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Universal health coverage through the community-based health planning and services initiative in Ghana: Hurdles to overcome

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Authors' contribution

AA conceived the study, served as the principal investigator, and drafted the manuscript. AT contributed to the conception of the study, interpretation of data and the intellectual development of the manuscript, and he is the guarantor. MA also contributed to the conception of the study, assisted in data collection and development of the manuscript, and technically reviewed the article. AAS also help to conceive the study, and facilitated the intellectual development of the paper.

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Abstract

Objective: The Community-based Health Planning and Service (CHPS) initiative emerged to facilitate the achievement of Universal Health Coverage (UHC). Although, CHPS, has created one of the best approaches in increasing communities' commitments towards health system strengthening, its performance has dwindled over the years. This study is first of its kind (following the launch of the SDGs) aimed to holistically explore the barriers limiting CHPS contributions to reach UHC in Ghana.

Design: Qualitative study design was adopted to explore the phenomenon. Face-to-face in-depth interviews were conducted from April 2017 until February 2018, through purposive and snowball sampling techniques. Data was analyzed using inductive and deductive thematic analysis approach.

Setting: Data was gathered at the national level, in addition to the regionals, district and sub-district /local levels of four regions of Ghana. Sampled regions were: Central Region, Greater Accra Region, Upper East Region (UER), and Volta region.

Participants: In total, 67 participants were interviewed – national level (5), regional (11), district (9), and the sub-district / local levels (42) Interviewees were mainly stakeholders – people whose actions or inactions actively or passively influence the decision-making, management, implementation of CHPS. They include; policy makers of the CHPS initiative, managers of CHPS compound and health centers, politicians, academics, health professionals, technocrats, and community health management committee members.

Results: Three broad themes where identified: Inadequate understanding of CHPS concept; major contextual changes with stalled policy change to meet growing health demands; and changes in political landscape and leadership with changed priorities threatens CHPS sustainability.

Conclusion: Barriers to attainment of UHC can be overcome through serious political commitment and attempt, in addition to the work of the community and international donors. Improved national health governance is a key driver for CHPS to maximize its contributions towards achieving UHC in Ghana.

Keywords: Universal Health Coverage (UHC), Community Health, Citizens' Engagements, Community-Based Health Planning Services (CHPS) initiative, Ghana.

Strengths and limitations of this study

- The stratified data collection strategy, and the diversity across the study settings helped keep a balance in the sampled participant across different levels, and with a broader understanding of the phenomenon from wide range of respondents.
- Our framework was able to accommodate a wide range of perspectives for pragmatic interpretation, which can help, we envisage, improve CHPS' contribution towards UHC in Ghana. This became possible through exploring the different components of the CHPS initiative, regarding how the content of policy, neglecting actors, context and processes interact to shape policy-making. Further, our model of policy analysis captured the comprehensiveness of the CHPS initiative – by going beyond the borders of the health sector – to study the elements of the CHPS policy, its formulation and evolution over time, how it was implemented and scaled up, and the changing political and social dynamics around it, plus its role in the Ghana's current health system.
- To improve study trustworthiness, we explored the phenomenon from different perspectives (ensuring triangulation), performed member check, ensured transparency of methods and analysis,

and involved multi researchers from different background and whose hidden beliefs, values, perspectives and assumptions were revealed and contested through constant dialogue, to enhance understandings to the findings.

- Although this study is the first of its kind to conduct such holistic analysis of the CHPS initiative, certain vagueness may have emerged while interpreting our themes – data was gathered from interviewees at various levels and places, and perhaps with different socio-political ideologies and background – hence we cannot be certain of participants' underlying rationale of responses especially with regards to the political, institutional and societal commitments towards the initiatives – requiring findings to be interpreted with caution.

Introduction

Health is a major concern in the global policy environment – an essential requirement for development. (1) From a broader perspective, population health has been causally associated as an input to economic growth, (2) either as ultimate goal of development or a vital tool to enhance other welfare outcomes. (3) For these and many other reasons, health system performance has become increasingly relevant to countries, both high and Low-Middle Income Countries (LMIC).

Today, international policy discussions are focused on accomplishing the Sustainable Development Goals (SDGs) – a milestone which places specific importance on Universal Health Coverage (UHC). As mentioned by WHO Director General, UHC is a political choice. (4) The concept of UHC is consistent with WHO's vision of "Health for All", which support a collective credence that all people should have access to the health services they need without risk of financial ruin or impoverishment. (5) Nonetheless, considering the existing disparities between and within countries, achieving UHC will require all-inclusiveness, transparency and participatory processes, and interactions between health systems and the population – rendering community participation essential to enhance country ownership and accountability towards efforts to attain UHC and sustainable health development. (6-8) Besides, civil engagement did influence the unprecedented progress in many areas of the Millennium Development Goals (MDGs), particularly in addressing AIDS. (9)

The health system of Ghana over the years has placed emphasizes on community-based strategy in delivery of Primary Health Care (PHC). (10) Following several debates and reforms which preceded the Alma Ata Declaration (1978) of "Health for All" through the PHC approach and Ghana's Health Sector Reform in 1996, the Community-based Health Planning and Service (CHPS) initiative emerged in the wake of geographical barriers to health, to facilitate the achievement of the vision based on the premise that UHC can be achieved if improved health services are delivered closer to the door-step of community

members, particularly to those at the rural and slummy areas. Key service package of CHPS include: maternal and reproductive health, child health services, treatment of minor ailments, health education and promotion of healthy lifestyles and follow-up on clients. (11, 12)

CHPS has created one of the best approaches in increasing community commitments and ownership towards health system strengthening, enhancing equitable access and delivery of primary healthcare, and resources mobilization. (13) Generally, it has also contributed significantly in reducing the MDGs targets on child (under-5) mortality from 111 per 1,000 live births in 2003 to 60 per 1,000 live births in 2014; and maternal mortality from 740 per 100,000 live births in 1990's to 319 per 100,000 live births in 2015 – hence serves as a dynamic window of opportunity to better reimagine health–related SDGs. (14) Yet, many challenges persist and threatens the successes and sustainability of the initiative. For instance, the implementation of CHPS is not meeting the expected outcomes, partly due to inadequate transport and equipment/medicines, poor supervision of CHPS programme, weak or destroyed health infrastructure, physical inaccessibility, insufficient trained community health workforce and high attrition rate, cultural and behavioral beliefs, and poor referral support. (15) As a result, its performance has dwindled across all regions of Ghana. (16) For example, the current contribution of CHPS to Out Patients Department (OPD's) attendance across the country is only 5%, which may not worth the resources vested into the initiative. (14) This study is first of its kind (following the launch of the SDGs) aimed to holistically explore the barriers limiting CHPS contributions to reach UHC in Ghana.

Methods

Study design, Settings, Sampling and Data collection

The qualitative study design was used to explore the phenomenon. The study was conducted in four regions of Ghana, to represent diversity in terms of socioeconomic status, cultural, religion, geographical position, and level of performance of CHPS in the country. (11, 14, 16) Sampled regions were: Central Region, Greater Accra Region, Upper East Region (UER), and Volta region. Data was gathered at four levels – national, regional, district and local levels to ensure triangulation. (17) A purposive and snowball sampling techniques was employed to identify study participants at the national and the regional levels. (18) At the districts and the local levels, participants were sampled through the snowball technique. (19) Three university graduates with experience in research were recruited and trained to assist in data collection. Training lasted for three days. Pre-testing of data collection instruments was done during the training session.

Face-to-face in-depth interviews were conducted from April 2017 until February 2018. Interviews were conducted in English. Separate semi-structured interview guides were designed for interviews at each

level. Data was gathered until saturation – where we realized no new data was emerging. (20) Interviews lasted between 25 – 45 minutes. In total, 67 participants were interviewed – national level (5), regional (11), district (9), and the sub-district / local levels (42) – refer table 1 for list of interviewees and their characteristics and study settings. Interviewees were mainly stakeholders – people whose actions or inactions actively or passively influence the decision-making, management, implementation of CHPS. They include; policy makers of the CHPS initiative, managers of CHPS compound and health centers, politicians, academics, health professionals, technocrats, and community health management committee members. Addition to the interviews were documents review and observation.

Data analysis

All interviews were audio recorded. Data gathered was transcribed verbatim. Coding was done manually. We used Walt and Gilson's policy triangle to guide data analysis. This framework was selected because it has influenced health policy research in a diverse array of countries, and has been used to analyze several health issues and health sector reform – which is appropriate in the context of our study. The framework enabled us to explore the perspectives of the different components of the CHPS initiative, regarding how the content of policy, neglecting actors, context and processes interact to shape policy-making (21). Further, we remained open to accommodate other emerging themes – hence we employed the hybrid interactive processes of inductive and deductive thematic analysis to interpret our data. (22)

Codebooks were developed, and themes that emerged from the data were repeatedly reviewed using the research questions. To enhance trustworthiness of findings, two research members (AA, MA) were assigned to do first coding (open breakdown of themes). This enabled us to identify all prevailing themes in the study. Next, (AT, AAS) created inter-code connections among themes. Relevant codes which were associated with study objectives were extracted, compared and discussed among members. Similarities and differences between codes were also addressed. (23)

Next, through thorough content analysis, we interpreted the categorized themes which were relevant to the accomplishment of the objectives of the study. That is, we read the documents and transcripts repeatedly (got immersed with the data), performed member checks, and coded them inductively and deductively, followed with iterative analysis. This enabled us to understand, interpret extracted themes, which were centered on, and relevant to the CHPS initiative. Finally, core categorical themes were selected, analyzed and compared with existing literature to ensure the reliability, validity and comprehensiveness of our findings (Selective coding). (23) Final codes were developed based on consensus of the entire research team (AS, AT, MA, AAS).

Ethical Considerations

This study was first approved by the ethics committee of Tehran University of Medical Sciences (code: IR.TUMS.VCR.REC.1395.1699), followed by the Ghana Health Service Ethical Review Committee (registration number: GHS-ERC: 08/03/2017). We also obtained written permission from the regional and district levels of all study settings, before commencing data collection. Further, we acquired written consent from all participants and guaranteed them of their privacy, confidentiality and anonymity of any information they provide. Participation was voluntary, and without any compensation. Participants were given the right to opt out from the study at any point.

Results

The Community-based Health Planning and Service (CHPS) initiative was found in 2000 to facilitate the achievement of Universal Health Coverage (UHC), by providing improved health services, mainly preventive, promotive and treatments of minor ailments closer to the door-step of community members, particularly to those at the rural areas – efforts aimed to address geographical barriers to health. Although, CHPS has created one of the best approaches in increasing communities' commitments towards health system strengthening, its performance has declined over the years. According to our findings, inadequate understanding of CHPS concept; major contextual changes with stalled policy change to meet growing health demands; changes in political landscape and leadership with changed priorities – threatens CHPS sustainability.

1. **Inadequate understanding of the CHPS concept**

CHPS has been in existence for almost seventeen years. Yet, the concept of CHPS has not been fully gripped by the major stakeholders, most importantly, political institutions and community members. To achieve universal access to healthcare in Ghana, CHPS remain ideal – serving as a vehicle not just for delivering health care, but to the very door step of the client. Nonetheless, according to our findings, major actors operate but at varying degrees to achieve personal interests – not necessarily to contribute to achieving the key mandate of CHPS. That is, political bodies, through active collaboration with District Assemblies construct CHPS compounds for political gains – i.e. to solicit for votes, sometimes without even consulting the health directorate. As a result, most CHPS structure do not meet the required building plan, while others are not strategically situated to address the geographical barriers to accessing health care – a primary goal the initiative seek to achieve.

"In fact, I should state that some stakeholders don't really understand the role as far as CHPS initiative is concern. Politicians one way or the other think we should construct CHPS compounds where they had won votes. Some even go to the extent of constructing CHPS facility without prior consultation from the

health directorate, which at the end are not being patronized by the clients because it may be either at the outskirt of the town where health officers find it difficult to reside there or where it's too far from clients". – Municipal Health Director

Our findings also revealed the community entry processes were not properly carried-out from the onset – influencing many implementation flaws. For example, community members routinely demand of services which do not form part of the service package of CHPS, and often beyond the capabilities of the community health professions. That is, communities consider CHPS to be a health centre or a hospital, hence, expect health professionals to be able to provide a more comprehensive service.

"the concept of CHPS is still not well understood by a bigger session of the community – clients today still perceive that when you talk of health, it is getting sick and being treated. They least understand the CHPS concept emphasizes more on health promotion and prevention. Due to that, you may get up in the morning with plans to go for home visit (for health talk) just to find clients in queues demanding for medical treatments – services which we are not even permitted to render. I think once the people know that the policy is to prevent them from being sick, then of course, they won't wait till they are sick and then be running to the health facilitates. – Community Health Officer

Again, members of the community were not made to fully understand that CHPS is community-driven and therefore it successes greatly depends on the community. Community members were of the belief that the government should be solely responsible for the total establishments and management of CHPS. In view of that, there is a growing perception that CHPS is a strategy used by the government to shift their core responsibilities to its citizens – given that the initiative is community-induced. Besides, as observed, majority of amenities of most facilities were either provided by the community and non-governmental organizations (especially the international donors).

"We have been convinced to build our own health facility, advocate for the provision of health amities and logistics, and pay our utilities, what then is the role of the government if health development of a community is to be exclusively provided by the community?" – Community Leader

2. Major contextual changes, with ensuing stalled policy change to meet growing demands

CHPS is currently faced with major contextual changes, with ensuing stalled policy changes to address current health needs and expectations of the communities – mainly due to inadequate dedicated resources to sustain the initiative, and rigid organizational framework.

Over a decade ago, people were travelling long distances to access health and therefore there was the need to send services to the rural areas, through which CHPS was originally birthed to primarily provide

services at the door-steps of households. CHPS compounds were strategically erected in selected communities to facilitate service provision – where community health professionals were tasked to provide door-to-door services to communities including those without a CHPS compound. Nevertheless, today, despites being a national policy for all electoral areas to have a CHPS compound, almost all communities demand CHPS compound to be constructed in their communities – many of which are even putting up structures without governments support. However, according to our study, the existence of a "physical CHPS structure" has implied increasing health demand by community members – as clients perceive it as a hospital. Hence, the present demand and expectations of communities extend beyond the services package of CHPS – which is mainly preventive, promotive and treatment of minor ailment. Based on our findings, community members upon constructing a CHPS compound would want CHPS to function as a health center or a hospital, and demand for extra health departments especially maternal health units – aspirations which are barely difficult to peruse considering the aim of CHPS. Besides, the rising health demands and the willingness of communities to expand the service package of CHPS exacts much pressure on the governments – largely due to unplanned resources to sustain the initiative. As a result, CHPS facilities lack basic logistics and medicines needed to treat minor ailments. This has led to rampant referral of health cases to either the health centre or the hospital. Yet, neither of the CHPS compounds across all the regions even had an ambulance to facilitate referral processes. Health professionals had to rely on commercial vehicles and motorcycles during referrals, and even with that, aside not appropriate for referrals, these vehicles are often either far away from CHPS compounds to render immediate service or clients don't have the money to pay for the fare, leaving the financial burden on the health professionals.

"*...CHPS is expanding at rate governments are not able to cope. The request for new facilities or units implies that the government need to increase the provisions for logistics, employ more staffs, pay workers their remunerations etc. Meanwhile, the budget for the sector is not growing at a rate we are expected to spread our services. Yes, our main objective is to improve access, but we are limited due to inadequate resources*" – Senior Policy Maker (National Level)

Moreover, improved knowledge is changing health practices especially among urban residents. Yet, CHPS is faced with inadequate resources for capacity building of community health professionals, to fully meet health needs and expectations, to match the changing health practices of their clients. To this end, urban residents especially evinced a negative attitude towards community health professions (particularly health volunteers), questioning their credibility to educate them about health.

"I was first working in a rural community, but we were recently reshuffled and was posted to the city. Fairly speaking, I prefer to work in the rural areas. You see my entire work is to promote health or educate the community about health. But within the city, the residents are knowledgeable. Some even refuse to listen to our health talk because they feel they are well informed even than the community health experts. Besides, they get any information they need on the internet. But working as a health officer in the rural areas is quite a different. I remember when I was first posted to my previous workplace (village), the entire community was exceedingly glad to have us. But in the city, in fact their responses to our questions are something demoralizing. I think, the training that I acquired was very useful to me when I was working in the village but the situation in the city is quite different". – Community Health Officer

Additionally, seventeen years ago, it might be relatively easier to reach all community members or villagers in person and in groups. According to our study, health professionals lack the appropriate mobilization skills to successfully organize health durbars. Again, there is a limited use of digital tools in ensuring that community members irrespective of place and time do have consistent access to health information. Further, while volunteerism was found fundamental in CHPS sustainability, the concept although is properly understood by community members, the idea has been met with strong resistance where volunteers today demand salaries for their services. According to volunteers, "it is very discouraging getting up every morning for work and at the end of the month you end up receiving no salary. I have been a community volunteer for over 15 years, yet I cannot boast of significant reward for my work. I understand I volunteered for this kind of work but mind you I also have families".

"*Currently, it is difficult mobilizing community members for health durbars. Most of them are engaged with economic activities – hence leave very early for farms (work) and return late. Also, community participation was initially stronger because we had active volunteers supporting our work. But today, volunteerism is no more, and is really affecting our work".* – Community Health Officer

3. Changes in the political landscape and leadership with changed priorities

Complex interactions of actors were found to have a critical influence on CHPS. To our participants, although a broader political process is required for CHPS sustainability, recent commitments of political bodies towards CHPS are not up to expectation. Every government comes with its own priorities – nobody continues from where the previous government ended. What governments commonly done is to construct CHPS compounds – leaving behind provision of logistics – since the number of compounds built is often considered as major political achievements. Also, although, our study revealed a more prevailing commitment by the community members and the international donors to improve CHPS, while communities lack the needed resources to sustain the initiative, policy inconsistency also threatens the

sustainability of projects pursued by international donors. That is, these international bodies mostly implement pilot projects for a stipulated time and then leave, but who to commit to the course left behind and provide the desired resources to sustain the initiative is a challenge which retards the progress of CHPS.

"CHPS is more a political tool now – it is just on the lips of our politicians. They promise a lot but deliver little. When it comes to logistics often rely on donor partners who mostly come to pilot projects for a stipulated time and then leave. But whether such projects are sustained is another issue because when they pull-out who to continue from wherever they ended is also a unique challenge altogether. Nonetheless, if the leaders are so vibrant and active, you see them going in and out sourcing for funding to sustain the initiative. But you wouldn't see that in places where the leaders do not believe in the concept of CHPS. So, there will be a bit of variation in the level of performance depending on who for example is the head, and more to the point where the developing partners seek to work. This is part of the reason why some regions have several partners helping to improve CHPS, and otherwise. So, that might resort to a bit of disparity in performance, but when you talk about challenges faced by the initiative due to governmental commitments, then that tends to be a countrywide challenge". – Renowned Researcher on CHPS

Furthermore, we found communities' independent efforts being driven by loss of trust in the Governments to fully provide their health needs. To the community members, Governments have shown inadequate exertion to provide CHPS compounds the basic resources. Hence, any initiative where communities can lead the forefront of their development and not to always rely on the government is worthy to embrace. In view of that, community leaders and members with improved understanding of the CHPS concept independently exhibited vigorous efforts towards issues of health and development.

"We never waited for the Ghana Health Service to inform us that we are due for CHPS compound. That would have taken a long time, considering the political processes involved. The community has formed an alliance with a UK based Trust that support our development. So, we proposed to them to also support the establishment of our facility, and over five years the community has also been contributing to pay the utilities of the facility.". – Traditional Leader (Chief)

On the other hand, where there were chieftaincy disputes, key stakeholders (especially traditional leaders) oppose decision-making processes and program implementation. As an example, we observed low community participation in communities facing chieftaincy and land disputes, or without a chief – since health professionals find it difficult identifying which leader to consult to serve as a focal point to engage

its citizens. Also, due to lack of consensus, family members and friends of opposing leaders also refuse to attend programs being organized for the community.

"Communities are encountering series of chieftaincy and land disputes. As a result, you may organize a health durbar in one community, and it will interest you to know that part of the community members will deliberately not attend, expecting a separate durbar to be conducted for them. The reason being that, opposing leaders would want to be also recognized and treated as community heads. Unlike elsewhere, where you find out that a community has just one chief (leader) who perhaps may serve as the head of the CHPS zone to engage its citizens". – Community Youth Volunteer

Discussion

The Alma-Ata Declaration identified the role of a comprehensive primary health care (PHC) as one of the cornerstones to any sustainable health system. Following that, the development of health delivery based on a primary health care approach of care delivery has received a paradigm shift towards the deployment of several forms of community health workers (CHWs) – as cadres capable of delivering effective care at the least cost, at the community and household levels. (24)

Most recently, community-based initiatives also served as a major contributing factor to the many achievements made under the Millennium Development Goals – particularly goals 4, 5 and 6, which aimed to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases. By this approach, several LMICs excelled in deploying CHW programs in recognition of their potential role towards UHC – by identifying, referring complex cases and, in many situations, managing minor ailments, particularly at the local/household levels. To state a few, a review literature on antiretroviral treatment programme delivery and outcomes in least resourced countries revealed positive impact of community-based support services on access, coverage, virological and immunological outcomes, patient retention and survival. (25) In Lesotho, South Africa, Namibia, and Botswana, a recent study also identified positive association between the community support programs and rapid increase and higher levels of adherence to HIV treatment. (26) Besides, the community initiatives helped improve clinical care quality in several countries, i.e. in Zambia (27), which could be the result of the strategy's ability to facilitate medical education to meet community needs through peer counselling, as occurred in Ethiopia and Uganda. (28) Furthermore, a study conducted in the Democratic Republic of the Congo also recorded a 50% decline in malaria morbidity in the project area, where CHWs were deployed to administer treatment but remained stable in the control area, as well as improving health care behaviors in the intervention area. (29) A most recent study in Ghana also revealed improved malaria prevention practices among individuals with a history of community volunteers having visited their households to

educate them about malaria. (30) Again, the role of lady health worker program in Pakistan was significant in raising awareness and changing attitudes regarding health and family planning – which contributed to about 15% reduction in the neonatal mortality rate in recent pilot projects. (31) In brief, a well-designed community-driven program has proved effective in representing one of the several initiatives capable of establishing a more substantial means in addressing crippling PHC system – most notably: its relevance in addressing shortage and poor distribution of health workers to the extent of producing physicians who choose to practice in rural and underserved areas, expanding and strengthening coverage of key health programs, and re-organizing health workforce to address challenges pertaining to low access to quality, people-centered, affordable and acceptable health care services. (24)

Yet, key challenges continue to threaten sustainability of community-based initiatives. As an example, Ghana's adoption of CHPS' initiative in the year 2000, was a strategic move to advance national health equity agenda in providing improved quality care to all – by bridging geographical barrier to health. (11) However, according to our findings, inadequate understanding of the CHPS concept and the lack of equal cooperation among major actors of CHPS including political bodies, NGO's, the health directorate and the District Assemblies, and chieftaincy disputes have produced disunity about what needs to be done. As a result, political parties today often situate CHPS compounds anywhere to fulfil a campaign promise and not necessarily to address geographical barriers to health. Conflicting stakeholder interests and ethical concerns have led to a several disorganized national debates, particularly during establishment or expansion of public health services. (32) Hence, politics and stakeholders' engagements matters at each phase of health reform – as existing institutions and interest groups often have both the reasons and the resources to vigorously oppose change, (33) as experienced for instance by the Iranian health system where medical doctors initially opposed family physician program in rural Iran due to lack of prior consultation. (19) Notwithstanding that, community participation in all aspects of policies is essential to enhance sustainability through country ownership and accountability. (7, 34) – if not, ensuring local ownership will continue to be challenging as occurred in Brazil. (35)

The governments' struggle to resolve the conflict between what they are willing to spend on and what clients want is a fundamental health sector reform dilemma anywhere. (36) In view of that, most LMICs are faced with the maldistribution of limited resources in the face of pressing health needs – where public sector is often perceived as providing inferior service, and many citizens – even among the poor – may have to pay for improved services out of pocket – resulting to a varying degree of service and health status between urban and rural residents and between the rich and poor. (32) In this respect, many countries that are even noted for sustainable community-based programs, maybe affected by the effect of

increase in workload on the community health professionals, which in turn can compromise the quality of health services they provide. (37)

In Ghana, the CHPS initiative is also increasingly becoming complex and difficult to manage. CHPS' openness to change and the increasing diversity of demand and expectations of clients, renders the entire initiative an "episodic and cyclical character". That is, any pressing demand is considered critical making it a target for reform, although it might not be strategic implementing such initiative at that level of care. As part of our findings, the increasing demand of maternity unit has raised varying views among stakeholders as whether all CHPS facility need to have a delivery ward, or clients should be referred to the next level of care. Adding to that, the component of minor treatments within the service package has rendered the initiative less effective and efficient, and eventually is causing the community members to lose trust in the community-based health system. That is, despite the rising demand and expectations, CHPS is challenged with inadequate resources (even basic logistics) to treat minor ailments, which has led to rampant referrals of health cases and its associated costs. In addition, some of the CHPS' compounds visited that have midwifery unit are faced with lack of basic equipment and the required infrastructure to foster efficiency of services provided. Hence, we are of the view that CHPS can achieve eloquent results if efforts are geared towards improving preventive and promotive services – rather than curative care. Besides, due to unplanned resource allocation by the governments, a midwifery delivery department at the facility will led to further unanticipated malfunctions of the system. In addition, as societies modernize and become more affluent and knowledgeable, what people consider to be desirable ways of living as individuals and as members of societies may change. (38) Yet, CHPS initiative is faced with lack of resources to help build the capacity of community health professionals – particularly regarding the use of tools in responding to changes in health practices, and ways to enhance better community participation and mobilization, as well as efficiency. As a result, clients, especially the urban residents show negative attitudes towards community health professions (especially health volunteers), questioning their credibility to even educate them about health. Notwithstanding that, these challenges could also serve as a platform for change and innovations. Yet, based on our findings, it might also overburden the international donors and the NGO's – considering the limited political commitments in sustaining the initiative. Again, it may place immerse strains on communities, where communities with least resources to support themselves and to meet challenges may produce little health performance, as happened in other settings. (38)

To fully address the phenomenon, it is recommended that health care financing for dispersed inhabitants often need larger per capita expenditure, and in countries with both high-density and low-density

populations, it is expected that dispersed populations receive some subsidy to promote equity. (39) In addition, countries are devising cost-effective innovations that meet the health and well-being of its citizens from an explicitly multi-sectoral perspective, with a focus on expanding coverage of curative healthcare, while reinforcing promotive strategies and cross-sectoral actions on social determinants of health. (40) Although, that tends to be expensive, communities can secure such inputs at a manageable cost by joining forces. (41) Our study revealed that communities that are making meaningful advancement through the CHPS initiative are those that are either resourced or have leaders constantly negotiating for support from non-governmental institutions. In addition, the use of radio communications has shown successful in overcoming geographical obstacles to health in such areas, in a more efficient and affordable manner. (39)

Community health workers have featured in the discourse of many global public health agenda – by proving effective in addressing issues that have adverse impact on moving towards UHC. Today, in the era of SDGs, health is considered a political choice, and everyone's concern to drive the world to a state where health must be universal and equitable. (42) Nonetheless, to achieve meaningful results, it is edged that countries adapt specific targets and actions based on national priorities that promote country ownership and accountability, (34) – reaffirming the profound role of community-based programs in many LMICs (43), including Ghana.

Policy recommendations to increase the chances of success

Community-based initiatives are increasingly represented as a potential strategy to strengthen PHC. Nonetheless, certain vital gaps still impede their progress. Based on our findings, the following are recommended for community-driven initiatives to better help serve its purposes.

1. Greater transparency and coordination among actors – particularly the community members, the NGO's, politicians and the health directorates is critical to sustain the community-based initiatives. Nevertheless, understanding the perspectives, the underlying values, the policy contents and the ways in which changed priorities or divergent institutional goals could emerge, can contribute to achieving intended purpose.
2. There is an increasing demand for services beyond the scope of community professionals. We therefore recommend the provision of an effective ambulances services to facilitate referral processes from the community level to the highest level of care.
3. Advancement in knowledge and urbanization are changing public health practices. Community health professionals need consistent training to be able to meet such terrain – to provide effective

treatments that take better account of addressing social determinants of health (SDH), and the use of digital tools and effective community mobilization skills in shaping public health practices.

4. We commend academic institutions to also build robust relations, training plans, and coordination with communities and community health development platforms to provide a framework for sustainable programs that are focused on achieving health equity, and capacity building. However, due to cultural variations and the nature of social contract in diverse sociocultural settings, the implementation of such plans is recommended to be done with caution.

Further studies are required to:

- Explore digital tools that can help improve knowledge of community health professionals, enhance community participation/mobilization and health practices and interventions, and can foster greater accuracy and efficiency of activities.
- Identify ways in which factors such as the quality of community health governance and policy coherence can be maximized.
- Investigate ways to provide sustainable community health financing and resource mobilization.

Conclusion

Universal health coverage is a growing concern and a core target of the SDGs. Nonetheless, considering the existing disparities between and within countries, attaining UHC will necessitate all-inclusiveness, a participatory processes and interactions between health systems and the population. This has led to a renewed relevance of CHPS in Ghana — an initiative which practically relies on citizen engagement as a central instrument in the delivery of services closer to the door-step of clients, particularly to those at the rural or slummy areas. Despite its recognition in safeguarding communities' commitments and country's ownership to attain UHC, gaps continue to impede its successes. They include: inadequate understanding of the CHPS concept – much of which is due to poor community entry and sensitization programs during the onset of CHPS scale-up. Again, major contextual changes, with ensuing stalled policy change to meet growing demands, and changes in the political landscape and leadership, with changed priorities or opposing forces – all threatens CHPS sustainability. Our study concludes that what is essential to influence positive change for achievements of UHC in Ghana (through CHPS) is the political will – an improved national health governance and the political determinants to lead actions of the community and international donors.

Data sharing

For extra data contact the corresponding author through takiana@gmail.com.

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Table 1: List of interviewees and their characteristics & Study settings

Region Levels	Central Region	Greater Accra Region	Upper East Region	Volta Region	Total
National Level	Head of CHPS (1), Head of monitoring and evaluation (1), other senior officials (2) at Policy, Planning, Monitoring and Evaluation unit at the Ministry of Health, and Renowned researcher on CHPS (1).				5
Region Levels	***Cape Coast*** Deputy regional director for health administration and support services (1); Regional director for public health (1); Senior public health nurse (1); Head of service training (1); Regional health information officer (1); Regional human resource manager (1)	***Accra*** Regional CHPS coordinator & deputy director of nursing services (1)	***Bolgatanga*** Regional CHPS coordinator (1); Senior reproductive and Child Health (RCH) (1); Information officer (1)	***Ho*** Regional CHPS coordinator (1)	11
District /Municipal Levels	***Assin North District*** Municipal health director (1) Municipal CHPS coordinator (1) Municipal nutrition technical officer (1); Community mental health officer (1)	***Kone Katamanso District*** District health director (1)	***Bolgatanga Municapal & Kassena Nankana West District*** Municipal CHPS coordinator (1); District CHPS coordinator (1); Nursing officer (1)	***Ho municipal*** Municipal CHPS coordinator (1)	9
Sub-district/ Local levels	***Assin Endwa CHPS compound*** Community health nurse (CHN) (1); Head of facility (1); Enrolled nurses(EN) (1); Community health management committee (CHMC) – Traditional leader (chief) (1), Assembly member (1); Other opinion leaders (2)	***Appolonia CHPS compound*** General nurse (1); CHN (1); Midwife (1); EN (1); Nursing officer (1); CHMC – Traditional committee members (2), Assembly member (1); Other opinion leaders (3)	***Yikene & Nania CHPS compound*** CHN (1); EN (2); CHO (2); CHW (3); Midwife (1); CHMC – (Traditional leader (chief) (1), Religious leader (1), Assembly member (1), Community youth volunteer (2)	***Loboli & Atikpui CHPS compound*** EN (3); Head of facility (2); CHOs (2); CHW (2); CHMC - Community youth volunteer (1)	42
Total	17	13	20	12	**67**

Universal health coverage through the community-based health planning and services initiative in Ghana: Hurdles to overcome

Standards for Reporting Qualitative Research (SRQR)

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S16	Synthesis and interpretation	Page: 7,8,9,10,11,12
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S18	Integration with prior work, implications, transferability, and contribution(s) to the field	Page: 12,13,14,15,16
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Challenges to achieving universal health coverage through community-based health planning and services delivery approach: a qualitative study in Ghana

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Authors' contribution

AA conceived the study, served as the principal investigator, and drafted the manuscript. AT contributed to the conception of the study, supervised the entire process of design, data interpretation and analysis, and the intellectual development of the manuscript. He is the guarantor. MA also contributed to the conception of the study, assisted in data collection and development of the manuscript, and technically reviewed the article. AAS facilitated and contributed to the intellectual development of the paper.

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Conflicts of interest

None declared

Abstract

Objective: Community-based initiatives have enormous potential to facilitate the attainment of universal health coverage (UHC) and health system development. Yet, key gaps exist and threaten its sustainability in many low-middle income countries. This study is first of its kind (following the launch of the Sustainable Developments Goal (SDGs)) that aimed to holistically explore the challenges to achieving UHC through the community-based health planning and service initiative (CHPS) in Ghana.

Design: Qualitative study design was adopted to explore the phenomenon. Face-to-face in-depth interviews were conducted from April 2017 until February 2018, through purposive and snowball sampling techniques. Data was analyzed using inductive and deductive thematic analysis approach.

Setting: Data was gathered at the national level, in addition to the regionals, district and sub-district /local levels of four regions of Ghana. Sampled regions were: Central Region, Greater Accra Region, Upper East Region, and Volta region.

Participants: In total, 67 participants were interviewed – national level (5), regional (11), district(9), and the local levels(42). Interviewees were mainly stakeholders – people whose actions or inactions actively or passively influence the decision-making, management, implementation of CHPS, including: policy makers,

managers of CHPS compound and health centers, politicians, academics, health professionals, technocrats, and community health management committee members.

Results: Based on our findings, inadequate understanding of CHPS concept; major contextual changes with stalled policy change to meet growing health demands; and changes in political landscape and leadership with changed priorities, threatens CHPS sustainability.

Conclusion: UHC is a political choice which can only be achieved through sustainable and coherent efforts. Along countries' pathway to reach UHC, coordinated involvement of all stakeholders, from community members to international partners is essential. To achieve UHC within the time frame of SDGs, Ghana has no choice than to improve its national health governance, to strengthen the capacity of existing CHPS.

Keywords: Universal Health Coverage (UHC), Community Health, Citizens' Engagements, Community-Based Health Planning Services (CHPS) initiative, Ghana.

Strengths and limitations of this study

- The stratified data collection strategy, and the variety of study participants from across different levels and settings helped gain a broader understanding of the phenomenon.
- Our framework enabled us to accommodate a wide range of disciplines for pragmatic interpretation of the phenomenon, by exploring different components of the CHPS initiative.
- To enhance the credibility of our study, we explored the phenomenon through various lenses (ensuring triangulation), performed member check, ensured transparency of methods and analysis, and involved multi researchers from different background.
- Although this study is the first of its kind and has used a robust methodology, we cannot be certain of participants' underlying rationale for responding, especially with regards to their political, institutional and societal commitments towards the initiatives – hence, like any qualitative study, our findings need to be interpreted with some caution.

Introduction

Today, a big proportion of health policy debate is focused on accomplishing the 2030 Sustainable Development Agenda – a milestone which places specific importance on universal health coverage (UHC) – a concept which supports a collective credence that all people should have access to the health services they need without risk of financial ruin or impoverishment. (1) Nonetheless, considering the existing disparities within countries, achieving UHC will require all-inclusiveness and participatory interactions

between health systems and the citizens. (2-4) As a result, community health system performance has become increasingly relevant to both high and low-middle income countries (LMIC).

Ghana, in 2000, launched the community-based health planning and service (CHPS) initiative to facilitate the achievement of the vision based on the premise that UHC can be achieved if improved health services are delivered closer to the door-step of community members, particularly to those at the rural and slummy areas. Under this initiative, community health professionals, supported by community volunteers are trained to provide health care in a CHPS zone (geographical coverage areas for community health services – presently, about 5487 zones in number). (5) Key service package includes: maternal and reproductive health, child health services, treatment of minor ailments, health education and promotion of healthy lifestyles and follow-up on clients. (6, 7)

CHPS has created one of the best approaches in increasing community commitments and ownership towards health system strengthening, enhancing equitable access and delivery of primary healthcare, and resources mobilization. (8) Yet, many challenges persist and threatens the successes and sustainability of the initiative, including: inadequate financial resources, poor management and supervision of programmes, insufficient health infrastructure, physical inaccessibility, inadequate trained community health workforce, high attrition rate, socio-cultural beliefs and poor referral system. (9) In this study, we aimed to enhance the understanding of the challenges limiting the effective role of CHPS in contributing to achieving UHC in Ghana. We used a theoretical framework (the Walt and Gilson's policy triangle) to guide the interpretation of findings. This research is the first of its kind. We anticipate that our findings could facilitate the achievements of Sustainable Development Goals, UHC in particular, in Ghana, and perhaps many other LMICs.

Methods

Study design, Settings, Sampling and Data collection

The qualitative study design was used to explore the phenomenon. The study was conducted in four regions of Ghana, to represent diversity in terms of socioeconomic status, cultural, religion, geographical position, and level of performance of CHPS in the country. (6, 10, 11) Sampled regions were: Central Region, Greater Accra Region, Upper East Region (UER), and Volta region. Data was gathered at four levels – national, regional, district and local levels to ensure triangulation. (12) A purposive and snowball sampling techniques was employed to identify study participants at the national and the regional levels. (13) At the districts and the local levels, participants were sampled through the snowball technique. (14) Three university graduates with experience in research were recruited and trained to assist in data collection.

Training lasted for three days. Pre-testing of data collection instruments was done during the training session.

Face-to-face in-depth interviews were conducted from April 2017 until February 2018. Interviews were conducted in English. Separate semi-structured interview guides were designed for interviews at each level. Data was gathered until saturation – where we realized no new data was emerging. (15) Interviews lasted between 25 – 45 minutes. In total, 67 participants were interviewed – national level (5 interviewees), regional (11 interviewees), district (9 interviewees), and the sub-district / local levels (42 interviewees) – refer table 1 for list of interviewees and their characteristics and study settings. Interviewees were mainly stakeholders – people whose actions or inactions actively or passively influence the decision-making, management, implementation of CHPS. They include; policy makers of the CHPS initiative, managers of CHPS compound and health centers, politicians, academics, health professionals, technocrats, and community health management committee members. Addition to the interviews were documents review and observation.

Data analysis

All interviews were audio recorded. Data gathered was transcribed verbatim. Coding was done manually. We used Walt and Gilson's policy triangle to guide data analysis. This framework was selected because it has influenced health policy research in a diverse array of countries, and has been used to analyze several health issues and health sector reform – which is appropriate in the context of our study. The framework enabled us to explore the perspectives of the different components of the CHPS initiative, regarding how the content of policy, neglecting actors, context and processes interact to shape policy-making (16). Further, we remained open to accommodate other emerging themes – hence we employed the hybrid interactive processes of inductive and deductive thematic analysis to interpret our data. (17)

Codebooks were developed, and themes that emerged from the data were repeatedly reviewed using the research questions. To enhance trustworthiness of findings, two research members (AA, MA) were assigned to do first coding (open breakdown of themes). This enabled us to identify all prevailing themes in the study. Next, (AT, AAS) created inter-code connections among themes. Relevant codes which were associated with study objectives were extracted, compared and discussed among members. Similarities and differences between codes were also addressed. (18)

Next, through thorough content analysis, we interpreted the categorized themes which were relevant to the accomplishment of the objectives of the study. That is, we read the documents and transcripts repeatedly (got immersed with the data), performed member checks, and coded them inductively and deductively, followed with iterative analysis. This enabled us to understand, interpret extracted themes, which were

centered on, and relevant to the CHPS initiative. Finally, core categorical themes were selected, analyzed and compared with existing literature to ensure the reliability, validity and comprehensiveness of our findings (Selective coding). (18) Final codes were developed based on consensus of the entire research team (AS, AT, MA, AAS).

Ethical Considerations

This study was first approved by the ethics committee of Tehran University of Medical Sciences (code: IR.TUMS.VCR.REC.1395.1699), followed by the Ghana Health Service Ethical Review Committee (registration number: GHS-ERC: 08/03/2017). We also obtained written permission from the regional and district levels of all study settings, before commencing data collection. Further, we acquired written consent from all participants and guaranteed them of their privacy, confidentiality and anonymity of any information they provide. Participation was voluntary, and without any compensation. Participants were given the right to opt out from the study at any point.

Patient and Public Involvement

This qualitative study focused on a nominated public health initiative (CHPS) through the lenses of policy, whose participants were mainly policy makers, managers and the representatives of the public, who were not conventionally classified as patients recruited for medical research. Nonetheless, the key actors were widely consulted in the development of the research questions and in assessing the implications of the findings. Further, findings will be disseminated through stakeholders' events (including one-on-one policy talk show) to enhance the significance and salience of findings.

Results

The Community-based Health Planning and Service (CHPS) initiative was found in 2000 to facilitate the achievement of Universal Health Coverage (UHC), by providing improved health services, mainly preventive, promotive and treatments of minor ailments closer to the door-step of community members, particularly to those at the rural areas – efforts aimed to address geographical barriers to health. Although, CHPS has created one of the best approaches in increasing communities' commitments towards health system strengthening, its performance has declined over the years. According to our findings, inadequate understanding of CHPS concept; major contextual changes with stalled policy change to meet growing health demands; changes in political landscape and leadership with changed priorities – threatens CHPS sustainability.

1. **Inadequate understanding of the CHPS concept**

CHPS has been in existence for almost seventeen years. Yet, the concept of CHPS has not been fully gripped by the major stakeholders, most importantly, political institutions and community members. To achieve universal access to healthcare in Ghana, CHPS remain ideal – serving as a vehicle not just for delivering health care, but to the very door step of the client. Nonetheless, according to our findings, major actors operate but at varying degrees to achieve personal interests – not necessarily to contribute to achieving the key mandate of CHPS. That is, political bodies, through active collaboration with District Assemblies construct CHPS compounds for political gains – i.e. to solicit for votes, sometimes without even consulting the health directorate. As a result, most CHPS structure do not meet the required building plan, while others are not strategically situated to address the geographical barriers to accessing health care – a primary goal the initiative seek to achieve.

"In fact, I should state that some stakeholders don't really understand the role as far as CHPS initiative is concern. Politicians one way or the other think we should construct CHPS compounds where they had won votes. Some even go to the extent of constructing CHPS facility without prior consultation from the health directorate, which at the end are not being patronized by the clients because it may be either at the outskirt of the town where health officers find it difficult to reside there or where it's too far from clients". – Municipal Health Director, Central region

Our findings also revealed the community entry processes were not properly carried-out from the onset – influencing many implementation flaws. For example, community members routinely demand of services which do not form part of the service package of CHPS, and often beyond the capabilities of the community health professions. That is, communities consider CHPS to be a health centre or a hospital, hence, expect health professionals to be able to provide a more comprehensive service.

"the concept of CHPS is still not well understood by a bigger session of the community – clients today still perceive that when you talk of health, it is getting sick and being treated. They least understand the CHPS concept emphasizes more on health promotion and prevention. Due to that, you may get up in the morning with plans to go for home visit (for health talk) just to find clients in queues demanding for medical treatments – services which we are not even permitted to render. I think once the people know that the policy is to prevent them from being sick, then of course, they won't wait till they are sick and then be running to the health facilitates. – Community Health Officer, Upper East Region

Again, members of the community were not made to fully understand that CHPS is community-driven and therefore it successes greatly depends on the community. Community members were of the belief that the government should be solely responsible for the total establishments and management of CHPS. In view of that, there is a growing perception that CHPS is a strategy used by the government to shift their

core responsibilities to its citizens – given that the initiative is community-induced. Besides, as observed, majority of amenities of most facilities were either provided by the community and non-governmental organizations (especially the international donors).

"We have been convinced to build our own health facility, advocate for the provision of health amities and logistics, and pay our utilities, what then is the role of the government if health development of a community is to be exclusively provided by the community?" – Community Leader, Greater Accra Region

2. Major contextual changes, with ensuing stalled policy change to meet growing demands

CHPS is currently faced with major contextual changes, with ensuing stalled policy changes to address current health needs and expectations of the communities – mainly due to inadequate dedicated resources to sustain the initiative, and rigid organizational framework.

Over a decade ago, people were travelling long distances to access health and therefore there was the need to send services to the rural areas, through which CHPS was originally birthed to primarily provide services at the door-steps of households. CHPS compounds were strategically erected in selected communities to facilitate service provision – where community health professionals were tasked to provide door-to-door services to communities including those without a CHPS compound. Nevertheless, today, despites being a national policy for all electoral areas to have a CHPS compound, almost all communities demand CHPS compound to be constructed in their communities – many of which are even putting up structures without governments support. However, according to our study, the existence of a "physical CHPS structure" has implied increasing health demand by community members – as clients perceive it as a hospital. Hence, the present demand and expectations of communities extend beyond the services package of CHPS – which is mainly preventive, promotive and treatment of minor ailment. Based on our findings, community members upon constructing a CHPS compound would want CHPS to function as a health center or a hospital, and demand for extra health departments especially maternal health units – aspirations which are barely difficult to peruse considering the aim of CHPS. Besides, the rising health demands and the willingness of communities to expand the service package of CHPS exacts much pressure on the governments – largely due to unplanned resources to sustain the initiative. As a result, CHPS facilities lack basic logistics and medicines needed to treat minor ailments. This has led to rampant referral of health cases to either the health centre or the hospital. Yet, neither of the CHPS compounds across all the regions even had an ambulance to facilitate referral processes. Health professionals had to rely on commercial vehicles and motorcycles during referrals, and even with that, aside not appropriate for referrals, these vehicles are often either far away from CHPS compounds to render immediate service or clients don't have the money to pay for the fare, leaving the financial burden on the health professionals.

"*...CHPS is expanding at rate governments are not able to cope. The request for new facilities or units implies that the government need to increase the provisions for logistics, employ more staffs, pay workers their remunerations etc. Meanwhile, the budget for the sector is not growing at a rate we are expected to spread our services. Yes, our main objective is to improve access, but we are limited due to inadequate resources*" – Senior Policy Maker (National Level)

Moreover, improved knowledge is changing health practices especially among urban residents. Yet, CHPS is faced with inadequate resources for capacity building of community health professionals, to fully meet health needs and expectations, to match the changing health practices of their clients. To this end, urban residents especially evinced a negative attitude towards community health professions (particularly health volunteers), questioning their credibility to educate them about health.

"I was first working in a rural community, but we were recently reshuffled and was posted to the city. Fairly speaking, I prefer to work in the rural areas. You see my entire work is to promote health or educate the community about health. But within the city, the residents are knowledgeable. Some even refuse to listen to our health talk because they feel they are well informed even than the community health experts. Besides, they get any information they need on the internet. But working as a health officer in the rural areas is quite a different. I remember when I was first posted to my previous workplace (village), the entire community was exceedingly glad to have us. But in the city, in fact their responses to our questions are something demoralizing. I think, the training that I acquired was very useful to me when I was working in the village but the situation in the city is quite different". – Community Health Officer, Volta region

Additionally, seventeen years ago, it might be relatively easier to reach all community members or villagers in person and in groups. According to our study, health professionals lack the appropriate mobilization skills to successfully organize health durbars. Again, there is a limited use of digital tools in ensuring that community members irrespective of place and time do have consistent access to health information. Further, while volunteerism was found fundamental in CHPS sustainability, the concept although is properly understood by community members, the idea has been met with strong resistance where volunteers today demand salaries for their services. According to volunteers, "it is very discouraging getting up every morning for work and at the end of the month you end up receiving no salary. I have been a community volunteer for over 15 years, yet I cannot boast of significant reward for my work. I understand I volunteered for this kind of work but mind you I also have families".

"*Currently, it is difficult mobilizing community members for health durbars. Most of them are engaged with economic activities – hence leave very early for farms (work) and return late. Also, community participation was initially stronger because we had active volunteers supporting our work. But today, volunteerism is no more, and is really affecting our work".* – Community Health Officer, Upper East region

3. Changes in the political landscape and leadership with changed priorities

Complex interactions of actors were found to have a critical influence on CHPS. To our participants, although a broader political process is required for CHPS sustainability, recent commitments of political bodies towards CHPS are not up to expectation. Every government comes with its own priorities – nobody continues from where the previous government ended. What governments commonly done is to construct CHPS compounds – leaving behind provision of logistics – since the number of compounds built is often considered as major political achievements. Also, although, our study revealed a more prevailing commitment by the community members and the international donors to improve CHPS, while communities lack the needed resources to sustain the initiative, policy inconsistency also threatens the sustainability of projects pursued by international donors. That is, these international bodies mostly implement pilot projects for a stipulated time and then leave, but who to commit to the course left behind and provide the desired resources to sustain the initiative is a challenge which retards the progress of CHPS.

"CHPS is more a political tool now – it is just on the lips of our politicians. They promise a lot but deliver little. When it comes to logistics often rely on donor partners who mostly come to pilot projects for a stipulated time and then leave. But whether such projects are sustained is another issue because when they pull-out who to continue from wherever they ended is also a unique challenge altogether. Nonetheless, if the leaders are so vibrant and active, you see them going in and out sourcing for funding to sustain the initiative. But you wouldn't see that in places where the leaders do not believe in the concept of CHPS. So, there will be a bit of variation in the level of performance depending on who for example is the head, and more to the point where the developing partners seek to work. This is part of the reason why some regions have several partners helping to improve CHPS, and otherwise. So, that might resort to a bit of disparity in performance, but when you talk about challenges faced by the initiative due to governmental commitments, then that tends to be a countrywide challenge". – Renowned Researcher on CHPS

Furthermore, we found communities' independent efforts being driven by loss of trust in the Governments to fully provide their health needs. To the community members, Governments have shown inadequate exertion to provide CHPS compounds the basic resources. Hence, any initiative where communities can lead the forefront of their development and not to always rely on the government is worthy to embrace. In

view of that, community leaders and members with improved understanding of the CHPS concept independently exhibited vigorous efforts towards issues of health and development.

"We never waited for the Ghana Health Service to inform us that we are due for CHPS compound. That would have taken a long time, considering the political processes involved. The community has formed an alliance with a UK based Trust that support our development. So, we proposed to them to also support the establishment of our facility, and over five years the community has also been contributing to pay the utilities of the facility.". – Traditional Leader (community Chief), Central region

On the other hand, where there were chieftaincy disputes, key stakeholders (especially traditional leaders) oppose decision-making processes and program implementation. As an example, we observed low community participation in communities facing chieftaincy and land disputes, or without a chief – since health professionals find it difficult identifying which leader to consult to serve as a focal point to engage its citizens. Also, due to lack of consensus, family members and friends of opposing leaders also refuse to attend programs being organized for the community.

"Communities are encountering series of chieftaincy and land disputes. As a result, you may organize a health durbar in one community, and it will interest you to know that part of the community members will deliberately not attend, expecting a separate durbar to be conducted for them. The reason being that, opposing leaders would want to be also recognized and treated as community heads. Unlike elsewhere, where you find out that a community has just one chief (leader) who perhaps may serve as the head of the CHPS zone to engage its citizens". – Community Youth Volunteer, Volta region

Discussion

The Alma-Ata Declaration of 1978 identified the role of a comprehensive primary health care (PHC) as the cornerstone to any sustainable health system. Now, in its 40th anniversary, while the philosophy of PHC is valid more than ever, the development of PHC-based healthcare delivery has received a paradigm shift towards the deployment of several forms of community health workers (CHWs) – as cadres capable of delivering effective care at the least cost, at the community and household levels. (19)

Social mobilization and community participation need to be at the centre of health policy planning and implementation to achieve UHC in any setting. Ultimately, the efficiency of the community health volunteers and managers (including community health management teams) through regular capacity building and constant training for building more effective and responsive systems to adapt the dynamic changing health needs, are the keys to the success of community-based programme. Well-designed community-driven initiatives have proved capable of establishing a more substantial means in addressing

crippling PHC system in several LMICs. For instance, addressing shortage and poor distribution of various health workers and encouraging them to choose to practice in rural and underserved areas, expanding and strengthening coverage of key health programs, and re-organizing health workforce to address challenges pertaining to low access to quality, people-centered, affordable and acceptable health care services, can be mentioned (19) The "Behvarz" of Iran, the village health volunteers in Thailand, the lay health workers in Pakistan, the health extension workers in Ethiopia, the BRAC community in Bangladesh, are all successful community-based models (20), which have contributed immensely towards programs focused on maternal, neonatal, child health care and development, and reproductive health.

Yet, even in countries with proved and meaningful success, key challenges continue to threaten the sustainability of such initiatives. Community-based necessitate active engagements of actors. However, often, stakeholders operate without robust mechanism for coordination, which may hinder achieving the intended purposes. As our study reveals, this challenge might emerge because of inadequate understanding of the policy content, and the lack of equal cooperation among major actors including political bodies, donors, the health directorate and the local partners at the district and sub-district levels. Conflicting stakeholder interests (especially among politicians) have led to a several disorganized national debate, particularly during establishment or expansion of public health services. (21) Hence, politics and stakeholders' engagements matter at each phase of health reform – as existing institutions and interest groups often have both the reasons and the resources to vigorously oppose change, (22) as experienced for instance by the Iranian health system where medical doctors initially opposed family physician program in rural Iran due to lack of prior consultation, and understanding of policy content. (14) Notwithstanding that, community participation in all aspects of policies is essential to enhance sustainability through country ownership and accountability. (3, 23) Otherwise, promoting local ownership of initiatives would become challenging, as it happened in Brazil. (24)

The key to attaining UHC through community-based programs is the ability of global, national and local partners to ensure much policy flexibilities, especially at the local levels. (20) However, our research revealed that the CHPS initiative is increasingly becoming complex and difficult to manage, due to its openness to change and the increasing diversity of demand and expectations of clients. Any pressing demand is considered critical and a potential target for reform, although it might not be strategic implementing such initiative at that level of care. As an example, the increasing demand of maternity unit has raised varying views among stakeholders as to whether all CHPS facilities need to have a delivery ward, or clients should be referred to the next level of care. Worse still, the component of minor treatments within the service package has rendered the initiative less effective and efficient, and

eventually is causing the community members to lose trust in community-based health system. Let alone that despite the rising demand and expectations, CHPS is challenged with inadequate resources (even basic logistics) to treat minor ailments, which has led to rampant referrals of health cases and its associated costs. Hence, we are of the view that CHPS can achieve eloquent results if efforts are geared towards improving preventive and promotive services – rather than curative care. Besides, due to inadequate resource allocation by the governments, adding facilities and interventions (a midwifery delivery department at the facility, in the case of our study) will led to further unanticipated malfunctions of the system. (25) In addition, as societies modernize and become more affluent and knowledgeable, what people consider to be desirable ways of living as individuals and as members of societies may change. (26) Yet, CHPS initiative is faced with lack of resources to help build the capacity of community health professionals – particularly regarding the use of tools in responding to changes in health practices, to enhance better community participation and mobilization, as well as efficiency. As a result, clients, especially the urban residents show negative attitudes towards community health professions (especially health volunteers), questioning their credibility to even educate them about health. Notwithstanding that, these challenges could also serve as a platform for change and innovations. Yet, it might also overburden the international donors and the NGOs – considering the limited political commitments in sustaining the initiative. This may in turn place immerse strains on communities, particularly the ones with least resources to support themselves and meet challenges, which may reduce health performance, as happened in other settings. (26)

Generally, the governments' struggle to resolve what they are willing to spend resources on and what clients want is a fundamental health sector reform dilemma. (27) Many LMICs are faced with the maldistribution of resources in the face of pressing health needs – where public sector is often perceived as providing inferior service, and many citizens – even the poor – may have to pay for improved services out of pocket – resulting to a varying degree of service and health status between urban and rural residents, and the rich and poor. (21) In this respect, many countries that are even noted for sustainable community-based programs, maybe affected by the effect of increase in workload on the community health professionals, which in turn can compromise the quality of health services they provide. (28) Nevertheless, although resources matter, countries like Cuba has shown that better health chances can be achieved without the best of resources being available. It is recommended that healthcare financing for dispersed inhabitants often receive larger per capita expenditure, and in countries with both high-density and low-density populations, it is expected that dispersed populations receive subsidy to promote equity. (29) In addition, countries are devising cost-effective innovations that meet the health and well-being of its citizens from an explicitly multi-sectoral perspective, with a focus on expanding coverage of curative healthcare, while reinforcing

promotive strategies and cross-sectoral actions on social determinants of health. (30) Although, that tends to be expensive, communities can secure such inputs at a manageable cost by joining forces. (31) Our study revealed that communities that are making meaningful advancement through the CHPS initiative are those that are either resourced or have leaders constantly negotiating for support from non-governmental institutions. Further, the use of radio communications has shown successful in overcoming geographical obstacles to health in such areas, in a more efficient and affordable manner. (29)

Community health workers have featured in the discourse of many global public health agenda – by proving effective in addressing issues that have adverse impact on moving towards UHC. Today, in the era of SDGs, health is considered a political choice, and everyone's concern to drive the world to a state where health must be universal and equitable. (32) Nonetheless, to achieve meaningful results, it is edged that countries adapt specific targets and actions based on national priorities that promote country ownership and accountability, (23) – reaffirming the profound role of community-based programs in many LMICs, (33) including Ghana.

Policy recommendations to increase the chances of success

Community-based initiatives are increasingly represented as a potential strategy to strengthen PHC. Nonetheless, certain vital gaps still impede their progress. Based on our findings, the following are recommended for community-driven initiatives to better help serve its purposes.

1. Effective coordination and transparency among actors, particularly, community members, NGO's, politicians and the health directorates is eminent to enhance understanding of policy contents and the ways in which changed priorities or conflicting institutional goals and values could emerge, to influence intended policy outcome.
2. There is the need for effective ambulances services to facilitate upward referral of health services which are beyond the scope of community health professionals.
3. Stakeholders, especially, academic institutions, the community, and governments, should create a sustainable framework to improve social determinants of health (SDH), and capacity building on the effective use of digital tools and community mobilization skills, to shape public health practices.

Further studies are required to:

- Explore digital tools that can help improve knowledge of community health professionals, enhance community participation/mobilization and health practices and interventions, and can foster greater accuracy and efficiency of activities.

- Identify ways in which factors such as the quality of community health governance and policy coherence can be maximized.
- Investigate ways to provide sustainable community health financing and resource mobilization.

Conclusion

Universal health coverage is a growing concern and a core target of the SDGs. Nonetheless, considering the existing disparities between and within countries, attaining UHC will necessitate all-inclusiveness, a participatory processes and interactions between health systems and the populations. This has led to a renewed relevance of CHPS in Ghana — an initiative which practically relies on citizen engagement as a central instrument in the delivery of services closer to the door-step of clients, particularly to those at the rural or slummy areas. Despite its recognition in safeguarding communities' commitments and country's ownership to attain UHC, gaps continue to impede its successes. They include: inadequate understanding of the CHPS concept – much of which is due to poor community entry and sensitization programs during the onset of CHPS scale-up. Again, major contextual changes, with ensuing stalled policy change to meet growing demands, and changes in the political landscape and leadership, with changed priorities or opposing forces – all threatens CHPS sustainability. Our study concludes that what is essential to influence positive change for achievements of UHC in Ghana (through CHPS) is the political will – an improved national health governance and the political determinants to lead actions of the community and international donors.

Data sharing

For extra data contact the corresponding author through takiana@gmail.com.

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Table 1: List of interviewees and their characteristics & Study settings

Region Levels	Central Region	Greater Accra Region	Upper East Region	Volta Region	Total
National Level	Head of CHPS (1), Head of monitoring and evaluation (1), other senior officials (2) at Policy, Planning, Monitoring and Evaluation unit at the Ministry of Health, and Renowned researcher on CHPS (1).				5
Region Levels	***Cape Coast*** Deputy regional director for health administration and support services (1); Regional director for public health (1); Senior public health nurse (1); Head of service training (1); Regional health information officer (1); Regional human resource manager (1)	***Accra*** Regional CHPS coordinator & deputy director of nursing services (1)	***Bolgatanga*** Regional CHPS coordinator (1); Senior reproductive and Child Health (RCH) (1); Information officer (1)	***Ho*** Regional CHPS coordinator (1)	11
District /Municipal Levels	***Assin North District*** Municipal health director (1) Municipal CHPS coordinator (1) Municipal nutrition technical officer (1); Community mental health officer (1)	***Kpone Katamanso District*** District health director (1)	***Bolgatanga Municapal & Kassena Nankana West District*** Municipal CHPS coordinator (1); District CHPS coordinator (1); Nursing officer (1)	***Ho municipal*** Municipal CHPS coordinator (1)	9
Sub-district/ Local levels	***Assin Endwa CHPS compound*** Community health nurse (CHN) (1); Head of facility (1); Enrolled nurses(EN) (1); Community health management committee (CHMC) – Traditional leader (chief) (1), Assembly member (1); Other opinion leaders (2)	***Appolonia CHPS compound*** General nurse (1); CHN (1); Midwife (1); EN (1); Nursing officer (1); CHMC – Traditional committee (2), Assembly member (1); Other opinion leaders (3)	***Yikene & Nania CHPS compound*** CHN (1); EN (2); CHO (2); CHW (3); Midwife (1); CHMC – (Traditional leader (1), Religious leader (1), Assembly member (1), Community youth volunteer (2)	***Loboli & Atikpui CHPS compound*** EN (3); Head of facility (2); CHOs (2); CHW (2); CHMC - Community youth volunteer (1)	42
Total	17	13	20	12	**67**

Challenges to achieving universal health coverage through community-based health planning and services delivery approach: a qualitative study in Ghana

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