

BMJ Open Local patterns of social capital and sustenance of the Community-Based Health Planning Services (CHPS) policy: a qualitative comparative study in Ghana

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To cite: Amoah PA. Local patterns of social capital and sustenance of the Community-Based Health Planning Services (CHPS) policy: a qualitative comparative study in Ghana. *BMJ Open* 2019;**9**:e023376. doi:10.1136/bmjopen-2018-023376

► Prepublication history for this paper is available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2018-023376>).

Received 5 April 2018

Revised 27 November 2018

Accepted 28 November 2018



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ABSTRACT

Objective Social capital—the resources embedded in social relationships—has been associated with health severally. Notwithstanding, only a handful of studies have empirically examined how it shapes health policies. This paper extends the discourse by comparatively examining how variations in local patterns of structural and cognitive social capital underpin the successes and challenges in managing and sustaining the Community-Based Health Planning Services (CHPS) policy in Ghana. The CHPS is an intervention to address health inequalities.

Design Qualitative study involving individual in-depth interviews and focus group discussions using a semi-structured interview guide. Thematic analysis approach, inspired by McConnell's typology of policy success (or failure) was adopted.

Setting Two rural communities in two districts in Ashanti region in Ghana.

Participants Thirty-two primary participants as well as four health personnel and four traditional and political leaders.

Results Both structural and cognitive components of social capital underpinned efficient functioning of the CHPS initiative regarding funding, patronage and effective information transmission. Sufficient level of social capital in a community enhanced understanding of the nature and purpose of the CHPS policy as well as complementary ones such as the referral policy. Contrary to popular conclusions, it was discovered that the influence of social capital was not necessarily embedded in its quantity but the extent of conscious activation and application. Furthermore, the findings contravened the assertion that social capital may be less potent in small-sized communities. However, elevated levels of cognitive social capital encouraged people to access the CHPS on credit or even for free, which was injurious to its sustenance.

Conclusion The CHPS initiative, and pro-poor policies alike, are more likely to thrive in localities with sufficient structural and cognitive social capital. Lack of it may render the CHPS susceptible to recurrent, yet preventable challenges.

Strengths and limitations of this study

- The study is the first to conduct a comparative analysis of the role of social capital in the implementation of the Community-Based Health Planning Services (CHPS) concept.
- It combined experiences of health service users, practitioners and community leaders.
- Some participants may have over-reported or under-declared their reliance on social capital for decisions and knowledge concerning the CHPS.
- The study was carried out in two communities in the Ashanti region and cannot be said to represent happenings in other places.

BACKGROUND

The study examines the state and functioning of the Community-Based Health Planning Services (CHPS) policy in Ghana from a social capital perspective. Social capital refers to the resources that are embedded in different social relationships.^{1–3} Several studies have found an association between various aspects of social capital and health.^{4–6} Regrettably, the focus on social capital in health and social policy research has been dominated by its direct relationship with health status, with only a few addressing how it shapes health policies.^{7–9} This paper extends the discourse by comparatively examining how variations in social capital underpin the successes and challenges in management and sustenance of the CHPS policy using two community-based case studies. The article is inspired by aspects of McConnell's typology of policy success (or failure) namely, the political (local level) characteristics, programme design and the processes involved in sustaining a programme.^{10 11} Of interest is how elements of social capital explain some of these typologies in the management and sustenance

of the CHPS. The paper thus discusses one of the critical micro-level issues in policy analysis,¹² through the lens of an essential but hugely neglected contemporary social concept particularly in low- and middle-income countries.¹³

The CHPS concept involves a consultative procedure leading to placement of a certified community health officer (CHO) in a locality to provide a package of preventative and basic curative health services.¹⁴ Conceptually, community leaders (traditional leaders, political leaders, opinion leaders, youth leaders) and the public are consulted and charged to raise a part of the project's cost. They are also expected to convene teams of volunteers to help in constructing a structure known as community health compound (CHC), where health services are offered.¹⁵ The CHC also houses the CHO. Some volunteers are trained to assist with patient/public mobilisation, and maintenance of community registers.¹⁴ The CHPS concept was adopted in 1999 after successful trials between 1994 and 2003 in the Kassena-Nankana District as a means to expand and promote access to healthcare.^{14 16} The policy primarily targets people in deprived and remote areas.^{15 17} The strength of CHPS lies in its flexibility to adapt services to local needs and cultural milieus.^{14 18}

Despite the earlier success, sustenance of the CHPS has been challenging in many localities. At a rather alarming rate, health personnel are often in a rush to transfer out of remote and infrastructurally-deprived communities. Others hasten to further their education, leaving their post vacant.^{14 18 19} Moreover, frequent shortages in logistics and materials for CHOs including essential drugs have also been reported.²⁰ Furthermore, the public's understanding of the CHPS concept in many communities is limited. For these reasons, fidelity to the original CHPS model such as close community engagement in the planning and delivery of services are gradually dissipating.²¹ Nonetheless, the CHPS remains critical to health service delivery in Ghana.¹⁶ For instance, 30.4% of family planning drugs or methods administered in 2014 were carried out through CHPS compounds.¹⁶ Therefore, plausible explanations and solutions to CHPS' challenges must be found urgently.

Social capital entails two components: structural and cognitive. On the one hand, structural social capital depicts the 'hard' aspects. It describes 'bonding social capital'—the resources embedded in close relationships such as those with families and intimate friends. There is also 'bridging social capital', which captures weak relationships such as those with neighbours, people in different communities and even a friend of one's friend. The structural aspect also considers 'linking social capital', which refers to the relationship between individuals of unequal power and socioeconomic status. It also describes the relationship between people and prevailing institutions. On the other hand, cognitive social capital represents the 'soft' side of the phenomenon such as trust, sense of fairness, attitudes, norms of reciprocity, sense of belonging

and harmony. Some attribute the essence of social capital to these abstract aspects.^{22–25} The components of social capital and their constituents can operate at both individual and community or ecological levels.²⁶

Earlier research indicates that policies in the shape of the CHPS concept exhibit more promise in localities where residents possess high levels of social capital.^{20 21 27 28} For instance, it is argued that trust—between CHOs and community members—is critical for patronage, especially in times of financial difficulties.^{21 29} A study in China also observed that structural social capital is related to increased utilisation of community-based health services even among migrants.²⁸ Furthermore, in a recent study to identify the sociodemographic determinants of utilisation of skilled birth attendants at the CHPS compounds in Northern Ghana, Sakeah *et al*³⁰ found that such services were less likely to be accessed by women from particular ethnic groups and those with uneducated husbands. Others suggest that the state of many CHPS facilities are linked to the extent of consultation and participation of members of an implementing locality.²⁷

However, a new wave of implementation of the CHPS entails an outright reliance on contractors instead of relying on community resources—at least in the initial phase. This practice has inhibited community participation in implementation and management, and reduced funding from both local and international donors due to increasing cost of implementation.²¹ Interestingly, these observations are not different from a related study of the Health Action Zones (HAZ) in England. It was found that poor collaboration with communities and limited knowledge of community members partly accounted for failures in some HAZ.⁷ Sheikh *et al*⁸ also note that in Iran, high levels of both cognitive and structural social capital (including associational affiliation, trust and citizenry activities) are associated with better operation and functioning of community-based initiatives (CBI) meant to improve health-related quality of life. It is thus high time to usher in further empirical evidence to ignite a rethink of strategies in sustaining the CHPS concept.

METHODS

Study design and context

The paper uses a qualitative comparative case study approach.^{31 32} However, it also adopts precepts of Bartlett and Vavrus³³ 'tracing' comparative logic in addition to the traditional method. This position allows for reconsideration of fluidity in concepts such as culture, place, space and time during case selection, analyses and interpretation. It tilts towards the interpretivist epistemological school of thought.^{34 35} Interpretivist epistemology helps to understand a given problem from the lived experiences and worldview of participants.³⁴ The adoption of comparative case study approach was to enable theoretical and empirical expatiation of social capital through multiple cases.³⁶ Yin³² argues that "if you can even do a two-case study, your chances of producing

Table 1 Variations in some indicators of social capital between the two communities

Community characteristics	Amo (population=3500)	Apem (population=1100)
1 Number of churches/mosques (religious affiliation)	6 (about 85% Christians and 12% Muslims)*	3 (about 92% Christians)*
2 Other associations	2: Women's welfare group Football group (for young men)	5: 1 (peasant farmers group for both sexes) 1 men's group 1 drivers' association (GPRTU) 1 women's group (mainly produce traders) 1 Football group (for young men)
3 Average household size (nuclear family)	4*	6*
4 Frequency of community gatherings	None	▶ At least once every 3 months ▶ Weekly communal work
5 Dominant occupation	Commerce/service with some agricultural activities	Crop farming
6 Ethnicity	Asantes (70%) and Northern tribes (17%)*	Predominantly Asantes (about 96%)*

*Figures were drawn from the quantitative part of the broader study.³⁸

robust results will be better than using a single-case design". It is also postulated that through comparison, researchers and policy-makers can de-centre what is taken for granted in a particular time or place—especially about policy-making after they learn that something was not always so, or that it is different elsewhere, or for other people.³⁷

The paper is part of a broader mixed method study based on a cross-sectional data, which was gathered from the Ashanti Region in Ghana.³⁸ Other aspects of the broader study have been reported elsewhere.^{9 39–41} The Region was selected because it is centrally located and attracts diverse people from other regions. The two forms of data were gathered concurrently. A few of the participants in the qualitative aspect of the study also took part in the survey, which did not focus on the CHPS policy. The case studies involved two communities, namely Amoam-Achiase (hereafter, Amo) and Apemanim (hereafter, Apem), in two districts namely Atwima Kwanwoma and Ejisu Juaben, respectively were used. Both communities had CHPS compounds. The selection of these cases was pragmatic. The case communities and the participants were selected using purposive sampling (deductive theoretical sampling strategy).⁴² Deductive theoretical sampling strategy helps to identify cases of theoretical relevance to a research.⁴² The two districts and the two communities therein presented characteristics that made them unique, yet, comparable regarding socioeconomic indicators such as economic activities and the population size (table 1). The two CHPS compounds also shared similar features regarding staff strength and logistics. However, there were some differences in the services offered. The Amo CHPS provided antenatal and neonatal services in addition to basic curative and preventative services, which were also present at Apem.

Participants

Altogether, 32 young and older adults (19 from Apem and 13 from Amo), participated in the study. They ranged from 18 to 63 years with most of them being females. Only adults were considered because they are more likely to use health services by themselves or even assist others to uptake needed care. The most common educational attainment among the participants was Junior High School, although some of them had attained tertiary level education. Most of them were indigenes of their respective communities. The data were supplemented by experiences of four traditional and political leaders (two from each community). Also, two CHOs from each of the case communities were interviewed to give a balanced perspective to the study.

Data collection

Data were collected through discursive engagements with primary players and users of the CHPS. The data were gathered from June to October 2015. A semi-structured interview guide was used to elicit the data through individual in-depth interviews and focus group discussions (FGDs). Eleven personal interviews and two FGDs were conducted at Apem community, whereas nine individual interviews and one FGD were carried out at Amo with the help of two research assistants. The two FGDs at Apem consisted of five and six participants each. The FGD at Amo community comprised six persons. Some of the participants of the FGDs had been interviewed individually. The mix of the old and new faces helped to generate further information while expatiating on previously puzzling ones. The deductive theoretical sampling strategy was used to select participants for both forms of interviews to ensure a balanced sample regarding sex, age and relationship to the community (whether an indigene or non-native). It was envisaged that such relationships

were likely to have effect on social experiences as regard the CHPS.

The interviews were conducted in-person and lasted approximately 45 min. They were carried out using the dominant local language ‘Twi’, as most of the primary participants could not express themselves in English adequately. All the interviews were audio-taped with permission from the participants. Topics included participants’ demographic information and their previous experiences and reflections from engaging with the CHPS. Emphasis was placed on how social relationships influenced one’s (and communities at large) willingness and ability to use the CHPS and partake in sustaining the initiative as well as their familiarity with its fundamental objectives. In all the interviews (including the FGDs), attempts were made to deliberately elicit the experiences of participants in the form of narrations. Participants were often asked to elaborate on their responses by asking them questions such as ‘and then what happened’. This helped to glean the meaning they ascribed to their individual and collective actions and inactions.

Data analysis

Thematic analysis approach was adopted.³⁵ The interviews were transcribed as well as translated into English verbatim within the first 48 hours by the author and one research assistant. A language expert validated all the transcripts by comparing them with the audio tapes. The analysis started during the data collection stage through constant reflexivity and reflection notes. Initial themes were therefore generated during the field study. The second stage of the analysis concentrated on how both primary participants and key stakeholders used and understood the role of different aspects of social capital in the operations of the CHPS concept. An ‘open coding’ technique³⁵ was used to categorise the data into themes that reflected the components and kinds of social capital (in the form of themes). As part of the process, McConnell¹¹ typology of policy success or failure was used to understand how different aspects of social capital shape facets of the CHPS’ policy. Thus, while an interpretivist paradigm was taken, an abductive reasoning approach³⁵ was also applied to provide a social scientific account of the social world as seen from the researcher’s perspective without losing touch with the world as seen by the participants. The analysis was carried out side-by-side for both cases under each theme. This approach helped to compare and contrast the findings³¹ while incorporating the unique, yet fluid, sociocultural dynamics of the two case settings.³³ Data from both in-depth interviews and FGDs were triangulated throughout the process. To authenticate the categories, themes and the meaning ascribed to them, one academic (social health researcher) and a community health practitioner scrutinised the analyses.

Public involvement

This paper emerged from initial sentiments of participants of the broader study, which indicated that the degree and

depth of social capital do affect the CHPS. This conjecture was then explored. Preliminary findings from the field study were discussed with selected key informants: two health personnel and two community leaders, who represented the interests of the communities and CHPS facilities, for ethical and factual validation.³⁴ Throughout the process, the data remained solely with the researcher. All copies of the data and findings that were made for experts and stakeholders for validation were destroyed after their contribution were ascertained. There was no patient involved in the study.

Ethical approval

All the names used in this paper are pseudonyms that were constructed together with the participants before the interviews to ensure anonymity. Informed consent was obtained from all participants before enrolling them in the study. The study thus followed the international guidelines for conducting health-related research involving humans.⁴³

FINDINGS

The findings are presented under six themes. The first theme (social capital indicators and the CHPS policy) describes the nature and state of various forms of social capital in the two contexts, whereas the others demonstrate how such differences affect the CHPS. They include: Distrust, sense of unfairness and patronage of the CHPS; weak linking social capital distracts operations of the CHPS; and high social capital promotes successful implementation of the referral component of the CHPS. The others are: civic engagement and cognitive social capital enhance affordability of the CHPS; and, elevated levels of social capital have adverse financial consequence for the CHPS.

Social capital indicators and the CHPS policy

Table 1 presents some preliminary indicators of structural social capital in the two communities. Apem residents were predominantly Christians compared with Amo where a considerable number of people were Muslims. Congruent to the religious composition of the two communities, Amo showed signs of heterogeneity considering its ethnic diversity compared with Apem where almost everyone was an Asante (the indigenous tribe). The only other vibrant non-religious association at Amo was a welfare group for women—aimed at seeking the financial and emotional well-being of members.

However, about four vibrant groups were identified at Apem including a peasant farmers group, which helped members in sourcing for market, labour and farming inputs. Membership cut across different classes of people including community leaders (the unit committee chairperson was a member of the group). There was also a women’s group, which focused mainly on members’ welfare and collaborated with drivers’ association to seek transportation for their produce. The drivers’ association

ensured that residents had access to transportation throughout each day while helping members to obtain employment—by connecting them to vehicle owners. There were sports groups in both communities. Nonetheless, the sports groups were more of an ad hoc recreational arrangement although their activities were quite regular. By its physical and other characteristics, Amo was becoming a peri-urban community with features such as increasing population diversity (eg, ethnicity and religious composition) and smaller household size (table 1). However, the scale of urbanisation had not reached the point of being a traditional urban community. Apem remained comparatively small and remote. Notwithstanding, both communities were fundamentally rural and comparable.

While residents and leaders at Apem met regularly to discuss common problems, none of such meetings had occurred at Amo—at least in the last 3 years preceding the study. Therefore, civic participation and communal activities were low at Amo. The low civic engagement at Amo can be gauged from this statement:

The unkempt dump site and the choked gutters all manifest in the kind of sickness we experience here in the community. ...Our toilets are not good. I don't visit those places lest I may contract a disease. ...We used to clean the public toilet and refuse site every week, but for over 3 years now, such activities have ceased. (Yao, 22 years, male, Amo)

By the physical environment in both communities alone, a sharp contrast could be drawn. All public sanitary places at Amo were in the deplorable state. The only public toilet facility was virtually non-functional while the community dump site was unkempt. Residents without toilet facilities at home took to defecating in bushes and along walkways while others dumped faecal matters in plastic bags indiscriminately. Although Apem residents used traditional latrines, they managed to keep the facility (a wooden structure) relatively tidy. In the ensuing findings, the paper elucidates how differences in precepts of social capital in the two communities help to explain the functioning of the CHPS.

Distrust, sense of unfairness and patronage of the CHPS

Patronage of the Amo CHPS was comparatively low. This was partly because people often depended on their structural social capital—particularly bonding, bridging, linking social capital, and group mates—as the primary source of information about the operations of the CHPS concept. Some of the information—which emerged out of sheer ignorance about the CHPS—were sometimes interpreted and transmitted in a manner that dented the image of the concept. This led to denial of the CHPS as the first option for healthcare and even for lay referral:

...I have not been to the clinic myself, but I heard that there is not enough space for patients to rest. ...looking at the building, the structure is not big

enough. ...I think more health personnel are needed. ...There is even no doctor there. (Julia, 55 years, female, Amo)

Currently, attendance has reduced. Last month, I received just 53 clients...I realised that many people had been spreading a falsehood that the cost of care is high (CHPS compound). (Medical officer 1, Amo)

However, the extent to which such distortions affected patronage was imputable to cognitive social capital. High sense of unfairness, suspicions among residents about a myriad of failed development attempts and lack of sense of communality at Amo somewhat accounted for why some residents distrusted the CHPS. Years of distrust in leaders and among members coupled with gradual physical expansion of the Amo community, which had culminated into increased diversity of population characteristics, promoted a sense of unfairness. The CHO lamented bitterly about the community's poor contribution towards the sustenance of the CHPS initiative. Indeed, residents had little interest in collaborating to address common problems due to mistrust among themselves and local leaders as one participant shared:

Our toilet facility is in a deplorable state. ...We need a new one. ... The toilet has been contracted to a private person for about 20 years to build and operate the facility. ...We could have built one as a community, but I don't think people trust the leaders here. ...I do not trust them. ... They took money from us for some projects that never came to fruition. ...They have still not accounted for the money. (Kwart, 34 years, male, Amo)

Weak linking social capital distracts operations of the CHPS

The weak relationship between residents and leaders at Amo had compounded into a situation whereby the local authorities were unable to effectively mobilise the people to educate them about the CHPS concept—an element which was expected of community leadership per the policy design and implementation process. This partly explained why many residents had limited knowledge about the policy and were disinterested in patronising the services or recommending to others as one of the participants revealed:

There was no proper mass education on the functions of the CHPS compound when it was set up here. ...To them, they see every health facility as a 'hospital' (a high order health facility). Also, to them, every health personnel is a doctor no matter the qualification of the person. (Medical officer 1, Amo)

On the contrary, at Apem, even community leaders assisted in instilling confidence in residents about the quality of services—which some people in both localities doubted. Some residents went as far as engaging with community leaders before patronising the CHPS:

People come to me regularly to discuss their health problems and seek information about the CHPS...I think people are not convinced about the quality of the services offered at the CHPS compound. ...Oh yes, whenever I ask people to go to the clinic (CHPS compound), they heed my advice. ...Because I tell them that I always use the services and it works for me and that the nurses are polite. (Local leader 2, Apem)

Moreover, there were fewer suspicions and distrust between the leaders and residents at Apem. Community leaders were regarded as knowledgeable and trustworthy:

...People often go to the Unit Committee chairperson to seek for information about the operations of the clinic. ...Sometimes when we are on outreach programs, people call to ask him about our whereabouts. ...He sometimes takes the contact number of the patients and gets them to come to the clinic when we are available. ...Occasionally, he also hosts the patients at his house until we are available or ready. (Medical officer 1, Apem)

Indeed, the numerous community gatherings made community leaders and the people more proactive about their role in the CHPS concept. Also, the community members had opportunities to discuss their concerns about the CHPS regularly. This underscored their familiarity with the initiative and their willingness to patronise:

The nurses are friendly. Whenever they meet us (community members), they encourage us to come and discuss our health problems with them. ...Except for maternity issues, I know they do the same work as Foase (Hospital), so I always use this clinic (the CHPS). (Faust, 38 years, female, Apem)

High social capital promotes successful implementation of the referral component of the CHPS

It was apparent in both cases that high social cohesion perpetrated by and through strong bridging and linking (close relationship between nurses, leadership and the people) social capital, as well as frequent civic activities (such as community gatherings and interactions), had a positive effect on the public's recognition of the CHPS' operational procedures. This was evident in one of the critical components of the CHPS programme, the referral policy. At Apem, elevated levels of these social capital proxies helped to expatiate and spread supportive information. The expectations of residents were therefore guarded:

... The community leaders organise durbars regularly in this community. ...On each of those occasions, they invite us (nurses) to explain our services to them. ...I think many people now understand that this is only a primary level facility and that we could

refer them to another facility anytime. (Medical officer 1, Apem)

(Exerpts from FGD)

Joyce (30 years, female, Apem): We have a clinic here, but it is not all diseases that they can treat. For the diseases they can't treat, they refer us to other places

Badu (46 years, male, Apem): (jumps in) ...for my wife and I, we mostly go to the Foase Hospital especially when she's pregnant. ...The nurses have told us that they can't handle antenatal issues

In contrast, residents at Amo demonstrated less familiarity with the referral and primary functions of the CHPS partly due to low community engagement during implementation and its operations. This laid the foundation for the lukewarm attitudes towards the services provided. Instead, many sought services of higher order facilities without recourse to the CHPS, although it was physically more accessible.

...There are specific medical procedures that I cannot perform. However, people think everything should be done here. ...So, when I refer them to a higher health facility, they become discouraged. Because of that, I have noticed that some people have ceased coming here. (Medical officer 1, Amo, rural)

(Exerpts from FGD)

Joe (30 years, male, Amo): The nurse at the CHPS compound is responsible for everything so when it's a little busy, she refers people to go to Ejisu Hospital...

Serwaa (45 years, female, Amo): There are not even enough equipment there. ...For my family, we usually go to Kenyasi (Health centre). ...When they announced at the information centre that there was going to be a hospital here, we thought, it would be the end of our problems, but we still go outside for treatment.

This confusion was ascribable to inadequate public sensitisation on the CHPS policy prior to its implementation. Low community interactions and lack of cohesive social activities—which enhance bridging and linking social capital—reduced the public's chances of learning about essential programme objectives and functions such as the referral. One community leader had, therefore, taken it on herself to ensure public sensitisation:

The nurse complained to us (Unit Committee) that attendance had decreased recently...Some people go to Ejisu and Kenyasi. ... I think the nurses need help to be able to perform effectively...This is why I have volunteered to help educate the people. I will make announcements at the information centre to explain things to people. (Empong, local leader 1, Amo)

Civic engagement and cognitive social capital enhance affordability of CHPS

Despite the availability of a pro-poor financial buffer system—the National Health Insurance Scheme (NHIS)—for all persons in Ghana, social capital played a significant role as to whether some groups gained adequate access to such provisions. Between the two cases, only the facility at Apem was accredited with the NHIS. A major explanatory factor was that low levels of communal cohesion reduced chances of the facility at Amo being accredited. The accreditation process at Amo unlike that of Apem was left solely in the hands of the CHO as she explained:

...The facility is not accredited by the NHIS. ... Everyone who has gone there complains that it is expensive. ... This is why I usually go to Kenyasi (a town with health facility) for healthcare. (Serwaa, 45 years, Female, Amo)

...It has been challenging to get the facility accredited by the NHIS. I am doing everything on my own, so I do not get ample time to follow-up. (Medical officer 1, Amo)

However, frequent social engagements at Apem ensured access to affordable healthcare. Regular community gatherings provided an opportunity for penetration of public opinion in matters concerning financial implications of accessing the CHPS. The public opinion pressured community leaders to act accordingly. Indeed, the Apem leaders were instrumental in getting the CHPS compound accredited with the NHIS according to the CHO. This reduced the burden of out-of-pocket payments and consequently increased patronage:

It is through the efforts of the incumbent chief and his elders that we got the community clinic (CHPS)... We spoke about it at our usual meetings, and they took it up. ...I know they helped to get the NHIS for the clinic when we complained about the cost. (Badu, 46 years, male, Apem)

The health facility in this community is very beneficial when you have the NHIS card. ...At first, it was expensive, but since we got the NHIS accreditation, everyone goes there (CHPS). (Addo, 63 years, male, Apem)

Elevated levels of social capital have an adverse financial consequence for CHPS

It was found that sometimes elevated levels of some aspects of social capital had adverse financial consequences for the CHPS in both cases. Some individuals and families (including community leaders) at Apem occasionally exploited their strong association with community leaders and CHOs—thus, linking social capital—to access services of the CHPS on credit and even free. Mostly, this was due to trusting relationships between local institutions and the public.

(Excerpts of FGD)

Interviewer: Has lack of money ever prevented you from visiting the CHPS?

Atta (50 years, male, Apem): No, it has never happened like that but even if I don't have money. ... They will treat me on credit, so I pay later

Interviewer: Really?

Bemah (22 years, female, Apem): Yes, they do that sometimes, and they trust we will come and pay later

(Individual interview)

In some cases, people fail to pay their debts... Sometimes, we have to go after them several times before they pay up. ...We realised that they were taking advantage of their good relationships with us to access our services for free. If you're familiar with the person, it is hard to turn them away because of money. (Medical officer 2, Apem)

Thus, trusting that people will settle their debt later by offering the service on credit endangered the financial sustenance of the CHPS concept. Nonetheless, the depth of social engagements at Apem, advanced the solvency of the CHPS compounds, although neither individuals nor groups directly made financial contributions towards its economic sustainability. Community leaders and some individuals served as watchdogs against bill defaulters by discouraging people from habitually accessing the services on credit:

...We told them (community leadership) about the continual refusal of residents to pay for services on one of those occasions (community meetings)...They immediately enacted a law that no one should visit the facility without money. ...Since then, the vast unwillingness to pay for services has reduced. (Medical officer 2, Apem)

(Excerpts from FGD)

Interviewer: Have you ever received treatment on credit from the CHPS?

Esther (32 years, female, Apem): Yes, but these days it's not everybody that the nurse treats on credit. It is only those she's close with that she does that for and even that she doesn't do it for everyone to see.

Bemah (22 years, female, Apem): ...But people don't make the payments, so the chief has asked them to stop treating people on credit.

Indeed, this measure was in force during the field study. A similar rule had also been enacted at Amo, although it was primarily left to the CHO to enforce it. While the contrasts here do not necessarily mean that the CHPS facility at Apem was functioning perfectly and successful, the relatively high social capital stock manifested positively in the operations of the facility, at least compared with the case of Amo.

DISCUSSION

This paper examined how patterns of social capital influence the functioning and sustenance of the CHPS concept. Consistent with related studies,^{1 27 28} the CHPS concept appeared successful in the locality with high stock of social capital. Based on extensive surveys and interviews in Italy, Putnam¹ asserted that social capital proxies such as associational activities—literacy guilds, service groups, sports groups—accounted for the differences in institutional performance between Northern and Southern Italy. With respect to the CHPS, it was apparent that implementing it in localities with low social capital may render it susceptible to recurrent challenges. Indeed, Halpern²³ posits that any “policy and debate that fail to address it (*social capital*) are doomed to be shallow and unconvincing”. The findings also add to the assertion that ‘health systems are inherently relational and so many of the most critical challenges for health systems are relationship and behaviour problems’⁴⁴ as expatiated below.

Given the uniqueness of the CHPS, its fiscal affairs are sensitive to the prevailing social environment. From the findings, social capital (both cognitive and structural aspects) can potentially impinge or facilitate the solvency of the CHPS. Effective demand, as economists would argue⁴⁵—in using and paying for the services was inextricably related to social capital. The biggest challenge, yet, remains the fact that many, especially rural residents, are poor and can barely afford the NHIS premium⁴⁶ If this continues, reliance on one’s social connections to use the CHPS on credit will only escalate. This finding supports the call for a more equitable distribution of the financial burden of Ghana’s NHIS. The core poor must be continuously identified and offered the chance to register for applicable exemptions, which are unknown to many.⁴⁷ Eventually, this will curb the need to exploit cognitive social capital to access the services on credit.

While financial difficulties hinder NHIS subscription, non-financial factors such as physical access to accredited service providers remain a challenge to residents in many remote localities.⁴⁶ At Apem, elevated linking social capital and civic participation ensured cohesiveness and trust among people. This contributed to a rapid identification and redress of hindrances to the patronage of CHPS and complementary policies such as the NHIS. There is a precedent for this. Fenenga *et al*⁴⁸ concluded from studies in rural and urban Ghana that civic engagements and trust in institutions including the NHIS, encourage patronage. Thus, community-level social capital—social cohesion and trust—partly alleviates inability of the core poor to benefit from these social interventions. For instance, Kotoh and Van der Geest⁴⁷ observed from prolonged studies in Central and Eastern Regions of Ghana that poor people, and especially those in deprived communities, were unable to access the NHIS even though they knew about it. Possibly, such limitations have to do with low social capital in such localities. Hence, the success of pro-poor programmes and allied policy initiatives rally on the depth of social capital as demonstrated in this article.

The referral policy also benefited from high stock of social capital. The case community with high social capital demonstrated ample appreciation of the general and specific characteristics of the referral component of the CHPS. Halpern²³ asserts that high levels of bridging and linking social capital, for instance, indicate a society that is highly interconnected, thereby sharing power and resources through a never-ending and evenly spun web of connections. By such empowerment, community members become gatekeepers for the health system by directing sick persons to a lower-level facility for appropriate evaluation at the onset. Sakeah *et al*,²⁰ therefore, associate community involvement in sensitisation about the referral system to improved use of primary health-care services. Furthermore, vibrant social engagements, coupled with the almost homogeneous nature of places such as Apem (regarding religion, ethnic and economic characteristics) ensured efficient information transmission. Previous works^{1 49 50} show that closed societies facilitated by religious and cultural precepts enjoy trust in public institutions and increases the likelihood of attaining desired behavioural outcomes. This is plausible because many in Ghana are known to consciously depend on their social networks for information and decisions concerning the referral policy and the health system in general.⁹

Moreover, the impact of social capital on the functioning of the CHPS could also be explained by the sizes or nature of the two communities. According to Putnam,⁵¹ small communities (such as Apem) propagate dense networks and nurture cognitive elements such as trust, which increase access to vital resources. Stolle⁵² argues that in areas with stronger, dense, horizontal and more cross-cutting networks, there is a spillover from membership in organisations to the cooperative values and norms that citizens develop. In contrast, others posit that weak or loose ties sometimes allow for efficient information flow and are particularly crucial for facilitating collective action.²² Grootaert and van Bastelaer⁵³ contend that communities with simultaneously high levels of bonding and linking social capital may lead to low levels of social cohesion. It has also been submitted that some small-sized rural communities might instead be too conservative to tolerate differences leading to low social capital.⁵⁴ The situation at Apem differs from these assertions. The difference in the functioning of the CHPS concepts in the two cases speaks to the presence of high social capital—at least for some of its proxies such as trust—as an indication of sufficient institutional performance. The findings in the present study are also consistent with the work of Sheikh *et al*.⁸ They noted from Iran that high levels of both cognitive and structural social capital (including associational affiliation, trust and citizenry activities) are associated with better operation and functioning of CBI that are meant to improve health-related quality of life and well-being. In their study, people in CBI areas had better access to public services and showed less segregation due to income or social status.⁸

To some extent, the findings also challenge the contention of Portes,⁵⁵ who argues that impoverished communities may be poor not necessarily because of their lack of social capital but rather because of the meagre resources they possess. Portes' proposition does not entirely hold when one considers the case of Amo. It was a community with comparatively low social capital (both cognitive and structural forms). While it was becoming peri-urban and had access to a wide range of resources, it failed to support the CHPS concept adequately. The failure of the community to support the policy suggests a new perspective. Thus, although more impoverished, and rural communities may collectively possess fewer resources, it appears that it is the generation and utilisation of available social capital instead of its quantity or diversity that makes an impact on livelihoods. A group with limited resources but located in a highly cohesive society would find a way to nurture the available assets, as the residents of Apem community demonstrated regarding subscription to complementary services such as the NHIS. Therefore, the assertion that the frequency and number of social interactions per se may not alter its impact, has a footing here.^{56 57}

In light of these, one could argue that critical elements of McConnell⁵⁸ typologies of success or failure featured minimally in the case of Amo. Although the policy process and design of the CHPS consider local level contribution as crucial to its success,¹⁴ it appears that little was done to marshal community support through regular consultation and communication as McConnell⁵⁸ advocates. Moreover, consideration of politics in the process may have been left at the macrolevel (district or even among community leadership) in the Amo community, leaving efforts at microlevels where political dynamics are formed, and agitations and opposition to programmes commence, unattended. Thus, while the CHPS as a health programme is pertinent, fidelity to the processes involved in its substance has been inadequate in the case of Amo and other places.²¹ Taking this back to the phenomenon of social capital in both cases, its high stock in the Apem community enabled the people to make collective choices in the public interest—both directly and indirectly about the CHPS through deliberative engagements and controversy resolution,⁵⁸ during community gatherings.

Despite the role of social capital in the differences in management and sustenance of the two CHPS concepts, it may be naïve to over-romanticise it.^{7 59} Such romanticism may “elevate mystical and personal experience over objective coherence, building to a national ecstasy that denies justice and social need”.⁵⁹ Indeed, not all the kinds of social capital were explicitly influential for the CHPS policy. Also, one cannot entirely stipulate that operations of Apem CHPS was successful given that policy success is predicated on attainment of set goals and the extent of criticisms it attracts.⁵⁸ Additionally, some participants may have over-reported or under-reported their reliance on social capital for decisions and knowledge of the CHPS. Moreover, the study was carried out in only two communities in the Ashanti region. Therefore, the findings

cannot be regarded as an absolute reflection of happenings in other contexts. It will be more useful to broaden understanding of social capital's consequence for health policies through repeated studies in similar and dissimilar contexts. A similar study involving more communities and districts as well as other pro-poor policies could expand knowledge. Nonetheless, the present study is the first to conduct a comparative analysis of the role of social capital in managing the CHPS concept, and its findings are critical to improving it.

CONCLUSION

The article examined the relationship between social capital and the sustenance of the CHPS concept in Ghana. Proxies of social capital including trust, sense of fairness and linking social capital were inextricably associated with patronage of the CHPS. Others such as civic engagement, indirectly promoted affordability of the CHPS while ensuring its solvency. According to the findings, social capital does shape the operations of the CHPS and related policies such as the referral system and the NHIS. However, people sometimes exploited their cognitive social capital to access the services on credit or even for free, which can be injurious to its sustenance. The paper suggests that when some of the challenges facing the CHPS concept are situated in the realm of social capital, causes and solutions may be identified. Hence, generating and incorporating it must be a critical component of pro-poor policies alike.

Acknowledgements The author would like to thank Professor David R. Phillips and Professor Roman David for their insightful comments. He also acknowledges the time and efforts of Madam Patricia Amponsaa (opinion leader, Amoam-Achiase), health personnel in the two CHPS facilities and Mr Osei (unit committee chairman, Apemanim), who helped to shape and validate the initial results. Lastly, the author would like to thank all the participants who granted interviews to the study.

Contributors This paper was conceived and prepared by PAA.

Funding The author acknowledges the Hong Kong Research Grants Council through its PhD Fellowship Scheme (reference number: PF13-11276), for funding the research on which this paper is based.

Disclaimer The funders played no role in designing the study, gathering and analysing data, manuscript preparation and the decision to publish the manuscript.

Competing interests None declared.

Patient consent for publication Not required.

Ethics approval The Committee on Human Research Publication, and Ethics (CHRPE) of School of Medical Sciences, Kwame Nkrumah University of Science and Technology and Okomfo Anokye Teaching Hospital, Kumasi, Ghana (CHRPE/AP/345/15).

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement The data used for this study are available from the author. It will only be made available for further research purposes.

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REFERENCES

- Putnam RD. *Making Democracy Work: Civic Tradition in Modern Italy*. Princeton University Press, 1993.
- Bourdieu P. *The Forms of Capital*, in *Handbook of Theory and Research for the Sociology of Education*, G. Richardson, Editor. New York: Greenwood Press, 1986.
- Lin N. *Introduction: Social Capital*, in *Social Capital: Critical concepts in the Social Sciences*, N. Lin, Editor. London: Routledge, 2011.
- Berkman LF, Kawachi I, Glymour MM. *Social Epidemiology*. Second ed. Oxford: Oxford University Press, 2014.
- Blackman TIM, Dunstan K. Qualitative Comparative Analysis and Health Inequalities: Investigating Reasons for Differential Progress with Narrowing Local Gaps in Mortality. *J Soc Policy* 2010;39:359–73.
- Kawachi I, Berkman LF. *Social Capital, Social Cohesion, and Health*, in *Social Epidemiology*. Berkman LF, Kawachi I, Glymour M, eds. Oxford: Oxford University Press, 2014.
- Bauld L, Judge KEN, Barnes M, et al. Promoting Social Change: The Experience of Health Action Zones in England. *J Soc Policy* 2005;34:427–45.
- Sheikh MR, Ali SZ, Hussain A, et al. Measurement of social capital as an indicator of community-based initiatives (CBI) in the Islamic Republic of Iran. *J Health Organ Manag* 2009;23:429–41.
- Amoah PA, Phillips DR. Strengthening the Referral System through Social Capital: A Qualitative Inquiry in Ghana. *Healthcare* 2017;5:80.
- McConnell A. *Understanding Policy Success: Rethinking Public Policy*. Basingstoke: Palgrave Macmillan, 2010.
- McConnell A. What is policy failure? A primer to help navigate the maze. *Public Policy Adm* 2015;30(3-4):221–42.
- Hudson J, Lowe S. *Understanding the Policy Process: Analysing Welfare Policy and Practice*. Second ed: The Policy Press, 2009.
- Story WT. Social capital and health in the least developed countries: a critical review of the literature and implications for a future research agenda. *Glob Public Health* 2013;8:983–99.
- Nyonator FK, Awoonor-Williams JK, Phillips JF, et al. The Ghana community-based health planning and services initiative for scaling up service delivery innovation. *Health Policy Plan* 2005;20:25–34.
- GHS and PPMED. *The Community-Based Health Planning and Services (CHPS) Initiative: The Concepts and Plans for Implementation*. Accra: Ghana Health Services (GHS) and Policy, Planning, Monitoring and Evaluation Division (PPMED), 2002.
- GHS. *Ghana Health Service 2014 Annual Report*. Accra: Ghana Health Service (GHS), 2015.
- MoH. *Strategic plan malaria for malaria control in Ghana: 2008-2015. 2008*. Accra: Ministry of Health.
- Gyapong J, Garshong B, Akazili J, et al. *Critical Analysis of Ghana's Health System: With a focus on equity challenges and the National Health Insurance*: Shield Workpackage, 2007.
- MoH. *Brief on status of Community-based Health Planning and Services (CHPS) implementation*. Ministry of Health, Ghana: Accra, 2012.
- Sakeah E, McCloskey L, Bernstein J, et al. Is there any role for community involvement in the community-based health planning and services skilled delivery program in rural Ghana? *BMC Health Serv Res* 2014;14:1–14.
- Awoonor-Williams JK, Bawah AA, Nyongator FK, et al. The Ghana essential health interventions program: a plausibility trial of the impact of health systems strengthening on maternal & child survival. *BMC Health Serv Res* 2013;13 Suppl 2:1–12.
- Granovetter MS. The Strength of Weak Ties. *Am J Sociol* 1973;78:1360–80.
- Halpern D. *Social Capital*. Cambridge, UK: Polity Press, 2005.
- Lin N. *Social capital: A theory of social structure and Action. Structural Analysis in the Social Sciences*, ed. M.S. Granovetter. New York: Cambridge University Press, 2001.
- Edwards BOB, Foley MW. Civil Society and Social Capital Beyond Putnam. *Am Behav Sci* 1998;42:124–39.
- De Silva MJ, Harpham T. Maternal social capital and child nutritional status in four developing countries. *Health Place* 2007;13:341–55.
- Baatiema L, Skovdal M, Rifkin S, et al. Assessing participation in a community-based health planning and services programme in Ghana. *BMC Health Serv Res* 2013;13:1–13.
- Hou Z, Lin S, Zhang D. Social capital, neighbourhood characteristics and utilisation of local public health services among domestic migrants in China: a cross-sectional study. *BMJ Open* 2017;7:e014224.
- Johnson FA, Frempong-Ainguah F, Matthews Z, et al. Evaluating the impact of the community-based health planning and services initiative on uptake of skilled birth care in Ghana. *PLoS One* 2015;10:e0120556.
- Sakeah E, Doctor HV, McCloskey L, et al. Using the community-based health planning and services program to promote skilled delivery in rural Ghana: socio-demographic factors that influence women utilization of skilled attendants at birth in northern Ghana. *BMC Public Health* 2014;14:1–9.
- Yin RK. *Case Study Research: Design and Methods*. 5th ed. Los Angeles: SAGE, 2014.
- Yin RK. *Applications of case study research*. 2nd ed. London: SAGE, 2003.
- Bartlett L, Vavrus F. Comparative Case Studies: An Innovative Approach. *Nordic Journal of Comparative and International Education* 2017;1:899–920.
- Angen MJ. Evaluating interpretive inquiry: reviewing the validity debate and opening the dialogue. *Qual Health Res* 2000;10:378–95.
- Bryman A. *Social Research Methods*. Fourth ed. Oxford: Oxford University Press, 2012.
- Aveling EL, Martin G, Herbert G, et al. Optimising the community-based approach to healthcare improvement: Comparative case studies of the clinical community model in practice. *Soc Sci Med* 2017;173:96–103.
- Bloemraad I. The promise and pitfalls of comparative research design in the study of migration. *Migr Stud* 2013;1:27–46.
- Amoah PA. *Social Capital, health literacy and access to healthcare: A study among rural and urban populations in Ghana*, Department of Sociology and Social Policy. Hong Kong: Lingnan University, 2017. http://commons.ln.edu.hk/soc_etd/41/.
- Amoah PA, Koduah AO, Gyasi RM. “Who'll do all these if I'm not around?”: Bonding social capital and health and well-being of inpatients. *Int J Qual Stud Health Well-being* 2018;13:1435108.
- Amoah P, Edusei J, Amuzu D. Social Networks and Health: Understanding the Nuances of Healthcare Access between Urban and Rural Populations. *International Journal of Environmental Research and Public Health* 2018;15:973.
- Amoah PA. Social participation, health literacy, and health and well-being: A cross-sectional study in Ghana. *SSM Popul Health* 2018;4:263–70.
- Patton MQ. *Qualitative Research & Evaluation Methods: Integrating Theory and Practice*. Fourth ed. London: SAGE, 2014.
- CIOMS. *International Ethical Guidelines for Health-related Research Involving Humans*. Geneva: Council for International Organizations of Medical Sciences (CIOMS), 2016.
- Gilson L. Trust and the development of health care as a social institution. *Soc Sci Med* 2003;56:1453–68.
- Kaldor L, Barrère A, ed. *The Role of Effective Demand in the Short Run and the Long Run*, in *The Foundations of Keynesian Analysis: Proceedings of a Conference held at the University of Paris I—Panthéon-Sorbonne*. UK: London: Palgrave Macmillan, 1988:153–60.
- Kusi A, Enemark U, Hansen KS, et al. Refusal to enrol in Ghana's National Health Insurance Scheme: is affordability the problem? *Int J Equity Health* 2015;14:2.
- Kotah AM, Van der Geest S. Why are the poor less covered in Ghana's national health insurance? A critical analysis of policy and practice. *Int J Equity Health* 2016;15:34.
- Fenenga CJ, Nketiah-Amponsah E, Ogink A, et al. Social capital and active membership in the Ghana National Health Insurance Scheme - a mixed method study. *Int J Equity Health* 2015;14:118.
- Koenig HG. Research on religion, spirituality, and mental health: a review. *Can J Psychiatry* 2009;54:283–91.
- Yeary KH-cheonK, Ounpraseuth S, Moore P, et al. Religion, Social Capital, and Health. *Rev Relig Res* 2012;54:331–47.
- Putnam RD. *Bowling alone: the collapse and revival of American community*. New York: Simon and Schuster, 2000.
- Stolle D. *The sources of social capital*, in *Generating Social capital: Civic society and institutions in comparative perspectives*: Hooghe M, Stolle D, eds. New York: Palgrave MacMillan, 2003:19–42.
- Grootaert C, van Bastelaer T. *Understanding and measuring social capital: A synthesis of findings and recommendations from the social initiatives*. Washington, DC: Social Capital Initiative, The World Bank, 2001.
- Putnam RD. Tuning In, Tuning Out: The Strange Disappearance of Social Capital in America. *PS* 1995;28:664–83.
- Portes A. The Hidden Abode: Sociology as Analysis of the Unexpected. *American Sociological Review* 2000;65:1–18.
- Kanamori S, Kai Y, Kondo K, et al. Participation in sports organizations and the prevention of functional disability in older Japanese: the AGES Cohort Study. *PLoS One* 2012;7:e51061.
- Lin N. ed. *Social Capital: Critical Concepts in the Social Sciences*. I. London: Routledge, 2011.
- McConnell A, Success P. Policy Failure and Grey Areas In-Between. *Journal of Public Policy* 2010;30:345–62.
- Epstein WM. Romanticism, community and social services. *Journal of Comparative Social Welfare* 2010;26(2-3):117–36.