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The Discourse of Japanese Development Assistance and the Scaling-up of Community-based Health Planning and Services (CHPS) in Ghana

Kweku Ampiah *

Abstract

The paper explores Japan's contribution to the provision of primary healthcare in Ghana through the Community-based Health Planning and Service (CHPS) strategy. The discussion trawls the policy regarding the development of the CHPS and highlights the specific role of the Japan International Cooperation Agency (JICA) in the 'Scaling up' of the CHPS project in the Upper West Region (UWR) of Ghana. It is suggested in this analysis that through the application of Facilitative Supervision (FSV), a supportive approach to supervision, JICA aimed to review and fine-tune the administrative capacity of the relevant health administrators of the UWR with the primary objective to improve and enhance healthcare delivery in the region. The study proposes that in tune with Michel Foucault's concept of 'administrative control' and 'noso-politics' the FSV initiative further essentialised the role of the state in healthcare delivery in the region.

Keywords: Primary Healthcare, Ghana, Michel Foucault, Administrative Control, Japanese Aid

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1. Introduction

This research is about Japan's role in the development initiatives of Ghana. Specifically, it examines the contribution of the Japan International Cooperation Agency (JICA) to the development and expansion of the Community-based Health Planning Services (CHPS) project in the Upper West Region (UWR) in the north of Ghana. CHPS is conceived as '.... a National strategy to deliver essential community-based health services involving planning and service delivery with communities...' with the primary focus on bringing health services close to ...' communities in 'deprived sub-districts...' (National Community-Based Health Planning and Services [NCBHPS Policy], 2016). The objective includes the provision of primary health care (Ghana Health Service, 2007, 53) through Community Health Officers (CHO) as frontline health workers. Incidentally this research underscores the ideal stated under Pillar 2 of the Nairobi Declaration of the Tokyo International Conference on African Development (TICAD) VI in 2016 about Promoting Resilient Health Systems for Quality of Life. The recent outbreak of epidemics such as Ebola and other health crises further necessitated the emphasis on better health chances through the application of high quality standards in health delivery in Africa. To achieve that it was agreed at TICAD VI to strengthen the relevant institutions and build 'national and local capacities by reinforcing capable, efficient, responsible, transparent, equitable and accountable health systems to improve essential service delivery'(Ministry of Foreign Affairs, 2016). Consequently the project under study demonstrates efforts in Japanese development assistance to Africa to improve and strengthen healthcare systems at various levels in the region. Essentially, the project, as designed in the UWR, was about strengthening administrative capacity for healthcare delivery.

The CHPS strategy is part of the Government of Ghana's national programme to repurpose healthcare delivery in a manner that values all sectors of society, thereby redressing inequalities in access to healthcare across the country, with the overall objective of balancing

efficiency and equity objectives. However, while the CHPS as a strategy is designed in principle to foster community ‘ownership’ (of its healthcare service) as well as engender community ‘empowerment’, not least because it is community-based and –oriented(NCBHPS Policy 2016, 13, 23; USAID/Ghana 2003, 66), in fact CHPS is under the firm control of the State (NCBHPS Policy 2016; Frank K. Nyonator et al. 2005, 28), in so far as it is orchestrated by the Ghana Health Services (GHS). It is in that regard conceived as a key component of the Ghana Shared Growth and Development Agenda (GSGDA 2014), which automatically makes CHPS an essential pillar of the country’s Sustainable Development Goals (SDGs) (NCBHPS Policy 2016, 3).

As they would be termed in the wider context of ‘administrative control’ (Michel Foucault 1973), the CHPS encompasses a dual body of interventionists: State policy-makers with authority over the practice of healthcare delivery and its socio-economic utility, and the external body in charge of disbursing economic assistance toward the project, JICA. Thus, disease is caught up in a double system of intervention, as it were (Foucault 1973, 42-43).

This study is not about diagnosing the strengths and weaknesses of the CHPS initiative; nor is it about finding out whether the CHPS project in the UWR, as it was formulated and implemented by JICA in its role as aid disbursing, was effective as a form of primary healthcare. In other words, although I discuss the automatic hypothesis of a correlation between JICA’s intervention in the project and better healthcare delivery in the region, I do not intend to, nor do I, test this hypothesis. Rather, the study maps out Japan’s role in the project, and attempts to evaluate the particular type of intervention JICA made in its planning and implementation, as well as how this might have impacted on the administration of healthcare delivery in the UWR, and in Ghana in general. With reference to Foucault’s concept of ‘administrative control’ and one of the five salient policy objectives of the Ghana Shared and Development Agenda relevant to the Ministry of Health, ‘Improve governance and strengthen

efficiency and effectiveness in health service delivery’ (NCBHPS Policy 2016, 8), I concentrate in particular on JICA’s application of Facilitative Supervision (FSV) to review the conventional monitoring ‘apparatus’ within Ghana’s healthcare delivery system in the UWR. In principle FSV is a supportive approach to supervision that promotes mentorship, joint problem-solving and communication between supervisors and supervisees’ (Ashley Marshall and Jessica Fehringer 2013) and ‘...expands the scope of supervision methods by incorporating self-assessment and peer assessment, as well as community input’ (Lani Marquez and Linda Kean 2002).

Essentially, this study, as the theoretical discussion will illuminate, underscores the role of the State in development, and illustrates a form of Japanese development assistance, which emphasise the role of the State as a leading agent in the provision of the basic infrastructure, including institutions, required for development. This challenges the hegemonic drive of the World Bank and the IMF to run the State, as a capitalising phenomenon, into the ground by stifling its role in economic development through their campaigns, in particular during the 1980s and 1990s, in favour of ‘public divesture, privatization and deregulation across infrastructure sectors’ (Michiko Nissanke and Yasutani Shimomura 2013, 12). Thus, the study should be seen in the context of the enormous deficit in economic infrastructure Ghana has suffered since the Structural Adjustment Programme of the 1980s (S. D. Barwa 1995; Ernest Aryeetey and Markus Goldstein 2000).

Two interrelated insights might be gleaned from the emphasis on developing and enhancing the administrative capacity of state officials towards healthcare delivery:

1. Growth promotion in Ghana can only be sustained if the leading implementers of development (which, in a developing country, are the State and its ancillary agencies) have the requisite administrative and technical (institutional) qualities to do so. This affirms Foucault’s ‘...assumption that from the very beginning of capitalism intervention and administrative control have defined the modern state’ (Srikant Sarangi and Stefan Slembrouck (1996, 5).

2. Japanese aid policy-makers are aware of the development modalities pursued by the traditional partners of African countries, including institutions such as the IMF and the World Bank and, where appropriate and feasible, would interrogate, challenge, and subvert them (Michiko Nissanke and Yasutani Shimomura 2013, 1-47; Lee. Y. W. 2008; Kenichi Ohno and Izumi Ohno 1988; Robert Wade 1996).

The research for this project involved a visit to the UWR project site in 2009, and interviews with senior Ghanaian health officials. Extensive consultation with JICA officials, both in Ghana and Tokyo, also contributed to the research. I should also note that I have followed the progress of the project since its inception in 2006, and its further development since the end of the first phase in 2010. It is therefore worth noting that this research concentrates on the project completed in 2010, and does not include the Project for Improvement of Maternal and Neonatal Health Services in the UWR, which was launched as a JICA technical co-operation project from September 2010 to September 2016.

2. The Inception of Community-based Health Planning Services (CHPS)

Decades of failed health policies, strategies and infrastructure by the Ministry of Health (MOH), exacerbated by the cuts in public services mandated by the World Bank reforms of the 1980s and beyond, created ‘...deficiencies in the health system [that] translated into severe capacity constraints...’ as well as limiting access to health facilities in general (Ernest Aryeetey and Markus Goldstein 2000, 290; Govindaraj et al. 1996). In part this necessitated the implementation of the CHPS, which was initiated in 1994 by reorienting and relocating healthcare at the sub-district level to rural areas, which often lack permanent healthcare infrastructure. More specifically, CHPS was adopted and scaled up from 1999, following the successful trial in 1994 in Navrongo, in part to (NCBHPS Policy 2016, 8, 16):

- a. Bridge equity gaps in access to health care

- b. Improve governance and strengthen efficiency and effectiveness in health service
- c. Expand access to and improve the quality of institutional care, including maternal health service delivery

The CHPS strategy was also designed to counteract poor attendance at outpatient departments (OPDs), and high maternal mortality, child mortality and morbidity in rural areas. The project was also initiated in response to the awareness that ‘there was no community participation in health decision making’. Consequently CHPS is seen as providing the ‘vehicle to deliver ... community level service by engaging communities to take decisions concerning their own health, and recognize that the primary producers of health are the individuals within the household – especially mothers’ (GHS 2005, 2).

Under this system, a trained community health nurse is assigned to a CHPS zone (with a catchment area of 3000-5000 people) as a Community Health Officer (CHO) who resides in a designated CHPS compound (Awonoor Williams et al. 2015, 7; NCBHPS Policy 17, 22-23) equipped with a clinic, and from where a close-to-client healthcare service is provided to those living within the zone. In principle, in accordance with the 3-tiered health delivery service designed at the district level within the structure of Ghana’s Primary Health Care (NCBHPS, 2016, 8-9), the CHO conducts home visits at the community level to provide basic medical treatment, advice, and health guidance; but they may, in accordance with the 3-tier matrix, refer patients to a health centre at the sub-district level, or the District Hospital at the top of the pyramid. As such, CHPS revolves around the CHO as a frontline healthcare provider serving a defined rural population in a a CHPS zone, and essentially entrusted with the responsibility to improve: a) access to healthcare services; b) efficiency and responsiveness to client needs; and c) develop effective inter-sectoral collaboration.

Basically, the CHO is a reoriented Community Health Nurse (CHN) relocated from a national health institution to a particular district as a resident paramedic (Stephen Ntsua et al. 2012, 8; NCBHPS Policy 2016, 9-15, 23-24). Also armed with community organisational

skills, especially in their dealings with Community Health Volunteers (CHV), the CHO's go about their duties, a major part of which is outreach, often on motorbikes, with which they are supplied and trained to conduct house-to-house visits to deliver and achieve basic primary healthcare objectives. Thus the 'CHO is a leader and community mobilizer', according to the general principles guiding the implementation of CHPS (NCBHPS Policy 2016, 23). Fundamentally, the CHO is technically qualified to provide both health post-based and doorstep services including the following (NCBHPS Policy 2016, 23):

1. Maternal and reproductive health
2. Neonatal and child health service (neonatal care, expanded programme of immunization, nutrition education and support, and growth monitoring and Promotion etc.)
3. Management of minor ailments including fever control, first aid for cuts, burns and domestic incidents, and referrals
4. Family planning counselling and services
5. Health education, sanitation and counselling on health lifestyles and good nutrition
6. Follow-up on defaulters and discharged patients

However, the success of CHPS is also dependent on the CHVs, who are trained by the sub-district health team with an emphasis on practical activities complemented with lectures, group work, and demonstrations (Stephen Ntsua et al. 2012, 5; NCBHPS Policy 2016, 15, 22, 25), which prepare them for their responsibilities, including conducting disease surveillance and identifying cases, and providing condoms and family planning information. The CHV may refer a patient to the CHO based on their diagnosis (Stephen Ntsua et al. 2012, 8; NCBHPS Policy 15). To carry out their roles (primarily home visits and assisting CHO's) more

efficiently, CHVs are provided with bicycles for easy mobility,¹ and often equipped with condoms, Oral Rehydration Salts (ORS), painkillers, and a home visiting bag. The CHV is instrumental in ensuring community interest and participation in the project through community mobilisation exercises that are designed to enhance collaboration between health administrators and the community, including community leaders, households, and civil society. Thus the CHVs serve as ‘...a bridge for the services between patients and the CHNs...’ and because they are not salaried they do not affect ‘...the national wage bill...’ (NCBHPS Policy 2016, 21). On the other hand there ‘...is no policy on reward and incentives for these volunteers ‘leading to volunteer fatigue and various programs introducing cash incentives...’ thereby compromising the volunteer system in several communities.

The project begins when communities with poor health services are designated for intervention by the GHS, and the process involves allocating an area for the construction of a CHPS zone, which includes the living quarters of the CHO as well as accommodating a clinic. The District Health Management Team (DHMT) then formally announces the project to the traditional leaders of the community and to the community at large at a public reception.

The strategy involves six activities referred to as the six CHPS milestones, which are: a) Planning, b) Community Entry, c) Community Health Compound Construction, d) Community Health Officer recruitment, e) Essential Equipment procurement, and f) Volunteer recruitment (Binka et al. 2009; Adongo et al. 2014), supposedly in that order. However, it has been found that in some cases ‘completing Community Health Compound construction/innovation [was] more widespread than community entry’, although the ‘financial resources required for construction were far greater than [the] resources required for community diplomacy’ (Nyonator et al. 2005, 31). Moreover community entry (as a diplomatic

¹ Because CVOs are not salaried, the bicycle was apparently used as an incentive to attract volunteers to commit to the project, but because bicycles are highly prized in the Upper West Region, community leaders such as Chiefs apparently reserved the CVO positions for their family members. JICA subsequently intervened to make the selection procedure for CVOs more transparent and democratic. Conversation with Mr. Takaharu Ikeda, Tokyo, July 2015.

function within the CHPS equation) is perhaps more important as it has the ability to determine the sustainability of the initiative, in so far as the effectiveness of such a project, either in the short- or long-term, is dependent on how the community reacts to it. This issue reflects the inherent problems with the concept of 'functional CHPS', which we shall discuss in due course. Suffice to say community entry (Nyonator et al. 2005, 27) as a diplomatic initiative is about creating the proper environment to enable the community to be receptive to the new (and potentially intrusive) phenomenon following the initial planning stage, which essentially entails 'assessing the existing situation...' to ascertain the '...baseline for further consultations and subsequent implementation of the programme' (Abongo et al. 2014, 4). Table 1 presents 2012 and 2014 figures for the on-going CHPS process across the length and breadth of Ghana.

Table 1. CHPS Implementation Status by Region

Region	Total no. of functional CHPS Zones at the end of 2014
Ashanti	736
Brong Ahafo	380
Central	207
Eastern	465
Greater Accra	142
Northern	172
Upper East	213
Upper West	145
Volta	263
Western	225
TOTAL 3500	2,948 (84%)

Source: Ghana Health Service, 2014 Annual Report, July 2015. p. 112.

Notes: According to the National Community-Based Health Planning and Services (CHPS) Policy (2016, 17) ‘The geographical demarcation for a CHPS zone has changed a few times over the years. It ‘...was changed in 2010 from size of population or unit Committees to be coterminous with electoral areas. This reduced the number of CHPS zones from 5, 280 to 2, 840.’ Due to the increase in electoral areas in 2013 the figure was revised to ‘...about 6,000.’ Apparently, ‘To date there are 3, 175 functional CHPS zones and 1, 410 functional CHPS compounds. Incidentally the figures do not synchronise with those in Table 1 and Figure 1. The data on this over the years is inconsistent.

The implementing institution of the project is, the GHS. More directly involved in the project as frontline agencies of the GHS are the Regional Health Management Teams (RHMTs), and the District Health Management Teams (DHMTs), who are in charge of each pilot district, although the Sub-District Health Teams (SDHT) also play a crucial role in serving as the direct link with the CHO. The operational mandate of the above ancillary agencies essentially concerns making CHPS functional, in addition to ‘scaling up’² its implementation.

As alluded to above a working definition of ‘functional CHPS’ is still work in progress. It is currently suggested that a facility is functional even if all six ‘milestones’ have not been completed, but if a CHO has been assigned to the project and it is providing a defined package of services to the catchment population, from house to house, in the unit area

² The term ‘scaling up’ is used in the same way Ruth Simons et al. (2007: i) applies it: ‘to expand the...successful small-scale pilot or demonstration project...so as to benefit larger populations than those initially served.’

(Ministry of Health 2014). The implication is that ‘... the functionality of the CHPS Zone does not necessarily depend on [a] compound, [although] a compound in the zone is highly desirable’ (Frank Nyonator 2010; Ministry of Health 2014; NCBHPS Policy 2016, 19, 22).

These issues notwithstanding, the indications are that CHPS is apparently making a much-needed contribution towards improving healthcare delivery in Ghana. According to the indicators the strategy contributes 30 percent, 36 percent, 10 percent and 3.8 percent respectively to Family Planning, OPV/Polio 3 doses administered, OPD, and skilled deliveries (Ghana Health Service 2014, 114). However, as a strategy the system is flawed on several levels, perforated with weaknesses within its operations in part because of a lack of resources, and, more acutely, due to weak administrative capacity (NCBHPS Policy 2016, 19-20; Republic of Ghana, Performance Audit Report 2010, 9-30; Fred Binka et al., 2009). For example, from the national to the sub-district levels ‘no administrator work[ed] full-time on CHPS, which creates the impression of a lack of commitment and support’ for the project (Ntsua et al. 2012, 12), despite policymakers’ claims that ‘there is political will from all angles to sustain the CHPS...’(Republic of Ghana et al. 2010, Annex 7:45). And it was found that, while the CHPS concept revolves essentially around home visits by the CHO, who should ‘conduct at least 10 home visits each day for preventive health education’, instead they conducted ‘on average, one home visit per week’ (Ntsua et al. 2012, 5), which defeats the essentially preventative purpose of the initiative and orients it more towards curative healthcare. In other words, the strategy seems inclined towards ‘static service provision’, with the CHO stationary at a delivery point where the patients have to go to receive the services they require, thus undermining the very essence of the strategy (Ntsua et al. 2012, 8).

Based on the GHS’s 2012 assessment ‘...the current population reached with CHPS service is 5 percent, which, according to the Government of Ghana’s own assessment, ‘...raises the question as to whether... the initiative is being optimally implemented, and ‘whether the CHPS strategy is value for money.’(NCBHPS Policy 2016, 20) From 2002 to

2008, the number of functional CHPS compounds grew from 39 to 409, and from 2009 to 2014 it further grew from 868 to 2,948³, as indicated in Figure 1. Meanwhile, the ‘...ratio of functional CHPS zones to CHN points to an overproduction of CHNs’ with a current ratio of about 1 to 11, compared to the initial assumption to have one CHO per CHPS zone (NCBHPS Policy 2016, 20). This inevitably presents logistic challenges including accommodation and amenities resulting in many CHNs residing outside the CHPS zone. This means that, despite the priority given to the strategy within the matrix of the GHS, it had remained largely immobile in terms of its expansion, principally because of the lack of administrative capacity in district health bureaus, a lack of well-qualified CHOs (Ghana Health Service/JICA 2009; JICA Ghana Office 2014), ‘sub-optimal levels of local people’s participation’, and a lack of consensus about the definition of ‘functional CHPS’ (Moses Aikins et. al. 2013, 1; NCBHPS Policy 2016, 19). The GHS (2007, 53-54) admits ‘the scaling up [of the CHPS] process has been hampered by inadequate resources and to some extent, inadequate understanding of CHPS by some people in various leadership positions within the Service.’ The problem is compounded by a general lack of urgency on the part of policymakers to realise the goals set for the initiative. Not surprisingly, therefore, there is no dedicated funding for the programme at the national level (Fred Binka et al. 2009; NCBHPS Policy 21). Although overwhelmed by a plethora of problems the GHS continues, as indicated in Figure 1, to pursue ‘the vision... to have the core services defined within the CHPS Initiative to be available and accessible to all Ghanaians who need it by 2015’ (GHS 2007, 53, NCBHPS Policy 2016). To mitigate the drawbacks, the Government of Ghana made appeals to international partners to contribute to the initiative, and attracted Japan and USAID, among others, to support the vision.

³ See footnote 2.

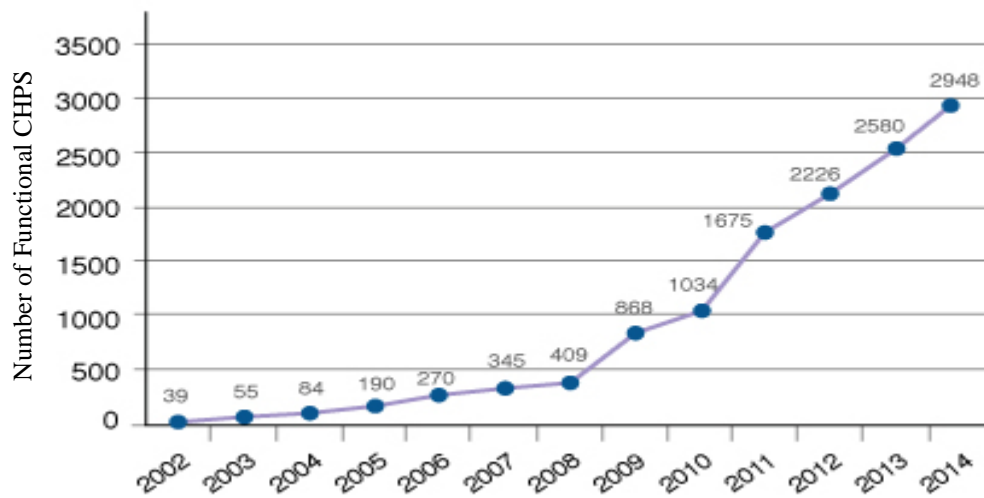


Figure 1. Trend in Implementing Functional CHPS across Ghana 2002-2014

Source: Ghana Health Service, 2015, 2014 Annual Report, July.

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

The health indicators for the UWR lag far behind those of the other regions of Ghana, as indicated by Figure 2, which shows that in 2013 and 2014 there were only 7 and 11 medical officers respectively in the region with a population of 702, 110, which is 2.8 percent of the national population.⁴ Despite the increase in the number of medical staff between 2013 and 2014 the figures are indicative of how far the UWR lacks behind the other regions. Indeed Ghana's dire doctor/ population ratio is exemplified in the region where in both 2010 and 2013 there was one doctor to over 50,000 people. The situation had improved markedly by 2014 with a doctor to 38,000 people but the region still had the worst doctor/population ratio compared to the other regions (GHS 2015, 32) As such, there is a desperate need for

⁴This is based on indicators published by the Ghana Statistical Service, 2010, Population and Housing Census: Summary Report of Final Results, Accra: 2012. According to the census 305, 245 of the population 3 years and older has no history of school attendance. Of those 15 years and older 203, 676 are illiterate.

intervention if the health services in the region, one of the least populated and least urbanised in Ghana, with 84 per cent of the population being rural, were to be improved.

Based on a request from the Government of Ghana to the Government of Japan for assistance towards the CHPS strategy, Tokyo agreed to support the Project for the Scaling-up of CHPS Implementation in the Upper West Region. Negotiations between the two governments were concluded in December 2005 following an on-site preparatory study by a Japanese team in November 2004, and an assessment in May 2005 of the grant aid and technical aid to be disbursed towards the project, as well as the role that the Japan Overseas Cooperation Volunteers (JOCV) would play. The project was launched in March 2006 and completed in February 2010, with a project cost of ¥500 million, approximately US\$4,000,000, through the cooperation of the GHS, the MoH (Ghana), and the JICA, with the latter as the aid disburser.

The terms of engagement as stated in the Record of Discussion [R/D] (Japan International Cooperation Agency 2006)⁵ between the Government of Ghana and the Government of Japan (Republic of Ghana et al. 2010, Annex 7:5) confirmed the responsibilities of the key stakeholders in the project as follows:

1. As Coordinator of the project the GHS would monitor and evaluate the project administration and implementation together with JICA.
2. The Director General of the GHS in UWR, who was technically in charge of the overall administration and implementation of the project, would serve as the project's Director.
3. The Regional Director of the Health Service would serve as Project Manager with responsibility over technical matters, including 'providing supervisory and

⁵ Mr. Shinji Obuchi, Deputy Resident Representative of JICA, signed for the agency, while Salimata Abdul Salam, acting Chief Director of the Health Ministry, and Dr George Amofa, Deputy Director-General of the Ghana Health Service signed for their respective institutions, March 2006.

facilitative support to district and sub-district teams on project planning and implementation’.

4. The JICA Chief Representative in Ghana would serve as chief advisor to the project: he/she would make ‘...recommendations and give advice to the project director and project manager on any matters pertaining to the implementation of the project.’
5. IC NET (which worked as a consultancy for JICA) would serve as the channel for funding and support for the project implementation; and in partnership with JICA give advice on the operations and direction of the project
6. The JICA/IC NET team would advise on the training for the staff of the GHS involved in the project implementation.

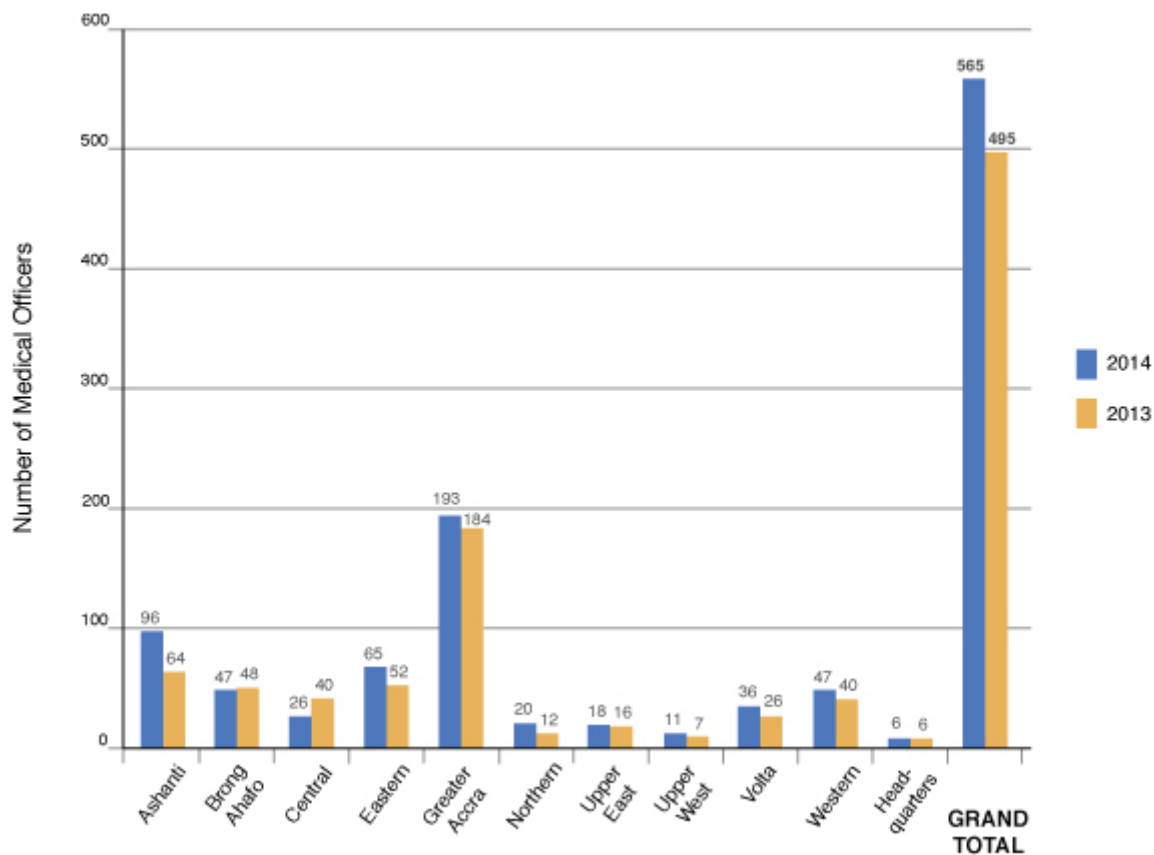


Figure 2. Regional Distribution of Medical Officers in Ghana

Source: Ghana Health Services, 2014 Annual Report, 2016. p. 32

There are indications that the roles of the stakeholders were not as clear as they could have been (Republic of Ghana et al. 2010, Annex 7:5), as a result of which it was reiterated at a Joint Coordination Committee (JCC) meeting⁶ that the ‘JICA team was an advisor to the project, not the implementer of the project’, which in principle meant that authorial control over the project was with the GHS and its ancillary agency in the UWR, the RHMTs. Concern was further raised at the meeting to the effect that the project manager was not made privy to how the JICA team managed the expenses of the project, in addition to not having informed

⁶ The JCC met twice a year to assist the senior members of the JICA and GHS teams to monitor ‘the progress of the project activities’ and ‘make the necessary adjustments to advance the scaling up of CHPS’ (Republic of Ghana et al. 2010, Annex 7: 4).

knowledge about the project's finances in general. It was also noted that while the JICA team was not the implementer of the project, somehow 'all decisions relating to the project activities were [being] made by the JICA team' (Republic of Ghana et al. 2010, Annex 7:7), which seemingly compromised the GHS's authorial control over the project. Perhaps as a demonstration of its authority, the Director of the GHS instructed the JICA team to refrain from contacting other implementing partners engaged in the CHPS initiative such as the CHPS Technical Assistance (team) and USAID in regards to the project, as that was not part of JICA's remit (Republic of Ghana 2010, Annex 7:8).

In terms of specific commitments by JICA and the local counterpart to the project, the aid disburser agreed to assign twelve Japanese experts to the initiative on short-term secondment 'to provide the necessary technical advice and guidance to their Ghanaian counterparts' (Republic of Ghana et al. 2010, Annex 7:17; Annex 2). Of these experts, one served as an advisor on Community Health Administration; an expert on community participation was also assigned to the project during its first and second years; another was also posted to the project site from the second to the fifth year as an expert on maternal and child health. In addition, there were four Training Coordinators, one of whom also served as Community Health Administrator, and two doubled as Project Coordinators. The team also included advisors on Community Participation, and a medical doctor presumably with expertise in health information systems and referral systems covered duties concerning referral planning. Two experts, one of whom was an IEC employee, were deployed as Programme Liaison Officers and Coordinators. These experts were at the project site for short periods; the Chief Advisor stayed approximately two weeks on his first visit to the site, and approximately two months on his second visit; his longest visit was approximately four months, from August to December in the fifth year of the project. However, this expert made eighteen visits to the project site, the last visit being for approximately a month, from 5 January to 3 February 2010.

The project design matrix also affirmed that JICA would accept nine senior GHS staff members for ‘counterpart training’ in Japan. This took place in the third to fourth year of the project, and the trainees comprised five females and four males of various ranks within the RHMTs, ranging from the Regional Director of Health Services to the Regional Training Coordinator, and including one practising medical doctor (a gynaecologist at one of the District hospitals), who undertook a training course in Maternal Health. Incidentally, two Regional Directors of Health (RDH)⁷ attended the training in the third and fourth years respectively, and apparently undertook seminars on ‘How to Reduce Child Mortality,’ ‘International Cooperation,’ and ‘Health Administration for Regional Health Officers for Africa.’ The Regional Training Coordinator and a District Director of Health also undertook the latter course. Two other District Directors of Health and the Regional CHPS Coordinator enrolled on a course on ‘Planning Management of Community Health.’ Aside from one officer who attended training from 7 May to 24 June 2007, three of the participants were enrolled from 29 November to 21 December 2007, and another set of three attended training from 29 June to 10 August 2008. The period of training for the remaining two was from 7 September to 4 October 2008. The training courses were short, lasting four to six weeks.

Again, as part of Grant Aid the Japanese counterpart provided equipment such as motorcycles (for the CHOs to use for their home visits), bicycles (to make the CVOs more mobile on their rounds), medical equipment, and a radio communication system for the project.

Consistent with the R/D, the Government of Ghana provided a management staff of nineteen (from RHMTs and DHMTs) towards the project, and made provisions for the premises of the project office, which was established in Wa, on the compound of the Regional Health Directorate. The Government of Ghana was also given responsibility over the parts of the budget dealing with the project’s operating expenses (utilities, office maintenance, motorcycle repairs, etc.). The Government of Ghana was also technically responsible for the

⁷ This was because the first RDH finished his term in the middle of the project period.

construction of the CHPS compounds, although this was subsequently designated as the responsibility of the community, as will be later discussed.

The project began in the second fiscal year (April 2006-March 2007) with the setting up of the JICA project office in Wa, which was completed in a period of six months from May to September 2006, and was followed by feasibility studies conducted in other regions of the country to observe existing CHPS projects. For four months from September that year, a baseline survey concerning the status of CHPS in the UWR and other health indicators was conducted, alongside a Knowledge, Attitudes and Practices (KAP) survey specifically in Wa-West and Jirapa and Lambussie districts (Republic of Ghana et al. 2010, 4).⁸ The KAP survey also included an assessment of the locals' knowledge of health issues and their tendency to seek medical care. Pilots to map out the feasibility of the project were carried out in the first and second years in the above districts, which were designated as Stage 1 districts, and in the third year the project was scaled up to include the other districts in the region, namely Lawra, Nadowli, Sissala East, Sissala West, Wa-East and Wa Municipal, although the region was subsequently sub-divided into nine districts.⁹

⁸ The survey was conducted by a contracted NGO to assess the current health status of the districts and needs of the health sector in the region.

⁹ There are now two additional districts in the region, Nandom and Issa.

4. Scaling up CHPS

The project objective as devised by JICA in principle followed the ambitions of the GHS, to enable community members in the project area to gain increased access to quality healthcare through improved coverage of functional CHPS,¹⁰ but with additional plans to scale up the initiative. This would be achieved by strengthening ‘the institutional capacity of the GHS [towards] the implementation of CHPS...’ (Republic of Ghana et al. 2010, 1-2; JICA [Ghana Office] 2014; Moses Aikins et al. 2013, 1). In effect, the project was about enhancing rural healthcare through the realisation of the following practices (JICA [Ghana Office] 2014):

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

The feasibility and success of these practices was dependent on improving and articulating the administrative capacity of the regional health administrators, which in turn was dependent on establishing, implementing, and strengthening the procedure for FSV to enable the reformulation and enhancement of the monitoring system within the RHMTs, DHMTs, and SDHTs, the three most important agencies of the region’s healthcare infrastructure. Capacity building for the CHOs was also incorporated within the framework of the FSV, as noted above.

¹⁰ According to JICA, making CHPS functional involved the actual assignment of a CHO to the community, and the making of home visits by the CHO, which does not require a CHPS compound. See JICA (Ghana Office) 2014.

Table 2 lists the capacity-enhancing activities designed for the three agencies, highlighting some of the responsibilities of the individual bureaucratic teams in the FVS process.

The decision to incorporate FSV into the CHPS process in the UWR was made early on, during the preparatory workshop for the project in May 2005, when the JICA team noted that there was a lack of awareness among RHMT and DHMT personnel of the importance of supervision as a managerial tool (Republic of Ghana 2010, 5; Aikins et al. 2013, 1).

Table 2. List of Capacity Building Activities

Level	Capacity Building Activities
RHMT	<ul style="list-style-type: none"> • Training in proposal writing for support for the construction of CHPS compounds • Providing support towards establishing the FSV implementation system and developing tools for FSV • Support for the implementation of FSV • Dissemination of best practices in training
DHMT	<ul style="list-style-type: none"> • Training in proposal writing for support for the construction of CHPS compounds • Establishing FSV implementation system and developing tools for FSV • Support for the implementation of FSV • Dissemination of best practices in training
SDHT	<ul style="list-style-type: none"> • Support towards enhancing a better understanding of CHPS implementation • Dissemination of best practices in training • Support towards enhancing the administration of the referral system • Support towards establishing FSV implementation system and developing tools for FSV • Supporting the implementation of FSV

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

The administrative structure of the GHS in regard to the CHPS assigned responsibility over planning and monitoring the progress of the project, including budgeting and supply of equipment, to the RHMTs. The DHMTs were responsible for the actual frontline service the CHPS provide, making them accountable for the status of the project in each district;

consequently the DHMTs had direct supervisory responsibility over the SDHTs. Within that regional administrative framework, the SDHTs supervised the CHOs, in part to alleviate the responsibilities of the DHMTs (Republic of Ghana et al. 2010, 33-34). The FSV could therefore be seen as a cascading system of supervision, which enabled a methodical process of supervision from the top to the bottom of the administrative hierarchy. Most importantly, the FSV as a network of managerial supervision was seen as critical to the matrix of the project, based on the assessment that ‘the success of the CHPS approach to Primary Health Care (PHC) delivery largely depends on [effective] supervision’ (Aikins et al. 2013, 1), which was derived from the awareness that ‘supervision as a measure to manage CHPS implementation was insufficient among personnel’ of the GHS (Republic of Ghana et al. 2010, 5).

The FSV is seen as ‘a major component of continuous quality improvement (QI) in health services’, which ‘helps supervisors at all levels in an institution focus on the needs of the staff they oversee, and to assist supervisors to consider their supervisees as their customers rather than as their subordinates.’ In its essence, the ‘approach emphasizes mentoring, joint problem solving, and two-way communication between a supervisor and those being supervised.’ (Facilitative Supervision Handbook 2001) For our purposes, it amounted to a cascading process of capacity building, starting with the RHMTs, who should then transfer the updated tools of engagement to the DHMTs through systematic training and supervision. The process continued with the DHMTs applying and implementing the same method of training and supervision to the teams below it within the bureaucratic structure, the SDHTs, whose responsibility was to supervise the CHOs. To operationalise the strategy the project devised its own manuals and tools, which among other things were designed to standardise the methods and procedures of the FSV (Republic of Ghana et al. 2010, 21, 30-31).

The discussion below about the FVS procedures within the agencies dwells at length on the study by Moses Aikins et al. to highlight the details of the cascading content and the dynamics of the strategy. The study confirms that guidelines and tools for the implementation

of FSV were designed to train RHMTs, DHMTs, SDHTs and CHOs, in that order. Thus, the process began with an in-house monitoring of the RHMT, which comprises of four main units (Public Health, Clinical Care, Health Administration and Support Services), and the Office of the Regional Health Director. The four units are 'responsible for strategic planning, resource mobilization and distribution, training, technical support, monitoring and evaluation of service delivery in the districts.' The self-monitoring exercise, which took place four times a year, kicked off with an assessment of the RHMT by a team of supervisors, followed immediately by the submission of a report of the findings. The process continued with an analysis of the data by the Health Information Office (HIO), followed by 'report writing' by the supervisors based on the analysed data, and finally reporting to the Regional Director of Health Services at the RHMT meetings, which takes place once a month.

This intra-agency supervision led to the next stages of top-down inter-agency monitoring, starting with FSV of DHMTs by RHMTs, the account of which provided by Aikins et al. (2013) is insightful indeed. The authors identify five stages in the process that occurred once every four months, as follows: Facilitative supervision over the DHMT was conducted quarterly by the RHMT Supervisory Team, which was immediately followed by a Supervisory Report submitted to the RDHS. The Regional Health Information Officer (HIO) then analysed the accumulated data and presented it in tabular form. On the strength of that, the Supervisory Team would write up an analysis report for each district in the following month, and an integrated report for all the districts every six months. A team report would be submitted to the RHMT/RDHS at the monthly RHMT meeting, following which, in the final stage of the process, feedback would be given to each district the following month, and to all districts during the half-year and annual review meeting, through presentations by the RHMT.

In tune with the cascading order of the process as shown in Figure 3, the next stage was the application of FSV by the DHMT over the SDHT, which also occurred quarterly and '...involve[d]: a) Supervision by the DHMT Supervisory Team; b) Submission of Monitoring

Sheets and Supervisory Report to the District Director of Health Services (DDHS), which was done immediately. This [was] followed by, c) Data analysis (in tabular form) by the Health Information Unit; d) Report writing (Analysis report) by the Supervisory team; e) Feedback to the SDHT in two forms: the Monthly Analysis Report for each individual CHPS zone; and an integrated analysis report for all CHPS zones presented at the monthly CHPS Review meetings, and also at Quarterly Review meetings through presentation; and f) Submission of copies of Analysis Report to RHMT on the 15th day of every month through the DHMT.’ (Aikins et. al. 2013) Following the supervision by the DHMT, the monitoring sheet and supervisory report were immediately submitted to the DDHS, and the data was analysed by the District Health Information Officer (DHIO) and collapsed into a tabular format. The feedback analysis report was then submitted through a presentation to each SDHT by the supervisory team at the following month’s FSV, and to all SDHTs (integrated) during the monthly CHO review meeting or quarterly review meeting. Concurrently, copies of the analysis report were submitted to the RHMT by the DHMT on the fifteenth of every month.

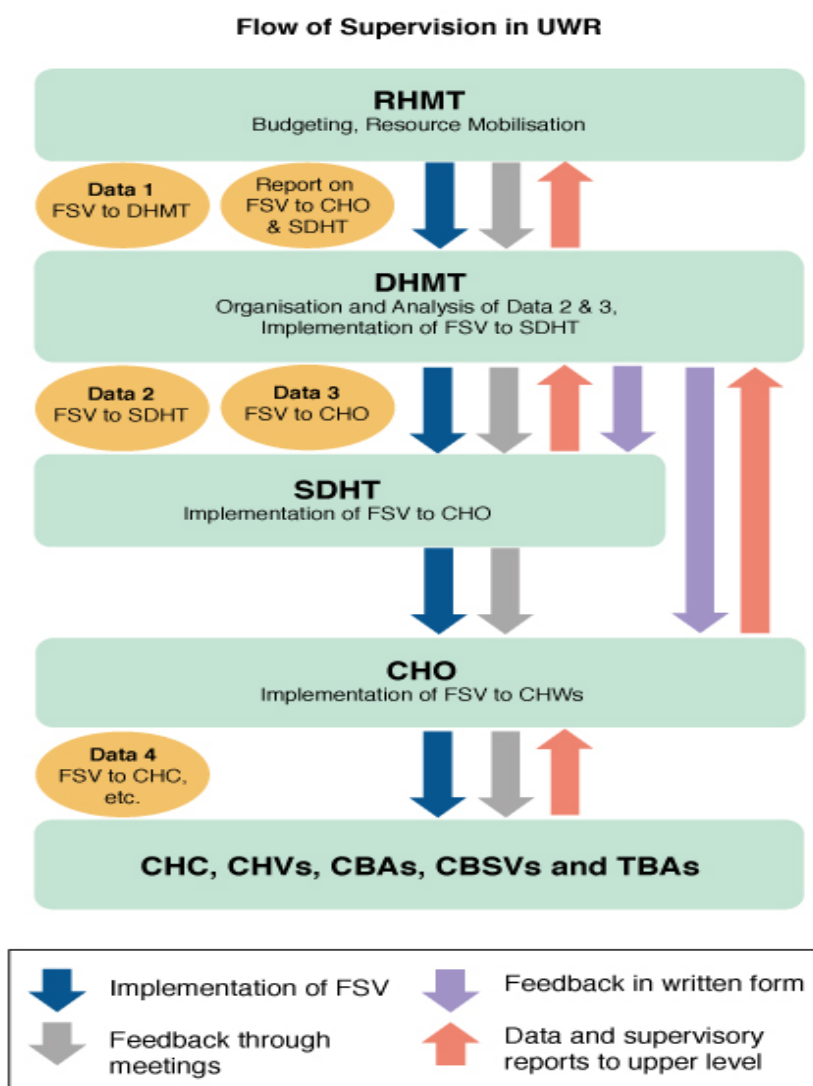


Figure 3. Flow of Supervision in UWR

Source: Adapted from Republic of Ghana et al. 2010 p. 32.

The specific areas involved in the FSV assessment of the SDHT by the DHMT were: timely submission of supplies; management of supplies; transport and equipment; information management; technical support; and referrals procedure. The final stage of the process involved the supervision of the CHO by the SDHT, which was conducted once a month, and followed by the submission of copies of the monitoring sheet and the supervisory report to the relevant DHMT staff member on the fifth of the month.

Following the data analysis by the DHIO, the supervisory team at the DHMT would write up the analysis report, on the basis of which feedback was constructed and given to each CHO at the following month's FSV. In addition, 'feedback is given to all CHO during [the] monthly CHPS review... and quarterly review meetings,' and the DHMT would also provide a report of the process to the RHMT on the fifteenth of every month. This supervisory process was replicated across all eleven districts of the region.

The FSV assessment of CHOs by SDHTs focused on the following areas:

- Condition of the CHPS compound (particularly in regard to: a) Basic facilities; b) Organisation of the rooms in the CHPS compound; and c) Organisation of documents, with filing being of immense importance);
- Reporting and Documentation, which dealt with questions about: a) Written reports to the SDHT; b) Statistical reports; c) Logistics documentation (checking tally cards, ledger books, requisitions, motorcycle logbooks); and d) Programme-based activities, which were assessed in the following areas: i) Health Promotion; and ii) Home visits.
- Reproductive health was also assessed in a number of areas, including: i) Immunisation; ii) Child welfare clinics; and iii) Morbidity (concerning malaria, diarrhea etc.).

Consultations about family planning, community-based surveillance, and HIV/Aids were also components of the assessment procedure. Other areas of assessment were referrals, equipment and supplies, and medical supplies and consumables. Improving the leadership skills of CHOs was also seen as a major challenge and a priority, to assist them to handle their relations with the community more efficiently.

Aikins et al. believe that FSV is an approach with the potential to significantly impact and improve quality healthcare services, not only in the UWR but in Ghana as a whole because, as demonstrated in Table 3, the FSV implementation within the project showed

positive outcomes in terms of job performance, although apparently lack of data about FSV from the SDHT to the CHO problematises the score, since for 2008-2009 the outcomes were less than impressive. It is also fair to assume that JICA's application of FSV as a method of capacity building concentrating on the health administrators and percolating down to the CHOs underlines the fact that the state institutions 'bear the responsibility to ensure that the primary healthcare service functions' effectively (Aikins et al. 2013, 4), and that their weaknesses, if not remedied, would undermine the healthcare system and stunt the scaling up and advancement of the CHPS project nationally.

Despite the FSV's supposed de-emphasis on hierarchy, a strategy that claims to support a non-binary relationship between the supervisor and the supervisee, the process as discussed above reflects what Foucault refers to, in the context of 'administrative control', 'as an art of correct training' (Foucault 1980, 170, 170-194), which evokes the concept of 'disciplinary power', the chief function of which is to 'train' (Paul Rabinow 1986, 118-205) the relevant staff by infusing them with 'correct training'. As a mechanism of power it links forces together through its measures of training in order to multiply their capabilities. The success of 'disciplinary power' is dependent on the application of the following instruments: hierarchical observation, normalising judgement, and examination. These will take place in organised space (architecture), during regulated times (timetable) and involving certain behaviours. This regime of discipline is reminiscent of the 'processing' of the peasantry into the progressive and aspirational machinery of the middle-class. We will continue this discussion about 'disciplinary power' in the domain of medicine in our observations below. Suffice to say, since among health workers in Ghana 'deficiencies in technical skills [are] widespread,' 'the quality of clinical care [is] substandard,' and 'total performance scores for all clinics remained well below the highest possible scores,' a problem that is exacerbated by the endemic practice of absenteeism among medical officers (Karima Saleh 2013, 59), the method of instilling a disciplinary practice through FSV as described above is imperative.

Table 3. Achievement of Project Purpose and Overall Goal of the CHPS project

Aim	Indicators	Results		
Project Purpose: To Strengthen the institutional capacity of GHS for CHPS implementation in the UWR	Performance of health personnel according to performance standards (PS) for RHMTs, DHMTs, SDHTs	FSV Implementation Rate		
		Target FSV	At the time of Terminal Evaluation (2009)	At the time of Ex-post Evaluation (March 2012)
		RHMT to DHMT	n/a	97.2%
		DHMT to SDHT	10.9% (2008) ⇐⇒ 56.7% (2009)	69.8%
		SDHT to CHO	7.5% (2008) ⇐⇒ 23.7% (2009)	n/a
		CHO to Community Health Volunteer (CHV)	52.5%	

Source: Adapted from JICA (Ghana), Internal Ex-post Evaluation for Technical Cooperation Project, March 2014.

Meanwhile, the indications are that apart from improving capacity of the staff in charge of health provision in the UWR, JICA's role in the scaling up of the CHPS implementation in the region also resulted in an increase in the coverage of the project from 24 CHPS zones in 2006 when JICA became involved in the initiative to 81 zones by 2009, 12% and 41% respectively of the target of 197 zones. Three years after the completion of the project in 2010, the Ex-post Evaluation, as evident in Table 4 shows a further expansion to 166 zones, which is 84% of the target. Moreover, in 2012,¹¹ through a separate grant, Japan agreed to assist Ghana in the construction of 73 CHPS compounds in the UWR by 2015.

Table 4. Increase in the number of functional CHPS zones

Items	Project Commencement 2006	Terminal evaluation 2009	Ex-post evaluation, 2013	Target for 2015
No. of functional CHPS zones	26	81	166	197

Source: Modified from JICA (Ghana), Internal Ex-post Evaluation for Technical Cooperation Project, March 2014.

¹¹ 'Ghana and Japan sign two Agreements,' *Business News Today*, 17 May 2012.

5. The Power of Discipline in the Domain of Medicine

The above discussion takes its cue from Michel Foucault's (1980) conception of 'disease as a political and economic problem'. Thus the problem of the sickness of the poor as discussed above is also framed in relation to the imperatives of labour and the needs of production, which society 'must seek to resolve as a matter of overall policy' (Foucault 1980).

In *The Birth of the Clinic* (1973), Foucault explores the historical development of the institution of medicine by critically assessing the contexts that define the role of the clinic in the 'organisation of a politics of health', which was about 'the consideration of disease as a political and economic problem' for society as a matter of government policy. Consequently medicine as a general technique of health, even more than as a service to the sick or an art of cure, assumed an increasingly important place in the administrative system and the machinery of state power (Foucault 1980, 177). This suggests that the configuration of the technology of power behind the construction of the institutions of health and medicine was fuelled in part by a need to heal the sick because of the upsurge of interest in 'distributing the living in the domain of value and utility' (Foucault 1990). The indigent were cured for productive purposes, and in tandem, the 'sick poor' were bundled into the clinics to be 'relieved' of their illnesses as part of the decomposition of the traditional notion of poverty (Bynum et al. 2006).

In his conception of 'noso-politics' Foucault discusses the inception and operations of the institutional structures that empower the state to intervene, through the medium of clinical experience, in the lives of its citizens by opening up 'the concrete individual to the language of rationality' (Foucault 1973, xiv). To put it differently, 'the best way of avoiding the propagation of disease is to spread medical knowledge' by means of a generalised medical consciousness, 'diffused in space and time, open and mobile, linked to each individual existence, as well as to the collective life of the [community]' (Foucault 1973, 31). In that regard, as our study also reveals, 'medical space ...coincides with social space [and] traverses

it and wholly penetrates it' (Foucault 1973, 31). The CHPS strategy, and more directly the role of the CHOs, who are trained to alert members of the community to the intrinsic value of modern healthcare, is indicative of this interventionist strategy. In essence, functional and efficient healthcare service demands medical practitioners whose responsibilities include the task of '... teaching individuals the basic rules of hygiene which they must respect for the sake of their own health and that of others' (Foucault 1980, 176), if only because 'the imperative of health [is] at once [conceived as] the duty of each person and the objective of all' (Foucault, 1980, 170).

Within that configuration, the first task of medical practitioners, as Foucault suggests, is political (Foucault 1973, 33) insofar as the struggle against disease must begin with a war against bad government (Foucault 1973, 33), suggesting 'a spontaneous and deeply rooted convergence between the requirements of *political ideology* and those of *medical technology*' (Foucault 1973, 38). Indeed, the policing of the medical health of the collective as a component of 'noso-politics' was legitimised (Foucault 1980, 171) on the basis of ideology as 'a theory of the social composition of interests' enshrined in 'a doctrine of contracts and the regulated formation of the social body' (Foucault 1990, 140). Thus, the ultimate objectives of medical practitioners on the one hand, and those of the state on the other, are not in conflict, since their respective objectives revolve around the identification of the problem of sickness among the poor in its economic specificity (Foucault 1980, 171). In essence, the economic management of the population, including its biological traits, is at the core of the medicalisation of society as part of the 'explosion of numerous and diverse techniques for the subjugation of bodies and the control of population' (Foucault 1990, 140). As we have attempted to demonstrate above, CHPS functions within this same historical understanding of the importance of the institutionalisation of healthcare within which administrative discipline is paramount.

Given this utilitarian agenda for the uses of medical health, the problem of children in the context of medicine is no longer merely about ‘...their number at birth and the relation of births to mortalities’, but is as much about ‘survival to adulthood, the physical and economic conditions of this survival, the necessary and sufficient amount of investment for the period of child development to become useful’ (Foucault 1980, 172). Consequently, ‘it [is] no longer just a matter of producing an optimum number of children, but one of the correct management of this age of life’ (Foucault 1980, 172). In that sense, it is a matter of expediting health, as ‘the health and physical well-being of populations [has come] to figure as a political objective which the police of the social body must ensure along with those of economic regulation and the needs of order’ (Foucault 1980, 171). This has engendered what Foucault refers to as ‘a medical police’, ‘ordained’, as it were, to impose its constraints and dispense its services, ensuring not only the subjection of the ‘body’ but the constant increase of its utility (Foucault 1980, 172).

This symbiotic relationship between medicine and politics (‘noso-politics’) as is evident in the CHPS initiative in the Upper West Region, reveals two main characteristics:

1. The privileging of the child and the medicalisation of the family. Within that construct is the organisation of the family, which prioritises ‘the health of the child [as] one of the family’s most demanding objectives’ (Foucault 1980, 173); and
2. The privileging of hygiene and the function of medicine as an instance of social control, enabling the state to assume authorial interventions and control in matters of medical health (Foucault 1980, 175).

In his seminal work *The Policing of Families*, Jacques Donzelot (1979, 188) provides detailed insights into how the privacy of the family was prevailed upon as a result of the development and expansion of the medical system, making it possible for the state to intervene in the familial haven by means of its ingenious application of the power made available to it

through healthcare. Donzelot draws an intricate picture of how medicine was used as a general technique of health in eighteenth century France to co-opt the unsuspecting family into ‘the administrative system and machinery of power’, while at the same time confirming the ‘sacred’ position of the doctor in ‘the different instances of social power’ (Donzelot 1979, 176). Thus the state’s responsibility to improve the social body and maintain it in a permanent state of health provided it with, as Foucault would put it, a ‘surplus of power’.

More specifically, Donzelot (1979, 18) examines the evolving dynamics of the medicalisation of the family, and shows how the organic links between doctor and family were to have profound influence on the latter, leading to its reorganisation in at least two directions:

1. The closing up of the family against the negative influences of the older educative milieu, and against the methods and prejudices of domestic servants (and the extended family); and
2. The making of a privileged alliance between the doctor and the mother, favouring the advancement of women by virtue of the recognition of their educative usefulness in the advancement of medicine and healthcare.

The configuration of CHPS also confirms the supreme importance of the mother, starting of course with matters relating to family planning, childbirth, and childcare, all of which are dependent on the well-being of the mother. As Philip Baba Adongo et al. (2013, 2) confirm in relation to the CHPS, most family planning programmes have viewed men as an obstacle to women’s ability to control their reproductive rights; thus the programmes are designed to ‘focus entirely on women...’ if only to reduce maternal and child mortality. Moreover, through the initiatives of the project (with its objective of instituting the norms and practices of modern medicine) it is assumed that the communities undergoing the CHPS strategy would be able to interrogate the negative influences of traditional healing practices (prevalent in Ghana) and reject them accordingly. Ultimately, the initiative ‘to raise the level of

health of the social body as a whole' in the UWR effectively amounts to aiding the community to achieve better health outcomes through 'administrative control'.

6. Conclusion

The object of CHPS is to link medicine by means of the GHS with the rural areas of Ghana more systematically and efficiently. Thus, the CHPS project, as discussed above, is about creating a sustainable primary healthcare system to provide better healthcare to all segments of the Ghanaian population. The focus of this study has been on JICA's attempts to streamline the management of the ancillary agencies of the GHS to maximise the provision of healthcare in the UWR through the CHPS project. Specifically the project entailed the systematic application of FSV to enhance the performance of the RHMT, DHMTs and SDHTs, and by extension the CHOs.

The emphasis on capacity building for the health personnel of these agencies presents a hypothesis, which is that the more capable the health management teams are, the more efficiently and effectively the CHPS project would be able to serve the target population, although this is not tested in this study. Instead, the focus is on JICA's initiative to fine-tune the performance of the health personnel, which implicitly suggests, from JICA's perspective, that a lack of resources in itself does not justify the poverty of healthcare delivery in the UWR, and in Ghana in general. It further implies that the deficiencies in healthcare delivery are perhaps more attributable to government policies that lack commitment and urgency, and programmes run by health officials without the requisite skills to do their jobs efficiently. The struggle against disease must thus begin with a war against bad government, as Foucault might say, and administrative discipline through 'the means of correct training' is one proposed panacea.

The point to stress here is that while the application of FSV to the management teams down to the CHOs might have been designed to reshape healthcare delivery in the UWR, the initiative further strengthened the power apparatus of the state, ultimately furnishing it with tremendous privileges over ‘the state of health of a population as a general objective of policy’. Based on Foucault’s conception of ‘noso-politics’, the state’s concern with the health of the population is dictated by its own interests in the functioning of the political economy of the country. In that regard, the scaling up of CHPS in the UWR should be considered in the context of the ‘...utilitarian decomposition of poverty’, that is, in how ‘the specific problem of the sickness of the poor begins to figure in the relationship of the imperatives of labour to the needs of production’ (Foucault 1980, 169). Essentially, the study has attempted to assess how CHPS feeds into the wider objectives of Ghana’s political economy. How this can be achieved in the context of post-colonial economic development is in part the focus of this research.

The analysis implicitly reveals a contestation about development models between, on the one hand, the perennial neoliberal attempt to disenfranchise the state from its responsibilities in development, and, on the other, Japan’s historical belief in the state’s role in the processes of development. Where the neoliberal policies of the 1980s and after, for example Structural Adjustment Policies and market liberalising principles, aimed to constrain the state, there seems to have been an attempt, through the initiative of the Japanese economic assistance towards the CHPS project, to bring the state back in, unavoidably alluding to the Washington-Tokyo controversy of the late 1980s and early 1990s over development models. Robert Wade (1996); Yong Wook Lee (2008); and Rei Taniguchi and Sarah Baab (2009) explore how the Ministry of Finance (MOF) and its agency the Overseas Economic Cooperation Fund (OECF), predecessor of JICA, rallied in the late 1980s to defend the Japan-led East Asian model of economic development (with its emphasis on state intervention in the process of economic development, such as through tariffs, subsidies, industrial policy, administrative guidance, among others) against the onslaught of the US-led neoliberal

economic model orchestrated by the IMF and the World Bank, culminating in the latter's less than enthusiastic publication of *The East Asian Miracle: Economic Growth and Public Policy* in 1993.

The form of state intervention as exemplified in the measures for capacity building in regards to the CHPS resonates with Foucault's conception of 'administrative control'- through the means of correct training- and underscores the role of the state in the development of the clinic, which invariably deviates from the neoliberal policies of the IMF that were designed to weaken the state's role in the advancement of the political economy of the country.

The CHPS project may also be assessed in the context of the TICAD, initiated in 1993 by the Government of Japan to reformulate and energise Japan's relations with Africa in the aftermath of the Cold War, with the view to providing more sophisticated and integrated forms of economic assistance to African countries. At TICAD's fifth summit, TICAD V, in 2013, the African Business Education (ABE) Initiative for Youth was launched by the Japanese government 'in recognition of the 'need for human resource development in both private and public sectors of Africa'. In relation to that, the Government of Japan is offering, through the Japanese Grant Aid for Human Resource Development Scholarship Programme, funding to Ghanaian government workers (excluding those in the military) to study in Japan for a Master's degree, including modules to help 'strengthen capacities for implementing health policies'. The target candidates for the latter course are, not surprisingly, employees of the MOH and GHS and their ancillary agencies¹² in tune with the Nairobi Declaration adopted at TICAD VI, 2016.

¹² Japanese Grant Aid for Human Resource Development Scholarship, Ghana, <http://www.jds21.com/en/ghana/>. Accessed 26 December 2015.

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Abstract (in Japanese)

要約

本論文は、ガーナ政府のプライマリーヘルスケアの普及に関する国家戦略である駐在地域保健師による基本的保健医療サービス（Community-Based health Planning and Services: CHPS）への日本の貢献について分析したものである。今後の CHPS 戦略の展開に向けた政策を引き出し、そしてガーナアッパーウェスト州内での CHPS のスケールアップにおける国際協力機構（JICA）の果たした役割を浮き彫りにする議論を展開している。JICA の狙いは、現場に即したより適切な監理が実施できる支援型監督指導（Facilitative Supervision）の適用を通じて、地域での医療制度の運用を改善・強化することを第一目的としたアッパーウェスト州における保健行政官の能力改善・強化であったことがこの分析において導き出されている。また、ミシェル・フーコーの「行政管理」と「非政治」の概念を通じて、FSV アプローチを進めるにあたり、地域での医療サービス改善において国家の役割がより重要である点についても触れている。