Strengthening community-based healthcare in Ghana in the context of the TICAD process -- promoting resilient healthcare systems (Special feature -- TICAD VI)

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Special Feature: TICAD VI

Current Topics

Strengthening Community-based Healthcare in Ghana in the Context of the TICAD Process :

Promoting Resilient Healthcare Systems

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For the first time since its inception in 1993 the Tokyo International Conference on African Development (TICAD) was held in an African country in 2016. The TICAD VI was held in Nairobi, Kenya, on August 27-28, and not in Japan where all the previous summits were held. The decision to hold the event in Africa follows the inclusion in 2010 of the Africa Union Commission as co-organizer of TICAD. These momentous developments in the TICAD process may be seen as an attempt on the part of the development partners, led by Japan, to further enhance Africa's ownership of the TICAD initiative.

The Yokohama Declaration of 2013, which was adopted at the TICAD V, underscored the concept of human security with emphasis on the primary importance of the safety and wellbeing of individuals. This is understood as an ideal that can be achieved by strengthening capacity in the areas of humanitarian concern, including healthcare provision (Ministry of Foreign Affairs 2013). In relation to that, and in response to the emerging challenges for the African countries since TICAD V, the three priority areas for discussion at TICAD VI included, Promoting Resilient Health Systems. The other two priority areas were designated as: Promoting Structural Economic Transformation through Economic Diversification and Industrialization; and Promoting Social Stability for Shared Prosperity. The recent outbreak of epidemics such as Ebola and other health crises conceivably necessitated the emphasis on better health chances through the application of high quality standards in health delivery in Africa. To achieve that it was agreed at TICAD VI to strengthen the relevant institutions and build 'national and local capacities by reinforcing capable, efficient, responsible, transparent, equitable and accountable health systems to improve essential service delivery' (Ministry of Foreign Affairs 2016).

This research reinforces the ideal stated under Pillar 2 of the Nairobi Declaration, Promoting Resilient

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Health Systems for Quality of Life, by focusing on a project that demonstrates efforts within the TICAD initiative to strengthen healthcare systems at various levels in Africa. The specific project for our analysis is the Scaling up of the Community-based Health Planning Services (CHPS) in the Upper West Region (UWR) in Ghana by the Japan International Cooperation Agency (JICA) between 2006 and 2010. CHPS is conceived as 'the mobilization of community leadership, decision-making systems and resources in a defined catchment area (termed a 'zone') to provide services according to the principles of primary health care' (Ghana Health Service 2007, 53) through Community Health Officers (CHO) as frontline health workers.

The focus on the JICA project in the UWR for analysis is because the region exhibits some of the worse indicators in healthcare delivery in Ghana, which is conceivably the reason why JICA chose it as the site for the project (JICA 2014). JICA's emphasis on fine-tuning the administrative capacity for healthcare delivery in the UWR (as the essence of the project) is another motivation for this study.

More specifically, the study maps out Japan's role in the project, and attempts to evaluate the particular type of intervention JICA made in its planning and implementation, as well as how this might have impacted on the administration of healthcare delivery in the UWR, and in Ghana in general. The discussion concentrates in particular on JICA's application of Facilitative Supervision (FSV) to review the conventional monitoring 'apparatus' within Ghana's healthcare delivery system, and reveals that the approach, as a supervisory system of practice, improved the administration of healthcare in the UWR (Aikins et al. 2013).

Essentially, this study underscores the role of the State (the government institutions) in Ghana's development, and illustrates its function as a leading agent in the provision of the basic infrastructure for development. Consequently, as the following discussion shows, as the implementer of Japanese aid JICA provided assistance towards strengthening the administrative capacity of the employees of the Ghana Health Service (GHS) in the region. This was necessary not least because, as Karima Saleh (2013, 59) has noted in a recent study about the health sector in Ghana, 'performance scores for all clinics remained well below the highest possible scores. Deficiencies in technical skills were widespread…[and] the quality of clinical care was substandard'.

The emphasis of the project on developing and enhancing the administrative capacity of state officials – in this case government health workers – affirms the donor's understanding of the central role the State and its ancillary agencies play in healthcare delivery in Ghana, and indeed in the country's development as a whole. Thus, I suggest as a thesis that given the existing deficiencies in the country's health infrastructure, the efforts to strengthen the health system in Ghana might only be fully realized if, and when, the GHS and its agencies have the requisite administrative and technical qualities to improve essential service delivery. In that regard, Japan's role as donor towards the project was to assist the government of Ghana to realise the development and enhancement of the country's healthcare system.

The CHPS Initiative in the context of the Healthcare System in Ghana

The CHPS is part of the Government of Ghana's national programme to repurpose healthcare delivery in a manner that values all sectors of society, thereby redressing inequalities in access to healthcare across the country, with the overall objective of balancing efficiency and equity objectives. However, while CHPS as a strategy is as much about the community embracing and enhancing its own healthcare delivery strategy as it is about owning the initiative, not least because it is community-based and -oriented, in fact CHPS is under the control of the State (Nyonator et al. 2005, 28), in so far as it is orchestrated by the GHS.

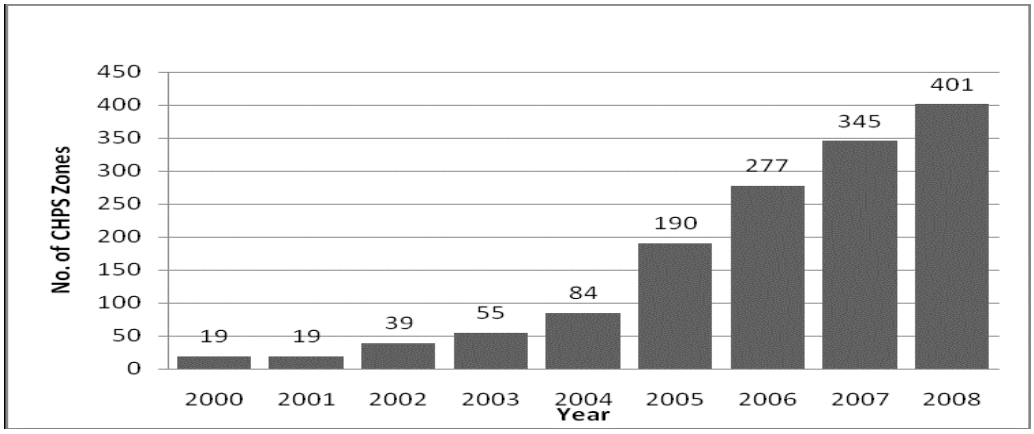
Decades of failed health policies, strategies and infrastructure within the GHS, exacerbated by cuts in public services mandated by the World Bank reforms of the 1980s and beyond, have created '…deficiencies in the health system [that] translated into severe capacity constraints…' as well as limiting access to health facilities in general (Aryeetey and Goldstein 2000, 290). In part this necessitated the implementation of the CHPS, which was initiated in 1994 by reorienting and relocating primary healthcare from sub-district health centres to rural areas, which often lacked permanent healthcare infrastructure. More specifically, CHPS was conceived to counteract poor attendance at outpatient departments (OPDs), and high maternal mortality, child mortality and morbidity in rural areas. Consequently CHPS is seen as providing the 'vehicle to deliver … community level service by engaging communities to take decisions concerning their own health, and recognize that the primary producers of health are the individuals within the household – especially mothers' (Ghana Health Service 2005, 2).

Under this system, a trained community health nurse is assigned to a zone (with a catchment area of 3000-5000 people) as a Community Health Officer (CHO) who resides in a designated Community Health Compound (CHC) (Williams et al. 2015, 7) equipped with a clinic, and from where a close-to-client healthcare service is provided to those living within the zone. In principle the CHO conducts household visits to provide basic medical treatment, advice, and health guidance; but they may also refer patients to more specialised medical institutions in the sub-District Health Centre or District Hospital, affirming Ghana's three-tier health delivery service.

However, as a strategy the CHPS system is flawed on several levels, perforated with weaknesses within its operations due to lack of resources, and, more acutely, due to weak administrative capacity (Republic of Ghana 2010, 9-30; Binka et al. 2009). For example, from the national to the sub-district levels 'no administrator work[ed] full-time on CHPS, [suggesting] lack of commitment and support' for the project (Ntsua et al. 2012, 12). And while the CHPS concept revolves essentially around home visits by the CHO, who should 'conduct at least 10 home visits each day for preventive health education', instead they conducted 'on average, one home visit per week' (Ntsua et al. 2012, 5), which defeats the essentially preventative purpose of the initiative and orients it more towards curative healthcare. In other words, the strategy seems inclined towards 'static service provision', with the CHO stationary at a delivery point where the patients have to go to receive the services they require, thus undermining the very essence of the initiative (Ntsua et al. 2012, 8).

According to the GHS's Annual Report for 2007, the population covered by CHPS was 6.4% (Ghana Health Service 2007, 53). A 2009 review (Binka et al. 2009, 18) of the strategy admits that from 2000 to 2008, the number of functional CHPS compounds grew from 19 to 401, as indicated in Figure 1. Basically, 'the Implementation of the CHPS programme nationwide was below average' because the planned roll out of demarcated CHPS zones at the end of 2008 was 1, 314, with only 31% of this planned total being released. This means that, despite the priority given to the strategy within the matrix of the GHS, it had remained largely immobile in terms of its expansion, principally because of the lack of administrative capacity in district health bureaus, inadequate number of CHOs, a lack of well-qualified CHOs (JICA 2014), 'sub-optimal levels of local people's participation', and a lack of consensus about the definition of 'functional CHPS' (Aikins et al. 2013, 1). The GHS (Ghana Health Service 2007, 53-54) noted that 'the scaling up [of the CHPS] process has been hampered by inadequate resources and to some extent, inadequate understanding of CHPS by some people in various leadership positions within the Service.' The problem is compounded by a general lack of urgency on the part of policymakers to realise the goals set for the initiative. Not surprisingly, therefore, there was no dedicated funding for the programme at the national level (Binka et al. 2009).

Figure 1: Number of CHPS Zone by Year, 2000-2008



Source: Binka et al. 2009.

Japan and the CHPS project in the Upper West Region of Ghana

Given the problems noted above and the fact that the health indicators for the UWR lag far behind those of the other regions of Ghana (Ghana Health Service 2011, 57), there was a desperate need for external intervention if the health services in the region, one of the least populated and least urbanised in Ghana, with 84 per cent of the population being rural, were to be improved. Based on a request from the Government of Ghana to the Government of Japan for assistance towards the CHPS programme, Tokyo agreed to support the initiative through the 'Project for the Scaling-up of CHPS Implementation in the

Upper West Region'. The project was launched in March 2006 and completed in February 2010, with a project cost of approximately ¥500 million (US$4,043,549), through the cooperation of the GHS, the Ministry of Health (MOH), Ghana, and the JICA, with the latter as the aid disburser. This research concentrates on the project completed in 2010, and does not include the Project for Improvement of Maternal and Neonatal Health Services in the UWR, which was launched as a JICA technical co-operation project from September 2010 to September 2016.

As noted above the Scaling-up of CHPS in the UWR was designed around strengthening 'the institutional capacity of the GHS [towards] the implementation of CHPS…' through the practice of FSV (Republic of Ghana et al. 2010, 1-2; JICA 2014; Aikins et al. 2013, 1). For our purposes, FSV amounted to a cascading process of capacity building, starting with the Regional Health Management Teams (RHMTs), who should then transfer the updated tools of engagement to the District Health Management Teams (DHMTs) through systematic training and supervision. The process continued with the latter applying and implementing the same method of training and supervision to the teams below it within the bureaucratic structure, the Sub-District Health Teams (SDHTs), whose responsibility was to supervise the CHOs. In effect, the project was about enhancing rural healthcare through the realisation of the following practices (JICA 2014):

1. Standardising training in health administration management;
2. Training CHOs and Community Health Nurses;
3. Conducting situation analyses on CHPS activities and developing a supervision system;
4. Conducting situation analyses and developing guidelines on a referral system;
5. Conducting situation analyses on community participation and developing training materials for that; and
6. Disseminating good practices to other districts in the region through training and sharing guidelines.

The feasibility and success of these practices was dependent on improving and articulating the institutional capacity of the regional health administrators, which in turn was dependent on establishing, implementing, and strengthening the FSV to enable the reformulation and enhancement of the monitoring system within the RHMTs, DHMTs, and SDHTs, the three most important agencies of the region's healthcare infrastructure. Capacity building for the CHOs was also incorporated within the framework of the FSV, as noted above. Table 1 lists the capacity-enhancing activities designed for the three agencies, highlighting some of the responsibilities of the individual bureaucratic teams in the FVS process.

Table 1. List of Capacity Building Activities

Level	Capacity Building Activities
Regional Health Management Teams	• Training in proposal writing for support for the construction of CHPS compounds. • Providing support towards establishing FSV implementation system and developing tools for FSV. • Dissemination of best practices in training.
District Health Management Teams	• Training in proposal writing for support for the construction of CHPS compounds. • Establishing FSV implementation system and developing tools for FSV. • Dissemination of best practices in training.
Sub-District Health Teams	• Support towards enhancing a better understanding of CHPS implementation. • Dissemination of best practices in training. • Support towards enhancing the administration of the referral system. • Support towards establishing FSV implementation system and developing tools for FSV.

Source: Adapted from Republic of Ghana et al. 2010, 10.

The performance standards (PS)[1] of the health personnel increased markedly, from 10.9 % in 2008 to 56.7 % for the SDHTs at the time of terminal evaluation in 2009, and at the time of the ex-post evaluation in March 2012 it had increased to 69.8 %. Progress was also made in regards to the CHOs whose performance increased from 7.5% in 2008 to 23.7 % in 2009 although no figures are available for its ex-post evaluation. The performance of the DHMTs was the highest amongst the health administrators in the region at 97.2 % (JICA 2014).

Apart from improving the capacity of the staff in charge of health provision in the UWR, the initiative also resulted in an increase in the coverage of the project from 24 CHPS zones in 2006 to 81 zones by 2009, 12% and 41% respectively of the target of 197 zones, as indicated in Table 2. Three years after the completion of the project in 2010, the Ex-post Evaluation, as evident in Table 2, shows a further expansion to 166 zones, which is 84% of the target (JICA 2014).

[1] The PS showed improvement in management of supplies, information management, technical support to the CHOs, management of meetings, conditions of CHO compounds, and documentation. According to Moses Aitkins et al. (2013, 4), '[t]he FSV assessment was based on 'yes' and 'no' responses to a series of questions relating to the identified issues …' for the relevant Teams. Each question was scored according to the answer given, and the scores were quantified using the developed scales in the area. 'The final score is standardised and value returned as a percentage. The final scores are then graded into ordinal scale of 'good', 'fair' and 'poor' with their equivalents in percentage scale'.

Table 2: Project Purpose and Overall Goal

	Items	Project Commencement 2006	Terminal evaluation 2009	Ex-post evaluation, 2013	Target for 2015
Increase in the number of functional CHPS zones	No. of functional CHPS zones	24	81	166	197

Source: Modified from JICA 2014.

Conclusion

The above discussion has focused on JICA's initiative to fine-tune the performance of healthcare personnel in the UWR through the CHPS project. The project is a response to the crises in healthcare infrastructure and delivery in Ghana. The emphasis on improving the working capacity of the healthcare personnel presents a hypothesis, which is that the more capable the health management teams are, the more efficiently and effectively the CHPS project would be able to serve the target population. Essentially the study underscores the role of the State in development, illustrating its primary importance as a leading agent in the provision of the basic infrastructure, including the institutions and skills required for economic development.

The project for the Scaling-up of CHPS Implementation in the Upper West Region clearly responds to at least two of the visions expressed in the Nairobi Declaration of 2016, 'accelerating the efforts for human resource development', and 'promoting resilient health systems' for better life chances (Ministry of Foreign Affairs 2016). Against that backdrop, it is worth noting that at TICAD V in 2013, the African Business Education (ABE) Initiative for Youth was launched by the Japanese government in recognition of the 'need for human resource development in both private and public sectors of Africa' (Opportunities for Africans 2016). Accordingly, the Government of Japan is offering, through the Japanese Grant Aid for Human Resource Development Scholarship (JDS Programme), funding to Ghanaian government workers (excluding those in the military) to study in Japan for a Master's degree, including modules to help strengthen 'capacities for implementing health policies'. The target candidates for the latter initiative are, not surprisingly, employees of the MOH and GHS.

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