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

Roger A. Atingaab, Irene Agyepongb, Gilbert Abiiroc, Patricia Akweongob, and Philip B. Adongob

aDepartment of Public Administration and Health Services Management, University of Ghana Business School

bDepartment of Health Policy Planning and Management, University of Ghana School of Public Health.

cDepartment of Planning and Management, University for Development Studies, Wa, Ghana

**abPresenter:** Department of Public Administration and Health Services Management, University of Ghana Business School and Department of Health Policy Planning and Management, University of Ghana School of Public Health

+233 243 260 423

ayimbillah@yahoo.com

**Background:** Over a decade ago, Ghana implemented a national primary health care policy reform known as the community-based health planning service (CHPS) initiative that mirrored the Alma-Ata principles of primary health care. 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 CHWs 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 others, mobilise resources and lead the way in managing implementation. Such leaders also shaped broad-based participation and contributions to implementation. On the contrary, disputes between some community leadership undermined the ethos of communal 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. The individual and collective obligatory prosocial values necessary to manage scaling up was shown to be declining. A cross-section of community members expected material compensation in order to voluntarily contribute to managing CHPS implementation. 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 draws policy makers attention to the need for more subtle approaches of building community capacity for better participation and management of CHPS. In particular, stronger collaboration between the community and policy bureaucracy is necessary to minimise limitations to implementation management by the community.