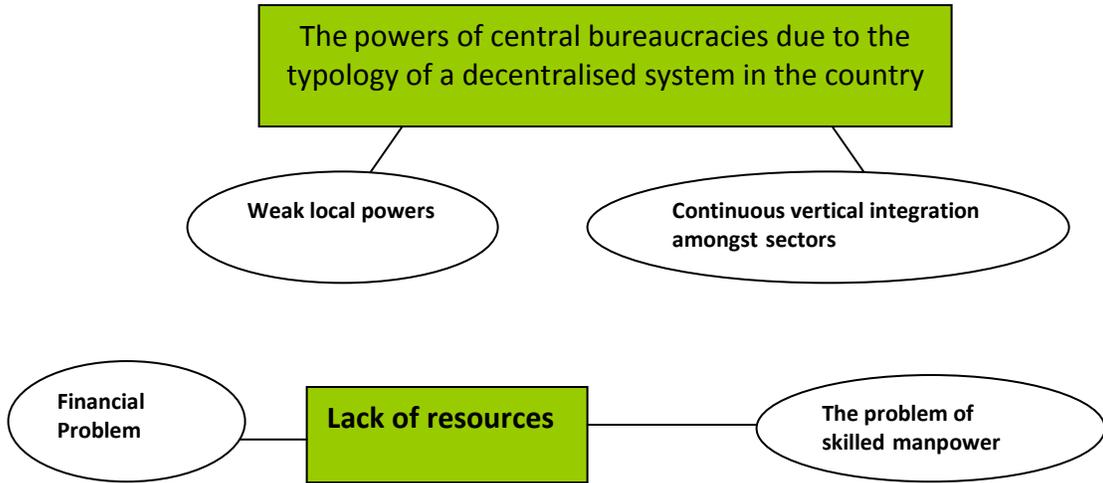


Fig. 4.5: Barriers that undermine community participation

(i) Barriers as perceived by health officials



(ii) Barriers as perceived by the community members

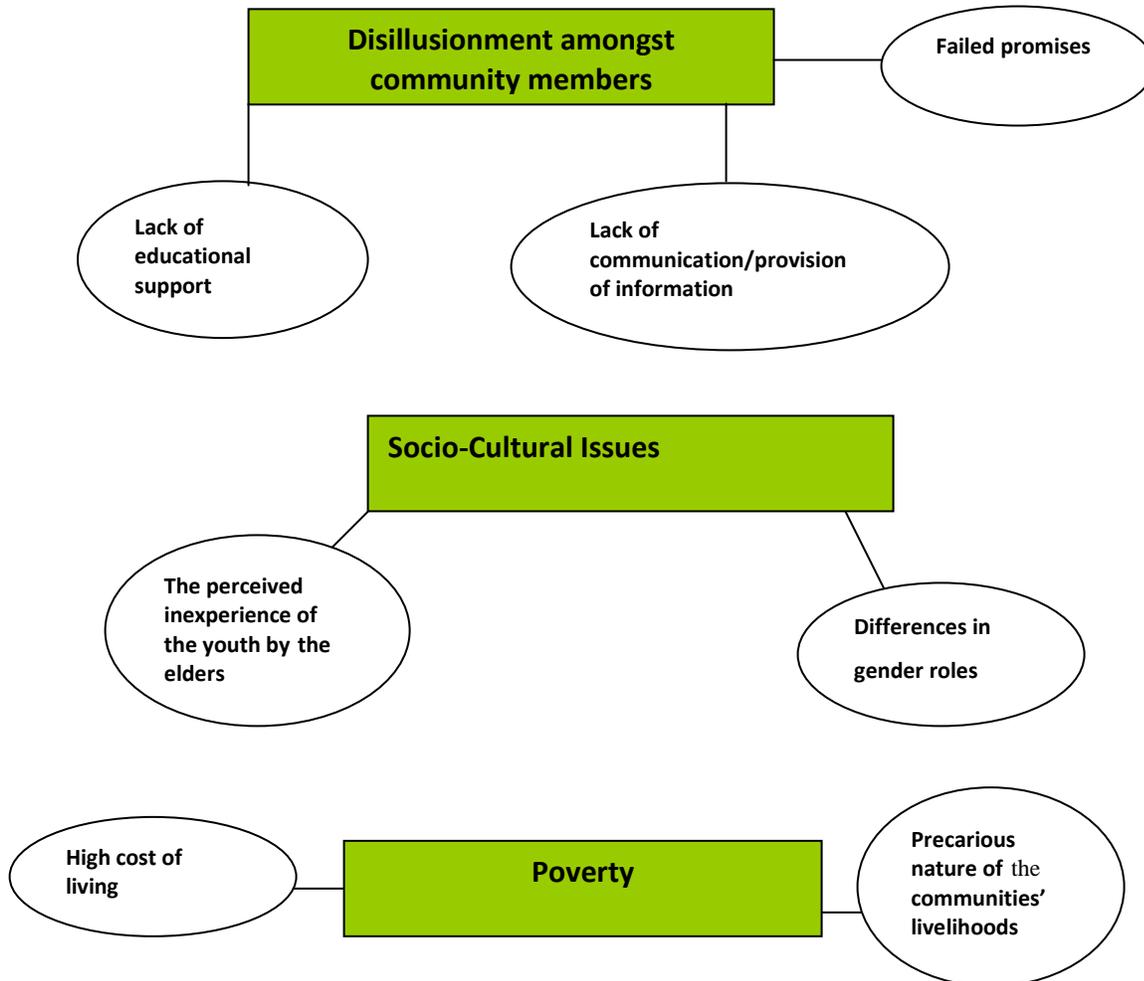
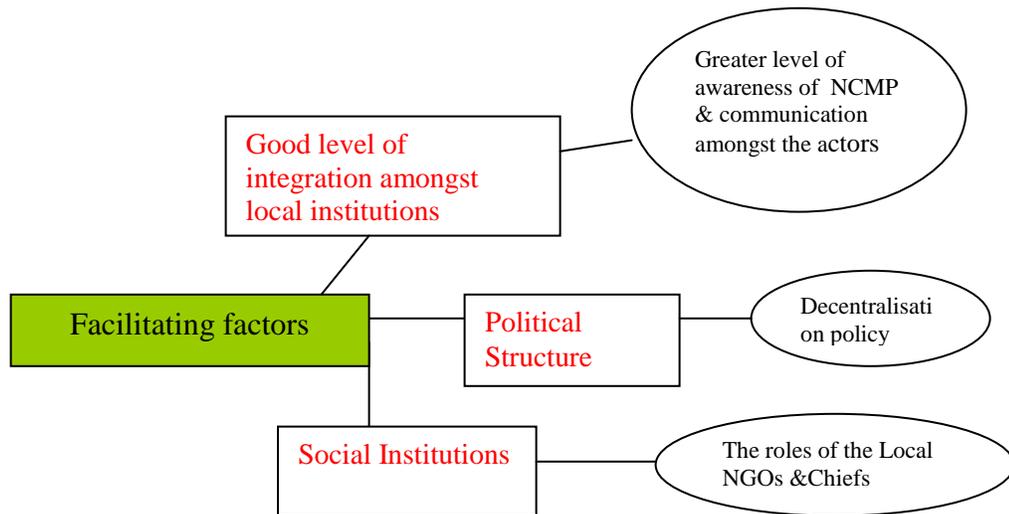


Fig. 4.6: Potential Facilitating Factors to Community participation found in the study sites



4.7 Data quality

In a qualitative research study, it is often said that the quality of the study depends on honesty both on the part of the interviewees and interviewer, (Davies, 2007). It was hard for me to be certain about the truth in the answers interviewees were giving on their behaviour or beliefs and in addition to the survey or interviews, observational studies were also carried out in an attempt to corroborate their response. This allowed me not only to study what the community members have said, but what they have actually been doing in practice. For example, in certain areas participants stated that community helped the health authority's efforts in controlling malaria through weekly general cleaning of the surrounding including the gutters. With this claim, to ensure the truth of what was said, the researcher and the assistant went through the village to observe it by themselves as illustrated by the photos 4.1 & 2.

Photo 4.1: A pit meant to contain bath-water at the rural areas



Source: The author's own photo taken at a village in Ghana

The photo shows how ignorantly the communities' own activities create fertile ground for mosquitoes to breed. It is a pit usually dug at the back of a house in rural areas in Ghana. In fact these are often done by those who could have money to afford buying cement bags and sand to be able to cement these holes, otherwise these waste waters are often left to run into the streets. Having done this, the individuals wait until it is full before any member, mostly women, in the household drains it but the number of days it takes to become full, according to one interviewee:

“depends on the number of people in the house and how many of them will like to take their bath everyday. So it can take weeks” (Nr 96).

Considering that it takes as few as 7 days in warm weather for a mosquito to complete its life cycle (egg to adult), and each raft contains 300-400 mosquito eggs, such pit could produce 1000s of mosquitoes within a week.

Photo 4.2: A broken bridge which has ended up being mosquitoes breeding site



Source: The author's own photo taken at a village in Ghana

Another observation was a broken bridge which has become a breeding place for mosquitoes due to the stagnated water (pools). The cause of the pools was attributed to the rain, especially during the raining season and the problem of stagnation was compounded by the pieces of materials that usually fell from the broken bridge into the pools. This bridge is situated in one of the major roads that lead the district capital to the main farming zones (Mpasaaso) in the district. The author was told that the bridge has broken down because of its bad construction of the bridge by the contractor coupled with the heavy timber trucks which used the road. Consequently:

“ once the car gets here, especially during the raining season, all the passengers have to get down for the driver alone to drive the car through a path that have been made by the communities themselves around the bridge” (Nr 45)

Significantly, this broken bridge has not only become a source of mosquitoes' breeding site but also source of problem for communities to participate in policy process since travelling to and from the district capital has become difficult.

Aside with the personal observation, additional notes were often made after every interview about what was observed during the interview and checking it with the assistant, while taking into account the significance of original statements of the interviewees. Thus, even though most of what participants said might seem not to be believed, or contradict the author's expectations or assumptions, everything said was taken seriously.

In reality, taking into account the fact that some of the questionnaires were asking the respondents to think back over the past two years in order to answer the questions, the respondents' memories were well considered during the interview. The fact that some people, especially the aged, could easily forget their past and could not effortlessly answer questions made me to avoid asking for answers soon after questions had been asked. In fact, those found to have problems due to cognitive, visual, auditory and level

of concentration for one reason or another were once in a while, during the interview, assessed by asking them questions on their understanding of issues discussed. However, throughout the entire data collection, there were only five occasions when the author had to deal with, at least, one of such problems. More often than not, for every discussion on a question, I would usually ask questions to check on respondent's understanding, or concentration and attentiveness during the interview.

Finally, the results of the qualitative analyses were compared to the literature including the theoretical frameworks used. Also at the data entry stage almost all the answers to the questionnaires were double checked with the aim of confirming their precision.

In terms of credibility of this study, it must be said that I carefully designed and organised the data collection and data analysis procedures to ensure the credibility of the study results. In the first place, the timeline interview technique asked for the interviewees' own accounts of the significance judgments they place on the study topic at their own natural background instead of in artificial experimental settings. Secondly, the credibility of the study findings also was validated by the fact that most issues that were raised were mentioned by more than one interviewees and in more than one setting (rural and urban)

In general, this triangulation of multiple sources of evidence corroborate Yin's (1994) construct validity test. I also recognised the issue of the reliability of this study and certainly the use of the qualitative method is by nature a 'subjective' analysis which makes the generality of the study results problematic (Irvine and Gaffikin, 1996). However, Chapman (1987) argues that a failure to provide simplicity, generality and accuracy is expected and therefore should not be a cause for disapproval. Many commentators, out of many studies, have also come to a conclusion that there is no such thing as a fully objective piece of research and therefore the 'validity' of a piece of research is a matter of whether it is a reasonable account of what has been observed

(Kirk and Miller, 1986; Glesne and Peshkin, 1992; Douglas, 1985). This study has made all efforts to make sure that the validity of the study results and conclusions are based on a realistic account of the recorded interview transcripts.

4.8 Response Rate

Being aware of the need for a high response rate in research studies, various actions were taken to maximize it during data collection. In the first place, a good atmosphere of friendliness and rapport were created with the potential participants, while making sure that their rights of choosing to be part of the interview were respected and not infringed upon. Furthermore, at the beginning of every data collection, an appointment would be made with the key informant within the community and the motive of the study would be made known to such a representative. Choice was often given to such contacted person as to when it would be possible to have a meeting with him/her and if such a person chose to have the interviews done that day, his/her wishes were respected. Data collection took place during the month of November-January and as far as conducting interview in the rural areas was concerned, this was a good time. This was because this period was often marked the end of the peak period of planting season and almost 80% of the population who were farmers were always at home. Moreover, during the Christmas celebration days, not were most of the people at home but also usually easier to find them at the public places like the local market.

In contrast, the urban centres had this period as the best period for them to engage in their economic activities due to the Christmas and as such had less time to be home. To counter this, the data collection in the urban centres was mostly done after the Christmas especially first three weeks in January.

Following these measures and the fact that I was conducting this study by myself, there was a minimization of non-response rate. Overall, the response rate for the quantitative survey was almost 93.4%. The final result of interview for the 165 targeted participants

of 18 years or older is presented in table 4.5 below. (See the list of interviewees who were to be quoted in appendix 6).

Table 4.5 Final Interview results and response rate

Final result of interview	Percentage (%)
Completed interviews	91.4
Did not want to be interviewed	3.4
Failed to keep the appointment and whereabouts not known	2.7
Other reasons	2.3
Total	100
N	165

Source: Author's analysis of survey

From the Table 4.5 it could be seen that there were several reasons why people failed to response to the interviews. For instance, the non-response rate was 8.6% but 3.4% of the non-respondent had no time and therefore refused to be interviewed. Others wanted to be interviewed but never kept the appointment time. 2.7% failed to meet the interviewer either the expected participants had travelled that day or gone to farm or market. In all, only 2.3% had other reason such as 'I have not done this before'.

4.9 Research Ethics

4.9.1 Informed consent

In line with the University research ethics guidelines, informed consent must be obtained from research participants either verbally or in writing in all the interviews conducted, (e.g. survey, qualitative and FGDs). As a result, apart from obtaining the informed consent, the goal of the research study was explained to the participants, in addition to the way the research finding would be used. The respondents were also assured of confidentiality in the information they would provide. (See Appendix 7A for a sample of an information sheet). The estimated duration of the interview was made

known to them as well. During the qualitative interview including the FGDs, extra information was given to the selected participants. They were told that they had the option to refuse the recording of certain information and permission to write down certain things as the interviews went along was also asked from the participants.

Participants were subsequently asked to sign a consent form (See Appendix 7B for a sample of a consent form). However, even though some people who had agreed to take part in the study signed, the majority refused to sign the consent form. Their refusal was based on the argument that, first, they could not read and write and second, for fear of victimization, even though they had been assured of no such a thing happening to them. In all, merely 18% accepted to sign a consent form while 68% were willing to sign but refused due to their inability to read or write. The rest of the participants (14 %) refused for no apparent reason known to the author since they had no problem in reading and writing.

4.9.2 Confidentiality

In this study during all the interviews, maintaining confidentiality was paramount. Participants were given massive reassurance of confidentiality and that every piece of information they provided would be treated with respect and private by both the interviewer and the rest of the interviewees. Aside with that all the information that was identifiable such as names and other identifiers were taken away from the data and the interview transcripts. Coded identifiers were used both in the analysis and presentation of the results. However, even though confidentiality was given a priority, the environmental settings where most of the discussions took place such as the nature of housing which had no ceilings with many openings, could not provide a guarantee of by-passers not hearing what was being said. Indeed, the overcrowded and clustered structures coupled with the type of material used for housing pointed to the fact that non-participants could potentially hear and follow conversation taking place next door. However, although there was not any ideal setting or environment favourable for

ensuring that the discussion took place in confidence, there was not any issue that was too personal or sensitive to the participants during the data collection. There is therefore no reason to believe that the environment in which the information was gathered limited its value.

4.9.3 Research and ethical approval

This study was reviewed and approved by the Ethical Committee of the School of Social Sciences, University of Southampton. (See Appendix 8 for Ethical Committee's approval). Written permission letter together with the Ethical Committee's approval were presented to the authorities in Ghana (MOH) before the research was allowed to be conducted.

4.10 Summary of the chapter

The purpose of Chapter 4 was to describe the case-study methods used in achieving the aim of this study. The chapter has described the rationale for a case study approach, and justified the selection of both the rural and urban districts of AAN and KMA respectively as a case study sites. So far there have been several methods for data collection and analysis, including the policy document review, key informant interviews, snowballing and focus group discussions. There has also been significant background information regarding the case study context of two districts including the way the actual data were collected. The significance of this chapter is that it sets the context for Chapter 5 which describes the findings concerning the policy process of malaria control in Ghana as well as the rest of the chapters which examine the findings derived from the key informant interviews.

Chapter Five

Malaria problem and the control policy making processes of Intersectoral collaboration in Ghana

5.1 Introduction

The focus of this chapter is to present, out of the five key research questions, the findings to the first two:

1. What is the extent of malaria problem and what are the key contextual factors undermining or contributing to government ability to effectively control the disease in Ghana?
2. How do the malaria control policy making processes of ISC take place in Ghana?

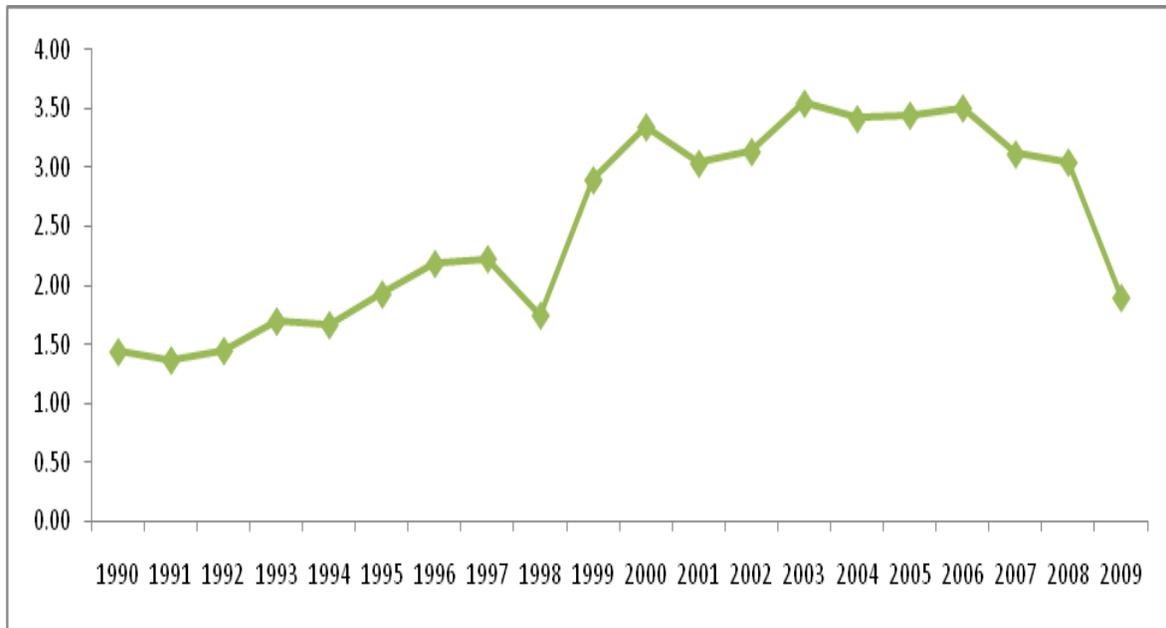
The chapter is an exploratory as well as descriptive and each question was examined differently. Drawing on materials collected in Ghana, these questions were investigated largely by the use of the official documents of Ghana. The first section explored the recent trends in malaria cases and compared it with the other diseases that make up the top ten diseases in terms of morbidity and mortality in the country. The second section also answered the second part of the first research question by examining both the key contextual factors which contribute to the government's inability to effectively control the disease and the facilitating factors that have contributed to the minimisation of malaria deaths of children under-five. The chapter ends with the third section which explored the processes of intersectoral collaboration (ISC) in Ghana.

5.2 Malaria situation in Ghana

Ghana is amongst the sub-Saharan Africa (SSA) countries that are most vulnerable to malaria. The disease is hyper-endemic in all parts of Ghana, with all the approximately 23.4 million population at risk and with transmission occurring all year round. Although a lot of efforts have been made in the

country in recent times to prevent and to control the disease, the problem of malaria is still persisting in Ghana (Adams et al. 2004; NMCP, 2007, WHO, 2006; MOH, 2008). Evidence has shown increases in malaria incidence rates from 1990 to 2006 as illustrated by Figure 5.1

Figure 5.1 Trends in malaria cases (in millions) between 1990 and 2009 in Ghana



Source: RBM/WHO/UNICEF 2010, (1990-2009)

Figure 5.1 presents changes in malaria incidence based on the number of malaria cases diagnosed each year. However, it must be kept in mind that these figures are facility-based and therefore may be considered not to represent the true picture of the problem of malaria. It is argued that the actual malaria incidence is often under-reported especially at the community level, particularly for rural areas where an unknown number of cases of malaria occur but not reported to public sector clinics (Aqyepong et al. 2004). The data also do not take into account situations where malaria was not the primary diagnosis, but where it might have been a compounding factor. It is also worth stating that malaria case detection and reporting are often incomplete due to the fact that surveillance and diagnostic systems are often not effective enough in Ghana. As a result, the real data on malaria and

parasitologic evidence of diagnosis are either not existing or less reliable (Asenso-Okyere et al. 1998; Agyepong et al. 2004). According to Agyepong et al. (2004), most diagnosis whether in clinics or at home is based on assumptions and therefore can be more precisely considered as:

“febrile illness presumed malaria rather than decisively as malaria” (p.162).

Furthermore, many cases are not diagnosed in medical setting. A number of morbidities, including fever episodes are treated at home and within the informal health services and networks in the community (Ahorlu et al. 2005). Such practices never become known to the formal health system and as such are never accurately registered by the health management information system (HMIS) and routine surveillance systems (Agyepong et al. 2004). For example, in Ghana when people contract mild fever, in a study in three districts in different regions of Ghana, Asenso-Okyere et al (1998) found that self medication was the first choice of treatment. The implication here is that the use of formal sector services is relatively low in Ghana.

Conversely, where the information becomes available to the authorities, there are often credibility issues emanating from lack of completeness due to missing information on specific questions as well as content errors. This is usually caused by incorrect recording of individual or household characteristics during data collection or data processing. Such limitations in the precision of data collections especially in rural areas, often lead to lower reporting of cases in malaria cases (NMCP Report, 2008; Agyepong et al. 2004). Thus, if under-reporting is taken into account, then it can be concluded that there are probably many more cases of malaria occurring in Ghana than those noted in Figure 5.1. In sum, it is fair to make an argument that there is often a huge gap between official numbers and the real figures which really reflect on the true nature of the problem.

However, until data collection is up to the international standard, Figure 5.1 will be taken to reflect the trend of the annual national malaria probable and confirmed cases between 1990 and 2009 in Ghana. It is a composition of aggregated malaria cases at the national level and was generated through Ghana surveillance systems

(RBM/WHO/UNICEF 2005). From Figure 5.1, it is evident that the rate at which malaria cases have been increasing in the early to the mid 1990s has been slower than during the later part of 1990s and beyond. For example, after an initial reported cases on 1.44 million in 1990, by 1997 malaria cases had risen to 2.23 million cases giving a general increase of about 79,000 cases over the seven year period (i.e. between 1990 and 1997). On the other hand, within a period of three years, (i.e. between 1998 and 2001) reported malaria cases have risen by 1.63 million cases. This is more than twice the figure in this short period compared to the previous seven years.

On a whole, considering only the trend in Figure 5.1, an argument can be made that in the last decades the control of malaria has not been sustainable. For example, since 1999, the extent of malaria problem has been increasing at a higher rate reaching its peak in 2001 and although from 2006 onwards there has been a steady fall, the extent of malaria cases has never got back to its original level. This assertion of unsustainable control of malaria becomes clear when compared with other diseases in the country.

5.2.1 Malaria compared with other diseases in Ghana

In terms of morbidity and mortality amongst the top ten causes of admission for all ages and under five children in the country, malaria is considered as the leading cause of admission as Table 5.1 indicates.

From Table 5.1, it can be noted that amongst the causes of admission in all age group, malaria is the first with the share of proportion being (32.9%) five times higher than the second highest, which is pregnancy and related complications (6.2%). Also, in the case of the under five children, malaria is still the highest (58.1%) and has its rate almost five times the second highest of anaemia (12.8%). In essence, when causes of admission is compared by age group, by far the highest proportional rate of morbidity can be found to be among children under five years of age with rates for these young children nearly double the rates of the older age group in the country.

Table 5.1: Top Ten Causes of Admission for All Ages & under-five children (2004)

All Ages			Under Five Children	
Rank	<i>Cause of Admission</i>	<i>Proportional Morbidity Rate (%)</i>	<i>Cause of Admission</i>	<i>Proportional Morbidity Rate (%)</i>
1	Malaria	32.9	Malaria	58.1
2	Pregnancy and related complications	6.2	Anaemia	12.8
3	Anaemia	5.3	Diarrhoeal	5.1
4	Diarrhoeal Diseases	4.2	Pneumonia	3.3
5	Hypertension	3.1	Malnutrition	1.1
6	Hernia	2.5	Septicaemia	0.8
7	Gynaecological conditions	2.3	Thypoid fever	0.8
8	Pneumonia	2.0	Upper respiratory tract infections	0.6
9	Typhoid fever	1.9	HIV/AIDS related conditions	0.5
10	Road traffic accidents	1.7	Injuries	0.4

Source: Centre for Health Information Management (CHIM) & Policy Planning Monitoring and Evaluation (PPME) - Ghana Health Service (GHS) (2005)

The same can be said to be associated with the top ten causes of hospital deaths for all ages and under five children. In both age groups, malaria is still the highest cause of death as Figure 5.2 and 5.3 demonstrate. From these figures, it can be noted that the groups most affected by malaria in the country are children under-five years with a proportional mortality rate of over 20% whilst that of all ages is little over 13%.

Figure 5.2: Top Ten Causes of Death for All Ages in Ghana (2005)

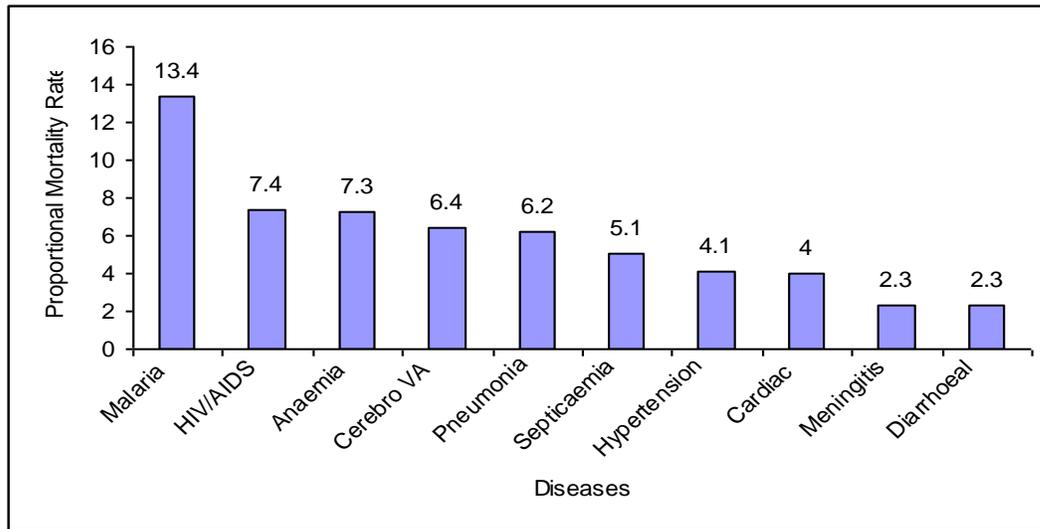
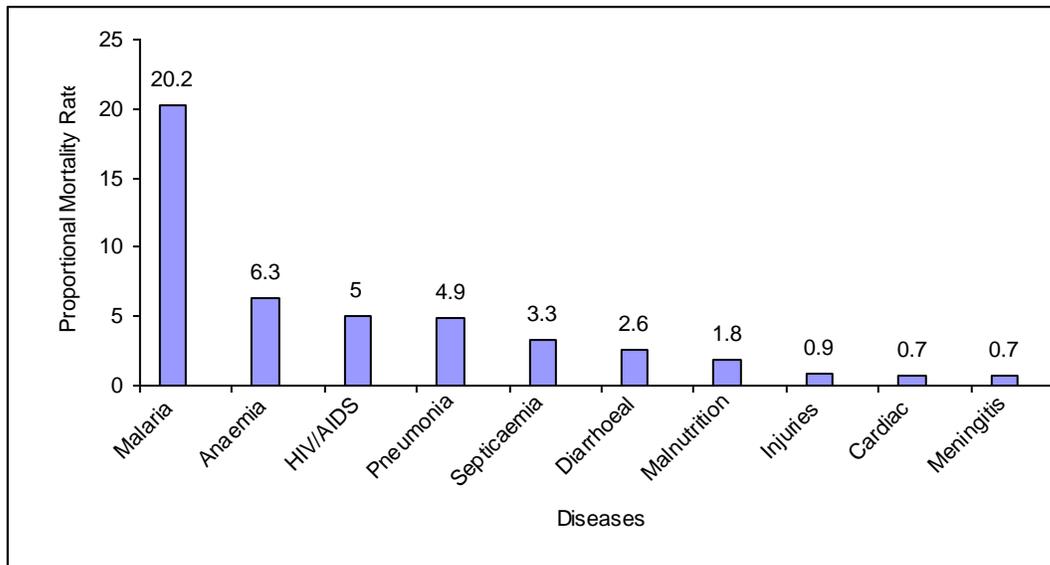


Figure 5.3: Top Ten Causes of Deaths for Children Under 5 Years - National (2005)



Source: Centre for Health Information Management (CHIM) & Policy Planning Monitoring and Evaluation (PPME) - Ghana Health Service (GHS), (2005)

However, although malaria is the leading cause of all these deaths, it is worth stating that there are many reasons that possibly can explain why other killer diseases in the country are causing relatively small proportion of deaths, particularly among children under five years of age. First, evidence has shown that there has been more improvement in vaccine preventable diseases such as measles and polio including high coverage of selected major child survival interventions such as immunization. Vitamin A supplementation, for example, has also achieved almost full coverage (99.6%) in Ghana in the last decade, while between 1988 and 2003, the percentage number of children who had received all vaccinations against all the six most killer diseases of children increased from 47% to almost 70% (WHO, 2006; MOH/GHS, 2005). Secondly, mothers who have been receiving antenatal care and have had skilled attendance at delivery have been continuously improving over the last two decades. Antenatal care, for example, increased from 82% to 92% during the period of 1988 and 2003. In contrast, chloroquine which was the main source of treating malaria in the past years has been ineffective in recent times due to malaria resistant to it (DHS, 2003; WHO, 2006; MOH/GHS, 2005). Thirdly, unsafe water and lack of sanitation which are considered to be one of the major risks to health in sub-Saharan Africa (WHO, 2004) have relatively been less problematic in Ghana. It is argued that due to the improvement in the economy in recent times, the country has achieved higher than expected levels of access to improved water which has caused the declining trends in mortality and morbidity from diseases like diarrhoea (MOH/GHS, 2006).

Overall, it is fair to say that while the above factors have helped the country to succeed in reducing children under-five mortality rates over the past decades, there are several contextual factors which make malaria still pose as the greatest burden in the country. It is therefore imperative to examine the contextual factors that have undermined the country's ability to respond to the disease in a more effective way.

5.3 Contextual factors undermining government's efforts

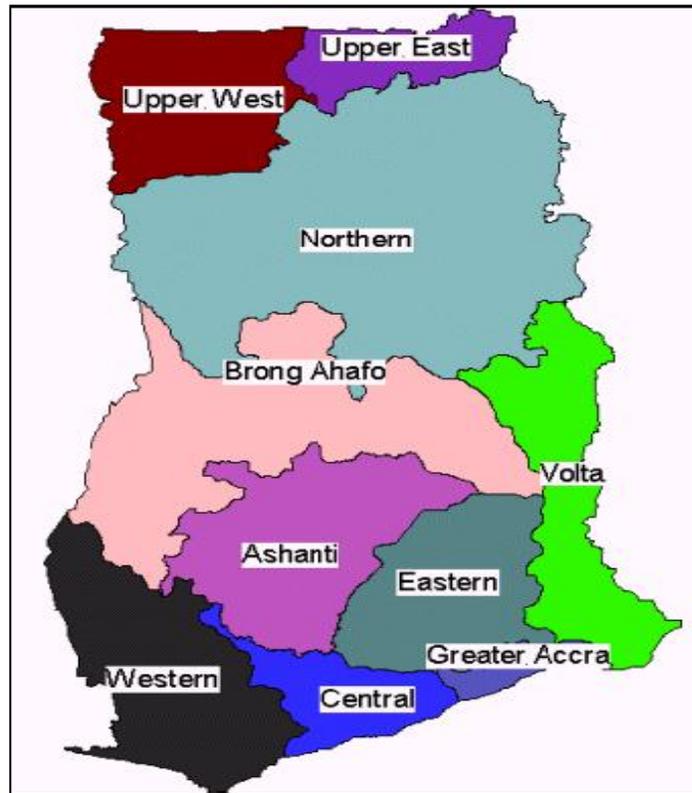
This section focuses on the contextual factors which have the potentials to shape and influence health policy around malaria control in the country. It begins with a description of the geographical location of Ghana and further discusses the environmental factors which make Ghana an ideal breeding ground for malaria. The final part of the section considers other factors such as socio-economic, cultural, political just to mention but a few.

5.3.1 The geography and ecology of Ghana

Ghana is one of the Africa countries which are located in the West of the continent, sharing its borders with Burkina Faso in the north, Togo in the east, La Coté d'Ivoire in the west and the Atlantic Ocean in the south. There are ten administrative regions (Figure 5.4). Ghana population as at 2009 was approximately 23.4 million, with an area coverage of 238, 537 square kilometres (92, 100 square mile a) and a population density of 79.3per square kilometre (Ghana Statistical Service, GHS, 2009).

Ecologically, Ghana is divided into four different zones with each, by nature having significant impact on malaria. These include: the northern Savannah, the central forest belt, the coastal Savannah and Tropical rain forest (MOH, 2008; Browne, 2000). The climate is tropical: warm and comparatively dry along the Southeast coast; hot and humid in the Southwest and hot and dry in the north. In the undulating savannas of the north, a long-lasting dry season takes place from September-November to March-April, with a rainy season reaching its climax in August. The mean annual rainfall is 45 to 50 inches.

Figure 5.4: Ghana and its regions



Source: WHO annual Report 2005

The southern part of the country is characterised by two rainy seasons (April-June and September-November) with the annual rainfall ranging between 50 to 86 inches. These regions also have two relatively dry periods that occur during the harmattan season (December-February) and in August. The Accra Plains are unusually dry at the coast, with a climate resembling that of the north. There are slight variations in temperatures throughout the country, with a mean annual temperature from 78° to 84° F (26° to 29° C). Average relative humidity ranges from nearly 100 percent in the south to 65 percent in the north; during the harmattan season the drier areas in the north can drop as low as 12 percent.

The significance of these ecological differences in relation to malaria control is that they create different “eco-epidemiological settings”, (Mlozi et al. 2006, p.2), leading to disparities in the distribution of endemic malaria as well as the rate of malaria transmission. This is because, the high humidity in the South could easily breed mosquitoes while the long dry harmattan season can affect food production causing famine or poor nutritional diets as well as population movement. The consequence of such population movement, fuelled in part by environmental degradation, famine and drought, is that it causes the spread of malaria as people move between malarious and non-malarious regions (Casman and Dowlatabadi 2002).

These claims are also consistent with most of the earlier findings in the country which indicate that differences in ecological risk factors like temperatures have significant impact on the rate of breeding and transmission of malaria (Owusu-Agyei et al. 2009). In addition, studies have found that the level of compliance with the use of ITN depends immensely on the differences in temperature due to seasonal differences. Often the rainy season is associated with more ITN use while the hot dry season is characterised by less ITN use, (Binka et al. 1997; Aikins et al. 1993; Guyapong et al.1996).

Another way by which these differences in ecology affect malaria incidence is farming. Evidence has shown that discrepancies in ecological zones and climate conditions often influence the type of agriculture practised in an area, which ultimately impact on malaria incidence. For example, due to draught caused by *harmattan* in the coastal regions of Ghana, the people in Accra have to irrigate their lands for farming purposes which has resulted in an increase in malaria transmission. This was evident in a study by Klinkenberg et al. (2008) who found that due to irrigated farming malaria transmission in Accra increased and also led to a rise in the annual entomological inoculation rate (EIR) in the areas where irrigated farming is practised.

In sum, the ecological differences are significant in the sense that ultimately, these ecological factors can determine the rate of transmission of the parasite and the nature of the strategy (short, medium or long term) that needs to be implemented, (Reiter,

2001). Currently, Ghana policy's on vector control against *Anopheles* vectors prioritizes the use of insecticide treated materials and indoor residual spraying. However, the efficiency of these interventions will depend on information on the distribution and abundance of the main vectors, which are contingent on ecological differences; (de Souza et al. 2010; Coetzee et al. 2000; Kelly-Hope et al. 2008).

5.3.2 Socio-Economic Context

Similar to most SSA countries, since independence in 1957, although the country has made tremendous efforts in economic development, Ghana is still poor with \$300 per capital and often depends on foreign donors to sustain the control of malaria (NMCP, 2008). Although the country generally relies on Gold, tourism and timber as its major sources of foreign exchange, Ghana's domestic economy continues to revolve around agriculture with cocoa production accounting for 35% of GDP and it employs 60% of the work force, who are mostly small landholders, (World Bank, 2004; UN, 1997). However, these socio-economic circumstances have considerable impact on government's attempt to control the disease. In terms of economic policy, some of the key features of the recent policy regime have been accelerated privatisation and trade liberalization. This policy of liberalization has led to increase in private economic activities such as mining and timber loggings in the country which have contributed to an increase in malaria incidence through deforestation and creation of suitable breeding grounds for mosquitoes, (Yasuoka et al. 2006; Uneke, 2009a). According to one estimate, at the start of the 1900's, one-third of Ghana's land area was covered by natural tropical forest (Wagner et al.1993). However, by 1989, studies show that only about 22% (18,000 km²) of the original tropical forest remained or 78% of Ghana's tropical forest had disappeared at a destruction rate of 1.3% annually for the period 1981–1985 (Hawthorne 1989; Repetto 1988).

The extent of deforestation taking place in Ghana was also witnessed during my field trip into the country. During this time I had the opportunity to be shown an area which, according to the community leader, was once formerly characterised by an enclosed

canopy and high species diversity but has been transformed into water-logged land place due to deforestation as illustrated in photo 5.1.

Photo 5.1: An example of the situation of deforestation in Ghanaian communities



The author's own photo taken in Ghana at Wiaso-Biemso area (Ahafo Ano South district)

Picture 5.1 (swamp/pool) was taken when one community leader took me to the outskirts of a village and showed me the extent of the damage caused by deforestation. Such environmental damage often produces breeding sites that propagate the infestation of malaria carriers (i.e. mosquitoes).

This assertion is consistent with some studies in other parts of SSA which have demonstrated that deforestation and land transformation influence the malaria vector *anopheles*, especially larval survivorship, adult survivorship, reproduction and vectorial capacity (Afrane et al. 2006; Yasuoka et al. 2007; Uneke, 2009). For example, in Southern Cameroon, a study by Manga et al. (1995) showed an increased density of *Anopheles gambiae* near the area where massive deforestation took place. Thus, despite the fact that other factors may contribute to the surge in malaria epidemics,

deforestation mainly caused by logging processes like dragging logs through the forest, has increased the breeding and quicker development of mosquito larvae causing communities that live close to these kinds of sites to be at risk of malaria (Afrane et al. 2005; de Castro et. al. 2006; Appiah, 2001; Walsh et al.1993).

Also, like most SSA countries, Ghana is not without its own challenges and one most important challenge facing the country is high level of poverty including the economic gap between the rich and the poor. This is demonstrated in Ghana Centre for Democratic Development study in 2002 (Prempeh, H.K, 2002). In this study, it was found that 20% of the poorest enjoy only 8.4% of the national income, whilst the richest 20% enjoyed as much as 41.7%). According to the 2007 estimate, almost 35% of the population lives below the poverty line (World Bank, 2007; UNDP, 2004). The consequence has been lack of access to malaria treatment. Also while few households, especially those in rich urban settings, spend large sum of money on commercial repellents such as mosquito coils, poor households in rural areas tend to rely on traditional herbalist for malaria cure due to poverty (Assenso-Okyere et al. 1998).

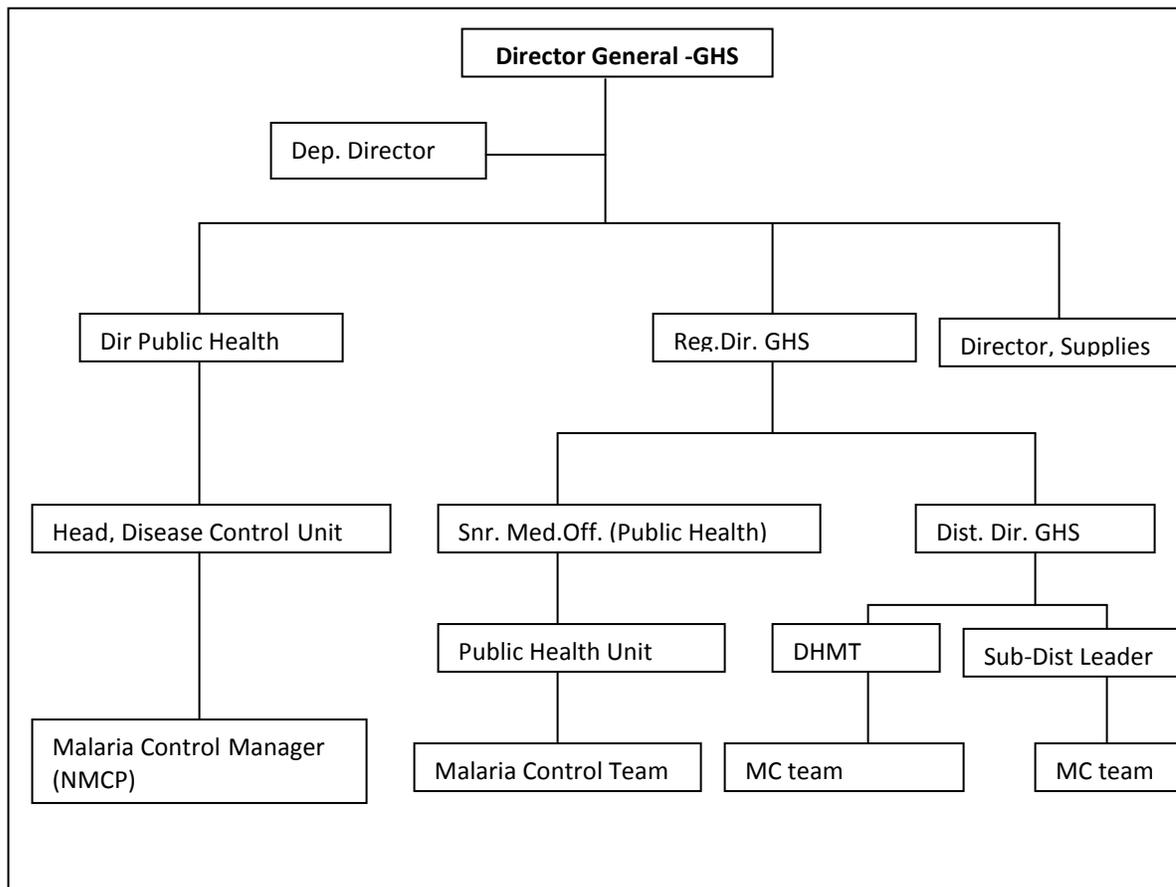
In conclusion, it has to be said that liberalisation has intensified private economic activities such as mining and timber logging causing deforestation which consequently has contributed to provide fertile grounds for the breeding of mosquitoes. Also persistence of poverty in the country has led to a creation of disparities in the use of malaria control products as well as access to health care between the rich and the poor as well as the building of a well-developed private system that serves only the rich.

5.3.3 Organisational structure and malaria control management

In terms of organisation, the management of national malaria control programmes (NMCP) can be considered to be hierarchical (see Figures 5.5 and 5.6). Figure 5.5 showed that the health sector has MOH as the body at the helm of affairs formulating policies. Under it is the Ghana Health services (GHS) acting as an implementing body

which has been decentralised and as part of GHS, since 1998 the country established NMCP Unit (MOH/GHS, 2008). The Unit has been charged with the responsibility of translating policy strategies into interventions. However, there are no designated malaria specific disease control officers at regional or district levels (NMCP Annual Report, 2008).

Figure 5.5: Organizational structure of the health sector in Ghana



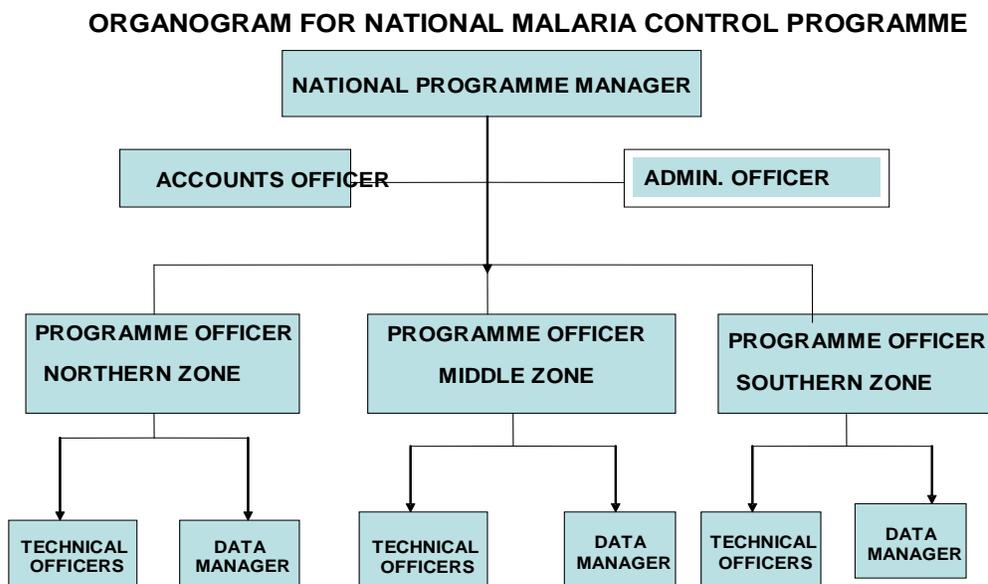
Key: MC - malaria control; DHMT – District Health Management Team;
(Source: MOH, 2008)

At the national level, NMCP Unit falls under the Disease Control Unit including other programmes that come publicly under the Directorate of Public Health mostly Senior Medical Officer as Figure 5.5 demonstrates. At the regional level, MCP unit is fused with the public health system, which is under the auspices of the Regional Director for Health

Services. The unit works along with other disease control officers who are charged with the responsibilities of all the daily health programme activities of the region

At the district level, the District Health Management Team (DHMT) led by the District Director of Health Services manages malaria control activities. There are also designated Disease Control Technical Officers who are responsible to the DHMT for malaria and other health activities in the districts. They team up to plan, implement and monitor control activities and any other activities that are related to health. Thus, rather than having a number of unit personnel all over the country, especially at the district levels, the Unit has only a few staff managing the whole programme as the Figure 5.6 indicates. Although the NMCP unit provides district staff with guidelines, it is ultimately up to the district health team to carry out programmes (NMCP Annual Report, 2008)

Figure 5.6: The organisational structure of NMCP



Source: Ghana Malaria 2008 Report

Figure 5.6 depicts a hierarchical structure within malaria control unit itself. The problem with the malaria control organisational structure is that unit has only three programme officers representing the whole country with no specific number of personnel for the regional and districts levels. At the regional and district levels, there is only one focal person each, and they have other responsibilities in addition to malaria. Also, the structure is “top-down” in nature and therefore coordination is difficult which poses as a challenge in dealing with malaria problems at the grassroots levels. For example, Agyepong (1998) found that, health staffs at the district level still tend to see themselves and their tasks by division rather than as a team causing problems of coordination of activities. It is also noted that there is a fundamental problem of lack of horizontal accountability caused by the influence of the centralised old structural relations and hierarchical culture of the health ministry, (Agyepong, 1998).

5.3.4 Cultural Context

For many years now traditional medicine and conventional medical practitioners have become one of the most important sources of malaria treatment among the communities in Ghana (Twumasi, 1986; Ahorlu et al. 1997). Besides the scarcity of public health facilities and the means to access them, the main underlying cause has been that culturally, there has been the tendency for Ghanaians to patronize indigenous and modern systems simultaneously (Aryeetey et al., 2000). Customary treatments for diseases regularly focus on supernatural causes and the use of medicinal plants. Thus, in spite of the fact that the world has witnessed the power and promise of modern medicine, large numbers of people in Ghana cannot do without traditional medicine or complementary and alternative medicine, (CAM) (Twumasi, 1986; Ahorlu et al. 1997). In effect, the significance of CAM represents a double-edged sword in the sense that on one hand, it helps the poor to have easy access to treatment and therefore contribute positively in sustaining healthy communities in Ghana at the local level where accessibility to health facilities is difficult. Conversely, such beliefs in CAM contribute to the delays in timely appropriate medical treatment seeking for malaria in Ghana. For

example, in a study conducted in southern Ghana, Ahorlu et al. (1997) found that a significant proportion of caregivers perceive uncomplicated malaria to be a mild disease which could be treated with modern medicine, while they associate severe or cerebral malaria with evil spirits which require spiritual healing.

Furthermore, communities often rely on traditional medicine such as burning of local herbs for protection against mosquito bites, (Ahorlu et al. 2006). According to some experts in the field, the efficacy of these traditional products is often doubtful and therefore they do not provide the necessary protection against mosquito bites or malaria as more modern types like ITNs (Snow et al. 1988; Ansari et al. 1990; Hewitt et al. 1996).

In conclusion, it can be argued that while traditional medicine is easily accessible to the poor, the belief in it and attitudes of the communities that mostly depend on it do make the work of malaria control health officials difficult, especially at the rural areas. In one way or the other, it makes the people reluctant to use other more effective services.

5.3.5 Education (high illiteracy rate)

In Ghana, although there is Free Compulsory Universal Basic Education (FCUBE) programme to every citizen, there is still high level of illiteracy rate in the country. At the moment, according to 2000 population census, considering those with the age 15 and over who can read and write, the literacy rate in Ghana is only 58% with 66.4% for male and 49.8% for Female.

In terms of malaria control, it has been noted that women's low literacy rate coupled with poverty is more likely to affect their involvement in the implementation of various disease control programmes and health projects (Bhutta et al, 2005; Paasche-Orlow et al. 2007). For example, Nutbeam et al. (2000), argue that literacy is one of the foundations of other life skills and has particular importance for the empowerment of women. It has intergenerational impacts because women with education care better for their families

and the girls of educated mothers do better on disease prevention and for that matter healthy living, (Nutbeam et al. 2000; 1993;). Education therefore helps more women to be able to sustain the economic and health needs of their family. It is also argued that better educational levels improve individual's access to information as well as the ability to assimilate and benefit from new knowledge on, for example, disease like malaria (Dalstra et al. 2005, Lynch et al. 2000). Accordingly, if the country wants to succeed in its efforts to control the disease, there is a need to increase the number of women who are literate.

5.3.6 Summary

This section has examined some of the contextual factors that have some level of relationships with the malaria problems in Ghana. From these factors, it has become clear that preventing and controlling malaria in Ghana have been undermined. Contextual factors such as poverty, illiteracy, environmental degradation, culture, top-down organisational structure coupled with lack of coordination and personnel have contributed to the government's inability to react effectively to the control of the disease.

Overall, it is important for this study to understand these contextual factors and their influence on malaria control since the persistence of malaria is deeply rooted in these factors. The implication here is that the answers to the problem of malaria lie mostly within the country's own characteristics and there is a need to acknowledge a changing context and to adapt malaria control interventions to the local contexts. Against this background, the main problem, which will be focused, is the extent to which these communities are allowed to participate in decision making process. This is significant because it is these local communities who feel the impact of these characteristics in terms of malaria incidence more than those distant policy makers. Thus, if the government's goal of controlling the disease is to be achieved and the RBM targets are to be met, most of these factors need to be examined and the problems addressed in collaboration with the very people who live and experience these problems. Moreover,

it is worth stating that the current problem of malaria is complex and as such there is no 'one size fits all' answer to it. Instead the government must address the problem from all angles by adopting integrated approach, which must involve the grassroots members. More challengingly, they need to find a way of recognising and getting in touch with those with extreme poverty, those that are, hitherto, marginalised and yet have local knowledge about the causes of malaria problems. The integration of such local communities in decision-making is likely to strengthen malaria control programmes' implementation process, which in turn could enhance better control policy outcomes. Without such deliberate efforts, beliefs and practices that militate against the control programme are likely to remain dominant and malaria disease likely to be with the people of SSA and for that matter Ghana for a long time to come (Agyepong 1992; Vundule and Mharakurwa 1996).

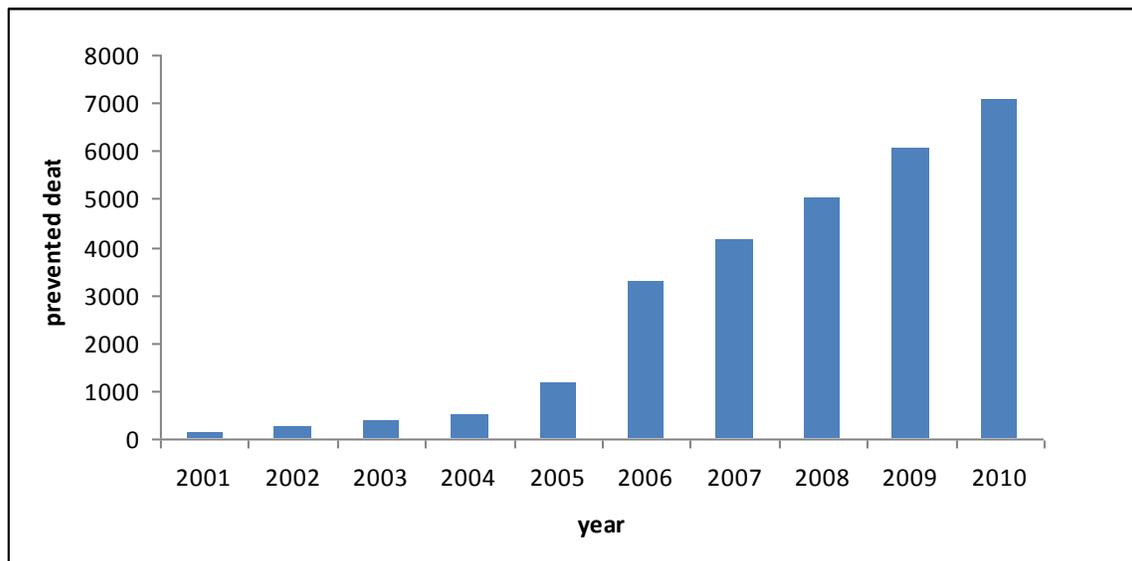
However, although these factors have undermined the government's efforts in achieving better results compared with the rest of the diseases, especially in terms of admission and death in the country, it will be unfair to conclude that all the government's efforts in controlling malaria have been futile. From a broader perspective, one can argue that the country has had some successes in terms of, for example, children under five deaths' prevention which can be accredited also to the existence of various contextual factors in Ghana as discussed in the next section.

5.4 Factors contributing to the minimisation of malaria deaths

Evidence has shown that malaria prevention scale-up through various means (e.g. Intermittent Preventive Treatment for pregnant women -IPTP); Insecticide Treated Net - ITN) over the past decade, in comparison with rates in the year 2000, has saved many lives of children. According to WHO/RBM recent report, (2010), since 2001, there have been steady increases in the number of malaria lives in children saved by both vector control and pregnancy scale-ups as Figures 5.7 and 5.8 illustrate.

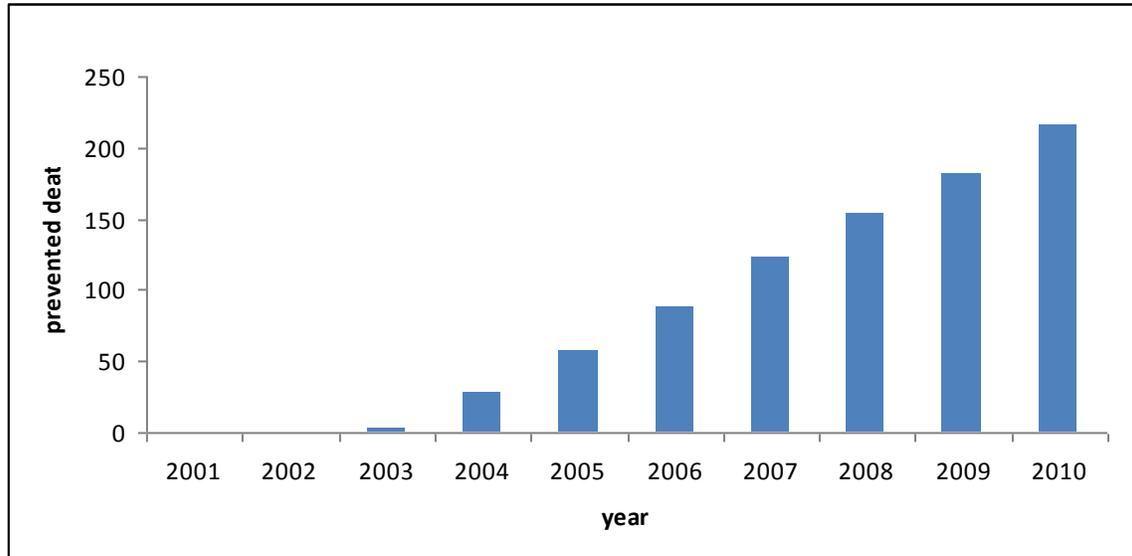
Figures 5.7 & 5.8 show estimated malaria deaths in children from 1 to 59 months old and in pregnancy respectively that have been prevented through vector-control scale-up from 2001-2010. These figures were generated by the use of the Lives Saved Tool, (LiST), modelled estimates developed by the Child Health Epidemiology Reference Group (CHERG) (Rowe et al. 2006). The data is generated based on estimates and assumptions about Ghana's population and growth rate, under-five mortality rate, cause-of-death patterns and estimates of coverage levels of proven child survival interventions (WHO/RBM, 2010). These assumptions could therefore put the quality of the data in doubt. Nonetheless, it is worth stating that within the context of health policy, there are various factors both at global and national levels which have positively influenced these outcomes (MOH/GHS, 2009; PMI, 2010; WHO/RBM, 2010).

Figure 5.7: Estimated malaria deaths in children from 1 to 59 months old prevented by vector control scale-up from 2001-2010



Source: WHO/RBM Report, No.3 Sept, 2010

Figure 5.8 Estimated under-five child lives saved by malaria prevention in pregnancy scale-up from 2001-2010



Source: WHO/RBM Report, No.3 Sept, 2010

5.4.1 Global and Regional Context

Globally, the launching of the RBM in 1998 created a favourable atmosphere for malaria-affected countries like Ghana to have the motivation to address the problem of malaria (RBM, 2005). Until this period, the country had not much resources devoted to address the problem. However, things began to change when the RBM programme was created with commitment to reversing the dramatic deterioration of malaria control in Africa. This was to be done through a more intensive case detection and treatment, integrated vector control, epidemic surveillance and to ensure that:

“countries had effective access to the information, technology, and financial resources required to reduce their burden of malaria” (Parkard 2007, p. 218).

Having been co-operatively sponsored by the United Nations agencies and the World Bank, RBM became part of a sector-wide approach to promoting health (WHO/RBM 2000; Parkard, 2007).

Besides the global strategy of RBM, at the regional level, the Abuja Declaration in April 2000, where senior representatives of 44 of Africa's 50 malaria-affected countries met in Abuja-Nigeria, also had influence on malaria policy in Ghana. In a general consensus statement, the representatives agreed to halving mortality by 50% reduction by the year 2010 and 75% by 2015 (World Bank, 2009; WHO/RBM 2006). The "Abuja Summit" brought the problem of malaria onto the world map of public health (Bates et al. 2007; WHO, 2005; 2006). The consequence of all these has been a promotion of partnership with several major programmes initiated by other partners. Amongst them include the President's Malaria Initiative (PMI); Global Fund for malaria and other infectious disease like HIV/AIDS and TB. There has also been the growth of philanthropic investments, which are best, documented by the efforts of the Bill & Melinda Gates Foundation, whose grant making has increased the number of individuals and organisations engaged in malaria-specific advocacy since 1998 (WHO/RBM, 2005). For example, The Global Fund committed a total of approximately US\$ 48 million for malaria control activities in Ghana between 2003 and 2008. Out of this, roughly US\$ 44 million was disbursed between August 2003 and March 2008 (National Global Fund Report, 2009, p.74). However, the problem of establishing the actual figures spent on malaria by the all these international agencies is that most of these expenditures are aggregated figures used for various diseases like TB and HIV/AIDS. Hence, it is difficult to know the expenditure trends in malaria control by these agencies.

In sum, since RBM inception in 1998, the country has witnessed the development of partnership giving rise to the implementation of multilateral programmes. There has also been coordination of efforts amongst these stakeholders who have taken preventive measures against malaria control in Ghana. These measures include the

promotion of ITNs for use by pregnant women and children under age of five, Intermittent Presumptive treatment (IPTs) with pregnant women with Sulfadoxine Pyrimethamine (SP), education of general public on environmental management of the disease and training of health staff in diagnostic and management skills (Ghana Global Fund Report, 2009; PMI, 2007).

5.4.2 National Context

Politically, the peace and stability enjoyed by the country have had significant impact on the continuity of control programme activities in the country over the past two decades (Ghana Health Equity Assessment, 2006; Ayensu et al. 2006). Currently, every year, 1% of government district budgeted fund for development is legislated to be used to fight malaria (MOH/GHS, 2006). Also, through stability, the government has been able to embark on general policy direction that is progressive. For example, there has been a redistribution of health workers towards the deprived areas through Community Health Planning and Services (CHPS) strategy which has helped rural residents to get easy access to health facilities. This has contributed to the reduction of malaria related infant-child and maternal mortality (Binka et al, 1995; Awoonor-Williams et al. 2002). Furthermore, the national government has promoted chemoprophylaxis for pregnant women and also improved environmental sanitation. These efforts have been a contributory factor in minimising malaria related morbidity and mortality in the country (PMI, 2010; MOH, 2009; NMCP, 2009).

Another national contextual factor that has contributed to the success story of malaria has been the introduction and expansion of a nation-wide health insurance scheme (NHIS) (MOH, 2007). The scheme aims at increasing access to health services, particularly in rural areas and in so doing help to reduce the rates of infant, child and maternal mortality and to have effective control of the risk factors that expose individuals to malaria (Osei et al. 2005; MOH, 1999). In order to achieve most of these

aims, the government has provided a package of services that is quite comprehensive, covering general outpatient and inpatient services at accredited facilities where citizens could go for treatment for not paying next to nothing. For example, with this NHIS pregnant women and children under the age of five could go to hospital free of charge. There has also been free availability and distribution of ITNs these vulnerable groups. As at October 2008, percentage number of people insured by NHIS was 61% of the total population (Agyepong et al. 2008; Sulzbach, 2008).

With this scheme, evidence so far has demonstrated that NHIS has positive impact on malaria victims' accessibilities to health facilities (Sulzbach, et al. 2008; Agyepong et al. 2008). For example, Ansah et al. (2009) showed that NHIS has led to a significant increase in health care utilisation. Children were taken to primary care facilities significantly more frequently than previously (2.8 episodes per person-year as against 2.5 episodes per person in the previous years). The researchers also noted that families with insurance who sought care for illness from a chemical seller and treated children at home were significantly less frequent than those who did not have insurance. Thus, the NHIS has not only increased the number of people who seek treatment at the formal health facilities but also has contributed to reduce the number of people who rely more on untrained drug sellers and home-managed malaria cases. However, while there was less utilisation of non-formal services as a whole, the same study found no significant difference in the mean number of fever episodes per person per year between children. This implies that the introduction of NHIS has not reduced the number of children who become victims of the disease, rather it only helps victims to have access to the cure but it does not help to prevent the disease itself.

5.4.3 Summary

This part of chapter five has discussed the factors that have contributed to Ghana government's achieved success in malaria control. Evidence has revealed the extent to which the government has achieved some successes in terms of prevention of death by vector control scale-up activities. It was argued that these successes have been possible

due to the existence of certain global and national contextual factors. Globally, it has been noted that the launching of the RBM as well as Abuja Declaration in 1998 and 2000 respectively led to the availability of resources through partnership.

Nationally, there has been political stability which has contributed to the implementation of the appropriate control measures which illuminate government awareness of the problems and the how to address them. For example, the discussion has demonstrated government concern of rural poverty and the difficulties of accessing health services in rural areas. As a result, achieving equitable access to health care have been the paths taken by the government. Nationally, the NHIS has been introduced by the government and to a large extent has facilitated easy accessibility to health care for most Ghanaians by removing the financial barriers to obtaining care. Also through NHIS, the government of Ghana has offered free ITN to the most vulnerable such as under-five children and pregnant women. All these, directly or indirectly have contributed in preventing malaria-related morbidity and mortality of children in the country.

However, while it is clear that these policies have brought positive results, the need to provide a better understanding of the policy process is paramount. The last section of this chapter therefore describes the policy making process of malaria control in Ghana.

5.5 Malaria Control Policymaking Processes

This section focuses on the examination of malaria control policymaking process in Ghana. Of particular significance to this section is the description of the various stages of policymaking process of which the model of Walt and Gilson (1994) is used as a framework. The identification of these stages plays a useful role in acting as a frame of reference from which to discuss the study results in the next chapter about the participation of the communities at the various stages of the malaria control policymaking processes.

5.5.1 Policy Planning and Formulation (Priority Setting)

In Ghana, the government has acknowledged that the health sector alone could not achieve the goal of controlling malaria. As a result, the health policy thrust (2007), intends:

“ to enhance the performance of the sector by promoting a well coordinated health systemand to focus on strengthening inter-sectoral action around the key health challenges and settings (MOH 2007, p.9).

Ghanaian's malaria control strategy involves multi- and inter-sectoral partnerships working under a single national plan and all the main decision making processes take place at the MOH (National) level (PMI, 2009; RBM/WHO, 2010; MOH, 2009). It begins with sectoral consultations and dialogue in which all the agencies and partners seek agreement on priorities that have been submitted by the various stakeholders (MOH/GHS, 2008). In general, in order to have input to be used by those at the national level as basis for their action plans, it is important that the district levels set their own priorities and these are determined during the annual planning and budgeting processes (MOH/GHS, 2008). However, although these priorities are expected to be set by the lower levels' health authorities, the guidelines within which they have to work are set at the national level, which often reflects the limited space within which the authorities at the lower level have to work. For example, within the Budget Management Centres' (BMCs) hierarchy, the measure of expenditure discretion offered by the national authorities to those at the lower level is under restrictions set by the ministry of finance and economic planning (MoFEP) (Bossert and Beauvais 2002). With these guidelines, the ministry at the national level will provide the various Regional Directors budget ceilings. These Directors in turn, will allocate these budget ceilings to regional, district and sub-district BMCs on the basis of district population, the number of health facilities and the distance from the regional capital (Bossert and Beauvais, 2002). From the MoFEP's

perspective, these ceilings are meant to help the sector work within its means due to limited available resources (Abeka-Nkrumah et al. 2009).

However, for MOH to ensure the increased harmonisation of the planning process at national and inter-agency level, the lower levels have to send their plans to the MOH.

The MOH then organises a summit, which is:

“a multi-sectoral and multi-stakeholder approach for policy dialogue, coordination, planning, resource mobilisation and allocation (MOH, 2007, p.6).

Such an approach often involves all the main stakeholders including foreign donors and others who are then invited to participate in the policy dialogue. Ultimately, the outcome is expressed in the Programme of Work (POW) and aide *mémoire* (MOH, 2006; 2007).

The health sector’s engagement with its partners through meetings often has four major components. The first summit of the year is usually held after a comprehensive review of the previous POW. This is a summit often conducted in an open hearing with invited stakeholders, and during this period, all the various districts are required to evaluate their achievements in comparison to the set targets (MOH, POW, 2002-2006; Birungi et al. 2006). The second part of the national meeting is the scientific session which offers an opportunity to participants in a form of presenting and having discussions on research issues (MOH, 2004, 2006). There are also thorough appraisals that are significant to the theme of the summit and in addition, certain specific questions related to the implementation of the POW including malaria control are posed and answered (MOH, 2004, 2006). The third component is the programme review session, which focuses on discussing the POW, its strategies, priorities and sector performance. This is open to all invited stakeholders including health sector staff, regional directors, other sector ministry representatives, development partners, coalition of NGO representatives, and private practitioner representatives. During this general meeting, all the reports of the first and second reviews are synthesized and the appropriate recommendations suggested (MOH, 2006, 2008; Birungi, et al. 2006). The final meeting at the national

level involves delegates of the MOH and funding partners having some discussions together. It is at this meeting that all the sector priorities are agreed upon on the basis of the results of data and dialogue that have taken place among the stakeholders in the earlier three sessions. The agreements in this meeting are then put together in the form of an aide *mémoire* which is then certified and signed only by the MOH and health donor partners. It is only at this stage that the whole approved plans are sent to the parliament for approval and then it becomes as a policy (MOH, 2006, Birungi, et al. 2006).

To put these processes into context, there are two points that can be made in relation to the policy documents regarding community participation. First, the fact that majority of the stakeholders are invited and most participation occurs collectively and directly or indirectly through interest groups or formal organisations that claim to speak for specific constituencies appear to suggest that there are some opportunities that are created for local levels' inputs into the decision making process. This is in line with WHO programme document: *Health for All by the Year 2000* which states that:

“measures have to be taken to ensure free and enlightened community participation, so that notwithstanding the overall responsibility of governments for the health of their people, individuals, families and communities assume greater responsibility for their own health and welfare, including self-care. This participation is not only desirable it is social, economic and technical necessity. Governments will therefore have to devise appropriate ways of promoting such participation, supporting it, effectively propagating relevant information, and establishing or strengthening the necessary mechanisms. Governments, institutions members of the health professions, as well as all agencies involved in health and development, will therefore have to take measures to enlighten the public in health matters so as to ensure that people can participate individually and collectively, as part of their right and duty, in the planning, implementation and control of activities for their health and related social development. In developing its strategy for this, each country will have to take into account its cultural and social patterns and its political system. As part of community participation, in the process of formulating national health policies, it may help to involve political, social and community leaders, organisations, industry, labour, relevant professions, and those engaged in the mass information media in appropriate local, district and national activities” (WHO, 1979, p. 17)

From the above quotation, it could be argued that on one hand, by inviting all sections of the people from the country, Ghanaian health authority has the belief that the goal of controlling malaria could be achieved through the principles of Health for All by the Year 2000. In essence by focusing of community participation to control malaria, the government tries to demonstrate a real political commitment to global programme initiative to accomplish effectiveness in malaria control (WHO 2000, 1988). However, no attempt is made to answer the questions concerning how it has to be implemented and therefore individual countries like Ghana are left to their own to decide on the way it chooses to implement community participation.

On the other hand, it could be argued that by involving individual stakeholders in malaria control policy and still leave the final decision to be taken by professionals alone reveals how community participation in malaria control programme is perceived among health policy-makers in Ghana. Implicitly, the understanding of community participation in the Ghanaian policy-making process of malaria control demands communities to be responding to the dictates of the national health professionals and international health donors. The idea here is that with the ultimate decisions regarding health sector priorities lying in the hands of professionals who make up the greater part of the actors involved in the process the perception of policy makers appears to limit the participatory role of the community.

The second point that can be made is by looking at the national context. At the national level, it can be said that the choice given to the local authorities to plan and to implement their own policies in line with the existing local challenges is limited. The fact that the local authorities have to work within the guidelines imposed on them from the national level guidelines means that the bottom-up approach is rhetoric. This is because by receiving guidelines from the central government suggests that the centralised system (top-down approach) is still in operation. This implies that the community is

considered here not only as a group of individuals who have to accept the decision made by policy experts or professionals, but also have limited power to consider what they really need in the policymaking process. This is in contrast to the Mission statement of the MOH Programme of Work (2002), which states that,

“The Ministry of Health will work in collaboration with all partners in the health sector to ensure that every individual, household and community is adequately informed about health; and has equitable access to high quality health information and related interventions” (p.10)

...Because good health is not only a function of the health service delivery, other government sectors, communities and civil society must be involved (p. 31)

It can therefore be argued that although collaborative effort in the decision making process which potentially offer some opportunities for community participation is cherished by the central government, in practice it is difficult to see it happening. The underlying reason for this conclusion is that when community groups are asked to participate, but the final decisions are still controlled by the state officials, then it is worth arguing that there is no meaningful community participation (Fisher, 2000). For many commentators, the only thing such a system does is the preservation and legitimisation of the top-down status quo through the superficial consideration of community participation. This is potentially a threat to participatory planning and it does not solve the problem of power imbalance and community exclusion (Brinkerhoff et al. 2003; Forester, 1998).

In conclusion, it can be said that in developing policy plans and setting priorities within health sector for malaria control there is an indication of the authorities at all levels accepting the significance of having inputs from all stakeholders. By encouraging public discussion in these processes, the health sector authorities in the country fully appreciate the need to help the public to contribute to the debate on their needs by ensuring that proper methods of public discussions on plans and priorities' settings are in place and followed. On the other hand, the government uses its position as an actor

with power to influence planning, shape perceived needs and direct the agreed priorities or resulting action plans of the local communities which has the potential to render the main participatory exercise ineffective. In effect, the utilisation of power through a top down approach to consultation and decision making weakens

“real participation, allowing organisations to claim that they are open, while effectively excluding those most affected by decisions” (Anderson and Barnett, 2006; p.78).

However, the extent to which this assertion is true remains to be examined in the next chapter based on the results obtained from the interviews that was conducted as part of this study.

5.5.2 Malaria Control Policy Implementation

With regards to the implementation in Ghana, while the local authorities have a greater role to play in the implementation, it is the GHS at the national level that gives directives as to what, where and how materials are to be sold or distributed (MOH/GHS, Regional Report, 2008). This often follows three main traditional implementation routes as observed elsewhere in SSA. For example, taking the case of ITN distribution into consideration, the methods include (1) the integration of ITNs distribution into community pharmacy networks (2) sales through local health units (or the existing PHC system, and (3) distribution through community groups (RBM Report, 2005; MOH, 2008; NMCP Report, 2008).

Nationally, the making of these nets have been contracted to private individuals within the country (e.g. the Kantamanto and Central markets in Accra and Kumasi respectively) with aim of boosting treated bed net coverage and usage. This has put these individuals and or firms in a position to have a say in the policymaking process since they tend to have control over the prices and the distribution of ITNs. The NGOs have also been involved in re-treatment activities at the various centres which have been built throughout the country. Although, reports have shown an increase in household use of

these nets in the last decade, the problem has been that most poor people cannot afford since the prices are often too high (WHO/RBM, 2008; NMCP Annual Report, 2008, Owusu-Adjei et al. 2007)

Another strategy for malaria control policy strategy implementation has been social marketing. Many commentators see this strategy as a flexible implementation model, which has shown to be successful in many countries in SSA (Abdulla et al. 2001; Fraser-Hurt and Lyimo1998; Van Bortel et al. 1996). However, it is mostly private individual donors who are in the forefront of such implementation strategy as the photo 5.2 indicates.

Photo 5.2: Creating awareness of malaria problem in Ghana



Source: The author's own photo taken in Ghana at Mankranso (Ahafo Ano South district capital)

Photo 5.2, the shows some of the methods used in providing information to community members. With this kind of approach (i.e. advertisement) is often sponsored by private companies who have partnership with the health sector in fighting malaria. One example is Pfizer who is one of the sponsors of 'Mobilise Against Malaria' (MAM), an NGO operating in Ghana. Although the message : "Malaria Kills" as depicted on the

board is significant as it warns the community to pay attention to the devastating nature of malaria, in contrast to the principles of Primary Health Care (PHC) which focuses on both curative and preventive approaches, such advertisement only focuses on curative. Private actors often tend to dwell on curative measures which help to enhance the demand for their products like the drugs used to treat the disease to the neglect of preventive measures. This kind of solution only serve the interest of the private firms as it only advises the community to seek for cure which means buying of drugs (WHO, 2005; RBM, 2006).

A third implementing strategy is through multi-media such as television, radio, posters, and music, which are used as means to send messages to the public. These communication campaigns not only complement efforts done on the ground (e.g. public education) by the health officials but improve community's access to malaria treatment. This strategy also helps to encourage the people to search for early treatment and to discourage home management of the disease. However, not many districts use this means since it is not effective because most of the grassroots community members do not have access to these media (MOH, 2008; NMCP Annual Report, 2008).

Finally, Community-based Health Planning and Services (CHPS) has been employed as a mechanism to have locally trained health care providers to supplement the few trained health staffs who accept posting to rural areas (MOH, 2008; NMCP, 2009). Through CHPS initiatives, some rural areas have been able to minimise barriers to geographical access to health care (Nyonator et al. 2005). This strategy has helped in shifting from conventional facility-based and 'outreach' services, to a programme of mobile community-based care. This care often includes "services that involve doorstep and community-based treatment of minor ailments and treatment of malaria" (Debpuur et al. 2002, p.143)

In a whole, the implementation of malaria control policy strategies has been a mixture of both top-down and bottom-up. This implies that the country has adopted an integrated approach, which also reflects the conflict between centralized control, government decision making power and community participation.

5.5.3 Evaluation of malaria control

In term of programme monitoring and evaluation (M&E) although the Ministry and its agencies have a structured system of data collection and collation from all the levels, the communities are mostly involved in them at the community levels (MOH/GHS, 2009; NMCP, 2009; PMI, 2009). Often, while the monitoring officers evaluates quarterly at the national or monthly at the regional levels, the districts' monitoring teams ideally have to monitor ongoing programmes at least once a week at the community level. The purpose is to develop new knowledge through operations research to produce evidence on which policy decisions can be taken in association with the options for programme implementation. M&E at the community level are sometimes done through open-structured interviews of the community members who can be used as informants or as mechanism for surveillance (MOH, 2008; NMCP, 2008).

However, due to a number of problems involved in the collection of primary data, its collation, storage, and at times, biased reporting, M&E private consultants have been used to carry out independent supervisory checks at the various districts. Broadly speaking, according to NMCP Report (2008), between 2005 and 2007, there were three midterm evaluations that had been conducted annually by NMCP with the mid-term evaluation of 2008 contracted out to Private Consultants. In either of these agents, the community members play significant role in the data collection (NMCP, 2008; GHS, 2007; MOH Report, 2006).

5.5.4 Summary

The discussion in this section has centred on policy making process in malaria control beginning with policy planning and formulation; implementation and evaluation processes. The Walt (1994) model of stages involved in policy making was used as a frame of reference. It is known that although many actors take part in the decision making process, the final decision at the planning stage lies in the hands of some of the national and international professionals and the donors. The community's ability to influence the planning and or priority settings outcome ultimately appears to be limited at this stage of the process. In the case of the implementation, the whole process involves the means by which the information or materials can be accessed by the communities. With this issue, a number of strategies were identified. These include: allowing private individuals to sell to the communities; local health units selling control materials like ITN to the public or communities, or distributing through community groups. Besides, the authorities either depend on media communication channels like local FM radios, TVs or by word of mouth. The national government through GHS also plays its parts by providing direction of the policy strategy's implementation. It is the national body, GHS that has the power to allow control materials like ITN to be sewn and treated within the country by private companies as well as allowing private partners to use posters to inform the communities about malaria. M&E discussion has also shown that the communities are often involved in all the activities of any of the agent. The collection of data and information are usually helpful because they can demonstrate the extent of achievements and failures in programme or project implementation. Such results become crucial for corrective measures to be applied by the stakeholders involved in the control programmes.

However, while there are several actors involved in the decision making process it is still not clear the nature of powers these actors have over the policy making process and what makes them more powerful than the community members. This will be an issue that will be addressed in the next part of this section.

5.6 Policy Actors

In Ghana, like most Africa countries, for the government to succeed in any of its plans to control malaria, there are certain groups of people (e.g. health professionals) whose supports are indispensable. In the words of Alford (1975), these are the dominant structural interest group and in the context of this study could be represented by the doctors and nurses. These are the groups who, by virtue of their knowledge and skills, both the government and the communities cannot do without them to solve the problem of malaria. Doctors in particular and to a lesser extent nurses enjoy high power and influence on issues affecting malaria control in Ghana. Thus, the medical profession along side with its' allied professions such as clinical nurses and clinical nutritionists, in terms of Alford's typology of structural interests (1975) are the professional monopolisers, and in the context of this study they can be regarded as those who fit into the dominant group (medicine).

Apart from doctors and nurses (dominant group) in the public sector, the rest of the health service staff could be viewed as those with 'challenging interests' or corporate rationalisers. These are the so-called 'bureaucrats' and private individuals or firms that are involved not only in policy formulation but also implementing control programmes as well as coordinating and integrating malaria control into planning framework, monitoring and evaluation. They are the groups who can influence the success of resource mobilisation and allocation as well as ensuring proper application of regulation on sanitation in the country. They are the groups on which all the programme activities depend (public corporate rationalisers). This makes them to have considerable amount of power and influence on policy making, although not as strong as those in the dominant group (medical profession). In Alford's (1975) model although he argues that the corporate rationalisers are players, in principle, responsible for improving the efficiency and effectiveness of health services and in doing so tend to pose a challenge to the fundamental interests of professional monopolisers such as the medical profession, this is hardly the case in Ghana (Nyonator et al. 2005). This is because, in

Ghana, the dominant group (doctors and nurses) could also at the same time be corporate rationalisers since either a nurse or doctor mostly heads most of the national health services at the district levels. In effect, it is difficult to separate the two when it comes to administration.

Furthermore, in Ghana, the private sector has, at the moment, become a good player in the fight against malaria. On one hand, they can be seen as dominants since some of them are part of medical practitioners' group and as such have power and influence just like that of other monopolisers. On the other hand, they can be considered as corporate rationalisers because they are the groups that are involved in manufacturing, distributing as well as selling of materials like drugs and or ITNs to the communities against mosquitoes or malaria (Ahorlu et al 1997; Smith 2004, Goodman and Proudley 2007a).

Finally, the third player is the grassroots community member, who from Alford's typology of structural interests (1975) can be seen as repressed interest group in Ghana. Their power and influence on malaria control policy making appear weak and also have their interests inadequately represented in the health care system (Agyepong et al., 1995).

The overall individual actors within the above mentioned three groups who are involved in malaria control in Ghana are shown in Table 5.2. In general, Table 5.2 shows the various groups of actors, which may include: the public (both dominants and rationalisers), the private (both dominant and rationalisers) and the local community (the repressed). Thus whilst public and private can both be dominants and rationalisers, the local community is the only actor who is repressed. According to Stone (1992) it is hard to imagine that the local community could be as powerful and influential as the other two, because the:

“health professionals often have the power to make decisions, and as such giving up the power to community members hardly ever happens” (p. 412).

This power imbalance makes a huge difference in terms of each actor’s participation and influence on the decision outcomes as Arnstein (1969) notes:

“there is a critical difference between going through the empty ritual of participation and [citizens] having the real power needed to affect the outcome of the process’ (p.216).

However, with the current reforms, there is a possibility of a change in their position and as to whether this repressed interest group are ‘roleless’ and ‘voiceless’ in the current NMCP debate over participation in policy making process of ISC is yet to be validated by the discussion in the next chapter six.

Table 5.2 Various actors involved in malaria control programme

Public Sector

MOH/GHS at all levels

Research Institutions

Civil servants in other decentralised Departments (Bureaucrats)

Private Sector

Donors

NGOs

Media

Drug/ITN sellers

Health care providers (doctors/herbalists)

Local Grassroots Community

District assemblymen/women

Opinion leaders/unit committees

Traditional leaders/chiefs

Ordinary community members

Source: Author's own questionnaires' results, 2009

5.7 Conclusion

Overall, through documentary review, chapter 5 has revealed the findings of the two major issues that include: the extent of malaria problem in Ghana and how malaria policy making process takes place.

On the issue of malaria problem, discussion has focused on the trend of malaria cases and the extent to which it has increased since 1990. Comparison was made with other

diseases, in relation to the causes of admission and mortality. In the analysis, it was noted that malaria was the highest amongst the top ten diseases in the country. Several factors were considered to be the causes for government's inability to effectively address the problem. These factors include: ecological, socio-economic, cultural, illiteracy and organisational structure including the management of the malaria control in the country.

However, an argument was also made that it was not all gloom and that the government has achieved some successes in its efforts to control malaria. Some evidence to demonstrate these successes on prevention of death amongst children under five and pregnant women were revealed. Later, it was argued that these successes have been possible as a result of the existence of certain global and national contextual factors. On the issues of Global and national contexts, it was noted that the launching of the RBM and Abuja Declaration in 1998 and 2000 respectively have given rise to the availability of resources through partnership. In the case of national context, the main themes of control policy contents identified were (i) decentralisation which provides power to the local authorities to address their own problems (ii) equity of access to health care as espoused in NHIS (iii) The work force initiative (CHPS) which dominate the government's approach to rural healthcare

In terms of policy making analysis, it was found that although the system of policy making encourages bottom-up approach, the whole process can not be completely be associated with one approach. Rather it has been a 'hybrid' or an 'integrated' system which favours both the top-down and bottom-up approaches.

Furthermore, in the case of the actors involved, there has been recognition that many actors are involved in the process. In discussing this, Alford (1975) structural interest model was used and accordingly on the basis of the structural interest perspective, actors have been identified as dominants, rationalisers and repressed. These groups have been considered to be the public, private and the grassroots local community and there is a similarity between public and private in terms of position on power, influence

and interest whilst the position of the local community seems to be weak. Community has less possibility of having the same power, and becoming as dominant and rationalisers as the public and private sectors' actors.

These results are based on documentary review. However, the next chapters of this thesis examine the empirical evidence of the study based on qualitative and quantitative data collected. The evidence will cover: the role of the community in the battle against malaria, investigation into the degree to which community members have been participating in and have been influencing the process of malaria control policy, the barriers to community participation as perceived by the actors involved in the control programme and lastly the potential factors that can facilitate community participation.

Chapter six

The roles of the community and the extent of its participation in the policymaking process

6.1 Introduction

The primary focus of this chapter is to present the empirical findings obtained from the interviews. The analysis and interpretation of the data have been carried out in the light of the third and fourth research questions set out in section 1.4 of the introductory chapter:

3. What roles do the communities play in the national malaria control programme (NMCP) activities?
4. To what extent do local communities participate in the policy strategy of ISC policy making processes in Ghana?

In addressing these issues, the first section of this chapter will fundamentally involve an investigation into how community participation occurs in NMCP as reflected in the major roles played by members within the communities. These communities are those in both the rural and urban districts of Ahafo Ano South (AAS) and Kumasi Metropolitan Assembly (KMA) respectively. The second section examines the extent of their participation in the policy processes of NMCP in these districts. These findings are descriptive and interpretive in nature and therefore provide broad, substantiated accounts of community participation from the views of those who are closely involved, or affected by the process of control programme policy making. Comparison between rural and urban communities will be made when it adds to a rich understanding of the phenomenon being discussed. The chapter begins with a description of the socio-demographic characteristics of the interviewees.

6.2 The socio-demographic characteristics of the participants

A total of 165 participants of both urban and rural districts took part in the survey of which 80 and 85 were for the rural and urban respectively. See the Table 6.1 below for the socio-demographic characteristics of the respondents in both districts.

In the rural area, 44 (55%) were females while males were 36 (45%). On the other hand, in the urban district, the females were fewer than the males with respondents of 40 (47%), while the males were 45 (53%). The overall mean age was 39.5 ± 1.5 years (ranging between 18 and 75 years). In total, there were 84 (50.9%) males participants from both districts while the total number of females was 81 (49.1%). In both the rural and urban areas the highest number of participants was found in the 30-49 years, (45% and 42% respectively). 69.7% of the participants were married and in terms of education, in the rural areas, only 11.2 % of both female and male had education equal to senior secondary school (SSS) or above. All the rest had either junior secondary school (JSS) or less than that (68.8%) or no education at all (20%). Relatively, the educational level of the rural interviewees was not all that different from the urban district except that those who have higher than SSS were higher than rural, (22.4%). What was striking, however, was the occupational level in these two districts. While most of the rural people were farmers (50%), with only 12.5% as salaried workers, the urban had only 4.2% as farmers and 70.5% as self-employed such as traders, mechanics, transport owners etc. This was a true reflection of the economic positions of the respondents, which tend to demonstrate the differences in wealth amongst rural dwellers and the urban inhabitants.

Table 6.1: Socio-demographic profile of the survey participants in rural and urban districts in Ghana

Characteristics	Males (Rural) N=36 (45%)	Female (Rural) N=44 (55%)	Male (Urban) N= 45 (53%)	Females (urban) N= 40 (47%)	Total (%)
Age in years					
18-29	7 (8.8)	7 (8.8)	15 (17.7)	10 (11.8)	39 (23.6)
30-49	16 (20)	20 (25)	16 (18.8)	18 (21.2)	70 (42.5)
50-69	9 (11.3)	12 (15)	8 (9.4)	8 (9.3)	37 (22.4)
69 above	4 (5)	5 (6.2)	6 (7.1)	4 (4.7)	19 (11.5)
Marital status					
Married	28 (35)	33 (41.2)	30 (35.4)	24 (28.2)	115 (69.7)
Single	8 (10)	11 (13.8)	15 (17.6)	16 (18.8)	50 (30.3)
Educational status					
No education	7 (8.8)	9 (11.2)	8 (9.4)	11 (12.9)	35 (21.2)
Less than or JSS	24 (30)	31 (38.8)	25 (29.4)	22 (25.9)	102 (61.8)
More than or SSS	5 (6.2)	4 (5)	12 (14.2)	7 (8.2)	28 (17)
Occupation					
Farmer	22 (27.5)	26 (32.5)	3 (3.5)	1 (1.2)	52 (31.5)
Self-employed	4 (5)	8 (10)	29 (34.1)	31 (36.4)	72 (43.5)
Salaried worker	6 (7.5)	4 (5)	12 (14.1)	7 (8.2)	29 (17.5)
Unemployed	4 (5)	6 (7.5)	2 (2.3)	1 (1.2)	13 (7.8)

**Source: The analysis of the field interviews
()= %**

6.3 The perceived roles of the community members within the NMCP

The roles of community members in helping health officials in organising NMCP activities in Ghana have been significant in recent times (Fiagbey, 2009). In this regard, during the interview, the interviewees were asked to come out with the most important role(s) played by the community members in NMCP with the question:

“What are the most important role(s) do you perceive yourself or other community members playing in NMCP activities in this area”?

In response to this, community members identified number of roles (see Table 6.2) which reflected on the mechanisms through which they used in participating in the control programme. In this section these roles will be discussed with the inclusion of the most important interviewees’ quotes to illustrate the more articulate views.

Table 6.2 shows the summary of the types of activities that community members have been involved in the NMCP with the percentage number of responses. It is an indication of all the major roles played by the rural and urban communities. The information on roles is summarized by response but not by respondent to illuminate the multiplicity of views. There is no evaluation of a priority attached to any of the roles and it is the total number of responses obtained from the interviewees that is shown at the bottom of the Table 6.2 rather than the respondents. Hence the number of responses is more than the number of interviewees since some informants gave more than one role. In general, the findings showed that the extent to which communities played these roles varied considerably between the rural and urban as discussed in more detail below.

Table 6.2: The various roles played by rural and communities in NMCP activities

ROLES	Rural		Urban	
	Responses (N)	Responses (%)	Responses (N)	Responses (%)
Contributing in outreach services by organising certain malaria control programme activities	9	7	5	4
Contributing in monitoring and evaluating malaria control programme activities	30	24	24	20
Helping malaria victims to cope with the disease	21	17	65	55
Provision of voluntary services to keep the environment of the community clean	64	52	24	21
Total Responses¹	124	100	118	100

(1) Responses do not correspond with the actual number of respondents of 80 and 85 for rural and urban interviewees respectively since some cited more than one role

Source: Analysis from the interviews

From Table 6.2, it can be noted that there are differences in these roles between rural and urban community members. In the case of urban, from these roles it is clear that the majority of the urban community members play a bigger role in assisting to send victims of malaria to the hospital (55%). This is followed by the role of providing voluntary services through, (e.g. communal labour) to keep the environment clean (21%) and thirdly contributing in the evaluation of malaria control programme activities (20%). The role played by small percentage number of community members interviewed was organising malaria control programme meetings, for example, community health education (4%) as a contribution to Outreach Services.

In contrast, a greater percentage number of rural community members perceived themselves to be more involved in most of the tasks than the urban community members. In comparing the results of the two communities' percentage number of responses, it can be noted that the task in which the least percentage number of community members perceived to be involved in was in relation to helping health staffs during the outreach services (7%) although it was higher than the percentage number of urban members' responses (4%). In this task, community members perceived their role as 'organisers' of NMCP meetings or 'informants' to the health authorities.

Moreover, amongst the rural community members, a greater percentage number (52%), claimed that provision of voluntary services through, for example, communal labour to keep the environment of the community clean was one of the major roles played by the members. This was in contrast to the small percentage number of urban community members of 21%. This was followed by their role in monitoring and evaluation (24%), which was almost similar to the urban of 20%. However, in the case of assisting in sending malaria victims to hospitals, while the percentage number of responses was 17% from rural community, a greater percentage number of responses from urban residents (55%) found it to be one of the major roles played by the community members. This may not be surprising considering the fact that in urban centres, there were only some few areas, which had access to government transport that could help the sick to access health facilities. Majority of the community members had to rely on private transport owners, which could be commercial or non-commercial. However, the reality was that, unlike the rural areas, most of the people had either their own means of transport or driving somebody's car which could help the malaria victims to be brought to the hospitals.

Overall, it can be argued that although there were differences in percentage number of responses between rural and urban, Table 6.2 at the same time showed that the various roles they played were similar. These similar main roles played by the communities can

also be considered as a manifestation of the forms of community participation in NMCP activities, which are discussed in detail in relation to the outcome of the coding in the previous chapter. These included:

- i) Contributing to the outreach services
- ii) Contributing in monitoring and evaluating malaria control programme activities
- iii) Helping victims to cope with the disease
- iv) Providing communal voluntary services to keep the community environment clean

6.3.1 The community's perceived roles in outreach services

In Ghana outreach services have become one of the strategies to mobilise health workers to serve underserved populations in remote and rural areas with the aim of providing continuous access to health workers (Nyonator et al. 2005). These services act as a complement to programmes that promote the permanent posting of health workers in remote areas (MOH, 2007). In terms of malaria control programme, such services are used for both curative and preventive purposes by providing treatment and education respectively to victims of the disease which otherwise could have been difficult to be provided by the local health facilities (Nyonator et al. 2005; Binka et al. 1995). However, often outreach services of the routine programme activities are especially affected by a number of constraints, which include: lack of health personnel, scattered nature of villages and limited transport as well as logistics problems. These problems make it harder for the health officials to execute their duties properly (e.g. unable to organise and or provide the right information to the communities about the impending meetings or services (WHO, 2005; MOH, 2007). As a result, health authorities often have to rely on the community members themselves which gives rise to the various roles played by the community members as confirmed in this study. In all the study sites, there were three major roles that were found to be played by the community members through their participation in the outreach services. These roles included:

i) The mobilisation of the people and organisation of NMCP activities

In both study sites, it was found that during the outreach services, community members often played the roles as both 'mobilisers' and 'organisers'. They often had, not only to mobilise the people but also organise the community meetings for the health officials, particularly at the rural district of AAS. This was confirmed by one NGO officer who stated that:

"Sometimes when I need to go there (AAS), once I send message to any of the volunteers, especially their head, all the organisation of the meetings will be done before I even get there. They are always ready to assist" (Nr 3)

Most community members confirmed this. For example, one community member stated that:

"Most organisations like the NGOs benefit from the roles we the communities play. I for one, all that they need to do is to send to me the message and I will make all the necessary arrangement for the meetings. We are always ready to offer our help" (Nr 124)

From the point of view of the health officers, it was important that they had some of the community members who were willing to help them in mobilising the people and organising some of the NMCP activities. It was reported that in the remotest parts of the district, (AAS, for example) most of their control activities would not have been possible without the help of the community members. This assertion was supported by the following reasons:

"we do not know much about these areas. The people know themselves, when individuals will be home on certain days and what time is convenient for them. So they need to advise us when it is better to come to them and at the same time how to organise the people to come to these meetings. If some of these community members are not there, we may go there and nobody will be around to meet us"
(Nr 48)

....In the area of organisation, they (the communities) help in arranging meetings with the rest of the communities that we can not reach particularly when we have to conduct an educational campaign” (Nr 24)

“.....The community members have the ability to bring the people together and ensuring that whatever the message that we health officials have for them reaches everybody” (Nr 50).

“.....The community members help in arranging meetings and they have the ability to bring the people together. The local chiefs or the elected Assemblymen make it their responsibilities to inform the community members and ask all of them to come out of their houses to listen to us” (Nr 50)

From the above statements, it is fair to state that the communities have a wealth of untapped human resources and energy that can be harnessed and mobilized through community participation (Robertson, & Minkler, 1994). By employing certain practical techniques that can engage the community members, (e.g. involving them in the organisation of NMCP activities and the officials taking their advice on when it is better to have such meetings) the health officials at the study sites were enhancing community participation. This provided the communities the chance to devise and initiate strategies that were suitable for them and also helped them to improve their situation. In essence, by involving the community members in strategic policy process, many commentators have argued that communities are often empowered which assist them to gain their self-confidence, self-esteem, and understanding that are necessary to articulate their concerns. In that way, they are able to make sure that proper action is taken to address their problems and more importantly gain control over their lives (Schuftan, 1996; Morgan, 2001; Espino et al., 2004). Besides, involving the community in a programme (e.g. malaria control) has the potential to increase local ownership of programme and enhance a sense of responsibility for maintaining services provided by the programme officials. These aspects of ownership and accountability are both crucial for the sustainability of such programmes particularly if outcomes such as health improvement and or quality of life are to be widely maintained (Tam 1995; Shiff, 1998).

ii) Communities as informants and peer educators

Another finding of this study was that during the outreach services, the community members played a role as informants as well as educators. It was found that due to the problems facing rural population, (e.g. lack of proper local media and or transport) the community members were always the people who took it upon themselves to inform others about any activities that needed to be done at the village levels. In addition, most of the interviewed people admitted that there were certain individuals within the community who often contributed in educating the rest of the communities on the prevention and control malaria. For example, one officer declared that:

“The community members help in informing the people as well as educating them on issues that have to be discussed during our meetings (e.g. prevention and control activities). Some of the members are very good in explaining things to the members particularly if we have to conduct any educational campaign. They play important roles during these campaigns as, if your like, educators” (Nr 118)

This was also corroborated by the most of the community members arguing that they had the belief that it was their responsibility to help the district health workers in carrying out their duties. Based on this belief, they were not only organising meetings during educational campaign but also advising the people about the dangers of malaria and at the same time assisting the health staffs to educate the communities. This argument was openly confirmed by some of the community members who said:

“...I contribute to disseminating the messages and creating awareness of the problems caused by malaria (Nr 61)

“.....We also contribute in disseminating information to other rural areas. At times, they will like to go rounds in the various towns, but there is no other means to let those there to have information before the date. So we can volunteer to go by bicycle and deliver such messages (Nr 41).

“Last month, we had a community officer in this village who came to talk to us on malaria control. In this occasion, I was able to go from one house to another and to most

villages to call the community members to come and listen to what malaria control educational campaign was all about (Nr 20).

“..... Sometimes, I also advise or educate pregnant women who get into my car about the necessity of attending antenatal care because I have experienced what malaria can do to pregnant women” (Nr 63).

The implication here is that the community members often adopt, in the words of Rifkin (1981) public health approach by revealing the causes of malaria and the its negative impacts to most of their members. In so doing, they contribute not only in organising meetings but also raising awareness of malaria control activities by assisting health officials to promote education on malaria control and prevention. In reality, it could be argued that community members inter-personal communication skills (via house-to-house visits) act as an incentive to other community members to actually participate in health programmes (Mboera et al. 2007; de Savigny et al. 2004). With such a role, it can be argued that because most community members often find support from their peer educators who are seen to be in similar situations, their positive attitudes in disease prevention and control are strengthened. Furthermore, it has been noted that such knowledge sharing amongst community members that builds on indigenous knowledge has the potential to be more effective in enhancing community participation in health educational activities (Perez et al. 2007; Okonofua et al. 2003). For individuals and households such multifaceted roles played by the community members fortify the effectiveness of health education and information provision which impact on behavioural changes. In effect, disease prevention and control could positively affect the communities if the right strategies (e.g. community participation) are adopted in health programmes (Mboera et al. 2007; de Savigny et al. 2004; Panicker and Dhanda, 1992; Harkins et al. 2008; Castro et al. 2009). In the case of the two study sites, it has been noted that with the help of peer educators, health officials were able to provide access to information for remote or marginalized populations which hitherto had been impossible.

iii) Community members as ‘motivators’ of health officials

The third finding on the issue of outreach services was in relation to the roles crucially played by the communities in helping to resolve the problem of low motivation of health workers at the rural areas. In particular in AAS study site, it was found that it was the communities who helped in mobilising and galvanising their own resources to motivate health officials. This was to complement the efforts of the national government by encouraging the few health officials posted to the rural areas to stay and work with them so as to improve their health status through, for example, malaria control.

The majority of the interviewees validated this. For example, one NGO officer explained this claim by stating that:

“These community members contribute in motivating or de-motivating most health staffs to either stay within the community or go out of the community. For example, they can contribute sometimes in kind by giving gifts such as farm produce to most of the health workers” (Nr 3)

One health officer also stated that:

“.....It is these same community members who provide assistance like supplying us with chairs and at the same time food stuffs from their own farms. These are some of the incentives in working in these rural areas. We do not need to buy food all the time (Nr 73).

Community members also confirmed their role in this area. For example, some members stated:

“..... Even when they were to station community nurses in the next town, they came to ask for our support in building a place for these nurses, which we agreed. So, we used to go to offer voluntarily our services in the form of a communal labour “ (Nr 49)

... I have even once helped the staffs by providing food and free accommodation. For me that is a token of solidarity in the fight against the disease” (Nr 61)

The kind of participation in the form of voluntary contribution resonates with the argument made in the literature which states that participation can be in cash or in kind (Woelk, 1992). In the case of the study sites, the latter (by kind) has been found to be one of the ways in which the poor community members in the rural area participate with the aim of effectively improving the retention of front-line health workers in rural district. This has been very significant since communities can no longer rely on central government alone to successfully address the health needs of the people by adequately providing the needed incentives to health officials to remain in the rural areas (Espino et al., 2004).

However, from the point of views of the urban (KMA) health officers these kinds of contributions could not easily be recognised in urban district. They argued that, in contrast to rural district (AAS), it was hard for officers to get much support from the community. The community members often regarded officers as those who were to work for their pay. They did not feel that it was the community's job to work for them or provide them with incentives. Majority of the interviewed officers agreed with this lack of support. For example, one officer said:

“ there is little support for we the officers. Most community members believe it is the sole responsibility of the health workers to deal with the problem of malaria since we are the people who get paid from the government. Even those who live in poor neighbourhood where they are more vulnerable to malaria and you think they should give us the needed support, there is lack of support from them in addressing some of these social problems...it is tough here in the city because there is this lack of communal support for us” (Nr 15)

This was also confirmed by community members during the Focus Group Discussions (FGDs) and the basic reasons, according to most of the interviewees, were that:

“unlike the rural communities who get their food freely from their farms, we need to go to the market for our living. In this city we need to sell something and that means going out of the house early and come late” (Nr 39)

“...Life in the city is tough and those who have jobs like the health officers are lucky. Their income is guaranteed at the end of the month while we common people need to go through a lot of struggles to get something to feed our families. I do not think they deserve any help from us” (Nr 40)

...“I believe the health officers have been employed for the purpose of helping us so why should we turn around and help them? Even if we have to help them, the way of earning our living by buying and selling is so difficult that we can not offer the necessary help they need” (Nr 44)

The main argument here is that while the rural people are self-sufficient in terms of food production and are able to feed their families, the urban residents have no farm and are therefore faced with a lot of challenges in order to survive. This finding corroborates with the argument made by Winch et al. (1992) who argued that:

“...health may not be a high priority for many poor people faced with a range of other more immediate problems. Employment, income, inflation, food are commonly thought to be more important than health concerns, especially in contrast to hard-to-recognize, vector-borne diseases” (p.343)

Thus to live through commercial activities, the life of urban dwellers requires them to be early out of the house in order to buy and sell and this affects the extent of their participation in NMCP. This trade-off between staying home to be able to participate in NMCP activities and going out to be able to feed the family goes to support the argument in the literature that the extent of participation is dependent on contextual factors (Rifkin et al. 2000; World Bank Group, 1999). Although these often cannot easily be altered, they must be understood in order to effectively manage programmes within existing constraints. The implication is that it will be difficult to transfer a community-based programme from one place to the next within the same region in the same country without facing many challenges (Rondinelli, 1986; Awoonor-Williams et al 2002).

The difference in the result of these two study sites on the issue of communities' role in outreach services demonstrated how rural communities usually contribute time,

resources and skills in support of NMCP in Ghana. Their belief and role in this programme exemplify one of the principles of the primary health care policy which asserts that community's health is not dependent on health services but equally important is what people within the community do and for themselves (WHO, 1978). For the rural community members, their main aim of participating in NMCP activities was not necessarily for their private gains but for the whole village. This was brought out vividly by one interviewee who argued that:

“ it is not only for my wife and children but my family as a whole in this village. Here, every body is my family and so the community members are the families I am talking about. All that I am doing is for this community because if the next house or neighbour is in trouble because of malaria, I can not go to farm or eat and be happy. In fact I can't sleep well. I will be worried” (Nr 64).

Thus the underlying reason for rural communities' participation is for the sake of the community. They have a deep sense of togetherness and belonging in working for a common purpose and they seem to understand community participation largely as collective actions rooted in a community of place (Taylor, 2004). This implies that the rural community role as 'organisers' to NMCP outreach services is in line with community general accounts about how the community functions. To AAS communities, community participation was an expression of being community minded and social unity (Walker 1993).

6.3.2 Perceived community roles in monitoring and evaluating malaria control programme activities

In general, it has been noted that when it comes malaria control, one of the most important actions that need to be taken in order to ensure the reduction of predisposing factors toward malaria infection is to have prompt and accurate epidemiologic data (Mboera et al. 2007). This means that for effective malaria control, getting information to those required to take action should be quick and correct. However, this has been difficult to achieve in Ghana because of a poor surveillance

system (PMI, 2009). With the health management information system (HMIS) in the country still weak, communication between the respective levels of health service delivery and planning, monitoring of results and evaluation at district and national levels are without problems. One of such problems is the delays in submitting reports due to lack of proper programme's information system (PMI, 2009; Nyonator et al. 2005). In the light of this, it was found that members in the study sites have been encouraged to be involved in these activities which consequently have resulted in a number of roles played by the majority of them community members. Amongst these roles included:

i) Communities as informants and advisors

In both study sites the study found that the communities were the people who were relied upon for vital information on malaria during assessment. Through the implementation of programme activities, it was found that most of the community members used their local skills and knowledge on the environment to play various roles as local 'informants' and 'advisors'. The perceptions of some of the health officials on this role played by the community demonstrated their appreciation towards communities, particularly in the rural district. One officer described the community's roles as "*irreplaceable*" and continued to say that:

....without the good will of the local people, we can not do anything. They are everything to us and their suggestions are valuable to our programmes. So they are our advisers and at times we need to depend on them for the progress of our job. I am sure it is not me alone who share this view. Most of my co-workers will agree with me, especially when it comes to implementation of control programme activities in these rural areas. While we can use them as instruments to achieve our goal, they can also be part of the solution. And when it comes to surveillance or monitoring, their role is significant because they know where possible malaria breeding sites are and they can show you where there is poor sanitation, wrong places for waste dumping and who has done it, gutters,.....I mean everything" (Nr 12).

The opinions of other interviewed officials did not differ from the above statement. Majority of the interviewed officials supported this claim and they also talked about, for example, the difficulties of controlling malaria without the help of the community members. For example, one health official argued that:

.....“controlling diseases like malaria is not easy especially in these rural areas where most of the community members do not like to go to the hospitals and without reporting to the health centres, we have no overview about the state of affairs....and the success of an active case detection is difficult because the information must be obtained at the right time so that the disease (e.g. malaria) can be contained. You see, it could have been better if we could always visit these rural areas to see things for ourselves but we can’t. Someone like me, going to these villages once in say two months is not enough and so It is extremely hard to execute any plan if the communities members do not help in carrying it out” (Nr 13)

Another officer also concluded that:

....” they communicate to us the results of our efforts. Without them, we will have no means to know what has happened to all the ‘beautiful plans’ we implemented. They are the ‘judge’ of all the programme activities. Simply they are our evaluators and we only contact them for results. They are our informants” (Nr 113)

A number of the community members also confirmed this. For example, one member admitted:

“We often assist health officials to have first hand information about this place, particularly when it comes to their M&E activities. The fact of the matter is most of the officials do not know this area so it is we the community members who assist them in all their activities. All the information they need, we usually have to go with them to let them know what is happening in some of these villages, even the way from village A to B, we need to be there for them” (Nr 64)

From the above statements it can be deduced that the members help in detecting and reporting unusual events and locally important disease conditions such as potential breeding sites of mosquitoes to the health team. This kind of role played by the community members enhances health officers’ access to quality of information on the outcomes of malaria control programme within the district. The information collected

through the participation of the community members helps district health teams to react swiftly to outbreaks, set priorities, plan interventions, and mobilize and allocate resources (Rumisha, et al. 2007). The implication here is that it is imperative for local health officers to appreciate the involvement of the communities in epidemiologic and technical dimensions of the malaria problem. The underlying reason is that, as it has been noted, whether particular control policy strategy will be technically possible, socially and politically acceptable, and advantageous, would depend on the extent of the communities' participation (Mboera, et al. 2007).

ii) Consultant and promoters of intersectoral collaborators' network on M&E in malaria control programme

Another finding about the role played by the community members in the area of M&E was the perceived role as the 'promoter of the intersectoral collaborators' network' in NMCP. The reason for this assertion was based on the fact that some health officials considered the community as an actor who was universally accepted as 'good consultants' by all the sectors (e.g. private-NGOs) involved in malaria control collaborative efforts. As a result, other sectors also depend on the community for all the necessary information.

"The community members hold the position of trust and they are the actors to which all of us direct our concerns to when it comes to evaluating the outcome of the implemented activities on say malaria. They make all efforts to supply each one of us (sectors involved in disease control like malaria) with up-to-date implementation activities of other organisations. We all depend on them and the power they have in terms of information makes them capable of being a good player in the collaborative efforts especially in the rural areas" (Nr 47)

From the point of view of some of the urban (KMA) health officers, urban communities, similar to rural communities, were also found to be playing a role as implementing agents. According to one officer, some of them could be described as:

"..... implementers of the malaria control programme (Nr 43)

Others, including the members themselves, also considered the community members as actors with local knowledge who are prepared to share with the health officials when it comes to M&E of programmes. For example, one interviewed official declared that:

“....They share with us their knowledge on any development in all the programmes that we have implemented. Without them our knowledge in these areas will be limited because we may not have the resources to monitor everything and understand why certain things do not go the way we want them” (Nr. 111).

Most of the community members also made it clear that:

“...Often, they are not aware of what is happening here and we let them become aware of what is leading to mosquito breeding in this area. We the members have all the good knowledge about the area and we always ready to help them whenever they need our assistance. They depend on us for everything on M&E” (Nr 26)

“.... we the community members are very instrumental in the achievement of their goals. I for one, I know every place in this area and any information about any possible place for mosquitoes to breed, I am aware of it. The same may apply to most of my friends. As a result, any knowledge they want to have about their work in this area, we can give to them”(Nr 106)

Overall, the finding corroborate with the results of earlier studies elsewhere in SSA. The results of these other studies indicated that this system of community-based surveillance approach has been used successfully in SSA. For example, in both Ghana and Niger, Binka et al (1995) and Ndiaye et al (2003) respectively found that such an approach motivated and enabled community members to identify local health problems. In a way, the role played by the communities in both AAS and KMA in implementing programme activities of malaria go to support the argument made by Prichett, et al (2004) that without the communities participating in programme activities and playing important roles, health programmes like malaria control will fail to produce any meaningful results. At the same time, this way of community participation in the NMCP validates the argument made by Rifkin (1996) that:

'Although difficult for planners to accept, it may well be that to gain improved health status they will have to surrender their dominant position and let community people decide in which way programmes will develop' (p. 246).

In effect, it can be argued that due to the communities' ability to possess the creativity to adapt their knowledge to their local realities (Acho-chi, 1998) health authorities must, the very least, involve them in their planning. This strategy can assist health workers to respond to diseases like malaria of epidemic potential and to take the necessary steps to avert the problem (Rumisha et al. 2007).

6.3.3 Helping victims to cope with the disease

From the literature it has been noted that there are so many reasons provided for the explanation of why individuals within the community often fall victims of malaria. Amongst these included: delay in receiving adequate treatment, non-compliance with treatment, or non-utilisation of the existing health facilities and preventive measures (Hausmann-Muela et al. 2003). Thus from an applied Public Health perspective and centring on the personal characteristics, models used tend to 'blame the victim', claiming that the individuals themselves are responsible for most of the malaria cases in SSA, especially when they do not seek for treatment. However, in general, various perspectives overestimate the capacity for an individual to choose and follow behaviour which is considered adequately, without giving room for the socio-economic conditions that members of the communities find themselves. Consequently, such perceptions often makes it hard for members to have sympathy from most health authorities giving rise to the caring of the victims to fall on the community members themselves (Hausmann-Muela et al. 2003; Mboera, et al. 2007).

This argument was confirmed by the study findings in the two study sites. Throughout the interviews, including the focus group discussions, (FGDs), although services varied between the urban and rural communities, there was strong degree of agreement

regarding the roles played by the community members when it comes to helping the victims to cope with malaria. These roles are discussed below.

i) Assistance in cash or kind to victims for treatment-seeking

One interesting findings about the role of the communities is their ability to ensure that malaria victims survive the disease. In both study sites, the study found that most community members often contribute either in cash or kind to assist victims to access the appropriate health facilities. This was confirmed by most of the interviewees. For example, some health officials argued that:

“.....I see the community members to be as if each one of them is each member’s ‘insurance’ against the disease (i.e. malaria). This is because they provide help to each other in times of sickness either through money or personal services even though they may be poor. This helps them to survive this terrible disease, which I find it to be remarkable” (Nr 88)

.. They provide help to each other in times of sickness. They can either give the victim some money if the family has no money or bring the person to the hospital by themselves”(Nr 58)

..... Most of the community members are from extended families and they always make sure they offer their help whenever one of them is sick. I have been seeing them making contributions by sending people to hospitals and I think such communal assistance is very important for their survival”

However, although the communities in rural areas make these financial contributions, the study found that a greater percentage number of people in urban centres are those who usually assist victims financially, while those in the rural areas offered their help in kind (e.g. carrying the sick to the hospital). This discrepancy in service provisions was found to be unsurprising considering the fact that:

“the means to assist a victim usually involve money, but most of the rural community members normally lack financial resources to undertake this kind of task” (Nr24).

In most of these communities, from the results of the in-depth interview, it was found that the moment a community member became sick it was the members in the house especially the women who took up most of the challenges involved in the caring. As some interviewees said:

“.....it is not the nicest thing to say but I have to tell you that sickness often brings unity in the house. As soon as one falls sick due to malaria, every member in the family rallies around him/her to provide the necessary support, but it is always the women in the house who take the greatest share of the responsibilities. It is the women who continue to maintain the house by collecting water and firewood, preparing food for the children and ensures that the victims also eat the meals that has been made for them” (Nr 39)

“.....Although the women are more involved in the caring, the men also play their part by making sure that there is money to support the victim’s family and by doing that they take the task of paying the victim’s household expenses” (Nr 29).

Thus, the cultural division of labour goes hand in hand with the divisions of power within the households, which often is generally based on gender. While the males take on the financial responsibility, the women are mostly in charge with everyday activities (Ahorlu et al, 2005).

For most of the people interviewed, particularly at the rural areas, the need to share resources was essential. For others while financial contributions were the most effective way of helping the victims to seek treatment, they still believed that contributing in kind could also be an important means of helping victims to access health facilities. This was confirmed by one local driver who stated that:

“One thing that I can not stand is to see a sick person or a pregnant woman struggling to have a taxi to go to the hospital. Whenever I see that, unless, my car is full I will stop and take such a person to whichever hospital the victim will like to go. So in my work as a driver, I try to provide the opportunity to people to have malaria treatment” (Nr 63)

Similar to this kind of role, one rural (AAS) community member openly stated that:

"I do not know if this is what you mean by role we play, but as the only person who has a means of transport in this village, I often take people to hospital free of charge with my motor whenever they are sick, whether malaria or any other disease.. At times, most of the sick people, especially pregnant women will like to go to hospital but the husband might not be around to give her money, so I would bring such people to hospital on credit and whenever the husband comes or whenever they have the money they pay me. Because I have been doing this, these days many people in this locality could go to hospital so easily" (Nr 59):

Others confirmed this and one local leader expressed his admiration for this young man who appeared to devote his time in helping the local community. The leader stated that:

"We those in this locality seem to be lucky that we have such a community that is closely related and because we trust each other, it is easy to help ourselves as well as contributing to the viability of the community. I do my best, at times to ask people to contribute money for sick people to be sent to hospital and they are always willing to do so" (Nr 61)

....."our contributions help victims to be able to cope with the problem which could not be possible on their own" (Nr 45).

For Hall (2002) this signifies a key element of a collaborative effort based on resource interdependence (i.e. where two or more individuals or organizations rely on each other for resources). From sociological perspectives this finding illustrates the extent to which each member with access to varying resources make attempt in sharing them with others. It is an indication of the recognition that each member within the community is mutually dependent on each other. According to Hall, (2002) it is the awareness of this resource inter-reliance and the common sense of duty to each other that helps to resolve complex societal problems within the intersectoral collaborative efforts. For most of the community members, it is the issue of poverty in particular and its consequence on malaria:

" which calls for solutions that need to be provided by all of us..." (59).

Thus just like collaborative efforts that can help organizations cope with the turbulence and complexity of their environments (Gray et al, 1991; Hall, 2002), this finding has also demonstrated that collaborative efforts amongst community members can help individuals to cope with dangers posed by malaria. As one interviewee said:

“through the help we offer to our people, they are able to survive malaria attack” (Nr 59)..

All in all, community members can be considered as a cornerstone for the scaling-up of prompt, appropriate treatment of malaria at the household and or community level (WHO 2001). In fact, this is typical cases of communal efforts where, based on the affection for individuals, community members are held together in webs of kinship and tribal obligation contributes tremendously to basic survival, social maintenance and development (Hyden, 1983). This confirms what is said in the literature about how malaria is mostly treated in SSA and for that matter Ghana. Generally, it is known that the treatment of malaria, in both mild and severe forms, always commences at home. It is only when the illness persists that people make an attempt to seek care from health-care facilities (Ahorlu et al. 2005). However, the ability to seek treatment often depends on the financial as well as the social circumstances of the victims (Tanner and Vlassoff, 1998) and this is where the community members play an important role in providing these services as was found in the study sites.

ii) Community as drug administrators and advisors to victims

Besides the physical caring, the study also found that community members also assisted the victims even after accessing the local health facilities by providing advice and ensuring that the victims took the right dosage of drugs. The role as advisors to self-medication often came about due to the fact that in these areas there was often very few or no nurse and or qualified health professional who would guide the use of these drugs. In this situation, it was the community members who usually acted as drug administrators as well as advisors to victims, for example about how many tablets

needed to be taken in the morning or afternoon or the need to sleep in a bed nets.

Majority of the interviewed members admitted to have played this kind of role as some interviewees declared:

“...the sick person must be lucky to have someone who could read and write so that the right amount of drug is taken at the right time. Sometimes, without the right person around, the victim will even make his/her sickness worst because there is potential for high or under dosage which can also have some effect on the sick person. I have been helping my mother all the time” (Nr 108)

“Another area that I see the communities making biggest contribution in helping or advising victims is in the area of self-medication or drug administration which is part of the management of the disease (malaria) at home. Most of us have not been to school so taking the right dosage is a problem even when we have been to hospital and we have had all the drugs we need. Most of the victims take wrong dosage just because they cannot read properly what they have been given to take. I always have to help my wife whenever she comes from hospital otherwise she will make a lot of mistakes in taking the drugs” (Nr 20).

“In fact, most of the members have a bit of knowledge about drugs and how to administer them through training. So we have to depend on them for the right dosage to be taken. We all make mistakes in taking these drugs because there is no body to help us in this village. The worst of all we do not know whether we have made a mistake or not. All that we know is that we have taken them”(Nr 26)

By putting the above roles of the community as drug administrators and advisors in the right context there are two positive things that can be said about it. In the first place, in the case of these communities, by contributing to the improvement of a community member's health means that the concept of community participation was identical with being a community member. Community participation was therefore an expression of community membership or in the words of Wilkinson (1998) *“a cognitive and emotional response to the experience of the community”* (p.97).

Secondly, this communities' role helps to minimise the problem of particular concern of controlling malaria, which include the inappropriate use of shop-bought medications and or self-medication emanating from medications given to them by the experts in the

hospital to treat malaria (Foster, 1995). In essence, for the most part, treatment continues outside of the formal health-care sector, which takes the form of self-medication with antimalarials and/or antipyretics (Mwenesi et al. 1995; Adeniyi, 2000; Foster, 1990; Agyepong & Manderson, 1994). The role of the community does not only facilitate prompt, correct treatment and accessibility, but also addresses the major problems of self-medication and poor adherence to completion of treatment. Without this role, there could be a high possibility of under- and or over-dosing which could lead to the spread of resistance to existing antimalarials and eventually persistence of malaria or at worst increase in infant mortality rate in malaria (Molyneux et al. 2002; Agyepong 1992; Vundule and Mharakurwa, 1996).

iii) Community as traditional healers

The study also found that there were other members within the communities who played important role as traditional and or faith healers (herbalists) in the management of malaria. During the interviews, most interviewed people concluded that traditional healers who were often part of the communities have been featuring as a common alternative for assistance in dealing with the problem of malaria. However, most of them agreed that the first step that most community members took when any member of the family suffered from malaria was to rely on the left over of the previous antimalarial medication that they bought. They would try to make use of such left-over medication to treat the disease and it was when such efforts failed that they would make a decision to either go to the hospital or consult traditional healers for treatment. It was reported that often, the choice between hospital and traditional healers was contingent on the economic situation of the family:

“ those who have no money or can not get any help (financial or material) go to the herbalists for treatment. But mostly they go to the hospital first and when the sickness is still the same then they will consider going to the herbalists. This is the way they have been able to survive this dreadful disease for all these years” (Nr 90).

..” People who fall victims are sometimes able to survive because of the help they get from most of these traditional herbalists. They often provide them with some herbs which can mitigate against the malaria problem and they do not charge as expensive as what the formal hospital will charge them” (Nr 81)

Most interviewees confessed seeking assistance from these traditional healers who provided them with home-based care although the order of consultation varied between the two sites. According to some interviewees:

“In the past it was the traditional herbalists that were playing major roles by taking care of the victims of diseases like malaria in all places but these days those in the rural areas are the ones who mostly go to these healers whilst those in Kumasi (Urban centre) prefer to access proper treatment from the hospital ” (Nr 49)

“We have these traditional herbalists who do help them (victims) once in awhile but these days I do not believe people go to these herbalists because of malaria. They use them for more spiritual purposes. Well, others (rural victims) still depend on them anyway so I will not argue too much” (Nr 83).

The inference here is that people still have faith in these traditional healers despite the fact that there has been doubt about the ability of these healers to properly heal malaria victims. In line with the literature, it was found that there were several reasons why community members would still use traditional healers. Amongst them included: their proximity to the community as well as easy accessibility by the community. Also, the cost involved was less than the formal hospital treatment and the belief that they were able to overturn any spells or bewitchment, which brought about bad luck in life like diseases (Padarath et al., 2006; Molyneux *et al.*, 1999).

6.3.4: Managing the environmental issues

In Ghana lack of proper construction of facilities like drains, roads, household sewerage systems, and garbage disposal systems are common features of most villages, town and cities. Consequently, these choked gutters and unclean environment creates breeding habitats for mosquitoes (Chinery, 1995). Thus the ability of the government to ensure neatness has been inadequate particularly in towns and villages in the rural areas. This has given rise to various roles played by the community themselves as manifested in this study. During the interviews, it was found that the community members have been playing various roles as follow:

i) Cleaners of the environment

In their attempt to prevent and control the malaria problem, the study found that one of the major roles played by the communities was the members' ability to keep the environment clean through communal labour. In the general interview and FGDs, most of the interviewed rural community members (AAS) described their role in malaria control programme as 'environmental cleaners' who help in keeping the environment neat. This was also revealed during the FGDs when most interviewed people including local officers agreed to this claim as the following statements indicate:

"They often provide communal labour to keep the local environment clean which contributes in reducing malaria cases" (Nr 4)

..... "Without the communal labour, we could not stay here. The environment was ideal for mosquitoes to breed and malaria would have killed us all" (Nr13)

.."They also provide services voluntarily in areas where it is bushy by clearing them which makes the place clean. Sometimes they will clean their gutters making sure that every traces of filth are swept away. They do well and that often keeps the place neat" (Nr 58)

.."We the communities help in keeping the environment clean. We do this through provision of manual labour and this is often out of our own will" (Nr 39)

Thus for most participants it was their duty and responsibility if they had to contribute to make the works of the health staffs easier and to prevent malaria through the provision of their time and energy. This was reflected in some of the statements made by a number of the FGDs' participants at AAS who explained that:

"For me I do not see these health workers as people who must do all these control activities alone. Our district basically has no electricity, no good roads and nothing for them to benefit from it. This means they have made a lot of sacrifice and therefore they need to be supported. If I have to offer my services through communal labour, I will be

happy to do it. The malaria problem has been a problem in this community for a long time and I think we should be motivators rather than de-motivators” (Nr 26)

One local leader also supported this argument and stated that he always saw the need to use his traditional authority to assist in mobilising the communities and to galvanise support for malaria control activities within the communities. He openly declared:

“ Life could have been harder for we those in these rural areas because of malaria if it had not been for the health workers who have taken the trouble to come to the village to help us.malaria affects all of us and we should be thankful to them in their everyday efforts to assist us in controlling this disease. I do not think taking part in malaria control activities and assisting the programme officers in this community, is too much to do. Even in my capacity as a local head, I do ensure the enforcement of better sanitation in this rural area, and I am happy to do it” (Nr 41)

However, despite this important role played by the communities in rural district (AAS) most participants in urban district (KMS) expressed the difficulties in influencing peoples’ attitude as reflected in these statements:

“...Honestly, influencing community members’ attitude, in particular the young ones is a problem. No matter who you are and how much you try to change their habits, they will never listen to you (Nr 37)

“..... Here, (KMA), it is hard. No body wants to be influenced by anyone. Everyone is anonymous and has no time for health educational issues. All that they care is about money and nothing else and often have no idea that when it comes to malaria, there is no boundary between neighbours. Compared to other places, we do not help each other and we seem to care less about whatever affects our neighbours and the community” (Nr 27)

This argument demonstrates that communities in urban district are neither, by and large, homogeneous nor do they realise the need for co-operating for the ‘common good’ (Rifkin, 1986). This evidence has shown that it is rather the concern of individual members in the community that they care about and that takes prominence over community problems. The community members in the urban district (KMA), despite the

fact the earlier finding indicated their willingness to offer help to solve certain members' problems like access to facilities they lack communal spirit to undertake any action collectively as compared to the rural communities. In rural community, (AAS) there is no or little difference between 'community' and 'participation' in the minds of the members. In the rural district of AAS, "communities are, most often, as suggested by Anderson, (1991) 'imagined' entities where members are bound in common reference to ideas and identity" (p. 15). The common interest is high and there is no lack of belonging and attachment which do augur well for the community to play a significant role.

In essence, when it comes to communal activities, in comparison to communities in urban area, the rural communities were primarily found to be more important for the whole of the members in the community. They had great interest in involving themselves in control programme activities, which emanated from the communal spirit and their desire to depend on each other for solving the problem of malaria had strengthened their enthusiasm. Members find the need to participate because:

" we fear malaria and we have no money to fight it once we are attacked. Prevention is better than cure and if we can prevent it from attacking us, we will do it on our own" (Nr 51)

Such positive perception has helped the individuals within the community to shift their perceptions away from the idea of the health workers being workers for government who were helping the community to become more self-reliant. The rural communities in particular have great interest in participating in control programme activities with the belief that it would enhance their chances of preventing and controlling malaria.

ii) Environmental Counsellors/educators

Another role that the study found to be played by the community members was educating most of the members on the need to keep the environment clean. In both

study sites, greater proportion of those interviewed saw the need to provide counsel for people to improve the environment or their surroundings as some interviewees said during the FGDs:

“We all feel part of the good course of the government on malaria and each one of us from time to time tries to play his/her part by advising people to keep the environment neat” (Nr 45)

“..I think the community members also have this will to educate themselves about the effect of keeping the environment untidy. They are all aware of the problem of malaria and some of them do well by letting their fellow members understand the necessity of keeping the environment clean. So they can be considered as ‘counsellors’ on environmental issues” (Nr 43)

“Most of us know that the communities are the people who can make this place neat. I do not think our government can extend its services to this place when it comes to environmental cleanliness and the fact that this place is what it is means they know how to educate themselves about the need to improve their conditions using their own available resources” (Nr 73)

...“These community members contribute in ensuring that the surroundings are habitable although not entirely as one would have liked. Nonetheless, I found their self-help spirit very amazing because the work they do here is unpaid and most of them are very real teachers to the communities. They teach the people the importance of keeping the place neat and they listen to them even more than they will listen to us (the health officials). It is remarkable how, in spite of their low level of formal education, they can impact their environmental knowledge on their fellow members” (Nr 58)

The above arguments illuminate the significance of involving community members in environmental management that can potentially result to a reduction in malaria cases. Through their involvement, communities are able to use their local initiatives and resources in their own hands to define their own development according to their own needs, values and aspirations (Preiswerk, 1980). By using their own available resources to manage their environmental problems to reduce malaria cases, the communities within the two study sites were able to achieve their own self-reliance. In real meaning the communities have been able to draw on their own mental and material resources as

the primary stock at their disposal in pursuit of their objective of environmental cleanliness. In so doing they have been able to satisfy their basic needs, have the ability to grow self-reliant, and to minimise uncertain dependence on authorities outside their own communities (Anyanwu 1992; Preiswerk, 1980; Hausmann-Muela et al. 2003)

In sum, by helping themselves through counselling or educating and making use of their under or over-utilised labour to keep the environment relatively safe from mosquitoes, the communities in the two study sites have exploited to their advantage resources, which would otherwise lie idle. Such illustration of self-help for developing the community, which is prerequisite for survival in this modern world, can enhance the capability and confidence of these communities in handling its affairs (Anyanwu 1992). Ultimately, the communities had been left on their own to look inwards by rallying local resources and efforts. This has the consequence of boosting their sense of responsibility, without looking for assistance from the government as a supplementary to their well-managed initiatives or local efforts (Robertson, and Minkler, 1994). The issue here is participation and how communities could do for themselves if they are allowed to be part of a process. Thus, the significance of participation is its opportunity to provide self-reliance which incorporates into the community development process the means of offering ordinary citizens the chance to be involved in making important decisions about their living conditions. This is community-centred approach, which contributes in satisfying the needs of the people, and this requires community participation at all levels of the decision making processes (Anyanwu, 1992; Schuftan, 1996, Robertson, and Minkler, 1994). The chapter that follows discusses this issue.

6.3.5 Summary

This section has focused on the roles of the various communities that also reflect the forms of participation in the NMCP in rural and urban Ghana. Interviews and focus group discussions were used to elicit data from community members in these areas. Some of the findings were that amongst the various tasks performed by the community

members, the most important ones include: contributing to the outreach services by helping to organise control programme meetings, assist in providing health information to the community, helping the community members who are victims of malaria to cope with the disease, helping to clean the environment and helping in the programme evaluation.

However, within all these major roles, there were differences in the forms of participations amongst those rural and urban communities. First, and foremost, in the rural areas, a number of community members perceived the support they gave to the health staff and the general control programme as part and parcel of community life. They had the beliefs that there was a strong sense of community life and there was an idea that health staff were working for the community and therefore needed to be supported. Thus, while the rural communities were homogeneous and they had high communal spirits most urban communities were more heterogeneous and therefore gave less value to the collective actions than individualism. In contrast to urban area of KMA, in the rural area of AAS the whole processes were directed to community benefit and community participation was regarded as service to the community members. The members encouraged community participation through the organisation of outreach services like meetings. The members' participation was therefore geared towards the viability of the community and they had the belief that:

“when individual members within the community is healthy, then the whole community is healthy” (Nr 51).

The community members therefore had a sense of duty not only to support each other but to the health staff and to be the 'guardian' of the NMCP. Their participation as an actor helped in promoting strong intersectoral collaborative efforts amongst the sectors within the district.

On the other hand, in urban district (KMA), the participation in NMCP was limited and individual roles were often made individually. Confirmed in almost all the FGDs, most

community members more or less saw themselves as 'customers' of health services and health officials as providers of services as one interviewee said:

"..When we see these health officials, we see them as either ordinary customers who want to buy our things or we see ourselves as their clients who need to be consulted for certain purposes. Sometimes they tell us something about the need to keep the environment clean, but in most cases I personally have no time to listen to them" (Nr 37).

Thus in urban district, the difference between community and participation was blurred. To most of the health officials, any form of participation was only based on consultation for the purposes of malaria control service delivery rather than any expectation of active participation like the rural areas. However, it must be argued that it was not that the urban communities did not understand community participation in the sense of developmental approach. Instead, they adopted an instrumental approach, which reflected the contextual factors, (i.e. the challenges of operating in the urban setting).

6.4 Community participation in malaria control policy process.

This section focuses on the findings regarding the extent of community participation in malaria control process. These results reflect on the perspectives expressed during the interviews by various actors at various levels of government, (national, regional, districts and sub-districts). On the basis of the stages of policy making process as discussed in chapter five, these findings start from the planning stage at the national level through to the local level.

6.4.1 Participant's views on the planning stage at the national level

The issue to be addressed in this section ranged from the lowest level of community participation to the highest level, which included empowerment, where the community members were allowed to participate in decision making at every stage of the process. In determining the extent of community participation in NMCP activities, the power

relation among between the community and the other main stakeholders (i.e. public and private) will be considered. This is necessary, because as suggested by Armstein (1969):

“Participation without redistribution of power is an empty and frustrating process for the powerless.....It maintains the status quo” (p.219)

During the interview, the main question posed to the policy actors involved in malaria control policy making process was:

“To what extent have the grassroots community members participated in the malaria control policy-making process?”

In response to the above question, although some of the officers believed that there has been participation, majority of the interviewed officers expressed doubts about the extent of community participation in the planning process. For one officer the complex nature of the concept ‘participation’ makes my question more difficult to answer as interviewee stated;

“participation is a ‘subtle concept’ and it can be interpreted by different people in various ways, so it all depends upon how one views it”(Nr 5)

However, in the context of health planning process and for that matter malaria control the interviewee acknowledged that there is high level of community participation. This is reflected in the argument put across:

“ for me, I will say yes, there is community participation in the planning process. if we do not communicate to them, how can we even get their views? They have representatives and all of them are invited to attend some of the general meetings. We expect them to consult their local people before they come and we believe that whatever they present to us here reflect the views of the community. It is not our task to find out if all that we receive from them have been discussed at the community level. When we are to take decision we do that by taking into accounts the interests of all those involved including the local community members. Soyes, in a way you can say that they are part of the process although we make the final decision on issues which, I think, benefit all the members” (N5)

Other interviewees also supported this idea of community participation. For example, two officers had the following to say:

“ ...there are clear guidelines given to the authorities at the lower level from the government to see to it that every member of the community has a say in whatever plans they want to adopt. Of course, I understand, it is difficult and may be it is not possible to consult all of them, but they have their assembly members, who have to represent them. These selected individuals have direct access to the health management team in the district who can share with them their ideas. That is democracy. You choose, and expect the chosen people to decide for you and even though their representatives do not usually come to Accra here, the district health managers who have direct contacts with them often take part in the planning. How they influence the final outcome is another issue. So the whole process is multifaceted which could be influenced by other factors.....but we at times have no control over these factors” (Nr 10).

“.....People talk about power that is kept by we those at the national level, but I do not see in that way..... In fact, whatever happens at the local level, we have no control over it. We have no control over road networks, transport, individual interest and they all contribute towards the success of community participation in planning in controlling malaria. They are always invited to attend general meetings, and although we do not send letters to all the people individually the idea is that their leaders will come and defend their interests. As a result, to say that we do not include the community members in our planning process, I will disagree (Nr. 7).

The above arguments suggest that through decentralisation, there has been a provision made for the community members to participate in the planning process which authorities at the higher level are aware of. To these officials, with decentralisation policy, there is an opportunity given to the community members to participate in health (e.g. NMCP) decision making process through their local representatives. However, it is the local representatives who have to ensure that their voices are heard. In the case of malaria control in Ghana, based on the arguments presented above, it can be argued that decentralisation policy has a positive link with community participation through

consultations with the local health authorities as well as the communities (Goldfrank, 2002; Blair, 2000; Brinkerhoff, et al. 2007).

However, this study's finding has indicated that community representatives as an institutional mechanism to enhance community participation in NMCP policy making process were not effective since they had no power to change policy decisions. This was validated by other interviewees who disagreed with the national health officials' arguments. The opposite view shared by majority of the interviewees was that although the local health representatives may be informed about the planning process, they had no power to influence any decision that would be made during meetings. In that case, the final outcome did not represent the views of all those involved. The arguments made by others during the interviews were as follows:

“Under normal circumstance, if we are to work in collaboration with each other, then we must ensure that the representatives are equally represented. We must not forget collaborative efforts demands that all actors from all sectors are represented in such coalition with equal chances of having their voices heard. But in this process, we have the donors, national, regional and district health directors, but who speak for the community members? Surely we can not say it is the district directors who are bureaucrats neither the NGOs who are working for some organisations outside the community. So I think, we need to do something about this” (Nr12)

“.....In partnership, everything should be transparent and those engaged in it must acknowledge that there are no ‘back-door’ deals. We talk about involving all partners at all stages of the decision making process, but if we go all the way to Accra (the national capital) and our views and interests are shelved, then why do we go there? For me, I think, they ask us to come to Accra because the national body and their donors want us to know what they have for us. That is to say, to bring to our attention some information on health issues but not to decide with us about some issues relating to health or if you like malaria control programme” (Nr 14)

“.....I think it has all to do with the issue of power and control. Although this is a partnership which demands all the sectors including the lower levels' representatives to work closely with each other, there appears to be the old administrative system. People at the top still always decide for those below. In fact, the whole process of planning makes you wonder if there is the need to have these general meetings at all. It should be

better if we only send our concerns (inputs) to them rather than we taking time and energy to travel to Accra. After all, what do we get?... something which may or may not reflect communities' wishes. In that case, I must be frank with you, we rob the local communities the chance to be part of the collaborative efforts and there is no attempt to offer them the opportunity to have their inputs into planning process" (Nr 23)

....."I feel our time and talents are not respected. When they (health officials) are telling you about the importance of community participation in health issues like malaria, you will stop whatever you have to do and participate in the process, but in practice it is hard to see us (community members) having any impact on the decision outcome. They have the power to decide on the final outcome, but not us" (Nr 65).

These arguments confirm that community representatives as an institutional mechanism in decentralisation policy of health to enhance community participation in (e.g. NMCP) policy making process have not been effective. The underlying reason was that they were either neglected or at best only consulted on priority issues but they had no power to decide on the final policy outcomes. According to some commentators, a collective discussion and decision making without all the parties involved do not necessarily represent all the common interest and concerns of all subgroups and communities that are not empowered (Putnam, 2000; Pelletier et al 2003; Labonte,1997). For example, with regards to the idea of local level "consultation" Arnstein's (1969, p.217) sees it as tokenism.

This raises a question as to whether community participation in NMCP at the national level is a *means* and or an *end*. From the above analysis it can be argued that there is an indication that the concept of community participation seems to be an empty ritual (Arnstein, 1969) that offers no opportunity to community members to attain real power at the national level policy planning process. This is in contrast to the findings in the health policy documents in chapter 5 of this thesis which made mention of some elements of community empowerment through the transfer of power. So far the study has found that the transfer of power to community members in making decisions on health issues is not obvious. Often it appears the community members including their representatives have been playing only, in the words of Arnstein (1969) a ritual role.

They are not permitted to have control over their own health situation rather they are co-opted into direct forms of participation which is:

“ essentially a static, passive and ultimately controllable form of participation” (Oakley, 1989, p.10). In this way, the community participation in the policy making process at the national level could be described as a means rather than an end in itself.

However, the problem with this lack of shared decision-making is that, on one hand it can potentially give rise to less understanding and commitment to the issues confronting actors involved in the intersectoral collaborative efforts as confirmed by an interviewee who said that:

..... “I think, the more they can involve us in the planning process the more we have the interest in being involved in malaria control activities”(Nr 29).

In that situation, partnerships tend to remain weak which undermines the confidence of and the commitment of individual members (Benard, 1989; Cohen *et al.*, 1990; Prestby *et al.*1985). On the other hand, when coalition is strong and all the agencies that are involved in the collaborative efforts are intact, there is a crucial sense of ownership which is developed (El Ansari, 2001). According to Lindsay *et al* (1988), without this sense of shared ownership, members usually have the belief that they have not a common agenda and that they are working for different agencies with diverse policy goals which can lead to ineffectiveness. This was confirmed by one interviewee who argued that:

“it makes me wonder if we are all having the same goal in this health issues. Sometimes I feel like not being a member of the health committee anymore. It looks like a waste of time” (Nr 100).

Furthermore, the failure to create equal power base has the possibility to damage the structure of negotiation that has been built in the collaborative efforts (Taylor, 2004). In that situation, although participation has taken place it could be seen to represent what Arnsten (1969) referred to as tokenistic participation. Also, in the words of Alford (1975),

it has made the repressed group (community members) more powerless while the *monopolisers* and the *rationalisers* (the health professionals and bureaucrats and private sector) become more powerful. Thus, such kind of participation might have validated or legitimated the *status quo* rather than promoting change. This was supported by several interviewees. For example:

“.....Let us not forget the community members are those closer to the problem especially malaria, and if we take decision without them, or we call them but in the end, their views do not count in the final decisions what do you think they will feel? I think the community members need to have something that will assure them that when it comes to health the partnerships are designed purposely for them to be part of us ” (Nr 22)

“..... I am not surprised that the community members are sidelined when it comes to the final decision on priorities because it is the national government and the donors who have the resources. They have to consider whether or not they have enough money to meet all the set priorities. So.....it is a pity but that is the reality of the situation. You have to balance the right of the communities to participate in deciding what they want and need and the practicality of having all their needs met. In this case, it is always those with resources who will decide for those without” (Nr 43).

In effect, the general picture that one can get from these arguments is that when it comes to planning process at the national level, the inclusion of community members' priorities as well as the chances to explore the cultural significance of their views has been limited. The consequence might, according to Anderson et al. (2006):

“lead to the neglect of important sources of lay knowledge particularly top local decisions” (p.79).

6.4.2 Summary

This part of my study findings reflects the extent of community participation at the planning stage of NMCP in Ghana. There have been underlying variations in the definition of community participation by those involved in health issues which has given rise to convergent and divergent perceptions. From the point of view of those who

support the proposition that there has been community participation, as long as there are community representatives from the district health sector who are often invited to attend meetings, the community members are indirectly involved in the planning process. The underlying reason is that they represent the interests of the community and therefore have the opportunity to bring their concerns to the discussion table.

On the other hand, there are those who believe that there has been limited involvement of communities in the planning process. Some interviewees agree with the idea that when community groups are invited to participate, the real ultimate decisions are still in the hands of the state officials. Therefore there is no empowerment and for that matter no effective participation which health policy of decentralisation purported to achieve (Fisher, 2000; Blair, 2000; Brinkerhoff, et al. 2007). It can then be seen as legitimization and maintaining of the top-down status quo through apparent consideration of community participation.

This is in line with Arnstein's ladder of participation (1969) which explains the lower rung of participation as tokenistic because the participation is basically not intended to offer any significant input from the community members into decision making process. This level of participation fits precisely within the rung of 'placation'. The degrees of placation depend on the factors such as technical assistance offered to the participants and the extent to which the community has been organised. Considering the planning process, it can be argued that the levels of participation in Ghana health sector and for that matter malaria control are a much lower level of placation. Essentially, community members are consulted just to maintain the status quo by the authorities. This is to say that they are only used as a means rather than the end in achieving policy goals.

Overall, this finding has shown key issues which negate successful implementation of intersectoral collaboration in malaria control planning process. It can be noted that there are two main issues that are at stake in the policy making process namely:

strategic and operational issues (Stewart et al. 1995). It is these issues that according to Stewart et al. (1995) are the covert dimensions of power. This is because whilst strategic power involves the ability to set targets, allocate priorities and determine policy the operational power implies having the ability to decide how these things are implemented (Hart et al 1997). In the case of NMCP, it is noted that the national health officials have the strategic power to make strategic or policy level decisions, while the local health authority has the operational powers. The latter has to make service level decisions on a day-to-day basis and to influence service delivery. It is therefore their responsibility to engage the community members during the implementation process. This means that the powers that have to be used to allow communities to participate are often left to the discretion of the 'street level bureaucrats' (Lipsky, 1980). The extent to which these powers are utilized by at the local level is to be discussed in the next section.

6.5 Local residents' views on the extent of participation in the policy making process at the district level

Similar to the national level, the findings on the extent of participation in policy making process at the district level were mixed although the perceptions of interviewees on the degree of participation were different compared with the national level. The findings generally came out from the question:

“Would you say that there is community participation in the policy making process (i.e. during the planning, implementation and evaluation) of malaria control programme activities at this district level?”

On the basis of the responses received from a greater number of the interviewees, one can make an argument that although they have been participating in the process in various forms (e.g. general meetings, workshops, interviews and indirectly through their local health committees) the level of participation needs much to be desired. This truth is that although majority of the interviewees believed there had been some kind of

consultation real participation has not been taking place and this is reflected in most of the comments made by the interviewees.

“ In fact, if you had asked me maybe five years ago, I would have said no but now, the answer is definitely yes. The reason for saying this is because I think they are doing well to consult us when they are to implement some programme activities (Nr 55).

“...In this village, for the past two month, they have been here twice and anytime they come, they organise something like public discussion on how best we can keep this place clean as well as finding out from us any area in this place that we think can easily bring about the breeding of mosquitoes. So they are consulting us on some of these issues which help in finding solution to the problem” (Nr 60).

For some people, the participation of the community has been a reaction to what health staffs or planners would like them to do for them. This was reflected in most of the arguments put forward by majority of those who voiced their opinions during all the focus group discussions:

“ they always come here to tell us what they intend to do but how they arrived at such decision is not something we have any means to know. I think that is where we lack the participation “(Nr 61).

“..... You know it is all good for them to contact us after they have taken a decision and come seek our support but what I would have liked to see is to have us during the time of taking the decision. In that case, we can understand better about the need for such a decision and be responsible for its failure or success” (Nr 44).

“...The concern we have is that although we have our community health committees, they only bring us into the discussion when they have made a decision on how they want us to support them and then they will seek for our support. I find it wrong. Why can't they let us decide for them on how we want to support them”? (Nr. 57)

“..... we are only to obey what they tell us to do or to help them to achieve but we no body comes to say, this date or that date we want you to come to the district capital to meet the district or regional or national health manager so we can all decide on what is best for you. No, I have never heard such information (Nr 65).

“.....Often when the health officials come here, I think they purposely come here to make us know what they intend to do which is not the same as asking for our opinions,

because whether we like it or not they will do what they think they have to do, any way” (Nr 71).

“.....From the way I see things, I believe the health officials could do more than simply getting us engaged in programme activities when decision has already been decided. That is not a transfer of decision-making power and if we need to have the chance to change the course of policy making on issue like malaria, which is so important to us then we must be allowed to take part in all the stages of the control policymaking process” (Nr 66).

However, for other groups of interviewees, although they do admit there is only consultation, they are satisfied with that kind of participatory approach. In all the interviewees and in most of the FGDs, these groups of interviewees had these to say:

“..Definitely, we are not considered at the initial stages of the planning process, but I can really understand that because when it comes to health, it is a very complex issue and in my opinion, doctors, nurses and all the managers, are there to be paid for those decisions. So it is good that they do the planning while we contribute by helping them to implement or evaluate” (Nr 49).

“.....For me, I think, we do need these experts to decide for us especially health complex issues that affect our lives like malaria. We can take our own decisions on simple issues like keeping the environment clean to make our area less vulnerable to mosquito-breeding, but I when it comes to such important decisions I think it will be wrong to let us decide on our own” (Nr 86) .

“....I do not think, even if the state really gives us the power to decide on our own or be part the planning process, there will be any difference in outcome. They are trained to do that job and we are only to support them. So consulting us alone for me is okay” (Nr 52)

The above arguments raise two different but important fundamental views on the definition of community participation that are in line with the literature. First, there were those who saw community participation to be minimal and that even if there was any participation at all, it should be a reaction to the wishes of the health experts. This perception of participation agrees with the narrowest level of Rifkin's (1985) idea of *medical approach*, which defines health as the absence of disease and describes community participation as:

“activities undertaken by groups of people following the directions of medical professionals in order to reduce individual illness and improve general environment” (Rifkin, 1986, p.241).

The implication is that community members are service users and therefore must follow orders provided by the professionals without any active participation in policy decision making process. Thus in the case of Malaria, some community members wanted to be passive in decision making and leave the task of making decisions in the hands of the health experts while following others from health experts. This also coincides with the weak and strong power relationship between the community and the health experts respectively as argued by Alford (1975). To adopt this kind of participation would mean that the community members would only have a voice in the decision making process. However, the members would only have little or no authority to guarantee that their more powerful stakeholder would take their views into consideration. According to Tosun, (1999a), this form of participation is the ‘induced’ type which is often practised in most developing countries where most communities only accept decisions regarding development issues developed for them rather than by them. In effect, although there has been health policy of decentralisation, policy making process still bears all the features of a top-down system of decision making (Harrison, et al., 2002; La Bonte 1997).

In contrast, the second group saw community participation in a wider context and perceived community participation as the community members’ involvement in NMCP policy decisions without necessarily resorting to the dictates of the health experts. This way of seeing community participation is consistent with the second approach of Rifkin (1986) called *health service approach*. It is participation viewed in the wider context and defines community participation as:

“the mobilisation of community people to take an active part in the delivery of health services” (Rifkin, 1986, p.241)

To this group of people, policy decision making on malaria should not be left solely in the hands of health professionals rather the community members should be involved. This is in contrast to the first group who argued that due to the complex nature of health and for that matter malaria, decisions should not be left to anyone else but health professionals. This seems to suggest that the second group's opinion exemplifies the belief that the definition of health should not merely be the absence of disease, (*medical approach*) rather it has to have the broader meaning of the word: "the physical, mental and social well being of the individual" (WHO, 1978).

6.6 Community participation as perceived by local health officials

Consistent with what the local community members have been saying, the interviewed local health officials agreed that consultation has been a key form of participation in the policymaking process of all matters relating to diseases including malaria at the district level. Majority of the officials believed that faced with the constraints in the various districts, all the institutional mechanisms that have been put in place at the community levels are the ideal way of consulting the community members. Arguments made in support of this claim reflected the views of almost all the officials. Most of them stated that:

" We have selected community health committee members who are frequently consulted whenever the need arises. These committee members act as the voices for the community and the health officials always give them information about health issues that are addressed at the district council. They often meet the health officials to discuss issues that affect this community and that is all we can do" (Nr 58).

"...In this district, there are so many ways that the communities have been participating in decisions. Through our consultation they are able to provide suggestions to the district during meetings. I am not saying we do whatever they tell us but at least we listen" (Nr. 50)

"...We consult them when it is necessary and it is not always the case that their decision is acted upon in the process, I must be frank with you. The district is poor and certain

constraints make it difficult to do all that need to be done for the community members. Even sometimes the means (resources) to do all the consultations become a problem” (Nr50).

The point to be made here is that although the officials have a number of several avenues through which community participation is promoted, the highest quality of participation is at consultation and placation levels. Thus, similar to argument made by the local community members, the use of these channels only guarantee information provision and consultation on issues but does not lead to citizen empowerment and there is no assurance of direct incorporation of inputs (i.e. decisions) into the policymaking process (Arnstein (1969).

In essence, despite the fact that the process and the right to participate may be devolved to the local level, the community’s power to legitimately shape the content of the policy processes, and to challenge as well as supervise the outcomes, are still in the hands of health authorities. Everatt et al. (2010) argues that participation is not merely about having the opportunity to consult or being informed about policy outcomes or attending meetings but also having the power to control inputs which other wise would have been controlled by others may or may not address communities’ priorities. This is not, in the words of Everatt et al. (2010)

“deliberative democracy which emphasizes on more active search for ‘real’ participation, i.e. participation that is both broad and deep, allowing citizens to reflect on policy options—and moving beyond the limits of representative democracy” (p. 230)

6.7 Conclusion

This chapter has considered the extent to which community participates in decision making process of malaria control. The findings showed that although the community members are allowed to take part at the district level’s policy making process of malaria control, their participation is limited only to consultation during implementation or evaluation stage of the process. In the context of Walt et al. (1994) policymaking

framework, it can be argued that there is no complete participation because these stages of policymaking are all interwoven. One can not participate in one without the other if better results are to be achieved (Walt et al.1994).

In all, it can be concluded that this study raises concerns over the ability of the intersectoral collaboration (ISC) policy strategy of NMCP to enhance community participation. The findings suggest that promoting through ISC strategy in the absence of a clear and effective mechanism for accomplishing community participation does not necessarily result in participation that is meaningful and empowering. The results show that the ISC as a strategy to ensure community participation have not been found to be effective since it does not provide the community with empowerment. This could be due to the fact that neither the government nor the local health bodies have set clear operational guidelines, such as designating the number and frequency of meetings or defining the mechanisms to be used to carry out representation or decision making. The government, in this situation, appears to be using community participation as a means of achieving their health goals as directed by the donors and while concentrating less focus on the empowerment of the people. The analysis indicates that although the idea of participation is rooted in both international and the national health policy documents there is little explicit practical operation of it in terms of power sharing.

Chapter Seven

Barriers and the extent of institutional involvement in Intersectoral Collaboration

7.1 Introduction

This chapter answers the last research question in this thesis:

'What are the barriers that undermine community participation in malaria control policy making process in both the rural and urban Ghana and what are the factors that can potentially facilitate it?'

The findings on these barriers and enablers to community participation are given below in two parts, supported by quotes obtained from interviews. The first section seeks to discuss the findings on barriers that undermine community participation in malaria control programmes. Following the discussions on these barriers, the last section of this chapter also examines the findings on contextual factors that might have facilitated community members' participation in the malaria control policy process. These issues will be examined from the perspectives of both governments' officials and the community members.

7.2 Barriers from the perspectives of the health officials

Health officials were asked for their views on the main potential barriers to community participation in the malaria control policy making. From the perspectives of the health officials, the two main barriers were the powers of the central bureaucracies and lack of resources. These barriers are discussed in details below.

7.2.1 The powers of central bureaucracies caused by the typology of a decentralised system of approach

From the results of the interviews corroborated by the documentary materials reviewed on Ghana's system of local administration, it was found that although for the past three

decades significant progress has been made in bringing administration and direction of health (and other) services closer to communities by the central government of Ghana: *“much still needs to be done in the area of participation”* (Nr 111).

The interviewed officials argued that through the policy of decentralisation, it was expected that the established mechanism of the Unit Committee leaders at the community level, together with the elected District Assembly members, would enhance community participation. This was reflected in the article 35 of the National Constitution, which required the State:

“... to take appropriate measures to ensure decentralization in administrative and financial machinery of government and to give opportunities to people to participate in decision-making at every level in national life and government.” (5d)

Purposely, the Act was to demonstrate the commitment of the national government to fundamental reforms of the local planning system to nurture a strategic, proactive force of ensuring that communities become part of the policymaking process. In essence, it was explained by one interviewee that the planning of programme activities, for example, should involve a change from the top-down to a bottom-up approach and the control of the local development planning would be handed over to the local authorities. However, although on paper it appeared the local authorities have political and administrative powers, (e.g. the communities have elections for members of district assemblies and the local authorities have to manage their own programmes activities) in practice, things are different due to a number of reasons which included:

(i) Weak local powers

From the interviews by the expressions of the opinions of the majority of the interviewees indicated that although there is a decentralisation, the power relationship between the central and the local health authorities (i.e. higher-level and lower-level authorities) was a complex one. The reality was that rather than having enough powers to decide on issues affecting the communities, the lower authorities have to work within

prescribed guidelines which had made the local authorities incapable to work outside the framework that has been created by the higher authority. For example, one official expressed that:

“ the districts departments and agencies such as the local health sector have to rely on the central authority for funds, priority-setting guidelines and all the rest. So we are not as independent as it seems and we can not mobilise the community the way we (local health authority) want it to be” (Nr 73).

The above argument suggests that instead of having the type and approach of decentralisation which should help the local authority to have devolved powers to decide on both issues and the amount of resources needed to implement them (i.e. devolution) there is a deconcentration approach which gives more powers to central bodies (Mills 1994; Mohan, 1996). Such powers of central bureaucracies limit local powers' decisions on many issues such as training of personnel, salaries, contracting, hiring and firing as well as local employee's benefits because they are all entirely centralised (Bossert et al. 2002). For most of these interviewed officers this system of deconcentration often weakens their local powers' ability to create a favourable climate for community participation in policymaking process. Consequently,

“majority of the community members lose interest in taking part in most of the programme activities” (Nr 73).

This view was similar to the views expressed by most of the officers who argued that:

“The existent of deconcentration type of decentralisation makes things too formal and bureaucratic, which negates the whole purpose of having bottom-up approach. For most of the community members this is still the old 'politics' of local authorities still depending on the powers of the national government. ...Of course, it is sometimes discouraging for us (officials) that we can not solve most of the problems that are in the local communities as they wish.....Our hands are tied. We can not determine the final outcomes of our plans, so we can not always fulfil the expectations of the communities. In the long run our failure keeps them away from participating in the process of policy making” (Nr 90)

....."It seems to me, with the power still centralised, we are basically detached from the communities and it does not help in minimising differences in powers between the community and the local health authority. I see us to be closer to the central government than the community members themselves. This is not a good way of motivating the community to participate in decision making process especially when they perceive that their needs have not changed over all these years. I do not blame them for being apathetic" (Nr 88)

.... I believe most of the community members think that we the officials are political appointees rather than civil servants (Nr 111).

The central issue here is that this type and approach adopted by the central government in the implementation of a decentralised policy often leads to, in the words of Skidmore et al. (2006) "*Self-exclusion*" (p. 42) by the community members. This is to say that community members may be willing to participate in policymaking process of malaria programmes but often decide to exclude themselves from it for various reasons. Some officers believed that the idea that more people will be motivated to participate in policy making process through the implementation of decentralisation policy can not be true at all times.

.... It seems it all depends on the type and approach that will be adopted by the country. The system (i.e. the local public officials depending on the central authorities for policy goals) here actually does not augur well for community participation in decision making, because it tends to create a distance between 'us' and 'them' " (Nr 113).

" at times ascertaining local communities' opinions for the purpose of district health planning issues, more often than not has been 'put aside' due to the need to meet deadlines proposed by central government" (Nr 65)

From the above quotes, it could be inferred that the myriad of bureaucratic processes involved in deconcentration type of decentralisation have made the powers of the local authority to be too weak. This has consequently given rise to lack of proper relations between the communities and the local health authorities. Evidence from the field interviews demonstrated that community meetings where participatory planning was

expected to occur were often lacking. During the interviews, a number of interviewed officers admitted that:

“... we always talk about community participation in decision making process but the problem is what contribution can they (community members) make if they only propose but we can not put into effect. We local officials are only delegated officials and neither we nor the community members have any power to effectively implement what they suggest because we have not the means to do so. So I am not sure this strategy of engaging the community in policy making decision process has any importance to the power sharing” (Nr 23)

In total, one could argue that participation in Ghana which aims at helping the communities to (re)define and to shape their own destiny from their own development discourse as advocated by Hickey & Mohan, 2004 has been thwarted by weak local powers. They have not the means which could help enhance community participation. The central government has simply to determine the direction of health programmes within the government preconceived frameworks of development and communities' have little or nothing to do to change it. This technical means to an end approach to participation is described as by Freire (1972) as 'domesticated' because it is the authorities at the higher level (that is, the oppressors) that dictates the framework within which those at the lower level including the communities (oppressed) have to work and the latter have no choice but to 'internalise' such kind of imposition (oppression) (Freire, 1972). Although this kind of system can be seen as socially constructed through power relations and therefore can be transformed, the lower authorities consider such system (oppression) as the natural order of things (Sinwell, 2008), which is due to their power weaknesses.

(ii) Continuous vertical integration amongst sectors

Another finding of this study in relation to central bureaucratic powers posing as a barrier to community participation was the continuous vertical integration amongst the sectors at the lower (district) level. The study finding showed that instead of building

and transforming their own reality in sectoral policy making processes in collaboration with the other sectors at the lower (district) level, (e.g. health), most of the sectors still depend on the national sectors for final decisions on matters affecting the community members as declared by most interviewees. Examples include:

“...the continuous vertical integration of some sectors like health has brought about central bureaucratic powers on everything especially planning, funding, regulation, you name them (Nr 113)

“...How can we have more integrated actions at the local level if there are still sectors which are still having vertical linkages with the national authorities? This obviously impacts any possibilities of having any proper partnership with actors outside the vertical linkages, particularly the communities. So I believe the current rhetoric of community participation has been made more difficult because of this issue of local-national linkage” (Nr 90)

“...This existence of vertical integration often makes it hard to share information us because instead of having information shared amongst we those on the same level (district) from various sectors, it is shared amongst people at the various positions ranging from the district to the national within one sector. This kind of communication alienates the communities and does not augur well for their participation since they hardly get any information compared to the information we those public workers get” (Nr 50)

In effect, most of the centralised institutions that existed before the decentralisation have not been dissolved and if anything their functions have rather been re-defined (Decentralisation policy review, Ghana, 2007). The implication is that the ‘decision space’, as Bossert and Beauvais (2002) put it, available to the local health authority for policymaking is narrow and the nature and degree of discretion on issues like community participation has been restricted (Bossert and Beauvais 2002). Thus

“Consistent with its overall character of ‘decentralised centralism’, the Ghanaian health system provided little or no mechanism for local governance or popular participation in health sector decision-making” (Bossert and Beauvais, 2002 p. 24).

Applying the Alford's (1975) structural interest framework to the above statement, it can be said that lack of community participation and the national government's willingness to delegate power can be viewed as representing an attempt to co-opt the communities by the corporate rationalisers. The aim is to ensure that the status quo in terms of distribution of power and decision-making responsibilities is preserved. In this case, the kind of chosen form of decentralisation does serve to repress the interests of the community members. Considering the core of the demands of participatory process, the local health officials also lack adequate room for taking decision and to effectively carry out the task of involving community members in health planning. For some of the local health officials this situation puts them at a tight corner without any better way of challenging it. According to one officer:

"I feel we the local health staffs are in a dilemma because while it is our duty to ensure that the community members participate in the decision making process, to draw a line of where they have to participate is not easy. Often we have to use our professional judgement but that is not enough. We either undervalue or overvalue their level of understanding in the process. We never get it right in our estimation and nobody will. So I do not think the community is given the whole field of decision making process to operate as they should in spite of the current policy of decentralisation" (Nr 123).

The opinion expressed above implies that, comparing the powers of these actors, (the health authority and grass root community members) in the development of the malaria control policy process, one could identify the different levels of powers. Amongst these two, it is fair to say that it is the health authority which is unmistakably the key power holder within the process since they have the power to use their professional judgement (*street level discretion*) to decide on when to include the community members in the decision making process. In the concepts of Alford's (1975), they are both the dominant group (monopolisers) and corporate rationalisers as against repressed group, (i. e. powerless community). As government officials, they are faced with, in the words of Giddens (1979), structural problems (e.g. internal organisation and political structures) that make it difficult for them to share power equally with the community members and to build upon their knowledge and experience. This situation appears to weaken the

partnership argument which is the main feature of intersectoral collaborative efforts. The situation also undermines the basic idea of policy network which characterises the network actors as equal within the ISC policy strategy (Rhodes and Marsh, 1992; Kickert et al., 1997). In a circumstance like this where partnerships are not based on equality, it is doubtful if the situation can be regarded as real partnerships since the opinions of more powerful partners are dominating agendas and processes (Balloch et al. 2001).

Summary

In all, it can be said that although operationally, the literature suggests that in order to attain broad-based influence and control, all the actors in the process needs to participate on an equal footing irrespective of their position in the social hierarchy (Robertson and Minkler, 1994; MacFarlane et al. 2000; Israel et al. 1994), yet in practice, there had been 'I plan, you participate' Lahiri-Dutt (2004) philosophy.

In the case of the study sites, the study's finding confirms that while considerable progress has been made in the establishment of political and administrative institutions, the typology of '*decentralised centralism*' has been a barrier to community participation. The local health decision makers' dependence on the central powers has prevented them from being open to the communities they serve. Such lack of openness has consequence on community participation based on the fact that:

"Where decision makers are prepared to be open and outward looking they are more likely to encourage public participation. An inward orientation, in which the agenda is defined by officials the 'rules of engagement' are imported from less inclusive settings and the substance of participation is dominated by bureaucratic rules and procedures, may squander 'the sense that these are locations in which social change can be achieved' (Barnes et al. 2001, p. 381)

The implication here is that although the policy of decentralisation might have facilitated community participation, with bureaucratic rules and procedures the communities have been prevented from having interest in taking part in the decision

making process (Barnes et al. 2007; Valentine et al. 1989). Moreover, the kind of decentralisation that has been adopted reflects the tradition of centralism within Ghana health sector and this has made the local government to be seen as an arm of the central government rather than a semi-autonomous body that can decide on its own plans. Such typology of decentralisation have failed to motivate the community members to be part of the decision making process (Decentralisation Review, 2007; Bossert et al. 2002). From this finding, it can be deduced that being accountable to the national government rather than the communities can be a source of barrier between potential community participants and the local health authorities (Taylor, 2003).

7.2.2 Lack of resources

The second barrier perceived by the local health officials was lack of resources. From the literature, it has been noted that in order for rural communities to play an active role in the policymaking process, access to resources is of overriding importance (Taylor, 2004; Lilley, 1993). However, from both study sites there were a number of resources that were not adequately provided and these included: inadequate funding, government training programmes, education, personnel, and volunteers to support rural causes and initiatives as an interviewee made it clear:

“Lack of resources is the cause of all the problems associated with community participation that we are facing here” (Nr 58).

The extent to which these were perceived to be barriers to community participation is discussed in details below.

(i) Financial Problem

From the point of views of most of the interviewed officers, financial problem has been one of the major obstacles facing the health authorities in their attempt to promote community participation. According to the majority of those interviewed due to lack of

funds, they were unable to engage with the communities in most of their activities. Some of their arguments pointed to the fact that most of the community members needed a better understanding of the policymaking process which required some training yet the funds to undertake such training was not available. There were various opinions expressed on this problem of finance as reflected in the following statements:

....."I know for participation to happen there is a need for a 'push' from authorities but this 'push' can only be possible if we have enough resources like funds, man power and others. Without these resources especially funds we can not let the communities even have access to simple information about programmes activities on say malaria" (Nr 24).

..."With appropriate incentives, people may want to volunteer, particularly the young ones, but I think we need to let them understand what they are getting into by training or supporting them so that they can be motivated. We also have to educate them on how the policy process works so that they can better understand, for example the procedure for organising the communities better. All these will be possible if we have enough funds. Due to lack of funds, we can not even buy fuel to be able to go to the villages with the only vehicle we have" (Nr 118).

"I think to summarise the whole problem it is true to say that we do not have enough resources. We have no 'big purse' to encourage people. We cant reach out to them as we should because of 'a gun without gunpowder is not worth having it'. What is the point in letting them come for meetings with empty stomachs and return empty handed" (Nr 39)

."....Over here we lack everything and it is like a chain, lack of one thing leads to another. Just look !We have no money so we can not have better training programme activities (Nr 123).

"....people who travel from the remotest areas often must be rewarded for their participation which in my view must include at least, reimbursement for out of pocket travel expenses but we have no means to do this which affect most members' interest in participating in programme activities" (Nr 89).

The above arguments depict that the efficacy of community participatory mechanisms (e.g. volunteerism, information exchange, consultation with advisory committees) should be given the necessary support as the literature indicates. For example, Wilson (1992) found that exchanging information between health agency and the community

led to several positive outcomes including the development of local planning groups, networking promotion, making the communities to be aware about the value of their opinions, and enhancement of collaborative efforts between the health providers and their communities. Besides, rewards can be a good source of motivating communities to play a good role in participation.

However, it must be argued that having enough funds alone is not sufficient to ensure participation in the policymaking process because participation should be viewed as an on going but not once off process (Meleis, 1992). Also, many commentators have argued that the adoption of any mechanism must give recognition of the fact that participation can not be brought to fruition without jointly harnessing all the necessary resources. Evidence has shown that failure to make use of the local resources jointly gives rise to a culture of dependency which has the danger of causing burn-out as a result of an over-use of the key available resources such as funds or the few individuals (Dukeshire et al. 2002). In such a situation, the whole idea of promoting community participation in policymaking process eventually tends to be less effective as the few participants lose interest in the long run (Skidmore, et al. 2006).

(ii) The problem of skilled manpower

Another problem associated with lack of resources, which was found in both study sites, was the shortage of skilled personnel caused by lack of training programme activities that will enhance the knowledge of the unskilled personnel. In both of the study sites, greater number of those interviewed admitted that bringing together community members and the public workers needed an adequate amount of training. This was believed to be able to enhance the individuals' knowledge and skills so that as a whole, the group could accomplish the breakthroughs in thinking as well as having the capacity to take critical actions to solve the multifaceted problem of malaria. However, almost all the interviewees accepted that the two districts, particularly the rural (AAS), had neither

the right skilled personnel nor enough training programme activities which could enrich the few unskilled volunteers to be able to work effectively to engage the rest of the community members. The interviewees' opinions on this issue were expressed in so many ways as could be seen from the following statements:

"I think the community members are mostly illiterate and therefore do not easily understand the complex process involved in the policy making. They simply do not want to participate because they lack the knowledge and to me it is illiteracy " (Nr 23).

..." Yes, money is the first thing that we need but I will go further to say, money alone is not enough. We need human capital (I mean, people) who are ready to volunteer to assist us in these complex tasks of controlling diseases in this community. We may have all the money but without human skills, which we are lacking at the moment, we can not achieve anything in participation" (Nr 58)

"..... most people here have never gone to school beyond JSS (junior secondary school) and therefore lack a good understanding of what entails to have these programmes in practice.....and these programmes are not something we can experiment with the suggestions of those who do not have any idea about planning. Until we can assemble the right community members who can understand the complexities involved in the processes, the demand for real participation can be hard to fulfil" (Nr 50)

....."We have not enough training programmes so the volunteers lack certain basic skills in communication. Helping the people to have access to information on malaria is something that is important but without enough staffs we can not do these things" (Nr123).

From the above arguments, it can be argued that the health officials were convinced that by combining the skills and resources of diverse participants, the communities in the study sites could have the chance to take actions that go beyond the capacity of any single person, organization, or sector. In practical sense, by not having enough training programme activities, the skills of the community members could not be improved and that would pose as a challenge in working together and attack malaria problem in a sustainable way. Their conviction is in line with the literature which argues that when a number of participants from different backgrounds develop and "own" a solution that

makes sense to them, carrying out such solution is more likely to go effortlessly and efficiently and is more likely to be sustained (Clark et al. 1993; Dearing et al. 1998).

In sum, it is fair to say that the issue of promoting broad community participation in addressing community health problems is complex and defies an easy answer. However it can be argued that it is only by combining the knowledge, skills, and resources such as the will-power of a broad array of people and organizations can communities understand the underlying nature of the process involved in developing effective and locally feasible solutions to address health problems (Zuckerman et al. 1994; Gray, 1989) like malaria. As suggested by Lasker and Weiss (1997), having access to knowledge, skills, and resources can help the members to be creative and look at things differently due to achievement in empowerment through collaborative processes. In that way, community members can create new ideas and strategies together. In the words of Roz et al. (2003):

“ When that happens, the way the group thinks about problems and the way it addresses problems are often very different from where any of the participants started” (p.29).

7.3 Barriers as perceived by the community members

This section reveals the views of lay informants, which is in contrast to the professional informants. It also addresses issues regarding the barriers to participation as perceived by the community members. During the interviews, amongst the main factors that were found included: lack of organisational support and disillusionment, culture and poverty as discussed in details below.

7.3.1 Disillusionment among community interests

From the interviews it was found that a number of interviewed community members were well aware of the limitations under which the local health officials worked and some of the constraints mentioned included: funding, lack of transport, personnel and

pressures from the central government as well. However, majority of the interviewed community members had different opinions arguing that the local health authority could achieve more than what they had achieved in participation and for that matter malaria control programmes if certain local issues had been correctly handled. Amongst them included: Lack of proper educational support; communication, fulfilling promises

(i) Lack of proper educational support

In both the study sites, majority of the interviewed community members admitted that there had been lack of support from the health authorities in so many areas. To most of these members, the health authorities often failed to pay attention their interest and therefore disregarded any support that was needed to motivate the community members. For example, some interviewed community members said that:

“ I do not think the health officials have ears to listen to us. The only ears they have are used for listening to the national government. I think the local health authority has a better chance of having a better results in controlling malaria if they focus on local issues by listening to the voices of the community members” (Nr 125)

The above comment was shared by majority of the interviewed community members who perceived lack of organisational support from local health authorities as one of the barriers to community participation. According to most of the interviewed members, the willingness to participate could always be rekindled

“...if only the local health authorities showed their readiness in supporting the community members” (Nr 121).

During the FGDs, most of the members agreed that there had been little encouragement from the government as reflected in the following statements:

.....“We see these health officials maybe, once in two months and to me, that is not enough to convince and to motivate our people to participate in these activities. To

motivate these our people to take part in these activities, there should be continuous education and many avenues through which they can let their voices be heard must be available but the authorities do not provide these things” (Nr 96)

..... our government is not doing enough to motivate us. These days our local government authorities do make us feel we are not part of them and the distance between us and them is widening everyday. They do not tell us anything and the communities do not know what is going on” (Nr 134)

“..... They are always in hurry and always looking at their watches, which to me is like they do not want to hear our concerns. That is discouraging” (Nr 139)

“...The communities are really willing to take part all the activities concerning diseases like malaria but I have the feeling that there is not much efforts and support from the local government. For a long time the communities have been let down by their governments and this has brought down some enthusiasm in participation” (Nr 114).

Explicitly, most of the interviewed community members could not play an active role in the policy-making process, because not much effort has been made in helping them. For example, it was found that an effective community education provision which could have had positive impact on participation had often not been neglected. On this issue, most of the interviewees admitted that community members have not been getting continuous and proper education on most of these programmes. Such insufficient education has not helped most of the community members to have positive views about the control programmes that the government undertakes. As some interviewees stated:

“ Most communities have the misconception that that getting the community involved will only help health officials to have more benefits from the central government. So more work needs to be done on educating the people, but not enough have been done” (Nr 91)

..”There is little education on most of the things the local authorities claimed they have planned for the communities and without such education we not understand most of the things they do. They just come here and ask us to assist them to implement this policy or that programme activities. But how can we participate effectively in something that we do not understand? Instead of taking time to explain things to us, once they are here, they seem to have no time for us” (Nr 139)

"I think in order to take part in the decision making process because of the complexities involved you need to be confident just like the health officials who know every aspect of the health issues. But because we do not get enough assistance from them our ability to participate every meeting is limited as most of us do not understand what is being said during the meetings" (147)

All in all, it can be concluded that ideas and the wishes of the health authorities in Ghana on community participation are little use if they cannot be put into practice what they wish to achieve by providing the necessary support to the communities. By failing to provide the right support, the revitalization of the communities' confidence and skills become difficult (Wilcox, 1994). According to Wilcox, (1994), many participation processes involve entering into new forms of social lives and it is unrealistic to expect individuals or small groups suddenly to develop the capability to make complex decisions and become involved in major projects. What they need is providing them with the necessary support like training - or better still the opportunity to learn formally and informally, to develop confidence and trust in each other (Wilcox, 1994). This has been perceived by the communities to be lacking hence a barrier to participation.

(ii) Lack of communication/information

Another finding with regards to disillusionment is lack of communication or information. Almost all the community members interviewed including those who took part in the FGDs felt strongly that information-giving had often been underprovided. Explicitly, most of the interviewed community members were disenchanted about health authorities' interest in promoting community participation. Thus, the community members could not play an active role in the policy-making process, because not much effort has been made in helping them, for example, to get access to adequate information. The acknowledgement of this barrier is reflected in the arguments made by most interviewed local residents who stated that:

“Many of our people usually rely on the information given to them by the government health workers or local volunteers before deciding to participate in most of these health programme activities. These pieces of information are important because they make the local people know all that they need to know about the significance of these control programme activities and what roles they can play when they become part of the process. Unfortunately, we tend to lack information on these programmes which creates skepticism... and you know when people doubt about the significance of something, they do not want to be involved or participate in it. It makes them not to see the value of it and this has been a major reason why I think, people do usually hesitate in participating in most of these control policy programme activities” (Nr 100)

“....I find it hard to believe that simply going to attend meetings will make me change what the authorities here will like to do. As far as I am concerned, and as a common man, whether I attend these meetings to speak out my mind, it will not make any difference to the outcome of the process. I therefore do not see any need to go and participate in these activities. They do not give us (rural communities) any proper information about the importance of participating in this policymaking process, so I better go to my farm and work. That will change my life” (Nr 80)

.....“It is hard to see any strong commitment from the local government to motivate us to participate in most of these disease control activities. Communication to and fro is lacking from the local health authority and public education is minimal” (Nr 82)

.....“Most of us do our best in devoting our time to make sure programmes like malaria and other diseases that have to be implemented in this community get a better start, but often it is not enough. The authorities will say we will come next week, but we will only see them two months later. No information from them to us. So we are not always sure how things are and what the next programme will be” (Nr 124)

“....Even if we make all efforts to attend these meetings, we do not get any feedbacks let alone information on when and what we are going to discuss in the next meeting so that we can prepare for it. We are asked to attend as if we are to go there just to make up the number needed to consider the meeting as general. In fact we do not contribute anything” (Nr 147)

These quotes could be interpreted in two ways. First, it indicated that more community members will participate and will have a meaningful role in local malaria control policymaking process if local health authority comes closer to the people to provide them with the necessary information (Blair, 2000). Secondly, it also showed that that in

order to mobilise the community to participate in their health planning there should be a creation of an atmosphere that fosters trust, awareness of belonging to the community and finally tangible support related to policy, guidelines and information. Thus if participation can be perceived as enriching and individuals' prospects of participating in policymaking process could be improved there is a need to have adequate and appropriate communication between the health authorities and the communities (Meleis, 1992; Brotchie et al. 1993; Sen, 1994). According to Brownlea, (1987), without sufficient resources such as information participation is:

“ simply tokenism and does nothing to alter the knowledge balance, the skills balance, and the power balance in the community” (p. 607).

The inference that can be made from these arguments is that information is the source of knowledge which also contributes to power and without information knowledge can not be enriched (Mayo et al 2001). Thus, without proper information, not only will be hard for community members to participate in policymaking process but it will be hard for them to become partners on the same level with the health officials to decide on programme activities. This is consistent with the argument made by Alford (1975) who argued that:

“...community representatives do not have the information necessary to play an important political role; they do not know the levers of power, the interests at stake, and the actual nature of the operating institutions, and they do not have the political resources necessary to acquire that information” (p. 219)

In effect, asking the community to participate in programme activities is necessary but not sufficient. There should be strenuous efforts in providing community with education on programme activities. Through education, information could flow between the community and the health officials and that can help the community members to have an understanding of the process involved. Without a better understanding, some of the

interviewees believe that most community members would find it difficult to know how participation in the policymaking process could empower them as well as helping them to impact the policy outcome (Sen, 1994; Artkinson et al, 2011).

(iii) Failed promises

Quite apart from lack of support from local health authorities, majority of the interviewed members revealed their disappointments on the repeated experiences of failures on the part of health officials to fully include the community members in policymaking process and how that have affected their interest. From the views of the some interviewed community members, the fact that the local health officials have for so many times failed to incorporate most of their priorities into the national programme activities has made them not to believe that local health authority could have local programme activities which could represent their needs and interests. For example, one local resident openly declared that:

“It appears the story about participation has been said and heard several times from the local health authorities and in the past, I used to believe in it but these days, I do not. They used to come and we would argue among ourselves on issues about our priorities setting only to know that nothing was acted upon” (Nr 132)

To the community members, the issue of participation has been seen as yearly government ‘festival’. The health officials come to them at a certain period of the year and once such a period was over, nothing would be heard again. The community members’ disappoint was illuminating as exemplified in some of their arguments made during the FGDs:

...” My son, if you were not a stranger, I would not have been here and I do not think I would attend any meetings that involve any of the local officials. It has nothing but the same old story: ‘government wants you to know your views on this or that issue’ and ‘you have do this and that’ .What sense does it make if I decide something and they do

not consider it. I think I am getting fed up with all these everyday arguments on participation” (Nr 134)

.....”I do not understand. They (health officials) always have excuses saying: ‘Oh that was the fault of the last government and this is a new government so everything is going to be different’. But nothing changes and everything is always as it has been. They promise us a lot but we receive nothing” (Nr 153)

These extracts illustrate a common theme. The community members see themselves led down by health officials. For some of the locals, the idea of participating in health planning was considered to be in conflict with their everyday experiences of their failures in their promises and the exclusion of their needs from most crucial issues that the health authorities at the district levels act upon. Most of the members spoke of experiences of health organisational culture of disrespect of the communities’ ideas and knowledge to health planning. They considered community’s exclusion from the health services as a means that offer no hope and confidence. This is:

“in contrast to what the authorities speak to us about the benefits of participatory practices on our lives” (Nr 144)

The response of some interviewees reflected these low expectations, as they argued that the community members had been consulted, communities have participated in the decision making process before and yet there had not been any evidence of increased local health support or benefits in solving the problem of malaria. According to one interviewee:

....”It is sometimes very motivating to have all these officials coming to us and asking for our opinions but at the same time very disheartening to realise that after spending our entire day waiting for them and having this meeting, they go back and do nothing about our suggestions. We do not even hear why it can not be accepted. So I often asked myself ‘why did they come then?’. These days, I have lost interest in all these programme activities (Nr 155)

This quote provides a vivid picture of the disillusionment of some of the interviewees and the kind of trust they have lost in local officials. The underlying cause has been due to their past experiences which have made them not to consider the whole idea of

community participation seriously anymore. This is in line with the literature which indicates that:

“...the biggest deterrent to participation among citizens is their perception – or experience – of a lack of council response (Lowndes et al. 2001; p. 635).

In general, it can be argued that while some may think that community members have been apathetic within their own community, most of the interviewed community members had different opinions. To some interviewed community members, the cause could be attributed to the disappointments from the local officials in terms of their persistent failures to support them and to fulfill their promises. This finding is consistent with the literature which indicates that people are most likely to be committed to carry something through a programme if they know they are part of the ideas which define the aims and objectives. Such involvement helps them to have stake in the idea and one of the biggest barriers to action is ‘not invented here’ (Willicox, 1994, p. 3). It has therefore been argued that there is a need to allow people to participate by providing them the right incentive such as communicating with them by running brainstorming workshops, helping people think through the practicality of ideas, and negotiating with them. This attitude will help to make programmes acceptable to as many people as possible (Willicox, 1994; Lahiri-Dutt, 2004; Rifkin, 1997).

7.3.2 Culture

Consistent with the literature, this study found that community participation in the study sites has been influenced by the local culture, which is also common in most Ghanaian regions (Wolke 1992; Ahorlu et al. 1997). For most of the interviewed community members, one of the perceived barriers to participation has been the culture of the people that tends to influence the degree of participation in so many ways. Amongst those factors contributing to culture as a barrier included: elders underestimation of the youth and differences in gender roles. These are discussed in details below:

(i) The underestimation of the youth by the elders

Several interviewed youths spoke about the capacity of participation to influence decision making within the community by the old people. They said that the adults always felt that the youth could not make any significant contribution towards the general well-being of the community, particularly when it came to malaria control programme activities. This perception, according to most of the young interviewees, sent a message that decisions for the community was not for the youth which had the consequence of limiting their level of participation that they would otherwise aspire to. From the interview there was a strong sense that the adult considered the youth to have less cultural experience about local beliefs and practices in the respective communities and therefore did not expect them to be part of the decision making process. Most young interviewees spoke of how, for example, this kind of culture has affected their enthusiasm by stating:

“if you have a society which sees youth as immature and not having enough wisdom to decide for the community, while the old people have often been seen as the wise people, then indirectly you sow the seed ofwhat I will say ‘disinterest’ amongst the youth to participate in any event that involves both the young ones and the adults” (Nr 73).

“.... they (the adults) always say we are not old enough and therefore have not enough experience to decide for the community. So it does not give me any incentive to wanting to know what all these disease control activities are about let alone getting involved or participating in meetings. Even if I attend, whatever I say will not be supported because of this perception of immaturity in thinking. So why bother, anyway” (Nr 103).

....” The attitude of our old local people is also not helping most of us (the young ones) to have any interest in participating in some these programme activities. They allow the culture to take a big part of them in their thinking. Just imagine in this times, they still want we the young ones to keep our mouth shut when there is an issue to be discussed, all in the name of respect. Oh, No, I cannot take it. I will not go to any of these gatherings” (Nr.132).

The concern here is that the adults culturally consider the youth to be immature and therefore expect them to play a different kind of role rather deciding for the general community. This has made them not to have enough knowledge to be able to come out with any meaningful ideas that can be used to address all-important communal problems like malaria. The consequence is that their participation in meaningful programme activities in any form is limited and there is not much expectation of what they can contribute in terms of decision making that will enhance the welfare of the community. In this case, it can be argued that even if there is an existence of opportunities for the young ones to take part in NMCP policymaking process, they are likely to be passive (Brownlea, 1987). In such a situation, Brownlea (1987) has argued that, even though the youths can be participants, they may, nonetheless, be:

“still observers; while being in the game, they are more reserves rather than players”
(p.605).

However, the idea that the youth are discouraged from taking participating in decision making was challenged by some interviewed adults who had different opinions from the youths. For example, some interviewed local leaders expressed their opinions that:

“because the youth are not used to working with the adults, they are often not prepared to accept any responsibility or any role that is offered to them. These days the young ones have everything done for them and do not want to accept the challenges that life throws at them in this community. When you call them for a meeting, it is only the adults who will come around and young ones will be roaming around doing practically nothing. They need to learn, but they can not learn if they do not work with the old people” (Nr 76)

..Sometimes we have to....like beg them before they join some of our community activities. They always feel it is not their responsibility to serve the community rather such communal services must be provided by we the old people. They like to be involved in a situation where they can control the participants or at least where nobody controls them” (Nr 82)

The quotes are stark contrast between the views of the youths and the adults. On one hand the youths need cultural change in terms of old peoples' attitude towards them so as to motivate them to participate, and the other hand, the adults need a change of youths' attitudes in order for them to effectively engage with the adults in policymaking process or programme activities.

In essence, although, this assertion tends to confirm the argument of Camino (2000) who describes partnerships between youth and adults as 'breaking new ground' and 'new territory', the outcome can be less effective. The main reason is that when adults and youth are not used to new participatory ways of working, there can be a problem for the youths in adapting to new roles and responsibilities, especially if they have never had the chance to experience them before (Eames-Sheavly et al., 2007; Lekies et al., 2007). Frank (2006) also argued that the other way could also be true if the Adults have not much understanding and experience working with young people. Such a situation could bring about lack of confidence and hesitation on the part of the adults on how to work together.

(ii) Differences in gender roles

Parallel to the above cultural barrier, it was also found that despite high level of social solidarity amongst communities and positive role in peoples' interpersonal networks, in most of these communities, the roles of the gender within the communities has been a source of a barrier to participation in decision making process (McEwan, 2000; Van Donk, 2000; Luzzo et al. 2001). During the interviews, it was revealed that most women were unwilling to be involved in the decision making process because of the way they were perceived by men. Most interviewees complained about lack of recognition during meetings. For example, a woman who once attended one of the health meetings spoke about the isolation she felt while in the meeting with the men who formed the majority of the participants. She stated that:

"I was there throughout the whole meeting but none of the participants, who were mainly men, controlling the meeting asked for my personal view. They talked so loud on

top of their voices that at one point I thought they were going to fight. I dared not asked to speak because I was even scared of some of them. I was really relieved when the meeting was all over. From there on, I decided never to take part in any of these meetings which I knew would be dominated by men” (Nr 39)

Another woman also spoke of her lack of interest in participating in meetings or programme activities which involved both men and women. She expressed her doubt about any possibility of a woman having any chance in making any meaningful contribution to decision making by stating that:

“Our culture does not make it easy for we women to share power with our male counterpart. Although things have changed, cultural values and ideas are still what they were many years ago in these rural communities. So knowing such beliefs, we women hardly participate in decision making that affect the community. We leave such big decisions to the men and I for one only attend meetings if it is only women” (Nr 91)

This extract suggests two significant common issues facing women in the study sites. The first is the acceptability of women in participating in policymaking process but with little or no power to make any great deal of impact. This reflects the opportunities available for both genders to participate in programme activities irrespective of the power imbalances. The second, an interwoven issue is the reluctance of male counterparts to surrender power to those that are considered as ‘weak’ or ‘incapable’. Besides, the quotes also illustrate the importance of understanding how the idea of community participation itself can be socially constructed (Barnes et al., 2003). In this case, community participation, in the minds of the communities in the study sites is for strong people (men) who are to make decision but not for those who are ‘weak’ (women) (Ahorlu et al. 2006; Agyepong, 1992, Binka et al. 1997). Some of them even considered some of the women to be indifferent irrespective of the motivation given to them. For example one man said:

“Some of the women are often apathetic and will never be prepared to participate in anything no matter what others do. Apathy is killing some of the women here which makes our officials less enthusiastic in encouraging them” (Nr 39)

These differences in perceptions alienate the women and highlights how men dominate and women have to respect such dominance in the study sites.

Thus with the experiences of exclusion as well as their perception of being the weaker ones in the society, women are less likely to be motivated to view themselves as welcomed or empowered members of the local community. Due to cultural norms which relegate women ideas to the background, the women lose interest in participating in policy process and they are unable to bring their ideas forward into the power domains. In this way, women feel less valued and ultimately believe that their suggestions would make no difference and their own cultural values (e.g. respect for men) has moved them into:

“ an almost reflexically non-participatory way of thinking” (Brownlea, 1987, p. 607)

One male interviewee who also had a similar view about women’s experiences of exclusion during meetings also supported this claim. The interviewee argued that:

“during meetings, women lack confidence to ask questions or contribute to certain proposals even though their decisions could be accepted. I guess it all to do with culture in which they have been dominated far too long by men and I know it will take some years before they realise their full potentials in our communities” (Nr 114)

The above quotation emphasizes the important limitation culture imposes on women’s participation in policymaking process. It also illustrates familiar points of interest and identification between women and some of the interviewed men about the impact of culture on women’s participation in the study sites. This finding is consistent with other findings on community participation in SSA. Many commentators have found that there have been often variations in the response to participation due to differences in gender and status (Jacobs et al. 2003; Woelk, 1992; Ndiaye et al. 2003; Marin et al. 2003).

Matembe (2009) epitomised the plight of Africa women by saying:

“culturally, women are not perceived to have a role to play in politics. They are expected to be home-makers and to stay in their homes. This being the case, women are frequently marginalised when it comes to debating and being listened to because they are considered to be women with not much to offer” (p.7).

These kinds of dynamics as it has been argued call to mind the culture of silence in that fear could not have been personal qualities of women in this society, but rather a psychological adjustment "*to the state of being without power*" (Gaventa, 1980, p. 16) relative to their male counterpart in the immediate setting. Thus the nature of gender relations can be hindrance to participation in a male dominated culture where women are preferred to be seen and not heard (Lockett-Kay, 2005).

In sum, it has been found that the perceived culture of the male dominance of the communities in the study sites have contributed to a culture where the participation of the females as well as youths has been less than important. Some women and the youths appear to be put off involvement in public life because of their perception of the culture of male dominance. This suggests that much more work needs to be done on women who find themselves alienated when it comes to decision making in order to motivate participation.

7.3.3 Poverty

Based on the results of the interviews, another finding of this study results was that the high level of poverty¹¹ amongst community members had been a barrier to community participation. In general, it has been noted that poverty as a barrier was integrally linked to the other factors. For example, due to poverty, community members had a greater risk of educational underachievement, which left them lacking the skills, qualifications and confidence to participate in decision making process. Also, due to poverty, the members could not afford transport fares to be able to attend meetings. Even if they tried to attend, due to poverty, in the traditional sense less attention was paid to their suggestions that also lowered their motivations and aspirations. However, the literature has indicated that it is these same poor people who are mostly affected by malaria

¹¹ Poverty in this study is considered to be people who are regarded to be living in a situation where their income and resources are too little as to prevent them from participating in malaria control programme activities which should be considered to be generally feasible for the who community members

((Okrah *et al.*, 2002; Olowu *et al.* 2000; Worrall *et al.* 2003). In both the study sites, it was found that there were two main factors, which, out of poverty, had compounded their ability to participate. These included: High cost of living and Poor source of income.

(i) High cost of living

Most interviewed local members explained that although participation was beneficial to the communities, the high cost of living has deprived them of participating in most of the malaria control activities. For example, most of them argued that there were costs such (e.g. transport) involved which had to be incurred particularly during meetings held at the district level. As a result, those who often had no money to travel also had no ability to participate in community health programme activities. Most of the interviewed community members disclosed their willingness to be part of such meetings that usually took place at the district or sub-district level and yet they found it hard to be part of it. For these members, meeting at the district was found to be important because:

“that was where at times most views were shared and decisions taken, in contrast to the village meetings which were usually about providing information on programme issues. Often, due to poverty, we normally have to choose a person who usually can pay the cost of transport” (Nr 108).

..... Our representatives have often been community members who are rich and can afford to participate in these kinds of health programmes without feeling much of the impact” (Nr 106)

...“most of these people live in far away places in rural areas and have to travel several kilometres to be able to get to the place where meetings or activities are taking place. There is poor transport and even if there is transport, the cost of travelling to the district centre is too high for them. So it is not that the community members do not want to participate” (Nr 16)

“I always want to attend some of these meetings, but I do not have money to go and walking from here to the place (district capital) is not easy. It takes about four hours to get there and be back here. If I go, I will be too tired the next day to be able to go to farm. On the other hand, even if I have money the means of transport to go there is also a

problem. During the day time, getting a local transport is difficult and the fare charge is also expensive” (Nr 90)

The quotes above raise very important point about the nature of people who often took part in the decision making process at the district level. These quotes suggest that it is often the rich within the communities that represent the community. In that case, only those with money that can gain from participating in the policymaking or planning processes and the ultimate ramification is that the poor usually have less chance to have their voices heard in policymaking processes. Thus, while most traditional analysis often blame communities’ non-participations in programme activities on their culture of apathy, a broader understanding of the such non-participation could be attributed to barriers like poverty (Dorsner 2004; Schlozman, et. al., 1994; Taylor, 1999). According to Taylor (1999):

“the things that disadvantage people make it harder for them to participate in group activities. This is not apathy. The pressures of bringing up a family on a low income leave little energy for the responsibilities of communitarianism” (p.4).

In essence, transport costs were found to be an important deterrent to participation. This usually was the case in the rural district (AAS). This significantly offers support to the argument for mobile clinics in such an area (Worrall et al, 2002).

(ii) Precarious nature of the communities’ livelihoods

Besides cost of transportation, it was also revealed that due to poverty in both urban and rural, a number of community members work seven days a week for long hours just to be able to feed their families, and as such most members have little or no time at all to participate in any programme activities relating to malaria control. From the views of local NGO interviewees, being poor and the most vulnerable members to malaria puts those people in a better position to provide important opinions to policy makers if only they could always have their voices heard.

“Sadly, they are never present not in meetings and not in programme activities so they are often left out in matters that are important to them, but I understand their situation. They need to work twice as much as some of us to be able to get their daily meal for themselves and their family” (Nr 8)

“..... In fact, majority of them are enthusiastic in taking part in most of these programmes activities, but the poor economic circumstances under which they find themselves makes it hard for them to be good participants in some of the programmes that could help them solve the problems that affect their health” (Nr 16)

These comments were confirmed by majority of the community members. For example: During the FGDs among community members, most of the participants expressed their interests in being part of the programme activities but because of their poor circumstances, they could not participate. For example, some argued that:

“Sometimes we get the information that tomorrow or this day, the district health staffs will come and talk to us about malaria or family planning, but I and my wife can not stop going to farm and wait for them. They usually come the day prior to a market day or the market day itself, when I need to bring my food stuffs from the farm to sell. So I can not go and take part in the meetings” (Nr 142).

.....”For me, the most difficult time is when we are in the planting season. It is so difficult to participate in these activities. Over here, as far as farming is concerned, the rain is everything to us and the timing is important so when the rains come, we have to seize the opportunity to do what we are to do in the farms. I can not imagine myself not going to farm for food.....Where will I get money?” (Nr 158).

.....There is no doubt in my mind that the work on malaria control is important for all of us and there is a need to support the district health staffs but our situation is different. The poverty level in the city is high and staying home without going to the market means no food for the family” (117)

.....Over here farming is our major source of income. Juggling between farming and participating in control programme activities is so hard that we always have to make a choice. Doing both is an impossible task and faced with a choice, we often choose to do the one that gives us income to feed our families. It is simple as that” (Nr 102).

The core of these arguments is that work demands and schedules perpetuated by poverty are major contributing factors that prevent rural community from participating

in programme activities. This is because their major priorities are to find the means to feed their families, and not to spend time in meetings (Russell et al. 2000). This is consistent with the finding of a study in other part of West Africa, Senegal, where Dorsner (2004) found similar result. Overall, the general level of participation and its quality was found to be affected by lack of money particularly access to transportation in terms of cost and inability to afford basic necessities.

The implication here is that with poverty the idea that through participation locally derived priorities are served and local communities are used effectively can sometimes be misleading (Brownlea, 1987). This is because participation does not portray the full story since it overlooks the operation of power relations at the local level which contributes to the recreation and amplification of more inequitable power balance between those who have money and those who have not. In this case, it is fair to say that the local community, given health development programmes like malaria control initiatives, will find participation a double-edge sword, unless power is shared equally and the gap between potential and actual participation in terms of power to influence decision is narrowed. Thus as a result of poverty, the poor are less likely to participate in policymaking process than the rich (Kinsley et al. 1997; Dreier, 1996). According to Skidmore et al. 2006, such power imbalance can perpetuate a vicious circle, which increases the problem and eventually dampens the interest of others in participating in the policymaking process. The authors argue that the cycle begins, on one hand, with non-participants expecting not to participate because they suppose others already will. On the other hand, existing participants believe they have to anticipate because if they do not, they expect nobody to be willing to participate. These anticipations ultimately becomes a self-fulfilling prophecy as the old-existing participants often perceive themselves as the right community members to take on such participatory responsibility.

7.3.4 Summary

This section has revealed the findings on the barriers to community participation in this study in two main parts which include those from the perspectives of the health officials and that of the community members. Barriers perceived by health officials included the power of central bureaucracies and lack of resources while that of the community members included: lack of organisational support and disillusionment, culture and poverty. Implicitly, malaria control policies which aim at enhancing community participation but fail to take into consideration these barriers are less likely to be effective.

From the perspectives of the health officials, it was clear that although the policy of decentralisation has opened up opportunities for the communities to be involved in certain aspects of local issues through consultations, most of the sectors like health are still maintaining their vertical structures. This implies that their independence in planning and implementing alongside what is decided at the local level is compromised due to the power of the central bureaucracy. *"Their hands are tied"*, it was argued and therefore unable to fulfil most of their promises and or act upon the priorities set with the community members. This serves as disincentive to community members' participation in policymaking process. In this situation, it can be argued that the system to ensure participation fails because, as O'Neil (1986) argues:

"it continues to exclude its clients from a fundamental involvement in its structure" (p. 1261).

However, the problem is not the results of conservative character of the community, rather it is the administrative structure which is organised on the idea that the central bureaucrats are knowledgeable and know what is right and proper for the communities (Welsch, 1986). There is therefore a problem where those at the higher level see themselves more superior to more knowledgeable than community members at the

lower levels. According to Rifkin (1986) this top-down approach is equivalent to a medical model which assumes health professionals, on the basis of their expertise in health technology, can define and find solution for the existing health problems in a relatively short time. This is in contrast to those who believe in the 'bottom up' approach and see community participation as a better way of solving health problems as the communities find a way of implementing some of the basic health interventions that professionals are trained to do (Rifkin, 1986)

The second barrier which is lack of resources also affects participation because the local health authorities are not able to provide services that will serve as incentive to the community members. They have no funds, no proper transport and or personnel to undertake programme activities at the remotest parts of the communities. Consequently, the authorities often can not provide training and education to the members. Lack of all these resources make it difficult for the community members to have a better understanding of the complex policy making process and the significance of participating in programme activities (Brownlea, 1987).

With regards to the community members' perspectives, the members claimed that the local health authority has not been able to support them in their attempt to be active participants in the policymaking process. Their arguments were similar to the officers' idea of lack of resources. For the community members, there has not been adequate information provision, proper community education and training that were essential tools to enhance understanding of the complex nature of policymaking process. In addition the persistent failure of the authority to fulfil its promise of including the communities' wishes or needs in their plans and to act upon has made the members to lose faith in the authorities. Some interviewed members felt disillusioned and no longer consider the authorities as those who have the communities' problems at heart. To ordinary community members, their efforts seem to have been used, in the words of Arnstein, (1969) to preserve alive the ineffective ritual of participation which provides

no opportunity to them to achieve real power. On the issue of culture, it was found that although the local youths might be interested in participating, most of them have had less interest in participating in policymaking process because they are culturally seen as those who have no experience and or lack the right skills to make decisions that can address critical community issues. In addition, it is revealed that due to culture, individual gender roles determine the extent of community members' participation in policymaking process. Women, in particular are therefore mostly the ones who are often excluded from decision making process in programme activities. Thus, beliefs and norms have considerable influence on participation in Ghana (Ahorlu, 1996; Agyepong, 1993).

The last barrier to participation is found to be related to poverty which puts pressure on the community members to give priority to engaging in activities that give them their livelihood rather than participating in health programme activities like malaria. Thus work demands and schedules caused by poverty are major contributing factors that prevent rural community from participating in programme activities. Another problem associated with poverty as a barrier is that poverty creates power imbalance. Such power imbalance can perpetuate the repressed structural interest of the community members (Alford, 1985).

However, the study also found that had not been these barriers there were other existing local factors which could have been capitalised on by both the communities and health officials to enhance participation in the NMCP activities. Amongst these enabling or facilitating factors included: the good level of horizontal integration amongst sectors at the district level; political and social structures and these are further discussed in the next section.

7.5 Potential Facilitating Factors to Community participation found in the study sites

Although there was a general consensus about barriers, majority of those interviewed also admitted that but for the barriers, ISC and other existing local contextual factors could have promoted community participation in the policymaking process. However, before discussing these facilitators, this section first discusses the findings on the extent of institutional involvement in ISC and how that was perceived to be an enabler to community participation in the study sites.

7.5.1 The extent of institutional involvement in ISC and its impact on community participation

From the interviews, it was found that the level of integration amongst sectors participating in malaria control programmes in both districts was so good (see Tables 7.1 and 7.2) that community members could have been encouraged to participate in the NMCP activities.

Both Tables 7.1 and 7.2 contain the main actors/stakeholders involved in NMCP activities in Ghana at the local levels which include government, non-governmental agencies and community members. Foreign donors were not included in this analysis as it was found that they did not participate in grassroots malaria control programme activities in the study sites. With regards to the public, the participating institutions were not restricted to the health sector, but included others as indicated in the tables. Where more than one representative (e.g. community leaders) was interviewed the integration response scores from one institution were averaged over the number of representatives.

In this study the continuum of integration scores developed by Browne et al (2004) was adopted which is based on awareness, communication, cooperation and collaboration. Thus for institutions to have full integration they are expected to be aware of each

others activities, communicate, cooperate and collaborate. The continuum of integration score is an ordinal scale measure which assigns an increasing score to four measures of integration – (0) non-awareness, (1) awareness, (2) communication, (3) cooperation and (4) collaboration. The measures of integration are defined as below:

Non-awareness (0): if an institution has no knowledge of another institution’s malaria control programmes. This is classified in this study as no integration. However, in our case, all the institutions were aware of each other, thus there was no score of zero.

Awareness (1): if an institution has knowledge of another institution’s malaria control programmes, but do not participate in their activities, classified as low level of integration.

Communication (2): if an institution has knowledge of another institution’s malaria control programmes and they exchange information but do not share ideas on their activities with regards to malaria control, classified as moderate level of integration.

Cooperation (3): if an institution has knowledge of another institution’s malaria control programmes, they share information and ideas to guide and modify their own planning and activities, classified as good level of integration.

Collaboration (4): if an institution has knowledge of another institution’s malaria control programmes, they share information and ideas to guide and modify their own planning and activities and also jointly plan and modify delivery of service based on mutual consent, classified as full level of integration (Browne et al, 2004).

Each of the sixteen institutions in each district was asked to score the level integration with the remaining fifteen institutions in the programme. The responses resulted in 480 (16 institutions * 15 responses from each institution * 2 districts = 480) observations nested within 32 institutions. The responses of each of the institutions are filled into a matrix of integration scores, with the left hand column of the matrix listing the sector representative’s scoring level of integration with the sectors listed in the first row of the matrix. From this matrix, three facets of integration are calculated – Group reported Depth of Integration (GDI), Self-reported Depth on Integration (SDI) and Total observed

Depth of Integration (TDI). The GDI measures the degree of communication and joint planning an institution has with each of the other institutions, as perceived by the other institutions (Browne et al. 2004). The SDI measures the average observed depth of an institution's interactions, communication and joint planning with other institutions (Browne et al. 2004). The TDI which measures the total observed integration score for the whole group is the mean of the average group reported observed depth of integration scores (Browne et al. 2004).

Table 7.1 is about urban district of KMA and from this table it can be noted that the results of the estimated levels of integration between community and malaria control programme health officials alone indicate that the self-reported score of integration (SRDI) is 2.8 while the group reported integration (GDI) score is 3.2. This implies that the malaria programme officials perceived the community and the rest of the institutions to be aware of malaria control programmes and they communicate on their activities with regards to malaria control, but at a moderate level. In this case there is no cooperation let alone collaboration and the health officials' plans and activities do not reflect on the ideas they get from these institutions since they only exchange information but do not share ideas. With regards to the perceptions between malaria control health officials and the communities, while the communities perceive themselves to be cooperating and at the same time collaborating (score = 4), the health officials see them to be exchanging information but not sharing any ideas (i.e. only communicating with a score =2). However, the whole 15 other groups perceive the communities and its leaders to be cooperating (GDI = 3.2). This means that although the communities are not collaborating, the communities exchange information and at the same time share ideas which help these other institutions in their planning and activities in the urban district of KMA. In terms of the overall total level integration amongst institutions participating in malaria control programme activities, the results, based on Browne et al (2004) indicators for level of service integration scores (Total Observed Integration Score =2.4) showed that there is a good level of integration.

Table 7.1. Level of integration among institutions participating in malaria control programmes in the Kumasi Metropolitan Assembly

	SECTORS BEING SCORED																TOTAL	GDI
	MC	MA	ME	SW	MF	CL	PP	HI	DP	AD	TP	WS	FP	NA	CS	TH		
MC		2	3	2	2	2	3	2	4	4	1	1	4	4	4	1	39	2.6
MA	2		2	1	2	1	2	1	2	2	3	3	2	2	2	1	28	1.9
ME	3	3		2	2	2	3	2	2	2	2	2	4	3	3	1	36	2.4
SW	2	2	2		2	3	2	3	2	1	1	1	3	3	3	1	31	2.1
MF	2	2	2	2		2	2	3	2	2	2	2	3	3	3	1	33	2.2
CL	4	3	3	3	3		3	3	3	3	3	3	3	4	4	3	48	3.2
PP	4	4	3	2	1	4		1	3	3	2	2	3	4	4	1	41	2.7
HI	1	1	2	1	2	2	1		1	1	1	1	3	3	3	1	24	1.6
DP	4	2	3	1	2	2	3	2		3	2	2	4	4	4	2	40	2.7
AD	4	3	2	2	2	2	3	1	3		2	2	3	3	3	2	37	2.5
RD	1	2	1	2	2	3	3	1	1	2		3	3	2	1	1	28	1.9
WS	2	1	2	1	2	4	3	1	2	3	3		2	2	1	1	30	2.0
FP	4	3	3	3	3	4	3	2	3	3	2	2		4	4	3	46	3.1
NA	4	3	4	3	2	4	3	2	3	3	3	2	4		4	3	47	3.1
CS	4	2	3	2	2	4	3	2	3	3	3	2	3	4		1	41	2.7
TH	1	1	1	1	1	4	1	1	2	2	3	3	3	3	3		30	2.0
TOTAL	42	34	36	28	30	43	38	27	36	37	33	31	47	48	46	23	579	
SRDI	2.8	2.3	2.4	1.9	2.0	2.9	2.5	1.8	2.4	2.5	2.2	2.1	3.1	3.2	3.1	1.5		38.6

GDI - Group reported Depth of Integration; SRDI - Self-Reported Depth of Integration

Total observed integration score = 38.6/16 = 2.4

Note: perceived Scope of integration and self-reported scope of integration is 100% because all the sectors are aware of each other.

MC – Malaria Control Programme; MA – Ministry of Agriculture; ME – Ministry of Education; SW – Ministry of Social Welfare; MF – Ministry of Finance and Economic Planning; CL – Community leaders/local politicians; PP - Planned Parenthood Association of Ghana; HI – Mutual Health Insurance Scheme; DP – Diseases Prevention Control; AD – Health Assessment and Disease Surveillance Unit; TP – Town planning; WS – Community Water & Sanitation Agency; FP – Family Planning & Immunization Programme; NA - National AIDS/STI Control Programme (KMA district) ; CS – Chemical Seller Association; TH - Traditional Healers

Source: Author’s own analysis

Table 7.2. Level of integration among institutions participating in malaria control programmes in the Ahafo Ano-South District

		SECTORS BEING SCORED																TOTAL	GDI
		MC	MA	ME	SW	MF	CL	PP	HI	DP	AD	TP	WS	FP	NA	CS	TH		
SECTOR REPRESENTATIVE S SCORING LEVEL OF INTEGRATION	MC		3	3	2	2	4	3	2	4	4	2	2	4	4	4	2	45	3.0
	MA	3		2	1	2	4	3	1	2	3	3	3	3	3	2	1	36	2.4
	ME	3	3		2	2	4	2	2	3	2	2	2	4	4	2	1	38	2.5
	SW	2	2	2		2	4	2	3	2	1	2	2	4	4	2	1	35	2.3
	MF	3	2	2	2		4	2	3	2	2	2	2	3	3	2	2	36	2.4
	CL	4	4	4	4	4		4	4	3	4	4	4	4	4	4	4	59	3.9
	PP	4	4	4	4	1	4		1	4	3	4	4	4	4	3	3	51	3.4
	HI	2	2	3	2	3	4	1		2	2	2	2	4	3	3	1	36	2.4
	DP	3	3	2	2	2	4	3	3		4	3	3	4	4	4	1	45	3.0
	AD	4	3	3	3	2	4	3	2	4		2	3	3	4	4	1	45	3.0
	RD	3	4	3	3	3	4	3	2	2	2		4	3	3	3	2	44	2.9
	WS	3	3	3	3	2	4	3	2	3	2	4		3	3	3	2	43	2.9
	FP	3	3	3	4	2	4	4	4	4	3	3	3		4	3	4	51	3.4
	NA	4	3	4	4	3	4	4	4	4	3	3	3	4		4	4	55	3.7
	CS	3	2	2	2	2	4	3	2	4	4	2	3	3	4		4	44	2.9
	TH	3	3	3	2	2	4	3	1	2	2	3	3	4	4	2		41	2.7
TOTAL	47	44	43	40	34	60	43	36	45	41	41	43	54	55	45	33	704		
SRDI	3.1	2.9	2.9	2.7	2.3	4.0	2.9	2.4	3.0	2.7	2.7	2.9	3.6	3.7	3.0	2.2		46.9	

GDI - Group reported Depth of Integration; SRDI - Self-Reported Depth of Integration

Total observed integration score = 46.9/16 = 2.9

Note: perceived Scope of integration and self-reported scope of integration is 100% because all the sectors are aware of each other.

Ministry of Social Welfare; MF – Ministry of Finance and Economic Planning; CL – Community leaders/local politicians; PP - Planned Parenthood Association of Ghana; HI – Mutual Health Insurance Scheme; DP – Diseases Prevention Control; AD – Health Assessment and Disease Surveillance Unit; TP – Town Planning; WS – Community Water & Sanitation Agency; FP – Family Planning & Immunization Programme; NA - National AIDS/STI Control Programme (KMA district) ; CS – Chemical Seller Association; TH - Traditional Healers

Source: Author’s own analysis

In the case of Table 7.2, the results show that the estimated levels of integration in rural district (AAS) have a different picture in terms of GDI and SRDI. From this Table, it is noted that the SRDI is 3.1 while the GDI score is 3.9. This implies that unlike the urban district, the malaria programme officials at the rural district perceived the community and the rest of the institutions to be aware of malaria control programmes,

communicate on their activities, and at the same time cooperate to the extent that they are almost collaborating. In this case the health officials' plans and activities do reflect on the ideas they get from these institutions since they do not only exchange information but also share ideas and more or less jointly plan and modify delivery of service based on mutual consent.

(i) General level of awareness of the NMCP and communication amongst sectors

The relationship between the communities and the malaria control health officials are both cooperative and collaborative (score= 4 each). In addition, the whole 15 other groups perceive the communities and its leaders to be more than cooperating (GDI = 3.9). The idea here is that the communities are rated favourably by the institutions in the rural districts due to their cooperation. They all consult the communities and share ideas. Considering the overall total level of integration amongst institutions participating in malaria control programme activities, on the basis of Browne et al. (2004) indicators for level of service integration scores (Total Observed Integration Score =2.9) the result showed that there is a very good level of integration amongst the rural institutions.

One significant thing about all these findings is that they reflect on what has been discussed already in terms of the differences in roles played and or level of cooperation provided by communities between urban and rural districts as perceived by the officials. However, it can be argued that although the level of integration is higher in AAS, the total score in urban district is at least as significant as the rural. Both scores indicate that each sector in both study sites is aware of the programme and at the same time communicate with each other on issues relating to malaria. This is significant because the communities are, at least, aware of the malaria control programme activities and as argued by Miller (2009) *"this awareness has the potential to create a more participatory environment"* (p10). Besides, with better communication feedbacks on reports could

have been easily accessible which could also enhance community participation (EL Ansari et al. 2001). This is validated by the statements made by most interviewed health officials who stated that:

“All the sectors are, these days, integrated and as a result we have all the departments in this district including the community working together as one body. They (community members) are part of us and I will say that they are our most important local partners and their services are also needed. We have good district co-ordinating team that could help in informing communities about all the services needed in this district. So the community members could never have been left out in our deliberations on local health programme activities. Such inclusion could have motivated them and made them prepared to assist what we (local health authorities want to do” (Nr 33)

.....”These days, because of the idea of working together in the areas of planning and execution of programmes amongst sectors including community members, sharing of information has been a priority and easy. This level of integration could have made us to see ourselves and the community as one group bound together with the aim of finding solutions to problems facing the community. We need the community members and it is good that they (community members) see the significance of their own roles in these efforts. They would have been willing to participate in most of the activities if they had been given the right incentive and that will help improve the health status of the members” (Nr 89)

These views were shared by some of the interviewed community members as reflected in some the comments made. For example:

“.....I think we the community members are aware of the level of unity that exists between health departments or officials and other governments departments which encourage some of us to participate more in these health programmes. They all come here often to talk to us in one voice and I think such atmosphere could be used to encourage others to be more active in whatever they want to do in this community” (Nr 114).

...”I see them working together as a group. They always come with most of the officers from other departments and anytime the health staff talks, he/she will hand over the next stage of the activity to his/her colleague who may be working in say, social welfare, who will also tell us something about government new policy on child care. After that he/she will say I have a colleague here from, say Family Planning Unit. All these show of togetherness could have made us to see the need to work better with them, but we have our own problems which make us incapable to fully involve ourselves in these activities..... So I think the strong show of unity amongst the local government officials

and interest in community participation could be contributing to our interest in participation” (Nr 116)

...”For me having been attending meetings with the various government departments, and seeing the way they communicate with each other these days, there could have been a number of opportunities that could have been used to incentivise community members to be more effectively engaged in local health issues. Long procedure in getting information could have been avoided and information could have been easily received from the local authorities. But with the central government always in the middle of affairs and other community problems, this working together is having less impact as most people are less encouraged to be active in government programmes than they should” (Nr 68)

The argument here is that without the contextual problems, intersectoral collaboration amongst sectors could have been a good source of community participation in control programme activities. This could have been possible because of the mutual communication and interaction amongst sector members including the communities. Such integration could have diminished individual and community isolation and consequently could have facilitated higher level of awareness of programme activities (Browne et al. 2004). Without the various barriers, the periodical meetings and sharing reports of control programme activities could have strengthened community’s working relationship with those involved in the intersectoral collaboration. For example, with bureaucratic systems in Ghana, institutions are usually to be organized units into one hierarchy, while as a result of horizontal integrative processes there would have been a linkage of key departments and community together without building any new bureaucracy. This could have increased the sharing of information on planning activities amongst those involved in the programme.

However, many commentators have argued that although horizontal integration could serve as catalysts to bring about community participation there is no guarantee that integration will ensure participation at all times (Butterfoss, 2006; O’Toole, 1997; Bermez et al. 1993). These authors argued that it all depends on whether the members are part of the ‘core or main group’ participants (health committees) who are more

likely to be involved in programme activity irrespective of its contents or part of the 'periphery group' (non-committee members). Where community members' interest in participating has been tied to their specific interests, then such people would require a lot of persuasion by the 'core group' members. In that case, it can be argued that there is a need for a strong commitment of programme organisers themselves to both higher level of integration and participation which can potentially serve as a motivating factor to the community members (Provan, et al. 2004; Straus, 2002). A statement given by one interviewed officer illustrates this point:

“ the mere fact that we have all the sectors working together does not mean anything to the community members if we do not demonstrate to them that there is a need for it. We have to commit ourselves to such efforts and show the community that the outcome of such a strategy is positive. That will motivate them to be part of the decision making machinery other wise it will be hard to win them” (Nr 81)

In essence, a weak commitment to do what is necessary to involve a diverse array of community members by programme organisers will not enable community members to also participate strongly in programme activities even if the level of integration is good.

Overall, with the existence of good level of integration at the local level, it could have been much easier to promote participation amongst community members. The occasional public consultation processes could have provided much more opportunity for community members to interact and speak to government officials directly around their policy concerns and issues. Thus by participating not only can the community members contribute in the identification of their needs, but also they can set their priorities as the means to meet those priorities (Koelen et al 2001).

In the context of Arnstein's (1969) ladder, having such an approach of working in collaboration with members of the community has the potential, to represent a degree of citizen power which has the potential for an interactive participation. However, with

the presence of the various local barriers, there has been either non-participation or participation has represented degrees of tokenism (Armstein, 1969; Pretty, 1995).

7.5.2 The existence of political structures within the communities

(i) The policy of decentralisation

The study also found other existing potential enabling factors, which were first related to political structures. These structures emanated from government's policy on decentralisation that has led to local government health officials to be committed to participatory process of decision making. These local structures included community health committees, local elected assemblymen and women and local development committee members. All these, in principle, could contribute in energising community members to be involved in local issues like malaria control. However, the evidence from the interviews suggested that due to certain problems associated with the Ghanaian system of decentralisation as discussed in section 7.1.1, the effectiveness has been less. Interviewed government officials were convinced that without the existing problems, these structures could have enticed members to participate more in policymaking process. One interviewee expressed his opinion by stating:

“I believe without the problems facing the communities, the existing political structures could have helped the community members to participate in local issues because they make us closer to them. I personally think being closer to the community through the structures in this community could have facilitated the willingness of the community to work in partnership with local health authorities” (Nr 118)

This argument was also supported by another official who also had the opinion that the recent increase in community participation in health programmes has all to do with the policy of decentralisation which gave rise to these political structures. It was explained that without the contextual problems like poverty, culture and central bureaucratic structures, the existing political structures could have led to more participating in policymaking process of malaria due to its closeness and embeddedness with local community situations (Atkinson et al. 2000). To this official:

“Often the tasks of the various community committees motivate the community leaders and their members to be interested in participating programme activities. So, a lot could have been achieved with the political structures that existed in this area in community participation if most of the problems that the community faced had not been there. If the person could not come for meetings because he/she had no money, no matter the good structures government puts in place, it would not be useful. That is why I have said the problems in this area tend to make some of these good factors not good anymore” (Nr 24)

The perspectives of rural communities also confirmed that the policy of decentralisation could have helped to motivate the grass roots communities to be involved in local issues including malaria control programme activities. This was validated by the various arguments put forward by the community members themselves during the FGDs:

“... Unlike the past, these days they have made us to understand that we the people in this district must take matters into our own hands and deal with our problems and I have seen that it makes sense to give us that power to decide for our selves. So I know being close to us we could have given the local health authorities all the help they needed for our own good and that could have encouraged me to be more involved in any programme activity that is taking place in this locality. But the problems are too many to put most of us off” (Nr 71)

“.....For the past five years I have also seen that the officials here are more committed to fostering community participation and that have encouraged me to participate in community issues and I think that could have encouraged others as well. I would not have bothered myself to voluntarily go and offer help to keep the environment of the community health-post clean. It is all because the government officials in this district are now able to demonstrate to us that they are prepared to work with the community” (Nr 115).

“.....I think, the government is committed to this idea of working with the community through the establishment of the structures in this locality which allow us to mobilise ourselves. So these structures are good for us but the problems in this community easily discourage people from getting involved in these activities” (Nr 127).

Thus, through decentralisation, the relations between the public officials and community members could be strengthened and the community’s awareness of their own health problems could be improved. Besides, community’s interest in resolving its

own problem could also be enhanced which ultimately could lead to increase in participation in health issues. This is consistent with the argument of Collins (1994) who argued that:

"In the absence of significant decentralization, community participation can be nothing more than a political facade for the legitimacy of political regimes." (p.252)

However, for the community members, the real impact of this policy has not been felt because of the local existing barrier to participation. In essence, the opinions expressed by the interviewees about decentralisation as a facilitating factor implied that the merits of decentralisation which could have been enjoyed by the community have been undermined by the local problems (Robertson 2002, Blair, 2000). Thus, the extent to which decentralisation has been used as a tool to mobilise community members and to enhance community participation in Ghana has been constrained by the problems discussed in section 7.1.1.

7.5.3 Socio-cultural institutions within the communities

(1) The roles of the traditional leaders and Ngos

Similar to the existence of political structure, the socio-cultural structures were also found to be potential enablers in the form of traditional institutions headed by traditional leaders (e.g. chiefs and elders). In addition, there were social organisations like the NGOs that were perceived to be one of the potential enablers to community participation. These socio-cultural traditional bodies have been acting as interfaces between the different areas of government which makes it easier to pass on information to the community members on matters that affect them (Wolke, 1992). From the interviews, it was realised that the community local leaders like the chiefs, for example, represented a key aspect of promoting community networks and unity. They also encouraged various small community heads as well as the other local community

members to think more positively about the problems in the community and at the same time help in stimulating community members to participate in community programmes. This is validated by local interviewees who admitted that:

....."Over here, the work of the health officials is often supplemented by the works of the community leaders and the NGOs who also help in encouraging we the community members in participating in the communal activities that help the community to develop, may that be from health, agriculture or social welfare officials. Our local leaders motivate us through advice and their show of interest in the welfare of the community" (Nr 66)

..... The NGOs are also good in these exercises especially when it comes to organising and creating community's interest in the remotest parts of this district. They sometimes make also know what the government officials will not tell us. I find them very useful and helpful in encouraging us to be part of the programme activities that are taking place in our locality" (Nr 76).

" the NGOs are able to persuade the local residents to be more involved in health activities like malaria because they are for our own good. The workers have time for us in contrast to the government officials and they are able to explain to us the causes of these problems like malaria which help us understand why there is a need for participating in these programmes" (Nr 60).

....."I think, our local leaders and the NGOS are able to minimise community members' sense of alienation from health programme activities like malaria control. They help in facilitating and in ensuring our influence on decision making process on health matters that affect the community" (Nr 96).

Also, during FGDs, it was also noted that the traditional institutions not only enforce beliefs in participatory process but also aware of the social benefits of such community participation. This was reflected in the following examples given by participants:

" The idea of community participation is not something new to us. For years now we have system which allows every member in this community to come to the house of the chief to participate in deliberations that affect this community. We all understand this system and we know the benefits of it. At least, it makes everybody feel inclusive in whatever is happening in the community. So I often advise the community residents to try to be present at any gathering which has something to do with the community's own

interest. In that way, they can express their own point of views in support or against any activity that has to with people here. I see this as a way of contribution to the society” (Nr 40).

...

.....”In this rural area, as a result of the work of our local leaders, we see themselves as a homogeneous group and there is no distinction between different sub-groups. The local chiefs represent the whole community and we can rely on local leaders and their own solidarity to obtain their cooperation in whatever we demand from them“ (Nr 142).

.....”the unity amongst members in this community is strong and we seek help from each other. We are often made to understand by our local leaders that ‘unity is strength’ and as such we work together as a group. Every member always wants to stand for each other” (Nr 129).

The whole idea behind these discussions is that the local leaders play important roles both stimulating and at the same time persuading community members to participate in health programme activities.

From a community perspective, community participation in malaria control programmes has been possible because community members, although may come from different sectors in a geographical area, could rally around their local leaders to participate in control programmes. The point raised here validates what has been said already in section 7.1.1 about the government continuous dependence on bureaucratic structures which sometimes alienates the communities. For the communities, the reliance on their traditional leaders can be viewed as an expression of their commitment and their sense of belonging to a community of place (Rifkin, 1998).

The implication here is that the local leaders not only see themselves as delegated to represent their communities in terms of their views and values, but also as symbols of unity amongst them. This means that the local institutional set up increases unity and strengthens solidarity while diminishing anonymity. Such situation enhances interaction amongst community members which can also increase the number of good ties necessary to build strong relationships and improve community participation (Wolke, 19992; Twumasi, 1986; Abelson 2001)).

In contrast to rural areas, in urban centre (KMA) these traditional institutions play little roles in facilitating community participation. It was found that there was little homogeneity as well as social cohesion and people were passive. In this study site, (KMA), it is found that there was lack of broader social solidarity amongst members which had negative impact on community participation as one local urban resident stated:

“ In Kumasi (KMA) here, the differences amongst the people is too big and there is nothing that unify us. Everybody is different, even the language in certain areas is different. The people are for their families and not for the community. I have lived here for more than twenty years now but I do not know what you mean when you asked me about health committees. I do not think they exist here” (Nr 83).

This difference between urban and rural areas is consistent with the literature. According to Scot et al (2007) there is a culture of impersonal and anonymous relationships amongst urban populations while rural areas are characterized by a “*more personal and intimate web of social relationships*” (p.4). In terms of the defining feature of a community of place, Taylor et al (2004) argue that it is the locally oriented social interactions which, as one would expect, come about as community members go about their daily duties. Basically, community is not only made of the total number of the formal structures, in spite of the fact that it can play a significant role, instead it is the members and their dealings with each other which at time times matters most. The simple reason is that it is by common interactions that community ties are created and commitments in finding solutions to common community problems come about. Without such communal spirit, community participation in programme activities is less likely to take place (Taylor et al. 2004; Wolke, 1992). This is corroborated by a study in Ghana by Gyapong et al. (2001) who found that community-directed programmes achieved much higher levels of coverage than those delivered exclusively through the formal health sector in another community.

Thus, in order to achieve higher levels of participation it is necessary to understand the socio-cultural differences between and amongst local communities.

7.5.4 Summary

This section has revealed the factors that have facilitated community participation in the study sites. These factors are the good level of intersectoral integration and the political and the socio-cultural institutional characteristics within the study sites. With regards to the first finding, it was noted that although the rural district (AAS) level of integration (2.9) is stronger than the urban district (KMA), (2.4) both study sites could be considered to be aware of the malaria control programme activities and the members communicate with each other. However, these study sites both lack cooperation and collaboration. If anything, it is the rural area (AAS) which is close to the level of cooperation amongst the collaborative efforts members, if the value of the integration level had been 3. Nonetheless, the good level of integration has facilitated community participation because working together amongst sectors has made the community realise their significance in participating in decision making process. The second factor has been associated with local structures that have brought by the policy of decentralisation. Although this policy had most of these structures which the health officials could have used to encourage participation, the existence of bureaucratic structures made it difficult to have effective participation from the communities. Finally, the existence of socio-cultural institutions within the study sites has also contributed community participation because these institutions like chiefs and NGOs have been playing 'mediating roles'. Such roles have had positive influence on members' interest in participating in health issues like malaria control as the communities have to rally on their local heads as a source of participation.

Collectively, however, it has been found that there is higher possibility of the rural communities participating in the communal activities than the urban communities. This has been seen to be related to the fact that in the urban study site the socio-cultural

institutional structures have not effectively been used to organise the communities on programme activities by community leaders like chief and the elders. The health officials could not therefore heavily rely on the community leaders to communicate with communities on health issues. Thus, there was weak cooperation and collaboration amongst the members and their leaders and consequently the health officials.

7.6 Conclusion

This chapter has examined the findings regarding the barriers and facilitators to community participation. The discussion in the first section has centred on barriers while the second section has addressed issues on facilitators. In discussing the findings, there were two perspectives namely the health officials and the communities. From the perspectives of the health officials, it was found that the continuous existence of the power of bureaucratic structures and lack of resources were the major barriers. However, the communities perceived that the lack of organisation support and disillusionment, culture and poverty has been their major barriers to participation.

With regards to facilitating factors, there were two main findings on enablers which include: good level of intersectoral integration and political structure emanating from the socio-cultural institutional characteristics within the study sites. The proposition here is that if community participation in Ghana has to be promoted and sustained, solutions to these problems have to be found within the context of the study sites. This means that, for community members to take advantage of health policy programme activities through participations, these barriers are to be minimised whilst the facilitating factors are to be allowed to thrive. In doing so, many authors have argued that community participation could lead to great amount of benefits which may include: the potential of empowering communities, minimising the impact of malaria cases by improving the health status of the community members, enhancing community support for health authorities' programmes, and above all inclusion of depressed groups which

hitherto has been neglected in decisions that affect the communities' lives (Arnstein, 1969; Veitch et al. 2004).

So far this study has aimed at finding out the extent of malaria in Ghana and tries to investigate the extent of community participation in the policy strategy of ISC including the barriers and facilitators. Chapters five, six and seven have come out with the results. However, the conclusions and the implications of all these findings in this thesis are yet to be known. Against this background, the next and the last chapter of this thesis will pull all these findings together and analyse the meanings and the implications of these findings.

Chapter Eight

Discussion and Conclusions

8.1 Introduction

The problem of malaria in Ghana has become one of the country's sources of underdevelopment due to its impact on the country's economy. Moreover, the biggest sources of the level of morbidity and mortality in the country could be attributed to the disease. These complex and intractable nature of problems caused by malaria has led to the implementation of National Malaria Control Programme (NMCP) strategy of intersectoral collaboration (ISC) for a decade now. This ISC strategy has been seen in terms of community health partnerships and a more holistic approach to health problems. It has the purpose of bringing all the sectors including local communities together in pursuit of a common goal of preventing and controlling diseases like malaria in Ghana. In doing so, it allows various sectors to positively discover their dissimilarities and collectively seek solutions to the problem which otherwise could have been impossible if health sector was to fight the problem alone (Ham 1999; Davies et al. 2000; Healey, 1997).

In this thesis, I considered the implementation of the NMCP strategy of ISC as policy model within which to investigate the issue of community participation in the policy making process. The NMCP was one of the first examples of health policy strategy in Ghana that supported broader level of community participation in health planning (MOH, 2006). In essence, my aim was to use the case of NMCP to explore the policy rhetoric and the reality of translating the policy directives on community participation in ISC into practice.

Against the background of the study aim, the main objectives were to explore: the extent of malaria cases in Ghana; how the policy making process of NMCP takes place; the roles of the community members in this malaria control and prevention process; the barriers that undermine community participation and the extent of local institutions' involvement in the ISC strategy and other factors which have the potentials to facilitate community participation in NMCP policy making processes.

Based on these objectives, a common thread weaving through this study will be presented in four main parts including:

- a) the research methods and their strengths and weaknesses;
- b) theoretical framework which centred on Alford's (1975) work on structural interests theory, Arnstein (1969) ladder of participation framework and Walt and Gilson (1994) triangle policy model;
- c) the roles and of the communities and the extent to which community participation in NMCP has been realised, and
- d) the final part examines conclusions and the broader implications of the findings for future participatory policies and programmes in controlling diseases like malaria in the country.

8.2 The study methods and their strengths and weaknesses

At the beginning of the study, I did present critical contextual background information that could allow the reader to have a better view on Ghana and at the same time have a clear picture of the case study areas. However, instead of testing fixed and pre-formed hypotheses, I chose to design the research in an exploratory manner in order to achieve the study aim. The data that were used mirrored a number of issues found in the literature on community participation. This includes the difference between the policy rhetoric of community participation and the reality of it happening as well as the

underlying reasons why health authority officials find it hard to achieve community participation in malaria policy making process.

I decided to understand such complex issue of community participation in malaria control by using two case studies, which involve the perceptions of rural (AAS) and urban (KMA) local residents and their health officials. By using these two different districts, I have been able to discover the roles of the community members in malaria control programme activities and the various contextual factors that act as barriers and enablers in these areas. As case studies, the main methodology was qualitative which included semi-structured interviews, FGDs, non-participant observation and documents analysis as a supplementary technique (Burns, 1994). However, a survey was also conducted to collect data on the perceptions of the extent of individual institution's level of integration with NMCP (see figures 7.1 and 7.2).

In general, the variety of inquiry techniques used during the investigation has been helpful. The knowledge I got on local barriers and enablers to community participation could not have been possible by only documentary analysis alone. In essence, through the combination of the literature and in-depth primary research methods in these two different districts, I have the belief that I have made some contributions. For example, until now, although the extent of community participation in NMCP activities was theoretically known, in practice it was never investigated. However, through this study, the extent of integration amongst various sectors involved in malaria control as well as the degree of community participation has been revealed. Secondly, the factors that have undermined community participation in the two study sites have also been exposed. These findings could be a powerful reminder to those who believe in community participation as a way forward in solving the problem of malaria in Ghana. They need to know that community participation in practice are faced with a number of challenges in different locations and therefore have to consider the significance of contextual factors when planning participative policies and programmes.

8.2.1 The strengths of the study

In enhancing the reliability and validity of my findings in this case study, during my data collection, all efforts were made to employ various data sources to allow for triangulation through converging lines of enquiry. As a result, it can be argued that there are some key features of this study which strengthen and increase confidence in the findings. For example, the multiple sources of evidence helped me to explore issues and contexts from a variety of different perspectives for analysis (Yin, 2003). It also provided me, as a researcher, to be on the ground to gather documents, observe certain evidence for myself and to interview the real people. By focusing on qualitative methods, I was able to see the research topic:

“...from the perspective of the interviewee, and to understand how and why they come to have this particular perspective.” (King 2004, p. 11).

Another tool that I also found useful during my investigation and had strengthened the study findings was the FGD. For example, during the FGD, I found that although some community members could have their own views on issues that were under discussions, as they began to listen to the answers from others’ they tried to say something in agreement or disagreement with what has been said. In this way FGD helped me by having interviewees probing each other’s view which was not possible with individual interviews. It can therefore be argued that the FGD not only helped me to access significant amount of data and exposed the individual community participant’s perceptions on the topic, but it also made the quality of information that was collected more valuable (Bryman, 2001; Stewart et al. 2007).

Moreover, other supplemented methods such as direct non-participant observation (e.g. taking time to go and observe swampy areas caused by deforestation which has become a source of breeding mosquitoes) also provided me the chance to cross-check the plausibility of the interviewees’ information given to me on that issue). In addition, it

offered me the opportunity to capture dynamics of behaviour and understand attitudes and situational barriers (e.g. bad roads) on community participation. Such opportunity provided rich contextual data for exploratory components of the research.

Finally, from the literature review and to my knowledge, this is the first time an attempt has been made to investigate into the degree of community participation in NMCP policy process in the country using qualitative as the main method of data collection. Thus, although I studied only two cases, and as such no extensive claims about the generalisability of findings can be made, the study provides a platform for further research in the country. This assertion is based on Maxwell (1998) who talks of the transferability of findings rather than generalisation. Transferability in this study is possible due to the results of the documentary review on NMCP in Ghana, the knowledge that has been developed on community participation and the suggestions arising from this study. These may be transferred to other similar rural or urban communities involved in such health programme activities.

8.2.2 Limitations of the study

In spite these strengths this study had its own limitations. The first of such limitations was that some of the interviewed public health officials were at times hesitant in their responses because they found themselves giving comments on the performances of their employer, the government. Although an attempt was made to rectify this problem by making it clear that responses would remain confidential and anonymous, I am not sure it completely eliminated this bias. Moreover, while the positive impact of FGD was realised amongst community members, it was not possible with the public health officials. I could not organise a FGD with them because these public officials were not willing to have such open discussions about the policies that have been implemented by their employer, the government. Besides, they all argued that they had no time for me to organise such a FGD.

Secondly, due to financial and time constraints, I had to rely on relatively small number of interviewees and communities to make my conclusions. In general, the findings about the extent of rural/urban community participation could have been strengthened if more case studies with more interviewees had been done. With community participation processes being more complex, and dynamic, the result that comes from the investigation of such limited cases could not be generalised (Bowling, 2002; Yin 2003).

8.3 The relevance of the study frameworks

During the literature review in Chapter three, there were a number of frameworks which I needed to use due to the interdisciplinary nature of the study. The critical roles of these models are discussed below.

8.3.1 Alford's theory analysis of participation in NMCP

In general, the use of Alford's (1975) structural interests theory was useful. This is because the theory helped me to understand the power relations within the NMCP planning process and its indirect repercussion on community participation. More specifically, this study made an attempt to find out whether the established government structures within ISC policy strategy exist to help the health authorities to consider only the interests of their employer (i.e. government) to the detriment of the repressed interests of the community members or were meant to serve the interests of the communities within the NMCP. So far, the finding showed little evidence that the ISC policy which was developed to promote community participation in the NMCP has helped community members. Evidence has shown that although there has been a policy of decentralisation which potentially demonstrates the central authority's commitment to devolve actual power to the local people, in the words of Alford (1975) the 'repressed community interests' were not served.

By applying Alford's structural interests theory, it was noted that both the health administrators (street-level bureaucrats) and or medical profession were, as Alford (1975) refers to as 'corporate rationalisers' as well as dominant group respectively. Despite the principle of partnership, the ISC has been led by corporate rationalisers who are mostly in medical profession. From the perspectives of Alford (1975) theory of structural interest the medical profession, due to its power and resources to resist change, has the powers to dictate the direction of the planning and regulatory functions within the health service. Their reluctance to share power and the responsibilities of policymaking with the community members could be seen as an attempt to maintain the status quo which fails to take into account the repressed interests of the community members. Thus although the ISC had the potential to solve the problem of power inequalities and to ensure that Alford's (1975) repressed interests of the community members is considered, the situation has not changed within the case study sites.

In reality, the study findings have demonstrated that the medical professionals are, in most cases, both the dominant (administrators) as well as monopolisers (medical experts) in the NMCP activities. It is often the medical doctors and their health allied professionals like nurses who have the power and responsibility to lead in malaria control policy development. Effectively, although in theory policy strategy of ISC was meant to provide better opportunity to bring those repressed community interests into the health planning field, in practice the participatory activities have failed to include the influence of the lay communities in the planning process. As found out in this study, neither the conducted local case studies nor the wider literature, including a national review of NMCP revealed any significant influence of community members in the malaria control policymaking process. In essence, it can be argued that the devolved policymaking responsibility has not provided any prospect to the community members to have the power to influence decision-making.

On the basis of the structural interests theory, one can argue that the ISC policy represented an attempt by the corporate rationalizers to win over the community members into activities controlled and organised by them. As the finding of this study indicates, they have the power to shape the perceived needs of the community members. This has been aggravated by the inflexibility of the administrative framework and related powers of central bureaucratic structures. As evidence has shown, the decentralised framework set up in the country to devolve power to the community members suggests that the final determinations of the priorities that have to be acted upon are in the hands of the central authorities. As such even if the communities are consulted on policymaking issues, the local authorities can not guarantee that their interest will be served.

The inference here is that the type of change that has been put in place to ensure participation (e.g. community health committees, elected district assembly men/women) envisaged by the authorities of the NMCP has failed to offer the grass roots community members the chance to have any significant impact on the policy making process. To Alford (1975), this can be seen as typical of the activities of corporate rationalisers who pursue their interests through the creation of more bureaucratic structures (and thus more layers of bureaucracy), but:

"none of which has sufficient power to do its job"... and these layers of bureaucracy only serves to "complicate and elaborate bureaucratic structures" (Alford, 1975: 207-208).

In conclusion, using Alford (1975) theory of structural interest, this study has painted a very negative picture of the position of community members with regards to NMCP policymaking process. So far it has been realised that community members' participation in the process has not really changed. Rather it has remained as it was and this picture is all the more pessimistic when one acknowledges the powers and the structural interests of the corporate rationalisers as theorised by Alford's (1975) and as borne out in this findings.

8.3.2 Measuring participation using the framework of Arnstein (1969)

In chapter six, the quality of the community participation in policymaking processes was assessed by using Arnstein's (1969) ladder of participation. According to Arnstein (1969) participation is not about looking at the mechanisms used rather it is the nature and quality of the participation by community members in the policymaking process that matter. This is based on the idea that most of the mechanisms for community participation often restrict the ability of participants to influence the policy process. Arnstein (1969) argues there are some forms of participation which can be "egotistical and underpinned by deceit" (p.218).

Similar to the conclusion drawn by using Alford (1975), based on Arnstein's (1969) ladder of participation, the study also found that there is no real community participation in NMCP policymaking process. Evidence in this study, so far, has shown that the mechanism used for public participation in the NMCP policymaking process has been a "degree of tokenism" with "informing and "consultation" and "placation" (p. 217) as types of participation. In terms of informing, the finding showed that the community members at times only participated in policymaking process of NMCP when health authorities had to inform them on certain activities rather than engaging them on policy plans. Often there was no chance of community members suggesting anything as well as getting any feedback from the authorities. Consequently, the community members have no power to influence negotiations and under this type of participation, Arnstein (1969) has argued that community participants simply seem to be participating in policy process essentially to give backing to government's decisions. Under "consultation" the authorities only consulted the community members by organising general community meetings but there was no guarantee that their suggestions (i.e. inputs) on priorities would be considered or would be acted upon in the final priorities' selection. This kind of situation leads to, as Arnstein (1969) puts it, "Placation". At times community members may have the chance to make contributions or suggestions either directly or indirectly through their community health committees. However, they have no power to

decide on issues that affect them, rather the powers to make the final decisions remain in the hands of the government health officials. This makes the participation of the communities to be seen as only 'ceremonial'

The study finding therefore demonstrated that the participation of the community members is only symbolic with no real significant impact on policymaking process. In this sense, it can be argued that community participation in NMCP policymaking process primarily serves as a means to obtain the needs and priorities of the communities but there is no guarantee that they will be acted upon by the local officials according to the wishes of the community members. Evidently, this has been a source of disillusionment to the communities and consequently has undermined the level of participation amongst members. Thus what needs to be borne in mind is that it is not just about participating and having a say in policy processes, but according to Arnstein (1969), it is more about having an influence on the results of the policy process. In NMCP as already shown, the extent to which community members could participate was mostly restricted to information sharing rather than a real debate and negotiation on their needs and priorities. This is in contrast to Arnstein (1969) idea that citizen participation involves the exchange of power through a mechanism which could promote the interests of communities in the policy processes. In essence, participation only takes place in NMCP when a decision has already been taken but people are consulted or have been made to be involved as though their views are of some significance, whilst in fact it is not. Arnstein (1969) shared this view and argued that such participation served as disincentive to prospective participants whose desire has been to have influence on policy programmes activities. Implicitly, the idea here is that little or no recognition is given to the need for the community members to participate, exchange and or share ideas in the policymaking process of NMCP activities.

Overall, using Arnstein's (1969) ladder of participation, ranging from 'degrees of non-participation' through to 'degrees of citizen power', has been useful in providing a

picture of the degree of powerlessness that communities have in the participation of malaria policymaking control processes. Through mechanisms used by the authorities, the members are prevented from participating in policymaking process and they have no power to effect decisions and to bring change in line with their interests. Thus, on the basis of this framework, it is fair to conclude that the study found no evidence to suggest that there is real participation in the NMCP policymaking process by community members.

8.3.3 Health Policy Triangle Framework of Walt and Gilson (1994)

The analysis of the policy making process in this thesis necessitated the use of health policy triangle framework to analyse NMCP strategy of ISC processes. This framework was pioneered by Walt and Gilson (1994), and the idea was that health policy analysis in general often concentrates on the content of policy, without considering actors, context and processes. As a result, this framework takes into account the process by which all four of these elements interact to shape policy-making.

In using this framework, I intended to explore how factors like actors, process and context come together to shape policy content of community participation in NMCP activities. As it turned out, it was noted that all the four factors were all intertwined and therefore needed to be considered in a holistic way. The evidence in this study so far showed that community participation has been influenced by the contextual factors (e.g. poverty, culture), actors (e.g. government officials who are the policy experts) and the content of the policy which gives power to the bureaucratic structures. Moreover, community participation has also been affected by policy process particularly at the planning stage where the community members had no powers to influence the policy outcome.

In essence, the use of this framework enabled me to explore the complex reality of policy-making process of NMCP in Ghana in which community participates. Also, by

breaking down the process into a series of functional and distinct stages and analyse each stage separately, I was able to examine the way policy planning and implementation have taken place. Thus, it offered a

“useful conceptual disaggregation of the complex and varied policy process into manageable segments” (Buse et al. 2005, p. 2).

In terms of its usefulness, I found the framework practically useful. In terms of context, the framework helped me to assess not only the present policies on NMCP but also the past as well (see chapter 2). The framework offered me a good “descriptive map” of the policy process and made it easier for me to discuss some of the factors that affect the community participation process within each stage. Also through the framework all the policy actors involved in the NMCP which included public, private and community members were identified and their perceptions on their level of integration in NMCP as well as the extent of community members’ participation in policymaking process were also examined. By knowing the actors, I was able to understand the positions of each of these actors with regards to their powers and how these powers were used to influence community participation in NMCP policymaking process.

In all, using this framework helped me to realise that policymaking process is dependent on only one factor but several of them and these factors such as context, content, process and actors are inter-dependent (Walt, 1994). Thus although I might have had the process in stages, I took the recognition of the fact that the stages were not linear rather interwoven of which one can influence one another. Given this interwoven nature of this policymaking process, the framework contributed to the robust analysis of the NMCP (Walt et al 2008).

In a whole, it can be said that the Policy Triangle framework for policy analysis and its application to the malaria control policy making process in this study demonstrate that policy process cannot be purely linear. Rather, the process is characterised by a number of messy and overlapping episodes in which different policy actors and organizations

with various viewpoints are keenly involved. This makes the development of malaria control policy and strategy processes to be based on collaboration amongst the various actors. This becomes more important especially considering the fact that its outcome has significant impact on several people including the health providers, community members and policy makers themselves. The framework also has helped me to understand that the policy making processes are contextual and or country-specific (even time bound) which can be said to be greatly reliant on various factors such as economic, culture, socio-political conditions and the power relations between the policymakers and the ordinary people (i.e. communities). Implicitly, an effective malaria control policy development should be based on strong contextual analysis of all the factors mentioned. What makes this argument more significant is the fact that the realisation of a policy's objectives has a long gestation period and as such policy development and its change should take place with careful assessment.

8.3.4 Structuration Theory

Structuration theory is basically about persons and society and it is based on the idea that apart from natural events, human agents are the causes of what happens in society. However, the extent to which agents can do or can be is enabled and constrained by what they have to work with. In the context of this study, therefore, the theory has contributed in my understanding of the essential roles of the organisational structures in constraining or facilitating agents like community members in participating in control policy making process. It also helps in understanding how the structures pose as barriers or potential enablers to local health authorities' efforts in promoting community participation.

Internally, the organisational and policy making structures within the health sector itself were identified to be barriers to community participation. It was realized that the health sector's organisational structure is highly bureaucratic and although it is decentralised, those at the lower level still depend on central body or top level for decisions on all

aspects of programme activities. Consequently, in terms of programme planning, the way the sector engages the communities to a large extent, de-motivates most members and therefore lower their level of participation in the process. In effect, these internal structures affect all aspects of programme activities, in particular the decision making procedures. This makes community members detached from the process and consequently leads to less community participation.

Externally, there are political structures that have acted as enabling factors. On one hand, the structure of the Ghanaian health system through decentralisation policy and subsequent formation of local committees has acted in favour of community participation. On the other hand, the changing nature of the system in the form of deconcentration has also been detrimental to community participation. This is because it has created a situation where the poor districts like AAS had mostly to rely on the central government for resources. Such dependence has made the local authorities less capable in implementing policies and strategies that could enhance community participation since they have to formulate policies based on national guidelines.

Secondly, it has also been noted that there are other socioeconomic structures which have impinged on participation strategies. Due to poverty, the study has found that most community members could not attend meetings while those who have the money to travel have become the de facto elected members to represent most of the members of the community. Thus poverty has represented and remained an important barrier to the sector's success on community participation strategy. However, it can also be argued that the existence of certain socio-cultural institutions such as chieftaincy and NGOs have contributed in facilitating community participation.

However, due to certain situations in Ghana, the potentials of this theory was not fully realised in this study. For example, it was found that the community members usually have not got enough say in the planning process in Ghana and decisions are made based

on national directives. This makes the local health structure (i.e. organizational rules, resources, and etc) less effective in influencing the local existing structures. In the light of this, the use of this theory was limited in this study.

8.3.5 Policy Network Approach

With this approach, it is understood that the actors are brought together based on a policy issue that none of them can fully deal with it on its own.

In applying this approach, I was able to understand the roles that the community members play within the Policy network in malaria control programme activities. The four major categories of roles were identified to be: outreach services; managing environmental issues; monitoring and evaluation of malaria programme activities and finally the helping malaria victims to cope with the disease. Besides, the policy network approach helped in getting deeper understanding of the extent of various actors' involvement in the malaria control programme activities. Although the level of participation varied amongst various actors, it was realised that these service delivery networks has emerged as a means to address so-called the 'wicked problem' (i.e. malaria).

In spite of the partnership or policy network amongst sectors at the local level, it was also found that almost all the sectors including health sector has still vertical linkages with the regional and central bodies. This makes the network very weak and with little or no cooperation and coordination amongst those involved in the malaria programme activities. Also, ideally, policy networks are non-hierarchical as all actors participate out of their own free will and decision-making must be mutual with no actor having the formal rights to decide over others. However, in the context of Ghana, power is asymmetric due to differences in the access to major resources or other forms of power such as political, financial or technical power. The government has the power over the

communities and other social organisations and as such the use of policy network approach was considered to be limited in this study.

8. 4 The roles of the community members and the extent of their participation in the NMCP policy strategy of ISC

Evidence found in this study has shown that the community members have been playing significant roles in the NMCP activities in both rural and urban districts although these roles are more prominent in the former district. Amongst the various tasks performed by the community members, the most important ones include: contributing to the outreach services by helping to organise control programme meetings; assisting in providing health information to the community; helping the community members who are victims of malaria to cope with the disease (e.g. accessing health centres); helping in programme monitoring and evaluation and lastly assisting in cleaning the environment. However, there were differences in these forms of participations amongst those rural and urban communities. Whilst the rural approach of participation was more geared towards the viability of the community, the urban was more for individual motives.

On the issue of the extent of community participation in NMCP strategy of Intersectoral collaboration (ISC), findings in this study showed no evidence that suggest that the implementation of ISC in the study sites (AAS and KMA districts) in Ghana has led to an increase in the empowerment of community members. Consequently community participation in NMCP activities has not been strengthened. In the context of health policy of decentralisation, this evidence is supported by other findings (e.g. Bossert et al. 2002) that in reality there is little participation in the health policy making process in Ghana. This study's finding, to some extent, raises some concerns about the ability of Ghana's current policy strategy of ISC brought by decentralisation in health to encourage community participation. However, it has to be borne in mind that the findings also demonstrate that the failure of ISC strategy to improve community

participation has been facilitated by different factors as discussed in chapter 7. On one hand, based on the perspectives of the health officials, there were two major factors that were found to be undermining the participation and these included the power of the central bureaucratic structures and lack of resources. On the other hand, community members had the opinion that lack of support from the local health officials, poverty and local culture were the barriers to participation.

Besides this finding, it has also been realised that had it not been these barriers, there were three existing major contextual factors which could have played significant roles in promoting community participation in the study sites. These included the good level of horizontal integration which exists amongst institutions that are involved NMCP and the existing socio-cultural institutions and thirdly the local political structures. It therefore stands to reason that despite the fact that certain barriers could take many years to be resolved (e. g, poverty), with increase in resources, the government can still pursue its dream of minimising the persistence of malaria by focusing on some of these local structures, particularly the new strategy of ISC, to achieve its dream.

8.5 Conclusions and implications of the key findings

The question that fundamentally underpins this thesis is: why malaria problem still persists in Ghana? In trying to find an answer to this question I chose to analyse the problem from the context of policymaking process by investigating into the extent to which community participate in NMCP policymaking process. The underlying reason is based on the idea that getting communities to participate in policymaking process will help the members to have ownership of the implemented policy which will serve as a good basis for behavioural change which otherwise may be rejected if imposed unilaterally (King, et al. 1998; Irvin et al, 2004; Stivers, 1990). I therefore regarded participation as a transformative tool for social change (Nelson et al.1995) which is an

ideal solution for minimising malaria problem in Ghana (Agyepong, 1993; Ahorlu et al. 1997). Subsequently, Ghana's most recent health policy strategy has been ISC in which communities have been assured of their place and they are expected to be one of the big players in the policymaking process. The main focus of this thesis has therefore been to investigate into how community participation in policymaking process is translated into practice.

However, as the study finding has indicated, there is no evidence to suggest that community participation has fully been translated into practice. The communities are either only informed and or at best consulted but no real engagement and negotiations in planning hence the neglect of communities' interests. Thus although ISC has been in place, in practice, however, the existing communication with the community members appears to be an *ad hoc in* nature and grassroots participation in programme planning has been inadequate. For example, access to local information on policy planning which are necessary for effective community participation in disease control activities at local level has often been lacking. All these have come about as a result of the present implemented system of decentralisation (i.e. deconcentration). With the current system, the district managers are more representatives of the central government who only have to work along the guidelines given to them by their superiors at the national level. Consequently, these local officials have their hands tied in terms of budgetary allocations which have made them incapable of doing what need to be done to enhance participation, hence little participation from the communities. The result of this study therefore poses two main questions in this malaria control debate:

- (1) Is real community participation really the answer to the problem of malaria to the extent that without it the persistence of malaria in Ghana can never be solved?
- (2) Is ISC necessary in solving the problem of malaria in Ghana and could the government have done better to solve the problem of malaria without the ISC strategy?

In response to the first question, it is fair to say that on one hand community participation is really the answer to the problem of malaria in Ghana. The underlying reason for this assertion is based on the fact that community participation offers the opportunity for the exercise of voice, by having elected members or through constant contacts with the authorities. Such contacts could provide proper information and with better information, (e.g., the problem of malaria and its impacts on households and communities) members of the community can be more aware of the need to take responsibility to control the disease. At the same time, they will be able to hold accountable their elected representatives and officials accordingly. Thus, a point can be made that exercising local voices and having information must go hand in hand (Paul, 1998) as a first step in ensuring community ownership as well as sustainability of the control programmes.

In addition, although there is lack of many success stories of lasting community participation, it can be argued that the sustainability and impact of programmes necessitate the ownership and active participation of communities as a non-negotiable pre-condition (Mathews, van der Walt & Barron, 1994; Quillian, 1993; Bhattacharyya et al., 2001; Gilson et al., 1989). However, if the government aim was to use community participation as means to allow the communities to have ownership of the malaria control programme and to have the power to change the way malaria affect them, then the kind of participation that was found in this thesis would not allow such opportunities to happen. For such opportunities to happen, in the words of Arnstein (1969) communities must reach the highest level of participation which ensures empowerment and they could decide for themselves. This will help create a malaria prevention culture in the community as the study by Rojas et al. (2001) showed. In his study, Roja et al (2001) found that community participation was good on condition that the level of participation could give rise to the culture of prevention. Thus, by considering the current system of participation in Ghana using Arnstein's framework as a measure, I do not believe such level of participation (consultation and placation) could

help the community to develop to that stage where the communities could take the control programme into their own hands to prevent and control the disease.

On the other hand, from the literature review, it has been noted that preventing and controlling malaria require resources both human and financial (Arkinson et al. 2011). This makes it harder for individual communities to have all the needed resources to implement the right policy strategy even if they are allowed to do so. In the light of this, it is fair to state that considering the contextual problems in Ghana, there is a need for the government with all the resources at its disposal to assist the communities to solve the complex problem like malaria. Thus even if the level of community participation as envisaged by Arnstein (1969) and the equalisation of power as argued by Alford (1975) were achieved in the study sites, without any accompanied economic assistance and or powers, minimising malaria persistence would be difficult for the communities to achieve it alone.

With regards to the second question on whether or not the ISC was a necessary strategy, I personally see the NMCP policy of ISC as a significant one. A number of reasons underlie this claim. Firstly, It has been known from the literature review that the persistence of the "vicious circle" between poverty and poor health caused by malaria illustrate the need to relate the activities of the health sector with those of other sectors such as education, housing, water and sanitation, labour, transportation, agriculture, environment, and others . However, these other sectors can not work with the health sector without an aim of strengthening collaborations and or partnerships, because there is no one government sector like health which can, on its own, find solution to the malaria crisis. The need for collaboration between these sectors can not be underestimated because no solution to any of the health problems like malaria that affect a given community can be found and sustained entirely by the health services alone. The close association between health and the factors that go beyond the health sector makes it an imperative to adopt an ISC strategy. It is through that health

development through the control of diseases like malaria could be enhanced (Holveck, et al. 2007). Thus as it has been noted in earlier discussions of this study, the barriers to community participation are structural and addressing any one barrier in isolation is unlikely to lead to the full participation of community members. There is therefore the need for a joint action amongst the various government sectors if these barriers are to be addressed in a strategic and not a piecemeal manner (Arkinson et al. 2011). Thirdly, I am also convinced that community participation can be a source of solution to some of the programme constraints such as, inadequate financial and human resources and 'human resistance' to interventions facing the country. This argument becomes more compelling considering the fact that in the past, health planners have used such a strategy of community participation as a means to solve the problem of programme constraints (Mantra 1992). Examples can be found right through the history of community health programmes, such as in the Philippines in the 1970s (Barcelon & Hardon, 1990), in India in the 1970s and 1980s (Kaithathara, 1990), in Kenya in the 1980s and 1990s (Katsivo et al. 1993) and in Belize since the mid-1990s (Council, 2004). In essence, taking into account the economic conditions facing the country, with multifaceted nature of malaria problem, there is a need for building a concerted effort through ISC amongst the actors involved in the disease control (WHO, 2003).

In addition, what makes the argument for ISC as a strategy more important is that as a third world country with poverty level of 35% and ranked 138 out of 177 countries on the 2005 United Nation's Human Development Index,(i.e. life expectancy, adult literacy, and per capita income) (UNDP Report, 2007; PMI 2007) it will be unthinkable for the government to do all that is necessary (e.g. proper drainage system in all the cities and towns, train qualified health workers to work in all the villages and towns) to minimise malaria persistence without a combined efforts of all actors involved. Even if ISC strategy is to be implemented there is still the need for cooperation from the various actors and or sectors. This is because at the moment, there are more challenging issues than anticipated in developing countries like Ghana in implementing the ISC strategy

with community participation in malaria control. In the first place, it must be acknowledged that globalization coupled with macro-economic reforms have created more economic hardships for the various members of communities (Sachs et al. 2002). Consequently, this has, to a large extent, worn down social cohesion that underpins community spirit and participation in most communities (Arkinson et al. 2011). Furthermore, a country like Ghana lacks the capacity of health systems to successfully respond to most of the challenges as well as to support the demands of community participation in other existing selective disease elimination programmes like Tuberculosis, HIV-AIDS which are competing with malaria control programmes (WHO, 2008). Thus with limited capacity, coupled with the need to avoid the risk of implementing an *ad hoc* approach, a sustained large-scale collective action becomes important. However, the success of this action will require better coordination amongst the actors, not the least, the community members in the form of ISC strategy (Arkinson et al. 2011).

Having said this, I would like to be cautious in stating that this can be achieved on a silver platter in Ghana. The fundamental reason is that despite the fact that the world has got to a stage where there is a general consensus about health being regarded as a human right issue (Visschedijk and Simeant, (1998), the means to capitalise on this general awareness and to minimise the transmission of infectious disease by means of behavioural change is relatively scarce. From this research, although I have learned to be more optimistic, my optimism only depends on a change of character, good planning, and availability of resources. History has taught us that the Western or developed world had gone through such challenges before but it was these three things I have mentioned that saw them through (Packhard, 2007). What need to be borne in mind is that government can not solve the problem alone. Communities must help but without a change of character or behavioural attitudes, I am not convinced full participation alone could solve the problem of programme constraints by reducing malaria persistence in Ghana. As a native of Ghana and with my experience on the field, I am aware of the fact

that communities are so deep-rooted in their culture that they choose their life based on what their culture demands of them but not what current circumstances require them to do. The required change in behaviour is so important but difficult to be achieved in these communities that there is a need for an authority to ensure that the right attitude of the communities is cultivated. This assertion can be supported by the photo taken during the field trip (see picture 4.1) which illustrates the extent to which communities do not change their behaviour even if they know their actions will cause malaria. With that picture, one does not need to be told about the possibility of producing mosquitoes and ultimately malaria, and yet, perhaps, it will take a health sanitary officer to bring the person responsible to court before something positive is done about it.

This argument is not to take the responsibility from the government and put it on the communities themselves, rather it is to lay emphasis on individual responsibility which makes community participation in policymaking worthwhile. My emphasis on behavioural change is based on the notion that changes made to the environment in relation to human activities have a major influence on the emergence, re-emergence and spread of diseases like malaria (Agyepong, 2003; Ahorlu, 1997; Heggenhougen et al. 2003). Hence, it is only when the communities begin to positively change their behaviour towards a better management of the environment in addition to ISC strategy that Ghana's dream of reducing malaria persistence can be accomplished.

In general, it can be argued that the control of vector-borne and tropical diseases like malaria has an altruistic undertone (Espino et al. 2004). This means that the activities involved in the controlling malaria such as disposal of potential breeding (water) containers, and use of insecticide-treated bed nets are beneficial to both those who undertake these control measures as well as the community members themselves. This makes community participation in the control activities more of an issue which is not only to be considered within health sector alone but beyond as well as (Espino et al.

2004). This therefore demands a wider view on disease control strategy, which takes into account the complicated nature of relationship between economic and political factors and how they relate with the social environment to produce better health outcomes (Patrick and Wickizer, 1995). In sum, it can be concluded that, community participation is still the major guiding principle in malaria control, but achieving any meaningful success in the future is conditional in that it all boils down to the sustained and continuous ISC amongst the actors such as private individuals, external agencies, governments and communities who are usually involved in its control (Espino et al. 2004).

8.6 Policy and practical recommendations

The above arguments imply that, if Ghana government wants to ensure greater reduction in malaria problems community participation strategy of ISC that includes real partnership with the community must be implemented. Through that it is my belief community members can learn to cooperate, change their behaviour, be more responsible and learn to control malaria in and around their environment. Secondly, the communities must be supported with the right resources in terms of financial and human capital so that they will be motivated and not left on their own. Obviously, there are challenges as this study has shown but the barriers can only be overcome if the government adopts the right strategy. Indeed, rather than assuming that the key factor undermining behaviour change is lack of knowledge, or that communities themselves on their own volition, will work together on environmental sanitation problems that appear to be a major cause of malaria in incidence, 'participation' must be considered seriously by the government as well as the private sector (Winch et al. 1992).

In reality, the government must effectively combine both public health and developmental approaches in the way it has been explained by Rifkins, (1981). By combining these two approaches, communities can be mobilized better and their

knowledge on certain issues about malaria could be enriched. On one hand, for example, with the public health approach, the communities can understand the dangers posed to themselves and especially to their families by malaria. Secondly, the communities will have some level of knowledge about how malaria is transmitted, the life cycle and main breeding sites of the mosquito and more importantly, how the threat of malaria can be lessened by everyone taking personal responsibility for mosquito production sites on their property (Winch et al. 1992). Together, it has been suggested that the means to behaviour change for those who adopt the public health approach is knowledge. With that approach, a considerable amount of efforts are made to guarantee that people within the communities acquire the necessary knowledge through various means such as organising special classes in schools, through advertisements and programmes on television and on radio; and pamphlets delivered to every door (Winch et al. 1992). According to Soper (1967) this kind of public health approach was used when *Aedes aegypti* was eradicated from almost the entire Western hemisphere during the earlier part of last century.

On the other hand, by using the community development approach, the communities would be involved in malaria control programme activities with the aim of not only to control the disease but also the development of the entire community as well (Rifkins, 1981; Roberts 1979). With this approach, the focus is often on self-reliance and planning as an answer to the needs expressed by the community itself. Indirectly, this approach suggests that having understanding of the problem of malaria make communities to be acquainted with other problems that are endemic within the community such as poor waste collection and or sanitation. With this in mind, the communities will become aware that by engaging in the process of addressing the sanitation problems, there will be two effects which include: bringing about better waste collection and secondly a reduction in disposable containers and other materials which normally can influence the breeding of mosquitoes.

Finally, for community participation to be promoted there should be education and training. It should be realised that much as the health officials require support to develop their community participation skills, so do the community members. Members of the community often have no or little knowledge about the best way of participating and therefore need support in learning how to participate effectively in policy making process of health programmes like malaria. Educating the community on some of its traditional mentality about the capabilities of the youth as well as women to work alongside the adults and male counterpart respectively must be its priority. Training must also be given to, particularly the volunteers, youth and women and it is essential that any participation-skills training results in members' realisation that participation in programme activities are their rights as citizens rather than just as consumers. Such training will improve both capacity and their confidence. The significance of these training needs has also been acknowledged by the World Health Organization who proposed that community participation skills could become part of the curriculum for health professionals when training (WHO, 1993). Thus, a point can be made that the training of community members has the potentials of breaking down any misunderstanding as well as barriers between the members themselves. It will also help in dispelling most of the negative stereotypes amongst the community members. There is also the need for those who are willing to be volunteers to be trained and to have increased knowledge base around diverse participative strategies as well as the importance of volunteering so as to motivate them to be more self-assured and devoted to the community.

With regards to the facilitating factors such as the level of integration at the local level, it must be said that although the level of integration has been a necessary enabler, such level of integration could be better. From the results of the integration level, it means that various sectors are aware of the existing NMCP and therefore communicate amongst themselves. It does not allow various sectors to cooperate and collaborate. This means that there are still some things that need to be done properly. This suggests

that although ISC at the local level alone is necessary it is not sufficient. What therefore needs to be done is that at the national level, there should be a coordination of this strategy with macro- and sectoral-level policy. The underlying reason is that with the vertical integration still stronger than horizontal integration in the country (Agyepong, 1992) cooperation and participation by communities at the local level can only be sustained if there is stronger coordination amongst governments sectors and other agencies at the national level. The health sector must begin to take other sectoral factors driving health conditions into consideration in their policy making process and should be able to coordinate inter-sectoral action to suit other sectors at all levels with more emphasis on integration through primary care and health promotion. Besides, there should be the political will, social commitment and financial investments by the authorities at the higher level in the strategy. ISC must be regarded to be more important on the national political agenda, with a concerted effort to motivate the interest and participation of community members. This will require re-channelling of government expenditures toward activities that will ensure that the health of the communities is protected through integrative and inter-sectoral efforts (Holveck, et al. 2007). This will lessen disillusionment and potentially motivate the community members to be more involved in control programme activities

At the local level, there should be a better recognition of individuals' contributions to malaria control and better synchronisation of integration of activities amongst sectors. Local social organisations like NGOS can also be used effectively by getting them more involved in the planning of the malaria control programmes at all levels. This will promote greater cooperation and collaboration amongst various local sectors and community members. With many local public sectors working in partnership with the NCMP Unit, the local health authority should build on this good practice and ensure that other local sectors work with the community members as well so as to enhance their participation. Such practice could be a means to fuel the development of participative practices. This will not only guarantee the acceptance of participatory practices by other

service providers but also can easily assist community members to comprehend more on how to get involved, and to have a voice in the policies that affect their lives.

In terms of poverty, it must be realised that in contrast to the condition of government officers who are well versed in the language of policy debates, community members have to invest their free time in getting understanding of the policy process. In addition, where health officials have commonly accepted roles, community volunteers are frequently challenged about their legitimacy and have not the strength of employment law to defend their livelihood and therefore have often to survive from month to month. There should therefore be some rewards for those who spend their time in serving the community. Example of such reward could be issuing of vouchers for travelling freely within the district. This can be done in collaboration with Ghana Private Road and Transport Union, (GPRTU).

Finally, I would like to conclude by proposing a novel approach which I regard it as “Care-extension Approach”. The aim of this approach is to potentially encourage the poor and hard to reach communities to participate in malaria control programmes. The idea behind this ‘untested approach’ is that in most of the hardest to reach communities, victims of malaria who come to the hospital are often accompanied by relatives. The role of this relative is only to come and take care of the sick particularly when the person is admitted. What happens is once at the hospital, the accompanied person has nothing to do apart from waiting for the time or day that the sick person will be allowed to go home. Sometimes, it takes, few hours while on admission, can take days and weeks. The purpose of this approach is to extend the care that is given to the sick to these relatives in a different way. A place like an educational centre must be set up just close to the hospital. In this place, these relative should be cared for by providing them with basic necessities like water or cup of porridge. Alongside with this care is the provision of malaria control education in the form of videos, talks, etc by health professionals, so that while the sick person is receiving the curative attention, the close

relative will be receiving a preventive attention. This Care-extension approach has the potential to have the following consequences:

- 1: Bringing curing and prevention closer to each other at the hospital
- 2: Engaging the 'sick carers' at the hospital and reducing their anxiety
- 3: Valuing them by involving them in the educational campaign against malaria
- 4: Making information on malaria more accessible to those who are most vulnerable
- 5: Enhancing cost effectiveness in malaria educational campaign
- 6: Encouraging the community to access the health facilities and in this way the health workers within the communities and volunteers will have constant interaction, instead of one-off meetings with the communities.

In general, on the basis of the findings of this study, in my discussion, I have tried to come out with contextual issues which need to be taken into account if community participation in Ghana, in particular rural and urban districts of Ashanti region are to be improved. In essence my suggestions here do not mean that they are panacea for all the problems involved in community participation in malaria control programmes. For many commentators, creating a welcoming environment, partnerships with trusted community organizations and making sure that there is an inclusive community development process need a considerable amount of commitment of human capital and other resources. These include enough staff, some financial incentive, training and technical assistance (Addae-Boahene,2000a; Rugh et al. 1998; World Bank,1990). Thus, my recommendations should be seen as prescriptive solution which may work in the context where this study was conducted. According to Holland et al (1994):

"Coming to conclusions is not just a process of following rules of method to the end point of a research project, but a very active and complex process of social construction that raises questions about what we mean when we claim that knowledge should be believed (p. 125)..... "The differing conclusions to which researchers come are based on the interaction of their various standpoints with their interpretations of their

data" (p.133).

Right through this study, all efforts have been made to offer as much information as possible about the context within which the study has occurred, the methods used to collect the data and the basis for my conclusions. It is my belief that such:

"competent description can challenge accepted assumptions about the way things are and can produce action" (de Vaus, 2001, p. 2).

I also hope that by conducting this research, not only have I rekindled the issue of community participation in health policy field in Ghana, but also I have contributed to the democratic or undemocratic issues involved in health planning in the country.

8.7 Conclusion

This study has been unique in developing my understanding of community participation in health and NMCP policy process through a case study, AAS and KMA in Ghana. The study showed the extent of community participation in planning and implementation processes. At the local level, comparing these two study sites (rural and urban) it is found that the issue of community participation is seen differently by different communities in these districts. Besides the findings demonstrate the roles played by the community, the barriers and potential facilitators to community participation. These issues form the basis of the study aim and objectives

This study finding has revealed the gap between the national community policy statement of the need to include community participation and what really happen on the ground. In reality, it is noted that although ISC is a good strategy to take the country into the future path of malaria control, there is no evidence to suggest that ISC has enhanced community participation in malaria control policymaking process. Key factors acting as barriers were identified including those that potentially acted as enablers to

community participation. The implication discussed was that the fact that community participation is not fully realised does not mean that ISC is not worth implementing. Indeed, what is needed is proper planning in terms of cooperation and coordination amongst various actors, enough resources (both financial and human) and a change of individual character in relation to causes of malaria. Certainly, I do support community participation with the conviction that it can change communities' attitude to the various socio-cultural causes of malaria. However, leaving the communities to fight for themselves with regards to a change of their attitudes will be an impossible task. It is therefore suggested that communities should not be left alone just as the government should not be on its own. Both should provide support to each other so that each of these players will be motivated to bear the responsibility of controlling malaria. Thus, any attempt to address the problem of malaria must involve the use of a holistic approach in the form of ISC and it is my belief that addressing malaria persistence in Ghana in unison is a way forward.

8.8 Recommendations for future research

Community participation in NMCP has been a new area of interest in research terms and all the perspectives discussed in the literature review as well as the results of this study leave us with the understanding of the role of community and the extent of its participation in NMCP including barriers and facilitators. However, while this research has offered an evidence base for the extent of community participation in NMCP, a number of questions for future research have been opened. I would therefore argue that there are still some ways to go before a coherent vision of community participation in NMCP and the sustainability of the programmes are realised.

The message from this study is that if the national government of Ghana really means its commitment to community participation as revealed in policy documents, then both structural and cultural barriers discovered should be seen as potential targets to address.

However, even if all these barriers are removed and the facilitators are improved, then the effect of community participation upon the NMCP can not still be known. What this study fails to deal with is whether community participation has the potentials to justify the claims that participation will lead to increased better programme outcome such as accountability, reduction in malaria incidence or increase in community accessibility of local health facilities et cetera. This is an important question which this study fails to answer and therefore need its own research study.

Also, this study has only examined extent of participation of one stakeholder. However, there is another important player that is involved in NMCP in Ghana today, the private. Until recently, the private sector had little role to play in disease control. However, the current partnership involves the private who is seen as a commercial player. Against this background, in my view, another research into the degree of private sector participation in NMCP could be of huge importance, particularly if it is compared with the community

Finally, at the heart of every research which addresses community contribution to disease control like malaria through decision making process there is often a tension between quantity and quality of data and this my research is without this issue. Even though, I believe, all efforts have been made in this my study to explore the extent of community members participation in NMCP activities, it has only been possible for me to come to a more qualitative conclusion whilst there has been little quantitative conclusion about exactly how community members participate in NMCP activities. I hope future researchers will be able to take on this challenge and to come out with the conclusion based on quantitative approach. In that case, sample size will not be relatively small and purposively drawn as used in my thesis.

With a complex problem like malaria, at last, I would like to share this sage advice in the words of the writer Scott Sanders (1991):

"I do not expect to arrive at the absolute centre or circumference of things, at least not along a path of words. I will follow that path as far as it leads, then go on ahead in silence. The journey home is my effort to come fully awake, to understand where I actually live. If, on the way, I discover any secrets worth telling, they must be ones known to all of us in our clear moments. I seek a truth as common as dirt or laughter, and as rare as itself" (p.10).

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APPENDICES

Appendix 1: The periodisation of malaria control policy strategies in Ghana before and after independence until 2010

Year	Ghana Policy	International Policy
VERTICAL MODE OF MALARIA CONTROL		
Pre-1957	Vertical (Top-down)	WHO Global Eradication Programme
1957-69	Vertical (Top-down) -The continuous use of anti-malaria drug of chloroquine and (DDT) for indoor residual spraying - the use of traditional herbs and promotion of - More focus on curative	WHO Global Eradication Programme
1961	The creation of national health services and the Ghana Psychic and Traditional Healers Association was established	
1969	Vertical	End of Global Eradication Programme
1970-1977	Vertical	End of vertical approach
HORIZONTAL (INTEGRATED) MODE OF MALARIA CONTROL		
1978-1989	Top-down Integration attempt and Multiple interventions (Both curative and Preventive) More on environmental management (good sanitary environment) Decentralisation- Legislative reforms on centralisation	-Alma Ata 1978: WHO policy on Primary Health Care -Intersectoral Action Conferences, Ottawa Charter for Health Promotion (1986) specific disease-focused programmes
1990-1999	Decentralisation (bottom-up) –Health sector reforms	-Global Malaria Control Programme Strategies inherent in “health for all” policies
1992		Amsterdam Global Strategy for Malaria Control. A shift from highly prescriptive, centralised programmes sustainable programmes adapted to local conditions

		and responsive to local needs
1993-1997	5-year National Malaria Control Action Plan	
1997	Sector-Wide Approach and Ghana approved WHO/AFRO programme of accelerated malaria control in 30 pilot districts	WHO Intersectoral Action for Health for the 21st Century (Halifax Conference)
1998	Creation of NMCP Unit	RBM
1999	RBM Partnership and Institutionalisation of GHS	
2000-2010	-Abuja targets -Public-private alliances and contracting out	WHO capacity strengthening through ISC/partnership - Bangkok Charter for Health Promotion, Health disparity policies in OECD countries (2000). Confirmed the need to work across sectoral boundaries. - Health in All Policies – EU (2006) a broad-reaching directive with implications for intersectoral policy development, implementation and evaluation
2002	Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)	
2003-2005	Ghana Poverty Reduction Strategy (GPRS I), which was implemented over the period	
2003	-National Health Insurance Scheme (NHIS) instituted (Act 650) - Intermittent Preventive Treatment in Pregnancy (IPTp) with Sulphadoxine-Pyrimethamine (SP) approved	
2004	anti-malaria drug policy of Chloroquine changed to Artesunate-Amodiaquine (AS+AQ) as first-line drug for uncomplicated malaria	

Appendix 2A: Health Officials' Interview Guide

- 1) Please, help me to understand why Malaria has been a major problem in this country for the past number of years?
- 2) Please, tell me something that you know about the type of policy or policies that have been implemented in this country since independence to control malaria.
- 3) What significant changes do you think have taken place in the control policy field?
- 4) What are your impressions about the past control policy/strategy?
- 5) Please, tell me something about the current policy/strategy of Intersectoral collaboration in terms of the way it is used to promote community participation?
- 6) How does the process of malaria control policymaking take place?
- 7) When it comes to preventing and controlling malaria, will you say that other governmental sectors or private actors have been actively involved in your district? What makes you say that and can you explain to me?
- 8) What major role (s) do you perceive the community members to be playing in malaria control programme activities?
- 9) When it comes to malaria control policymaking process, in what way(s) are the communities allowed to take part in all the stages of the process? In your opinion, is it fair to say that the community members have often been allowed to participate fully (i.e. in all the stages) in the malaria control decision making process? Why?
- 10) What have been the challenges/barriers that the local health authorities face in their attempt to promote community participation in this district?
- 11) By looking at the local conditions here, had it not been the barriers you have just told me, what existing factors do you think potentially could have contributed in making it easier for you as the local health authority to promote community participation in this district? Will you explain the significance of these factors?
- 12) Will you explain to me why you think ISC strategy is as an effective tool to promote community participation? Also why is community participation in policymaking process essential in minimising the persistence of malaria in this district?

Appendix 2B: Community members' Interview Guide

- 1) Please, help me to understand why Malaria has been a major problem in this country for the past number of years?
- 2) How do you like the way the government has been handling the problem of malaria in this community?
- 3) What significant changes do you think have taken place in the control policy field in the past ten years and do you think these changes are important? Will you explain to me why you hold this opinion?
- 4) Are you involved in malaria control activities? What major role (s) do you perceive yourself or any other community members play in malaria control programme activities?
- 5) Are you aware of the way decisions on malaria control are made in this district? Can you share with me how malaria control policymaking process usually takes place? For example, how does the planning take place, who implement them and how is it monitored and evaluated?
- 6) In your own view, explain to me the way the community members are allowed to take part in the decision making process? Will you say that the community members are fully allowed by the health authorities to participate in the process? What are your reasons for saying that?
- 7) From your own perspectives, what have been the existing challenges/barriers that often prevent the communities from fully taking part in the malaria control decision making process?
- 8) If you put these barriers or problems in this community aside, what local existing factors do you think could have made it easier for the local health authority to promote community participation in this district?
- 9) Do you believe community participation is the key to the success of malaria control in this district? What are your reasons?

Appendix 3: Questions about the interviewees' backgrounds relating to socio-demographic characteristics

Introduction

The main aim of this study is to investigate the malaria control policy making process and the level of community participation in the policy strategy of intersectoral collaboration in this district (KMA/AAS). To this effect, your involvement in the study has of great importance to the research's output. I would therefore like to ask you if you were interested in allowing me to have an interview with you? (◊ Yes ◊ No).

Please, be informed that the information collected is only for academic purpose. Hence, any part of the information secured from you will be kept confidential and you have the option to accept or reject this offer of being interviewed.

Thank you for agreeing to be interviewed on malaria problems in this district. However, before I continue, I would like to ask you a few questions about your background relating to socio-demographic characteristics

1: Which of the following age group do you think you belong?

- A. 18-29
- B. 30-49
- C. 50-69
- D. 70 above

2: Gender

- A. Male
- B. Female

3. What is your marital status?

- A. Married
- B. Single

4: What is your educational status?

- A. No formal education
- B. Less than or JSS
- C. More than or SSS

5: What is your occupation?

- A. Farmer
- B. Self-employed
- C. Salaried Worker
- D. Unemployed

Appendix 4: The Degree of Integration amongst sectors at the local level on malaria control

I will like to ask you some questions about the extent of integration amongst actors who are involved in malaria control in this your district. Please answer the questions at the left and right columns on a scale of 0-5

On a scale of 0 to 5, where:

0 = No Awareness: Your programme is not aware of any such sector/agency.

1 = Awareness: Your sector has knowledge of each others' services although no effort is taken by any one of you to organize your activities according to any principles except those that conform to your agency's service missions.

2= Communication: Your sector has an active program of communication and information sharing in order to maintain meaningful relationships but individual programs are totally separate.

3 = Cooperation: Your sector use the knowledge of this service to guide and modify your own service planning in order to avoid duplication of service and to obtain a better set of links among you. You also assist each other with respective activities, giving general support and information for each other's programs or services.

4=Coordination: Your sector does have joint activities with each other and communications are more intensive and far-reaching. Your sector engages in joint planning and synchronization of schedules, activities, goals, objectives, and events.

5 = Collaboration: Your sector not only has joint planning but also actively modify their own service activity based on advice and input from the mutual discussions with other sectors. Your sector also willingly relinquishes some of their autonomy and changes its values to support collective goals or ideals in the interest of mutual gains or outcomes how will you evaluate the level of integration between your service and the others

Section 5: Measuring the level of Policy Integration at the local level

To what extent are you (your sector) involved with the following services?	<u>AGENCY/SERVICE</u>	
Rating Scale	Rate (0-5)	Do not rate your own service – leave it blank
		Malaria Control Program Team
		Ministries of Local Government
		Food and Agriculture
		Education
		Social Welfare
		Finance and Economic Planning
		National Development Planning Commission
		MOH/GHS
		NGOs: Christian Health Association of Ghana (CHAG)
		Foreign Donors
		Other Programmes
		Communicable Disease Prevention & Control
		Health Assessment & Disease Surveillance
		Town & country planning
		Community Water and Sanitation Agency
		Family planning

Appendix 5A, B and C: Samples of an Interview Transcript on Roles, Barriers and potential Enablers

Examples of an organised list of interviewees' responses to the question:

What are the most important role(s) do you perceive community members playing in NMCP activities in this area?

INTERVIEWEES	RESPONSES	MAJOR CATEGORIES	OTHER CATEGORIES
1 (LHO)	In the area of organisation, they help in arranging meetings with the rest of the communities that we can not reach particularly when we have to conduct any educational campaign. It is these same community members who provide assistance like supplying us with chairs and at times food stuffs from their own farms. These are some of the incentives in working in these rural areas. We do not to buy food all the time.	Outreach services	Motivators and organisers
3 (NGOs)	Various organisations benefit from the communities in so many ways, especially we the NGOs. I for one, sometimes when I need to go to the rural areas, once I send message to any of the volunteers, especially their head, all the organisation of the meetings will be done before I even get there. They are always ready to assist	Outreach services	organisers
8 (CM)	We also contribute in disseminating information to other rural areas. At times, they will like to go rounds in the various towns, but there is no other means to let those there to have information before the date. So we can volunteer to go by bicycle and deliver such messages.	Outreach services	Disseminating information (messengers)
9 (CM)	We help the health officials especially during their educational campaign. Most of the officials do not know this area so we can usually go with them to show them the way to the various villages. These are not done just because it our duty or we have nothing to do but we deem them necessary for our own good. It also gives these health officials some kind of protection because being on their own and travelling around in this forest is a bit risky. I am not saying people here are bad but you never know who they will meet in a particular day, especially when they are women. But once we the local people, particularly men, are with them, they are safe since we know every person in this area.	Outreach services	Helpers, protectors and educators
11 (LHO)	The community members help in arranging meetings and they have the ability to bring the people together and ensuring that whatever the message that we health officials have for them reaches everybody. The local chief or the elected Assemblyman makes it their responsibility to inform the community members and ask all of them to come out of our houses to listen to us.	Outreach services	People mobilisers and informants
47 (LHO)	Amongst all the roles that the community plays, the one that		Informants or

	find it interesting is the way they help in promoting the networks amongst all the intersectoral collaborators. The fact is “The community members hold the position of trust and they are the actors to which all of us direct our concerns to when it comes to evaluating the outcome of the implemented activities on say malaria. They make all efforts to supply each one of us (sectors involved in disease control like malaria) with up-to-date implementation activities of other organisations. We all depend on them and the power they have in terms of information makes them capable of being a good player in the collaborative efforts especially in the rural areas”	<u>Monitoring & Evaluating (M & E) issues</u>	<u>Promoters of ISC ‘network’</u>
11 (LHO)	Well, to talk about what the community members have been doing will take a whole day but if I am to sum up I will say they communicate to us the results of our efforts. Without them, we will have no means to know what has happened to all the ‘beautiful plans’ we implemented. They are the ‘judge’ of all the programme activities. Simply they are our evaluators and we only contact them for results. They are our informants.	<u>Monitors & Evaluators (M&E) issues</u>	Informants and programme ‘judge’
12 (LHO)	For me one area that I admire communities’ contribution in this district is when it comes to monitoring and evaluation. In fact, they are “irreplaceable”without the good will of the local people, we can not do anything. They are everything to us and their suggestions are valuable to our programmes. So they are our advisers and at times we need to depend on them for the progress of our job. I am sure it is not me alone who share this view. Most of my co-workers will agree with me, especially when it comes to implementation of control programme activities in these rural areas. While we can use them as instruments to achieve our goal, they can also be part of the solution. And when it comes to surveillance or monitoring, their role is significant because they know where possible malaria breeding sites are and they can show you where there is poor sanitation, wrong places for waste dumping and who has done it, gutters,.....I mean everything	<u>M&E issues</u>	<u>Advisors and informants</u>
13 (LHO)	One thing that I find it helpful with regards to the role of the communities is their contribution in monitoring and evaluation of the programmes. Over here, “controlling diseases like malaria is not easy especially in these rural areas where most of the community members do not like to go to the hospitals and without reporting to the health centres, we have no overview about the state of affairs....and the success of an active case detection is difficult because the information must be obtained at the right time so that the disease (e.g. malaria) can be contained. You see, it could have been better if we could always visit these rural areas to see things for ourselves but we can’t. Someone like me, going to these villages once in say two months is not enough and so It is extremely hard to execute any plan if the communities members do not help in carrying it out”	<u>M&E Issues</u>	informants

52 (LHO)	The community members are our monitors and evaluators because the means to travel to these villages are lacking. Can you imagine travelling every week to all the villages around Mpassaso with bicycle or motor. It will not be possible because the roads are bad and we have not the money to hire better transport to go to these areas for monitoring. So we need to depend on the good will of the community members. These days thanks to mobile phones, we can phone to some of them at certain locations and certain times to have access to certain information. It is not easy but these community members who help us make it easy for us.	<u>M&E Issues</u>	Informants, messengers
54	I think, we can not disregard the role the community members play in monitoring and evaluation of the programmes activities. They save the district huge sum of money through that because we have no means to do all these things. Those at the higher authorities are aware of this problem but that one of the requirements in these programmes. That is ensuring that all the implemented plans are monitored and evaluated but how do we do these things if we only have one car for the whole ministry and even at times the money to buy fuel is a problem? So for me, the most important role these community members play is on the field of M&E. We need to depend on them for every information	<u>M&E Issues</u>	informants
56	Frankly speaking, no government official will deny the fact that community members are the ones that help us in our M & E activities. You have to know that to be able to monitor or evaluate you need quality flow of information but over here we have not any means to have access to such information. Our only means is to rely on the community members which I think they do well in that area	<u>M&E Issues</u>	Quality informants
58 (LHO)	I think, if we are to be very honest with ourselves, then every government official here will admit that the role the community members play in monitoring and evaluation of the programmes activities is very significant. They help the district in not only information gathering but also contribute our inputs when it comes to M&E. They make sure we get all the necessary information for the implemented plans. Without them we could not have been able to know the outcomes of some of these health programmes like the extent of the use of ITN. So, I for one, I think, the most crucial role these community members play is their ability to provide all the required information the during M&E.	<u>M&E Issues</u>	Informants, evaluators and monitors
60 (LHO)	For all the things the community members do to help us, one most important role they play, for me, is the area of monitoring and evaluation. In fact, they are exceptionally good and they help us a lot in this area. We need to depend on them for the progress of our work and I believe most of my colleagues will support me on this view. All of us know that when it comes to implementation of control programme activities, especially in these rural areas, not only do we use	<u>M&E issues</u>	Informants, evaluators and monitors

	them as useful tools to assess our performance, but also they help in finding the solution to the evaluation problems. They know all the contaminated places where mosquitoes are likely to breed. So we can not do without them in these activities.		
69 (LHO)	For all the things the community members do to help us, one most important role they play, for me, is the area of monitoring and evaluation. In fact, they are exceptionally good and they help us a lot in this area. We need to depend on them for the progress of our work and I believe most of my colleagues will support me on this view. All of us know that when it comes to implementation of control programme activities, especially in these rural areas, not only do we use them to have access to quality of information, but also they help in finding the solution to the evaluation problems. They know all the places where mosquitoes are likely to breed. So we can not do without them in these activities.	<u>M&E issues</u>	Informants, evaluators and monitors
72	Frankly speaking, community members are the ones that help us in our M & E activities. You have to know that to be able to monitor or evaluate you need quality flow of information but over here we have not any means to have access to such information. Our only means is to rely on the community members which I think they do well in that area	<u>M&E Issues</u>	Informants, evaluators and monitors
120 (LHO)	I think, if the community members are good when it comes to M & E activities. They have all the information we need and they are always willing to provide us such good amount of information. Through them, we can have access to all that we need on important M&E. We have to depend on them for all the things we need to do for our quarterly reports on surveillance. I am really pleased about their contribution in this field	<u>M&E Issues</u>	Provision of information
121 (CM)	In all fairness, we community members play an important role in the area of M & E programme activities. We the community members are very helpful in the achievement of health officers' goals and they themselves know that. In fact, if they want to do any better work on M&E then they need us to be there for them especially when it comes to provision of good information.	M&E issues	Provision of information
124	Another area that I see the communities making biggest contribution in this district is when it comes to monitoring and evaluation. In all fairness, without the help of the local people, we can not do anything. They are very helpful and are priceless to our programmes. I believe this argument can be made by most of us because without these members I do not have any idea how we could have fulfilled our obligations on M&E. The means are not there and it is these community members who help us to achieve some measure of success in programme activities M& E with their information	M&E issues	Provision of information
5 (LHO)	I will say that the role played by the community members can be seen to be beneficial to themselves. I see the	Helping Victims to	Helping each other either in

	community members to be as if each one of them is each member's 'insurance against the disease- malaria' This is because they provide help to each other in times of sickness either through money or personal services even though they poor. This helps them to survive this terrible disease, which I find it to be good	cope with the disease	cash or in kind
6 (CM)	There is culture of helping each other here and so we tend to help people when they are sick. We often contribute in either carrying him to the hospital or financially so that the victim can go to the hospital.	Helping Victims to cope with the disease	Helping each other either in cash or in kind
10 (CM)	As far as I am concerned, the role we play is for our own benefit. If one of us is sick of malaria and has no money, it is we who have to make sure that the person goes to the hospital through contributions. At times, there is no car and we have to carry the person at the backs of the members especially the men when the person is old.	Helping Victims to cope with the disease	Helping each other either in cash or in kind
19 (CM)	In the past when we used to go to the herbalist, then it was only these herbalists who would have played a bigger role, but these days we all play our parts in many ways. At the moment, we do take care of ourselves if one is sick of malaria by providing money so that the person goes to the hospitals. Hardly do we make contributions for victims who wants to go to the herbalists because that is not expensive	Helping Victims to cope with the disease	Traditional healers
33 (LHO)	The role they play is to help each other to cope with the disease when infected. After being here for sometime now, roughly six years, I see that the community members are good in providing help to each other when it comes to sickness either through money or personal services. For example, they can lend the person some money without any interest to go hospital or make contributions. At times, those who have no money or can't get such help go to the herbalists for treatment. But mostly they go the hospital first and when the sickness is still the same then they will consider going to the herbalists. This is the way that they have been able to survive this dreadful disease for all these years. Without their own self-help, I wonder how they would have withstood this situation.	Helping Victims to cope with the disease	Helping each other either in cash or in kind
59 (CM)	"I do not know if this is what you mean by role we play, but as the only person who has a means of transport in this village, I often take people to hospital free of charge with my motor whenever they are sick, whether malaria or any other disease.. At times, most of the sick people, especially pregnant women will like to go to hospital but the husband might not be around to give her money, so I would bring such people to hospital on credit and whenever the husband comes or whenever they have the money they pay me. Because I have been doing this, these days many people in this locality could go to hospital so easily"	Helping Victims to cope with the disease	Accessing health facility in kind

	The poverty level here is high and because of it is its impact on the disease” which calls for solution that need to be provided by all of us”		
61 (CM)	We those in this locality seem to be lucky that we have such a community that is closely related and because we trust each other, it is easy to help ourselves as well as contributing to the viability of the community. I do my best, at times to ask people to contribute money for sick people to be sent to hospital and they are always willing to do so	Helping Victims to cope with the disease	Accessing health facility through contribution
63 (CM)	The good thing about this place is that we help ourselves especially if any of us is sick and the family has no money. In that case, it is we who have to make sure that if one of us is sick of malaria and has no money, we make contributions to send him/her to the hospitals.	Helping Victims to cope with the disease	Accessing health facility through contribution
5 (LHO)	They also provide services voluntarily in areas where it is bushy by clearing them which makes the place clean. Sometimes they will clean their gutters making sure that every traces of filth are swept away. They do well and that often keeps the town neat	Environmental management issues	Sweeping the gutters
26 (CM)	For me I do not see these health workers as people who must do all these control activities alone. Our district basically has no electricity, no good roads and nothing for them to benefit from it. This means they have made a lot of sacrifice and therefore they need to be supported. If I have to offer my services through communal labour, I will be happy to do it. The malaria problem has been a problem in this community for a long time and I think we should be motivators rather than de-motivators	Environmental management issues	Keeping environment clean
44	We the community members have not much time to offer our full help to the health officials. Nonetheless, we put in extra effort in assisting the people in their daily duties. We do clean the surroundings, we give the officials the necessary respect and offer them safe environment to work which makes them feel comfortable	Environmental management issues	Safe environment making them comfortable
45	We all feel part of the good course of the government on malaria and each one of us from time to time tries to play his/her part in educating others on the need to keep the environment neat	Environmental management issues	educators
46	One thing that I like the community members here is their role in keeping the environmental surroundings clean. I could not have lived here as long as I have been (for almost 5years now) if this efforts are not often made by the community members to make the place neat. In this case, I must say they are not helpful, although there are others who will not like to do such communal services. But I will not brush the whole community with the same paint because of them are very good. You know in every house there is ‘Mensah’	Environmental management issues	cleaners

65 (LHO)	I think the community members also have this will to educate themselves about the effect of keeping the environment untidy. They are all aware of the problem of malaria and some of them do well by letting their fellow members understand the necessity of keeping the environment clean. So they are can be considered as educators on environmental issues	Environmental management issues	educators
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5B: Interview Transcript: BARRIERS TO COMMUNITY PARTICIPATION IN POLICY PROCESS

List of interviewees’ responses to question relating to community participation in malaria control policy processes:

What are the barriers that undermine community participation in malaria control policy making process in your district?

BARRIERS

INTERVIEWEES	RESPONSES	MAJOR CATEGORIES	Sub- CATEGORIES
1 (CM)	I think there is lack of interest in these issues because people have more important things to be worried of. Most people often think of what they will eat or how to feed their families. If “if the bridge that will take me to the other side of the river is not there, why should I bother about what is happening over there”.	Poverty issue	Lack of interest
8 (NGO)	Sadly, they are never present not in meetings and not in programme activities so they are often left out in matters that are important to them, but I understand their situation. They need to work twice as much as some of us to be able to get their daily meal for themselves and their family	Poverty issue	Struggle to get their daily bread
11 (CM)	For me it is poverty that makes people not to attend meetings. It is simple as that. It is usually those who can pay for lorry fares or have money who go and speak for us. I would like participate especially when I look at the work of the social institutions like the NGOs. They are good and helpful in this community	Poverty issue	The rich are at the advantage
28 (CM)	I will say poverty is the problem but I still participate most of these meetings because of the political system that the government has put in place. Now I am an Assemblyman which makes me both a representative of the community and also the local authority. So I am a bridge between the two parties which makes communication easier.	Poverty as a barrier and political system as a facilitator	Easy communication between the community and the local authority
99 (CM)	I always want to attend some of these meetings, but I do not have money to go and walking from here to the place (district capital) is not easy. It takes about four hours to get there and be back here. If I go, I will be too tired the next day to be able to go to farm. On the	Poverty issue	Inability to attend meetings

	other hand, even if I have money the means of transport to go there is also a problem. During the day time, getting a local transport is difficult and the fare charge is also expensive		
102 (CM)	Over here farming is our major source of income. Juggling between farming and participating in control programme activities is so hard that we always have to make a choice. Doing both is an impossible task and faced with a choice, we often choose to do the one that gives us income to feed our families. It is simple as that	Poverty issue	Farming constraints participation
106 (CM) Our representatives have often been community members who are rich and can afford to participate in these kinds of health programmes without feeling much of the impact	Poverty issue	The rich are mostly the participants
108 (CM)	“that was where at times most views were shared and decisions taken, in contrast to the village meetings which were usually about providing information on programme issues. Often, due to poverty, we normally have to choose a person who usually can pay the cost of transport	Poverty issue	The rich are often the local representatives
117 (CM)	There is no doubt in my mind that the work on malaria control is important for all of us and there is a need to support the district health staffs but our situation is different. The poverty level in the city is high and staying home without going to the market means no food for the family	Poverty issue	People not willing to stay home
142 (CM)	Sometimes we get the information that tomorrow or this day, the district health staffs will come and talk to us about malaria or family planning, but I and my wife can not stop going to farm and wait for them. They usually come the day prior to a market day or the market day itself, when I need to bring my food stuffs from the farm to sell. So I can not go and take part in the meetings.....	Poverty issue	Marketing of farm product limits participation
158 (CM)	For me, the most difficult time is when we are in the planting season. It is so difficult to participate in these activities. Over here, as far as farming is concerned, the rain is everything to us and the timing is important so when the rains come, we have to seize the opportunity to do what we are to do in the farms. I can not imagine myself not going to farm for food.....Where will I get money?”	Poverty issue	Farming activities limiting participation
2 (CM)	Oh, there are so many of them but I will look at it in a simple way, our government is not doing enough to motivate us. These days our local government authorities do make us feel we are not part of them and the distance between us and them is widening everyday. They do not tell us anything and the communities do not know what is going on.	Disillusionment amongst community members	Lack of information/com munication
5 (NGO)	The communities are willing really to take part in all	Disillusionment	Failed promises

	the activities concerning diseases like malaria but I have the feeling that there is not much efforts from the local government. For a long time the communities have been let down by their government and that this has brought down some enthusiasm in participation	amongst community members	
19 (CM)	It is hard to see any strong commitment from the local government to motivate us to participate in most of these disease control activities. Communication to and fro is lacking from the local health authority and public education is minimal	Disillusionment amongst community members	Lack of communication and public education
80 (CM)	".....I find it hard to believe that simply going to attend meetings will make me change what the authorities here will like to do. As far as I am concerned, and as a common man, whether I attend these meetings to speak out my mind, it will not make any difference to the outcome of the process. I therefore do not see any need to go and participate in these activities. They do not give us (rural communities) any proper information about the importance of participating in this policymaking process, so I better go to my farm and work. That will change my life"	Disillusionment amongst community members	information provision
96 (CM)	We see these health officials or volunteers maybe, once in two months and to me, that is not enough to convince and to motivate our people to participate in these activities. To motivate these our people to take part in these activities, there should be continuous education and many avenues through which they can let their voices be heard must be available but the authorities do not provide these things	Disillusionment amongst community members	Lack of educational support
100 (CM)	Many of our people usually rely on the information given to them by the government health workers or local volunteers before deciding to participate in most of these health programme activities. These pieces of information are important because they make the local people know all that they need to know about the significance of these control programme activities and what roles they can play when they become part of the process. Unfortunately, we tend to lack information on these programmes which creates skepticism... and you know when people doubt about the significance of something, they do not want to be involved or participate in it. It makes them not to see the value of it and this has been a major reason why I think, people do usually hesitate in participating in most of these control policy programme activities	Disillusionment amongst community members	Lack of communication/information
121 (CM)	if only the local health authorities showed their readiness in supporting the community members	Disillusionment amongst community members	Lack of support
124 (CM)	Most of us do our best in devoting our time to make sure programmes like malaria and other diseases that	Disillusionment amongst	Failed promises

	have to be implemented in this community get a better start, but often it is not enough. The authorities will say we will come next week, but we will only see them two months later. No information from them to us. So we are not always sure how things are and what the next programme will be.	community members	
139 (CM)	There is little education on most of the things the local authorities claimed they have planned for the communities and without such education we not understand most of the things they do. They just come here and ask us to assist them to implement this policy or that programme activities. But how can we participate effectively in something that we do not understand? Instead of taking time to explain things to us, once they are here, they seem to have no time for us. They are always in hurry and always looking at their watches, which to me is like they do not want to hear our concerns. That is discouraging”	Disillusionment amongst community members	Lack of educational support
147 (CM)	“....I think in order to take part in the decision making process because of the complexities involved you need to be confident just like the health officials who know every aspect of the health issues. But because we do not get enough assistance from them our ability to participate every meeting is limited as most of us do not understand what is being said during the meetings. Even if we make all efforts to attend these meetings, we do not get any feedbacks let alone information on when and what we are going to discuss in the next meeting so that we can prepare for it. We are asked to attend as if we are to go there just to make up the number needed to consider the meeting as general. In fact we do not contribute anything”	Disillusionment amongst community members	Lack of communication/ information
3 (LHO)	Well, we the local officials are working under an authority that is above us. Central government is more powerful than the local authority and although we need to do things on our own, we need to be careful not to do things over and above what we have been directed to do. Central government should be able to afford what we want to do and the level of participation of the community is what we deem appropriate.	The power of the Central Government	Directives of the Central government should be considered first
23 (LHO)	we always talk about community participation in decision making process but the problem is what contribution can they (community members) make if they only propose but we can not put into effect. We local officials are only delegated officials and neither we nor the community members have any power to	Central Government powers	delegated officials

	effectively implement what they suggest because we have not the means to do so. So I am not sure this strategy of engaging the community in policy making decision process has any importance to the power sharing		
65 (LHO)	at times ascertaining local communities' opinions for the purpose of district health planning issues, more often than not has been 'put aside' due to the need to meet deadlines proposed by central government	Central Government powers	Putting the needs of community members aside
73 (LHO)	.. the districts departments and agencies such as the local health sector have to rely on the central authority for funds, priority-setting guidelines and all the rest. So we are not as independent as it seems and we can not mobilise the community the way we (local health authority) want it to be..... majority of the community members lose interest in taking part in most of the programme activities	The power of central government	Lack of independent decision taking
90 (LHO)	The existent of deconcentration type of decentralisation makes things too formal and bureaucratic, which negates the whole purpose of having bottom-up approach. For most of the community members this is still the old 'politics' of local authorities still depending on the powers of the national government. ...Of course, it is sometimes discouraging for us (officials) that we can not solve most of the problems that are in the local communities as they wish.....Our hands are tied. We can not determine the final outcomes of our plans, so we cannot always fulfil the expectations of the communities. In the long run our failure keeps them away from participating in the process of policy making	Central bureaucratic powers	Depending on the powers of the central government
113 (LHO) It seems it all depends on the type and approach that will be adopted by the country. The system (i.e. the local public officials depending on the central authorities for policy goals) here actually does not augur well for community participation in decision making, because it tends to create a distance between 'us' and 'them'. "...., the continuous presence of vertical integration within our sector (i.e. health) has led created central bureaucratic to have powers on everything especially planning, funding, regulation, you name them	Central government powers	Vertical integration causing dependence on the central ministries
160 (LHO)	I believe we have not been given the necessary room to do our own things that will match the needs of our people. We tend to rely too much of the central government and you know 'dependency breeds helplessness'. Because we are not independent, wan not decide to do things the way we want it and I think the communities are not to be blamed if they lose hope in us	Central bureaucratic powers	Too much dependence on the central government
68 (CM)	But with the central government always in the middle	Central	Too much

	of affairs and other community problems, this working together is having less impact as most people are less encouraged to be active in government programmes than they should”	bureaucratic powers	dependence on the central government needs of the community
4 (LHO)	I think to summarise the whole problem it is true to say that we do not have enough resources. We have no ‘big purse’ to encourage people. We cant reach out to them as we should because of ‘a gun without gunpowder is not worth having it’. What is the point in let them come for meetings with empty stomachs and return empty handed.	Lack of resources	Financial problem
50 (LHO)	most people here have never gone to school beyond JSS (junior secondary school) and therefore lack a good understanding of what entails to have these programmes in practice.....and these programmes are not something we can experiment with the suggestions of those who do not have any idea about planning. Until we can assemble the right community members who can understand the complexities involved in the processes, the demand for real participation can be hard to fulfil	Lack of human resources	Not many educated personnel
39 (CM)	I was there throughout the whole meeting but none of the participants, who were mainly men, controlling the meeting asked for my personal view. They talked so loud on top of their voices that at one point I thought they were going to fight. I dared not asked to speak because I was even scared of some of them. I was really relieved when the meeting was all over. From there on, I decided never to take part in any of these meetings which I knew would be dominated by men	Culture	Differences in gender roles
42 (CM)	The attitude of our old local people is also not helping most of us (the young ones) to have any interest in participating in some these programme activities. They allow the culture to take a big part of them in their thinking. Just imagine in this times, they still want we the young ones to keep our month shut when there is an issue to be discussed, all in the name of respect. Oh, No, I can not take it. I will not go to any of these gatherings.	Culture	Elders underestimation of the youth
82 (CM)	Sometimes we have to....like beg them before they join some of our community activities. They always feel it is not their responsibility to serve the community rather such communal services must be provided by we the old people. They like to be involved in a situation where they can control the participants or at least where nobody controls them	Cultural defence	The unwillingness of the youth to take responsibilities

91 (CM)Our culture does not make it easy for we women to share power with our male counterpart. Although things have changed, cultural values and ideas are still what they were many years ago in these rural communities. So knowing such beliefs, we women hardly participate in decision making that affect the community. We leave such big decisions to the men and I for one only attend meetings if it is only women	Cultural issues	Women not feeling comfortable and respected at meetings
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Appendix 5c

List of interviewees' responses to question relating potential enabling factors to community participation in malaria control policy processes:

what do you think are the main existing factors that could have potentially facilitated the participation of the communities in the making and implementation of malaria control policy in this district?

FACILITATORS

INTERVI WEES	RESPONSES	MAJOR CATEROIES	OTHER MINOR CATEGORIES
24 (LHO)	Often the tasks of the various community committees motivate the community leaders and their members to be interested in participating programme activities. So, a lot could have been achieved with the political structures that existed in this area in community participation if most of the problems that the community faced had not been there. If the person could not come for meetings because he/she had no money, no matter the good structures government puts in place, it would not be useful. That is why I have said the problems in this area tend to make some of these good factors not good anymore	Good political structure	decentralisation
28 (CM)	I participate most of these meetings because of the political system that the government has put in place. Now I am an Assemblyman which makes me both a representative of the community and also the local authority. So I am a bridge between the two parties which makes communication easier.	political system	Community representatives leading to easy communication between the community and the local authority
71 (CM)	Unlike the past, these days they have made us to understand that we the people in this district must	Political structure	Decentralisation bringing

	take matters into our own hands and deal with our problems and I have seen that it makes sense to give us that power to decide for our selves. So I know being close to us we could have given the local health authorities all the help they needed for our own good and that could have encouraged me to be more involved in any programme activity that is taking place in this locality. But the problems are too many to put most of us off		community closer to the government
33 (LHO)	All the sectors are, these days, integrated and as a result we have all the departments in this district including the community working together as one body. They (community members) are part of us and I will say that they are our most important local partners and their services are also needed. We have good district co-ordinating team that could help in informing communities about all the services needed in this district. So the community members could never have been left out in our deliberations on local health programme activities. Such inclusion could have motivated them and made them prepared to assist what we (local health authorities want to do	Good integration	Working together of the sectors
46	Integration has been encouraged these days amongst the community and the rest of the local government officials which, I think, should have been a source of encouragement to all of us. But the thing is; that alone is not enough to ensure participation because of all the problems in this village like poverty, cultural behaviours and all the rest of it.	Good integration	Working together of the sectors
68 (CM)	..."For me having been attending meetings with the various government departments, and seeing the way they communicate with each other these days, there could have been a number of opportunities that could have been used to incentivise community members to be more effectively engaged in local health issues. Long procedure in getting information could have been avoided and information could have been easily received from the local authorities"	Good integration	Working together of the sectors
81 (LHO)	" the mere fact that we have all the sectors working together does not mean anything to the community members if we do not demonstrate to them that there is a need for it. We have to commit ourselves to such efforts and show the community that the outcome of such a strategy is positive. That will motivate them to be part of the decision making machinery other wise it will be hard to win them	Good integration	Motivation to the community members
89 (LHO)	These days, because of the idea of working together in the areas of planning and execution of programmes amongst sectors including community members, sharing of information has been a priority and easy. This level of integration could have made us to see	Good integration	Motivation to the community members

	ourselves and the community as one group bound together with the aim of finding solutions to problems facing the community. We need the community members and it is good that they (community members) see the significance of their own roles in these efforts. They would have been willing to participate in most of the activities if they had been given the right incentive and that will help improve the health status of the members”		
114 (CM)	“.....I think we the community members are aware of the level of unity that exists between health departments or officials and other governments departments which encourage some of us to participate more in these health programmes. They all come here often to talk to us in one voice and I think such atmosphere could be used to encourage others to be more active in whatever they want to do in this community	Good integration	Motivation to the community members
116 (CM)	...”I see them working together as a group. They always come with most of the officers from other departments and anytime the health staff talks, he/she will hand over the next stage of the activity to his/her colleague who may be working in say, social welfare, who will also tell us something about government new policy on child care. After that he/she will say I have a colleague here from, say Family Planning Unit. All these show of togetherness could have made us to see the need to work better with them, but we have our own problems which make us incapable to fully involve ourselves in these activities..... So I think the strong show of unity amongst the local government officials and interest in community participation could be contributing to our interest in participation	Good integration	Motivation to the community members
11 (CM)	I would like participate especially when I look at the work of the social institutions like the NGOs. They are good and helpful in this community	Social Institutions	NGOs very good and helpful
40 (CM)	The idea of community participation is not something new to us. For years now we have system which allows every member in this community to come to the house of the chief to participate in deliberations that affect this community. We all understand this system and we know the benefits of it. At least, it makes everybody feel inclusive in whatever is happening in the community. So I often advise the community residents to try to be present at any gathering which has something to do with the community’s own interest. In that way, they can express their own point of views in support or against any activity that has to with people here. I see this as a way of contribution to the society”	Social Institutions	Advice from the elders

60 (CM)	The NGOs are able to persuade the local residents to be more involved in health activities like malaria because they are for our own good. The workers have time for us in contrast to the government officials and they are able to explain to us the causes of these problems like malaria which help us understand why there is a need for participating in these programmes”	Social Institutions	the work of NGOs
62 (CM)	I will say the works of the NGOS have been inspiring to me. They contribute to the community and you can not stop helping them or doing what they ask from you. They are more understanding and sympathetic to our problems. I think they serve as the main back bone of ‘a horse which helps it to carry its heavy load’.	Social Institutions	Very understanding and sympathetic to community problems
66 (CM)	Over here, the work of the health officials is often supplemented by the works of the community leaders and the NGOs who also help in encouraging we the community members in participating in the communal activities that help the community to develop, may that be from health, agriculture or social welfare officials. Our local leaders motivate us through advice and their show of interest in the welfare of the community”	Social Institutions	The work of NGOs
76 (CM)	The NGOs are also good in these exercises especially when it comes to organising and creating community’s interest in the remotest parts of this district. They sometimes make also know what the government officials will not tell us. I find them very useful and helpful in encouraging us to be part of the programme activities that are taking place in our locality	Social Institutions	The work of NGOs
96 (CM)	I think, our local leaders and the NGOS are able to minimise community members’ sense of alienation from health programme activities like malaria control. They help in facilitating and in ensuring our influence on decision making process on health matters that affect the community	Social Institutions	Minimising community members’ sense of alienation from health programme activities
129 (CM)	The unity amongst members in this community is strong and we seek help from each other. We are often made to understand by our local leaders that ‘unity is strength’ and as such we work together as a group. Every member always wants to stand for each other	Social Institutions	Local unity

Appendix 6: List of interviewees who were to be quoted

	Interviewees and their Institutional Affiliation
10	Officer, MOH, Ghana
5	Policy officer GHS
12	Officer, The Global Fund
48	Programme officer, NMCP (GHS),
7	Officer NMCP
22	Employer Ghana
13	GHS employer, Ashanti Region, Kumasi
47	Health officer, Kumasi
23	NGO Officer, Kumasi
14	Officer -Environmental Health and Sanitation Kumasi
13	The Metropolitan officer (KMA)
4	Officer, Waste Management (KMA), Kumasi
43	Officer- Kumasi
63	Officer-Kumasi
65	Officer- Kumasi
111	Officer-, Kumasi
50	Officer-Kumasi
73	Officer-Kumasi
90	Officer-Kumasi
88	Clinical nurse-Kumasi
113	Officer-Kumasi
123	Employee-Mankraso (AAS)
24	Community Health Nurse, (GHS), AAS,
118	Community Nurse, AAS,
3	Officer AAS, Mankraso
50	Officer, AAS, Mankraso
58	Officer, AAS, Mankraso
81	Officer, AAS, Mankraso
89	officer, AAS, Mankraso
89	Officer, AAS, Mankraso
73	Officer, AAS, Mankraso
33	Officer, AAS, Mankraso
39	Traders Association, KMA, Kumasi
40	Hair-dresser, Central market, KMA, Kumasi
44	Seamstress, Central Market, KMA, Kumasi
37	Taxi driver, GPRTU-KMA, Kumasi
27	Teacher, KMA, Kumasi
22	Assemblyman, Kumasi
33	Assemblyman, Kumasi
55	Food-seller, Tafo, KMA, Kumasi
65	Unemployed, Tafo, KMA, Kumasi
71	Medical student, Kwame Nkrumah Univeristy of Science and Technology, (KNUST) Kumasi
125	Taxi driver, Kumasi
91	Taxi driver, Dotiemu, AAS
139	Cloth-seller, Central Market, Kumasi
147	Taxi driver, Kumasi

153	Pastor, Kumasi
155	Susu-collector, Kumasi
103	Fish-seller, Kumasi
91	Yam-seller, Kumasi
117	Shoe-seller, Kumasi
89	Unemployed, Kumasi
115	Farmer, Kuamsi
127	Street cleaner, Kumasi
83	Butcher, Kumasi
29	Taxi driver, Kumasi
61	Farmer, AAS, Mankraso
20	Farmer, AAS, Mankraso
64	Farmer, AAS, Mankraso
61	Farmer, AAS, Mankraso
45	Cocoa-farm labourer, AAS Mankraso
59	Fruit-seller, AAS, Mankraso
26	Food-seller, AAS, Mankraso
41	Farmer, AAS, Mankraso
45	Cocoa farmer, AAS, Mankraso
49	Trader, AAS, Mankraso
51	Farmer, AAS, Mankraso
100	Truck driver, AAS, Mankranso
60	Farmer, AAS, Mankraso
66	Farmer, AAS,
49	Farmer, AAS, Mankraso
86	Teacher, AAS, JSS
52	Cocoa purchaser, AAS, Mankraso
80	Plantain-seller, AAS, Mankraso
96	Seamstress, AAS, Mankraso
124	Farmer, AAS, Mankraso
132	Seamstress, AAS, Mankraso
134	Farmer, AAS, Mankraso
144	Farmer, AAS, Mankraso
76	Farmer, AAS, Mankraso
82	Electrician, AAS, Mankraso
39	Farmer, AAS, Mankraso
114	Truck driver, AAS, Mankraso
108	Ex-Teacher, AAS, Mankraso
106	Farmer, AAS, Mankraso
190	Farmer, AAS, Mankraso
142	Farmer, AAS, Mankraso
158	Farmer, AAS, Mankraso
102	Cocoa-purchaser, AAS, Mankraso
116	Ex-policeman, AAS, Mankraso
114	Plantain-seller, AAS, Mankraso
140	Farmer, AAS, Mankraso

Appendix 7A: Information Sheet

My name is Nico Owusu from University of Southampton and I am conducting this interview as part of a research for my PhD study which is on Malaria Policy and Strategy in Ghana: The extent of community participation in the intersectoral collaboration strategy. My research project aims at enhancing knowledge on why policies on malaria in Ghana fail to bring about the desired outcomes by comparing both the rural and urban Ghana. It intends to look at this problem from policy analysis perspective. I would therefore like to interview you about your involvement in malaria policy management in the past and present and I would be glad to you if you could share with me your knowledge on these policies. I would also be very grateful if, at the end, you spend some time (roughly 30-45mins) with me to answer some questions. It is worth noting that this research is conducted independently. Everything you tell me will be strictly confidential. The answers you give will not be seen by anybody – your answers are strictly for the research project only. You are also not obliged to answer any questions you do not want to and you may withdraw from the interview at any time.

Do you have any questions, please? May I continue?

I would also like to ask your permission for the interview to be recorded and again this is purely for academic purpose and therefore absolutely confidential. It is only to make it easier for me to recollect all that will be said here when I am analysing.

Finally, before I start I would like you to sign this consent form for me. The aim is to make sure you have taken part in this interview willingly.

Thank you,

Nicodemus O. Owusu

Appendix 7B: Consent form document

Malaria Control Policy and Strategy in Ghana: The level of Community Participation in the Intersectoral Collaboration

I have read and understood the information sheet about the research version 1, 29/10/09. I have been given the opportunity to ask any additional questions about the research project and what I would be expected to do and these questions have been answered by the researcher.

I understand that my participation in this study is entirely voluntary, and that I can withdraw from the study or stop the interview at any time, and that I do not need to give any reasons or explanations for doing so. I understand I will not be penalized in any way for withdrawing from this study.

I understand that in any reference to my interview made in research presentations, reports and articles and so on, personal, organizational and place names will be changed (anonymised) so that I, and any other individuals mentioned, cannot be identified. What I say will also not be shared with other members of my family or with my friends or colleagues.

As required under the Data Protection Act (1998) no details will be passed on to anyone else and information from me as interviewee will be held securely.

I agree to participate in an interview about malaria control practice in my organization and the level of community organizational participation in intersectoral collaboration strategy.

Yes No Please initial

I agree to being contacted again during the project for clarification of points raised in the interview.

Yes No Please initial

I agree to the interview being audio-recorded and transcribed for research purposes.

Yes No Please initial

The transcript will also be totally anonymised so that nothing in it, such as organization, place or individual names can be identified. I assign the copyright for my contribution to the Faculty for use in education, research and publication.

Yes No Please

initial

I understand that I will be sent a summary of the research findings at the end of the research if I wish.

Yes, I do want a copy of the project report

No, I would rather not have a copy

I, _____, have read and understood the above information and agreed to participate in this research project on "*Malaria Policy and Strategies in Ghana: The level of*

community participation in the intersectoral collaboration being conducted by Nicodemus Osei OWUSU at the University of Southampton.

Signature _____ Date _____
interviewee

Signature _____ Nico OWUSU _____ Date _____
interviewer

If you have any comments or concerns about this study please contact:

Professor John Mohan
Deputy Director
ESRC-OTS Third Sector Research Centre
School of Social Sciences
Sociology and Social Policy Division
University of Southampton
Southampton SO17 1BJ
United Kingdom

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Email: J.F.Mohan@soton.ac.uk

Appendix 8: Letter of approval from School Research Ethics Committee

UNIVERSITY OF Southampton School of Social Sciences
Nico Owusu Sociology and Social Policy School of Social Sciences
8 th October 2009
Dear Nico,
Approval from School Research Ethics Committee

I am pleased to confirm that the Research Ethics Committee of the School of Social Sciences has given your research project ethical approval:-

Application Number: SOC200910-05

Research Project Title: Malaria Control Policy and Strategy in Ghana: The level of Community participation in the Intersectoral Collaboration.

Date of ethical approval: 8th October 2009

In order for the University to ensure that insurance is in place for this research, please complete the Insurance and Research Governance Application form attached and return to the address below as soon as possible, along with a copy of this letter and all supporting documents relating to your project:-

Research Governance Office
University of Southampton
Building 37
E-mail rgoinfo@soton.ac.uk

It is your responsibility to complete and return this form, and work on the project should not begin until insurance is in place. The form may also be found on our intranet in the Staff and PGR Zones:-

<http://www.soton.ac.uk/socscinet/>

Yours sincerely,

Professor S J Heath
Chair, School Research Ethics Committee
School of Social Sciences
Direct tel: +44 (0)23 80592578
E-mail: Sue.Heath@soton.ac.uk
CC: file