

# The Challenge of Communicating Change: A Case Study of Ghana's Community-based Health Planning and Services (CHPS) Policy

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## Abstract

In settings where health reform has been launched, the momentum for organisational change is slow because information used for management decisions assumes a top-down character at the expense of lateral and bottom-up models that seem more appropriate. While no one communication approach is sufficient, this study investigated the effect of exposure to six communication mechanisms under Ghana's pro-poor Community-based Health Planning and Services (CHPS) policy. Findings show that districts' exposure to the various information sources directly correlates with progress made in the implementation of CHPS.

**Keywords:** innovation, laggards, moderates

## 1. Introduction

Health care is rich in evidence-based innovations, yet even when such innovations are implemented successfully in one location, they often disseminate slowly – if at all. This is partly because conditions under a pilot study are markedly different from those experienced during scale up of results of the pilot. One other issue has to do with how the results are communicated that puts managers at ease about the feasibility of scale up outside experimental conditions. Communication is increasingly recognized, communication is seen, at least conceptually, as fundamentally a two-way rather than one-way; bottom-up as opposed to the top-down hierarchic approach; interactive and participatory rather than linear.

Increasingly, the need for "bottom-up" and "lateral" communication is particularly crucial to health reform initiatives that build strategies on findings from operations research into large-scale organizational reform programmes. One question always comes up: How can the "top-down" and "bottom-up" communications be combined with peer exchange mechanisms that prioritize learning-by-doing?

An experimental project in northern Ghana has provided a platform for testing the relative efficiency of a combination of the "top-down", "bottom-up" and "horizontal" or "lateral" communication mechanisms. This adds a new impetus to the ever-revolving nature of communications, thus successfully shifting away from a "one-to-many" model of communications to a "many-to-many" model (Tiffany Shlain, 2006).

Launched by the Ghana Health Service in 1994 as a pilot project, and expanded in 1996 to a factorial trial, the Community Health and Family Planning Project (CHFP), explored the effects of two sets of strategies for mobilizing existing resources for health service delivery. i) traditional mechanisms for community organization and mobilization and ii) underutilized resources of the health service system, such as community health nurses, who were based in inaccessible clinics rather than communities. Two domains of the resource mobilization were tested independently, jointly, or not at all, comprising a four-celled factorial trial that was evaluated with fertility and mortality endpoints. The overall aim of the experiment was to determine the most appropriate means of bringing health to the doorsteps of poor people in hard-to-reach locations.

### 1.1 Results

Three years into the experiment, results came into sharp focus. The experiment had an immediate impact on knowledge of contraception and a major impact on health service coverage and utilization. Contraceptive use shot up from 3% to 20% in the area where the nurse works in the context of active community support; childhood immunization coverage also increased from 30% to over 83%. Infant mortality rates declined from 141 to 96 per 1000 live births (Fred N. Binka et al., 1995). Total fertility rate (FTR) declined 15%, the equivalent of one birth per woman (TFR from 6 to 5 children), representing the largest fertility effect ever demonstrated in Africa through programmatic intervention.

*The Navrongo experiment* thus demonstrated, convincingly, that community mobilization combined with community-based deployment of the nurse represents the most effective innovative intervention to enhance service coverage and utilization (Fred N. Binka et al, 1998).

### 1.2 Scale-up challenges

Initial deliberations on the potential use of results of *The Navrongo experiment* focused on the possibility of extending operations to the three northern regions where the health indicators, cultural institutions, and ecological zone were similar to Navrongo. However, this option was redirected by the Ministry of Health in

favour of an approach that would foster the diffusion of operational change throughout Ghana simultaneously. The Ghana government in October 1999, adopted the Navrongo innovation as the basis for organizing community-based health service operations. Known as Community-based Health Planning and Services (CHPS), the new policy initiative became an integral component of the government's national poverty reduction strategy (Opt cit).

Enthusiasm for starting community-based care based on the Navrongo model quickly outpaced the capacity of the health system to cope. Districts were ready to launch CHPS but had no idea how to proceed (James F. Phillips et al, 2006). Since 2000, efforts to replicate and scale up CHPS have been implemented throughout the country. As of 2004 reports by the CHPS Secretariat indicated that 106 of the 110 districts nationwide had launched preliminary activities for implementing CHPS although only about 3 percent of the population receives the services of a resident nurse. An overwhelming number of districts are unable to proceed beyond the planning stage.

In 2005, a baseline survey conducted in 28 selected districts in the seven southern regions of Ghana by the CHPS Technical Assistance project revealed that, although 22 percent of the population in the 28 districts is covered by the CHPS "planning milestone," 13.2 percent of the population lives in functional CHPS zones, i.e., zones where community health officers are posted and providing services (Population Council, 2006).

### *1.3 Bridging the implementation gap*

The implementation gap is attributed to lack of actionable information. Here communication was seen as playing a unique role in fostering the diffusion of the Navrongo health innovation based on solid scientific evidence about what has worked in decentralizing access to basic health services for the poor.

As Barnes, Grace (2007:73) points out, innovations should be predicated on proper identification of the healthcare needs of the people so that policies can be well tailored to meet the needs of the health service users. Since CHPS became a national policy, enthusiasm for community based care has grown but this did not automatically lead to increased health service utilisation (James F. Phillips et al (2006). The wide geographical disparity in the implementation of CHPS is attributed to many factors including insufficient information. Health managers have expressed concern that once CHPS is launched, the requisite information for accelerating the pace of organisational change is either lacking, inadequate or diffused through inappropriate channels, all of which hinder rather than help the adoption process. This constitutes a setback to the diffusions model (Rogers Everett M, 1962) which represents the conceptual framework for the diffusion and adoption of innovations.

Indeed critics such as Florangel Rosario Braid (2006:186-190) have criticised Rogers' diffusion model as being inappropriate for developing countries, and called for an abandonment of the "vertical" approach to diffusion in favour of more "horizontal" methodologies emphasizing access, dialogue and participation.

Rogers himself acknowledged the deficiencies of his diffusions model which itself may be the biggest barrier to the adoption of innovations. He began advocating for the principles of "bottom-up" participatory planning as against earlier editions of his work that focused on the "top-down" diffusion of technology (Rogers Everett M, 1962; Rogers, Everett M. and F. Floyd Shoemaker (1971). In later editions (Rogers Everett M, 1983, 1995, 2003) he emphasized the role of communications for social change in the development process.

According to Adam Rogers (2005), communications for social change or Development Communication, as he called it, is "the planned use of communication in any effort to improve the lives of the poor, be it through engaging them more fully in decision-making processes, or getting them to adopt new practices that will make their lives easier, healthier and more secure".

Whereas mass media channels are more effective in creating knowledge of innovations, interpersonal channels are more effective in forming and changing attitudes toward a new idea, and thus influencing the decision to adopt or reject a new idea (Rogers Everett M, 1995:409).

Gray-Felder, D. and Deane, J. (1999) recommend a process of dialogue through which people realize "who they are, what they want and how they can get it". The researchers emphasize that the true power of communication is to give people the confidence and conviction to own the process and the content of communication in their communities. This is the thinking behind the mixture of different (top-down, lateral and bottom-up) communication mechanisms developed to facilitate the CHPS implementation process.

Bridging the implementation gap in the CHPS process and providing impetus for speeding up the process of organizational change, six communication mechanisms were instituted. Navrongo, in addition to its core mandate of conducting research on health and policy issues, was to continue playing its key role in disseminating lessons from its research by orienting visiting teams to *The Navrongo experiment*. The six communication mechanisms are explained below.

#### *1.3.1. The CHPS Implementation Guides*

The CHPS Implementation Guides, developed by the Johns Hopkins Centre for Communication Programmes, contain a roadmap to CHPS implementation. The approach captures the CHPS process in six implementation milestones; Planning, Community Entry, Community Health Compound, Community Health Officer, Essential

Logistics, and Volunteers. These have been broken down into 15 steps and 20 activities with detailed explanation about what is expected at every stage of the process (PPMED/GHS (2002). Though the milestones are distinct they are by no means discreet. However, Richard Killian and others (2002) observed that “the most frequently named criteria for selection of communities for CHPS implementation were remoteness, inaccessibility, and distance from a Health Centre and deprived (sic) ... community preparedness was infrequently mentioned”. Their assertion that “it would take effective coordination and leadership for CHPS to achieve its objectives, the many challenges notwithstanding,” will come under investigation as part of the study.

#### 1.3.2. The *What works? What fails?*

The Navrongo Health Research Centre created the *What works? What fails?* series as a bottom-up communications approach to assist health workers adapt innovative service strategies to local circumstances and needs. The *What works? What fails?* series provides a mechanism for participants of the Community Health and Family Planning (CHFP) project or the *Navrongo Experiment* to communicate their experiences and insights to District Health Management Teams throughout Ghana. These newsletters also enable CHFP skills to be shared more broadly elsewhere around the world to show what has worked and what has failed in an experiment to make primary health care more accessible to rural people. *What works? What fails?* based its approach on the principle that communities, service providers and managers develop ownership when they participate in the development and improvement of systems and processes for service delivery.

A typical *What works? What fails?* is a 1,200-word, two-page, easy-to-read leaflet. Every newsletter stands independently and reflects information about the experiment and the processes and roles of the various stakeholders. Various strategies used in the documentation include personal testimonies and in-depth interviews with principal investigators, field coordinators, research scientists, paramount chiefs, community opinion leaders, ordinary community members, clan and lineage heads, health committee members, health volunteers, community health officers. Some notes are also based on review and simplification of published scientific papers on the CHFP.

In all, 89 title notes have been written, printed and circulated over a period of three years. Notes are distributed first to paramount chiefs in the district, Community Health Officers, and health volunteers. Notes are then snail-mailed to all districts countrywide using a distribution list which includes Nurses Training Institutions, universities, some national and international NGOs, libraries and diplomatic missions.

#### 1.3.4. The National Health Forum

The National Health Forum on CHPS was created in 2000 as the crucible for national discourse and consensus building on how to fast track the national CHPS programme. A typical Forum brings together between 150-200 people made up of health managers, policy makers, programme implementers as well as development partners and potential donors who share knowledge and experiences on issues related to implementation of CHPS as a national programme.

The Forum 2000 gave participants an insight into the new health service delivery regimen by clarifying the concept and definition of CHPS. It reached a broad consensus that implementing CHPS represents a complete paradigm shift in service provision and will depend on innovation and regular sharing of experiences from the field – a process of learning-by-doing – to speed up the process.

The Forum 2004 under the theme, “Community Partnership for Health development” built on the maiden one and reached a clearer understanding of CHPS implementation mechanism and coordination. It also reviewed the CHPS Operational Policy and the CHPS Implementation Strategy which set the contours of a roadmap for rolling out CHPS within the 5yr Programme of Work. The Forum evolved strategies for marshalling resources for CHPS implementation, and agreed that implementing CHPS requires the concerted efforts by all stakeholders and not simply the Ghana Health Service alone.

#### 1.3.5. The Peer Advocacy Programme

To free resources from both governmental and non-governmental sources, the CHPS technical assistance (CHPS-TA) project supported by the USAID, implemented a peer advocacy programme on CHPS with political authorities at the district level. The programme used the interpersonal and learning-by-doing communication approach in which high-performing districts are paired with those wishing to learn firsthand how to launch and sustain a CHPS programme. This initiative was based on the conviction that districts that are the most advanced in CHPS have considerable experience in addressing practical challenges in implementation and can help others speed up the process. During the exchange, visiting teams share experiences with their counterparts and visit a functional CHPS zone to interact with the CHO and health volunteers. The visiting teams also attended a community durbar where they learned more about the benefits of CHPS and hear testimonies about community contributions to getting started. The program proved that peer exchange is an effective organizational diffusion methodology that facilitates lateral communication and adoption of innovations. District-to-district peer advocacy learning exchanges improved understanding of the CHPS concept, accelerated its launch, galvanized local level political support, and leveraged resources for its implementation.

The CHPS-TA Final Project Report (Population Council, 2009) indicated that the number of District Assemblies supporting CHPS rose from 8 at baseline in 2005 to 15 by midterm in 2007 and 29 by the end of the project in 2009. It noted that before the advocacy programme, the total contribution to CHPS in the 30 project districts was GH¢11,700 approximately (US\$8,000). However, within a year after the first advocacy event, support for CHPS increased by almost 700 percent to GH¢88,000 or US\$61,000. The number of Functional CHPS Zones in the 30 districts equally increased (Population Council, 2008).

#### 1.3.6. The *CHPS News*

Various stakeholders such as policy makers, health managers, regional and district directors of health services, development partners, the media, District Assemblies, NGOs, the general public, and members of the scientific community needed to access and share appropriate information relative to CHPS. CHPS-TA introduced the CHPS NEWS newsletter as a bottom-up and lateral communication tool for exchanging experiences in CHPS and sharing best practices and innovations in the implementation process. In all, 72,000 issues of twelve editions of the newsletter were distributed to all relevant stakeholders associated with the implementation of the CHPS initiative across the country, which includes regions and districts that are not covered by CHPS-TA. Monitoring reports showed that the newsletter reached its target audience; twenty-six districts out of 30 reported they had received at least two editions of the newsletter (Population Council, 2009).

#### 1.3.7 The CHPS Video

In recognition of audio-visuals as formidable communication tools, the CHPS newsletter was complemented by a 30-minute (with a 15-minute version) CHPS video documentary entitled “Close-to-Client”. The documentary was produced and aired twice weekly during primetime on national television networks. The CHPS video was conceived basically as an advocacy tool to engender policy reform, galvanize political support and leverage resources from public and private entities for CHPS implementation. Members of Parliament, District Assemblies, Non-governmental organisations, and development partners constitute the primary audience. Over 240 copies of the video were subsequently distributed to relevant stakeholders across the country.

The effect of these communications mechanisms on clarifying key concepts for rolling out CHPS remains a subject of intense debate. Nyonator Frank et al (2005) has noted that many districts still lack a clear understanding of the CHPS concept. “Without a firm grasp of the concept of CHPS,” concludes Nyonator, “fears about starting CHPS remain largely justified”. The extent of exposure of districts to these major sources of authentic news and information about CHPS gives a fair indication about the level of preparedness of districts to roll out the health innovation.

## 2. Methodology

A cross-sectional survey was conducted using structured questionnaires to conduct interviews with health managers, frontline cadres and health volunteers in CHPS process.

### 2.1 Aim

The overall aim of the study is to assess the level of exposure of health managers, frontline cadres and health volunteers to the six communication mechanisms and its effect on the implementation of CHPS.

### 2.2 Sampling

An exploratory study was conducted to clarify key concepts. All Functional CHPS Zones (FCZs) in all 30 districts under the CHPS Technical Assistance (CHPS-TA) project as contained in the “2008 CHPS-TA Assessment Report of CHPS Implementation” (Population Council, 2008:4) constituted the study population. The number of FCZs was used as a proxy indicator of progress in CHPS. Using this criterion, districts were classified as “Innovators” (doing exceedingly well), “Moderates” (doing fairly well) or “Laggards” (performing below expectation). Only four districts qualified as “Innovators”. Six districts each from the “Moderates” and “Laggards” were randomly selected. Three more “Laggard” districts from the Central region, which had 40% of the districts (12 out of the 30), were included to give the region a fairer representation and Laggard districts a better chance of being heard. Thus the total number of districts for the study was 18. Three Functional CHPS Zones were randomly selected from each selected district, thus 54 FCZs. Two volunteers were also randomly selected from two different communities in each Functional CHPS Zone, thus 108 volunteers.

### 2.3 Data collection and analyses

Questionnaires were pretested from June 28 to 30, 2009 whilst actual data collection was conducted from July 11 to 31, 2009. The study is non-invasive and did not cause any physical harm. Permission was obtained from the District Health Administration before interviews were conducted. The purpose of the study was first explained to respondents by trained data collectors and respondents’ verbal consent obtained before the interviews. Where the target respondents were not available, those next in command were interviewed. Since these are role responsibilities, the representatives are considered competent enough to answer the questionnaires and their views are held as valid. Respondents were assured of confidentiality of their identity in the study. Data

entry was done simultaneously as questionnaires came from the field. Data was entered and edited in EpiData 3.1 and transferred to SPSS 16.0 for analysis. All data was entered twice thereby subjected to 100% verification.

#### 2.4 Limitations of study

Only districts supported by the CHPS-TA project were sampled for the study. Since all these districts are in southern Ghana, the views expressed may not necessarily mirror the general picture of CHPS implementation in the entire country. The reasoning being that northern Ghana and southern Ghana are different in terms of geography, settlement patterns and economy. CHOs had to be relied upon for the selection of volunteers since it was practically impossible for the researcher to do so without such assistance. In the process, CHOs may have selected communities and volunteers of their preference and not necessarily randomly, thus introducing some bias into the sampling procedures which the researcher himself sought to avoid. This may have affected, though insignificantly, the outcome of this research work.

### 3. Findings

Seventeen District Directors of Health Services out of 18 were interviewed, representing 94% response rate. Of the 54 CHOs expected, 49 or 91% were interviewed whilst for volunteers, 96 out of 108, representing 89%, were interviewed.

#### 3.1 The CHPS Implementation Guides

An overwhelming majority (94%) of District Directors of Health Services (DDHS) have seen the CHPS Implementation Guides. All DDHS from Innovator and Laggard districts have seen the Guides as compared to 80% for Moderates. Twenty-two percent CHOs have seen the CHPS Implementation Guides. Of this number, 55.6% are from Moderate districts, none (0%) from Innovator districts and a quarter from Laggard districts. Among District Directors 70.6% knew the Six CHPS Implementation Milestones, 29.4% did not. All District Directors from Innovator districts knew the Six Milestones as compared to 60% for Moderates and 67% for Laggards.

When asked to choose the three most critical Milestones, District Directors from Innovator, Moderate and Laggard districts chose "Planning" and "Community Health Officer (CHO)" as the first two. However, whereas Innovators chose "Community Entry" as their third most critical Milestone, Moderates chose "Logistics" and Laggards chose "Community Health Compound". Thus districts prioritize the Six CHPS Implementation Milestones differently depending on their level of CHPS implementation. Among CHOs, 33.3% from Innovator districts knew the Six CHPS Implementation Milestones as compared to 41.2% for Moderates and 63.2% for Laggards. Whereas knowledge of the Six CHPS Milestones among District Directors increased with progress in CHPS, it decreased among Community Health Officers. This partially supports the view held by Phillips JP et al (2003) that where CHPS is working people are less concerned about steps and milestones – they just focus on practical ways of getting things done.

When asked to choose the three most critical of the Six Milestones, all Community Health Officers in Innovator, Moderate and Laggard districts unanimously chose "Planning", "Community Health Officer" and "Logistics". This is not surprising; as the frontline staff in CHPS service delivery, Community Health Officers are the first to face the practicalities of CHO deployment which is equipment for service delivery.

#### 3.2 The What works? What fails?

Nearly a quarter (23.5%) of District Directors have seen the *What works? What fails?* series. No Innovator, 20% of Moderates and 33.3% of Laggards have seen the *What works? What fails?* series. Only 4% of Community Health Officers have seen the *What works? What fails?* series whilst an overwhelming majority have not. Thus those lagging behind in CHPS are those most likely to have seen the *What works? What fails?* series.

#### 3.3 The National Health Forum

Nearly two-thirds (59%) of District Directors have attended the National Health Forum on CHPS, whilst for Community Health Officers, only one in ten (11%) has attended it. Whereas 66.7% of District Directors who have attended the Forum are from Innovator districts, two-thirds are from Moderate districts and 55.6% from Laggard districts. Thus the more advanced the district is in the implementation of CHPS the more likely it is for District Directors to have attended the National Health Forum.

#### 3.4 The Peer Advocacy Programme

Four out of five District Directors in Moderate and 77.8% in Laggard districts have attended an advocacy programme with District Assemblies as compared to 66.7% for Innovators. This finding was to be expected because the advocacy programme is meant to pair districts lagging behind with those making the most progress in CHPS to foster peer learning. Innovator districts were not likely to have been invited to be part of the learning exchanges except if they were hosts.

#### 3.5 The CHPS NEWS

Nearly one out of ten (88%) District Directors have seen the *CHPS NEWS* newsletter. All District Directors from Moderate districts, 88.9% of Laggards and 66.7% of Innovators have seen the CHPS newsletter. Close to two-

thirds (36%) of CHOs have seen the CHPS newsletter as compared to 19% of Health Volunteers who have seen it. Of the almost one fifth of volunteers who have seen the CHPS newsletter, 38.9% are from Innovator districts, 31.4% from Moderate districts and 13.9% from Laggard districts. As with District Directors of Health Services and Community Health Officers, Community Health volunteers in districts advanced in the implementation of CHPS are those most likely to have seen the CHPS newsletter. Thus the CHPS newsletter which shares best practices in CHPS has been more popular with Innovators than Moderates and Laggards.

### 3.6 The CHPS Video

With respect to the CHPS Video, 88.2% of District Directors as compared to 71% of Community Health Officers and over a quarter (26%) of Health Volunteers have seen it on national television. All District Directors from Innovator districts, 80% of Moderates and 89% of Laggards have seen the CHPS Video on television. With regard to Health Volunteers, 38.9%, 11.4% and 16.7% in Innovator, Moderate and Laggard districts respectively, have seen the CHPS Video Documentary on television. Many more districts are likely to have seen the video but not necessarily on television since copies were distributed to all districts.

### 3.7 Other sources

Other sources for diffusing CHPS information included workshops, radio, newspapers, peers, durbars, television, and the Internet. When asked which of these has been the most useful channel for diffusing CHPS information, 81.8% of District Directors mentioned “workshops” as against 18.2% who cited Television. All District Directors in Innovator and Moderate districts as compared to a third of those in Laggard districts chose “workshops”.

Thirty-seven percent of Community Health Officers consider “workshops” as the most useful channel for diffusing CHPS information. Nearly a quarter (24%) chose “television”, 5% chose radio and 2% chose “newspapers”. Learning exchanges, books, colleagues and staff meetings make up ‘other sources’.

When asked which source has been the most useful for diffusing CHPS information, 64% of Community Health Volunteers mentioned “workshops”. Over one-tenth (11%) chose “television”, 6% chose “radio” and 2% chose “colleagues”. Seventeen percent mentioned ‘other sources’ which include durbars, information, and education and communication materials. “Newspapers” did not feature as a useful source for diffusing CHPS information for Community Health Volunteers. This may largely be because most Community Health Volunteers are non-literate.

## 4. Conclusion

The analyses show that districts at the various stages of the CHPS process (Innovators, Moderates and Laggards), have been exposed differently to the various communication mechanisms designed to guide implementation. However, districts doing very well in CHPS are those most likely to have been exposed to the communications channels.

Inadequate knowledge of the Six CHPS Implementation Milestones is widespread, and this largely explains why districts making little progress in CHPS are stuck at the planning stage, unable to move forward. Both health managers and frontline staff in all three categories of districts under this study, rightly see “Planning” and the “Community Health Officer” as the two most important Milestones in the CHPS process. This, among others, indicates that districts may not be implementing CHPS according to prescribed procedures.

The Community Health Compound is the most capital intensive of the Milestones. By prioritizing construction of a Community Health Compound, districts lagging far behind in CHPS have shot themselves in the foot by choosing a Milestone that is the most difficult to achieve. This largely explains why progress in CHPS among Laggards is much slower.

Good information is still considered to be the best medicine. It is more likely that a new idea or practice will be adopted if the receiver is involved in a dialogue and discussion about his or her own needs, alternative courses of action, and acquisition of resources to accomplish development goals. All the communication mechanisms may have been successful in building consensus and clarifying roles and responsibilities in the CHPS process but what people need is practical knowledge defined as actionable information for decision making that enables health managers implement the CHPS innovation. A participatory, interactive and interpersonal means of sharing information about CHPS – such as during workshop settings – seems more useful to health managers, community health officers and community health volunteers than the current communication mechanisms, and much worse the traditional communication channels such as radio, television and newspapers.

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Table 1. Regions and districts where interviews were conducted

DISTRICT	REGION
EASTERN	Birim North
EASTERN	Afram Plains
WESTERN	Bia
WESTERN	Ahanta West
WESTERN	Bibiani Anhwianso Bekwai
VOLTA	Nkwanta
VOLTA	Akatsi
VOLTA	Kadjebi
BRONG-AHAFO	Sene
BRONG-AHAFO	Asutifi South
GREATER. ACCRA	Dangme West
CENTRAL	Komenda Edina Eguafo Abirem
ASHANTI	Bosomtwi Atwima.Kwanhwoma
CENTRAL	Asikuma-Odoben-Brakwa
CENTRAL	Assin South
CENTRAL	Cape Coast Metro
CENTRAL	Assin North
CENTRAL	Ajumako-Enaym-Esiam

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