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Ghana's community-based primary health care: Why women and children are 'disadvantaged' by its implementation

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ABSTRACT

Policy analysis on why women and children in low- and middle-income settings are still disadvantaged by access to appropriate care despite Primary Health Care (PHC) programmes implementation is limited. Drawing on the street-level bureaucracy theory, we explored how and why frontline providers (FLP) actions on their own and in interaction with health system factors shape Ghana's community-based PHC implementation to the disadvantage of women and children accessing and using health services. This was a qualitative study conducted in 4 communities drawn from rural and urban districts of the Upper West region. Data were collected from 8 focus group discussions with community informants, 73 in-depth interviews with clients, 13 in-depth interviews with district health managers and FLP, and observations. Data were recorded, transcribed and coded deductively and inductively for themes with the aid of Nvivo 11 software. Findings showed that apart from FLP frequent lateness to, and absenteeism from work, that affected care seeking for children, their exercise of discretionary power in determining children who deserve care over others had ripple effects: families experienced financial hardships in seeking alternative care for children, and avoided that by managing symptoms with care provided in non-traditional spaces. FLP adverse behaviours were driven by weak implementation structures embedded in the district health systems. Basic obstetric facilities such as labour room, infusion stand, and beds for deliveries, detention and palpation were lacking prompting FLP to cope by conducting deliveries using a patchwork of improvised delivery methods which worked out to encourage unassisted home deliveries. Perceived poor conditions of service weakened FLP commitment to quality maternal and child care delivery. Findings suggest the need for strategies to induce behaviour change in FLP, strengthen district administrative structures, and improve on the supply chain and logistics system to address gaps in CHPS maternal and child care delivery.

1. Introduction

Health systems constantly seek better ways to make health services accessible, affordable, equitable and responsive to disadvantaged populations. Such efforts resonate with the Alma Ata Primary Health Care (PHC) philosophy of 'health for all' (WHO, 1979) underpinned by the implementation of close-to-community health programmes to end health disparities, social injustices, tackle disease burden of the poor, reduce deficits of hospital services and minimise risks factors of the social determinants of health (Kruk et al., 2010; Lawn et al., 2008; McCollum et al., 2016).

In Low- and Middle- Income Countries (LMICs) PHC programmes are widely implemented (Lewin et al., 2008; Rosato et al., 2008) with priority given to maternal and child care (Bhutta et al., 2010), primarily because these populations often lack access to, and face difficulties interfacing with complex hospital systems to have their health needs and challenges adequately addressed (Goroll and Hunt, 2015). Thus, PHC adapted to local conditions and relying on cost-effective local resources and community mobilisation can improve access and use of health services and ultimately maternal and child health (Rosato et al., 2008). PHC is shown to contribute to better overall population health in LMICs (Marmot et al., 2008; Rifkin, 2014). However, the poor maternal and child health and survival (Alkema et al., 2016; You et al., 2015), coupled with weak micro-health systems resilience and responsiveness to health shocks in these countries (Gilson et al., 2017; Kieny et al., 2014), have generated questions around the effectiveness of these programmes scale up (Rosato et al., 2008).

Additionally, despite PHC programmes implementation in low- and middle-income settings, women and children are still disadvantaged by access and use of health services (Kruk et al., 2016). The gaps in

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implementation have been diagnosed as: poor community participation in delivering health benefits, and in promoting choices, social accountability and uptake of health services (Marston et al., 2016; Rosato et al., 2008); weak inter-sector collaboration leading to human, physical and material resources being poorly harnessed for delivering health services at scale (Lawn et al., 2008; Lewin et al., 2008); and poverty, economic marginalisation and entrenched socio-cultural norms shaping decisions around health service use (Atun et al., 2007; Rosato et al., 2008). And although the literature continues to proliferate, little efforts have been made to broaden understanding of other factors underlying the gap. Moreover, an understanding of whether and how the implementation processes and structures themselves generate the gap has received limited focus. Analysing the gap from a policy perspective, however, is crucial to enable policy makers benefit from more nuanced and expanded set of alternative solutions for health systems strengthening. Drawing on the bottom-up policy implementation literature, this study sought to provide further in-depth explanation to the problem.

Bottom-up literature attribute implementation outcome success or otherwise to the influence of implementers at the operational level (Matland, 1995). Because these implementers work remotely from the sight of central bureaucrats, it becomes difficult to maintain perfect hierarchical control over their routine activities (Buse et al., 2012), thus, giving them more discretion and control over how policy is administered (Erasmus, 2014). Usually policy-practice divergence occur because of implementer's flexibility in making choices. A range of evidence attest to these. In South Africa, a free care policy was poorly delivered as nurses' discretionary decisions dominated normative prescriptions (Walker and Gilson, 2004). A maternal care subsidy policy implementaion in Burkina Faso was altered as health providers used their own discretion to charge unapproved fees (Ridde et al., 2013). And in Liberia, a key barrier to implementation of a Basic Package of Health Services programme was nurses attitudinal obstacles to health service use (Petit et al., 2013).

Reflecting these implementation experiences, is Ghana's Community-based PHC known as Community-Based Health Planning and Services (CHPS) to be referred to as such in this paper. Despite decades of scaling up to improve maternal and child health, women and children are still faced with multiple barriers accessing care as are opportunities to have their needs and concerns adequately addressed (Engmann et al., 2016). There is also evidence of women delivering at home despite CHPS proximal distance, particularly where this study was conducted (Rishworth et al., 2016). Unpublished reports have attributed these gaps in part to Frontline Providers (FLP) attitudes and practices, and weak governance and administrative structures nested within the district health systems (Agongo, 2014; Ministry of Health, 2009). This call for empirical evidence situated within the policy lens to understand the scale of the problem. Accordingly, this study sought answers to two research questions: how and why do FLP attitudes and practices influence access and use of health services by women and children and with what consequence? What health systems factors hinder quality maternal and child health service delivery and with what effect on women and FLP practice?

To explore the underlying research questions, the study drew on Lipsky's (1980) street-level bureaucracy theory. Lipsky (1980) framed the term street-level bureaucrats to describe public servants who routinely interact with citizens and have discretion performing their functions. Although work requirements for street bureaucrats are often scripted to achieve specified goals (Scott et al., 2014), they have relative autonomy and exercise discretion and power in discharging their duties to the extent that such prescriptions are hardly followed (Erasmus, 2014). The lack of adherence to rules sometimes produce unintended policy outcomes (Lipsky, 1980).

Street bureaucrats typically work amidst constraints, tight schedules, heavy client demands and poor working conditions (Erasmus, 2014). They get around these by establishing routines and coping mechanisms (e.g. service rationing, misuse of resources, lacklustre attitude to work, poor commitment to policy goals) in order to have more control over their work (Lipsky, 2010). Elements of the routines and coping methods typically override bureaucratic prescriptions of policy requirements and become implementation in practice. Clients are also important in understanding implementation processes and outcomes. Clients are non-voluntary usually faced with limited control over street bureaucrats' actions and alternative services they provide (Erasmus, 2014).

2. The Ghana community-based primary health care programme

The CHPS programme emerged from a trial of a community health service model (CHSM) implemented between 1994 and 2001. The CHSM was driven by failure of vertical primary care interventions implemented between the 1970s and 1980s. At the time, Ghana implemented the Village Health Worker and Community Health Nurse programmes as part of broader primary care strategy to make health services accessible and affordable (Lamptey et al., 1980). Both programmes, however, failed to survive the test of time due to poor implementation structures and technical problems (Agyepong and Marfo, 1992). The CHSM programme was subsequently piloted to provide family planning, immunisation and maternal and child care taking into account community participation, voluntarism, social mobilisation, clinical outreaches, home visits and resident community health nursing (Nyonator et al., 2005).

Evaluation of the pilot programme showed that deploying health services to the community provided by resident nurses stimulated utilisation and improved maternal health and child survival (Phillips et al., 2005). The pilot programme was expanded and replicated in other communities with proven similar positive results (Awoonor-Williams et al., 2004). The CHSM programme was subsequently adopted and integrated into the health system known as CHPS (Nyonator et al., 2007). CHPS became a national primary health care policy with nationwide scale up in 2002. There is detailed information about CHPS elsewhere (Awoonor-Williams et al., 2013; Nyonator et al., 2005; Phillips et al., 2006). CHPS Implementation and management is bottom up. Community members, Frontline Health Providers (FLP) and District Health managers are the key implementing stakeholders.

Frontline providers (trained and salaried community health officers, midwives and enrolled nurses) are reoriented to the community to perform four broad spectrum of tasks (Fig. 1) (Ghana Health Service, 2005). Cases beyond their clinical capacity are referred to health centres and district hospitals. They are assisted by Community Health Volunteers (CHVs) to deliver family planning, reproductive health services, immunisation and more, depending on local needs. District health managers perform supervisory and other roles (Fig. 1). The community provides social mobilisation, voluntary services and needed support systems to aid care delivery. The community also provides local administrative oversight by instituting Community Health Management Committees (CHMC) to serve as watchdog of CHPS affairs (Ghana Health Service, 2005).

3. Study context

The study was conducted in the Upper West Region (UWR) of Ghana. The region is one of 3 savannah regions north of the country. It has the least national population (702,110), population density (38.0), urban population rate (16.3%) and population growth rate (1.2%) (Ghana Statistical Service, 2012). At the time of the study, the region was divided into 11administrative districts: 1 municipality and 10 district assemblies, well below the national average of 6 and 15 respectively (Local Government Service, 2013).

Although poverty incidence in the 3 savannah regions is marginally higher than the national average (24.2%), the UWR has the highest poverty incidence. About 71% of the population are living below the