# The limits of community capacity to manage implementation scale up of Ghana’s community-based health planning and services programme

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**Background:** Ghana is implementing a national community-based primary care known as the community-based health planning and services (CHPS) programme which is built on the principles of community participation and volunteerism. Building community capacity to effectively participate and manage the programme is important for scaling up implementation. Yet little is known about whether poor and peripheral communities have the capacity to effectively participate and manage CHPS to maximise implementation gains. Guided by Simmons (2011) community capacity framework, we assessed the limits of community capacity to provide social, economic, leadership and voluntary services in managing CHPS scale up.

**Methods:** We conducted a qualitative study in four communities in northern Ghana. In each community, data was collected from in-depth interviews with Community Health Officers and Focus Group Discussions (FGDs) with a purposefully sampled community level stakeholders of CHPS: traditional authorities, district assembly members, community health volunteers, community health management committee members and clients. Data was tape-recorded, transcribed verbatim and thematically analysed using Nvivo 10.

**Results**: We found that, local leadership was fairly effective in the capacity to motivate community members, mobilise resources and lead the way in managing implementation. Such leaders also created incentives that shaped broad-based participation and contributions to implementation. On the contrary, disputes between some community leadership undermined the ethos of collective involvement in managing the programme. The communities also demonstrated strong social capacity to participate and manage the programme. This social will power was grounded in the formation of social organisations, whose command over social resources greatly leveraged minds for participation and management of the programme. The individual and collective voluntarism necessary to manage scaling up was shown to be declining as some community members often asked for material compensation in return for services rendered. Finally, the communities were economically weak to invest material resources for scaling up implementation. As a result, they preferred health authorities playing a lead role in providing financial resources to facilitate implementation.

**Conclusion:** Finding draw policy makers’ attention to finding more suitable ways of building community capacity for stronger participation and management of CHPS. In particular, stronger collaboration between the community and district health leadership is necessary to minimise limitations to implementation management by the community.