Better Care, Better Health: Optimizing Healthcare Provision in Ghana

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As enshrined in Article 16 of the African Union’s Charter for Human Rights, also known as the Banjul Charter, “every individual shall have the right to enjoy the best attainable state of physical and mental health.” Ensuring that every African enjoys a state of complete physical, mental, and social well-being has proven to be an uphill battle for many national governments, as evinced by the alarming human development indicators that have characterized the continent since its decolonization era in the mid-20th century. In Ghana, a country in the western region of Africa, actualizing this right as a signatory of the Banjul Charter has been a significant feat since the late 1990s. Due to the introduction of the National Health Insurance Scheme in 2003, along with related policies in maternal and child health care, Ghana has seen a marked improvement in the provision of healthcare for all of its citizens as indicated by health outcomes that are comparatively better than other African countries. Nevertheless, systemic barriers and challenges still exist that impede the quality of, and access to, healthcare. An examination of these constraints and their social costs show the need to alleviate the burden and bottlenecks they cause. From this examination it is clear that a comprehensive approach entailing reforms and innovations geared towards bolstering accountability, monitoring and evaluation, and the retention of Ghana’s health workforce could optimize healthcare provision in Ghana.

“The Health of the People: What Works”

In sub-Saharan Africa, a region characterized by political instability, poor governance, natural resource wealth, and extreme poverty, human development indicators—particularly health outcomes—continue to lag in comparison to the rest of the world. As reported in a 2018 report published by the Africa Growth Initiative at the Brookings Institution examining the region’s progress towards meeting the human development objectives envisioned in the 2030 Agenda for Sustainable Development, sub-Saharan Africa experiences the highest loss of human development due to inequality. As shared in the report, twenty-eight sub-Saharan African countries are not on track to meet any targets for maternal mortality and child mortality. Given that health yields economic dividends, the health challenges that have plagued countries within the region have had significant implications for productivity and have been a chief contributor to stagnant economies and dilapidated social infrastructures. For this reason, in a 2014 report, entitled “Common Africa Position (CAP) on the Post 2015 Development Agenda,” the African Union identified health as a substantive issue of importance in the region worthy of regional cooperation.
Responding to the data that has been collected and collated by international organizations, along with national and regional stakeholders, which illuminates the severity of health challenges in Africa, a substantial amount of literature has been published proposing remedies. Several of these strategies have been echoed by development practitioners and researchers in other regions of the world grappling with similar concerns.

In “The Health of the People: What Works,” a 2014 regional health report for Africa, the World Health Organization (WHO) provided ten recommendations for improving the health of people living within the region. The first recommendation– good governance– is premised on the belief that good leadership for health requires accountability from the community-level up, and that policies in all areas have a direct and indirect bearing on the health of a country’s people. Hence, where leaders are actively engaged in promoting health interventions, demand for such interventions increases as seen in the success of WHO’s Polio Eradication Initiative. The positive correlation between governance and health in sub-Saharan Africa has been well-documented. In an ecological analysis examining the relationship between governance and the performance of health systems in the region, cross-sectional data from forty-six African countries revealed that governance (measured using the World Bank governance index and the Ibrahim Index of African Governance) was strongly associated with the under-five mortality rate and moderately associated with the under-five mortality rate quintile ratio. Even after controlling for confounding factors, governance remained significantly correlated to this health outcome.

The second recommendation calls for health mainstreaming in affiliated policy areas such as sanitation and infrastructure, which will purportedly help in lowering the incidence of death and disability in the region. Partnerships and coordinated strategies across these sectors have proven to be effective in improving health outcomes in African countries. In Liberia, for example, recognizing that the incidence of Ebola could be curtailed in a more enabling environment, a package of interventions to improve and monitor water, sanitation, and hygiene, the health ministry was implemented in 2014 with support from the World Health Organization (WHO). After an assessment revealed challenges with water treatment, water quality, and health-care waste management, multi-stakeholder meetings were held to develop a national water, sanitation and hygiene, and environmental health package. Implementation of the package included the creation of county health teams. These teams, comprised of medical directors, community health administrators, and environmental health technicians, were responsible for county outbreak preparedness and response efforts related to water, sanitation and hygiene, and infection prevention and control. Their work was pivotal in the declaration of the country as Ebola-free in 2016 and the aversion of outbreaks since then.
The third recommendation suggests a widening and strengthening of real-time data collection efforts in countries within the region to provide policymakers with the information needed to respond appropriately to their country’s health needs. The lack of rigorous data collection and coordinated systems to disseminate findings inhibit the accurate planning, funding, and evaluation of development activities in the region. The emergence of actors like the Kenya-based African Population Health Research Center, a research institution committed to developing an Africa-led and Africa-owned body of evidence to inform decision-making for a sustainable and effective response to the critical hardships facing the continent, have helped galvanize the generation of evidence for meaningful action to improve lives across sub-Saharan Africa.

The fourth recommendation highlights the severe shortage of health workers in the region and calls for further institutionalization of increased salaries and guaranteed payments, a viable approach financed by increased government spending on health. The maldistribution of health workers in sub-Saharan Africa cannot be understated. Out of forty-six countries in the sub-Saharan Africa region, forty-three have a health workforce density that averages less than one worker per 1,000 people, significantly low compared to the world median density of five per 1,000 people. The impacts of improved salaries and more posts on the retainment of health workers and, ultimately, on the health of a country’s population have been well documented. In Brazil, for instance, the integration of a community health worker (CHW) program into the National Family Health Plan by the Ministry of Health in 1994 has contributed to significant improvements in infant and child mortality. The program, which has expanded from six thousand CHWs in 1987 to more than 250,000 today, considers CHWs as employees of the Ministry of Health and pays them a salary of $112 per month (the national minimum wage), which is twice the average local monthly income for rural workers. The retention of these CHWs has led to an expansion of reach with the Ministry of Health’s Family Health Program, covering 120 million people. Resultantly, the program has been associated with a twenty-two percent reduction in infant and child mortality between 1996 and 2004.

The fifth recommendation suggests harnessing local technologies to assist in the creation of surveillance systems, the amplification of health trainings, and the provision of diagnostic support for remote health workers. The use of information and communication technology (ICT) in improving health have been well documented. In a study using a multi-method approach to investigate the impact of ICT on health systems in twenty-seven African nations from 1998 to 2007, researchers were able to demonstrate that by investing in ICT, such as mobile phones and telephone lines, countries can significantly increase life expectancy at birth and reduce the infant mortality rate. The integration of ICT in health improvement
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initiatives also notably facilitated an increase in health expenditures due to the rising health awareness and subsequent high demand for health care services.  

The sixth recommendation outlines mechanisms geared toward enhancing the quality of all health care, which includes building in benchmarking along with systems of accreditation, oversight, and evaluation from the community-level upwards. These mechanisms have been proven to enhance the functionality, quality, and responsiveness of healthcare facilities in Africa. A study examining the impact of a hospital accreditation system coordinated by the Council for Health Services Accreditation of Southern Africa (COHSASA) in the KwaZulu-Natal (KZN) province of South Africa is one example of their effectiveness. The 2001 study measured the effects of the accreditation program through a comparative assessment of ten hospitals that entered the program in 1998 with ten that did not. An analysis of survey data from the COHSASA accreditation program mapping hospital processes and structures, along with eight indicators gauging hospital quality of care, showed that the COHSASA-facilitated accreditation program was effective in increasing public hospitals’ compliance with performance standards. Better fidelity to these standards helped improve the quality of healthcare facilities which in turn contributed to a drop in mortality and morbidity rates.

The seventh and final recommendation focuses on the necessity of community-based health interventions in transforming health outcomes. Ultimately, to turn recommendations into implementable actions, a genuine partnership must be established with those whom a community trusts for health advice, often traditional healers. In several African countries, partnerships with traditional healers have helped optimize health interventions. In South Africa, for example, a national HIV/AIDS and STD prevention program that enlisted the assistance of traditional healers recruited through formal associations found in the country was launched in 1992. An original group of twenty-eight healers (the “first generation”) were trained in HIV/AIDS and STD prevention and, in turn, trained a total of 1,510 additional healers (the “second generation”) in formal week-long workshops within ten months of the first workshop. An assessment of the impact of this training showed that the dissemination of advice related to condom use by a traditionally reliable source of health advice expanded the internalization of safe sex practices in respective localities.

Each of these recommendations illuminates several strategies that can be adopted in sub-Saharan African countries to improve the health of their people. An examination of the provision of healthcare in Ghana, a country within this region, illustrates how some of these strategies have been adopted and how effective they have been in mitigating constraints and challenges that once plagued the health sector. An overview of the country’s current healthcare system also illuminates opportunities for reform and innovation that can
maximize the delivery of this public service.

**Case Study: The Provision of Healthcare in Ghana**

When compared to other countries in sub-Saharan Africa, Ghana, a country in West Africa, has a well-developed health system. While the country’s physician density, and nursing and midwifery personnel density, fall short of WHO’s recommended minimum threshold of twenty-three doctors, nurses, and midwives per 10,000 population at almost one and over nine respectively, Ghana performs satisfactorily in this indicator compared to most African countries.\(^{[14]}\) Also, between 2009 and 2014, nearly seventy-one percent of live births were attended by skilled health personnel as compared to the average of over forty-eight percent of births that were attended by skilled health personnel in the continent at-large.\(^{[15]}\)

The health indicators seen in the country over the last five years also attest to the efficacy of Ghana’s health system. According to the 2013 United Nations Development Programme (UNDP) Health Index, Ghana ranks 138th out of 187 countries with an index of just over zero point six and lags behind only six other African countries.\(^{[16]}\) Ghana’s status as a relatively healthier country is further corroborated by key health indicators provided by the World Health Organization (WHO). According to its 2016 health profile, life expectancy at birth for males is sixty-two years old and sixty-four years old for females, surpassing the average life expectancy on the continent (fifty-eight years old and sixty-two years old, respectively). The neonatal and child (under-five) mortality rate is also ranked at over twenty-four and over forty-nine per every 1,000 live births respectively, faring well when juxtaposed to the continent’s average (thirty-four and 100 deaths respectively).\(^{[17]}\)\(^{[18]}\)

**Ghana’s National Healthcare Insurance Scheme (NHIS)**

A chief contributor to these outcomes has been the policies instituted in the country in the late 1990s and early 2000s. Recognizing how the financing of health services affects health outcomes, Ghana embarked on a health financing reform process in 1997 which ultimately led to the establishment of the Ghana National Healthcare Insurance Scheme (NHIS). At the time the national insurance policy was introduced, Ghanaian politicians understood the negative impact that the reliance on out-of-pocket payments had on the access to services and health outcomes in a country where thirteen percent of the population lived on less than two dollars a day. Resultantly, the policy, which was pushed forward by strong political will, has survived democratic transitions in political power during the last decade. The implementation of NHIS capitalized on preexisting mutual health insurance organizations (MHOs) that were established in the early 1990s with the technical and financial support of humanitarian agencies and international donors. These community-based, voluntary MHOs
started at the local level, pooling risk for no more than 1,000 people. Noting the fragmentation of these units, the NHIS process combined them into building blocks that ultimately became the district-level mutual health insurance schemes (DMHIS) that comprised the national system that was formalized through the 2003 National Health Insurance Act and was effectively rolled out in 2005. Funds channeled from multiple sources sustain the health financing pooling mechanism that underlies the NHIS. Most funds are sourced from a value-added tax (VAT), two and a half percent of which is explicitly designated for the NHIS. Another source is the payroll tax from the Ghana pension scheme for the formal sector, two and a half percent of which is earmarked for the NHIS. The financial contribution of NHIS members represents only a small fraction of the NHIS total revenue and these contributions often stay at the DMHIS level. Paying members from the informal and formal sectors constitutes less than ten percent and about twenty percent of membership, respectively. In addition to these funding channels, revenue progressivity is supported by cross-subsidies on primary necessity products.

Maternal and Child Healthcare Policies in Ghana

A woman and her child in Tamale, Ghana (Eghosa Asemota, 2018)

In addition to the National Healthcare Insurance Scheme, policies targeting maternal and child healthcare have helped to optimize health outcomes in the country. In the realm of child healthcare, Ghana has implemented two national-level interventions, the Child Health Strategy (CHS) and the Ghana Child Health Policy (CHP) in 1998, both of which aim to improve access to healthcare services and guarantee the quality of medical care. In 2000, the Ghana Essential Health Intervention Project (GEHIP) and community-based health planning and services (CHPS) were also established to reduce child mortality, particularly in rural areas. Under the CHPS and GEHIP, community healthcare officers are trained to treat malaria, diarrhea, and acute respiratory diseases, and administer child immunizations. In the realm of maternal healthcare, the Ghana Health Service (GHS) implemented several policies to help improve maternal health and reduce maternal deaths, namely an antenatal care policy and a safe motherhood initiative in 1998. Because these initiatives had a limited effect on maternal mortality, policymakers, recognizing the preference rural populations had for unskilled maternity care services, introduced the delivery exemption policy in 2003 to provide free maternal delivery and reduce the financial constraints associated with using skilled maternal services. This policy, which covers deliveries, cesarean sections, and management of complications arising from maternal deliveries, was incorporated in the National Healthcare Insurance Scheme.
Over the past two decades, government spending on health has increased to enhance healthcare provision and the acquisition of better hospital resources. Because of the increase in health expenditures along with complementary health policies since 2001, infant mortality and child (under-five) mortality have declined by fifty percent and twenty-five percent respectively while life expectancy has increased from almost sixty-one to almost sixty-five years.\

**Challenges in Ghana’s Healthcare Provision**

Despite the adoption of these policies and interventions, challenges, constraints, and bottlenecks– namely, limited health facilities, human resource challenges, and suboptimal health outcomes particularly for rural remote communities– remain in the country.

**Administrative Failings of the National Healthcare Insurance Scheme (NHIS)**

Though Ghana’s ambitious national health insurance policy has been applauded considerably, criticisms of the system illuminate shortcomings in the administration of healthcare. Notable failings have included long delays in provider reimbursement which ultimately threatens the financial sustainability of hospitals, accusations of fraud and abuse, unreliable record keeping, unclear lines of authority, and delays in issuing patient registration cards. In response to these criticisms, a National Health Insurance Authority (NHIA) council was created in mid-2009 to introduce reforms aimed at increasing membership and improving public confidence in the NHIS. Amid concerns about financial sustainability, the NHIA is also exploring ways of maximizing revenue and curtailing costs.

**Limited Health Facilities**

Although capital investment and government spending on health has increased, the capital being poured into healthcare facilities has been based on administrative levels (regions and districts) rather than on need or equity-based principles. Planning for the location of these hospitals has also been poorly coordinated. This is evinced in the spatial distribution of hospitals. Several districts have multiple hospitals whereas other districts have none. Shortages also exist of both lower-level health facilities as well as equipment at the sub-district level. Investment in the maintenance of health facilities is also inadequate.

**Human Resource Challenges**

Amidst an emigration trend, the recruitment of health workers, particularly physicians, remains a challenge and has created daunting shortages in the health sector. As health
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workers age and recruitment remains stagnant, these shortages have hindered the operational capacity of many lower-level facilities, including community-based health planning and services (CHPS). The training of physicians is also low relative to the country’s needs. These low levels of training are attributed mainly to preservice training being concentrated in just a few cities. Responding to this, the national government, since 2014, has been implementing efforts to set up tertiary teaching hospitals as a training ground for physicians in more regions and districts. Assessments on the quality of care, productivity, and competencies of health workers also illuminate poor reception by clients. Though absenteeism is modest, evaluations of health workers reveal that motivation is low—hence the prevalence of poor attitudes toward patients. Health workers report that this lack of motivation has contributed to the issue of low retention.

Ghanian doctors striking against pension deductions in 2013. (Grandmother Africa, 2013)

To assist with the preservation of health workers, the Ghanaian government has offered several incentives geared towards enhancing their productivity and attitudes, including subsidized and free housing, additional allowances, and professional development opportunities. Despite this, shortages still ensue outside of large cities and health workers still fail to perform up to standard, particularly in rural areas, among the poor, and in the Northern Region of the country. Given that health workers are integral agents in the provision of healthcare, the barriers that inhibit their work and functionality have critical implications for patient access.  

Health in Rural, Remote Communities

Though private spending on health, particularly out-of-pocket payments, decreased, it is still higher than the World Health Organization’s recommended financial threshold. Since the inception of NIHS, those exempted from premium payments constitute over half of the total members, with youth under eighteen years forming the largest faction of that group. Nevertheless, the number of exempted indigents, or individuals living in impoverished conditions, is deficient. This exclusion is amplified by the skewed distribution of health workers who favor urban settings instead of rural areas and hospitals rather than clinics, hence creating uneven access to healthcare services. Consequently, the health outcomes in rural areas compared to urban areas are starkly distinct with higher rates of infant mortality, child mortality, maternal mortality, and lower life expectancy.
Opportunities for Healthcare Reform in Ghana

To adequately internalize the premise that good leadership for health demands accountability at all levels from the community upwards in all areas that have a direct and indirect bearing on health, Ghana will need to tackle the corruptive practices that generate impediments to healthcare access. As presented in Transparency International’s Corruption Perceptions Index, Ghana ranks seventieth on a list of 176 countries. With its score of forty-three on the Corruption Perceptions Index, corruption is relatively low compared to other African countries. However, because of its prevalence within the health sector, there are severe implications for patient access. With corruption dictating locally funded contracts, the reporting of hospital revenue, and the misallocation of resources, Ghana’s health sector is ranked as the second most corrupt in Africa. These corruptive practices often have grave implications for patient access. In Koforidua in the Eastern Region of Ghana, for instance, a team of medical professionals working for an initiative aiming to perform surgeries on selected arthritis patients charged prospective beneficiaries varying sums of money ranging from twenty dollars to $1,300 for what was to be a free procedure. Throughout the health sector, the lack of oversight is also responsible for the prevalent sale of adulterated drugs. Accountability mechanisms are, therefore, needed to ensure the proper functionality of health services and the improvement of health outcomes for the country at large.

In addition to the need for better governance and accountability, reflecting on the second recommendation outlined in “The Health of the People: What Works,” Ghana will need to explore new partnerships with sectors related to health. While some of the Ministry of Health’s current strategies have been coordinated with the Ministry of Food and Agriculture, there exists little partnership with the private and public actors that comprise other sectors related to health. Coordinated strategies with the education sector, for example, have proven to enhance health outcomes and health equity in African countries. As seen in important initiatives like Africa Ahead, complementing health policy with a sustained effort to impart adequate health education on a population can foster behavior changes that have a positive impact on health. Africa Head works to enable government ministries, private agencies, and NGOs to roll out sustainable development programs, and to adopt an integrated and holistic approach capable of eradicating five communicable diseases and improving standards of living. Inter-sectoral collaborations in Ghana will be necessary for curtailing non-communicable diseases, an area that is projected to grow in prevalence due to Ghana’s population growth rate.

Adopting the third recommendation in WHO’s 2014 report to Ghana will require the
institutionalization of monitoring and evaluation systems managed by the government. Currently, data collection efforts throughout the country are lacking, and the subunits that comprise the Ministry of Health lack evaluative mechanisms that regularly examine program inputs, outputs, outcomes, impact, and the use of government funds. In developing countries struggling with human development, the presence of institutions tasked with monitoring and evaluating the entities responsible for public service provision has proven to be correlated with enhanced public service delivery. The 2010 establishment of the Department of Performance Monitoring and Evaluation in South Africa and their adoption of a results-based approach centering on improved service delivery led to the enhanced performance of all spheres and organs of the country’s public sector. By monitoring internal governmental performance processes and assessing the nature of external governmental outcomes and impacts on South African society, this department has helped the country with recognizing bottlenecks on delivery times and thus averting the inaccessibility of public services. With an arm of the Ministry of Health charged with conducting rigorous and continuous program evaluations across the ministry, the collection of high-quality data will become standardized and will help with data-informed decision making.

In alignment with the fourth recommendation outlined in “The Health of the People: What Works,” Ghana must adopt a holistic approach capable of mitigating its current shortage of health workers. Overcoming staffing gaps will require Ghana’s Ministry of Health to innovate and invest in new categories of health workers. This practice, known as task-shifting, re-allocates non-specialized duties from the limited pool of highly trained medical practitioners and health professionals to general health staff and community health workers. Task-shifting has helped to alleviate challenges related to the retention and recruitment of health workers in other African countries. For example, in both the Republic of Mozambique and the Republic of Zambia, where health workers often work beyond the traditional scope of their professional practice to cope with their daily tasks, cadres of ancillary staff and nurses assuming a greater diversity of functions were added to the health workforce. This addition ultimately contributed to the improvement of each country’s health delivery systems where procedures were better defined, and staff members worked in a more coordinated and organized manner. The adoption of task-shifting could help Ghana alleviate the ad-hoc responsibilities that health workers often cited as the cause for their lack of motivation while also assisting with their retention.

To be on par with WHO’s fifth recommendation, Ghana should consider the use of information and communication technologies (ICT) such as electronic health records, telemedicine, and e-learning to improve health education and the efficiency of health service
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delivery. Several case examples throughout the African continent illustrate how advantageous ICT integration is to sustainable health development. In the Eastern Cape Province of South Africa, for instance, the Presidential National Commission (PNC) on Information Society and Development’s introduction of e-health solutions like telemedicine and computerized health information systems in 2006 has helped with the generation, transmission, storage, and retrieval of digital data for clinical, administrative, and educational purposes. Through this enhanced connectivity, the provision of healthcare has improved, the digital divide between rural and urban professionals has lessened, the distribution of health professionals has become more equitable, and the management of health institutions has become better. Investing and incorporating ICT and e-health solutions in Ghana’s health sector could enable the country to increase its efficiency in healthcare delivery and improve access to essential services.

In addition to ICT incorporation, Ghana’s health sector can adopt WHO’s sixth recommendation by introducing accreditation to ensure the quality of public and private healthcare providers. Currently, Ghana’s healthcare facilities experience is characterized by varying levels of care and a lack of fidelity to standards outlined by the Ministry of Health. Extensive literature illuminates the ability of general accreditation programs to enhance the overall performance of healthcare providers and hospitals. In a systematic review that identified and assessed twenty-six instances of general accreditation programs in African countries, the training of external peer reviewers capable of evaluating a healthcare organization’s compliance significantly improved the quality of care and clinical outcomes in subspecialties, specifically sleep medicine, trauma management, and chest pain management. The creation of a national accreditation board could enhance the process of care provided by healthcare services and the clinical outcomes of a broad spectrum of clinical conditions within Ghana’s health sector.

Lastly, the adoption of the seventh recommendation outlined in “The Health of the People: What Works” would require Ghana’s Ministry of Health to foster more partnerships with local actors and amplify community-based interventions. Currently, spatial inequality and a skewed distribution of healthcare workers contribute to the inaccessibility and inadequacy of healthcare services in rural areas. In a study assessing access to healthcare among rural dwellers in the Pru District of Brong Ahafo Region of Ghana, for example, individuals living in rural areas detailing their physical accessibility to healthcare facilities cited poor transportation systems, unavailability of equipment for Traditional Birth Attendants (TBAs), long travel distances, and low income levels as impediments to access. Other obstacles to the attainment of better health outcomes have been fidelity to traditional health practices proven to be detrimental to early childhood development and maternal health. As a result of
this, rural areas have seen high maternal, infant, and child mortality rates. To respond to this, Ghana must consider the social realities of indigents and adopt culturally responsive approaches that enlist the assistance of traditional health actors like traditional birth attendants, community health workers, and traditional healers as extension health workers. In the Power and Systems Approach (PSA) outlined in How Change Happens, author Duncan Green advocates that local-organizing efforts should begin with a power analysis where those who hold power are identified, and the dynamics of power beyond apparent structures are mapped. Once this fundamental step is undertaken, local context and culture are better understood, opportunities for meaningful partnerships become more recognizable, and community change becomes attainable. As echoed by Green, Ghana’s Ministry of Health must consider the benefits of local knowledge and recognize the necessity of empowering those within the community. The adoption of a bottom-up approach and local-level organization with actors traditionally affiliated with health outcomes in rural contexts could help foster behavior changes that optimize rural livelihoods.

**Policy Recommendations**

Based on these insights, to optimize the provision of healthcare in Ghana, the national government, particularly the Ministry of Health, should consider the following recommendations:

**Recommendation #1:** To ensure transparency in the provision of healthcare and combat corruptive practices that affect patient access, community scorecard meetings facilitated by Ghana’s Ministry of Health should be held at the district level. Community scorecard meetings are derived from a CARE International initiative launched in Malawi in 2002 as a citizen-driven accountability measure for the assessment, planning, monitoring, and evaluation of service delivery. The tool is used to gather feedback from service users and improve communication between communities and service providers.

**Recommendation #2:** The Ministry of Health should foster intersectoral collaborations with private and public entities within the education sector to promote peer education and health education initiatives that aim to impart localities with knowledge that can change behaviors related to communicable and non-communicable diseases (i.e., best practices in hygiene, etc.).

**Recommendation #3:** The Ministry of Health should develop a branch of its ministry tasked with conducting rigorous and continual program evaluations that assess the functionality of healthcare facilities and providers, the collection of high-quality data, and data-decision making.
Recommendation #4: The Ministry of Health should adopt task-shifting practices to alleviate the changeability that characterizes the current organization of Ghana’s health workforce. The addition of cadres of workers responsible for the non-specialized, ad-hoc tasks that medical professionals take on out of their purview could assist with efficiency and quality of healthcare provision.

Recommendation #5: The Ministry of Health should integrate eHealth innovations into their current health policies. Telemedicine, the practice of making physical and psychological diagnoses and treatments remotely, can ease the patient load medical professionals often report in the wake of shortages. ICT technologies can also be incorporated to assist with the training of the health workforce and the dissemination of best health practices throughout the country.

Recommendation #6: A national accreditation board should be developed, comprised of trained peer reviewers tasked with evaluating healthcare organizations and providers’ fidelity to the Ministry of Health’s performance standards to help improve the quality of care and clinical outcomes.

Recommendation #7: The Ministry of Health should embark on fostering partnerships with the local, traditional actors often sought for medical advice in rural contexts. Given that current health policies have failed to encapsulate the social realities of indigents, innovative and culturally responsive approaches that aim to optimize health outcomes will need to be employed. The development of partnerships should begin with localized power analyses where significant actors are identified and approached. Through these partnerships, coordinated community health education initiatives can be undertaken to target regressive health practices that impede health outcomes specifically in child and maternal health.

Given the positive relationship between health and productivity, inclusive and high-quality healthcare systems are indispensable to the social and economic development of a country. These healthcare systems, tasked with providing healthcare to localities with different socioeconomic realities, are only as effective as the parts that comprise them. In Ghana, specifically, the acknowledgment of financing as a chief impediment to healthcare provision led to a political effort to reform health financing mechanisms and eventually adopt the National Health Insurance Scheme (NHIS) which lessened citizens’ reliance on out-of-pocket payments. Though admirable in its aims to ameliorate disparities in healthcare access and improve health outcomes in the country, systemwide barriers that impede healthcare delivery and exacerbate the variability in the quality of, and access to, healthcare services still exists. To address these barriers and optimize healthcare provision in the country appropriately, Ghana’s Ministry of Health must adopt a comprehensive approach
that strengthens key elements of its current health system—namely, in the realm of accountability, monitoring, and evaluation, and in the retention of Ghana’s health workforce. The recommendations mentioned above—once undertaken in coordination with regional- and district-level counterparts, providers in the public and private sector, and donor agencies—can extend the reach of health care, develop new delivery models that increase access, and improve health outcomes of the country.

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