GHANA
Community engagement, financial protection and expanding rural access

COUNTRY CASE STUDIES ON PRIMARY HEALTH CARE
Acknowledgements

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Background

During the 1990s, Ghanaians experienced a multitude of barriers to accessing primary health care (PHC). More than two thirds of the population lived more than 1.5 hours from their nearest health centre (1). Rural infant mortality rates were double the rates in urban centres, and the public were becoming aware of the need for financial protection from catastrophic health expenditures (2). From the 1978 Alma-Ata Conference onwards, Ghana made achieving community-based PHC a pillar of its approach to population health (3) and, by the end of the 1990s, two critical opportunities emerged to improve access to PHC.

In 1999, the Community-based Health Planning and Services (CHPS) programme became a new part of Ghana’s national health policy. This programme initially focused on rural and hard-to-access districts. Rather than relying on conventional facility-based services, the CHPS programme aimed to connect community members with preventive and public health services, through mobile community-based care provided by a resident nurse or a community health officer (1). A few years later, in 2003, the National Health Insurance Scheme (NHIS) was established to provide access to a broad range of health care services, with the goal of increasing affordability in health care and the use of health services, particularly among poor and vulnerable populations (4).
Intervention

One of the primary goals in implementing the CHPS programme was a focus on evidence-based organizational change (1). This involved an iterative roll-out, beginning in the 1990s with a pilot in the Navrongo district, followed by multiple replication and validation experiments. Initiation of the programme involved extensive dialogue and planning between the Ghana Health Service, which implemented CHPS, and the community. CHPS relies largely on the traditional community structure for setting priorities and delivering services (1), and its deep level of engagement with the community allows for the development of trusting longitudinal relationships. CHPS zones cover a catchment area of about 3000 people, and community health officers (CHOs), typically nurses, are supported by community volunteers. The CHOs, who often come from the region (although not the village) where they work, are based at CHPS compounds that are built by the community. They work with the community volunteers to travel to households to provide services including treatment of minor ailments, immunizations, community education, health promotion, health screening and timely referral. They also provide basic services at the CHPS compounds.

CHOs engage community members individually through “door-to-door” service delivery, and through community meetings and events held at the CHPS compounds. Community durbars are local gatherings at CHPS compounds that allow for key discussion between CHPS staff and the community about which health areas to target and focus on over the coming months. They also serve as opportunities for health education and promotion. Early pilot results from CHPS showed dramatic health improvements, including statistically significant declines in child mortality and reductions in fertility rates (3). With the successful pilot and replication experiments came a scale-up that targeted national coverage, beginning in 2000. This gradual roll-out and iterative implementation of the most effective components of the model found that the community’s engagement and participation were critical to the successful adoption of CHPS in a district (5). To ensure that districts would adhere to this approach, the Ghana Health Service began to conduct trainings of regional health teams that would, in turn, provide training for each district team on using an implementation guide to establish and manage CHPS (5).
Ghana’s NHIS was the first of its kind in sub-Saharan Africa (6). Before the roll-out of NHIS, there had been a few small projects and efforts towards health insurance, including a community-based health insurance scheme that only covered about 1% of the country’s population and did not improve health care accessibility among the poor (7). NHIS was more inclusive, and built upon the successes and challenges of these previous efforts. Full implementation began in 2004, with the creation of a National Health Insurance Authority (NHIA). NHIS is funded largely through the National Health Insurance Levy (a 2.5% value-added tax on selected goods and services). However, financing also comes from contributions – mainly by public sector workers – to the Social Security and National Insurance Trust, as well as premium fees, donor funds and money allocated by Ghana’s parliament (6). The single benefit package is available to everyone who registers, regardless of employment, income or age, and it aims to cover 95% of all diseases in Ghana (7). NHIS covers outpatient services, including diagnostic testing and operations; most inpatient services, including specialist care, most surgeries and hospital accommodation; oral health treatments; all maternity care services, including caesarean deliveries; emergency care; and all drugs on the NHIA Medicines List (4); however, it does not cover most cancers (6). In 2008, the Maternal Exemption Policy was added to eliminate premiums for women who were pregnant and to automatically cover neonates; the aim was to remove any coverage gap between birth and registration (8).
Barriers and facilitators

The CHPS roll-out plan targets full coverage across all districts, although this has not yet been achieved; to date, 4800 of the 6000 districts in Ghana have CHPS (9). One challenge has been that of “perpetual planning”; in 2005, more than three quarters of the districts implementing the programme had completed the formal CHPS planning process, but relatively few of these districts had actually moved towards the implementation phase (1). CHPS implementers conducted focus groups, which indicated that much of the hesitation in moving forward was associated with uncertainty and concerns about financing. As a result, exchange programmes were developed, because mentoring from communities that have successfully adopted CHPS has been shown to be one of the most successful routes to fostering adoption in additional districts (3).

In the early years after NHIS was implemented, the Ghana Health Service found that the insurance scheme added to the demands on the country’s health infrastructure and workforce, which led to longer wait times and decreased quality of care, and caused some patient dissatisfaction (6). Reimbursement to health centres was also slow (8), which affected the financial sustainability of service provision. Although enrollment is legally mandatory, people are not automatically enrolled and there is no penalty for those who do not enrol (4). In addition, high user uptake costs – in the form of a fee required for enrollment, which has to be paid in person – has meant that a high proportion of especially poor and rural people have yet to enrol (4); by 2016, only about 40% of the population was enrolled (6). Additionally, although the NHIS aims to cover the bulk of Ghana’s burden of disease, it does not cover some expensive treatments and procedures (including most cancer treatments and certain surgeries) (4). As a result, even some individuals who have insurance coverage still face high health care costs, or find themselves unable to afford access to the care they need. Nonetheless, national health insurance has been hugely important politically, and is one of the unifying interventions in the country (2). The infrastructure challenges are slowly being remedied, as private sector providers begin to make investments in rural and less privileged communities, buoyed by the assurance of guaranteed reimbursement for treating patients in these settings (2).
Impact

The two decades since the establishment of these national health programmes have seen important improvements in the health landscape for Ghanaians. Life expectancy at birth increased from 60.7 years in 1995 to 64.8 years in 2014 (7). Under-5 and infant mortality declined substantially between 2003 and 2014, from 111 to 60 deaths per 1000 live births among children aged under 5 years, and from 64 to 41 deaths per 1000 live births among infants (10). The NHIS and CHPS programmes contributed to these successes (1,2). Studies of the impact of the NHIS found strong improvements in maternal health outcomes; pregnant women who are enrolled in the NHIS have free access to maternal care, and are more likely to receive prenatal care, give birth in a hospital and have skilled attendants present at birth (4). Skilled assistance at birth increased from 59% in 2008 to 74% in 2014 (11). Other studies confirmed these findings, and reported that pregnant women insured under the NHIS were also less likely to experience birth complications (6). Although Ghana did not achieve the full Millennium Development Goals (MDGs) related to maternal and child health goals – that is, a two thirds reduction by 2015 in maternal mortality rates (MDG 4) and in infant mortality rates (MDG 5) – mortality rates did decline by more than 50% in both groups (12). It is likely that both CHPS and the health insurance scheme played an important part in this reduction (2). In addition, hospital and clinic attendance grew dramatically after the introduction of NHIS. Per capita use has improved markedly, and people are seeking care not only when they are ill but also for checkups and preventive health services, something that happened only sporadically in the past. Among communities where CHPS nurses were deployed, child mortality declined by one half in only 3 years, and child mortality dropped by two thirds within 7 years (3). The CHPS programme has grown to reach 80% of Ghana’s districts to date, providing more consistent access to family planning information and services, and health promotion services (3).
The way forward

Research on how best to scale up CHPS has shown that a successful way to strengthen the community connection is to place community nurses in their respective regions, but preferably not in their local village (because the nurses thus speak the local languages but also have some social removal). And community engagement is paramount: “a decade of systematic problem solving with community engagement has been the single most important factor explaining the rapid scale up of CHPS” (3). Commitment to CHPS arises from experience with the programme, with health workers participating in CHPS tending to be some of the strongest proponents of the programme (1). However, cost – to both the districts and the Ghana Health Service – continues to be an important hurdle to expanding the programme.

Today, Ghana is grappling with the challenges of the double burden of disease; that is, the ongoing health burden from infectious diseases compounded by the rising burden of noncommunicable diseases. Hence, prevention, screening and chronic disease management are becoming increasingly important components of the PHC service package. The Ghana Health Service is working with the NHIA and other decision-makers to change policy, so that the NHIS can pay for both disease treatment and the increasingly important prevention efforts provided by CHPS community health workers to engage communities in their own health. This is an important step in equitable health care delivery; other countries can look to Ghana as an example for how to take on this 21st-century challenge, while still remaining committed to the promises of the Declaration of Alma-Ata and health care for all Ghanaians.
References


2. Interview with Dr Lydia Selby, Ghana NHIA Chief Operations Officer, 30 May 2018.


9. Interview with Dr J Koku Awoonor-Williams, Director of the Policy, Planning, Monitoring and Evaluation Division, Ghana Health Service, 31 May 2018.


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