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Local patterns of social capital and sustenance of the Community-Based Health Planning and Services (CHPS) Policy: A qualitative study in Ghana

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Abstract

Objective: Social capital—the resources embedded in social relationships—has been associated with health severally. However, only a handful of studies have examined how it shapes health policies. This paper extends the discourse by comparatively examining how variations in local patterns of social capital underpin the successes and challenges in implementation, management and sustenance of the Community-Based Health Planning Service **(**CHPS) policy in Ghana. The CHPS is a social and public health intervention to address health inequalities and improve health.

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

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

***Participant*s:** Thirty-two adult primary participants as well as four health personnel and four traditional and political leaders.

Results: The findings indicated that both structural and cognitive components of social capital underpin efficient functioning of the CHPS initiative in terms of financing, patronage and rapid and effective information transmission. Sufficient level of social capital in a community ensured relatively better understanding of the nature and purpose of the CHPS policy as well as complementary ones such as referral policy and health insurance scheme. Contrary to popular conclusions, it was observed that the influence of social capital was not necessarily embedded in its quantity but the extent of conscious activation and application. Furthermore, the findings negated the assertion that social capital may be less potent in small-sized communities.

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

Strengths and limitations of the study

- The study is the first to conduct a comparative analysis of the role of social capital in the implementation of the CHPS concept
- It combined experiences of health service users, practitioners and decision makers.
- The interviews and focus groups were carried out in 'Twi' and the transcripts and results validated by a language expert and key stakeholders of the CHPS
- Some participants may have over or under-reported their reliance on social capital for decisions and knowledge in relation to the CHPS.
- The study was carried in two communities in Ashanti region and cannot be said to represent happenings in other places.

Background

The study examines the state and functioning of the Community-Based Health Planning Service (CHPS) policy in two rural communities in the Ashanti region in Ghana from a social capital perspective. Social capital refers to the resources that are embedded in different social relationships and the glues that make those relationships work [1-3]. Several studies have observed an association between various aspects of social capital with health [4-6]. Regrettably, the focus on social capital in health and social policy research has been dominated by its direct relationship with health, with only a few addressing how it shapes health policies [7-9]. This paper extends the discourse by comparatively examining how variations in local patterns of social capital underpin the successes and challenges in implementation, management and sustenance of the policy. The article is inspired by McConnell's typology of policy success (or failure) namely; the nature of the programme design (e.g. meeting set objectives), the political (local level) characteristics and the processes involved in implementing and sustaining a programme [10, 11]. Of interest, is how elements of social capital explain these typologies. The paper thus addresses one of the critical micro-level issues in policy analysis [12], through the lens of an essential but hugely neglected contemporary social concept particularly in developing countries [13].

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

Despite earlier success, implementation and sustenance of the CHPS have been challenging in many localities. At a rather alarming rate, health personnel are always in a rush to transfer out of the remote and infrastructurally deprived communities. Others hasten to further their education leaving their post vacant [14, 18, 19]. Moreover, frequent shortages in logistics and tools for the CHOs including essential drugs have also been reported [20]. The state has also been battling to meet the resource requirement of the concept [19]. Furthermore, there is limited understanding of the public of the CHPS concept. For these reasons, fidelity to the original the CHPS model such close community engagement in the planning and delivery of services are gradually dissipating [18, 21]. Regardless of its challenges, the CHPS remains critical to health service delivery in Ghana [16]. For instance, 30.4% of family planning drugs/methods administered in 2014 were carried out at CHPS compounds/zones [16]. Therefore, plausible explanations and solutions for its challenges must be found urgently.

Social capital entails two components namely structural and cognitive aspects. On the one hand, structural social capital depicts the 'hard' aspects. It describes 'bonding social capital'—the resources embedded in close relationships such as families and intimate friends. There is also 'bridging social capital' which captures weak relationships such as neighbours, people in different communities and even a friend of one's friend. Lastly, the structural aspect also considers 'linking social capital' which refers to the relationship between individuals of unequal power relationships and different social and economic status. It also describes the relationship between people and prevailing institutions. On the other hand, cognitive social capital manifests in the form of 'soft' side of the phenomenon such as trust, sense of fairness, attitudes, norms of reciprocity, sense of belonging and harmony. Some attribute the usefulness of social capital to these abstract aspects [22-25]. The components of social capital and their constituents can operate at both individual and community/ecological levels [26].

Earlier research indicates that policies in the shape of the CHPS concept exhibit more promise in localities where residents possess high levels of social capital [20, 21, 27, 28]. For instance, it is argued that trust—between CHOs and community members—is critical for patronage, especially in times of financial difficulties [21, 29]. A study in China has also observed that structural social

capital is related to an increased utilisation of local public health services even among migrants [28]. Furthermore, in a recent study to identify the sociodemographic determinants of utilisation of skilled birth attendants at the CHPS compounds, in Northern Ghana, Sakeah, Doctoret al. [30] found that women from particular ethnic groups and those with uneducated husbands were less likely to access services of skilled attendants at birth in rural settings. Other studies suggest the state of many CHPS facilities are linked to the extent of consultation and participation of members of the implementing locality [27]. However, a new wave of implementation entails an outright reliance on contractors instead of using community resources—at least at the initial phase. This practice has not only inhibited community participation but also reduced funding from both local and international donors due to increasing cost of implementation [21]. Interestingly, these observations are not different from a related study of the Health Action Zones (HAZ) in England. It was observed that poor collaboration with communities and experiential knowledge of community members partly accounted for failures in some HAZ [7]. Also, Sheikh, Ali [8] noted in Iran that high levels of both cognitive and structural social capital (including associational affiliation, trust, and citizenry activities) are associated with better operation and functioning of community-based initiatives (CBI) that are meant to improve health-related quality of life. It is thus high time to usher in further empirical evidence that ignites a rethink of dangers in ignoring the social content of the CHPS' policy.

Methods

Study design and context

The study used a comparative case study research in a priori qualitative approach [31]. It thus tilts towards the interpretivist epistemological school of thought [31, 32]. This approach helps to understand a given problem from the lived experiences and worldview of participants [32]. The study is based on a cross-sectional data gathered from Ashanti Region in Ghana as part of broader mixed method research. The Region is centrally located, which makes it attractive to people from several other regions and countries. Participants for this study emanated from two communities, Amoam-Achiase and Apemanim, in two districts, Atwima Kwanwoma and Ejisu Juaben districts respectively, which had instituted the CHPS policy. For simplicity, the two communities are referred to from here on as Apem (instead of Apemanim) and Amo (Amoam-Achiase). The two districts, and the two communities therein presented characteristics that made

them unique, yet, comparable regarding socio-economic indicators such as economic activities and the population size (see table 1). The two CHPS compounds also shared similar features regarding staff strength and available logistics.

Participants

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

Data collection

Data were collected through discursive engagements with primary players and users of the CHPS concept. The data was gathered from June to October 2015. A semi-structured interview guide was used to elicit the data through individual in-depth interviews and focus group discussions (FGDs). Eleven personal interviews and two FDGs were conducted at Apem community whereas nine individual interviews and one FDG were carried out at Amo with help from two research assistants. Purposive sampling technique was used to select participants for both forms of interviews to ensure a representative sample regarding particularly sex, age and relationship to the community (whether an indigene or non-native). It was envisaged that non-natives were likely to have different kinds of social connections which may result in different experience as regards the CHPS initiative. The two FDGs at Apem consisted of five and six participants each. The FDG in the Amo community comprised six persons. Some of the participants of the FDGs had been interviewed individually. The mix of the old and new faces helped to generate further information while expatiating on puzzling ones.

The interviews were conducted in-person and lasted approximately 45 minutes. The interviews were carried out using the dominant local language, 'Twi' as most of the primary participants could not express themselves in English adequately. All the interviews were audio-taped with permission from the participants. Topics included participants' demographic background and previous experiences and reflections of engaging with the CHPS in their localities. Emphasis was placed on how social relationships influenced one's (and communities at large) willingness and ability to use the CHPS and partake in the initiation, implementation, and sustenance of the policy and their familiarity with the fundamental objectives of policy. In all the interviews (including the focus group discussions), an attempt was made to deliberately elicit the experiences of participants in the form of stories/narrations about the critical discussion topics. Participants were continually asked to elaborate further on their responses by asking them questions such as "and then what happened". This helped to glean the meaning they ascribed to their actions and inactions.

Data analysis

The interviews were transcribed into English verbatim within the first 48 hours by the author and one research assistant. A language expert validated the transcripts by comparing it with the audio tapes. The analysis started during the data collection stage through constant reflexivity and reflective notes. Initial themes were therefore generated during the field study. The second stage of the analysis comprised a priori approach by concentrating on how both primary participants and key stakeholders used and understood the role of different aspects social capital in the operations of the CHPS concept. An 'open coding' technique [31] was used to categorise the data into themes that largely reflected the various components and kinds of social capital (in the form of themes). The categories were later analysed to identify similarities and differences between them while also drawing meaning across the themes to do away with repetitions. As part of the process, McConnell [11] typology of policy success/failure was used to understand how different aspects of social capital shape facets of the CHPS' policy. Thus, while an interpretivist paradigm was taken, an abductive reasoning approach [31], was applied to provide a social scientific account of the social world as seen from their perspective without losing touch with the world as seen by the participants. This approach helped to make a comparative analysis and discussion. Data from both in-depth interviews and FGDs were triangulated throughout the process. To authenticate the

categories, themes and the meaning ascribed to them, the preliminary analysis was subjected to scrutiny by an academic (social epidemiologist) and a community health practitioner. Throughout the process, the data remained with the researcher.

Public Involvement

This paper emerged from initial sentiments of participants of the larger study, which indicated that the degree and depth of social capital do affect the CHPS. This conjecture was then explored deeper leading to this article. Preliminary findings from the study were discussed with selected key informants: two health personnel and two community leaders, who represented the interests of the communities and CHPS facilities, for ethical and factual validation [32]. All copies of the data and findings that were made for experts and stakeholders for validation were destroyed after their contribution was ascertained. There was no patient involved in the study.

Ethical approval

The Committee on Human Research Publication, and Ethics (CHRPE) of School of Medical Sciences, Kwame Nkrumah University of Science and Technology and Okomfo Anokye Teaching Hospital, Kumasi, Ghana, (CHRPE/AP/345/15) approved the study. All the names used in this paper are pseudonyms that were constructed together with the participants before the interviews to ensure anonymity. Informed consent was obtained from all participants before enrolling them in the study. The study thus followed the international guidelines set forth for health-related research involving humans [33].

Findings

The findings are presented under five themes. The first theme describes the nature and state of social capital in the two contexts whereas the others demonstrate how such differences shape the CHPS policy.

Social capital and the CHPS policy

Table 1 presents some preliminary indicators of structural social capital components of the two communities. Apem residents were predominantly Christians as compared to Amo where a considerable number of people were Muslims. Congruent to the religious composition of the two

communities, Amo showed signs of heterogeneity considering its ethnic diversity compared to Apem where almost everyone was an Asante (the indigenous tribe). The only other vibrant non-religious association at Amo was a welfare group for women, which was sought the financial and emotional well-being of members.

However, about four vibrant groups were identified at Apem including a peasant farmers group, which helped members in sourcing for market, labour, and inputs for their activities. Membership cut across different classes of people including community leaders (the unit committee chairperson of the community was a member of the group). There was also a women's group, which focused mainly on members' welfare and seeking transport for their produce in collaboration with a drivers' association. The driver's group ensured that residents had access to transportation throughout each day while helping each member to obtain employment—by way of sourcing vehicles from owners to drivers. There were sports groups in both communities. Nonetheless, the groups were more of an ad hoc arrangement for fun and exercise although their activities were quite regular. The characteristics of Amo mimicked that of a peri-urban community with a relatively lower household size although both communities remained fundamentally rural and comparable.

Table1: Variations in Some Indicators of Social Capital between the Two Communities

	Community Characteristics	Amo (Population =3500)	Apem (Population =1100)
1	Number of churches/Mosques (Religious affiliation)	6 (About 85% Christians and 12% Muslims) [a]	3 (About 92% Christians) [a]
2	Other associations	2: Women's welfare group Football group (for young men)	5: 1 (Peasant farmers group for both sexes) 1 men's group 1 drivers' association (GPRTU) 1 women's group (usually produce traders) Football group (for young men)
3	Average household size (Nuclear family)	4 [a]	6 [a]
4	Frequency of community gatherings	None	-At least once every three months -Once a week of communal work
5	Dominant occupation	Commerce/service with some agricultural activities	Crop farming
6	Ethnicity	Asantes (70%) and Northern tribes (17%) [a]	Predominantly Asantes (about 96%) [a]

[a] *Figures were drawn from quantitative part of the broader study.*

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

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

Furthermore, by the physical environment in both communities alone, a sharp contrast could be drawn. All public sanitary places at Amo were in the deplorable state. The only public toilet facility was virtually out of commission while the community dump site unkempt. Residents without toilet facilities at home took to defecating in bushes and along walkways while others dumped faecal matters in plastic bags indiscriminately. Although Apem residents used traditional latrines, they managed to keep the facility (wooden structure) relatively tidy. In the ensuing findings, the paper elucidates how differences in precepts of social capital help to explain these discrepancies. The themes are aligned to McConnell [10] thesis on policy success/failure.

Distrust and sense of unfairness, and policy design and sustenance

Patronage of the Amo initiative was comparatively low. This was partly because people often depended on their structural social capital—particularly bonding, bridging, linking, and group mates—as the primary source of information about the operations of the CHPS concept. For varying reasons, some of the information was sometimes interpreted and transmitted in a manner that put a dent in the image of the CHPS. This led to denial of the CHPS as the first option for health care and even for lay referral:

> *Currently, attendance has reduced. Last month, I received just 53 clients. ...I realised that many people had been spreading a falsehood that the cost of care here (CHPS compound) was too high as compared to other places. ...I do not even get why someone would go all the way to Ejisu or Manhyia Hospital when he or she would spend the same amount on transportation and time for the same treatment, but they do (Medical officer 1, Amo, rural)*

However, the extent to which such distortions affected patronage was imputable primarily to cognitive social capital. Traits of a sense of unfairness, suspicions among residents about a

myriad of failed development attempts and the lack of sense of communality particularly at Amo partly accounted for why some residents distrusted the CHPS. Years of distrust in leaders and among members coupled with the gradual physical expansion of the Amo community, which had culminated into continual growth and diversity of population characteristics (multi-ethnicity), yet rural, promoted a sense of unfairness. Even the CHO lamented bitterly about the community's poor contribution towards the sustenance of the CHPS initiative. Residents had no interest in collaborating to address common problems due to mistrust among themselves and local leaders as one participant shared:

> *Our toilet facility is in a deplorable state. ...We need a new one. ... The toilet has been contracted to a private person for about 20yrs to build the facility. ...We could have built one as a community, but I do not think people trust the leaders here. ....I do not trust them. ... They took money from us for some projects that never came to fruition. ...They have still not accounted for the money. ...We hope the private person will construct a new one for us. ...It is part of the agreement (Kwart, 34 years, Amo, rural)*

Linking social capital and local level structures and processes in the CHPS' operations

The distance between residents and leaders at Amo compounded into a situation whereby the local authorities were unable to mobilise the people effectively for education about the CHPS concept—an element which was expected of community leadership per the policy design and the implementation process. This partly explained why many residents had limited knowledge about the policy and showed disinterest in patronising its services or in recommending to others.

> *"There was no proper mass education on the functions of the CHPS compound when it was set up here. ...To them, they see every health facility as a 'hospital'. Also, to them, every health personnel is a doctor no matter the qualification of the person. ...Therefore, when they come in, I teach them a lot. ...I think they are now getting to know the functions of this facility (CHPS)" (Medical officer 1, Amo, rural)*

On the contrary, at Apem, even community leaders assisted in instilling confidence in residents about the quality of services—which people in both localities doubted. Some residents went as far as talking to community leaders before deciding to patronise the CHPS' services:

> *"People come to me regularly to discuss their health problems and seek information about the health facility to use. ...I think people are not convinced about the quality of the services offered at the CHPS compound. ...Oh yes, whenever I ask people to go the clinic [CHPS compound] they heed my advice. ...Because I tell them that I always use the services and it works for me and that the nurses are polite (Local leader 3, Apem, rural).*

There were fewer suspicions and distrust between the leaders and residents at Apem. Community leaders were regarded as knowledgeable and trustworthy. Indeed, the numerous community gatherings made them proactive about their role in the CHPS concept:

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

Also, the community members discussed issues about the CHPS habitually, which underscored the familiarity of residents of Apem about the initiative and their willingness to patronise it.

> *...I can say that majority of the community members are aware of our services ...At least they all know that we do not offer antenatal services here... (Medical officer 1, Apem, rural).*

The strength of weak ties: Social capital and implementation of the referral component of CHPS

An observation in both communities indicated that high social cohesion perpetrated by and through strong bridging and linking social capital, as well as social engagement (such as community gatherings and interactions), had a positive effect on the public's acknowledgement of the CHPS' design and operational procedures. This was particularly apparent in one of the critical components of the CHPS programme, the referral policy. At Apem, elevated levels of these social capital proxies helped to expatiate and spread supportive information. The expectations of residents were therefore guarded as one health personnel disclosed:

> *"…. The community leaders organise durbars regularly in this community. ...On each of those occasions, they invite us (nurses) to explain our services to them. ...I think many of the people now understand that this is only a primary level facility and that we could refer them to another facility anytime. ...Well, at least we do not have to spend much time before they understand why we need to refer them to a higher facility (Medical officer 1, Apem, rural).*

In contrast, residents at Amo demonstrated less familiarity with the referral function. This laid the foundation for the lukewarm attitudes towards the services provided. Many instead sought

services of higher order facilities without recourse to the CHPS although it was physically more accessible and relatively affordable.

> *This is a CHPS compound. ...There are certain medical procedures that I cannot perform. However, the people think everything should be done here. ...So, when they come, and I refer them to a higher health facility, they become discouraged. Because of that, I have noticed that some people have ceased coming here. ...They go to Ejisu hospital or Manhyia hospital [District Hospitals] directly (Medical officer 1, Amo, rural)*

This confusion was ascribable to inadequate pre-implementation public sensitisation on the health policy. Low community interactions and lack of cohesive social activities—which enhance bridging and linking social capital—reduced the public's chances of learning about important programme objectives and functions such as the referral.

Civic engagement, cognitive social capital and institutional exploitation for access to health care financing

Despite the availability of a pro-poor financial buffer system—the National Health Insurance Scheme (NHIS)—for all persons in Ghana, social capital tended to play a crucial role as to whether certain groups could gain access to such provisions. A case in point between the two communities signified such discrepancy in access to healthcare financing facilities. Between the two communities, the facility at Amo was yet to be accredited with the NHIS while that of Apem had long been accredited. A major explanatory factor that emerged was the fact that the low levels of communal cohesion reduced chances of the facility at Amo being accredited. The accreditation process at Amo unlike that of Apem was left to the fate of only the resident health officer as she explained:

> *The attendance was very low earlier on when I started working here. ...I told the people that I would soon be accepting the NHIS. They were willing to patronise. However, it has been challenging to get the facility accredited quickly. I am doing everything on my own, so I do not get ample time to follow up. ...Eventually, the clients got disappointed, and patronage has reduced. I am sure people will troop in once I am through with the registration (Medical officer 1, Amo, rural).*

Nonetheless, the comparatively vibrant social engagements at Apem ensured access to affordable healthcare. Regular community gatherings provided an opportunity for penetration of public opinion in matters of common interests including views on financial implication in patronising the services offered by the CHPS. Such deliberations to some extent pressed on community

leaders to act. Indeed, the leaders were instrumental in getting the CHPS compound accredited by the National Health Insurance Authority. This reduced the burden of out-of-pocket payments and consequently increased patronage:

> *Yes, this facility (CHPS) is NHIS accredited. …Getting the facility certified was one of the main discussions in some durbars. …We [the CHOs] then initiated the process of accreditation. The chief, one of the sub-chiefs, and the assembly representative accompanied us to apply for it. …The chief paid for the entire accreditation process (Medical officer 1, Apem, rural).*

Withal, elevated levels of some aspects of social capital had adverse ramifications for the CHPS concept financially. Some individuals and families (including even community leaders) at Apem instead exploited their strong association with community leaders and CHOs—thus, linking social capital—, to access services of the CHPS on credit. Mostly, this had to do with trusting relationships between local institutions and the public. This was a downside to having high social capital:

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

Trusting that people would defray their debts later by offering the service on credit endangered the financial sustenance of the CHPS concept.

Nonetheless, the depth of social engagements and the sense of fairness advanced the solvency of the CHPS initiative in both localities. Although neither individuals nor groups directly made financial contribution towards the sustenance of the CHPS, some particular efforts of people in Apem ensured economic sustainability of the initiative. Community leaders and some individuals served as watchdogs against bill defaulters by discouraging people from accessing the services on credit habitually:

> *…We told them (community leadership) about the continual refusal of residents to pay for services on one of those occasions. …So, the chief and community leaders took issue with the people. …They immediately enacted a law that no one should visit facility without money. …That whoever does not have money for healthcare should instead go for a loan before venturing the clinic. …Since then, the vast unwillingness to pay for services have reduced (Medical officer 1, Apem, rural)*

Indeed, this measure was in force and working to the advantage of CHPS facility at Apem during the field study. A similar rule had also been enacted at Amo. Moreover, while the contrasts here do not necessarily mean that the CHPS facility at Apem was functioning perfectly, the high level of social capital had extensively manifested positively in the operations of the facility, at least in comparison to the case of Amo.

Discussion

This paper has elucidated how patterns of social capital account for in the functioning and sustenance of the core programme design and implementation procedure as well as the political foundations of the policy. According to the findings, the CHPS concept is likely to be successful in localities where residents possess higher levels of social capital as studies have observed elsewhere [27, 28]. The community with high social capital ample appreciation of the general and specific issues about the CHPS policy such as the referral policy. Halpern [23] asserts that high levels of bridging and linking social capital for instance, indicate a society that is highly interconnected, thereby sharing power and resources through a never-ending and evenly-spun web of connections. By such empowerment, community members become gatekeepers for the health system by directing sick persons to a lower-level facility for appropriate evaluation at the outset. Sakeah, McCloskey [20] attribute community involvement in referring neighbours and educating them about the referral system to improved use of primary healthcare facilities. Furthermore, vibrant social participation coupled with the almost homogeneous nature of places such as Apem (regarding religion, ethnic, and economic characteristics) ensured efficient information transmission. Previous works [1, 34, 35] show that closed societies facilitated by religious and cultural precepts enjoy trust in public institutions and increases the likelihood of attaining desired behavioural outcomes. This is plausible because many in Ghana are known to consciously depend on their social networks for information and decisions concerning the referral policy [9].

While financial matters have been identified as a bottleneck in subscription to the NHIS, non-financial factors such as physical access to accredited service providers remains a challenge to residents in many remote localities [36]. In the study communities, elevated linking social capital and social engagements ensured cohesiveness and trust among members. This contributed to

quicker identification and redress of hindrances to the patronage of CHPS and complementary policies such as the NHIS. There is a precedent for this. Fenenga, Nketiah-Amponsahet al. [37] concluded from studies in rural and urban Ghana that social engagements and trust in institutions including the NHIS, encourage people to patronise the initiative. The role of community-level social capital—social cohesion and trust—to some extent, alleviates the inability of the core poor to benefit from these financial interventions. Kotoh and Van der Geest [38] observed from prolonged studies in central and eastern regions of Ghana that poor persons, and especially those in deprived communities, were unable to access the NHIS even though they knew about it. Perhaps such limitations have to do with low social capital in these localities, as the findings here seem to suggest. The success of pro-poor programmes and allied policy initiatives rallies on the depth of social capital.

Given the uniqueness of the concept and policy objectives of the CHPS initiative, its fiscal issues are sensitive to the prevailing social environment. From the findings, social capital (both cognitive and structural aspects) either impinges or facilitates the solvency of CHPS compounds. Effective patronage of the CHPS' services coupled with willingness to pay is crucial to its growth. Therefore, patronage—or effective demand as economists would argue [39]—in using and being able to pay for the services was inextricably related to social capital. The biggest challenge, yet, remains the fact that many, especially rural residents, are poor and can barely afford the basic premium of the NHIS in Ghana [36]. If this continues, reliance on one's social connection for utilising the CHPS on credit will only escalate. This finding supports the call for a more equitable distribution of the financial burden of Ghana's NHIS. The core poor should be continuously identified and offered the chance to register for applicable exemptions, of which many are still unaware [38]. In so doing, the need to exploit cognitive aspects of social capital for the sake of using health services on credit will be curtailed with time.

Furthermore, the impact of social capital on the functioning of the CHPS could also be explained by the sizes of the two communities. Amo was becoming peri-urban with features such as increasing population diversity (ethnicity and religious composition for instance). However, the scale of urbanisation had not reached the point of being a traditional urban neighbourhood. Apem remained comparatively small and very remote. According to Putnam [40], small

communities propagate dense[1] networks and nurture cognitive elements such as trust, which increase access to vital resources. In contrast, some earlier studies posit that weak or loose ties sometimes allow for efficient information flow and are particularly crucial for facilitating collective action [22]. Grootaert and van Bastelaer [42] contend from a review of several works that communities with simultaneously high levels of bonding and linking social capital may lead to low levels of social cohesion. It has also been submitted that some small-sized rural communities might instead be too conservative to tolerate differences leading to low social capital [43]. The situation at Apem differs from these assertions. The difference in the functioning of the CHPS compounds in the two selected localities speak to the presence of high social capital—at least for some of its proxies such as trust—as an indication of sufficient institutional performance, civic activities and linking social capital. The findings in the present study are also consistent with the work of Sheikh, Ali [8]. They noted from Iran that high levels of both cognitive and structural social capital (including associational affiliation, trust, and citizenry activities) are associated with better operation and functioning of community-based initiatives (CBI) that are meant to improve health-related quality of life and well-being of people. People in CBIs areas had better access to public services and less segregation due to income or social status [8].

To some extent, the findings challenge the contention of Portes [44] who argues that more impoverished communities may be impoverished not necessarily because of their lack of social capital but rather because of the meagre resources they possess. Portes' (2000) proposition does not hold true when one considers the situation at Amo. It was a community with comparatively low social capital (both cognitive and structural forms). Although it was becoming peri-urban and had access to a wide range of resources, it failed to support the CHPS concept adequately. This failure of a community to support a health policy despite having access to diverse resources suggests a new perspective. Although poorer and rural communities may collectively possess fewer resources, it appears that it is the generation and uses of social capital instead of its quantity or diversity that makes an impact on people and policy. A group with limited resources but located in a highly cohesive society would find a way to nurture the available ones, as the residents of Apem community demonstrated regarding subscription to complementary services

[1] The claim is that in areas with stronger, dense, horizontal and more cross-cutting networks, there is a spillover from membership in organizations to the cooperative values and norms that citizens develop. [41]

such as the NHIS. Therefore, the assertion that the frequency and number of social interactions per se may not alter its impact has a footing here [45, 46].

The paper suggests that high social capital improves functioning and sustenance of the CHPS concept (e.g. in enhancing patronage). This is congruent with the discovery by Putnam [1] in his work in Italy. Based on extensive surveys and interviews, Putnam asserted that vibrant associational life—literacy guilds, service groups, sports groups—accounted for the differences in institutional performance between northern and southern Italy. Comparing this with the findings from the present study, it is safe to argue that implementing the CHPS initiative, and similar pro-poor policies, in localities with low social capital both structural and cognitive forms may render it susceptible to recurrent challenges. Indeed, Halpern [23] posits that any "policy and debate that fail to address it *[social capital]* are doomed (*sic*) to be shallow and unconvincing". The findings also add to the assertion that "health systems are inherently relational and so many of the most critical challenges for health systems are relationship and behaviour problems" [47]. Social capital generation must, therefore, be a quintessential component of the CHPS initiative for it to be sustainable.

Despite the differences in implementation and sustenance of the CHPS concept in the selected contexts in relation to levels of social capital, it is prudent not to over-romanticize the concept of social capital, as it may be naive to do so [7, 48]. Such romanticism may "elevate mystical and personal experience over objective coherence, building to a national ecstasy that denies justice and social need" [48]. In fact, not all the forms of social interactions were explicitly influential for the CHPS policy. Additionally, some participants may have over or under-reported their reliance on social capital for decisions and knowledge in relations to the CHPS. The findings can therefore not be taken as an exact reflection of happenings in other contexts. It will be more useful to broaden understanding of social capital's consequence for health policies through repeated studies in similar and dissimilar contexts. A similar study involving multiple communities and districts could expand knowledge base of the role of different forms of social capital on pro-poor health policy implementation and sustenance. Nonetheless, the present study is the first to conduct a comparative analysis of the role of social capital in the execution of the CHPS concept.

Conclusion

The article set out to examine the relationship between social capital and implementation and sustenance of the CHPS concept in Ghana. The paper shows that the successes and failure of the CHPS have much to do with the depth of social capital in a given context. It suggests that when some of the numerous challenges facing the CHPS concept are situated in the realm of social capital, causes and solutions may be identified. In fact, regardless of the stage in policy development, social capital can be useful to ensuring its success. Hence, generating and incorporating social capital must be a critical component of pro-poor policies alike throughout their lifespan.

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Standards for Reporting Qualitative Research (SRQR)

	Page/line no(s).
Title and abstract	
Title: Local patterns of social capital and sustenance of the Community-Based Health Planning and Services (CHPS) Policy: A qualitative study in Ghana	Page 1, line 1-2
Abstract - The abstract have been structured according the requirements of the journal.	Page 2, lines 44-67
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; and problem statement have been provided at different parts of the background to the paper	Page 3-5 Lines 79-157
Purpose or research question: the purpose of the paper has been stated clearly	Page 3 Lines 80-94
Methods	
Qualitative approach and research paradigm The type of qualitative approach (case study) and the paradigm (interpretivist) have been specified in the paper	Page 5, lines 159-173
Researcher characteristics and reflexivity - The researcher's characteristics was not directly critical to the study. Nonetheless, since the researcher was familiar to the research context, reflexive approach was used to ensure objective reporting and analysis of the data through notes taking and validity assessment from independent reviewers and public feedback	Page 7-8, lines 215-243
Context - Setting/site and salient contextual factors have been provided under a section titled as study design and context	Page 6-7, lines 187-213
Sampling strategy - The criteria and approaches for selecting participants for data as well as the rationale have been provided under the headings: study design and context, participants and data collection for the sake of replicability.	Pages 5-7, lines 160-213
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues An ethical approval was sought for the study. This has been acknowledged in the paper	Page 8, lines 245-252

Data collection methods - The sources data, the methods used, the dates for data collection and the specifics of the approach and procedure have been documented in the paper under the section, data collection	pages 5, lines 135-146
Data collection instruments and technologies The instruments, the topic discussed and other practical aspects of the data collection process are documented in the paper under the data collection section	Page 6-7, Lines 187-213
Units of study - The characteristics of the participants including their community of affiliation, age, gender and educational attainment are specified under 'participants'.	Page 6, lines 176-185
Data processing - The procedure for processing the data including the data transcription, security, validation of transcripts has been documented under the section, data analysis	Page 7-8, lines 216-234
Data analysis - The data analysis procedure has also been documented under the section data analysis	Page 7-8, lines 216-243
Techniques to enhance trustworthiness - To enhance trustworthiness, the procedure and the initial results were subjected to validation by language experts, social health researchers and community leaders. This is also mentioned under 'data analysis'	Page 7-8, lines 231-243

Results/findings

Synthesis and interpretation The results are presented under five themes. These are highlighted in the text under the heading of 'findings'	Pages 8-15, Lines 254-450
Links to empirical data - All the results of the paper (each theme) are supported with quotations from the field notes and transcripts	Pages 8-15, Lines 254-450

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field The paper has discussed and located the findings in line with prevailing local and international discourse.	Pages 15-19, lines 452-575
Limitations - The limitations and strengths of the study have been provided in the paper	Pages 18, lines 553-565

Other

Conflicts of interest – None declared	Page 19, line 576
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting The partial support of funding has been acknowledged in the paper	Page 18, lines 577-578

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Local patterns of social capital and sustenance of the Community-Based Health Planning and Services (CHPS) Policy: A qualitative comparative study in Ghana

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Local patterns of social capital and sustenance of the Community-Based Health Planning and Services (CHPS) Policy: A qualitative comparative study in Ghana

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Abstract

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

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

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

***Participant*s:** Thirty-two primary participants as well as four health personnel and four traditional and political leaders.

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

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

Strengths and limitations of the study

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

Background

The study examines the state and functioning of the Community-Based Health Planning Service (CHPS) policy in Ghana from a social capital perspective. Social capital refers to the resources that are embedded in different social relationships [1-3]. Several studies have found an association between various aspects of social capital and health [4-6]. Regrettably, the focus on social capital in health and social policy research has been dominated by its direct relationship with health, with only a few addressing how it shapes health policies [7-9]. This paper extends the discourse by comparatively examining how variations in social capital underpin the successes and challenges in management and sustenance of the CHPS policy based on two community-based case studies. The article is inspired by relevant aspects of McConnell's typology of policy success (or failure) namely; the political (local level) characteristics, programme design, and the processes involved in sustaining a programme [10, 11]. Of interest, is how elements of social capital explain some of these typologies in the management and sustenance of the CHPS. The paper thus discusses one of the critical micro-level issues in policy analysis [12], through the lens of an essential but hugely neglected contemporary social concept particularly in developing countries [13].

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

Despite earlier success, sustenance of the CHPS has been challenging in many localities. At a rather alarming rate, health personnel are always in a rush to transfer out of remote and infrastructurally deprived communities. Others hasten to further their education leaving their post

vacant [14, 18, 19]. Moreover, frequent shortages in logistics and tools for CHOs including essential drugs have also been reported [20]. Furthermore, there is limited understanding of the public of the CHPS concept in several communities. For these reasons, fidelity to the original CHPS model such close community engagement in the planning and delivery of services are gradually dissipating [21]. Regardless of its challenges, the CHPS remains critical to health service delivery in Ghana [16]. For instance, 30.4% of family planning drugs/methods administered in 2014 were carried out through CHPS compounds [16]. Therefore, plausible explanations and solutions for its challenges must be found urgently.

Social capital entails two components; structural and cognitive parts. On the one hand, structural social capital depicts the 'hard' aspects. It describes 'bonding social capital'—the resources embedded in close relationships such as families and intimate friends. There is also 'bridging social capital' which captures weak relationships such as neighbours, people in different communities and even a friend of one's friend. The structural aspect also considers 'linking social capital', which refers to the relationship between individuals of unequal power and socioeconomic status. It also describes the relationship between people and prevailing institutions. On the other hand, cognitive social capital represents the form of 'soft' side of the phenomenon such as trust, sense of fairness, attitudes, norms of reciprocity, sense of belonging and harmony. Some attribute the essence of social capital to these abstract aspects [22-25]. The components of social capital and their constituents can operate at both individual and community or ecological levels [26].

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

access services of the skilled attendants. Others suggest that the state of many CHPS facilities are linked to the extent of consultation and participation of members of an implementing locality [27]. However, a new wave of implementation entails an outright reliance on contractors instead of relying on community resources—at least in the initial phase. This practice has not only inhibited community participation in implementation and management but also reduced funding from both local and international donors due to increasing cost of implementation [21]. Interestingly, these observations are not different from a related study of the Health Action Zones (HAZ) in England. It was found that poor collaboration with communities and experiential knowledge of community members partly accounted for failures in some HAZ [7]. Also, Sheikh et al. [8] noted in Iran that high levels of both cognitive and structural social capital (including associational affiliation, trust, and citizenry activities) are associated with better operation, and functioning of community-based initiatives (CBI) meant to improve health-related quality of life. It is thus high time to usher in further empirical evidence that ignites a rethink of strategies in sustaining the CHPS concept.

Methods

Study design and context

The paper used a qualitative comparative case study approach [31, 32]. However, it also adopts precepts of Bartlett and Vavrus [33] 'tracing' comparative logic in addition to the traditional method. This position allows for reconsideration of fluidity in concepts such as culture, place, space and time during case selection, analyses and interpretation. It tilts towards the interpretivist epistemological school of thought [34, 35]. This approach helps to understand a given problem from the lived experiences and worldview of participants [34]. The adoption of comparative case study approach is to enable theoretical and empirical expatiation of social capital through multiple cases [36]. Yin [32] argues that "if you can even do a two-case study, your chances of producing robust results will be better than using a single-case design". It is also postulated that through comparison, researchers and policy-makers can de-centre what is taken for granted in a particular time or place–especially about policy-making after they learn that something was not always so, or that it is different elsewhere, or for other people [37].

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

Participants

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

Data collection

Data were collected through discursive engagements with primary players and users of the CHPS concepts. The data was gathered from June to October 2015. A semi-structured interview guide

was used to elicit the data through individual in-depth interviews and focus group discussions (FGDs). Eleven personal interviews and two FDGs were conducted at Apem community whereas nine individual interviews and one FDG were carried out at Amo with the help of two research assistants. The two FDGs at Apem consisted of five and six participants each. The FDG at Amo community comprised six persons. Some of the participants of the FDGs had been interviewed individually. The mix of the old and new faces helped to generate further information while expatiating on puzzling ones. The deductive theoretical sampling strategy was also used to select participants for both forms of interviews to ensure a balanced sample regarding sex, age and relationship to the community (whether an indigene or non-native). It was envisaged that non-natives were likely to have different social experiences as regards the CHPS.

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

Data analysis

Thematic analysis approach was adopted [35]. The interviews were transcribed as well as translated into English verbatim within the first 48 hours by the author and one research assistant. A language expert validated all the transcripts by comparing them with the audio tapes. The analysis started during the data collection stage through constant reflexivity and reflection notes. Initial themes were therefore generated during the field study. The second stage of the analysis concentrated on how both primary participants and key stakeholders used and understood the

role of different aspects of social capital in the operations of the CHPS concept. An 'open coding' technique [35] was used to categorise the data into themes that reflected the components and kinds of social capital (in the form of themes). As part of the process, McConnell [11] typology of policy success/failure was used to understand how different aspects of social capital shape facets of the CHPS' policy. Thus, while an interpretivist paradigm was taken, an abductive reasoning approach [35], was also applied to provide a social scientific account of the social world as seen from the researcher's perspective without losing touch with the world as seen by the participants. The analysis was carried out side-by-side for both cases under each theme. This approach helped to compare and contrast the findings [31] while incorporating the unique, yet fluid, sociocultural dynamics of the two case settings [33]. Data from both in-depth interviews and FGDs were triangulated throughout the process. To authenticate the categories, themes and the meaning ascribed to them, the preliminary analysis was subjected to scrutiny by an academic (social health researcher) and a community health practitioner.

Public Involvement

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

Ethical approval

The Committee on Human Research Publication and Ethics (CHRPE) of School of Medical Sciences, Kwame Nkrumah University of Science and Technology and Okomfo Anokye Teaching Hospital, Kumasi, Ghana, (CHRPE/AP/345/15) approved the study. All the names used in this paper are pseudonyms that were constructed together with the participants before the interviews to ensure anonymity. Informed consent was obtained from all participants before

enrolling them in the study. The study thus followed the international guidelines set forth for health-related research involving humans [39].

Findings

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

Social capital indicators and the CHPS policy

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

However, about four vibrant groups were identified at Apem including a peasant farmers group, which helped members in sourcing for market, labour, and inputs for their activities. Membership cut across different classes of people including community leaders (the unit committee chairperson of the community was a member of the group). There was also a women's group, which focused mainly on members' welfare and collaborated with drivers' association to seek transportation for their produce. The driver's group ensured that residents had access to transportation throughout each day while helping each member to obtain employment—by way of sourcing vehicles from owners to drivers. There were sports groups in both communities. Nonetheless, the groups were more of an ad hoc arrangement for fun and

exercise although their activities were quite regular. From the physical appearance and other characteristics, Amo was becoming a peri-urban community with features such as increasing population diversity (ethnicity and religious composition for instance) and smaller household size. However, the scale of urbanisation had not reached the point of being a traditional urban neighbourhood. Apem remained comparatively small and very remote. Notwithstanding, both communities remained fundamentally rural and comparable.

Table1: Variations in Some Indicators of Social Capital between the Two Communities

	Community Characteristics	Amo (Population =3500)	Apem (Population =1100)
1	Number of churches/Mosques (Religious affiliation)	6 (About 85% Christians and 12% Muslims) [a]	3 (About 92% Christians) [a]
2	Other associations	2: Women's welfare group Football group (for young men)	5: 1 (Peasant farmers group for both sexes) 1 men's group 1 drivers' association (GPRTU) 1 women's group (usually produce traders) Football group (for young men)
3	Average household size (Nuclear family)	4 [a]	6 [a]
4	Frequency of community gatherings	None	-At least once every three months -Once a week of communal work
5	Dominant occupation	Commerce/service with some agricultural activities	Crop farming
6	Ethnicity	Asantes (70%) and Northern tribes (17%) [a]	Predominantly Asantes (about 96%) [a]

[a] *Figures were drawn from the quantitative part of the broader study.*

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

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

Furthermore, by the physical environment in both communities alone, a sharp contrast could be drawn. All public sanitary places at Amo were in the deplorable state. The only public toilet facility was virtually out of commission while the community dump site was unkempt. Residents without toilet facilities at home took to defecating in bushes and along walkways while others dumped faecal matters in plastic bags indiscriminately. Although Apem residents used traditional latrines, they managed to keep the facility (wooden structure) relatively tidy. In the ensuing findings, the paper elucidates how differences in precepts of social capital help to explain these discrepancies. The themes are aligned to McConnell [10] thesis on policy success/failure.

Distrust, sense of unfairness and patronage of the CHPS

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

> *...I have not been to the clinic myself, but I heard that there is not enough space for patients to rest. ...looking at the building, the structure is not big enough. ... I think more health personnel are needed. ...There is even no doctor there (Julia, 55years, female, Amo,)*

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

However, the extent to which such distortions affected patronage was primarily imputable to cognitive social capital. Traits of a sense of unfairness, suspicions among residents about a myriad of failed development attempts and lack of sense of communality at Amo somewhat accounted for why some residents distrusted the CHPS. Years of distrust in leaders and among members coupled with gradual physical expansion of the Amo community, which had culminated into continual growth and diversity of population characteristics, promoted a sense of unfairness. Even the CHO lamented bitterly about the community's poor contribution towards the sustenance of the CHPS initiative. Residents had no interest in collaborating to address common problems due to mistrust among themselves and local leaders as one participant shared:

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

Weak linking social capital distracts operations of the CHPS

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

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

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

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

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

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

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

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

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

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

> *"…. The community leaders organise durbars regularly in this community. ...On each of those occasions, they invite us (nurses) to explain our services to them. ...I think many people now understand that this is only a primary level facility and that we could refer them to another facility anytime (Medical officer 1, Apem).*

[Exerpts from FGD]

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

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

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

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

[Exerpts from FDG]

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

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

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

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

Civic engagement and cognitive social capital enhance affordability of CHPS

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

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

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

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

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

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

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

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

[Excerpts of FDG]

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

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

Interviewer: Really?

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

[Individual Interview]

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

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

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

[Excerpts from FDG]

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

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

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

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

Discussion

This paper has elucidated how patterns of social capital influence the functioning and sustenance of the CHPS concept. Consistent with other studies [1, 27, 28], the CHPS concept is likely to be successful in localities with a high stock of social capital. For instance, based on extensive

surveys and interviews in Italy, Putnam [1] asserts that social capital proxies such as associational activities—literacy guilds, service groups, sports groups—accounted for the differences in institutional performance between Northern and Southern Italy. With respect to the CHPS, it is apparent that that implementing it in localities with low social capital may render it susceptible to recurrent challenges. Indeed, Halpern [23] posits that any "policy and debate that fail to address it *[social capital]* are doomed to be shallow and unconvincing". The findings also add to the assertion that "health systems are inherently relational and so many of the most critical challenges for health systems are relationship and behaviour problems" [40] as expatiated below.

Given the uniqueness of the CHPS, its fiscal affairs are sensitive to prevailing social environment. From the findings, social capital (both cognitive and structural aspects) can either impinge or facilitate the solvency of the CHPS. Effective demand as economists would argue [41]—in using and paying for the services was inextricably related to social capital. The biggest challenge, yet, remains the fact that many, especially rural residents, are poor and can barely afford the NHIS premium [42]. If this continues, reliance on one's social connections for utilising the CHPS on credit will only escalate. This finding supports the call for a more equitable distribution of the financial burden of Ghana's NHIS. The core poor must be continuously identified and offered the chance to register for applicable exemptions, which many are still unaware [43]. Eventually, this will curb the need to exploit cognitive social capital to access the services on credit.

While financial difficulties hinder NHIS subscription, non-financial factors such as physical access to accredited service providers remain a challenge to residents in many remote localities [42]. Among the two cases, elevated linking social capital and civic participation ensured cohesiveness and trust among members. This contributed to quicker identification and redress of hindrances to the patronage of CHPS and complementary policies such as the NHIS. There is a precedent for this. Fenenga et al. [44] concluded from studies in rural and urban Ghana that civic engagements and trust in institutions including the NHIS, encourage patronage. Thus, community-level social capital—social cohesion and trust—partly alleviates inability of the core poor to benefit from these social interventions. For instance, Kotoh and Van der Geest [43] observed from prolonged studies in central and eastern regions of Ghana that poor persons, and

especially those in deprived communities, were unable to access the NHIS even though they knew about it. Possibly, such limitations have to do with low social capital in such localities. Hence, the success of pro-poor programmes and allied policy initiatives rally on the depth of social capital.

The referral policy also benefited from high stock of social capital. The case community with high social capital demonstrated ample appreciation of the general and specific characteristics of the referral component of the CHPS. Halpern [23] asserts that high levels of bridging and linking social capital, for instance, indicate a society that is highly interconnected, thereby sharing power and resources through a never-ending and evenly-spun web of connections. By such empowerment, community members become gatekeepers for the health system by directing sick persons to a lower-level facility for appropriate evaluation at the outset. Sakeah et al. [20] associate community involvement in education about the referral system to improved use of primary healthcare facilities. Furthermore, vibrant social engagements, coupled with the almost homogeneous nature of places such as Apem (regarding religion, ethnic, and economic characteristics) ensured efficient information transmission. Previous works [1, 45, 46] show that closed societies facilitated by religious and cultural precepts enjoy trust in public institutions and increases the likelihood of attaining desired behavioural outcomes. This is plausible because many in Ghana are known to consciously depend on their social networks for information and decisions concerning the referral policy and the health system in general [9].

Moreover, the impact of social capital on the functioning of the CHPS could also be explained by the sizes or nature of the two communities. According to Putnam [47], small communities (such as Apem) propagate dense networks and nurture cognitive elements such as trust, which increase access to vital resources[†48]. In contrast, some earlier studies posit that weak or loose ties sometimes allow for efficient information flow and are particularly crucial for facilitating collective action [22]. Grootaert and van Bastelaer [49] contend that communities with simultaneously high levels of bonding and linking social capital may lead to low levels of social cohesion. It has also been submitted that some small-sized rural communities might instead be

[†] The claim is that in areas with stronger, dense, horizontal and more cross-cutting networks, there is a spillover from membership in organizations to the cooperative values and norms that citizens develop. [48]

too conservative to tolerate differences leading to low social capital [50]. The situation at Apem, differs from these assertions. The difference in the functioning of the CHPS compounds in the two cases speaks to the presence of high social capital—at least for some of its proxies such as trust—as an indication of sufficient institutional performance. The findings in the present study are also consistent with the work of Sheikh et al. [8]. They noted from Iran that high levels of both cognitive and structural social capital (including associational affiliation, trust, and citizenry activities) are associated with better operation and functioning of community-based initiatives (CBI) that are meant to improve health-related quality of life and well-being. In their study, people in CBIs areas had better access to public services and showed less segregation due to income or social status [8].

To some extent, the findings challenge the contention of Portes [51] who argues that more impoverished communities may be impoverished not necessarily because of their lack of social capital but rather because of the meagre resources they possess. Portes' (2000) proposition does not hold true when one considers the case of Amo. It was a community with comparatively low social capital (both cognitive and structural forms). While it was becoming peri-urban and had access to a wide range of resources, it failed to support the CHPS concept adequately. This failure of the community to support the policy suggests a new perspective. Thus, although more impoverished, and rural communities may collectively possess fewer resources, it appears that it is the generation and uses of available social capital instead of its quantity or diversity that makes an impact on livelihoods. A group with limited resources but located in a highly cohesive society would find a way to nurture the available ones, as the residents of Apem community demonstrated regarding subscription to complementary services such as the NHIS. Therefore, the assertion that the frequency and number of social interactions per se may not alter its impact has a footing here [52, 53].

In light of these, one could argue that critical elements of McConnell [54] typologies of success or failure featured minimally in case of Amo. Although the policy process and design of the CHPS consider local level contribution as crucial to its success [14], appears that little was done to marshal community support through regular consultation and communication as McConnell [54] advocates. Moreover, consideration of politics in the process may have been left at the macro-

level (district or even among community leadership) in the Amo community leaving efforts at micro levels where political dynamics are formed, and agitations and opposition to programmes commence, unattended. Thus, while the CHPS as a health programme is pertinent, fidelity to the processes involved in its substance has been inadequate in the case of Amo and other places [21]. Taking this back to the phenomenon of social capital in both cases, its high stock in the Apem community enabled the people to make collective choices in the public interest—both directly and indirectly about the CHPS through deliberative engagements and controversy resolution [54], during community gatherings.

Despite the role of social capital in the differences in management and sustenance of the two CHPS concepts, it may be naïve to over-romanticise it [7, 55]. Such romanticism may "elevate mystical and personal experience over objective coherence, building to a national ecstasy that denies justice and social need" [55]. Indeed, not all the kinds of social capital were explicitly influential for the CHPS policy. Also, one cannot entirely stipulate that operations of Apem CHPS was successful as given that policy success is not only predicated on attainment of set goals but also the extent of criticisms it attracts [54]. Additionally, some participants may have over or under-reported their reliance on social capital for decisions and knowledge of the CHPS. Moreover, the study was carried in only two communities in Ashanti region. Therefore, the findings cannot be taken as an exact reflection of happenings in other contexts. It will be more useful to broaden understanding of social capital's consequence for health policies through repeated studies in similar and dissimilar contexts. A similar study involving more communities and districts as well as other pro-poor policies could expand knowledge. Nonetheless, the present study is the first to conduct a comparative analysis of the role of social capital in managing the CHPS concept, and its findings are critical to improving it.

Conclusion

The article set out to examine the relationship between social capital and sustenance of the CHPS concept in Ghana. Proxies of social capital including trust, sense of fairness, and linking social capital were inextricably associated with patronage of the CHPS. Others such as civic engagement indirectly promote affordability of the CHPS while ensuring its solvency. According to the findings, social capital does shape not only the operations of the CHPS but also related

policies such as the referral system and the NHIS. However, people sometimes exploit their cognitive social capital to access the services on credit or even for free, which is injurious to its sustenance. The paper suggests that when some of the challenges facing the CHPS concept are situated in the realm of social capital, causes and solutions may be identified. Hence, generating and incorporating it must be a critical component of pro-poor policies alike.

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Standards for Reporting Qualitative Research (SRQR)

	Page/line no(s).
Title and abstract	
Title: Local patterns of social capital and sustenance of the Community-Based Health Planning and Services (CHPS) Policy: A qualitative comparative study in Ghana	Page 1, line 1-2
Abstract - The abstract have been structured according the requirements of the journal.	Page 2, lines 44-68
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; and problem statement have been provided at different parts of the background to the paper	Page 3-5 Lines 80-153
Purpose or research question: the purpose of the paper has been stated clearly	Page 3 Lines 86-88
Methods	
Qualitative approach and research paradigm The type of qualitative approach (comparative case study) and the paradigm (interpretivist) have been specified in the paper	Page 5-6, lines 155-184
Researcher characteristics and reflexivity - The researcher's characteristics was not directly critical to the study. Nonetheless, since the researcher was familiar to the research context, reflexive approach was used to ensure objective reporting and analysis of the data through notes taking and validity assessment from independent reviewers and public feedback	Page 7-8, lines 223-242
Context - Setting/site and salient contextual factors have been provided under a section titled as study design and context	Page 5-6, lines 170-184
Sampling strategy - The criteria and approaches for selecting participants for data as well as the rationale have been provided under the headings: study design and context, participants and data collection for the sake of replicability.	Pages 5-7, lines 156-221
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues An ethical approval was sought for the study. This has been acknowledged in the paper	Page 8, lines 254-261

Data collection methods - The sources data, the methods used, the dates for data collection and the specifics of the approach and procedure have been documented in the paper under the section, data collection	pages 6, lines 196-208
Data collection instruments and technologies The instruments, the topic discussed and other practical aspects of the data collection process are documented in the paper under the data collection section	Page 6-7, Lines 187-213
Units of study - The characteristics of the participants including their community of affiliation, age, gender and educational attainment are specified under 'participants'.	Page 7, lines 213-221
Data processing - The procedure for processing the data including the data transcription, security, validation of transcripts has been documented under the section, data analysis	Page 7-8, lines 216-234
Data analysis - The data analysis procedure has also been documented under the section data analysis	Page 7-8, lines 223-242
Techniques to enhance trustworthiness - To enhance trustworthiness, the procedure and the initial results were subjected to validation by language experts, social health researchers and community leaders. This is also mentioned under 'data analysis'	Page 7-8, lines 223-242

Results/findings

Synthesis and interpretation The results are presented under five themes. These are highlighted in the text under the heading of 'findings'	Pages 8-16, Lines 263-504
Links to empirical data - All the results of the paper (each theme) are supported with quotations from the field notes and transcripts	Pages 8-16, Lines 263-504

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field The paper has discussed and located the findings in line with prevailing local and international discourse.	Pages 16-20, lines 506-621
Limitations - The limitations and strengths of the study have been provided in the paper	Pages 19-20, lines 607-621

Other

Conflicts of interest – None declared	Page 20, line 635
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting The partial support of funding has been acknowledged in the paper	Page 20, lines 637-638

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Local patterns of social capital and sustenance of the Community-Based Health Planning and Services (CHPS) Policy: A qualitative comparative study in Ghana

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Abstract

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

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

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

***Participant*s:** Thirty-two primary participants as well as four health personnel and four traditional and political leaders.

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

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

Strengths and limitations of the study

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

Background

The study examines the state and functioning of the Community-Based Health Planning Service (CHPS) policy in Ghana from a social capital perspective. Social capital refers to the resources that are embedded in different social relationships [1-3]. Several studies have found an association between various aspects of social capital and health [4-6]. Regrettably, the focus of social capital in health and social policy research has been dominated by its direct relationship with health, with only a few addressing how it shapes health policies [7-9]. This paper extends the discourse by comparatively examining how variations in social capital underpin the successes and challenges in management and sustenance of the CHPS policy based on two community-based case studies. The article is inspired by relevant aspects of McConnell's typology of policy success (or failure) namely; the political (local level) characteristics, programme design, and the processes involved in sustaining a programme [10, 11]. Of interest, is how elements of social capital explain some of these typologies in the management and sustenance of the CHPS. The paper thus discusses one of the critical micro-level issues in policy analysis [12], through the lens of an essential but hugely neglected contemporary social concept particularly in developing countries [13].

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

Despite earlier success, sustenance of the CHPS has been challenging in many localities. At a rather alarming rate, health personnel are always in a rush to transfer out of remote and infrastructurally deprived communities. Others hasten to further their education, leaving their post

vacant [14, 18, 19]. Moreover, frequent shortages in logistics and tools for CHOs including essential drugs have also been reported [20]. Furthermore, there is limited understanding by the public of the CHPS concept in several communities. For these reasons, fidelity to the original CHPS model such as close community engagement in the planning and delivery of services are gradually dissipating [21]. Regardless of its challenges, the CHPS remains critical to health service delivery in Ghana [16]. For instance, 30.4% of family planning drugs or methods administered in 2014 were carried out through CHPS compounds [16]. Therefore, plausible explanations and solutions to CHPS' challenges must be found urgently.

Social capital entails two components; structural and cognitive. On the one hand, structural social capital depicts the 'hard' aspects. It describes 'bonding social capital'—the resources embedded in close relationships such as those with families and intimate friends. There is also 'bridging social capital' which captures weak relationships such as those with neighbours, people in different communities and even a friend of one's friend. The structural aspect also considers 'linking social capital', which refers to the relationship between individuals of unequal power and socioeconomic status. It also describes the relationship between people and prevailing institutions. On the other hand, cognitive social capital represents the form of 'soft' side of the phenomenon such as trust, sense of fairness, attitudes, norms of reciprocity, sense of belonging and harmony. Some attribute the essence of social capital to these abstract aspects [22-25]. The components of social capital and their constituents can operate at both individual and community or ecological levels [26].

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

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

Methods

Study design and context

The paper used a qualitative comparative case study approach [31, 32]. However, it also adopts precepts of Bartlett and Vavrus [33] 'tracing' comparative logic in addition to the traditional method. This position allows for reconsideration of fluidity in concepts such as culture, place, space and time during case selection, analyses and interpretation. It tilts towards the interpretivist epistemological school of thought [34, 35]. This approach helps to understand a given problem from the lived experiences and worldview of participants [34]. The adoption of comparative case study approach was to enable theoretical and empirical expatiation of social capital through multiple cases [36]. Yin [32] argues that "if you can even do a two-case study, your chances of producing robust results will be better than using a single-case design". It is also postulated that through comparison, researchers and policy-makers can de-centre what is taken for granted in a particular time or place—especially about policy-making after they learn that something was not always so, or that it is different elsewhere, or for other people [37].

The paper is based on a cross-sectional data gathered from the Ashanti Region in Ghana as part of broader mixed method research. The Region was selected because it is centrally located and attracts diverse people from other regions. The two forms of data were gathered concurrently. A few of the participants in the qualitative aspect of the study also took part in the survey, which did

not focus on the CHPS policy. Two case studies involving two communities, namely Amoam-Achiase (hereafter, Amo) and Apemanim (hereafter, Apem), in two districts namely Atwima Kwanwoma and Ejisu Juaben districts respectively were used. Both communities had CHPS compounds. The selection of these cases was pragmatic. The case communities and the participants were selected using purposive sampling (deductive theoretical sampling strategy)[38]. The deductive theoretical sampling strategy helps identify cases of theoretical relevance to research [38]. The two districts and the two communities therein presented characteristics that made them unique, yet, comparable regarding socio-economic indicators such as economic activities and the population size (see table 1). The two CHPS compounds also shared similar features regarding staff strength and logistics. However, there were some differences in the services offered. The Amo CHPS provided antenatal and neonatal services in addition to other curative and preventative services.

Participants

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

Data collection

Data were collected through discursive engagements with primary players and users of the CHPS . The data was gathered from June to October 2015. A semi-structured interview guide was used to elicit the data through individual in-depth interviews and focus group discussions (FGDs). Eleven personal interviews and two FGDs were conducted at Apem community, whereas nine individual interviews and one FGD were carried out at Amo with the help of two research assistants. The two FGDs at Apem consisted of five and six participants each. The FGD at Amo community comprised six persons. Some of the participants of the FGDs had been interviewed

individually. The mix of the old and new faces helped to generate further information while expatiating on puzzling ones. The deductive theoretical sampling strategy was also used to select participants for both forms of interviews to ensure a balanced sample regarding sex, age and relationship to the community (whether an indigene or non-native). It was envisaged that non-natives were likely to have different social experiences as regards the CHPS.

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

Data analysis

Thematic analysis approach was adopted [35]. The interviews were transcribed as well as translated into English verbatim within the first 48 hours by the author and one research assistant. A language expert validated all the transcripts by comparing them with the audio tapes. The analysis started during the data collection stage through constant reflexivity and reflection notes. Initial themes were therefore generated during the field study. The second stage of the analysis concentrated on how both primary participants and key stakeholders used and understood the role of different aspects of social capital in the operations of the CHPS concept. An 'open coding' technique [35] was used to categorise the data into themes that reflected the components and kinds of social capital (in the form of themes). As part of the process, McConnell [11] typology of policy success orfailure was used to understand how different aspects of social capital shape facets of the CHPS' policy. Thus, while an interpretivist paradigm was taken, an abductive reasoning approach [35], was also applied to provide a social scientific account of the social world as seen from the researcher's

perspective without losing touch with the world as seen by the participants. The analysis was carried out side-by-side for both cases under each theme. This approach helped to compare and contrast the findings [31] while incorporating the unique, yet fluid, sociocultural dynamics of the two case settings [33]. Data from both in-depth interviews and FGDs were triangulated throughout the process. To authenticate the categories, themes and the meaning ascribed to them, the preliminary analysis was subjected to scrutiny by an academic (social health researcher) and a community health practitioner.

Public Involvement

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

Ethical approval

The Committee on Human Research Publication and Ethics (CHRPE) of School of Medical Sciences, Kwame Nkrumah University of Science and Technology and Okomfo Anokye Teaching Hospital, Kumasi, Ghana, (CHRPE/AP/345/15) approved the study. All the names used in this paper are pseudonyms that were constructed together with the participants before the interviews to ensure anonymity. Informed consent was obtained from all participants before enrolling them in the study. The study thus followed the international guidelines set forth for health-related research involving humans [39].

Findings

The findings are presented under six themes. The first theme (social capital indicators and the CHPS policy) describes the nature and state of various forms of social capital in the two contexts whereas the others demonstrate how such differences affect the CHPS. They include: Distrust,

sense of unfairness and patronage of the CHPS; weak linking social capital distracts operations of the CHPS; and high social capital promotes successful implementation of the referral component of the CHPS. Others are: Civic engagement and cognitive social capital enhance affordability of CHPS; and, elevated levels of social capital have adverse financial consequence for CHPS.

Social capital indicators and the CHPS policy

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

However, about four vibrant groups were identified at Apem including a peasant farmers group, which helped members in sourcing for market, labour, and inputs for their activities. Membership cut across different classes of people including community leaders (the unit committee chairperson of the community was a member of the group). There was also a women's group, which focused mainly on members' welfare and collaborated with drivers' association to seek transportation for their produce. The driver's group ensured that residents had access to transportation throughout each day while helping each member to obtain employment—by way of sourcing vehicles from owners to drivers. There were sports groups in both communities. Nonetheless, the groups were more of an ad hoc arrangement for fun and exercise although their activities were quite regular. By its physical environment and other characteristics, Amo was becoming a peri-urban community with features such as increasing population diversity (ethnicity and religious composition for instance) and smaller household size. However, the scale of urbanisation had not reached the point of being a traditional urban neighbourhood. Apem remained comparatively small and very remote. Notwithstanding, both communities remained fundamentally rural and comparable.

Table1: Variations in Some Indicators of Social Capital between the Two Communities

	Community Characteristics	Amo (Population =3500)	Apem (Population =1100)
1	Number of churches/Mosques (Religious affiliation)	6 (About 85% Christians and 12% Muslims) [a]	3 (About 92% Christians) [a]
2	Other associations	2: Women's welfare group Football group (for young men)	5: 1 (Peasant farmers group for both sexes) 1 men's group 1 drivers' association (GPRTU) 1 women's group (usually produce traders) Football group (for young men)
3	Average household size (Nuclear family)	4 [a]	6[a]
4	Frequency of community gatherings	None	-At least once every three months -Once a week of communal work
5	Dominant occupation	Commerce/service with some agricultural activities	Crop farming
6	Ethnicity	Asantes (70%) and Northern tribes (17%) [a]	Predominantly Asantes (about 96%) [a]

[a] *Figures were drawn from the quantitative part of the broader study.*

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

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

Furthermore, by the physical environment in both communities alone, a sharp contrast could be drawn. All public sanitary places at Amo were in the deplorable state. The only public toilet facility was virtually non-functional while the community dump site was unkempt. Residents without toilet facilities at home took to defecating in bushes and along walkways while others dumped faecal matters in plastic bags indiscriminately. Although Apem residents used traditional latrines, they managed to keep the facility (wooden structure) relatively tidy. In the ensuing findings, the paper elucidates how differences in precepts of social capital help to explain these discrepancies. The themes are aligned to McConnell [10] thesis on policy success/failure.

Distrust, sense of unfairness and patronage of the CHPS

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

> *...I have not been to the clinic myself, but I heard that there is not enough space for patients to rest. ...looking at the building, the structure is not big enough. ... I think more health personnel are needed. ...There is even no doctor there (Julia, 55years, female, Amo,)*

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

However, the extent to which such distortions affected patronage was primarily imputable to cognitive social capital. Traits of a sense of unfairness, suspicions among residents about a myriad of failed development attempts and lack of sense of communality at Amo somewhat accounted for why some residents distrusted the CHPS. Years of distrust in leaders and among members coupled with gradual physical expansion of the Amo community, which had culminated into continual growth and diversity of population characteristics, promoted a sense of unfairness. Even the CHO lamented bitterly about the community's poor contribution towards the sustenance of the CHPS initiative. Residents had no interest in collaborating to address common problems due to mistrust among themselves and local leaders as one participant shared:

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

Weak linking social capital distracts operations of the CHPS

The weak relationship between residents and leaders at Amo had compounded into a situation whereby the local authorities were unable to effectively mobilise the people to educate them about

the CHPS concept—an element which was expected of community leadership per the policy design and the implementation process. This partly explained why many residents had limited knowledge about the policy and showed disinterest in patronising its services or in recommending to others as one of the participants revealed:

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

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

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

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

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

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

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

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

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

> *"…. The community leaders organise durbars regularly in this community. …On each of those occasions, they invite us (nurses) to explain our services to them. …I think many people now understand that this is only a primary level facility and that we could refer them to another facility anytime (Medical officer 1, Apem).*
>
> *[Exerpts from FGD]*
>
> *Joyce (30 years, female, Apem): We have a clinic here, but it is not all diseases that they can treat. For the diseases they can't treat, they refer us to other places*
>
> *Badu (46 years, male, Apem): [jumps in] …for my wife and I, we mostly go to the Foase Hospital especially when she's pregnant. …The nurses have told us that they can't handle antenatal issues*

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

> *…there are specific medical procedures that I cannot perform. However, people think everything should be done here. …So, when they come, and I refer them to a higher health facility, they become discouraged. Because of that, I have noticed that some people have ceased coming here. (Medical officer 1, Amo, rural)*
>
> *[Exerpts from FGD]*
>
> *Joe (30 years, male, Amo): The nurse at the CHPS compound is responsible for everything so when it's a little busy, she refers people to go to Ejisu Hospital…*

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

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

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

Civic engagement and cognitive social capital enhance the affordability of CHPS

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

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

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

Nonetheless, frequent social engagements at Apem ensured access to affordable healthcare. Regular community gatherings provided an opportunity for penetration of public opinion in matters concerning financial implications of accessing the CHPS. The public opinion pressured community leaders to act accordingly. Indeed, the Apem leaders were instrumental in getting the

CHPS compound accredited with the NHIS. This reduced out-of-pocket payment burden and consequently increased patronage:

> *It is through the efforts of the incumbent chief and his elders that we got the community clinic [CHPS]…We spoke about it at our usual meetings, and they took it up. …I know they even helped to get the NHIS for the clinic when we complained about the cost (Badu, 46 years, male, Apem)*
>
> *The health facility in this community is very beneficial when you have the NHIS card. …At first, it was expensive, but since we got the NHIS accreditation, everyone goes there (CHPS) (Addo, 63 years, male, Apem)*

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

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

> *[Excerpts of FGD]*
>
> *Interviewer: Has lack of money ever prevented you from visiting the CHPS?*
>
> *Atta (50 years, male, Apem): No, it has never happened like that but even if I don't have money. …They will treat me on credit, so I pay later*
>
> *Interviewer: Really?*
>
> *Bemah (22 years, female, Apem): Yes, they do that, and they trust we will come and pay later*
>
> *[Individual Interview]*
>
> *In some cases, people fail to pay their debts. …Sometimes, we have to go after them several times before they pay up. …We realised that they were taking advantage of their good relationships with us to access our services for free. If you're familiar with the person, it is hard to turn them away because of money (Medical officer 2, Apem).*

Thus, trusting that people will settle their debt later by offering the service on credit endangered the financial sustenance of the CHPS concept. Nonetheless, the depth of social engagements at Apem, advanced the solvency of the CHPS compounds although neither individuals nor groups directly made financial contributions towards its economic sustainability. Community leaders and

some individuals served as watchdogs against bill defaulters by discouraging people from habitually accessing the services on credit:

> *…We told them [community leadership] about the continual refusal of residents to pay for services on one of those occasions [community meetings]. …They immediately enacted a law that no one should visit the facility without money. …Since then, the vast unwillingness to pay for services has reduced (Medical officer 2, Apem)*
>
> *[Excerpts from FGD]*
>
> *Interviewer: Have you ever received treatment on credit from the CHPS?*
>
> *Esther (32 years, female, Apem): Yes, but these days it's not everybody that the nurse treats on credit. It is only those she's close with that she does that for and even that she doesn't do it for everyone to see.*
>
> *Bemah (22 years, female, Apem): But people don't make the payments, so the chief has asked them to stop treating people on credit.*

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

Discussion

This paper has elucidated how patterns of social capital influence the functioning and sustenance of the CHPS concept. Consistent with other studies [1, 27, 28], the CHPS concept is likely to be successful in localities with a high stock of social capital. For instance, based on extensive surveys and interviews in Italy, Putnam [1] asserts that social capital proxies such as associational activities—literacy guilds, service groups, sports groups—accounted for the differences in institutional performance between Northern and Southern Italy. With respect to the CHPS, it is apparent that implementing it in localities with low social capital may render it susceptible to recurrent challenges. Indeed, Halpern [23] posits that any "policy and debate that fail to address it *[social capital]* are doomed to be shallow and unconvincing". The findings also add to the assertion that "health systems are inherently relational and so many of the most critical challenges for health systems are relationship and behaviour problems" [40] as expatiated below.

Given the uniqueness of the CHPS, its fiscal affairs are sensitive to the prevailing social environment. From the findings, social capital (both cognitive and structural aspects) can either impinge or facilitate the solvency of the CHPS. Effective demand, as economists would argue [41]—in using and paying for the services was inextricably related to social capital. The biggest challenge, yet, remains the fact that many, especially rural residents, are poor and can barely afford the NHIS premium [42]. If this continues, reliance on one's social connections for utilising the CHPS on credit will only escalate. This finding supports the call for a more equitable distribution of the financial burden of Ghana's NHIS. The core poor must be continuously identified and offered the chance to register for applicable exemptions, which are unknown to many [43]. Eventually, this will curb the need to exploit cognitive social capital to access the services on credit.

While financial difficulties hinder NHIS subscription, non-financial factors such as physical access to accredited service providers remain a challenge to residents in many remote localities [42]. At Apem, elevated linking social capital and civic participation ensured cohesiveness and trust among people. This contributed to quicker identification and redress of hindrances to the patronage of CHPS and complementary policies such as the NHIS. There is a precedent for this. Fenenga et al. [44] concluded from studies in rural and urban Ghana that civic engagements and trust in institutions including the NHIS, encourage patronage. Thus, community-level social capital—social cohesion and trust—partly alleviates inability of the core poor to benefit from these social interventions. For instance, Kotoh and Van der Geest [43] observed from prolonged studies in central and eastern regions of Ghana that poor persons, and especially those in deprived communities, were unable to access the NHIS even though they knew about it. Possibly, such limitations have to do with low social capital in such localities. Hence, the success of pro-poor programmes and allied policy initiatives rally on the depth of social capital.

The referral policy also benefited from high stock of social capital. The case community with high social capital demonstrated ample appreciation of the general and specific characteristics of the referral component of the CHPS. Halpern [23] asserts that high levels of bridging and linking social capital, for instance, indicate a society that is highly interconnected, thereby sharing power and resources through a never-ending and evenly-spun web of connections. By such empowerment,

community members become gatekeepers for the health system by directing sick persons to a lower-level facility for appropriate evaluation at the onset. Sakeah et al. [20], therefore, associate community involvement in sensitisation about the referral system to improved use of primary healthcare services. Furthermore, vibrant social engagements, coupled with the almost homogeneous nature of places such as Apem (regarding religion, ethnic, and economic characteristics) ensured efficient information transmission. Previous works [1, 45, 46] show that closed societies facilitated by religious and cultural precepts enjoy trust in public institutions and increases the likelihood of attaining desired behavioural outcomes. This is plausible because many in Ghana are known to consciously depend on their social networks for information and decisions concerning the referral policy and the health system in general [9].

Moreover, the impact of social capital on the functioning of the CHPS could also be explained by the sizes or nature of the two communities. According to Putnam [47], small communities (such as Apem) propagate dense networks and nurture cognitive elements such as trust, which increase access to vital resources[†48]. In contrast, some earlier studies posit that weak or loose ties sometimes allow for efficient information flow and are particularly crucial for facilitating collective action [22]. Grootaert and van Bastelaer [49] contend that communities with simultaneously high levels of bonding and linking social capital may lead to low levels of social cohesion. It has also been submitted that some small-sized rural communities might instead be too conservative to tolerate differences leading to low social capital [50]. The situation at Apem differs from these assertions. The difference in the functioning of the CHPS compounds in the two cases speaks to the presence of high social capital—at least for some of its proxies such as trust—as an indication of sufficient institutional performance. The findings in the present study are also consistent with the work of Sheikh et al. [8]. They noted from Iran that high levels of both cognitive and structural social capital (including associational affiliation, trust, and citizenry activities) are associated with better operation and functioning of community-based initiatives (CBI) that are meant to improve health-related quality of life and well-being. In their study, people in CBI areas had better access to public services and showed less segregation due to income or social status [8].

[†] The claim is that in areas with stronger, dense, horizontal and more cross-cutting networks, there is a spillover from membership in organizations to the cooperative values and norms that citizens develop. [48]

To some extent, the findings challenge the contention of Portes [51] who argues that more impoverished communities may be impoverished not necessarily because of their lack of social capital but rather because of the meagre resources they possess. Portes' (2000) proposition does not hold when one considers the case of Amo. It was a community with comparatively low social capital (both cognitive and structural forms). While it was becoming peri-urban and had access to a wide range of resources, it failed to support the CHPS concept adequately. This failure of the community to support the policy suggests a new perspective. Thus, although more impoverished, and rural communities may collectively possess fewer resources, it appears that it is the generation and uses of available social capital instead of its quantity or diversity that makes an impact on livelihoods. A group with limited resources but located in a highly cohesive society would find a way to nurture the available ones, as the residents of Apem community demonstrated regarding subscription to complementary services such as the NHIS. Therefore, the assertion that the frequency and number of social interactions per se may not alter its impact has a footing here [52, 53].

In light of these, one could argue that critical elements of McConnell [54] typologies of success or failure featured minimally in the case of Amo. Although the policy process and design of the CHPS consider local level contribution as crucial to its success [14], it appears that little was done to marshal community support through regular consultation and communication as McConnell [54] advocates. Moreover, consideration of politics in the process may have been left at the macro-level (district or even among community leadership) in the Amo community, leaving efforts at micro levels where political dynamics are formed, and agitations and opposition to programmes commence, unattended. Thus, while the CHPS as a health programme is pertinent, fidelity to the processes involved in its substance has been inadequate in the case of Amo and other places [21]. Taking this back to the phenomenon of social capital in both cases, its high stock in the Apem community enabled the people to make collective choices in the public interest—both directly and indirectly about the CHPS through deliberative engagements and controversy resolution [54], during community gatherings.

Despite the role of social capital in the differences in management and sustenance of the two CHPS concepts, it may be naïve to over-romanticise it [7, 55]. Such romanticism may "elevate mystical and

personal experience over objective coherence, building to a national ecstasy that denies justice and social need" [55]. Indeed, not all the kinds of social capital were explicitly influential for the CHPS policy. Also, one cannot entirely stipulate that operations of Apem CHPS was successful given that policy success is not only predicated on attainment of set goals but also the extent of criticisms it attracts [54]. Additionally, some participants may have over or under-reported their reliance on social capital for decisions and knowledge of the CHPS. Moreover, the study was carried out in only two communities in the Ashanti region. Therefore, the findings cannot be regarded as an exact reflection of happenings in other contexts. It will be more useful to broaden understanding of social capital's consequence for health policies through repeated studies in similar and dissimilar contexts. A similar study involving more communities and districts as well as other pro-poor policies could expand knowledge. Nonetheless, the present study is the first to conduct a comparative analysis of the role of social capital in managing the CHPS concept, and its findings are critical to improving it.

Conclusion

The article aimed to examine the relationship between social capital and the sustenance of the CHPS concept in Ghana. Proxies of social capital including trust, sense of fairness, and linking social capital were inextricably associated with patronage of the CHPS. Others such as civic engagement, indirectly promote affordability of the CHPS while ensuring its solvency. According to the findings, social capital does shape not only the operations of the CHPS but also related policies such as the referral system and the NHIS. However, people sometimes exploit their cognitive social capital to access the services on credit or even for free, which is injurious to its sustenance. The paper suggests that when some of the challenges facing the CHPS concept are situated in the realm of social capital, causes and solutions may be identified. Hence, generating and incorporating it must be a critical component of pro-poor policies alike.

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Standards for Reporting Qualitative Research (SRQR)

	Page/line no(s).
Title and abstract	
Title: Local patterns of social capital and sustenance of the Community-Based Health Planning and Services (CHPS) Policy: A qualitative comparative study in Ghana	Page 1, line 1-2
Abstract - The abstract have been structured according the requirements of the journal.	Page 2, lines 44-68
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; and problem statement have been provided at different parts of the background to the paper	Page 3-5 Lines 80-153
Purpose or research question: the purpose of the paper has been stated clearly	Page 3 Lines 86-88
Methods	
Qualitative approach and research paradigm The type of qualitative approach (comparative case study) and the paradigm (interpretivist) have been specified in the paper	Page 5-6, lines 155-184
Researcher characteristics and reflexivity - The researcher's characteristics was not directly critical to the study. Nonetheless, since the researcher was familiar to the research context, reflexive approach was used to ensure objective reporting and analysis of the data through notes taking and validity assessment from independent reviewers and public feedback	Page 7-8, lines 223-242
Context - Setting/site and salient contextual factors have been provided under a section titled as study design and context	Page 5-6, lines 170-184
Sampling strategy - The criteria and approaches for selecting participants for data as well as the rationale have been provided under the headings: study design and context, participants and data collection for the sake of replicability.	Pages 5-7, lines 156-221
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues An ethical approval was sought for the study. This has been acknowledged in the paper	Page 8, lines 254-261

Data collection methods - The sources data, the methods used, the dates for data collection and the specifics of the approach and procedure have been documented in the paper under the section, data collection	pages 6, lines 197-208
Data collection instruments and technologies The instruments, the topic discussed and other practical aspects of the data collection process are documented in the paper under the data collection section	Page 7, Lines 211-221
Units of study - The characteristics of the participants including their community of affiliation, age, gender and educational attainment are specified under 'participants'.	Page 6, lines 187-195
Data processing - The procedure for processing the data including the data transcription, security, validation of transcripts has been documented under the section, data analysis	Page 7-8, lines 211-234
Data analysis - The data analysis procedure has also been documented under the section data analysis	Page 7-8, lines 223-242
Techniques to enhance trustworthiness - To enhance trustworthiness, the procedure and the initial results were subjected to validation by language experts, social health researchers and community leaders. This is also mentioned under 'data analysis'	Page 7-8, lines 232-242

Results/findings

Synthesis and interpretation The results are presented under five themes. These are highlighted in the text under the heading of 'findings'	Pages 8-16, Lines 263-508
Links to empirical data - All the results of the paper (each theme) are supported with quotations from the field notes and transcripts	Pages 8-16, Lines 263-508

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field The paper has discussed and located the findings in line with prevailing local and international discourse.	Pages 16-20, lines 510-609
Limitations - The limitations and strengths of the study have been provided in the paper	Pages 19-20, lines 611-625

Other

Conflicts of interest – None declared	Page 20, line 639
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting The partial support of funding has been acknowledged in the paper	Page 20, lines 641-644

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388