

Capacity issues in primary health care implementation: examples from Ghana

Capacity issues in implementing PHC and Ghana

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Abstract

Purpose – Resources as well as the capacity to employ them judiciously may well be the key to the attainment of the SDGs and other related health goals through primary health care (PHC). Within this PHC framework, however, the source of resources for PHC as well as the systems for managing these associated resources remain unclear, complex and lack substantive integration systems of implementing ministries, departments and agencies (both local and international) in Ghana. These issues are addressed by this study.

Design/methodology/approach – The framework approach to thematic analysis was used to analyse qualitative data collected from key PHC managers in Ghana selected purposively from the national, regional and district levels. Data were collected through in-depth interviews specially designed in line with the study objectives. The study was also governed by the Noguchi Memorial Institute for Medical Research which provided ethical clearance for the study.

Findings – As per Alma Ata's recommendation, PHC in its purest form is a resource dense activity with far-reaching implications on individuals and communities. Without adequate resources, PHC implementation remained merely on paper. Findings show that the key capacities required for PHC implementation were finance, human resource, technology and logistics. While significant cases of shortages and inadequacies were evident, management and maintenance of these capacities appeared to be another significant determinant of PHC implementation. Additionally, the poor allocation, distribution and sustainability of these capacities had a negative effect on PHC outcomes with more resources being concentrated in capital towns than in rural areas.

Research limitations/implications – This study has significant implications on the way PHC is seen, implemented and assessed not in Ghana but in other developing countries. In addition to examining the nature and extent of capacities required for PHC implementation, it gives significant pathways on how limited resources, when properly managed, may catalyse the attainment of the PHC goals. Subsequently, PHC implementation will profit from stakeholder attention and further research into practical ways of ensuring efficiency in the allocation, distribution and management of resources especially considering the limited resources available and the budding constraints associated with the dependency on external stakeholders for PHC implementation.

Originality/value – This study is part of a series on PHC implementation in Ghana. Quite apart from putting core implementation issues into perspective, it presents first-hand information on Ghana's PHC implementation journey and is thus relevant for researchers, students, practitioners and the wider public.

Keywords Developing countries, Community based interventions, Primary health care

Paper type Research paper



Introduction and problem analysis

Primary health care (PHC) is “essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO, 1978, p. 1). Since its inception at the Alma Ata Summit, PHC’s promise of a basic low-cost yet efficient health delivery system that addressed the immediate health problems in resource constrained countries has been a key in ensuring its wide acceptance and support across the globe (Taylor *et al.*, 2020). By the turn of the century, therefore, the comprehensive PHC or a selective variant was heralded in many developing countries as flagship national health interventions evidenced through system-wide health initiatives or concurrent vertical programmes (Krumholz *et al.*, 2015; Rohde *et al.*, 2008). Consequently, PHC appears to enjoy significant attention from key health stakeholders in Ghana and many developing countries and has been largely responsible for gains made in ensuring universal coverage as well as increasing geographical and financial access to healthcare.

While some PHC activities may be present at the secondary and tertiary care levels through some public health interventions, PHC implementation in Ghana is epitomized by the Community-based Health Planning Services (CHPS). The CHPS initiative is a community-based service delivery model aimed at changing PHC and family planning from a focus on clinical care at district and sub-district levels to a new focus on convenient and high quality services at community and doorstep locations (GHS, 2002). Adopted in 1999, Nyong’oro *et al.* (2005) explain that the major strength of the CHPS concept is its bridging of the geographical barriers to access healthcare in Ghana and making basic healthcare services available at every part of the country with emphasis on addressing local health conditions through basic preventive, promotive and curative services. Consequently, CHPS has remained the flagship PHC implementation policy in Ghana and an integral part of healthcare delivery.

However, a key issue in the design and implementation of PHC interventions has been the paucity of resources together with one who bears the cost of PHC initiatives (Li *et al.*, 2017; Collins and Green, 1994). Though the PHC declaration suggests that the cost incurred in the provision of essential services should be one that the community and country could afford to maintain at every stage of its development (WHO, 1978), it provides no acceptable limits or caps (Lafond, 2013). Nor does it provide practical guidelines for how much resource must be made available by states for the attainment of the PHC goals (Macdonald, 2013).

In practice, therefore, Ghana and other PHC implementing countries have expended only the barest minimum on healthcare and even more minute resources to PHC arguing that was what they could afford looking at the stage of their development (Rohde *et al.*, 2008; Appiah-Agyekum, 2020). In these same countries, however, significant resources are channelled to other sectors like sports and the military or even if it is in health, these resources go to tertiary services and medical infrastructure (Mcpake, 2013; Collins and Green, 1994) rather than PHC. PHC implementation in these countries have therefore lacked the resources and capacity to fully operationalize PHC tenets, make healthcare universal and ensure its sustainability (Krumholz *et al.*, 2015; Taylor *et al.*, 2020).

The attendant effects of the above include a limitation in the attainment of the PHC outcomes and the creation of a yawning gap between PHC policy intent and actual implementation in practice. Again, knowledge and skilled persons to operationalize PHC and the related disciplines will not translate into measurable outputs in health systems where requisite resources and community support mechanisms are also non-existent (Pew Health Professions Commission, 1995; Coreil, 2019). Further, developing countries are unable to sustain, in the long term, investments in expanding health infrastructure and coverage of medical services unless PHC implementers develop evidence-backed means of building and managing the capacities directly and indirectly associated with PHC (Phillips, 1990; Talbot and Verrinder, 2009).

In addition to the above, there appears to be very limited research on the key capacity issues driving its implementation to inform policy termination, continuance or reform decisions (Awoonor-Williams *et al.*, 2015). In the absence of these essential evidential studies to guide its implementation, the practice appears to be that the health authorities together with their development partners continually introduce initiatives and commit scarce resources to PHC without a holistic appraisal of its impact *vis-à-vis* the required capacity to operationalize them (El-Jardali *et al.*, 2019; Rifkin, 2018). Black *et al.* (2017) for instance observe that generally evidence on the capacity of implementers to back PHC decisions was lacking while De Graft Aikins *et al.* (2013) also bemoan the little attention given to the management and maintenance of existing resources towards an efficient attainment of PHC goals.

Using the above as a starting point, this study delves into the essence, adequacy and management of capacity in PHC implementation in developing countries using evidence from top and middle level PHC managers in Ghana as an example. In doing so, the study attempts to answer the questions of what is required to implement PHC and from which sources, how resources meant for PHC implementation are managed as well as how resource capacity issues affect PHC implementation in Ghana.

Methods

The study was approached from an interpretivist perspective. The choice of interpretivism is influenced by the situational nature of implementation processes which enforces the view that there is no objective truth in implementation analysis (Palumbo and Calista, 1990). Specifically, a qualitative case study approach was adopted using the PHC implementation evaluation tools by Bhuyan *et al.* (2010) and El Bindari-Hammad and Smith (1992) as guides. A qualitative case study approach was also considered suitable for this study's quest to answer "how" and "why" questions about PHC implementation from key informants whose behaviour cannot be manipulated based on Yin (2014). Even though some modifications to these assessment guides were made by the study to suit local conditions, the guides amongst other things were essential in the study design, fieldwork and data management processes in the study. To gain insights and on-hands evidence on capacities required for PHC implementation and how they were managed in Ghana, the study focussed on key PHC managers at the national, regional and district levels. Respondent selection was also influenced and justified by Mcape's (2013) findings that PHC implementation is driven more by top and middle level implementers than by lower level actors.

The gained ethical clearance from the Noguchi Memorial Institute for Medical Research with certificate numbers NMIMR-IRB 087/12-13, NMIMR-IRB CPN 087/12-13 revd. 2014. In addition, appropriate permissions and official approval were given by the Ghana Health Service and the Ministry of Health.

Sampling for the study involved a combination of convenience sampling and snowballing approaches. Sampling began with the use of convenience sampling to recruit two initial respondents for the study and then using snowballing to recruit 17 subsequent respondents with the aid of the initial respondents. The two initial respondents were the deputy director general of the Ghana Health Service (GHS) and the director of the Health Promotion Division of the GHS who were conveniently sampled from the national level through personal networks. They then aided in recruiting the respondents from the regional level who subsequently aided in recruiting respondents from the district level.

By combining these approaches, the study was able to traverse the initial limitations of gaining access and recruiting the PHC implementers who also doubled as top level bureaucrats in the Ghana Health Service and Ministry of Health. It also allowed the study to draw on the personal links and goodwill of national PHC managers to traverse the administrative bottlenecks in gaining access to prospective respondents across the 216 local

government areas in the 16 regions of Ghana. Similar approaches were recommended by [Bhuyan *et al.* \(2010\)](#) who observe that they allowed the study to use existing chains of command and reporting to overcome key challenges in recruiting top level PHC implementers and administrative bottlenecks. Sampling and in effect, data collection was truncated when saturation was reached after recruiting the 18th and 19th respondents. Details of sampling and respondents are shown in [Table 1](#).

Data were collected from respondents through in-depth interviews over a six month period. Interviews lasted between 45 and 142 min and were guided by a semi-structured interview guide design based on the key issues for assessing PHC implementation proposed by [El Bindari-Hammad and Smith \(1992\)](#). The guide was non-restrictive and was facilitated by probes and prompts that helped elicit authentic experiences of respondents on the key issues under the study. The interviews were recorded, transcribed and later shown to respondents for approval prior to analysis.

The data were analysed using the framework analysis approach. As a variant of thematic analysis that is specially designed for applied policy research in health ([Ritchie *et al.*, 2003](#)), framework analysis facilitates the synthesizing of data gathered from original accounts and observations into recognizable general categories and emergent themes. The actual steps of analysing the data gathered included immersion, developing thematic frameworks, indexing, charting and then mapping and interpretation in line with the prescriptions of [Pope *et al.* \(2000\)](#). The emergent themes from the analysis were then discussed within the context of the relevant literature.

Key findings

All respondents agreed that the full implementation of PHC required significant resources without which all interventions, policies and activities remained merely on paper. However, PHC was not being implemented in several geographical and service delivery areas because of the lack of resources or stakeholder capacity to follow the prescriptions of the Alma Ata declaration. Even in places where it was being implemented, there were still challenges in getting required resources on time and in the needed quantities.

PHC is really good for us and we had the necessary resources, we would have moved a lot of the ideas from paper to the ground. The people are committed but the resources are just not there (R11, Regional level)

A key resource issue in PHC implementation across national, regional and district levels was the human resource capacity in terms of numbers and skill sets. Quite apart from the general shortage of health workers across the country and the attrition to the western world, a dominant theme was the attrition of trained health promoters and community health officers for PHC to other medical professions or other non-medical professions. Findings also show the fluid mobility of PHC workforce from rural to urban areas as well as the strong refusal to accept postings to rural and deprived areas.

Level	Designation	Number
National	Deputy Director General, GHS	1
	Director, Health Promotion Division	1
Regional	Regional director of GHS	3
	Deputy regional director of GHS	3
	Regional health research officer of GHS	3
District	Metropolitan/Municipal/District director of health	8
<i>Total</i>		<i>19</i>

Table 1.
Study respondents

There are just not enough PHC workers on the ground generally but the situation is worse in rural areas because no one wants to work there (R19, District level)

Respondents linked human resource challenges to poor incentives and remuneration for PHC workers, lack of social amenities and public infrastructure in rural and underserved communities and a lack of recognition of PHC workers. Additionally, other respondents identified the lack of training facilities and opportunities for PHC workers, poor enforcement and management of transfers, promotions and postings amongst others.

The salary of PHC workers are low and there are no incentives for them doing outreaches. Also, some PHC workers can't stay or refuse to come to this area because there are no good schools for the children or proper social infrastructure for their families (R12, District level)

Though respondents shared varied opinions on the forms, sources and quantum of financial resources needed for PHC implementation, they all agreed that funding was a critical element in executing and sustaining PHC implementation. While some respondents expected increased contributions from the central and local governments, others also bemoaned the lack of contribution for PHC activities by the general public, community members and other beneficiaries of PHC implementation.

PHC implementation requires a lot of funding which difficult to get in Ghana. Everyone is waiting for government to provide and the local communities don't even contribute a cedi (R15, National level)

Another point of consensus amongst respondents was the fact external stakeholders and development partners committed more financial resources to PHC than both state and non-state local actors. Importantly, respondent views suggest that because the Ministry of Health (MoH) and the GHS made very little financial contribution, they appeared to have little control over the scope, pace and direction of PHC implementation. Community participation and involvement in PHC also did not cover financial responsibility or bearing costs of services which in turn made communities dependent on external stakeholders and the government.

Most of the funding for PHC comes from foreign governments and international NGOs who control PHC and how it is implemented. . . it is their money so they determine who gets what and how it should be used. The local people and even the government cannot do or say anything. . . (R17, Regional level)

Respondents also revealed how funding for PHC and health promotion was often redirected to other medical interventions or how politics influenced the disbursement of PHC funds and caused inequitable distribution of PHC funds across regions and districts. Alongside the inability to internally generate funds for PHC respondents also identified the poor healthcare finance structures, poor financial contributions by local and central governments, corruption and poor management, and accountability practices are also key causes of financial challenges in PHC.

Even the small funds we have are given to control programmes and other clinical initiatives at the expense of health promotion and PHC or simply not managed well (R7, Regional level)

The final theme that runs through respondents' accounts was the challenges with logistics and equipment. Respondents explained how most PHC initiatives could not be implemented because the necessary equipment, tools and logistical arrangements were not available or inadequate. For areas outside the capital towns, technology and connectivity were commonly cited by respondents while maintenance and investments in replacing obsolete equipment were key across all.

Sometimes the people are there to work but there are no tools to work with. Even stationary is a problem in some rural areas (R3, District level)

Other key issues raised that cut across all respondent views were the poor supply chain management system for both medical and non-medical consumables, resistance to changing to online systems and poor transport and storage systems and the general poor knowledge in using, managing and maintaining logistics. Even where logistics became available, they were poorly distributed and skewed in favour of big towns and cities at the expense of communities on the fringes. In several cases, respondents also explained how the necessary social infrastructure for utilizing these systems were not present thereby rendering them obsolete.

I have several areas where they don't have facilities and coolers to store vaccines and other items they use for outreach. In some areas, we don't even send vaccines there because there is not electricity for the storage fridge to work (R9, District level)

In addition to the funding, personnel and equipment challenges that affected PHC implementation in Ghana, respondents also tied the availability and sufficiency of PHC resources to existing socio-economic conditions that hindered PHC implementation efforts directly and indirectly. A common theme along this line were security, education and other prevailing circumstances in local communities that influenced the commitment, contribution and utilization of PHC implementation resources by stakeholders. Even more crucial were the popular belief amongst respondents that the limited PHC resources available were mostly mismanaged or subject to allocative inefficiencies, duplicated, poorly accounted for and in several instances wasted.

The issue at times is not lack of resources or the inadequacy. Sometimes, resources are mismanaged, poorly allocated or simply wasted (R1, District level)

Discussion

PHC as a monumental effort towards revolutionizing the way health is perceived and approached requires the injection of significant resources to build and boost the capacity for implementation (Andrews and Crooks, 2012). Without capacity, therefore, PHC remains merely a declaration of intent without practical steps to achieve it. Findings in support show how resources for implementation including the capacity to create, sustain and continually improve the enabling environment conducive for PHC practice were essential especially in rural communities. Additionally, PHC also implies that countries have the capacity to establish a health promoting system, improve access and empower local communities to take control of their health (Mcmanus, 2013; El-Jardali *et al.*, 2019). Consequently, PHC is a dense resource and capital intensive intervention requiring significant investments in human resources, technology, logistics, institutions and sustainable funding. As findings show, the absence of these in their appropriate quantities and required specifications hinder the successful implementation of PHC even in environments where the concept of PHC has been embraced and stakeholders are committed to implementation.

The issue of capacity is a well-discussed one especially as it was a major thrust of the selective primary health care (Obimbo, 2003; Birn, 2018). Initially restricted to financial capacity, it was acknowledged that many developing countries at the inception of PHC were confronting inflation, recession, and economic adjustment policies, and suffocating foreign debts (Cueto, 2004). Ghana was, for instance, undergoing a series of economic and administrative reforms to stabilize the economy after successive military coups and economic mismanagement in the periods between the Alma Ata declaration and the Ottawa charter (Mba and Kwankye, 2007). It was therefore ill resourced to implement the resource-intensive PHC declaration. Ghana's case is made clear by Mcpake's (2013) argument that addressing these economic and developmental issues in developing countries had taken a severe toll on public health resources and their specific commitment to PHC. In addition, human resource, logistics and technical challenges were also associated with PHC implementation within these

countries (Tunkulaitė and Kontrimienė, 2021; Parfitt, 2018). However, evidence from this study while showing that capacity is and will always be key to PHC implementation, importantly contributes to the evidence base by stressing that addressing capacity issues will require more than merely ensuring availability of sufficient funds, personnel and equipment.

Findings confirm that of Krumholz *et al.* (2015) that the human resource capacity for Ghana's PHC is inadequate across levels and regions and further worsened by limited skilled professionals and health promoters involved in mainstream activities. While the medicalization of PHC may play a part in the limited numbers of health promoters and non-medical PHC personnel (Mcmanus, 2013), findings recognize a general shortage of health sector workers and a high attrition of skilled personnel to the western world. Similar findings were made by Awoonor-Williams *et al.* (2015) who explain how high attrition rates limit the ability to scale up community-based PHC initiatives, and Bach (2008) who attempts to distinguish between brain drain and brain exchange.

Findings also note a high level of uni-directional mobility of PHC labour from rural areas to urban areas, and from non-medical cadres to medical cadres of PHC personnel. This creates a shortage of PHC staff in rural and underdeveloped areas and a surplus in urban and developed areas in Ghana with serious implications on access, utilization and the quality of PHC service provision. Also, the increasing numbers of community health officers (CHOs), public health officers and health promoters converting to clinical roles and other medical professions reduced the available numbers of personnel for real PHC work. Generally, intra-sector mobility of labour must not be a key setback if backed by appropriate promulgation and enforcement of legislations to control, restrict and reverse the movement of labour (Dutz *et al.*, 2013; Mason *et al.*, 2020). Alternatively, the much more subtle approach of incentivizing affected professions and jobs to make it attractive has also been used for decades with significant results (Crisp, 2018; Krugman, 2005; Doeringer and Piore, 1985).

Though not in the majority, some respondents in this vein supported Thompson and Smith (2010) and Van Ham (2002) that some level of professional mobility was essential for knowledge transfer, experience sharing, creativity and entrepreneurship that will lead to growth and efficiency. In Ghana's case, however, findings suggest that poor promulgation and enforcement of legislations on postings and transfers as well as poor incentives for PHC workers in rural areas were key catalysts of the scarcity of PHC personnel in rural areas. Findings, generally linked mobility decisions of PHC staff and health sector workers in general to socio-economic factors, general level of development, available public infrastructure and standards of living of the location of their jobs and their job roles. However, determinants like gender, intra-organizational mobility (Valcour and Tolbert, 2003), societal characteristics of regional segmentation and discrimination (Ng *et al.*, 2007) and workforce characteristics (Parfitt, 2018) were not supported by findings.

This study also identified several challenges in the recruitment, training and distribution of PHC personnel across the country. Issues of remuneration, incentives and motivation are also common challenges for all PHC interventions across the country even though it was more challenging for CHOs and other local level workers. Contrary to Ibrahim (2007) and Böhmig (2010), PHC personnel seemed to be influenced more by non-financial motivators like recognition and opportunities for development than they were by financial incentives. Importantly, findings reiterate Manongi and Marchant (2006) call for a closer examination of off-the-job conditions rather than job-related conditions as the decision to accept postings and commitment, and output levels of PHC staff in this study were strongly linked to the comfort, safety and convenience of their families and dependents. The apparent inferiority of CHOs and other CHPS workers to clinic-based health workers was also a key de-motivator for PHC staff. Cueto (2004) and Kane (1984) had earlier presented discussions on how the "barefoot doctor" tag reduced the appeal of PHC ancillary work in China. Similarly, connotations of inferiority associated with "basic health nurses" made PHC personnel appear as second class healthcare

providers in Nigeria (Okonofua *et al.*, 2018). This study further places strong emphasis on the poor mentorship, coaching and career development of PHC personnel especially at the local level as well as the poor human resource planning and policies of the health sector in general.

The capacity to finance PHC is an important determinant of PHC success. Generally, it is recognized in the implementation literature that without the funds to execute, policies often remain a mere expression of intent that makes no impact in the lives of people (Wildavsky and Presman, 1973; Datnow and Park, 2009). Findings in support of Magawa (2012) place significant emphasis on finance as the lifeblood of PHC implementation with varying levels of success recorded on different PHC components depending on the levels of funding. Quite like Nazzar (2012), findings link the availability of finance to the success and sustenance of PHC initiatives in Ghana. However, in contrast to Mc Sween-Cadieux *et al.* (2019), findings suggest that finance is not a passive resource but the active determinant of the pace, direction and scope of implementation.

An important theme was the sources of funding and the relationship between local and external financiers of PHC initiatives. Even though various forms of financial contributions were recorded from varying stakeholders, external stakeholders appeared to be the main financiers of PHC in Ghana with the GHS and government rather playing a minor role. When compared to those of Kai (2009), findings suggest a reversal of roles that deviates from the ideal situation where local stakeholders are the main financiers of implementation with external stakeholders playing a supporting role. This however appears to be the norm with PHC in SSA with similar findings made by Rohde *et al.* (2008) and Hone *et al.* (2018).

The source of policy funding is an important consideration in the policy cycle not only because it determines the progress and sustainability of implementation (Honig, 2006; Mazmanian and Sabatier, 1983) but also because it determines the nature and type of relationship existing between implementing stakeholders (Majone, 1984; Love, 2004). Instead of a partnership relationship where proportionate financial contributions are made by all implementing stakeholders (Hupe, 2011), findings in contrast suggest the existence of an agency relationship where the GHS, MoH and other local PHC stakeholders acted as implementing agents of external partners who provided funding. This is in spite of PHC policy documents naming the GHS, the government and external stakeholders as PHC implementation partners. Butterfoss (2007) similarly suggests the lack of clear relationships between stakeholders of local health interventions especially where an imbalance exists in the financial contributions of named stakeholders.

Distinctively, this study makes a significant contribution to the evidence base by highlighting that the agency relationship in some cases may further degenerate into a master-servant relationship where implementing stakeholders who have made little or no contribution appear to have no control or influence over implementation decisions and actions and have to obey financing stakeholders unquestioningly. In particular, findings show several instances where the GHS and other local stakeholders had no power to refuse, alter, abate and review PHC implementation decisions and actions by donors and international organizations. This confirms the classical implementation construct (Elmore, 1979, McLaughlin, 1987) where power and influence of the policy cycle may be exerted by assuming full responsibility for funding.

The power play associated with financing PHC is varied and has strong implications for PHC implementation success. Because of the strong link between financing and the ability to control policy progress and outcomes, policy stakeholder relationships are often characterized by struggles for financial responsibility and in effect policy control (Fry and Raadschelders, 2013). However it appears that the GHS, the MoH and the Ghanaian government have rather not maximized the opportunity; this presents for directing PHC. Instead, findings point to them having relinquished financial decisions and responsibilities to external partners, and with it, their rights of control over PHC implementation. This gives external stakeholders unlimited access and control over PHC outcomes which may sometimes have negative implications when

seen in the context of [Deleon and Deleon \(2002\)](#) that different policy actors have different, sometimes ulterior interests and motivations for funding policy. Though no clear instance was recorded by findings, other studies ([Hjern and Porter, 1993](#); [Nakamura, 1987](#); [Mason et al., 2020](#)) have shown how control of public policies drawn from sole financial responsibility have been negatively used to discriminate or exploit local people for pecuniary gain.

The politics of financing public policies ([Nakamura and Smallwood, 1980](#); [Pülzl and Treib, 2006](#)) evidenced by the remarkable increase in the ability to determine who gets what, when, how and in what quantities was also confirmed by findings. Generally, findings recognized that the approaches, professionals, equipment and benchmarks used for health interventions were generally dictated by financiers more than by the bureaucratic implementation structure and processes in line with [Weber \(2004\)](#) and [Kosar \(2011\)](#). Especially when financing is done by multiple stakeholders whose activities are poorly coordinated, it is common to get divergent or conflicting policy directives from different financing parties with varying preferred approaches and expected outcomes ([Stewart and Gray, 2006](#)). Findings in this vein presents the frustrations of PHC implementers on having to meet different often conflicting requests of different funding parties for PHC interventions. Importantly, the group struggles associated with the politics of policy finance ([Kraft and Furlong, 2012](#)) were captured by findings in two instances, firstly, in the struggles amongst professional groups for financial support for either clinical or public health interventions and secondly, in the struggles and competition amongst local NGOs, the GHS and other agencies of the MoH for donor funding at national, regional and district levels. While struggles may lead to improved services, efficiency and healthy interaction amongst competing institutions ([Kai, 2009](#)), findings suggest that unhealthy competition may also flourish amongst competing agencies especially where external funding is the main source of financing PHC activities and funding sources are limited.

The financial challenges of PHC are also linked by findings to the inability to generate resources for health internally. Generally, findings show that local communities are limited in their ability to fund PHC as a result of poor socio-economic conditions, unemployment and low standards of living. This appears to be the situation in many developing countries where local communities are solely reliant on central government funding for public services including health ([Tanner and Harpham, 2014](#); [Green, 2007](#)). However, findings show that central government funding for PHC directly has for years been non-existent and very scant for the health sector in general. Even where local governments are involved, their capabilities and levels of commitment are linked to the quantum and frequency of financial support received from central government. Findings along this line confirm those of [Apetorgbor \(2009\)](#) that the interest and financial commitment made by local governments to CHPS in Ghana was strongly dependent on the frequency and amount of district assemblies common fund received from the central government. For PHC in particular, financial responsibility may be a shared function between local and central governments ([Logie et al., 2010](#)) or the sole responsibility of either the central or local government ([Li et al., 2017](#)). In Ghana's case, findings show the lack of clearly defined roles and responsibility for local level healthcare finance with PHC torn between local and central governments who are each currently shirking and tossing financial responsibility to the other. Consequently, findings contribute to the evidence base by identifying decentralization and the politics associated with it as a strong determinant of PHC finance and specifically, the ability and responsibility to finance PHC initiatives from within.

Generally, PHC activities appear to be constrained by the fact that the limited funds available are channelled into medical interventions rather than in health promotion and PHC initiatives. Findings in particular note how funds meant for empowerment go into training health workers to empower local people rather than actually empowering local people. In addition to increasing paternalism and professional elitism in PHC activities ([Macdonald, 2013](#)), it fosters a sense of powerlessness and dependence of local people on health professionals and limits community participation in PHC activities. Consequently, the study

contributes to PHC practice by drawing attention to the negative effects of misplaced prioritization and utilization of scarce PHC funds. Corruption, financial mismanagement and low levels of accountability that characterize health sectors in SSA (Lewis, 2006; Dietrich, 2011) were also believed to be rife in Ghana by PHC implementers.

Besides the financial and human resource paucities, findings suggest that logistics and equipment were also lacking for PHC interventions. Manongi and Marchant (2006) believe that most PHC initiatives are doomed to fail from the start because the necessary equipment and tools needed are in most instances not readily or fully available. Findings in confirmation show how essential items like motorbikes, vehicles, stationary, refrigerators and spaces needed for storing and preserving vaccines and medicines were not available or inadequate. Similar claims are made by Awoonor-Williams (2014) who further contributes that sterilizers, disposable gloves, syringes, thermometers and other supplies were also in short supply thereby increasing exposure of PHC staff and service users to infections. This issue appears to be an SSA one as similar findings were also made by Logie *et al.* (2010). It is thus unsurprising that Pandey (2018) concludes that PHC has generally not been backed by the technological and logistical capacity needed for its smooth implementation.

While the over-reliance on existing technology and available equipment may be responsible for this (Bosu, 2013), limited commitment and investment from stakeholders towards technical and logistical growth of PHC activities is unearthed by findings. Importantly, the study highlights the need for continuous assessment and revision of logistical and technological needs for PHC initiatives considering the high volumes of outdated and obsolete techniques, technology and logistics that epitomize Ghana's PHC. The poor maintenance culture recurring across findings of this study appears to be a general problem of PHC in developing countries (Ogembo-Kachieng'a and Ogara, 2004; Taylor *et al.*, 2020), that is linked to the lack of human and financial resources to maintain donated or procured equipment.

Generally, high resistance to modern technology and approaches has been associated with policy resistance especially amongst core health staff lacking continuous professional development and familiarity to e-health systems (Witz, 2013). In SSA for instance, some PHC personnel have resisted attempts at modernizing PHC services out of contentment with the status quo or for fear of losing their relevance or jobs to electronic systems (Macdonald, 2013). In Ghana, however, findings in contrast show that technology and IT systems were unavailable in PHC centres even though personnel were trained, ready to use and had requested them. Similar to earlier findings by Gyenfie (2005), computers, printers, phones and Internet connection were only present at the regional offices and in some district offices with serious implication on communication and information search, storage, transmission and reporting at the local levels. Besides these, this study contributes by pointing out the poor supply chain management, centralized management of PHC supplies and the storage capacity across the country that have had an effect on the preservation, distribution and availability of medicines and general items for PHC across the country.

Additionally, medical supplies and equipment were more readily available in local communities rather than those needed for health promotion and PHC. Further, findings show a chronic shortage of information materials and essentials needed for health education and behaviour change communication outreaches while those on treatment, approved cure and care in hospitals were relatively easier to find. Similar findings were made by Conrad (2008) and Macdonald (2013) who blame the dominance of medicine and the control exerted by medically oriented national health services for this situation. In contrast, Bosu (2014) explains that the epidemiological landscape of developing countries makes tropical and infectious diseases a key priority for health sector stakeholders such that more effort were likely to be put towards these conditions than in the prescriptions of the Ottawa charter. While the both cases may be true in Ghana, stakeholder perspectives link the availability of supplies and materials for PHC to the well-resourced vertical programmes and national disease control

programmes. Consequently, medication, supplies and equipment for TB, HIV/AIDS and other vertical programmes were very available even though availability was limited to focus areas and targeted sections of the population. PHC supplies, vaccines and equipment were however limited, poorly distributed and relatively difficult to obtain.

Conclusion and contributions

Generally, the bane of implementation appears not to always be about the lack or inadequacy of resources or capacity as several examples exist of well-resourced policies that did not achieve desired results (Appiah-Agyekum, 2020; Abbas and Riaz, 2013; Honig, 2006; Majone, 1984). For PHC policy sustenance and effective implementation, evidence from conventional backward mapping in policy analysis (Elmore, 1979) has long suggested that regardless of resource scarcity or surplus, effective resource management based on context-specific policy limitations may still lead to implementation success. In addition, effective and proportionate resource allocation and distribution based on specific local needs and contextual differences appears to be more beneficial in implementing PHC and public policies over a wide multicultural geographical area than routine and equal distribution of resources. As demonstrated in Ghana's PHC implementation, different PHC components had different levels of importance and unique implementation conditions across the multicultural Ghanaian society. However, the uniform distribution of resources and PHC interventions across the breadth of the country resulted in shortages in some areas and surpluses in others based on varying local needs and utilization levels. These together with the poor management of capacity, wastage and other inefficiencies of the resource management and supply processes limit PHC implementation.

Based on findings, the study contributes that capacity in PHC goes beyond ensuring availability of resources into having the ability to make judicious use of resources in a timely and purposeful manner. In implementation, capacity strives at efficiency rather than effectiveness and is concerned about making optimum outputs from limited inputs (Bhuyan *et al.*, 2010). Consequently, this study contributes to the evidence base that PHC success might not be tied to piling up resources for implementation but rather the ability to manage and sustain PHC with the limited resources available. For other logistics and equipment, the watchwords have always been servicing, maintenance, storage and proper usage. Clearly, findings suggest that significant investments in new machinery, equipment and technology will yield no benefits without the proper use and maintenance culture. In addition, findings show that effort at building capacity to implement PHC must focus on enhancing the ability to generate and sustain resources from within, and putting them to judicious use. While spreading resources too thin may restrict capabilities and capacities, focussed interventions also limit equity and fairness in the provision and subsequent utilization of PHC interventions across the country. Importantly, focus must be put not on the acquisition and building of capacities but on the efficient management and utilization of acquired capacities. Additionally, the study raises the need for further research into finding evidence-based solutions to the capacity challenges in PHC implementation in Ghana that is grounded in the experiences of implementers. It also raises the need for further studies on the contributions of external stakeholders to PHC *vis-à-vis* that of the government and how their relative contributions influence their power and control over PHC implementation activities. Ultimately, innovation and creativity in resource generation and management inspired by local people offers a key pathway to addressing capacity issues affecting PHC.

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