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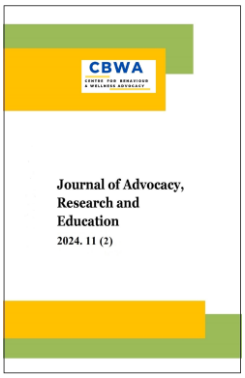

Capacity Building in Ghana's Decentralised Health System: A Qualitative Study

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Abstract

Capacity building is a crucial management tool used to enhance and sharpen the competencies of staff in health facilities. The core objective of this study is to assess how health performance in decentralised health systems can improve through capacity building. The study adopted a descriptive-exploratory design with a qualitative approach. A semi-structured interview guide is the primary tool for data collection in this study. The purposeful sampling technique was used to sample eight respondents from selected hospitals in Accra, Ghana. A one-to-one interview process was conducted, and sampling continued until saturation was reached. Thematic content analysis is the method employed for data analysis. The results of the study showed that though Ghana's health system is implementing the decentralisation reform, to some extent, some core functions like human resources, procurement, logistics, and recruitment are still centralised, with the majority of the actions taken at the top management level. Again, capacity building is reported to be carried out in all health facilities, but in some cases, the frequency with which they are organised is the issue, as sometimes they are initiated by the specific department and not by the organisation. All respondents were of the view that the more capacity-building programs are organised, the greater the chance of increased performance as accountability is improved.

Keywords: Decentralisation, Decision Space, Capacity Building, Health.

1. Introduction

Most health system strengthening and implementation surveys agree that building capacity is crucial for any policy to work effectively (Abor, 2013; Bossert et al., 2015; Crisp et al., 2014). Capacity relates to the talent mix, skills, know-how, and institutional capacities, which involve financing, administrative practices, and information and logistics arrangements, among others. Literature from developing countries suggests that strengthening management and leadership skills, such as setting priorities and problem-solving abilities, could be significant in improving the performance of healthcare organisations and health systems more generally (Bossert et al., 2015; Sakyi et al., 2011).

Capacity building through human capital development is essential for the workforce capability of any sector, and thus, health officials should be equipped with the necessary skills through periodic in-service training and adequate resources (Boohene, Amita, 2017a; Boohene, Amita, 2017b). This will foster a positive environment for nurse education and the implementation of performance execution practices (Barnes, Boohene, 2024). Specifically, in the health sector,

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it has become fundamental to the development of health systems, particularly in low-income countries. For better health outcomes, organisations are required to invest financial resources and ensure sufficient local capacity to utilise those resources effectively. One way to enhance the effective allocation of resources is to roll out a decentralised governance system.

The concept of decentralisation dates back to the period before Ghana attained its independence in 1957. Frantic efforts were, however, made in the post-independence era to institutionalise decentralisation as the preferred governance strategy, which led to the promulgation of the Local Government Act, Act 54 (1961). The Local Government Act 54 (1961) was built on the foundation of ordinances that sought to establish towns and municipalities, sustained peculiarity amongst local government and central government arrangements and operated dual hierarchical structures in parallel with central government structures (Atkinson, Haran, 2004; Sumah, Baatiema, 2018).

The health sector at the local levels is accorded delegated authority from the Ministry of Health to the Ghana Health Service (GHS) and Teaching hospitals, resulting in a deconcentrated Ghana Health Service as enshrined in ACT 525. This has influenced the creation of Ghana Health Service at the national, regional, district and sub-district levels, resulting in a 5-tier (national, regional, district, sub-district, and community-based health planning and services zones) control structure as is evident in the existing practice in the GHS. The variation in the forms of decentralisation exercised by the political local government system and the health sector has generated a mixed model of both devolution and deconcentration, leading to unclear and, in some cases, opposing transformation efforts (Abimbola et al., 2015; Diana et al., 2015; Sumah et al., 2016; Liu et al., 2006).

Thus, the issue of capacity building in the health system, which has the propensity to enhance healthcare delivery at the local level, has not received much attention and focus from researchers, thereby creating a literature gap in the case of Ghana. This study aims to examine the effects of capacity building at the decentralised level on health system performance using selected health facilities in the Greater Accra Region of Ghana.

2. Theoretical Framework

The concept of decentralisation is an ideology that has been adopted by Ghana and advocated over the years. The concept is extended to all parts and sectors of the Ghanaian economy. This study adopted and applied the decision space framework to discuss the various aspects of capacity building in the decentralised health system. A model of the relationships adopted by Bossert et al. (2015), as shown in Figure 1, indicates that there are different measures for evaluating the performance of a health system. Bossert et al. suggest a complex set of objectives, including ultimate objectives of improved health status, citizen satisfaction with the services, and financial protection to cover costs of care. These objectives all contain an equity concern. Intermediate objectives of improved access, efficiency, and quality of services are also considered performance measures that, in empirical studies, have been found to be related to the ultimate objectives (Bossert et al., 2015).

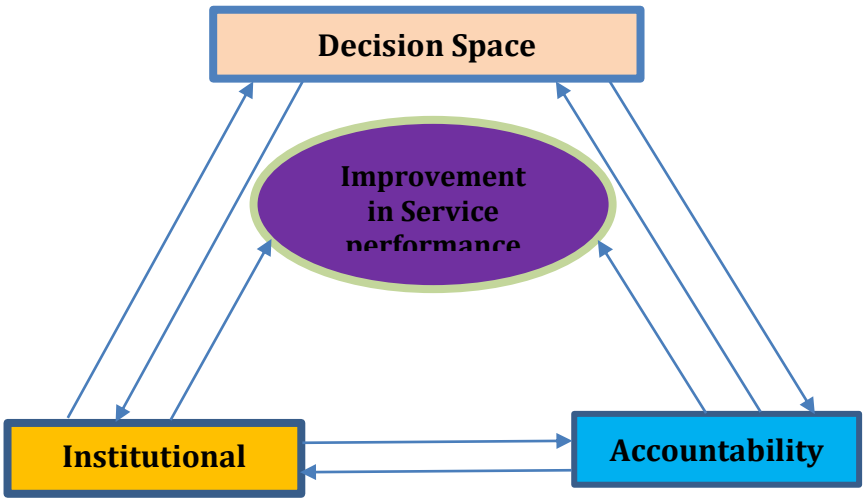

Fig. 1. Decision Space Analysis Framework
Source: Bossert et al. (2015)

2. Method and Materials

Approach and Design

The study adopted a descriptive-explorative design with a qualitative approach. Qualitative research is a research approach that enables the researcher to explore and understand the sense of a group of individuals' attributes to a societal issue and rely on the fact that human experience is the way knowledge about human beings can be described. This is described, lived, and defined by the individuals involved (Schneider, Whitehead, 2016).

Sampling and Sampling Procedure

The study was conducted in four organisations under the public health sector of the Ghana Health System; due to the bounded nature of this study, facilities are given coded names. Specifically HA, HB, HC and HD. The purposeful sampling method was employed to recruit eight respondents from the selected organisations. Four respondents were drawn from the Korle-Bu Teaching Hospital, specifically from the sub-BMCs (Budget Management Centers), namely the Obstetrics and Gynecology (O&G) Department, the Orthopaedic and Trauma Unit, and the National Reconstruction and Burns Units. Two of the remaining four respondents were drawn from the Accra Regional Hospital and two from the Police Hospital and Catholic Hospital. These were either administrators, heads of departments, or directors with at least three years experience in their current role as the study explored the extent of decentralisation and the role of capacity building in improving the performance of the health system in Ghana, and such respondents could offer detailed accounts and in-depth information about the subject matter based on their experience.

Data Collection Tool and Procedure

One–on–one interviews by means of a semi-structured interview guide, which was designed based on the objectives of the study, was used for the data collection. The tool was structured in three sections. The first section, Section A, explored the demographic data of respondents, and Section B assessed the concept and levels of decentralisation and decision-making in resources management, such as finance, service organisation, human resources, and governance. The third part, Section C, focused on capacity building, such as training and development, as well as logistics and infrastructure. The interview was conducted at the convenience of the respondents. This method of data collection was deemed more suitable for this study as it offered respondents the chance to express their opinion about the concept freely and also enabled the researcher to probe further for clarifications and to gain in-depth knowledge of the phenomenon (Creswell et al., 2007; Sarfo et al., 2021). Interviewees were made aware of the fact that the interviews were being recorded, and they were further assured of anonymity after the purpose of the study had been explained. Their consent to engage and participate in the study was sought after, and a day was scheduled for the interview. The study was conducted from September 2020 to October 2022.

Data Analysis

Data was analysed using thematic content analysis. Audio-recorded interviews were in English and transcribed verbatim by the researcher. Audio-recorded interviews were transcribed verbatim, and transcripts were read over again to ensure the researcher familiarised herself with the data, and thereafter, coding and generation of themes were done (Creswell et al., 2007).

3. Results

Based on the information in Table 1, eight respondents were recruited from four hospitals, coded as HA, HB, HC, and HD for anonymity. The respondents are labelled individually and numbered from 1 to 8. Respondents 1 to 4 were from HA, a teaching hospital, with 18 years, four years, 18 years, and four years of experience in their respective roles and departments. Respondents 5 and 6 were from HB, with 6 and 20 years of experience, respectively. Respondent 7 was from HC, identified as the Police Hospital, and had 20 years of experience. Respondent 8 was from HD, identified as Catholic Hospital, and had ten years of experience. The variety of highly experienced and moderately experienced professionals across various departments in different facilities added depth and richness to the study.

Table 1. Demographic Summary

Hospital	Department	Role	Years of Experience	Interviewee
HA	Nursing Administration	Director Nursing Services	18	1
	National Plastics & Burns,	Administrator	4	2
	Maternity Unit and Obstetric, Gynaecological Theatre	Head of Department	18	3
		Medical Director	4	4
HB	General Administration	Hospital Administrator	6	5
	Human Resource Department	Deputy Director	20	6
HC	Maternity Unit and Obstetric	Specialist	20	7
HD	Gynaecological theatre	Medical Doctor	10	8

Source: Field Data 2022

Concept and Current State of Decentralisation

To answer the first research question about the current state of decentralisation of the health system in Ghana, three major themes emerged from the data collected. Respondents described their understanding of decentralisation and the current state by defining decentralisation from their perspective and outlining the levels of decentralisation. They also detailed the decision space of staff concerning financial autonomy and human resource (HR) decisions. Additionally, respondents discussed leadership, governance, and accountability, highlighting the bureaucracies and lines of authority within the organisation.

Understanding of Decentralisation

Respondents understood the concept of decentralisation and provided definitions from their perspectives, using their hospital structure as examples. A common understanding that emerged was the notion of power being devolved to the operational or local levels, allowing them to make their own decisions regarding the management of their unit or facility:

*"Decentralisation is the transfer of power from the centre to the periphery". "You know transfer, so you have the power to plan your department and manage your budget, etc." (**Interviewee 1**).*

*"Decentralisation is the health sector, which is the process of shifting various administrative and service functions from a central location to regional, district, and sub-district levels, thereby improving efficiency and bringing healthcare services closer to the community." (**Interviewee 7**).*

Levels of Decentralisation

Knowledge about the level of decentralisation elicited varied responses. Some respondents felt that their level of decentralisation was sufficient and an improvement over the previous level. However, others believed that while their health system was decentralised to some extent, certain major aspects remained centralised to maintain consistent standards.

*"Yes, it is decentralised enough that we are able to do the basic planning for the facilities. We cannot handle infrastructure provision, facilities cannot put up hospitals themselves, and in terms of HR, certain functions cannot be decentralised, like training needs. If decentralised, you can have differentiation in standards". (**Interviewee 6**).*

*"Not enough; there is still some aspect of centralisation; this facility does not follow the typical Ghanaian health system." (**Interviewee 7**).*

Decision Space

Regarding the level of decision-making space, which addresses the second research question, staff are allowed in their respective hospitals, based on indicators such as finance, service organisation

and human resources, as well as leadership and governance, the study revealed variability depending on the facility and type of decision involved. Some simple decisions are made at the facility or sub-BMC level, with reports submitted afterwards. However, major decisions, such as procurement, require approval from top management or headquarters as per established protocol:

Level of Human Resource Decision-Making

The Interviewee highlights the challenges of operating in a restrictive environment where significant decisions must be authorised by headquarters, limiting local autonomy. This includes issues with recruitment, selection, training, and other human resource activities, where local input is minimal, impacting the efficiency and effectiveness of healthcare service delivery.

*"The way this system is structured, it doesn't follow the typical Ghana Health Service, and it is a restrictive environment. We do not have full autonomy; headquarters must authorise everything you do, so it makes the autonomy half. So when you want to make decisions based on your health background, they do not understand it that way, and they will not take it that way, especially in terms of recruitment, selection, training, and human resource activities; we don't have the latitude". (**Interviewee 7**).*

The above response was further buttressed by other respondents who indicated that:

*"Let's take appointments. The bureaucratic process required to appoint senior officers highlights the need for regional approval and multiple levels of justification. Despite decentralisation, significant bureaucratic obstacles remain, particularly for higher-level appointments, while casual appointments face fewer restrictions but still require oversight". (**Interviewee 5**).*

Financial autonomy

The respondent lamented that, in terms of autonomy and decision-making, the hospital solely manages revenue generation, but there are limitations regarding salaries, which are controlled by the government. This necessitates financial clearance before employing any staff, especially senior-level staff, thus limiting the workforce in terms of numbers. Contract staff are paid from the hospital's Internally Generated Funds (IGFs). Additionally, procurement processes and budget approvals for expenditures remain centralised.

*Revenue generation: We generate a lot, but there is a limit to what we do with our money, such as how much you can spend as a facility. Money goes to designated accounts. For instance, there are general accounts, pharmacy accounts, and procurement accounts. Still, the level of control is minimal. In terms of expenditure, if HR wants to spend some money internally, you come up with a budget approved by my immediate supervisor, who is the administrator, and the Medical Director, who is the final authority. The amount will be released, but if it has to do with employment at senior levels and a certain amount of money, then the Director has to confirm that with the Regional Director for auditing purposes***. (Interviewee 5).**

*"The government generally pays salaries for staff, but those on contract and some officers are paid from Internally Generated Funds (IGF), with spending limits in place. For hiring, approvals are needed for contract duration and payment amounts. Government-paid staff require a complex process for financial clearance involving regional offices, IPPD, and finance, which can delay payment and lead to complaints despite HR's efforts". (**Interviewee 5**).*

Autonomy in service organisation

*"Though we can plan and organise programs, many are driven by regional or national initiatives. Any new program we propose requires approval from headquarters because of limited funds, which constrains our ability to innovate and initiate new service delivery methods". **(Interviewee 5).***

Leadership, governance and accountability

The theme highlights the existing bureaucracies and lines of authority within the organisation. Respondents note that bureaucratic structures persist, and appointments to certain positions are still controlled by top management and, in some cases, the government. Furthermore, all staff members are accountable to top management through their department heads or managers, who report on activities annually as part of the accountability process. Below are some responses related to this observation.

*"Appointments at the facility level are based on recommendation, but for senior appointments, it is done at the highest level, which is affecting the system and service delivery". (**Interviewee 5**).*

*"The problem has to do with who authorises what you do, when and how. So, the bureaucracy is still there irrespective of the decentralisation. With the award of contracts and procurement, all these go through the Director and then to the authorities. In everything, there is a final approval from the top". (**Interviewee 6**).*

"The Sub-BMC run the hospital at the operational level and reports to the central administration" Interviewee further indicated that the central administration sits there as a supervisory entity or body. *(**Interviewee 4**).*

Institutional Capacity Building

To address the third research question, the study examined the institution's capacity for efficient and effective service delivery. Key thematic areas included capacity building programs and their focus areas, as well as capacity building as a core function of Human Resource Management (HRM).

Capacity Building Programs and Areas of Focus

Respondents classified capacity-building activities as training programs conducted both within and outside the hospital or country. The basic theme that emerged focused on the types, frequency and funding mechanisms for capacity-building programs. In-country and in-organisation programs include in-service training, unit meeting presentations, and workshops organised by companies or institutions that benefit the staff. These workshops may or may not be sponsored by the hospital. Additionally, specialist training based on the hospital's needs assessment is also considered a form of capacity building. The following responses are in line with the theme.

"Yes, it is very key, and we do organise for our staff; we have a clinical meeting every Wednesday, and I view that as capacity building; the nurses also have a program they organise, which is also good; apart from these, I don't know of any other again". **(Interviewee 7).**

The respondent highlighted that while capacity-building efforts exist, they are insufficient and often biased towards nurses due to their higher representation and willingness to share knowledge.

*"Paramedics have received little training over the past four years compared to nurses. Funding constraints also affect training opportunities, with resources being limited and sometimes prioritised for doctors. Currently, some officers are pursuing health administration at GIMPA, but financial limitations restrict the number of people who can be supported. There is a lack of recognition and support for paramedics' training needs, contributing to these challenges". (**Interviewee 5**).*

*"As HR, when we come out with our need's assessment from appraisal and observation, and we come out with our training plan, you realise for nurses' side we don't have a problem, but for paramedics and administrative staff, it requires more money, and when you come up with the budget it is a bit discouraging. I acknowledge the fact that areas like accounting and security need continuous training". (**Interviewee 6**).*

The study respondents discussed various capacity-building activities and their frequency, including those involving functional units and supporting staff. Opinions were mixed; for example, in some facilities, training programs were concentrated on specific professionals, leaving others underserved. Additionally, the extent of capacity building often depended on the facility's characteristics and the level of decentralisation.

*"Capacity building is carried out frequently in the Catholic Hospital to empower participants or staff. "The HR is frequently invited to educate directors and managers on their roles and responsibilities; once they know their roles and responsibilities, you can hold them accountable". (**Interviewee 8**).*

"Plastic surgery, we do a lot of training for our team, our staff, our administration, our doctors and nurses. As I speak with you, one of our doctors is in the UK, London, who is training on breast cosmetics". **(Interviewee 3).**

"Yes, it mostly favours nurses and doctors; the paramedics are out of it, and the administrative staff. At least every department must get at least one training in a year will be the best". **(Interviewee 5).**

Leadership training was cited to be organised for lower, middle and upper-level managers and the hospitals emphasise building teams, most attested that the team approach is the way to enhance service delivery:

*"The last time was several years ago. We haven't had anything like that in a long time; last time, we went to GIMPA for some training, and we were awarded some certificates; I think we were the last batch. Now people build themselves". (**Interviewee 7**).*

The respondent explained that despite initial training, staff may still struggle to perform effectively in their roles. To address this, they provide ongoing support to help general nurses develop specialities within the department, as a respondent cited.

*"For administration, leadership training has been offered to all staff categories. For example, under Bukle's leadership, staff attended a four-day leadership training at GIMPA, followed by additional training at Korle-Bu for nurses, supporting staff, doctors, and other personnel. Currently, strategic planning is also being conducted for staff development". (**Interviewee 1**).*

*Another respondent added that "Health Administration and Management (HAM) programs are organised for health administrators. Initially, these programs were designated for senior nurses who were being considered for positions such as Deputy Director of Nursing Services (DDNS) or Chief Nursing Officers (CNOs), preparing them for these advanced roles. (**Interviewee 3**).*

Capacity building as a core function of Human Resource Management (HRM)

This theme generated sub-themes on capacity-building being a core mandate of HRM, and for that reason, HRM should spearhead the planning, organising, and evaluating capacity-building programs. Most respondents cited that planning programs are done at the top management level and implemented at the operational level; sometimes, when a new program or activity is to be introduced in the hospital then, department heads are briefed on the agenda and the plan of action prior to implantation:

*"Not on a regular basis and as and when something is to be introduced, then facility heads and administrators are engaged before implementation". (**Interviewee 2**).*

*"It depends on the activities, but a planning workshop is done yearly for managers". (**Interviewee 6**).*

In many instances, respondents felt that the Human Resource Department should lead the organisation of workshops for all staff within facilities. They emphasised the need to identify training needs and outline structured program activities regularly to enhance staff capacity. However, some believed this responsibility could be managed at the departmental level, and in cases where there is no HR department, such activities fall to the hospital administrator:

*"Yes, now we have come far, so HR is to lead the process and bring everybody on board. Those days, there were no HR Directorates, and hospitals were doctor-centred, so now that we have HR, they can assess and train in terms of quality and others; this has made the work easier". (**Interviewee 6**).*

*"We don't have a human resource department; we have the administrator, staff officer, and a medical director. The administrator does everything". (**Interviewee 7**).*

Performance is assessed using specific targets, which provide a clear method for measurement and help health facilities achieve their goals effectively. Respondents noted that their facilities have performance targets that are reviewed annually. Some set departmental goals and evaluate them to determine if they have been met, while others view these evaluations as a mere formality with limited benefits:

*"Nothing like performance target for the whole hospital, but departmentally, we submit our program for the year, and nothing comes out of it; it's just a formality, no feedback, and you will wait for a long time, everything comes from the top". (**Interviewee 7**).*

"Yes, we have performance targets and review meetings are organised half yearly and at the end of the year, so we have an annual review every year for every department present. We critique and make recommendations, and we assess progress. GHS, one thing they are trying to do is assign performance contracts, but that is up there, so that the Director General appraises all regional directors, and all regional directors appraise all facility heads, and then it goes down to the operational level. A performance target is assigned to all facilities, and there is an annual review. This year, I can attest that my Director was appraised by region, and we were supposed

*to replicate this here such that he will appraise all his heads, but we haven't been able to do that; we hope it comes to pass. I am pushing that agenda". (**Interviewee 6**).*

*"Yes, we have every unit draw an action plan that is the performance target, and at the end of the year, we check to see if you have been able to achieve them and if you could not meet the target, what were the challenges and how we can help to address it. This has made the hospital what it is today, but there is still room for improvement". (**Interviewee 1**).*

The role of capacity building for improving the health system performance

The above theme generated sub-themes discussing the benefit of capacity building to the organisation and whether they are deriving the full benefit. For most study respondents, their hospital is deriving the full benefit of investing in capacity building and that has improved the performance of the hospital, while others are of the view that not much is being achieved:

*"No, there is more to be gained once we build the capacity of our staff and encourage speciality in all critical areas so one area does not dominate as that will not improve service delivery". (**Interviewee 3**).*

*"The little that has been organised, we have seen the benefit from the work output of staff, and So yes, but more can be done". In contrast, **Interviewee 8** indicated, "Yes, that is the aim and with what we have started definitely it will impact the performance of the hospital as a whole, that we can see that".* (***Interviewee 6***).

Study respondents generally believe that it is worth decentralising the health system in Ghana and building capacity as this would increase efficiency and effectiveness in operations.

*"Yes! If we really decentralise well and the hospital has autonomy in certain issues and reports to headquarters, it will be better, and it will improve service delivery". (**Interviewee 7**).*

"… health still has maintained its decentralisation status. It has made health systems better; we just need an efficient system to manage activities. We have to decentralise fully to minimise some delays and inefficiencies in our health system. In terms of healthcare, each qualification should be at the highest level. There should be clear lines of duties and responsibilities. Why can't a nurse move up to become Medical Director of a facility when we say capacity building? We should make sure we put the right people in the right place rather than allowing doctors to dominate the health sector. How can a doctor manage a transport unit when we have transport officers who can manage affairs? We underutilise our staff. Please stress that capacity building does not mean take others roles and responsibilities as though you can do a better job". (***Interviewee 8***).

Generally, respondents most cited that capacity building in health facilities in Ghana is key to improving the efficiency of health services once all service areas are considered and leadership, as well as staff, are granted some decision space:

*"Capacity-building should be done across the board, but not one professional body dominating and taking other people's roles as though they are better than anyone. Let's get people with the experience and training into the right places, not just because they are medical directors". (**Interviewee 6**).*

*"My advice is that if we build the capacity of all your staff, you're looking at the end, the output, and efficiency. Once the capacity is built, as I said earlier, then you can actually expect much cause you've given out much. So, you can expect a lot once you think you've given a lot to your staff. But if you don't do that and we do our own capacity building, then you can't expect a certain standard from us. I think Korle-Bu should think about improving capacity. (**Interviewee 1**).*

4. Discussion

Concept and Current State of Decentralisation

The study explored the concept and current state of decentralisation within Ghana's health system. Findings suggest a nuanced understanding of decentralisation among respondents, highlighting a shift of power from central to local levels, which theoretically empowers local units to manage their own affairs. Respondents described decentralisation as the process of transferring decision-making authority to regional, district, and sub-district levels to enhance efficiency and bring services closer to the community (Interviewee 1; Interviewee 7). This understanding aligns with the broader literature, which emphasises decentralisation has significant impacts on health sector planning and financial management (Tsofa et al., 2017).

The study evaluated the current state of decentralisation within Ghana's health system and the impact of capacity building on system performance. The findings indicate that Ghana's health system is partially decentralised, with most organisations having moderate autonomy in decision-making related to financing, expenditure, human resources, logistics, and procurement. These results align with Bossert et al. (2015), who noted that Ghana's approach to autonomy is quite limited.

Decision Space

The study revealed variability in decision-making autonomy across facilities. Local staff generally have the authority to make minor decisions related to operational matters, but major decisions, particularly in procurement and human resources, still require approval from higher management or central headquarters (Interviewee 5; Interviewee 7). This centralised control limits the potential for local units to respond swiftly to their unique challenges and needs, impacting overall efficiency and service delivery. This finding is consistent with Bossert's (2015) analysis of how decision space in decentralised systems affects operational efficiency and a study by Chen et al. (2021), who examined whether the decentralisation of health systems leads to a corresponding decentralisation of authority.

For instance, significant human resource decisions, such as recruitment and training, are highly centralised, constraining local autonomy and affecting operational effectiveness (Interviewee 7). Financial autonomy is similarly restricted, with central oversight on salary payments and procurement processes, which complicates the management of internally generated funds and delays in hiring senior staff (Interviewee 5). These constraints echo concerns raised by Cavalieri and Ferrante (2016) about the impact of centralised financial controls on health system performance. Thus, decision space available to local managers in decentralised health systems plays a crucial role in determining operational efficiency. By balancing autonomy with adequate oversight and support, health systems can enhance their responsiveness and effectiveness in meeting the health needs of a population.

Leadership, Governance, and Accountability

The theme of leadership, governance, and accountability highlighted the persistence of bureaucratic structures despite decentralisation. Respondents noted that while local facilities have some operational autonomy, significant appointments and approvals still rest with central management or governmental authorities (Interviewee 5; Interviewee 6). This hierarchical structure creates layers of accountability but also contributes to delays and inefficiencies, as all significant decisions must pass through multiple levels of approval (Interviewee 4; Interviewee 6). This observation supports Faguet's (2014) discussion on how bureaucratic structures can persist even in decentralised systems, affecting governance and accountability.

Institutional Capacity Building

Regarding capacity building, the study identified several key themes: the nature and frequency of capacity-building programs, the focus areas of these programs, and the role of Human Resource Management (HRM) in organising and evaluating these efforts. Capacity-building activities include both in-country and international training programs, workshops, and specialised training based on needs assessments (Interviewee 3; Interviewee 5). However, there are concerns about the adequacy of these programs, with some staff, particularly paramedics, receiving less attention compared to their nursing counterparts (Interviewee 5; Interviewee 6). This is consistent with findings by McCoy et al. (2012) on the disparities in capacity-building efforts across different workforce groups.

Capacity building is recognised as essential for improving service delivery and staff performance, yet challenges remain in ensuring that all staff categories benefit equally from training opportunities. The frequency and focus of capacity-building programs often depend on available resources and facility-specific needs (Interviewee 7; Interviewee 8). This reflects the challenges noted by Robins (2008) regarding the effective implementation of capacity-building programs.

Capacity Building as a Core Function of HRM

Respondents generally agreed that capacity building should be a core function of HRM, with HR departments ideally leading the planning, organisation, and evaluation of training programs (Interviewee 6; Interviewee 7). Despite this, some facilities still rely on administrators to manage these activities due to the absence of dedicated HR departments. Effective capacity building requires a structured approach to identifying training needs, setting program goals, and assessing outcomes, which is often challenging due to resource constraints and the lack of systematic implementation (Interviewee 2; Interviewee 6). This aligns with the observations of the World Health Organization (2006) and Robins (2008) on the critical role of HRM in supporting capacity-building efforts.

Role of Capacity Building in Enhancing Health System Performance

The study confirms that capacity building is crucial for improving health system performance. Effective training programs equip staff with the necessary skills to enhance job performance, which, in turn, positively influences hospital performance and service delivery (Interviewee 1; Interviewee 6). Respondents highlighted that while capacity-building efforts are beneficial, there is a need for ongoing support and structured training programs to realise their potential impact on the health system fully. This supports the broader literature on the importance of continuous capacity building in achieving improved health outcomes (Boohene, Amita 2017a; Leatherman et al., 2010).

5. Conclusion and Recommendations

Capacity building is a fundamental management approach designed to enhance the skills and capabilities of staff within health facilities. This study reveals that while decentralisation has been largely adopted in Ghana's health system, crucial functions such as human resource management, procurement, logistics, and recruitment remain centralised. Despite this, decentralisation has provided health institutions with a substantial degree of autonomy, particularly in financial and human resource decisions. However, bureaucratic constraints and the necessity for top management approval for key decisions continue to be challenged within the current decentralisation framework. Strengthening the capacities of these healthcare institutions through capacity building can improve performance and accountability. To further enhance the efficiency of health services, the study recommends implementing more frequent, extensive, and inclusive capacity-building programs. It is suggested that health facilities and departments develop a comprehensive and ongoing professional development plan that includes all healthcare staff, including administrators and paramedics. Additionally, policymakers are encouraged to create a standardised framework for skill enhancement in the healthcare sector, incorporating regular training sessions and competence assessments.

6. Declarations

Ethics approval and consent to participate

Ethics approval: IRB KBTH/MD/G3/19; Institutional approval: KBTH/MD/G3/2020

Consent for publication

Not applicable.

Availability of data and materials

Please contact the corresponding author for data and materials associated with this study.

Conflict of interest statement

The authors declare that there is no conflict of interest

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References

Abimbola et al., 2015 – *Abimbola, S., Olanipekun, T., Igbokwe, U., Negin, J., Jan, S., Martiniuk, A., ... Aina, M.* (2015). How decentralisation influences the retention of primary health care workers in rural Nigeria. *Global Health Action*. 8(1): 26616. DOI: 10.3402/gha.v8.26616 15

Abor, 2014 – *Abor, P.A.* (2014). *Healthcare governance, ownership structure and performance of hospitals in Ghana*. Doctoral dissertation, University of Southampton.

Atkinson, Haran, 2004 – *Atkinson, S., Haran, D.* (2004). Back to basics: Does decentralization improve health system performance? Evidence from Ceará in North-East Brazil. *Bulletin of the World Health Organization*. 82: 822-827.

Barnes, Boohene, 2024 – *Barnes, T., Boohene, D.* (2024). *Performance execution practices of nurse managers: Evidence from a teaching hospital. Journal of Medical Education Development,* 17(54): 111-121.

Boohene, Amita, 2017a – *Boohene, D., Maxwell, A.* (2017). HCD practices and its impact on sustainable growth: A study on selected banks in Ghana. *Saudi Journal of Business and Management Studies*. 2(7):711-715.

Boohene, Amita, 2017b – *Boohene, D., Maxwell, A.* (2017). Perception of employee's on HCD Practices in the Indian information technology industry. *International Journal of Development Research*. 7(7): 13876-13878.

Bossert et al., 2015 – *Bossert, T.J., Mitchell, A.D., Janjua, M.A.* (2015). Improving health system performance in a decentralized health system: capacity building in Pakistan. *Health Systems & Reform*. 1(4): 276-284.

Bossert, 2015 – *Bossert, T.J.* (2014). Empirical studies of an approach to decentralization: "decision space" in decentralized health systems. *Public Administration and Development*. 26(4): 303-315.

Cavalieri et al., 2016 – *Cavalieri, M., Ferrante, L.* (2016). Does fiscal decentralization improve health outcomes? Evidence from infant mortality in Italy. *Social Science & Medicine*. 164: 74-88.

Chen et al., 2021 – *Chen, J., Ssennyonjo, A., Wabwire-Mangen, F., Kim, J.H., Bell, G., Hirschhorn, L.* (2021). Does decentralization of health systems translate into decentralization of authority? A decision space analysis of Ugandan healthcare facilities. *Health Policy and Planning*. 36(9): 1408-1417.

Creswell et al., 2007 – *Creswell, J.W., Hanson, W.E., Clark Plano, V.L., Morales, A.* (2007). Qualitative Research Designs: Selection and Implementation. *The Counseling Psychologist*. 35(2): 236-264.

Diana et al., 2015 – *Diana, A., Hollingworth, S.A., Marks, G.C.* (2015). Effects of decentralisation and health system reform on health workforce and quality-of-care in Indonesia, 1993-2007. *The International Journal of Health Planning and Management*. 30(1): E16-E30.

Faguet, 2014– *Faguet, J. P.* (2014). Decentralization and governance. *World Development*. 53: 2-13.

Leatherman et al., 2010 – *Leatherman, S., Ferris, T.G., Berwick, D., Omaswa, F., Crisp, N.* (2010). The role of quality improvement in strengthening health systems in developing countries. *International Journal for Quality in Health Care*. 22(4): 237-243.

Liu et al., 2006 – *Liu, X., Tim, M., Lieping, C., Shaokang, Z., Shenglan, T.* (2006). Does Decentralization improve human resource management in the health sector? A case study from China. *Social Science Medical*. 63(7):1836-1845.

Robins, 2008 – *Robins, L.* (2008). Perspectives on capacity building to guide policy and program development and delivery. *Environmental Science & Policy*. 11(8): 687-701.

Sakyi et al., 2011 – *Sakyi, E.K., Awoonor-Williams J.K., Adzei F.A.* (2011). Barriers to implementing health sector administrative decentralization in Ghana: A study of the Nkwanta district health management team. *Journal Health Organisation Management*. 25(4): 400-419.

Sarfo et al., 2021 – *Sarfo, J.O., Debrah, T., Gbordzoe, N.I., Afful, W.T., Obeng, P.* (2021). Qualitative research designs, sample size and saturation: Is enough always enough? *Journal of Advocacy, Research and Education*. 8(3): 60-65.

Schneider, Whitehead, 2016 – *Schneider, Z., Whitehead, D.* (2016). The significance of nursing and midwifery research and evidence based practice. In Schneider, Z, Whitehead, D., *Nursing and midwifery research: Methods and appraisal for evidence-based practice*. 5th ed. (pp. 3-14). Marrickville, Sydney: Elsevier – Mosby.

Sumah et al., 2016 – *Sumah, A.M., Baatiema, L., Abimbola, S.* (2016). The impacts of decentralization on health-related equity: A systematic review of the evidence. *Health Policy*. 120(10): 1183-1192.

Sumah et al., 2018 – *Sumah, A.M., Baatiema, L.* (2018). Decentralisation and management of human resource for health in the health system of Ghana: A decision space analysis. *International Journal of Health Policy and Management*. 8: 28-39.

Tsofa et al., 2017 –*Tsofa, B., Molyneux, S., Gilson, L., Goodman, C.* (2017). How does decentralisation affect health sector planning and financial management? A case study of early effects of devolution in Kilifi County, Kenya. *International Journal for Equity in Health*. 16(1): 1-12.