Improving health insurance coverage in Ghana: A case study
Kotoh, A.M.

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Creating problem-solving groups

Introduction

In Tiase (not real name), the selection process changed three times before the community could select problem-solving group (PSG) members. After a hectic durbar in Tiase, George, a health provider, walked straight to me. He wanted to know the necessity of the elaborate participatory process (described later in this chapter) we used to select PSG members with a string of questions as follows:

Why do you have to go through all these? Why didn’t you just let the chief give you people to join us [health providers and DHIS staffs]? That’s what we have been doing. Who has time to do all these? We don’t follow any laborious process like what you have done. We normally discuss what we want to do with the chief or people we know in the community and request for people to work with. If necessary then we organise a community durbar to inform them about the intervention.

George’s statements represent his experience (and perhaps that of many others) of how community representatives are selected to form stakeholder collaborative groups. His expression of surprise about the elaborate process used in forming PSGs and why we committed ourselves to it suggests that in spite of all the rhetoric about community involvement and participation, a few people probably decide on what to do and who to engage in the process. It also suggests that even those who claim to engage stakeholders in their intervention programmes often do not involve them from the onset.

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Since my study was part of a multidisciplinary research project, some, but not all activities were carried out by the research team (two health economists and me, the medical anthropologist). Research assistants were hired to lead the PSG creation process.
A literature search on partnerships and participation shows that despite the long history of collaborative groups globally, the process of creating them is given less attention. Many studies argue in favour of and give positive accounts of partnership outcomes (Hawkes et al. 2004, Hawkins et al. 2002, Schensul et al. 2004). However, processes involved in reaching that goal are not well documented. The UK Department of Health (2004) notes that despite the desire to include patients and the public in the planning and development issues, it is less clear how their involvement should be undertaken. This implies that even though partnership formation is not new, there are no blue prints to follow for creating partnerships, so most programme officers do their ‘own thing’.

This chapter provides a systematic description of the selection processes and specific activities carried out to create and initiate PSGs. It seeks to answer three main questions: What processes are followed when creating PSGs? Who are involved? How are PSG members and facilitators selected? I provide insight into the complexity of the process. I also describe the challenges we encountered and how they were addressed. Lastly, I give suggestions to improve the PSG creation processes.

Steps and activities in problem-solving group formation

Figure 4.1 shows the four major processes and activities followed in the creation and initiation of PSGs. The PSG formation process started with a stakeholders’ orientation and ended with the PSG facilitators training. Although I was active in contacting stakeholders and arranging the logistics to ensure that PSGs’ were formed, I did not play a lead role during the sensitisation durbar or in the selection of PSG members and facilitators. However, I did observe events, listen to discussions and contribute ideas when necessary. I also engaged community members, DHIS staff and health providers in conversations during the process.
Stakeholders’ orientation

The PSG formation began with a stakeholders’ orientation. During this phase we interacted with key stakeholders (community members, health providers and DHIS staff) and created awareness about the problem of low enrolment and membership retention rates. After opinion leaders, health providers, DHIS staff and the research assistant presented the purpose of the intervention (see chapter five for details) in open forum, those present asked questions for clarification and also added their observation. The research team believed that sensitising the stakeholders about the purpose of the intervention (increasing enrolment and retention in the NHIS) would make them interested and willing to work together for change. I will describe how the community members, health providers and DHIS staff were mobilised, oriented and motivated to address the problems of low enrolment in the NHIS and high membership non-renewal rates. Before this could happen, the stakeholders had to recognise the problem and be concerned about coming together to address them.

Guided by the multi-level perspective (MLP) that emphasises studying a phenomenon by engaging actors at all levels (Press 1990, Green et al. 2001, Van der Geest et al. 1990), key stakeholders of the NHIS were engaged in the mobilisation effort to set up PSGs from the onset. The process started with visits by the research team to the District Director of Health Services (DDHSs), District Health Insurance Scheme (DHIS) managers, heads of local health facilities and community leaders. After our meetings with the DDHSs, we were introduced to disease control officers (DCO) who had in-depth knowledge about all the communities in their districts. The DCOs led us to the community-based disease surveillance volunteers, popularly called ‘volunteers’, who they engage in outreach programmes. The volunteers led us to the chiefs, elders and opinion leaders of the intervention communities. Discussions with the volunteers focused on the intervention and its purpose. We solicited their support for the intervention and asked permission to engage their staff and community members in the programme. We also sought the volunteers’ views on the selection of PSG members. These visits gave us the opportunity to learn about the community dynamics and to utilise community structures and leaders to lead the PSG creation process. The orientation phase lasted three weeks during which an average of two visits was paid to each community, health facility and DHIS office.

As researchers in the communities and among health providers and DHIS staff, we (the research team) were not sure what process would be acceptable and how to

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2 Disease control officers are staff of GHS stationed in the district health directorates. Their job is surveillance and reporting on disease outbreaks.

3 Community-based disease surveillance volunteers are community members who work with DCOs. They are key persons in health-related community educational and intervention programmes. Their main task is to report the presence of any communicable or infectious disease in the community to the DCOs. They also give advice to community members to seek appropriate medical care promptly when sick.
motivate interest in the intervention. We decided to start our discussions by presenting the pre-intervention household survey results that generally showed low NHIS enrolment and high membership non-renewal rates. We arranged a meeting to introduce the project to opinion and community leaders, the DDHSs and DHIS managers and their staff. We discussed the problems captured by our survey. After presenting the results, the discussions generally became brainstorming sessions. All stakeholders spoke about their concerns regarding the NHIS and focused on challenges at their level: the community, health facility and the DHIS. Our meetings usually ended with discussions on how to address the raised concerns and the best strategy for selecting PSG members. Next, we introduced the purpose of the intervention and rationale for the multi-stakeholder problem-solving programme (MSPSP).

At the health provider level, discussions were held with DDHSs, doctors, medical assistants, disease control officers, nurses, and those who work on NHIS forms among others. In most of the discussions, these stakeholders voiced concerns over the lack of consultation by the DHIS and NHIS operational difficulties. Dr Gyena, a DDHS staff member made remarks about the NHIS and support for the intervention and typified the health providers’ concerns. He said:

The National Health Insurance Authority (NHIA) is not listening to those of us on the ground providing service. They could have improved their operations if they had a ‘listening ear’. Now we have all sorts of problems; even they can’t pay us. By bringing all of us together half the problem is solved. Many people come here and talk of collaboration but they tell us what to do. They think we don’t know anything. Our ‘voices’ don’t go anywhere. They forget that we also know what is ‘workable’ at the local level. Sometimes what is lacking is that the right people are not selected into such groups. We will support the intervention and make sure we get the right people in the group.

The DHIS staff included DHIS managers, public relations officers (PROs), management information system (MIS) officers and other staff who took part in the discussions. They were all excited about the intervention and indicated that enrolling people in the NHIS was their core business, so they would support any programme aimed at helping them achieve their goal. However, they lamented the lukewarm attitudes of people towards the NHIS and the challenges of implementation. They indicated they had been conducting many educational activities, but people were just not responding. However, some DHIS staff were utterly surprised at the low enrolment and high non-renewal figures we had obtained from our pre-intervention household survey; nevertheless they did not dispute our data. One of them said: “Though I know that many people are not enrolling, I didn’t know the situation was all that bad. In fact, we really have to act.”

In the community, chiefs and their elders, volunteers, NHIS collectors and opinion leaders (such as assemblymen and Unit Committee chairmen) were those involved in discussions. Our meetings with them focused on why some people were
not enrolling and others were not renewing their memberships. Similar to other stakeholders, these respondents expressed worry about the low enrolment situation and some admitted that they had not registered themselves. Others recounted their own experiences with the NHIS. Below is an excerpt from one meeting with community leaders:

Agnes (member of research team and medical anthropologist): We are here this morning as a follow-up to the baseline [pre-intervention] survey we carried out in March this year [2009]. Our purpose is to share our survey results with you. The results generally showed low enrolment in the NHIS and high non-renewal rates. Out of the 13 communities surveyed in this region [Central Region], only four had 33 per cent of households enrolled. Individual enrolment was less than 10 per cent in three communities. In this community, when you count 10 households only one (9.2%) had at least one member with valid NHIS card. The situation is even worse when you consider everybody.

Community elder: Thank you for your information. I didn’t know so many people have not enrolled. I’m happy you are here to let us know how serious the situation is. I’ll say that the problem with health insurance is not just that we are not enrolling, but also the problems people encounter when they enrol or go to the health facility after enrolling.

Agnes: So, we are here to discuss what could be done to improve the situation. Specifically, what action we can take to encourage people to enrol and remain with the scheme.

Assemblyman: Definitely something must be done to get more people enrolled. Though we all agree that health insurance is good and that everybody should register, there are problems that discourage many of us from enrolling. We were told when you have the hospital [NHIS] card and you go to the hospital you do not have to pay, but that is not what is happening. Insured patients are still paying at health facilities. In this town there is no accredited drug store so you have to travel to other places to get your drugs. Moreover the cards are delayed after registration. All these discourage people from joining and the insured renewing their cards.

Agnes: We are here to discuss how we can best deal with the problems you have mentioned. When we met healthcare providers and DHIS staff, they also mentioned a number of challenges that undermine their work. The SHINE Ghana project team thinks that factors that discourage people from enrolling or renewing their NHIS card could be better dealt with if community members, health providers and DHIS staff work together to identify and address them. We are proposing an intervention called a multi-stakeholder problem-solving programme to help address these barriers that undermine enrolment and retention of members. So we are here to seek your views and support for the project. The first step is how to set up what we called problem-solving groups consisting of representatives of the community members, health providers and DHIS staff. As the name implies this group is expected to meet regularly to identify barriers to enrolment and retention of members at each level, share ideas and develop their own solutions and implement them.

Chief: I’m happy you are here to discuss your ideas with us, and how we can work together. I’m also happy about the fact that you are involving health providers and the DHIS staffs. I think if we work together we can achieve better results.

Agnes: Thank you for accepting to be part of the process. The first step now is the method to use to get your representatives to join the PSG.

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4 Of the 13 communities surveyed in this region (Central Region), four had enrolment levels between 31.8% and 39.1%, and the other nine had enrolment levels between 9.2% and 29.6%. Individual enrolment was less than 10% in three communities and the lowest was 4.8% (see Table A.3, Appendix 2).
At the end of the visits, all professional stakeholders indicated that access to healthcare is an endemic problem that the NHIS is expected to solve. Therefore, since very low enrolment and high drop-out rates have been recorded in most communities, pragmatic interventions are needed to create and sustain community members’ interest in health insurance while all stakeholders re-orient their world-views about the NHIS. For example, health providers and the DHIS staff lauded the MSPSP as an intervention that would help them address the demands of community members while giving them the opportunity to talk about the NHIS implementation challenges they were facing. They also promised to have their staff join the PSGs. Community leaders were happy about their involvement in the mobilisation process. The typical response after being briefed was: “Yebehwé ayi won a wébetumí aye edwuma no” (We will select people who can do the work). All key stakeholders provided very useful information about their communities.

Hawkes et al. (2004) analysed potential barriers to the implementation of a syphilis control programme. The authors observed that engaging key players is crucial to ensure that an intervention programme receives adequate support and health policies become effective in practice. In this study, we observed that the key stakeholders’ involvement raised interest in the intervention. The question of the appropriate method for selecting community representatives to form PSGs was settled in our follow-up visits. After a number of techniques were suggested by community members, health providers and DHIS staff, a final decision was made. Some community leaders, who were in favour of handpicking members of PSGs, argued that an open selection method would be an arduous process and might not be successful. Others who supported the open selection process argued that the process would identify more credible individuals to represent the community since many people would be critical of the selected PSG members. In one community, an assemblyman who argued in support of the open selection at a community durbar described the advantage as follows:

It is better if everybody participate in selecting representatives to the group than the few of us gathered here decide to pick people to represent the community. More importantly, taking those who will finally be selected through a vigorous selection process will let them be more serious with the intervention. They will feel they are accountable to the whole community not the few of us and be serious with their work.

Kekeli, an assemblyman in another community explained why an open selection process in a community durbar was preferred:

Instead of a few people deciding on who should be PSG members, it is better we involve the whole community even if it is strenuous and time consuming. With the durbar, the right message will spread faster since many people will attend and start talking to their family members and friends. So awareness is created among the majority within a short time. It would actually influence the majority of them to take the intervention seriously and hopefully will motivate them to respond positively to whatever the group decides to do.
After extensive discussions, opinion and community leaders in the first two communities unanimously agreed upon an open selection process at a durbar to select PSG community representatives. The consensus was that the durbar would create awareness among community members and lay the foundation for the intervention even before it started. The meetings usually ended with opinion leaders taking the responsibility to mobilise people to attend the durbar.

The community orientation visits to the seven intervention communities went well except for the last one in Jakakrom (not real name), an urban community. As usual a volunteer arranged the pre-durbar meeting. Here the chief, Nana Ansah’s first reaction was negative. After a briefing, he indicated that he was not going to tolerate such things (intervention programmes anymore), so he was not going to give me permission to enter the community. He told me he was not happy with the activities of NGOs who came to the community without properly consulting him. He indicated that the NGOs want to use communities to make money, so he would not allow me to do so. In fact, he nearly walked me out of the room. I asked politely if I could review what I had said and he agreed. So I repeated what I initially said and emphasised that I was just a researcher from the university and not from an NGO. Then he changed his mind and told me that he had also retired from the university two years ago. He explained his initial negative stand.

I agree that any intervention that will make my people have access to healthcare must be supported because development can only occur in a community if everybody is healthy and can work. But people come here without proper consultation. The ‘so-called’ experts think they know everything and don’t involve us. The other day, I just heard a group was doing something down there [pointing his finger to a school]. They came without seeking our views [pointing to a number of elders he had summoned to come and listen to me] about what they want to do. They just waste money sometimes doing things that do not benefit us or solve the problem. It is good you want us to be part of the intervention. I’m happy you are also involving health providers and DHIS staff. I hope whatever comes out of your research will be used to improve the situation.

At this point, the meeting turned into a conversation and Nana Ansah recounted his experience with programmes that performed poorly because the people were not given the opportunity to add their input about how things should be done. He told me that he personally had gotten the women in his community to use treated mosquito nets.

Chambers (1983), a key proponent of participation, has noted the concerns like those of Nana Ansah and Dr Gyena. The author remarked that even when development workers talk about community participation, at the end of the day it is still an

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5 Chiefs in Ghana have jurisdiction over a particular geographical area. So outsiders entering the community must seek his permission. This is sometimes violated especially in urban communities where the local government agencies, such as the district assemblies, have political power and oversee civic activities. As a result, a chief’s authority is not felt as much and is sometimes taken for granted as the case of Nana Ansah shows. Nana Ansah lives in an urban community and is a retired public servant.
outsider seeking to change things for local people. This was what the MSPSP sought not to do; it did not intend to treat key stakeholders of the NHIS as only consumers of the intervention to expand coverage, but rather to engage them from the onset.

Furthermore, casual remarks made during conversations with community members gave me insight into the local situation and appropriate measures needed for support of the intervention. For example, a conversation with Agya Mensah, a Unit Committee chairman, during one of our familiarisation visits in the Kaja community, alerted us to a chieftaincy dispute that required slightly changing the protocols we were following. This hint was dropped when the volunteer introduced us to Agya Mensah as someone we could talk to about the project. After telling Agya Mensah about the intervention and creation of the PSGs, I asked him which persons were likely to be nominated as PSG members. He told me there were many people, but the volunteer I was walking with had problems with a section of the community, so I should be careful how I involve him. I was curious and asked what kind of problem. He said the family of the volunteer was involved in a chieftaincy dispute so including him might not be helpful. To be sure about what Agya Mensah had told me, I verified the situation with the NHIS collector (the next person the volunteer took me to). He confirmed the story and said that the volunteer’s family had refused to take part in community activities, so if he played a front role in organising the durbar, people might not attend.” I came back to ask Agya Mensah about when we could visit the chief. He said: “Due to the chieftaincy dispute, if some people see you going to any of the contesting chiefs, they might boycott the durbar. They might associate what you are doing with him. So I think we don’t have to visit any of them.”

I must say that this advice yielded rich information. We gained significant insight into community dynamics that helped address stakeholders’ concerns. Stakeholders’ observations and advice informed us about the local conditions and procedures we could utilise to guide the selection of community PSG representatives. For example, due to the existing chieftaincy dispute in Kaja (not real name), Agya Mensah became the rallying point for mobilisation activities. He was perceived as neutral and acceptable to the whole community, so he took it upon himself to invite the feuding factions to the community-sensitisation durbar. He informed the community about the intervention and the need to attend the durbar. I did not visit any of the contesting chiefs. A public announcement was made by the village announcer inviting everybody, including the contesting chiefs, to the sensitisation meeting. Agya Mensah also advised that we use an open selection process to minimise the

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6 A Unit Committee is the lowest level in Ghana’s decentralisation structure of governance. It is at the community level. Elections are non-partisan, so members are supposed to be politically neutral and not to show open support for any party.
effect of local politics on the selection process. In fact, the durbar was well attended and true to Agya Mensah’s word (and contrary to what happened in other communities where nominees were unanimously accepted), the nomination of one person was contested. The details of what happened will be discussed later in this chapter. It was also remarkable that no one nominated the volunteer to be a member of the PSG, which was not the case in other communities. My observation during the durbar and the selection process confirmed that the volunteer was not popular with the people because of his involvement in traditional politics.

Another important issue worth mentioning is that getting people to attend durbars in fishing communities was very difficult compared to farming communities. Though they could not give me a reason, I was happy to have been cautioned by DHIS staff and health providers of the low attendance they normally record when durbars are organised in fishing communities. Armed with this information, I made an extra effort to interest fishermen in particular to attend the durbar so they could also be selected. In fact, in my conversations with them during my community orientation visits, they were not enthusiastic about participating in the PSGs. Therefore, I took pains to talk to them while they were busy mending their nets. Even when I explained to them that the PSG meetings and other activities would not take much of their time nor disrupt their work since they would be scheduled at their convenience, they were still adamant about not participating. I later asked the volunteer who normally accompanied me about the fishermen’s lukewarm attitude. He told me that the reason for their general lackadaisical attitudes towards such programmes could be because of their inability to converse in English. This was confirmed when I engaged one of them in a conversation. Below is an excerpt.

Agnes: Why are you not interested in being a member of the group?

Ebo: We don’t understand English. When people come here, they will be speaking English and we will not understand. But also let me ask you what do you want from the group?

Agnes: The group is expected to meet at least once every month to discuss the reasons why many people are not enrolling in the NHIS and why the few who enrol some do not renew their membership. The group will plan activities that they think will improve enrolment and influence people to remain in the scheme. All communication will be done in Fanti (the local language), so you will have no problem communicating your views. Are there any other challenges?

Ebo: If the language problem is solved, then we will come. We don’t have any problem with the group.

Despite Ebo’s assurance, not many fishermen attended the durbars. As it was, fishing communities generally recorded the lowest attendance confirming what I had been told. The situation in fishing communities therefore demands a rethinking of how to get them into PSGs since they appear not to be interested in community durbars. This challenge is addressed in the next chapter that describes how PSGs devised other strategies in addition to community durbars that made it possible to reach fishermen with intervention activities.
Criteria for selecting PSG members

Having settled on a durbar as the best forum to select PSG members we (health providers, DHIS staffs, community leaders, my research assistant and I) discussed the best selection procedure. Ideas gathered from these discussions were used to develop detailed guidelines for the selection process. These ideas also helped me to develop the framework for the PSG creation process. The following criteria were determined after discussions with the DHIS staff, health providers and community members involved in organising the durbar. We agreed that any adult resident in the community was eligible to nominate someone and be nominated and that at least two women should be in the group. Another condition was that all speakers including the DHIS staff and health providers should communicate in the local language. The decision to include at least two women in each PSG was reached after the first community durbar when only one woman had been selected after the initial selection round. This attracted our (the research assistant and I) attention. We immediately alerted the assemblyman who was helping to facilitate the selection process. After a short discussion, he drew the community’s attention to the sole woman participant. The situation was discussed and everyone agreed on the need to have at least two women in the group. The research assistant and all those involved in organising the durbar agreed that since women are caregivers, they should be part of groups that discusses healthcare issues. So a second woman was nominated to join the PSG and having at least two women became a condition for all other PSGs. This was to ensure that women were given the opportunity to participate effectively in the intervention. The argument was that if we left women’s nominations open, they might not have been selected at all in some communities.

I must admit that the initial selection of only one woman was actually not a surprise to me since Ghana is a male-dominated society and women’s leadership capacities are generally undervalued. There is the belief about the superiority of men and specific roles are assigned to men and women. In this regard, Cusack (1999: 25) observed that in Ghana, role expectations generally “confine women to specific spaces.” Leadership positions for example, are seen as the preserve of men, and women are generally associated with reproductive functions. Farmer (2005) also contends that throughout the world, women are confronted with an ideology that situates them as inferior to men.

Lessons learned from community orientation

Key stakeholder engagement in setting the path for the formation of PSGs during the orientation phase of the process brings to the fore a number of key lessons that are relevant to intervention practices in Ghana. Not nominating women in the first group illustrates how women are relegated to the background when it comes to leadership
in many community gatherings and explains their under representation in leadership positions at the national level.

First, discussions with health providers, DHIS staffs and community members indicated they were interested in the intervention because of the opportunity for open dialogue. Health providers felt that by working together with DHIS staff, their situation could improve because these discussions provided them the opportunity to speak about how the NHIS affected their work.

With DHIS staff, their motivation to participate in the intervention was the opportunity to discuss the challenges they were confronted with when implementing the NHIS. They also said they were happy that the intervention was likely to enhance their work. Moreover, since they would be working with community members who were the targets of their membership drive activities and health providers who were expected to help them achieve their goal, the collaboration would help them expand NHIS coverage.

Community leaders and members I spoke with asserted that in the midst of low enrolment, the intervention was an opportunity for them to work with DHIS staff and health providers to address the issues that discourage people from enrolling and renewing their membership. They contended that this would help solve the problem of lack of access to healthcare in their communities, so it must be supported. Building collaborative groups around perceived problems and creating an environment of mutual dependency are strategies that are more likely to arouse stakeholders’ interest and encourage them to participate. As Nana Ansah pointed out, consulting targets of an intervention made them commit to the intervention’s success, since it reduced resentment towards such programmes by the people who are supposed to help mobilise support. This perspective echoes Hawkins et al.’s (2002) observation that it is imperative to use methods that effectively mobilise various sectors of a community to support the implementation of interventions. Similarly, this study found that stakeholder involvement from the beginning helped create a platform to discuss pertinent issues related to the intervention and its relevance.

Second, the massive attendance at the seven durbar shows that once stakeholders were adequately sensitised to the scope of the problem, they would mobilise their members to patronise the selection of PSG members and take the intervention seriously. Events at the durbar showed that people who were committed to work in a group to achieve the desired change attended the durbar and were consequently selected. They created the support base for the intervention from the outset. This echoes the observation of Van der Geest et al. (1990) that involving all actors when studying a phenomenon is important, so the various meanings of the same phenomenon can be revealed. The authors argued that what may appear as self-evident at one level may be totally irrelevant at another. Similarly, the pre-durbar consultations
led to a common understanding of the intensity of the problem of low enrolment in
the NHIS, which was not perceived by community members. This resulted in
stakeholders’ commitment to help achieve the intervention goals.

Third, by involving stakeholders and incorporating their ideas, such as Nana
Ansah’s suggestion to thoroughly discuss objections raised against nominees during
the PSG creation process, helped reduce conflict. Even when conflicts occurred, as
in the Kaja and Tiase communities, they were resolved without confrontation. This
shows that challenges may arise during the process, but when handled properly,
popitive results can be achieved.

Understanding community dynamics is of interest to many researchers. As Higgins &
Metzler (2001: 490) have pointed out, “Insights and perspectives of commu-
nity participants enhance the knowledge and understanding of researchers about
community dynamics and conditions.” This study in Ghana found that understand-
ing community dynamics is not only useful to researchers, but also even more useful
to those engaged in carrying out intervention activities. This is because the interven-
tion groups’ ability to tap information about local conflicts and dynamics helps them
to address issues and ensure the successful formation of the PSGs.

Finally, presenting the intervention as three-pronged targeting the three key
stakeholders of the NHIS (community members, health providers and DHIS staff)
with ‘no blame attached’ was helpful. The stakeholders appreciated the low enrol-
ment and the difficulty of retaining members as a mutual challenge requiring a
 collaborative effort. This finding was similar to the observation of Porter et al.
(2007) in their study of a medicine and public health partnership that the reason(s)
for group formation (though not very strong) contributes to their success. This study
found that forming partnerships on the basis of mutual problems requires the
contribution of all to improve the situation and results in the stakeholders’ commit-
ment to work together to solve the problem. Health providers’, DHIS staff’s and
community members’ recognition of their capacity to contribute to improve enrol-
ment and that they were not expected to function only as recipients of intervention
activities made them view the intervention in a positive way. They became more
receptive to the idea of collaboration and their interest in participating increased.
Thus, the participatory approach we adopted in setting up PSGs indicates that
seeking local stakeholder support for intervention programmes from the onset
provides a fertile ground for success.

Community durbars and selection of PSG members

Community durbars were held to sensitize stakeholders about the intervention and
select PSG community representatives. The durbars were attended by chiefs and
their elders, community members, health providers and DHIS staff who were targets
of the intervention. Being quite conscious of my position as a researcher, I did not
take a leading role at the durbars. Research assistants\(^7\) facilitated the proceedings at the durbars assisted by opinion leaders and community leaders (Assembly and Unit Committee members).

On durbar days, we (the research assistant and I) always arrived early. From my observation, there was usually an air of anticipation before the durbar began. People who came early gathered in small groups and discussed the NHIS. Eavesdropping on their conversations, I heard community members generally talking about their experiences with NHIS, such as delays in receiving NHIS ID cards. Health providers were discussing the community’s lack of interest in health insurance. DHIS staff discussed the lukewarm attitude of community members towards the NHIS. These discussions boosted my morale since it was obvious that barriers to enrolment and retention in the NHIS were real and cut across communities, health facilities and DHISs. These conversations also indicated that each stakeholder’s perspective influenced how they define the barriers. Therefore, to understand and address the barriers adequately, each stakeholder’s perspective needed to be explored.

**Welcome and introduction:** Typical of durbars in Ghana, proceedings started with the observation of the protocol\(^8\) related to traditional procedures at official functions, especially when chiefs are involved. We, the researchers and research assistants, were regarded as visitors to the community, so we were welcomed and introduced to the community by the *Okyeame* (the chief’s spokesman). He asked about the purpose of our visit and the objective of the durbar. My research assistant briefly talked about the reasons for the durbar and the goal of the intervention emphasising the role of PSG members and facilitators. Next, a DHIS staff and health provider gave brief speeches emphasising the benefits of the NHIS. They indicated they were happy about their involvement in the intervention and were confident that the expected objectives of bringing about significant increases in NHIS enrolment and ultimately ensuring equity in access to healthcare would be achieved.

The durbar thus created a common platform for stakeholders to interact and communicate their views about the NHIS. It also created support for the intervention and highlighted the need to work together to reduce barriers to enrolment. This is in line with the issue of “cultural brokerage,” which implies bringing about communication, interaction and mutual dependency as expressed by Bailey & Van der Geest (2009: 217). The absence of which, Kinsman (2008) observed, had accounted for the failure of HIV/AIDS interventions in Tanzania and Uganda. This study also showed

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\(^7\) Research assistants were hired to facilitate the durbar and the selection of PSG members and train PSG facilitators. They were experts in community mobilisation and development.

\(^8\) Before the start of any gathering involving chiefs, especially among the Akans in Ghana, traditional protocol demands that visitors in a single file go to shake hands with the chief and his elders and vice versa as a form of greeting.
that it is essential to create a forum that encourages broader networking and integration of stakeholders’ ideas into processes that reflect their reality from the onset. A NHIS collector’s remark after one of the durbars typifies comments made by community members to show appreciation for their involvement in the intervention.

This is one of the best things that have happened in this community. Everybody must support it, since access to healthcare is an important issue. In fact, I have been trying to convince people to register, but they will not listen. I see this programme as something that will enhance my work. Bringing health providers, DHIS staff and community members together will send positive signal to all those sitting on the fence. They will see that the NHIS is good and change their mind and register.

Selection of problem-solving group members: The effectiveness of any intervention depends to a large extent on choosing the right people to form the group. Selection of the community representatives required special focus because the calibre of the people selected to form PSGs was likely to have impact on the intervention programme. Therefore, to ensure the acceptance of the selected community members, extensive consultation and locally designed procedures were used. This approach was guided by Butt et al.’s (2008) assertion that the success of interventions is related to who is involved and how they are involved. Since the intervention was guided by a multi-level perspective, each community was given the opportunity to decide on how to proceed. As mentioned earlier, the idea of an open selection procedure was raised by community members, such as Agya Mensah (a Unit Committee chairman) and Kekeli (an assembly member) in the first two communities we went to. Open selection then became the popular option when suggested by the research team to other communities, even when it was mentioned first. Open selection was therefore discussed and adopted as the procedure in all 15 intervention communities based on the assertion that if targets of the intervention selected their representatives and gave them the mandate to plan and execute their own activities, the likelihood of success appeared to be high.

With regard to the selection of DHIS staff and health providers for the PSGs, heads of their institutions using their wisdom determined the process. This was because of the study’s emphasis on the effective participation of stakeholders in the selection of PSG members as an alternative to a predetermined top-down process. We requested a minimum of two representatives from DHIS staff and health providers to ensure that one would be available at all times. Therefore, the heads of the institutions selected PSG members who had insight into the NHIS in the District Health Directorate (DHD) and health facilities. All DHIS staff qualified for inclusion in the PSGs, so the selection was based on the manager’s discretion with the PROs as the first choice since their main work is promoting NHIS.
A typical process of selecting PSG community representatives: The climax of the durbar was the selection of PSG members. Before the selection, my research assistant spelt out the criteria for membership and guidelines to be followed, emphasising the selection of women. Below is a summary of what took place:

Research assistant: “Who do you nominate to represent you in the PSG?”

A community member [Raised his or her hand and mentioned an individual’s name]: “Kwesi Mensah.”

Another community member [at least two other people needed to second the nomination] said: “I agree to Kwesi Mensah’s nomination”

The nominee was asked to stand in front of the crowd for everybody to see him or her and then return to his or her seat. Next, community members were asked whether anybody had anything to say against the selection of the nominee. This question was repeated three times. For each round, about a minute was given to allow people to think through the issue and raise objections if necessary. If nobody raised an objection, then the nominee was accepted. Every nomination was taken through the same process till the required number

When all nominations had been accepted, all persons selected were shown to the gathering as representatives of the community. The research assistant then finally asked if someone had anything to say about a nominee. If no objection was raised, the nominated representatives of health providers and DHIS staff joined the selected community members for the inauguration. All participants in the durbar faced the crowd while the chief and his elders congratulated the selected nominees and declared them officially as PSG members. Next, a PSG member pledged the group’s commitment to the task ahead and asked the community to support them to achieve the goals of the intervention.

The chief or his representative normally gives the final word. This person advises the selected PSG members to work in harmony and uphold their virtues. He also asks the community members to support them in their work. A typical statement by the chief or the elder was:

You have been selected today to serve in this important group, make sure your conduct does not bring any disgrace to us. Don’t betray the confidence and trust the community has in you. Eschew any negative tendencies and work diligently to help achieve the objectives of the group.

9 The required number was determined by the number of health providers and DHIS staff already nominated.
The chiefs also pledge the community elders’ support to ensure that the objectives of the intervention are achieved. When a chief agrees to witness the formation of PSGs, this means that the intervention is an important programme for the community and should be taken seriously.

Generally, the selection processes were smooth without incidents except in two communities when objections were raised against a nominee’s selection and the selection process. However, these objections were discussed and an agreement was reached by a vote and the selection processes continued. The two cases with objections are presented below to show the importance that community members attached to the community participatory process, the important issues that informed people’s decisions to nominate an individual to represent them, and how conflicts were addressed.

Rejection of nominees: In the few cases when a nominee was rejected, the participants at the gathering discussed the issues to ensure that the process was transparent and no one would be blamed for favouring a particular person. In the Kaja community (not real name), for example, the first three nominations were accepted without objection. When the name of a fourth nominee, Kwaku Manu was mentioned, the facilitator asked as usual whether all agreed to his nomination. A man got up and raised an objection saying that Manu was working and staying in the next town, so he did not qualify. However, another person supported the nomination and insisted that Kwaku Manu was almost always in town and his contribution to development activities was enormous. When given the opportunity, the nominator explained his position as follows:

You all know Kwaku Manu’s contribution to the development and welfare of this town. Though he does not currently live in town, he is almost always here and his contribution to the development of this town cannot be compared to anyone of us here. Moreover, he is coming down to settle here soon. I think this qualifies him to be part of the group.

These arguments held up proceedings for about five minutes. A man then suggested that they vote to settle the issue by show of hands, his suggestion was accepted, and a vote was cast. An overwhelming majority supported his nomination. The selection continued without any incident and everything went well. From my observation, the majority of the people were happy with the process.

Rejection of selection process: In the Tiase community, the customary procedure used for selecting PSG community members was rejected three times. The first process, an open nomination of potential PSG members described above, was rejected when the selection process was almost complete. All seven candidates were lined up and shown to the community for the final approval. When the research assistant asked the final question of whether everybody agreed to the selection of the
nominees, a community member named Kisi protested against the selection process. He said:

Nominating only seven people and accepting them by clapping hands is not good enough. People were not given enough opportunity to reject nominees they do not want. More people should be added to the seven already selected so we could vote to determine who should be part of the group.

Kisi’s comment brought arguments. Some people raised objections to his suggestion arguing that the process was not feasible given their situation. Others said that this was not a political event and there were no ballot papers to organise the election that Kisi wanted. This resulted in counter arguments holding up proceedings for about ten minutes. When the assemblyman helping to facilitate the selection managed to restore order, the group agreed to vote by a show of hands. Two more people were nominated, bringing the total to nine. The nine nominees were kept inside a room where they could not see what was going on in the hall. People were asked to vote for their favourite nominee when his/her name was mentioned. As people voted, they were moved to one side of the hall to prevent double voting. However, after the first two nominees were selected, another man also objected to this process. He said:

This cannot be a better selection process. How sure are we that people are not voting or counted more than once? This is not acceptable. It must be replaced by a better way of voting and counting votes if we still want to maintain an election process.

This resulted in another hold up with many arguments for a few minutes. Now people were not happy about what was happening and started leaving the hall. The assemblyman, and the research assistant had difficulty maintaining order and bringing those who were leaving back to the hall. Order was restored when Nana Ameyaw, one of the elders, intervened and asked everybody to remain calm. He appealed to those who were leaving to come back. He said:

These people [pointing to us] are here to involve us because they trust us. They trust that we can help solve the problem with insurance so we have to make sure the objective of this meeting is achieved. Let’s co-operate and decide on a feasible selection process. It is an opportunity we have to handle well. We have to support the facilitators and make sure we form this group.

When the situation returned to normal, the on-going voting process was also abandoned. After a short discussion about what procedure to use, everybody in the hall realised it was not possible to hold a ‘proper’ election where everyone could vote in a secret ballot given the large number of people present (about 300). At this stage, Kisi, who had raised the first objection, looked confused and was worried that it might not be possible to form the PSG. Arguing about the community’s inability to agree on a process to allow everyone to vote, he appealed to all those present to cooperate in setting up the group. Consequently, a community member suggested a third process and this was accepted after many arguments. In the new process, instead of the community members voting for the nominees, the nominees would be
in a lottery (explained below). Appealing to the people, the assemblyman, who was moderating the nominations said: “This is the only realistic process, you must all cooperate. There is no other way we can get these people elected since we can’t get ballot papers and boxes to make the process efficient.”

Before the selection resumed, the assemblyman raised the issue of a minimum of two women being selected to join the group. The conclusion was that if they did not select two women, the community would then decide what to do. To move the process forward, the assemblyman wrote the word ‘Yes’ on seven pieces of paper and ‘No’ on two pieces of paper and put them in a bowl for the nominees to pick in the full view of everybody. Those who picked ‘Yes’ formed the group and those who picked ‘No’ were left out. Interestingly, all the previous nominees picked ‘Yes’ and three women picked ‘Yes’. A young man, sitting beside me, dissatisfied about the earlier confusion, but happy with the results, commented: “Do you think we are children. After all what was earlier rejected is what we still had.” The rest of the PSG formation activities went smoothly. The durbar ended with the following remarks from Nana Ameyaw:

What happened today should be taken as something that should strengthen you [pointing to PSG members]. It means people are really interested in what you are going to do and want to see you perform. It also shows the dynamism of people in Tiase community and not division among them. I urge all of you to support the group to achieve the objective of the intervention.

After the durbar in Tiase, I asked a community member how she felt about what happened. She said:

I’m just happy that we were able to get the right people selected despite the confusion. I’m even surprised about how they had time to get all those problems solved [hold ups during the selection of PSG members]. It shows that they are serious and trust that if the right people are selected the problems will be solved. We have to support the group.

Drawing on the above comment and the peaceful atmosphere I observed after the durbar, most people were happy about their involvement in the selection of PSG members. Disagreements were discussed freely. Comments by Nana Ameyaw, the Unit Committee chairman and others showed that community orientation and extensive pre-durbar consultations made the community leaders and members recognise their involvement in the selection process and intervention as laudable. They saw participating in the selection process as an opportunity that should be utilised well. Interest in the intervention was generated. Tiase is a vibrant community where the people ensure issues are discussed objectively and the right thing is done to maintain unity and achieve positive results. As Nana Ameyaw observed, the ‘hectic’ selection process shows the dynamism of people and not division.
Profile of PSGs’ members

At the end of the process in all seven communities, I found that the selected PSG members cut across all sections of the community. Neither age, religion, level of education nor disability influenced a person’s selection. For example, a disabled man was selected as a PSG member and even as a facilitator, but unfortunately had to turn the position down because of the problem of how to attend the facilitators’ training workshop. The man needed an aide to accompany him to the meeting, but the project could not provide funding for that. Intrigued by the disabled man’s selection, I asked community members what informed their nomination. Yaw, like many people I spoke with, told me that the critical attribute he considered for selection was the individual’s conduct, especially his or her commitment towards the welfare of the community. I asked a similar question after the incidents in Kaja when a nomination was contested and Tiase when the selection process was modified. Janet, who I saw arguing among the crowd in Tiase, told me that the person she nominated was “hard working, well-behaved and would bring development to the community. Not those who are only interested in their own welfare.”

Others told me they did not want people who would bring confusion to the community because of their involvement in local politics. The two selection processes thus created space for everybody to participate and gave voice to those who rarely have the opportunity to select their representatives in forming such groups. The people appreciated the process since their involvement in the planning broadened the base of potential members. This was in contrast to the usual practice in Ghana of handpicking people to form intervention groups. The selection processes gave people like Ebo (fisherman), who were committed to the welfare of their communities but worried about alienation and their effective involvement, the opportunity to participate. As indicated earlier, in my conversations with community members after the durbar, the extent of the community members’ involvement and the elaborate procedures followed in the selection processes were seen as a welcome development in intervention practice. This approach created room for the majority of the targets of the intervention to participate from the onset; this is rarely the practice in Ghana and that is a source of worry for most community leaders and experts in community development. For example, Chambers (1983) criticises the behaviour of development workers who claim to have used participatory approaches, but often end up deciding what to do for the community.

PSG members range from 11-15. The variation was due to the differences in the number of health providers and DHIS staff who were nominated to join each group. There were seven community members in all the groups. PSG members included:
• Fishermen, farmers, GPRTU\textsuperscript{10} chairman, self-employed
• Teachers and other formal sector workers
• Cocoa purchasing clerks
• Assembly/Unit Committee members\textsuperscript{11}
• Religious leaders

(See Table A.7, Appendix 2)

\textbf{Figure 4.2} Map of Central Region showing all seven intervention communities where PSGs were established

Figure 4.2 shows the seven communities in Central Region where durbar sessions were held to sensitise stakeholders about the intervention and select PSG community representatives.

\textit{Lessons learned from the PSG selection process}
Lessons drawn from the participatory process used to form PSGs provide a framework to address concerns about stakeholders’ involvement to attain positive results.

\textsuperscript{10} GPRTU – Ghana Private Road Transport Union is the largest association of private commercial drivers in Ghana.

\textsuperscript{11} Assemblymen and Unit Committee members are part of the political structure in Ghana. They are local representatives in the District Assemblies and non-partisan. They work with the district chief executive who is the government representative at the district level.
For example, the UNICEF’s Accelerated Child Survival and Development Programme to reduce death among children less than five years in Ghana did not achieve the expected targets because there was lack of engagement of the implementers and the target population of the intervention from the onset (Bryce n.d.). This suggests that excluding stakeholders from programmes and treating them only as consumers, increases the risk of failure.

Stakeholders exchanging ideas, participating in decision-making and planning the durbar all worked to establish linkages and build trust. Open selection of PSG members laid the foundation for the intervention. For example, Nana Ameyaw, an elder of Tiase who saw the process as based on trust, gave his support and this helped to convince the people to participate so the selection of the PSG members could succeed. This echoes Gilson’s (2003) claim that trust facilitates collective action and elicits co-operation among people to achieve common goals. Similarly, Mantoura et al. (2007) and Bailey (1992) suggest that for networks to succeed a team should be well integrated in the community and be motivated to risk working together to prevent narrowly focused self-interest activities. Comments made after the durbar show that extensive consultation resulted in deeper community penetration since the message about the intervention was spread even before PSGs began their work. Thus, the stakeholders’ motivation to work together could be enhanced if they are given the chance to take charge of events and decide on the process of selecting members of an intervention group.

The incidents of disagreement in Tiase and Kaja show that to have a positive outcome in setting up collaborative groups, the process should be painstakingly followed without rushing through the steps. Attention should be paid to issues that come up during the process and these should be addressed in an open manner. Since it is not likely that the provided guidelines can capture every possible scenario, provision should be made for adjustments (as was done in Tiase), so controversies can be properly handled and PSG members who are selected are acceptable to community members. The selection of appropriate community-supported people to form the PSGs laid the foundation for success in this phase of the project.

Finally, this study shows that extensive consultation with stakeholders and non-interference by outsiders in the selection of representatives to form collaborative groups created interest in the intervention and increased the probability of selecting committed PSG members. The incidents at Kaja and Tiase indicate that when community members assume the responsibility of forming PSGs, they will do everything possible to resolve the challenges that arise. Compromises are easily reached if outsiders do not impose their ideas on community members. Although local politics may mar community programmes, if properly handled, a positive outcome is possible. In the end, for successful PSG member selection and commitment to a community-based intervention, adequate space should be created for
community members to decide what to do and who to select since they know who can best represent their interests.

Selection of facilitators

Two facilitators were selected among the selected PSG members for each PSG in all seven sites. The facilitators were expected to act as the leaders of PSGs, stimulate change and work for the sustainability and effectiveness of the groups. Facilitators were selected immediately after each durbar. Their task was to lead the group through the intervention phase; they were responsible for organising meetings and carrying out intervention activities.

Guidelines for selecting PSG facilitators

The decision to have two facilitators for each PSG was because the project only had funding to support two. However, guidelines for selecting the facilitators were discussed by all stakeholders and finalised by the PSGs. The facilitator criteria included:

- One facilitator must be a community member and the second must be a health provider or DHIS staff
- Both facilitators must be literate
- Both facilitators must be relatively neutral and not actively engaged in local or national politics.

The rationale for using local facilitators for PSGs was that as part of the community they could best address practices within the group that might undermine the intervention. Thorp et al. (2003) in their work on the relevance of groups in economic development and poverty reduction in developing countries reported that the role of external leaders can be useful, but does not help in the long-term sustainability of groups. In this study, lessons learnt during formation of PSGs clearly indicated that internal leadership would help mobilise support for the intervention programme and resolve problems that might arise. Also, the non-engagement in politics criteria was informed by the rejection of potential candidates because of their relationships with local traditional leaders. This indicated that politics have the potential of undermining the collaborative process.

The brief meeting to select two facilitators and a secretary for each PSG was chaired by the research assistant. One facilitator was chosen from the community members and the other from either the health providers or DHIS staff. The facilitators were selected after the group members conferred among themselves. Community members met separately to select their facilitator, while the health providers and DHIS staffs also had a joint meeting to select one facilitator and a secretary. When a
facilitator was selected from the DHIS, a health provider became the secretary and vice versa.

It is interesting that at the end of the selection only two facilitators were health providers out of the fifteen facilitators selected from health providers and DHIS staff, (Table A.8, Appendix 2). This indicates that while all stakeholders showed interest in the intervention, the DHIS was seen as having the responsibility of leading the programme. Some health providers cited a lack of time when I asked why they were not keen to be facilitators. Others said they saw the NHIS as the core business of DHIS staff, so they should play the lead role. But, what became clear during the course of the intervention was that the health providers saw the leadership position as adding to their workload. Even when the field of play was level for participation, occupational interest and perceived gains determined the level of involvement.

Figure 4.3 Outcome of PSG selection process

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Main focus of anthropological research in this study

Each PSG has
- 2 facilitators
  - 1 from community members
  - 1 from health provider or DHIS members
- 11-15 total members (depending on the number of health providers and DHIS staff)
- 7 community members
  - Fishermen, farmers, GPRTU chairman, self-employed
  - Teachers and other formal sector workers
  - Cocoa purchasing clerks
  - Assembly/Unit Committee members
  - Religious leaders
Training the PSG facilitators

Facilitators were PSG members selected by their colleagues to lead the group through the intervention period. Evidence shows that management of intervention groups closely correlates with their ability to achieve positive outcomes. As Keltner (1989) posits, the role of a facilitator is complex because human beings are complex, suggesting the need to equip them with special skills to lead the PSG groups. In this study, a three-day training workshop equipped facilitators with skills that would help them perform their role effectively. Skills included leadership, facilitation of PSG meetings, and mobilisation of stakeholders to effectively participate in intervention activities to achieve positive outcomes. The trainers were consultants with expertise in community mobilisation and participatory approaches.

The training workshop was interactive and characterised by an exchange of ideas and experiences among the trainers and the facilitators. The facilitators were introduced to the problem-solving cycle and techniques. Three main techniques were addressed: 1) brainstorming, 2) ‘but why’ and 3) using a flow chart. Also, the various stages of the problem-solving cycle (problem identification and prioritisation, development of solutions and implementation strategies, drawing and implementation of action plans) using mock problem-solving sessions and several exercises were discussed and practised. After the practice sessions, the facilitators received personal feedback on their competency. This provided them with the ‘hands on’ experience needed to manage group members and stakeholders’ participation for the task ahead.

Trainers engaged facilitators in exercises that helped them recognise that they occupied a position of relative equality; communication should be horizontal to dissolve any power differential with group members. They were asked to facilitate mock PSG meetings and they asserted that this was beneficial. The facilitators told me during and after the training that it had exposed them to skills they believed would help them perform their new role effectively. One said: “This training benefited me. I learnt skills that have improved my communication. This will help me be a good facilitator and build relationships among group members.” Also, the course prefect, a DHIS facilitator made the following remarks at the end of the training session:

Initially most of us didn’t know exactly what we were going to do. This training has motivated us. Now we have the zeal to do the work. The exercises and assignments gave us the opportunity to practice what we learnt. We now feel competent and prepared to take up the task ahead of us, and the challenge of mobilising stakeholders and commitment to participate in the intervention. I think we will have no problems applying the skills acquired to achieve positive results in our respective communities.

These comments show that the training created confidence in the facilitators to face their tasks. It also suggested a relationship between the training and the motiva-
tion to assume leadership positions. Lasker & Weiss (2003: 15), in their work in the US on how to make collaborations more effective, point out that collaborative groups need a special kind of leadership to turn the “rhetoric of abstract principles into practice” and maximise the benefits of collaboration. They argued that leadership influences how participants are involved in collaboration groups and determines outcome. In the current study, it appeared that the training was a critical component of the intervention programme, especially if it was to fulfil the purpose of increasing the facilitators’ commitment to the intervention. The training also helped to create a shared vision among stakeholders to develop the various intervention activities and strategies to reach all targets. In the subsequent chapters, I present how these skills (learned in the training workshop) were utilised to elicit the stakeholders’ cooperation and commitment to the intervention and outcome.

**Reflection on the selection of PSG members and facilitators**

The primary goal of choosing an open and participatory process was to provide community members the opportunity to nominate and be nominated for PSGs. The concerns of a community member, George, about the complexity and time-consuming process stated in the introduction may have been due to challenges to the status quo that come with an apprehension of the unknown and questions being raised about benefits. While I agree with George, that the process might not have been a perfect alternative to the ‘handpicking’ approach commonly used to select representatives, his remarks and my observations indicate that although the involvement of targets of intervention programmes has become popular, translating it into practice remains a challenge. Critical anthropologists and development experts have been advocating for multi-level and participatory approaches in planning and executing intervention projects to ensure that marginalised groups are included (cf. Farmer 2005, Chambers 1994). From this perspective, rather than demanding a choice between the two approaches, the analytical question should be whether or not the two main objectives were achieved. One, did ordinary people participate in the selection process and did dedicated people formed the PSGs? Two, were targets of the intervention fairly represented in PSGs?

First, the reasons that the community members gave for their choice of candidates and their satisfaction with the outcome indicate that the open process of nominating, accepting and rejecting nominees (not necessarily democratic) with the objective of penetrating community structures and getting many people to participate in the process was achieved. Power brokers were the research assistants and opinion leaders who took charge of events and moderated the process. Nominations were keenly contested and the majority of people present took the final decision. The community appreciated that this innovation set aside the authority of the chiefs in deciding who should represent them. As revealed in the subsequent chapters,
although the process was tedious in terms of travelling to meet opinion and community leaders\textsuperscript{12}, the level of commitment of community representatives (compared with DHIS staff whose core duty it is to promote the NHIS) showed that it was worth the cost. The outcome suggests that the more critical people are about who represents them the more likely it is that committed people will be selected. However, since involvement of the targets of the intervention (the community) was an important factor for choosing the multi-level approach, the question is whether or not the elected PSG members fairly represented all sub-groups in the community.

As described earlier, the background of PSG members spanned various occupational and social groups so one may have been tempted to consider the group as representative of the community. However, the following observations question the effectiveness of the method: no woman selected in the first community, an average of two women out of thirteen PSG members in each group, only three women facilitators out of thirty (total) and no poor person in any PSG. These outcomes clearly indicate that the PSGs are not necessarily as representative of the targets of the intervention as expected. This revelation underscores the fact that participation in community groups is gendered and also not for the poor. Full participation in selecting group members is an admirable goal, yet it is quite challenging to make the final group fully representational. One could argue that women and the poor risk exclusion even from the groups that seek to promote their interests. I observed that while the poor were excluded because of poverty, women’s exclusion was due to their position in society regarding leadership roles.

For women, the explanation for their exclusion is largely embedded in the culture and historical system in Ghana where women seem to be confined to their reproductive role. A woman’s position is reflected in proverbs that reinforce traditional values. One popular Akan proverb is: “Even if a woman possesses a talking drum she keeps it in a room belonging to a man” (see Van der Geest 1975). Only chiefs in Ghana own talking drums. This means that no matter how great a woman is, she has to depend on a man. The proverb is emblematic of Ghanaian women’s experiences and illustrates their subordinate position regarding public leadership. Therefore, despite women’s inclusion in community and national activities being on the national agenda for decades, women continue to be less represented in heterogeneous groups – even if the project is in their domain.

Women’s disadvantages in health and wellbeing have been documented. Buor (2004) observed in his study of utilisation of healthcare in Ashanti Region that women have greater need for services than men, yet they have less access to quality care. He reported that there is a male dominance of decision-making, including causing women to have poor access to healthcare. Ironically, this study was carried

\textsuperscript{12} An average of three visits was paid to each intervention community during the PSG selection process.
out in communities with matrilineal dynastic descent and inheritance; yet, the women were not perceived to be capable leaders. This shows the contradictions that exist between women’s social power and leadership roles in Ghana. Women’s non-selection in the first community illustrates that despite all the rhetoric about gender equality and mainstreaming, women are still relegated to the background regarding leadership positions. One point that emerged during the community conversations was that most people find it difficult to accept a woman as a leader. Some authors have shown contradictions in women’s positions. Van der Geest (1975), in his study in Kwahu, Ghana, observed that women’s subordination does not reflect reality. He showed that women have considerable power in traditional and modern politics. Bartle (n.d.) speaks of a covert gynaecocracy. Both authors argue that women’s power is hidden under a barrage of ideology expressing male dominance (van der Geest 1975, Bartle n.d.) and illustrate this by pointing to women’s position in traditional governance in Ghana. A queen mother is a member of the chief’s counsel and influential in selecting a chief. On the lineage level, the male head is assisted by a female. In these positions, women take part in all discussions and their opinions are much respected, but remain in subordinate positions. At the national level, access to formal education and income generation activities have empowered and enhanced the image of women. They are seen as vessels of development just like men, yet their representation in leadership positions is still low. It is intriguing that women’s leadership capabilities are underestimated and they are the last to be thought of as leaders.

Therefore, it is no surprise that in local and national gatherings women are not considered first as potential leaders. In Parliament, women generally occupy about 10 per cent of the seats in Ghana. In the current Parliament, they form only 8.3 per cent though they constitute the majority (52.1%) of the population (Ghana Statistical Service 2012). Women are perceived as trespassers or supporters who are often brought out to campaign and win votes for men. I observed during the PSG formation that even the women did not nominate fellow women for consideration. This suggests that their leadership capabilities hardly intrude into the consciousness of men and women. I argue that women do not see themselves as capable of occupying leadership positions and therefore do not elect each other. Otherwise, they would have nominated other women and voted for them, since they usually form the majority in such gatherings to enhance their image.

Critical feminist theorists emphasise women’s social exclusion and the need for their emancipation. In the view of Lauer (2006: 622-623) for women to be able to take up leadership roles requires “Profound qualitative change in the nature of social transformation for the country overall, both in its crucial domestic development policies and in its profile as a nation participating in the broader geo-political environment.” She showed that the causal effects of women’s secondary leadership
roles go beyond correcting gender-specific injustices, because circumstantial conditions responsible for such a change have very little, if anything, to do with gender differences. I add that to achieve such a qualitative change, efforts should be directed at both men and women and the focus should be more on the later to encourage them to assume authoritative and self-efficacious positions. It is only when women recognise their capabilities and have confidence in themselves and their peers that they can nominate, be nominated and voted for as leaders. Taking such a stance could help break the antecedents of women’s exclusion from leadership to make meaningful change.

With regard to the exclusion of the poor – the main targets of the NHIS policy and also the intervention – their exclusion from the PSGs indicates that the selection method did not achieve the objective that all actors must be engaged when addressing a phenomenon that affects them. The reason for their exclusion is pithily expressed in another Akan proverb: “Ohiani ano nnuru bawam” (A poor man’s voice is not heard on the floor of meetings). When put in the context of this study, it means no one takes what the poor say seriously during community gatherings. Other researchers have made similar observations. In his study of respect among the elderly in Kwahu, Van der Geest (1997) observes that having money measures one’s prestige and level of respect in the community. Similarly, Mercier (2002) found in her study of women’s groups in Tanzania that groups consisted mainly of the middle class. She reported that the poorest women were excluded on social grounds. These observations demonstrate that poverty is not only associated with economic status, but also a lack of recognition and access to social networks and groups (even those groups that seek to promote their interest). As revealed later in this book, the core poor, who need health insurance most, are denied access to it as they are almost entirely overlooked.

Thus focusing exclusively on an open election process as the basis of involvement has the tendency to reinforce rather than challenge the status quo. Without devising strategies alongside an open election to ensure that all sub-groups are represented means that only lip-service is paid to participation. The implication of this finding is that this approach leaves the poor trapped at the bottom of a socially stratified class system with no possibility of challenging their condition. Lasker & Weiss’ (2003: 39-40) also observe that to solve complex community problems, a collaborative process needs to “… involve diverse groups of people from different backgrounds to regularly listen to each other, talk with each other, and influence each other ... Without it, a collaborative process cannot achieve individual empowerment.” Concluding, I argue that when poor people are treated as objects of concern and not directly involved in intervention groups, they remain powerless, dependent and unable to harness external support to gain access to decent healthcare.
Conclusion

This chapter has shown that much is gained from involving stakeholders in an intervention programme from the onset. It indicates that if all stakeholders assume the responsibility of creating PSGs, they are capable of developing effective methods of selecting who can best represent their interest. Being in charge of events creates trust among participants and the commitment to achieve the set objectives is developed. Challenges might come up, but compromises are easily reached to ensure the task is completed. This approach also provided information on the important criteria people considered when selecting their representatives: the person’s commitment to promoting the welfare of others and development of the community, good conduct and non-engagement in local politics. However, the low representation of women and exclusion of the poor indicate that unless strategies are developed to include these two groups, the open election processes reduce participation to abstract theory. The key challenge for critical medical anthropologists, then, is how to increase the participation of women and the poor within the context of multi-level perspective to ensure that no category of actors involved in a phenomenon is marginalised.

In the case of health providers and DHIS staff, with the benefit of hindsight, their selection based on their work schedule meant that some people who were not willing to devote their time and effort to PSG activities got into the group. As revealed in subsequent chapters, it was naïve for heads of institutions to base their selection solely on a DHIS staff work schedule and assume that they would perform. Their effective participation requires personal commitment and an inclination to pursue social interest rather than personal gains in the form of salaries and promotions that generally motivate them to excel. Therefore, there is a need to go beyond an employee’s work schedule and use more rigorous procedures to select those who are truly interested in the intervention.

In the case of facilitators, selecting them on the durbar day meant that some unreliable persons were chosen to lead PSGs. Later events showed that those who nominated themselves were not honest enough to be given that responsibility as they misappropriated funds provided for PSG activities. This suggests that self-selection could be a sign of self-seeking individuals whose intention is to highjack leadership positions to pursue their selfish ends. This is a revelation that programme managers should watch out for and they should be sceptical about anyone who nominates himself or herself to be a facilitator. It is therefore important that facilitators are taken through a rigorous screening process to allow dubious characters to be rejected by their colleagues at the start. This would minimise the incidence of those who are not trustworthy becoming leaders. This is particularly important, since the facilitators were expected to be the catalysts around whom sustainability and effectiveness of the group rested. Further, training for facilitators was found to be an
important motivating factor that helped them develop the zeal to lead the group through the intervention period. The training equipped the facilitators with skills that increased their confidence and commitment to the intervention.

Finally, although the scope of this study is limited (covers only seven communities in one region), it provides systematic documentation of the steps that were followed, activities performed and the roles that the stakeholders’ played at each stage. This contributes knowledge to the literature on the formation of stakeholder groups and could be a useful framework that can be adapted in other contexts. How PSGs function to identify, develop and implement interventions to improve enrolment in the NHIS and retain members is discussed in the next chapter.