



# Rethinking Malaria in the Context to COVID-19

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**“Malaria in the Governance of District Health Systems:  
Engaging Communities and Local Authorities,” by Nii Ayite Coleman**

**Note:** This preprint is part of the “Rethinking Malaria in the Context of COVID-19” series. All of the manuscripts produced in this effort will be submitted for peer-review and published as a compendium. This preprint is being made available to enable a broader discussion around key challenges and solutions.

The “Rethinking Malaria in the Context of COVID–19” global engagement was constituted as a consultative process to ‘take stock and push beyond conventional thinking to question fundamental assumptions and approaches, with a focus on bold new ideas to achieve real-world progress. The process managed by three governance bodies comprising a Steering Committee, Working Group Co-Chairs and contributing authors, and an External Advisory Committee. For a listing of the "Rethinking Malaria" Working Group Co-Chairs and contributing authors and External Advisory Committee members, see Text A1.

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**Supporting Information:**

**Text A1:** ["Rethinking Malaria in the Context of COVID-19" website.](#)

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## **Abstract**

The goal of global malaria programs is to eliminate and eventually eradicate the disease. Achieving the global goal would require eliminating malaria in individual endemic countries. Are national malaria strategies adequate to achieve elimination of the disease? This study examines Ghana's malaria strategy to determine its adequacy for the elimination of malaria in the country, with a focus on the governance of district health systems.

The study found Ghana's malaria strategy to be medically oriented, focusing predominantly on the diagnosis and treatment of the disease. The strategy ignores the lifestyle and environmental determinants of malaria. There is limited engagement with stakeholders within districts, and the engagement is neither systematic nor sustained. Ghana's malaria strategy therefore requires a systematic rethinking to mobilize the participation of communities in district governance for malaria.

The paper proposes several actions to restructure district governance of malaria. First, in Ghana, the malaria program must engage with key stakeholders in the district in a systematic and sustained approach in order to strengthen multisectoral action and community participation. This will require new accountability relationships for malaria progress within communities and between the District Assembly, the district health authorities and communities.

Second, malaria programs in other African countries need to be similarly redirected towards community health governance for malaria progress.

Third, the global malaria agencies must redefine malaria as a social problem and collectively adopt a social determinants approach to the development of national malaria programs.

The goal of elimination and eventual eradication of malaria without effective control of mosquito breeding and public health regulation is fundamentally flawed. Progress on malaria will require a paradigm shift from a medical perspective to a social determinant approach with a sustained and systematic engagement of all stakeholders in local communities.

## **Introduction**

As national health systems and global health programs strive to improve the performance of health interventions, governance of health systems is receiving increasing attention. The proliferation of work on health systems governance over the past decade is based on the expectation that good governance will ultimately lead to better health outcomes.

The notion of governance is universal and found in many communal contexts such as families, clans, villages, associations, companies and nation-states. In each communal context, representatives are chosen to act on behalf of the collective. The domain of governance can be considered the relationships between the representatives and the represented aimed at ascertaining responsive and effective action in the interests of the collective.

There are multiple definitions of governance. The definition offered by Lehman and Gilson [1] demonstrates the multidimensional nature of governance: "ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability."

In practice, national governance is about the relationships between the government and the governed within a nation, and is dependent on arrangements set at the political or national level and enshrined in a national constitution. The constitutional arrangements for national governance form the basis of governance in all sectors of the economy including health, and for sub-national levels, including the district level. In the health sector, governance needs to be operationalized by individuals at lower levels in the health system. The importance of district health systems governance is increasingly being recognized as crucial to the achievement of universal healthcare coverage as well as sustained improvements in the performance of health interventions and outcomes, including malaria.

This paper explores the challenges of governance for malaria at the district level in Ghana and broader implications for other malaria-endemic countries. First, it outlines Ghana's malaria strategy and assesses the nature and scope of engagement by the malaria program with communities, district authorities, and other stakeholders. Second, it examines the relationships between and within stakeholder groups in the district. Then, it discusses the challenges of district health system governance to the implementation of the malaria program. The paper concludes by making suggestions to facilitate improvement in the governance of the district health system in Ghana, with a consideration of broader implications.

The paper is based on a review of documents of the malaria program, interviews with some officials of the Ghana malaria program, and the experiences of the writer, who served at district, regional, and national levels of the Ministry of Health in Ghana. In a 34-year career, he served as a medical practitioner in a few district hospitals, as a District Medical Officer of Health in Jasikan, as a Regional Director of Health Services in Brong Ahafo, and as Director of Policy, Planning, Monitoring and Evaluation of the Ministry of Health. As a Regional Director of Health Services, he supervised the implementation of the malaria program in the districts in Brong Ahafo region. He also worked with the Ministry of Local Government and the Accra Metropolitan Assembly from 2002 to 2004, and served as Director of the Accra Metropolitan Public Health Department.

### **Malaria strategy and engagement with stakeholders in the district**

According to the global malaria elimination program, Ghana is classified as being in the malaria control phase. Malaria specific mortality among children less than 5 years old has declined from 14.4% in 2000 to 0.6% in 2012. The same level of success, however, has not been achieved with malaria morbidity [2].

The national malaria strategy was reviewed in 2013, and based on the recommendations from the review report as well as new and emerging interventions at the global level, Ghana's National Malaria Control Program, in August 2014, developed the National Malaria Control Strategic Plan for 2015 - 2020.

The plan, aimed at reducing the malaria morbidity and mortality burden by 75% (using 2012 as baseline) by the year 2020, had the following specific objectives:

1. To protect at least 80% of the population at risk with effective malaria prevention interventions by 2020
2. To provide correct diagnosis to all suspected malaria cases and prompt and effective treatment to 100% of confirmed malaria cases in accordance with treatment guidelines by 2020
3. To strengthen and maintain the capacity for program management, partnership, and coordination to achieve malaria programmatic objectives at all levels of the health care system by 2020
4. To strengthen the systems for surveillance and monitoring and evaluation in order to ensure timely availability of quality, consistent and relevant malaria data at all levels by 2020

5. To increase awareness and knowledge of the entire population on malaria prevention and control so as to improve uptake and correct use of all interventions by 2020

The thrusts of the strategic plan are to consolidate the recent gains, to accelerate malaria control in the high transmission areas, and to move towards establishing lower-transmission areas in Ghana by the end of 2020 [3].

Even though the strategy seeks “to increase awareness and knowledge of the entire population on malaria prevention and control,” the engagement with stakeholders by the malaria program is constrained by a medically oriented strategy. The Social and Behavior Change Communication (SBCC) Strategy for the National Malaria Control Programme [4] has a limited scope of activities based largely on national and regional mass media campaigns. Facility- and community-based interpersonal communication activities are targeted at adherence to national malaria case management guidelines and prompt care seeking. School-based interpersonal communication activities, in tandem with school-based Insecticide Treated Nets (ITN) distribution activities, have focused on correct and consistent use of ITNs and ITN care practices. The communication strategy focused on “Advocating to political leaders, policy makers, opinion leaders and corporate bodies for support for malaria control” and “Sustaining communication, education, and community mobilization to increase knowledge among the general population to enhance uptake of malaria prevention interventions” [5].

The community mobilization is implemented predominantly through the District Health Service, and engagement with stakeholders has to be carried out by the District Health Management Team (DHMT). The Ghana Health Service legislation, Act 525 of 1996, makes provision for a certain degree of engagement with some stakeholder groups through the District Health Committee [6]. Section 23 of the Act establishes the District Health Committee.

A District Health Committee shall comprise the following members - a) a chairman; b) the District Director of Health Service; c) two representatives of the District Assembly; d) one representative each of the Christian and Muslim religious groups in the district; e) two health care personnel in the district one of whom shall be from the private sector; f) a representative of the Traditional Councils in the district; and g) two other persons at least one of whom shall be a woman.

The core function of the District Health Committee is advisory. Section 24 (1) of the Act says:

A District Health Committee shall advise the District Director of Health Service in the performance of his functions in the district and shall perform such functions of the [Ghana Health Service] Council in the district as the Council may assign to it.

Apparently, the District Health Committees are not in place. As a result, engagement with stakeholders is adhoc and often associated with implementation of specific activities such as distribution of bednets and larviciding. In the words of one district malaria focal person, there are “no real relationships ... we only engage stakeholders when we have a program.” “We deal with the hospital when there are any problems with data such as when there is a variation between the number of diagnosed cases and the number of patients treated” (District focal person, 2021). In some districts, larviciding is carried out by private companies without the knowledge and participation of the Public Health Department of the District Assembly. “We should have involved them [the District Public Health Department] but ...,” said one district malaria focal person. In most districts, engagement within the health system is very limited. It appears there is limited stakeholder participation in the malaria program, and it is prescriptive without accountability to beneficiaries.

The lack of effective engagement of stakeholders in the malaria program can be attributed not only to its medical orientation and the rigidity of program protocol. The absence of the District Health Committees as stipulated by Act 525 of 1996 demonstrates the institutional incapacity or unwillingness of the Ghana Health Service to engage with a broad spectrum of stakeholders over the long term.

The current malaria program is dominated by a medical approach; malaria is viewed as a disease requiring treatment in a healthcare facility. The medical approach can only keep Ghana in the control phase. Ghana's malaria strategy is inadequate to achieve elimination and eradication of malaria.

Malaria is a social problem because it is influenced by social determinants such as lifestyle and environmental factors. It is the outcome of the interaction between environmental and lifestyle factors leading to poor sanitation and indiscriminate disposal of anything and everything, anywhere and everywhere. The result is uncontrolled mosquito breeding in communities. Malaria cannot be eliminated without eliminating the major mosquito breeding sites. Malaria elimination and eradication must therefore address mosquito breeding in every community in Ghana. The goal of elimination and eventual eradication of malaria without effective control of mosquito breeding and public health regulation is fundamentally flawed. Elimination and eventual eradication of malaria would require a paradigm shift from a medical perspective to a social determinant approach. A social determinant approach to malaria would engender a sustained and systematic engagement with the whole spectrum of stakeholders in the communities.

Quenum, while addressing the WHO Regional Committee for Africa in Kampala, in September 1976, said

We can no longer consider health programs without reference to other sectors of socioeconomic development. Development as we conceive of it should be a total dialectic of progress, achieved through a continual dialogue between equal partners ...

The myths of the past imposed a dichotomy between politics and health, a dichotomy between socioeconomic development plan and the health program, as if health, which is essentially a social sector, could be dissociated from the national will expressed through a particular political choice. Among present-day myths, we should mention the view that external aid is necessary and inevitable in the socioeconomic development of the less-favoured countries, this development being very frequently regarded merely as a collection of disparate efforts to catch up a supposed lag, in relation to the so-called developed countries, as if there were only one single model of development.

Quenum [7] added that

We must also devise new procedures for strengthening health services. This requires a special effort to make the most of local resources, particular manpower. It is fair to say that there can be no development without using all human resources to full advantage, i.e. without material and cultural development of the people as a whole. Regrettably, the existing health delivery systems exclude the communities concerned; their health and their environment can be improved only if they play an active part in the systems organized for that purpose. That is why all our future efforts must be aimed at enlisting authentic community participation so as to help its members become aware of their needs and to encourage them to cooperate in finding solutions and managing services.

Elimination and eventual eradication of malaria require a more nuanced appreciation of malaria as a social problem that calls for a coherent community response.

### **Relationships between and within stakeholder groups in the district**

Various malaria stakeholder groups exist at the community and district levels in Ghana. There are several stakeholder groups within the community, including households, youth organizations, women's groups, religious organizations, elected local officials, and traditional leaders. The other key stakeholders are the healthcare service providers, the district health authorities, and the district assembly.

#### Households and Community-based Organizations

Malaria is endemic in Ghana and every person living in the country is at risk of contracting it. It is the number one killer of children and the leading cause of reported morbidity in the country. Households as well as the various women's groups, youth organizations, and religious bodies in towns and villages across the country are stakeholders in malaria. Indeed, everyone living in Ghana has an interest in the control, elimination, and eventual eradication of malaria.

By virtue of the different roles people play in society, individuals and groups often have other stakes in malaria besides self-interest. Civil society organizations, both indigenous and international, are growing in numbers and have emerged as an important stakeholder group representing the voiceless people. For example, there is a National Coalition of NGOs in Health and a specific coalition of NGOs in malaria. Increasingly, civil society organizations are becoming active in the implementation of social programs including malaria in districts across the country.

#### Healthcare Service Providers

Healthcare services in the district are provided through facilities with varying capabilities and owned by various groups including government, private and religious organizations. Public services are provided by the District Health Service (DHS), usually through a network of health centers, clinics, CHPS compounds and outreach centers with a district hospital serving as a referral facility. This public network provides allopathic medical care and preventive medicine including maternal and child health services and immunization. A few district hospitals around the country are now also practicing herbal medicine.

National legislation on traditional and alternative medicine has engendered a growth in pluralism in healthcare delivery. As a result, although allopathic medicine is dominant, under the guise of alternative medicine, other forms of healthcare practices are springing up [8]. The production and use of traditional herbal preparations are growing, and traditional medical practitioners such as Traditional Birth Attendants, herbalists, bone-setters, and spiritualists are still well patronized. Allopathic medicine does not have a monopoly over the diagnosis and treatment of malaria.

#### District Health Authorities

The district health system is characterized by multiple care systems, varied ownership, and fragmented leadership. The current legislation regime on districts has created a District Health Service of the Ghana Health Service and a Public Health Department of the District Assembly. Therefore, there is no single district health authority. The Public Health Department of the District Assembly, made up of health inspectors, is responsible for public health services, oversees sanitation and waste management, and enforces public health regulations. The District Health Management Team (DHMT) oversees health

centers, clinics, CHPS compounds and outreach services, and the district hospital under the medical superintendent provides a comprehensive range of basic healthcare services including emergency surgery, blood transfusion and laboratory services [6]. In essence, the district health leadership is fractured along the three core health services—medical care, preventive medicine, and public health services—each with a different source of funding.

### Traditional Council

For the majority of Ghanaians, traditional leaders, chiefs, in villages and communities are the frontline authorities and are regarded as representatives of the people in their respective towns and villages.

Ghana’s traditional system of government “has evolved along ethnic lines of affinity” and predates colonialism [9]. For example,

The Asantes were politically united under the Asantehene before colonial rule ... At the side of the Asantehene stands the Asanteman Council, composed of paramount chiefs of the member states of the Asante confederacy. The paramount chiefs assist the Asantehene in his direction of the affairs of the Asante nation. The paramount chiefs also hold positions in their own states. As paramount chiefs of their states, they govern their people with a council comprised of elected representatives of the state. Similarly, sub-chiefs and village chiefs serve their smaller communities with the help of elected representatives from the local communities.

Within these communities the town chief or village head serves the people as the leader of the community. But he consults with a council which is made up of the heads of the respective lineages who are resident in the village or the community. In other words the political structure of the Asante social system radiates the authority of the Asantehene through to the level of the extended family network. As argued by Apter, this political structure reveals a logic and a degree of centralization that is capable of providing a stable government with the consent of the governed. For example, to be eligible for a village chief, the person is selected only from among the members of the royal family. But the final choice, from the number of eligible persons requires the approval of the constituent commoner groups in the community. A poor selection could be deposed by popular demand.

This political system is in evidence today in the traditional society. It is popularly known as an “indirect system of Government” meaning that at the Governmental level (central government of Ghana) the chiefs are given the authority to deal with traditional matters [10].

The legitimacy of traditional political authority is enshrined in Ghana’s constitution and institutionalized with the existence of a Ministry of Chieftaincy Affairs. Article 270 of the 1992 Ghana constitution [11] guarantees the institution of chieftaincy together with its traditional councils as established by customary law and usage.

Traditional Councils have stakes in the well-being and development of their people. The endorsement of chiefs, though informal, is important for the implementation of public sector projects and programs in communities within districts.

### District Assembly

Ghana's current phase of decentralization began in 1988 with the promulgation of PNDC Law 207. Article 240 of the 1992 Ghana constitution stipulated "a system of local government and administration which shall, as far as practicable, be decentralized" [11]. The Local Government Act of 1993 (Act 462) sanctions the District Assemblies to be responsible for the overall development in the districts through the exercise of deliberative, legislative and executive powers [12].

The decentralized system comprises a two-thirds elected and one-third appointed District Assembly (DA) headed by a non-elected District Chief Executive (DCE) appointed by the President in accordance with the constitution [11].

The DA operates under the committee system. It has two committees, the Audit and Executive Committees. The Executive Committee (EC) is headed by DCE and serves as the cabinet. The EC has five statutory sub-committees namely, Finance and Administration, Development Planning, Social Service, Justice and Security, and Works. The DA also has elected sub-district councils and committees - locally elected officials in the communities.

The role of the District Assembly is to coordinate and oversee implementation of public programs by the decentralized departments of the Public Service. These departments provide the needed technical advice and carry out the actual implementation of policies, projects and programmes of the Assembly and Government. The coordination and oversight of social services is by the Social Services Sub-committee (SSSC) of the District Assembly. It comprises heads of district departments and agencies providing social services such as health, youth and sports, education, water, community development, physical planning, agriculture, disaster prevention and management, and social welfare.

Beyond coordination, the Social Services Sub-committee also has a strategic function. It is expected to:

- take a comprehensive and long term look at areas of social development in the district, in particular education; health, social welfare, sports, culture;
- develop the information base on these areas of social development;
- identify the strengths and weaknesses in the social services areas; prepare a social development plan (long, medium and short term), for the district;
- examine the implications of the social development plan on other sub-sectors of the district economy; and
- submit the plans to the Executive Committee for harmonization.

"The District Assemblies were to be the foundation on which Ghana's new democracy was to be erected. The thrust of Ghana's policy has been to promote popular participation by shifting processes of governance from command to consultation, and by devolving power, competence and resources and means to district level" [13]. However, "Fiscal decentralization remains one of the most intractable problems" [13].

The absence of fiscal decentralization is a major roadblock in the evolution of decentralization in Ghana. Without fiscal decentralization, the decentralized departments of the DA continue to be funded through their respective sector Ministries. As a result, district heads of departments and agencies have stronger vertical alliances to higher levels of their sectors ministries than to the District Assembly. The DA is funded through an irregular and unreliable District Assembly Common Fund and the meagre local taxes it is able to collect. The DA has severe budgetary constraints and does not have effective control over departments and their programs in the district.

In practice, the absence of fiscal decentralization has paralyzed the DA, rendered the SSSC weak and ineffective, and made assembly members as well as the sub-district structures—zonal councils and the unit committees—almost redundant in their communities. As a result of the ineffectiveness of the Social Sector Sub-committee, multisectoral action is incoherent.

The District Assembly’s inability to effectively coordinate the decentralized departments is a significant challenge to the malaria program and other programs dependent on some form of multisectoral collaboration. The fractured district health leadership and the complicated financing architecture of the district turn departmental programs into vertical programs, hampering the development of alliances and coalitions, and forestalling multi-sectoral collaboration.

Succinctly, there is an absence of accountability relationships between and within the District Assembly, the district health authorities, and the communities.

### **Challenges of district health systems governance**

Ghana’s decentralization process has a long history that predates independence and began with efforts by the colonial administration to establish a local government system. After the initial “Indirect Rule” through the Traditional Councils, disagreements over taxation and other issues between the colonial administration and the Traditional Councils led to the establishment of an alternative and parallel modern local government system; the 1944 Native Authority Ordinance neglected the traditional authorities and put the colonial administration in direct control of the localities [9].

Since independence in 1957, subsequent governments have focused entirely on developing a local government system that is an appendage of the central government. Traditional political authority, though legitimate, has been marginalized in the national development agenda. As a result, traditional political authority and modern local government offer disparate political leadership at the community level, impeding systematic local development. The dichotomy between traditional and modern political authorities present formidable challenges in the relationships between the District Assembly, the district health authorities, and the communities.

The key challenges within the District Assembly, the district health authorities and the communities are:

1. Dichotomous political leadership and unaccountable frontline workers

Both traditional and modern political leadership have constitutional legitimacy but chiefs and elected officials within the community have often been unable to provide collective community leadership. The decentralization policy has left a gap in local governance by failing to create a working interface between traditional and modern political authorities at the community level.

The challenges of governing district health systems are inseparable from the burdensome challenges of local government reforms and decentralisation in Ghana and from the perennial journey “towards democratic local government structures, and accountable systems of public administration that are able to deliver on the developmental demands of the people” [13].

2. Weak District Assembly and ineffective SSSC hamper intersectoral collaboration, coordination and efficiency

The DAs do not have strategic policy frameworks that would help foster multi-sectoral collaboration and coordination of the implementation of departmental programs. What exists as a district agenda is the disparate projects and programs of the central government implemented through the various ministries, departments and agencies. The notion of a composite district budget remains an idea and requires fiscal decentralization to become reality. In essence, there is no district malaria agenda, no district health agenda, and no coherent district agenda.

### 3. Legal regime fractures district health leadership

Currently, the three components of the district health system, that is, medical care, preventive medicine and public health services, operate independently without any set of arrangements to foster sustained collaboration and the coordination of health programs in the district. There is no joint planning for health in the district, and there is no district health strategy. In sum, the district health system does not own the malaria program.

### **The Way Forward**

Exploring the challenges of district health systems governance for malaria raises broader questions about the relationship between central and local governments, about the political economy of global health, about local development and the delivery of social services, about health as a catalyst for community development, about the relationship between traditional political authority and modern political authority, and about the governing of community health.

Such questions may seem intractable. However, an effective community response to malaria requires establishing improved relationships between traditional and modern political authorities at the district level in Ghana.

The constraints of stakeholder engagement encountered by the malaria program is an indication of the need for better governance of malaria in Ghana; the need for “the alignment of multiple actors and interests to promote collective action towards an agreed upon goal” of the malaria program [14]. Malaria control in Ghana has been managed by experts in the health sector. For the elimination and eradication of malaria, better governance of community health is essential.

Ahwoi [13] indicated the need to promote popular participation by shifting processes of governance from command to consultation, and noted that

The trends in Local Government Reforms and Decentralisation in Ghana today are quite clear. They are towards democratic local government structures and accountable systems of public administration that are able to deliver on the developmental demands of the people. There have been very positive achievements, but a lot also remains to be done. What we all ought to remember, however, is that decentralisation is a process, not an event. We must therefore not throw up our hands in despair when we confront obstacles. Ours is to devise strategies to overcome those obstacles.

“Whether we like it or not, we are now in the midst of a health revolution since in order to shoulder our responsibilities when we come to the choice of social justice we require a total renewal of health system through an intelligent combination of mental and social changes making the communities able to promote, in cumulative and lasting fashion, their own state of health” [7].

Bossert and Brinkerhoff [15] identified four principles that could assist in changing the culture of governance of health systems. First, governance rules should ensure some level of accountability of the key actors in the system to the beneficiaries and the broader public. Second, health governance involves a policy process that enables the interplay of the key competing interest groups to influence policy making on a level playing field. Third, health governance requires sufficient state capacity, power, and legitimacy to manage the policy making process effectively. Finally, governance depends upon the engagement and efforts of nonstate actors in the policy arena as well as in service delivery partnerships and in oversight and accountability.

### Community Health Governance

District health systems governance is about accountability relationships between and within the communities, the district health authorities, and the district political authorities. Effective governance of district health systems depends on better governance of community health in towns and villages in the district. Community health governance is about establishing accountability relationships between and within traditional leaders, elected local officials, civil society organizations, community-based organizations, and healthcare service providers.

“A weak system of accountability renders the task of public management difficult and the establishment of good governance unattainable” [16]. Good governance in health requires the existence of standards, information on performance, incentives for good performance, and, arguably most importantly, accountability” [17]. Ackerman described accountability as “a proactive process by which public officials inform about and justify their plans of action, their behavior and results, and are sanctioned accordingly” [18].

Community health governance offers the pathway to engaging all stakeholders in a systematic, sustained and dynamic manner. For malaria, community health governance is the coming together of stakeholders in the community to determine what to do about mosquito breeding; to oversee the activities to control mosquito breeding; to monitor progress in the control of mosquito breeding; to ensure the community has access to the diagnosis and treatment of malaria; to monitor the number of malaria cases and deaths from malaria; and to hold the malaria program and public officials (i.e., the District Assembly and the District Health Service) accountable. Community health governance would strengthen the mobilization and effective use of human and financial resources within the community and engender public-community partnership for health development, including malaria.

The notion of community health governance is within the context of the national development framework of decentralization articulated by Article 240 of Constitution, Local Government Act of 1993 [12] and related subsidiary legislation; and “towards democratic local government structures, and accountable systems of public administration that are able to deliver on the developmental demands of the people” [13].

This paper thus advocates for the nurturing of community health governance as an integrated component of the national malaria program. It envisions communities with unified political leadership and established accountability relationships between community political leaders, civil society, and frontline service providers.

To achieve the vision of community health governance, three strategies are suggested:

1. Foster alliances and coalitions to govern community health

- Facilitate alliances between elected local officials (assembly, zonal council and unit committee members) and traditional leaders (chiefs and elders) in the communities to support and coordinate community projects and programs, to oversee frontline workers in the community, and to ensure efficient use of resources available
  - Foster coalition between community groups, religious groups, and other civil society groups
  - Nurture community health governance by establishing accountability relationships between traditional and elected leaders, civil society, and frontline service providers
2. Develop the capability of the Social Services Sub-Committee of the DA to engender multi sectoral action
- Strengthen the SSSC's capability to coordinate and oversee the implementation of social programs in the district through strategic technical support, continuing education, and logistic support in a sustained manner
  - Facilitate the development of a strategic policy framework for malaria and health
3. Promote a more unified district health leadership under a District Medical Officer of Health (DMOH) to develop a district strategy
- Foster more unified leadership of the district health system through joint planning, monitoring of implementation and assessment of performance
  - Recruit and develop DMOH for district health leadership
  - Promote the development of district health/malaria strategy by bringing three components of the malaria program into a single district malaria implementation strategy with oversight from the SSSC of the DA

Given adequate institutional incentives, effective engagement can strengthen direct accountability relationships between the communities, the District Assembly and the district health authorities [19].

In the medium term, improvement in some dimensions of malaria governance such as coalition building, oversight and accountability has the potential to enhance program implementation and result in better health outcomes. Effective community health governance has the capability to enhance the implementation of Ghana's malaria program, to improve the chances of malaria elimination and eradication, and to engender community development.

## **Conclusion**

Primary health care is the mechanism for attaining universal healthcare coverage in Ghana and remains the cornerstone of health development in Ghana. Section 3 (2) of the Ghana Health Service Act 525 of 1996 [6] highlights the importance of primary health care in Ghana's health development strategy.

For the purpose of achieving its objects, the [Ghana Health] Service shall perform the following functions - a) ensure access to health services at the community, sub-district, district and regional levels by providing health services or contracting out service provision to other recognized health care providers; ... c) plan, organize and administer comprehensive health services with special emphasis on primary health care ...

*“Primary health care means the provision of essential services which correspond to basic needs, made available through acceptable technology and made universally accessible with the full participation of the community. It includes at least eight essential components: appropriate health education, promotion of food supply and proper nutrition, basic sanitation including an adequate supply of safe water and hygienic waste disposal, maternal and child health care, including family planning, immunization against major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common ailments and injuries, and the provision of essential drugs. As this list shows, primary health care is comprehensive care comprising promotional, preventive, curative and rehabilitative care. It is provided at local level, at the point of entry into the national health system, which is simply a coherent entity of institutions and resources with multiple aims. As an integral part of this coherent entity, primary health care is given the support of the referral facilities of other levels of the health pyramid, namely intermediate and central levels. Setting up such a system efficiently in Africa requires the fulfillment of certain preconditions, given the chaotic situation at present prevailing in health development” [7].*

Most African nations have, after attaining political independence, under the guidance of WHO Regional Office for Africa, followed this strategic path for health development.

Primary health care forms an integral part of the country’s health system, of which it is the central function and main agent for delivering health care. It is also an integral part of the overall social and economic development of the community. For these reasons, the concepts of primary health care, as decided in Alma Ata, should be the driving force behind the determination of policies and should be kept in mind when formulating strategies and plans for action [20].

One of the underlying concepts of primary health care that has been widely promoted is community participation.

Measures have to be taken to ensure free and enlightened community participation, so that notwithstanding the overall responsibility of governments for the health of their people, individuals, families, and communities assume greater responsibility for their own health and welfare, including self-care. This participation is not only desirable, it is a social, economic and technical necessity. Governments will therefore have to devise appropriate ways of promoting such participation, supporting it, effectively propagating relevant information, and establishing or strengthening the necessary mechanisms. Governments, institutions, members of health professions as well as all agencies involved in health and development, will therefore have to take measures to enlighten the public in health matters so as to ensure that people can participate individually and collectively, as part of their right and duty, in the planning, implementation and control of activities for their health and related social development [20].

The concept of community health governance is an enhanced interpretation of community participation. The bedrock of community participation under primary health care is the village health committee. Community health governance builds on the achievements of the village health committees established by the primary health care program. In essence, community health governance is an adaptation of an old primary health care concept by revising the composition of the village health committee to include all stakeholder groups in the community, and broadening its functions to encompass accountability. Community health governance would nurture accountability relationships between the entire spectrum of stakeholders in the community and thereby engender better district health systems governance.

Community health governance is the next logical step in the development of health systems in Ghana. The concept builds on the foundations of decades of development of primary health care policy and

programs, community participation and village health committees, alongside the development of district health systems. Community health governance is the mechanism to make the paradigm shift from a medical orientation to a social determinants approach reality.

### Implications for Action

A paradigm shift to social determinants approach calls for reorientation of how malaria is handled at the community, district, national and global levels. There are broader implications for consideration in Ghana, in other African countries, and within the global malaria agencies.

**First, the Ghana malaria program must engage with the key stakeholders in the district in a systematic and sustained approach in order to make progress towards elimination and eradication of the disease.** This would require nurturing, fostering or facilitating alliances and coalitions among stakeholders and strengthening multisectoral action. The malaria program must invest in establishing accountability relationships within the communities and between the District Assembly, the district health authorities and the communities.

**Second, malaria programs in other African countries need to be similarly redirected towards community health governance.** The district health system exists in most former British colonies and decentralization is taking place in most of those countries. As a result, the specific country contexts for malaria programs are similar to what pertains in Ghana, making the proposals relevant and applicable.

**Third, improving malaria governance at the district level in African countries has implications for the governance of malaria at the global level.** It calls for a rethinking of the malaria problem by the global malaria agencies. The high malaria burden - the morbidity and mortality from malaria - is an indication of a fundamental problem in African societies. Malaria is a social problem; an indicator of social underdevelopment, poor living standards, and unacceptable quality of life. COVID-19 may have opened the global policy window to enable consideration of fresh policy initiatives to address the problem of malaria in Africa. **The global malaria agencies must, as a matter of urgency and with unity of purpose, redefine malaria as a social problem and collectively adopt a social determinants approach to the development of national malaria programs.**

Beyond opening the global policy window, COVID-19 also offers valuable lessons about strengthening local health systems and facilitating community organization in preparedness for the next pandemic. Redefining the malaria problem as a social one would expand the options for addressing the malaria problem beyond healthcare delivery to include community response. Given adequate institutional incentives, a community response initiative would facilitate the forging of relevant alliances and coalitions, engender the alignment of multiple stakeholders and interests to promote collective action, and lay the foundation for establishing community health governance. We may find a post-COVID-19 policy window that provides an opportunity to put community health governance on the global malaria policy agenda.

### **References**

1. Lehmann U, Gilson L. Action learning for health system governance: the reward and challenge of co-production. *Health Policy Plan.* 2015 Oct;30(8):957–63.
2. Awine T, Malm K, Bart-Plange C, Silal SP. Towards malaria control and elimination in Ghana: challenges and decision making tools to guide planning. *Glob Health Action.* 2017;10(1):1381471.

3. President's Malaria Initiative. Ghana malaria operational plan FY 2018. Washington, D.C.: U.S. Agency for International Development; 2018.
4. Republic of Ghana. Social and behavior change communication (SBCC) strategy for the national malaria control programme (2015-2020). Accra: Ministry of Health; 2015.
5. Republic of Ghana. National malaria control strategic plan for 2015-2020. Accra: Ministry of Health; 2015.
6. Republic of Ghana. Ghana health service and teaching hospitals act. Accra: Government of Ghana; 1996.
7. Quenum C. Twenty years of political struggle for health. Brazzaville: World Health Organization Regional Office for Africa; 1985.
8. Republic of Ghana. Traditional medicine practice act: an act to establish a council to regulate the practice of traditional medicine, to register practitioners and license practice, to regulate the preparation and sale of herbal, medicines and to provide for related matters. Accra: Government of Ghana; 2000.
9. Kessey DK. Financing local development in Ghana: mobilization and management of fiscal resources in Kumasi metropolis. Dortmund: Spring Research Series; 1995.
10. Twumasi P. Medical systems in Ghana: a study in medical sociology. Accra: Ghana Publishing Corporation; 2005.
11. Republic of Ghana. Constitution of the Republic of Ghana. Accra: Government of Ghana; 1992.
12. Republic of Ghana. Local government act: an act to establish and regulate the local government system in accordance with the constitution and to provide for related matters. Accra: Government of Ghana; 1993.
13. Ahwoi K. Enhancing the decentralisation programme: district assemblies and sub-structures as partners in governance. Accra: Institute of Economic Affairs; 2000.
14. Omaswa F. Strong ministries for strong health systems. New York: African Center for Global Health and Social Transformation, New York Academy of Medicine; 2010.
15. Brinkerhoff D, Bossert T. Health governance: concepts, experience, and programming options. Washington, D.C.: U.S. Agency for International Development; 2008.
16. Shafiqul AH. Accountability and governance: strengthening extra-bureaucratic mechanisms in Bangladesh. Halachmi A, Greiling D, editors. International Journal of Productivity and Performance Management. 2011 Jan 1;60(1):59–74.
17. Lewis M, Petterson G. Governance in health care delivery: raising performance. Washington, D.C.: World Bank Group; 2009.
18. Ackerman JM. Social accountability in the public sector: a conceptual discussion. Washington, D.C.: World Bank Group; 2005.
19. Campos PA, Reich MR. Political analysis for health policy implementation. Health Syst Ref. 2019;5(3):224–35.
20. World Health Organization. Formulating strategies for health for all by the year 2000. Geneva: World Health Organization; 1979.

