Synergies and Fragmentation in Country Level Policy and Program Agenda Setting, Formulation and Implementation for Global Health Agendas: A Case Study of Health Security, Universal Health Coverage, and Health Promotion in Ghana and Sierra Leone

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Research

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Abstract

Background: Global health agendas have in common the goal of contributing to population health outcome improvement. In theory therefore, whenever possible, country level policy and program agenda setting, formulation and implementation towards their attainment should be synergistic such that efforts towards one agenda promote efforts towards the other agendas. Observation suggests that this is not what happens in practice. Potential synergies are often unrealized and fragmentation is not uncommon. In this paper we present findings from an exploration of how and why synergies and fragmentation occur in country level policy and program agenda setting, formulation and implementation for the global health agendas of Universal Health Coverage (UHC), Health Security (HS) and Health Promotion (HP) in Ghana and Sierra Leone. Our study design was a two country case study. Data collection involved document reviews and Key Informant interviews with national and sub-national level decision makers in both countries between July and December 2019. Additionally, in Ghana a stakeholder workshop in December 2019 was used to validate the draft analysis and conclusions. This study is part of a series of country case studies to inform the Lancet Commission on synergies between UHC, HS and HP.

Results: National and global context, country health systems leadership and structure including resources were drivers of synergies and fragmentation. How global as well as country level actors mobilized power and exercised agency in policy and program agenda setting and implementation processes within country were also important drivers.

Conclusions: There is potential in both countries to pull towards synergies and push against fragmentation in agenda setting, formulation and implementation of global health agendas despite the resource and other structural constraints. It however requires political and bureaucratic prioritization of synergies, as well as skilled leadership. It also requires considerable mobilization of country level actor exercise of agency to counter sometimes daunting contextual, systems and structural constraints.

Background

Introduction

UN Member states including most LMIC have committed to the global health agendas in the SDG Goals. Inherent in SDG Goal 3, which focuses on health are the agendas of universal health coverage (UHC), health security (HS) and health promotion (HP). All these agendas have the common end goal of contributing to population health improvement. In theory therefore, policies and programs should be formulated and implemented synergistically such that whenever possible, efforts towards one agenda promotes efforts towards the other agendas. Given chronic resource constraints, the low and middle income countries (LMIC) of sub-Saharan Africa (SSA) stand to gain by prioritizing synergistic approaches to implementing global health agendas. Observation suggests however that this is not necessarily what happens in practice. [1] In this paper we ask and explore questions about how and why synergies and fragmentation occur in policy and program agenda setting, formulation and implementation for UHC, HS and HP in two LMIC in SSA, Ghana and Sierra Leone.

Given there is sometimes variation in meaning when the terminology UHC, HS and HP are used, to avoid ambiguity; throughout this paper we use UHC, HS and HP in the meanings adopted in the ongoing work of the Lancet Commission on Synergies. By UHC we refer to the most important activities to ensure *access for everyone to quality essential health-services, including medicines and vaccines, and to financial risk protection (linked to payment for services).* By HS we refer to the most important activities required for *reduced vulnerability of people to rapidly spreading risks to health, particularly those with great potential to cross international borders.* By HP we refer to the most important *activities to enable people to increase control over the determinants of their health and to change social, environmental and economic conditions for better health.*

Theoretical Concepts

We drew on the theoretical concepts of: the policy process, actor agency and power, health systems and context from the policy analysis and social science literature to inform our exploration and analysis.

The policy process

Lasswell's[2] introduction of the concept of modeling the policy process into stages has gone through several modifications by various authors since it was first introduced. A common adaptations is the four policy process stages of policy agenda setting, formulation,

implementation and evaluation. Despite valid critiques[3] that this linear model is a somewhat unrealistic conceptualization of an iterative, messy and somewhat unpredictable process; it retains value in organizing thinking and analysis. We therefore use the concepts of agenda setting, formulation and implementation to help organize and structure our enquiry; even while acknowledging the limitations. By the agenda we refer to: *"the list of subjects or problems to which government officials, and people outside the government closely associated with these officials are paying serious attention at any time"*. [4] Policy formulation describes the cluster of complex decision-making processes between agenda setting and implementation.[5] Implementation we use to refer to the execution of decisions taken to make a program happen. [6,7]

Actor agency and power

Agency in sociology refers to the capacity of people to act independently and make their own free choices.[8,9] We theorized therefore that country actors are not helpless victims of global forces. Global as well as country level actors have agency and power. Mintzberg[10] defines power as the capacity to effect (or affect) decisions and actions and labels an actor who seeks to control decisions and actions as 'influencer'; arguing that the influencer's use their sources or levers of power as means of influence. Levers of power include the *control* of a resource, a technical skill, or a body of knowledge; *authority* by virtue of one's legal and structural position; and *access* to those who can rely on the other sources of power. Power can take *visible* forms with levers of power vested in obvious formal rules, structures, authorities' institutions and decision-making procedures. It can also be *invisible* using levers that are often psychological and ideological, shaping how people think about issues, give meaning and decide what is acceptable (or not). Issues are kept out of the consciousness and decision-making agendas of actors and stakeholders – even those directly affected by the issue at stake. Power can also be *hidden* with power used to control who gets to participate in decision making and what items make it to the decision-making agenda.[11]

Health Systems

Health systems are the primary arena in which much of health policy and program agenda setting formulation and implementation occur. We use the WHO definition of a health system as consisting of: *"… all organizations, people and actions whose primary intent is to promote, restore or maintain health*"[12]. There are several frameworks for describing and analyzing health systems in the literature[13,14,15,16,17] The WHO building blocks framework[18] remains a very useful and enduring one. However, it is also recognized that health systems are more than these building blocks. They are complex adaptive systems in which 'people' are central.[19] People are the mortar that determines how well or otherwise the building blocks are arranged and hold together to provide a resilient shelter for the health of the population even in the face of external shocks. Health systems are embedded in wider global, national and sub-national contexts which which effectively form a foundation influencing their robustness. [20].

Context

To obtain a uniform schema for describing context in the two countries, we draw on Leichter's adaption of Alford's[21] work, categorizing context into situational, structural, cultural and environmental.[22] A situational factor refers to '…a *more or less transient, impermanent, or idiosyncratic condition or event that has an impact on policy (decision making)…'.* Examples include violent events such as international and civil wars, communal conflict, terrorism, assassination, economic cycles: depression, recession, inflation, natural disasters: epidemics and pandemics such as Ebola and COVID-19, droughts, floods, oil spills and earthquakes. Political events and technological changes such as the introduction of the world wide web can also be considered situational factors at the time of their emergence. If they persist, over time they can become part of the established and relatively unchanging elements of the society or structural factors. Structural factors include *'… more permanent and persistent features of a system, such as its economic base, political institutions or a demographic structure'.* 'Cultural factors' refers to *'…the value commitments of groups within the community or the community as a whole…'.* Examples include norms and values, national heritage, formal and informal political culture norms and values concerning the role of the individual and the state, as well as the wider general or macro culture such as traditional social values relating to social institutions and arrangements such as marriage, the family, sex roles; religious values and role of religious institutions in society. 'Environmental factors' or 'global context' describes context outside the country itself such as the international political environment, policy diffusion, international agreements and obligations and pressures. We theorized that context can push policy processes towards synergies or pull them apart towards fragmentation.

Methods

Aim

The aim of this study was to explore how and why synergies and fragmentation occur (or not) between the global health agendas of UHC, HS and HP in Ghana and Sierra Leone.

Study Design

The study design was a multiple (two) country qualitative exploratory case study in Ghana and Sierra Leone. The case was defined as: *"UHC, HS and HP country level policy and program agenda setting, formulation and implementation over the period 1992 - 2019"* We purposively selected Ghana and Sierra Leone for the case studies to study the issues in contrasting country contexts in West Africa. In both countries data collection involved a desk review of grey and published literature and key informant interviews. Additionally, a stakeholder validation meeting was held in Ghana in December 2019.

The case study countries

The period covered by this study was one of political stability and economic growth in Ghana. At the start of the period it was classified as a low-income and by the end as a lower middle-income country. Politically, the December 1992 elections ushered the change from over a decade of military rule and a preceding unstable period of attempts to establish multi-party democracy cut short by military coups to the stable multi-party democratic governance of the fourth republic. Since 1992, there have been back to back elections every four years with peaceful transitions of power between the two major political parties – the National Democratic Congress (NDC) and the New Patriotic Party (NPP). Ghana's population is currently almost thirty million. The 2019 Human Development Index (HDI) Report[23] reports Ghana's HDI in the medium human development category at 0.596; positioning it at 142 out of 189 countries and territories. In 2016/17, using the upper poverty line, the proportion of the population defined as poor (poverty head count ratio) was 23% while the population in extreme poverty was 8%. Progressive Ghana Living Standards Surveys since 2005 show a decline in the rate of poverty.[24]

The same period has been one of political and economic turbulence for Sierra Leone and it has remained one of the poorest countries in the world partly because of two major situational crisis. The first situational crisis was the devastating 11 years of civil war between 1991 – 2002. The second was the 2014 – 2016 West African Ebola outbreak. Just before the Ebola outbreak in 2014, the country was experiencing a growth rate of 4.6%. This contracted to negative 20.5% in 2015. The period also coincided with the 2014-2015 fall in iron ore prices, one of the country's primary export commodities. Sierra Leone's population is currently approximately 7 million. The 2019 Human Development Index (HDI) Report[25] ranks its HDI in the low human development category at 0.438 positioning it 181 out of 187 countries and territories. The overall poverty headcount ratio of the country is 57 percent, while the population in extreme poverty is 10.8 percent.[26] Politically, Sierra Leone is a multi-party democracy. There have been two main political parties, that have alternated power since independence in 1961: the All People's Congress (APC) and the Sierra Leone People's Party (SLPP). While the SLPP ushered the country into independence, the APC has been in rule for most of the post-independence period, with Siaka Stevens becoming president in 1968 after a series of coups and countercoups. He established a republic in 1971, and one-party rule in 1978. Entrenched poverty and excesses such as patrimonialism, and corruption have been blamed for the 1991-2002 civil war. Since the end of the Civil war in 2002, there have been peaceful elections and back to back transfers of power between these two dominant political parties.

Sampling, Data collection methods and tools and analysis

Desk review

In both countries the research team searched the websites, institutional libraries and archives of the Ministries of Health; and of health sector agencies such as the Ghana Health Service, Non State providers e.g. Religious Health Associations; development partners and Civil Society Organizations (CSO). In Sierra Leone, the team also reviewed Service Level Agreements (SLA) that were part of documents stored by the Integrated Health Planning Administration Unit (IHPAU).

Key Informant Interviews

Key informants in Ghana were purposively selected from immediate past and present senior mainly national but with one regional and one district level decision makers in Government (MOH and its agencies), non-State and donor agencies active in the health sector. Key informants were initially identified from the research team's knowledge of the health sector and from the desk review. A snowballing approach was then used to follow suggestions from people already interviewed as to who else to interview. A total of 27 KI interviews were conducted. Twenty (20) KI were still in active service and seven (7) had retired. Fifteen (15) were or had been public sector employees (MOH and its agencies) at the level of director or deputy director; ten were employees of Development Partners (DP) active in Ghana and two (2) were from non-state agencies. Twenty two (22) were male and four (5) were female.

In Sierra Leone, sixteen (16) respondents were from the public sector (MOH) and two from the donor and NGO community making a total of 18 KI. A first set of interviews was held with KI within the MOH at the district level based on previous work in the health sector and knowledge of who the key stakeholders were . Using a snowballing approach, the initial key informants helped to identify other potential informants. The respondents included district medical officers, chief and medical superintendents, councilors and senior nurses across most of the districts in Sierra Leone. There were 16 males and 2 females.

The gender imbalance in both countries reflects the continuing male dominance at the most senior decision making levels in the health systems of West Africa. All KI interviews were conducted between July and December 2019.

Stakeholder Validation meeting

A stakeholder validation meeting was held in December 2019 in Accra with national and sub-national decision makers from state, non-state and development partner agencies. Some were participants in the Ghana KI in-depth interviews, others were people who had not been available at the time of the interviews. To help assure open and transparent discussion the forum observed the Chatham house rule.[27]

Data processing and analysis

Apart from one interview in Ghana where the KI declined to be recorded and for whom the research team relied on interviewer notes only; all KI interviews were tape recorded with informed consent . The tapes were transcribed by research assistants who did not participate in the interviews and did not know the respondents. Data analysis involved manual text analysis of transcripts for themes, commonalities and contrasts related to the theoretical concepts as well as new emerging themes. In Ghana two members of the research team (ADK and HBA) conducted the interviews with TED and WOO assisting. Three members (IAA, ADK and HBA) independently read through the transcripts and identified themes and then discussed and reconciled their conclusions as part of quality assurance. Analysis was done on an ongoing basis alongside the interviewing and transcribing. Where there was any disagreement the transcripts were revisited and if indicated the area was probed in further depth in subsequent interviews.

In Sierra Leone three data collectors were hired to collect the data. Prior to embarking on data collection, they were trained by a member of the research team (FMH), on research objectives, methodology, informed consent and the questions. FMH and a research assistant independently read through the transcripts, identified themes and discussed conclusions as part of quality assurance.

Ethical Considerations/Ethical Issues of Concern

Ethical clearance was obtained from the Ghana Health Service Ethics Review Committee (GHS-ERC 007/03/19. Approval date 9th July 2019). All interviews were conducted with Informed consent. All data is stored with utmost confidentiality by the research team in a password protected database and used solely for answering questions related to this study. Respondents are identified by codes rather than by names. In this paper, to preserve anonymity, we label respondents by their institution as: "MOH /State"; "Non-State Partner" and "Development Partner".

Results

'I think that it's unfortunate ... that there's not been a conscious effort to link them up….' (MOH /State Ghana).

Synergies and fragmentation were perceived to be occurring between all three agendas in both countries with fragmentation being more common. They were described as occurring across all levels of the health system as well as in the different stages of the policy cycle. Synergies were generally perceived as beneficial and fragmentation as undesirable. KI felt that international agendas sometimes offered

opportunities for synergy and sometimes for fragmentation. The SDG and Primary Health Care (PHC) potentially offered opportunity for synergies. Within the country itself however, there was some discrepancy between narrative and practice. Although development plans appeared to focus synergistically on broad development outcomes and incorporate at least two or all three agendas, implementation was not synergistic.

Why do synergies and fragmentation occur

Policy processes

The national political arena was the highest level of agenda setting in both countries and the two main political parties in both countries consistently made high level policy agenda statements on health in their manifestos. These statements reflected aspects of all three agendas but especially UHC and HP. They did not necessarily using the terminology of UHC, HS and HP.

In Ghana, the NPP election manifesto for the December 2000 and 2004 elections which they won reflected these agendas in statements such as: "*Recognising that the major causes of diseases and premature death in Ghana result from deficiencies or defects in our social, cultural and economic environment, the NPP government will vigorously pursue the removal of these handicaps as prescribed in other parts of this Manifesto. Its health policy will be devoted to health promotion and disease prevention as a priority. In addition, the care of the sick will be pursued on an equitable basis so that the needs of the sick are addressed according to their circumstances rather than their ability to pay..*."[28] Similarly, the NDC manifesto statements for health for the 2008 elections which they won reflected all three agendas with phrases such as: "*Promoting health, preventing illness, providing cure,…extend access to health services…Provide clean and portable water and increase sanitation….. Extend decent, affordable houses for a healthier living environment…..Continue high level support for HIV/AIDS and TB initiatives*".[29] Their manifesto for the 2012 election focused similarly on access, equity, affordability and inclusion for communicable and non communicable diseases. In the 2016 election manifesto of the NPP the terminology of HS and cross border communicable disease control distinctly emerges probably reflecting the West African experience of the 2014 – 2016 Ebola outbreak. Additional to previous language such as: *'…Right to Health through health promotion, disease prevention.. improve access…,*' the 2016 manifesto states: '*The NPP seeks to position Ghana to address comprehensively local, national and emerging global health concerns e.g. Zika and Ebola viruses…..*"[30]

In Sierra Leone, UHC related agendas were reflected in framing and statements around expanding access as well as affordability of health services. For example in their 2018 election manifesto the SLPP indicates an agenda to: *'… transform the under-resourced, ill-equipped, dysfunctional and inadequate health infrastructure and healthcare delivery system to make it high quality, efficient, reliable, cost-effective, affordable and sustainable capable of responding to epidemics such as cholera, Ebola Virus Disease. …. increasing access of the population (particularly mothers, children and the elderly) to quality health services in an equitable and efficient manner.*"[31] The ACP also indicate that in their list of priorities is: "*Expanding access to and improving the quality of services in our health, education, water, energy and justice sectors*".[32] Health promotion was reflected as an intent to address factors that contribute to poor health outcomes such as water and sanitation and nutrition. Before the 2014 Ebola outbreak the language in relation to diseases with epidemic potential predominantly reflected framing related to preventing and controlling communicable diseases rather than dealing with cross border communicable disease spread threats.

The broad framing of political agendas for health meant that the senior civil servants immediately below the political leadership were important in shaping the detail of policy formulation and thus held potential to ensure synergies or fragmentation.

'… basically, we influenced a lot of things that happened….. In health, it is the technocrats that are responsible for policies… The difficulty they are having now in the ministry is that the technical people they have there are very young, they lack the experience' (MOH /State Ghana).

The high political leadership turnover in both countries made the role of these senior civil servants even more important.

'… for the seven years that I was Director of Health Services, I served under four ministers. So, their lifespan was about one and half years. So, they're just passing by… (MOH / State Ghana)

Contextual and Structural factors

Global agenda rebranding and reframing

'…..there is a concept UHC, so we're implementing UHC, there is a concept MDG, we're implementing MDG and MDG comes in components, so we're implementing maternal health….' (Non State Partner Ghana).

Several KI felt that the concept of the 3 agendas was not new. Rather a rebranding and reframing that occurs periodically in global health was occurring once more. This was itself a source of fragmentation. It sometimes caused some distraction at country level from consistently pursuing long term goals. New programs to do the same thing were set up rather than continuing and reinforcing already existing programs.

For example, though in health sector policy and program documents pre-2015; the terminology of UHC and HS were not necessarily used the principles were felt to be inherent in the meaning of the text. In Sierra Leone, it involved efforts to improve the quality and efficiency of health care making it more affordable, and available to more people, with particular emphasis on vulnerable populations of mothers, and children under 5. In Ghana, the National Health Insurance scheme (NHIS) legislation was passed in 2003 when the terminology of UHC was not in use. However the policy and program was effectively a UHC effort. In both countries Health Security was largely reflected in measures undertaken to enhance the ability of the country to protect citizens from infectious diseases, through prevention, early identification, response and containment. Following the 2014 – 2016 West African Ebola outbreak the terminology of "Health Security" began to increasingly appear. HP was conceptualized through the period studied in both countries in terms of promoting health by influencing social determinants that can lead to better quality of life, including health education, nutrition, environmental protection as well as sanitation and hygiene; community engagement and social mobilization.

Pressure to comply

"…. As a State or as a Ministry, you are bound to comply with international benchmarks. Otherwise you will stand to lose, and you know what will befall you and your government." (MOH /State Sierra Leone)

Like most other LMIC, Sierra Leone and Ghana are members of global international bodies and signatory to a host of international declarations and policies. Governments try to align to these international policy commitments regardless of whether the agenda supports synergies or fragmentation. Of more concern is that failure to align could have negative consequences such as loss of desperately needed Development Partner (DP) funds.

For example, considerable DP resources have been poured into addressing infant and child mortality, in Sierra Leone. It was felt the focus could be purely due to Sierra Leone having one of the highest maternal and child mortality rates in the world[33]. However, it also appeared to be due in part to the irresistible lure of the resources that follow global health priorities. Similarly, the Ebola outbreak commanded significant global attention and resources. Ebola was couched as a security threat: global powers were concerned about the threat the disease posed to their own citizens, as well as to international stability. To quote the then US Secretary of Defense: "*such events threaten not only the health of our citizens but also geopolitical stability … When states are unable to provide basic services for their citizens, dangerous regional and global security consequences result.*"[34]. In September 2014, the UN Security Council convened over a health issue for the first time, calling the outbreak a "*threat to international peace and security*"[35]These concerns translated into increased resources during and after the Ebola outbreak. The greater prioritization of HS, is partly evidenced in the number of laws passed in Sierra Leone that reference HS. The speed with which policies were developed meant that they were not necessarily cohesive or synergized with pre-existing policies.

National Contextual drivers

The severity of the 2014 Ebola outbreak in Sierra Leone, and the inability of the government to successfully contain it for so long was seen by some as a result of the health system fragmentation in the immediate post Civil war reconstruction period as well as the mistrust between citizens and the state engendered by years of neglect and policies that reinforced inequity and marginalization.[36] Post war efforts in rebuilding were largely confined to infrastructure, prioritizing this over investments in staffing. There was also a DP preference for funding selected diseases like malaria, HIV/AIDs and TB[37].

However, the 2014 Ebola outbreak in Sierra Leone also helped to raise attention to fragmentation, despite also being a cause of fragmentation during and after its eventual successful containment. During the outbreak, there were many calls to re-think development work in the health sector[38] and focus on health systems strengthening rather than vertical projects. A good number of respondents saw

the Ebola outbreak as well as the post war context all as incentives, or imperatives to help push a synergistic agenda and to move away from fragmentation. Some felt that some of this opportunity was realized. E.g:"

"... The post Ebola security agenda has helped to improve synergies in the national health policy making as there is strong coordination between MOHS and Donor partners in terms of health service delivery …. . " (MOH / State Sierra Leone).

However, despite the positive expressions and testimonials from primarily government (State) respondents, others felt that in practice, what was strengthened was the State's ability to address HS. It was less clear, the extent in which this translated into greater synergies with other agendas. Thus it was felt that the aftermath of Ebola was a: "*mixed blessing…on the one hand, the resources made available in the wake of Ebola have brought new and heretofore unseen attention and energy to areas such as human resources for health (HRH), medical products and information systems …. On the other hand, as the health sector has become more diverse, it has also become more fragmented….* "[39]

Global and country level Actors, Agency and Power

Multiplicity of actors

In both countries, there was a multiplicity of institutional actors in the health system. Mechanisms for DP coordination in Sierra Leone were fragmented, with many different management meetings and structures both within and without the health sector and a lack of clarity regarding who or what body was responsible for what. For example, there was a health development partners forum, as well as a health NGO forum. Coordination bodies included a Health Sector Coordinating Committee (HSSC), a Health Sector Steering Group (HSSG) and technical working groups.

At the time of this study, Tthe trend among DP in Ghana was donor transitions out of the health sector since the country had been reclassified from low income to lower middle income. The country had also reverted to the fragmentation that existed before the Sector Wider Approach (SWAp) of the nineteen nineties. During the Ghana sector wide approach (SWAp) that started implementation in 1997 several DP put their funds into the donor pooled fund. In exchange they took part in agenda setting, policy formulation and developing comprehensive and synergistic health sector annual and medium term plans as well as their monitoring and evaluation. The Ghana SWAp gradually died out as actors in the sector changed and with global ideology shifts, the DP involved in the SWAp moved to donor budget support in the ministry of finance. When donor budget support ended most DP reverted to selective program support.

Media and CSO were mentioned as part of the multiplicity of actors in the policy process. Though Academia was mentioned as a policy actor in agenda setting, formulation and implementation in both countries; there was a perception that the focus of academia was rather "different" and more on conducting research than engaging in the policy process.

Self Interest

'……everything is done and then you are not seen even though you have contributed so much... So if I get my own resources, I get my own thing and I push for my own level; then that will enable me to achieve my own goals, ,… but I will be implementing it in maybe competition with another same player within the same ministry or agency' (Non State Partner Ghana).

'it's the way we've set up our system; that there are divisions responsible for certain things. So, then they're, like protective of their turf…. So, they shove people off, and they do their mandate'(MOH/ State Ghana).

Several KI observed that institutions and individuals are keen to protect their visibility and interests in the policy process. These concerns can over-ride any common good concerns about synergies. Actors are less likely to work synergistically if it reduces their visibility.

Self interest leading to fragmentation was also mentioned as occurring because of the jostling of professional groups for power and influence to promote the welfare of their particular group.

'… what I've observed (about the position of the minister), anytime it's a medical doctor, all other groups will fight him or her. If it's a pharmacist, all other groups will fight because they think that,… If you put a pharmacist there, everything (is) reserved for pharmacists.. If you put a nurse or whatever…, he/she will promote (that professional group)…. ' (MOH /State Ghana).

Political machinations, the lack of institutional memory due to politically motivated appointments and reshuffles, the ownership of clinics by senior officers within the health administration, suggesting tensions between job performance and personal gain, has led some writers

to suggest that fragmentation is Sierra Leone is actually a deliberate self interested policy[40].

Stakeholder engagement

'…involvement in the policy discussion has narrowed to some few people, even within the ministry…. I think stakeholder involvement is very minimal, and I think that's where the worry is….'. (MOH /State Ghana)

Although there are various regular meetings for health sector actors in Ghana KI observed that important actors were often missing during the discussions. This leads to a narrow scope of discussion, viewpoints and ideas as well as misunderstanding of roles and approaches to implementation that drives fragmentation. Related to these concerns about stakeholder engagement were concerns about perceptions of who matters in the policy process.

'…who are the key or who should be, they are two things; ….others are left in the periphery by the view that it is policy…service providers are only to implement policy; which for me is absurd because policy doesn't refer to only the formulation stage but a whole cycle of processes, and a policy without implementation is no policy'. (MOH / State Ghana)

There appeared to be dominance of a top down model of "policy making" which several KI felt did not match the reality. It contributed to patchy implementation and sometimes fragmentation. Considerations of the resources for implementation, and the opinions and experiences of frontline health workers needed to inform policy design. It was observed that faced with inadequate resources frontline workers preferentially invested their time in implementing well funded DP programs or activities that raised out of pocket fees from clients rather than comprehensive and integrated national policies and plans. Concern was also expressed that short term pilot projects deprived countries of the incremental knowledge to be gained from longer term implementation processes.

In Sierra Leone, one of the criticisms mentioned in the 2017 National Health Sector Strategic Plan (NHSSP) was that the plethora of policies developed around health care, post-Ebola, while welcome, suffered from some level of fragmentation. Policies were developed in silo, without the input of a wide variety of stakeholders and in some cases, without attempts to synergize them with pre-existing policies. This has resulted in laws and policies that do not necessarily always align, and create gaps as well as overlap in terms of responsibility for both delivery as well as coordination of deliverables.[41].

Capacity for Inter and cross sectoral collaboration

'…my big question is where is the Ministry of Finance …, where is the Ministry of Roads …, where is the ministry responsible for water …Where is the Ministry of Education …?' (Development Partner Ghana).

'we tried to involve other ministries and organizations. But we soon realized that whenever we called a meeting, other ministries and organizations sent people who could not commit their organizations to this thing… and that has been the failure of collaboration in Ghana'(MOH / State Ghana).

Several KI felt that HP is integral to all three agendas and requires the ability to work with sectors beyond health. However effective intersectoral collaboration remains a challenge. Cross-sectoral coordination can be messy, and subject to political calculations, creating obstacles to effective cross-sectoral links.

Nearly, if not all, of the multiple plans and policies developed to respond to health shocks and epidemics post-Ebola in Sierra Leone incorporate multisectoral collaboration with representatives from partners, ministries and institutions outside of health. However, it was observed that the actual response is overly militarized, and anecdotally, there has been some reports about jockeying for power and influence between and among response agencies, as well as politicization of key posts and response efforts more generally.

Trust and accountability

'You can't micromanage everything in life… there should be a little trust otherwise we can't live' (MOH / State Ghana).

Trust and accountability between institutions, individuals and public and private sectors were seen as drivers of synergies if high and fragmentation if low. At the time of the study trust was unfortunately seen as low in both countries. The mistrust was not only in donor-government relationships but also between country institutions and system levels. In Ghana it was mentioned that sometimes DP did not trust the government and its agencies and vice versa. The DP mistrust was sometimes founded on accountability concerns.

'…. If you have the systems in place, then the donor can say take my money because you can account for it. I only earmark if you can't account for my money' (Development Partner Ghana).

In Sierra Leone despite calls for change, many programs implemented by DP and NGO continue to be vertical in nature[42]. A lack of trust in the political system as well as perceived weaknesses in state-run accountability systems mean that DP are still loath to use government institutions or processes and feel safer by establishing parallel structures such as their own supply chain for drug procurement[43]. One way in which Sierra Leone has tried to minimize fragmentation and amplify synergies related to lack of accountability has been through the government requirement that DP sign Service Level Agreements (SLA) prior to implementing any projects. SLA are supposed to operate at all levels of government to ensure compliance and alignment with national health policies and avoid duplication of efforts and resources. In practice SLA are not routinely signed, and government finds it difficult to implement and monitor them.

Country Health Systems

Leadership, institutional governance arrangements and structure

'I wouldn't say it is inevitable. It can be changed. And it requires the ministry as a leader to be able to bring all the various parts to see that "this is the goal and these are the synergies that I am focusing on"' (Non State Partner Ghana)

'I don't think fragmentation is inevitable. I think fragmentation is a creation of lack of policy direction and leadership' (Development Partner Ghana)

Country level exercise of agency through strong leadership came up consistently as a way of reducing fragmentation and increasing synergies. Several KI in Ghana felt fragmentation was not inevitable. However, it would continue to exist where there were leadership weaknesses combined with resource limitations.

An example of leadership weaknesses causing institutional fragmention that was brought up by many KI in Ghana was the leadership and management of the move from a unitary MOH to an implementation agency model following the passage of Act 525 of 1995[44].

"I think that the biggest fragmentation in Ghana was the GHS MOH split….the crème de la crème moved to GHS leaving a weak MOH" (Development Partner Ghana)

Act 525 created a health system organizational design where the MOH became a small national level only Civil Service institution responsible for coordinating policy planning monitoring and evaluation across larger service delivery and other agencies such as the Ghana Health Service (GHS) and the Teaching hospitals. KI felt such complex organizational reform needed leadership and a capacity to administer that was and remained missing.

'..the Act was not properly implemented and it's still not being implemented ….in that Act the ministry is not supposed to do any implementation… but the ministry has jumped into implementation….. the Act said no, you (MOH) are for providing policy direction. … they are in (implementation) simply because I understand that's where the money is…'(MOH /State Ghana).

The long drawn covert as well as overt bureaucratic infighting and power struggles between MOH and its major service delivery agency, GHS, over turf, power, position and control of resources was seen as having weakened and fragmented the health system. Successive waves of legislation that have created more implementing agencies, services and authorities – sometimes in reaction to strong pressure and lobbying by interest groups and individuals was felt to have worsened the fragmentation.

'you are having so many agencies, currently we have 26 agencies. The more you have these agencies, then the more fragmented you will become because the agencies are given different functions, and it makes them more fragmented…'(MOH /State Ghana).

Fragmentation driven by weak institutional arrangements and structure in the health sector and leadership also emerged in Sierra Leone. A winner -take-all political system where a change in party might mean a change also in key personnel with a loss of institutional memory, knowledge, skills and experience, was seen as a driver of fragmentation. One of the concerns expressed by some KI was that the current ruling party, was not in power during the Ebola outbreak. Only a handful of those who were involved in Ebola were now available to advice as many people affiliated with the previous administration, the APC had been let go. The result was an inability to sufficiently leverage the expertise and learning that was developed during the Ebola response.

Resources

"[it]it boils down to the power of resources in the hands of donors and the often weakness of government to say no to funding for interventions outside the strategic framework of government," (……)." (MOH /State Sierra Leone)

Health financing arrangements were described as a driver of fragmentation in both countries for several reasons. First was the inability to generate and also to commit sufficient financing for health on the part of government. Secondly, what funds flowed into the sector were unpredictable and slow. Thirdly funding was through diverse means and fragmented funding pools. Sometimes resources for some plans came from outside the responsible agency, necessitating time consuming discussions with other institutions and difficulties in accessing the money. Fourthly, the priorities of the DP who sometimes stepped in to fill the funding gaps, rather than national plans were droving implementation.

"Donors tag their support to health priorities that fall within their strategic framework. The question often asked is whose reality counts?" (MOH /State Sierra Leone)

However, the government was also blamed for contributing to the fragmentation by being more interested in receiving donor funds than in ensuring donor alignment with government agendas and national priorities.

"Fragmentations are inevitable in the sense that donors provide the much-needed resources and the tendency is that we go for the windfall. Example, the Global Fund was down loaded on us. We went for the money regardless of whether it reflects a priority health need in our country" (MOH /State Sierra Leone).

Internal as well as external funding flows were mentioned as contributing to fragmentation in Ghana. For example, the NHIS fund supports clinical care mainly and ignores health promotion. Additionally, the fund is inadequate for the services guaranteed free under the policy and delays in provider reimbursement has led to the overt and covert withdrawal of certain services by providers.

Some KI in Ghana felt some fragmentation was inevitable because of resource constraints and the need to prioritize.

'… because of limited resource envelopes, you cannot build a system in its holistic nature. No matter how rich a country is. So, you need to prioritize pathways to achieve priority goals…'. (Development Partner Ghana).

'…, we cannot do away with it, you can't' because it boils down to funding. … (Non State Partner Ghana).

'fragmentation is part of human nature. I mean even in your own house there may be some divisions, but we can manage it' (MOH /State Ghana).

Health Information systems (HIS)

By providing information on morbidity, mortality and health system performance, a well-functioning health information system can contribute to synergies between UHC, HS and HP. However, for this to happen there needs to be capacity within the health sector to manage and utilize the information. One of the focal areas of the policies developed post-Ebola was to strengthen Sierra Leone's health information systems (HIS). HIS weaknesses contributed to the initial inability to detect the scope of the EVD outbreak.

Discussion

Concerns about fragmentation in agenda setting, formulation and implementation of global health agendas in low and middle income countries (LIMC); and expressed desire for more synergies are not new. Multiple global level efforts to promote synergies and reduce fragmentation, often initiated and led by global multi-lateral agencies and wealthier countries that provide development assistance to LMIC have emerged over time and continue to emerge.[45], [46],[47],[48],[49]. At the global level, several inter-related problems or challenges account for the persisting difficult in reducing fragmentation and increasing synergies. They include the proliferation of global health actors, global health leadership, accountability, power relations and divergent interests.[50] Focusing efforts to reduce fragmentation and increase synergies predominantly at the global level is clearly challenging. Is the situation any different at country level in LMIC? In this study we have tried to understand how and why fragmentation and synergies occur (or not) at country level in Ghana and Sierra Leone between the global health agendas of UHC, HS and HP.

The drivers we found include some well know challenges related to global actors and institutions.[51] However we also found country level drivers such as the nature of the policy process, country level context, how actors exercise agency and power as well as health systems leadership and structural factors. Moreover, the local and the global work together rather than in isolation.

Despite power imbalances often related to resources and expertise, countries like Ghana and Sierra Leone are not totally powerless victims of global forces of fragmentation. Country level actors have agency and various forms of power. The question is how well this potential is developed and mobilized in agenda setting, formulation and implementation of global health agendas despite resource and structural constraints. Its mobilization requires political and bureaucratic commitment to and prioritization of synergies, as well as skilled leadership and considerable exercise of country level actor agency to counter sometimes daunting contextual, system and structural constraints.

Implicitly underlying our starting position as researchers was that synergistic approaches to policy and program agenda setting, formulation and implementation are better than fragmented approaches in terms of maximizing generation of desired results with a given set of resources. We did not try to empirically test this normative assumption. However, our respondents generally appeared to agree with the assumption. At the same time, they pointed out several factors that make fragmentation inevitable and synergies difficult. They did not however equate difficult with impossible. Given the multiple factors pulling towards fragmentation, an active and deliberate push towards synergies is needed. Based on our findings, several related rather than any single considerations need to inform how to make this push happen.

Firstly, is the recognition that generally a shared interest among the different health system actors was the desire to see improved health outcomes. This shared interest should be a starting point for any intervention. Another shared interest, related to the first is the need for global as well as country actors to demonstrate results and have visibility of effort. However, there is also a potentially major divergence in this second shared interest that has to be managed. The constituents to whom the results of the efforts of different actors need to be visible are not necessarily be the same. LMIC governments need to demonstrate valued results to citizenry who live day to day in that context and ‘next door’ to decision makers; if they are to remain in power. Citizens are more likely to be impressed by efforts that improve the totality of their day to day lives. Such efforts often have to be multi-agenda, multi-sectoral and synergistic. Development partner agencies on the other hand need to demonstrate valued results to the governments and citizens in countries somewhat remote from the day to day context and lives in the LMIC they are supporting. A brochure or documentary showing dramatic improvements in selected measurable dimension such as immunization coverage or access to anti-retrovirals is relatively quickly achievable and will impress. The implication of this is that without collaborative mechanisms and skills that enable dialogue and arrival at common agreed outputs and how to share visibility; fragmentation is likely to persist as different actors try to maximize their interests.

Secondly is that factors such as accountability and trust (or the lack thereof) between actors influence how actors decide and act (or not). To move away from fragmentation and towards synergies the importance of creating and maintaining transparency, trust and accountability should not be under-estimated. Thirdly is that context matters. The external global as well as the national context in which national health systems function affects decision making towards synergistic or fragmented approaches. Context can be much harder to control from within health systems. It requires long term effort in many sectors. In a way Covid 19 is a window of opportunity in that it is an unfortunate natural experiment demonstrating the intricate interlinkages between health, economics, trust and mis-trust, social and political stability and well being.

Finally, despite the truth of the popular phrase “he who pays the piper calls the tune”; even in the face of donor dependency, LMIC are not totally helpless pawns in the global power game. They also have some agency and sources of power. Health sector leadership in LIMC needs to mobilize agency to pull towards synergies and push back against fragmentation. However, this requires leadership competence, vision, credibility and as well as political and bureaucratic prioritization of synergies promotion and fragmentation reduction.

Conclusions

Despite power imbalances related to resources and expertise, countries like Ghana and Sierra Leone are not totally powerless victims of global and country level forces of fragmentation. Country level actors have agency and power that can be mobilized to resist fragmentation and pull towards synergies. To mobilize this sometimes relatively dormant potential requires political and bureaucratic commitment to and prioritization of synergies at global as well as national and sub-national levels; as well as skilled and empowered country leadership at all levels to counter sometimes daunting contextual, system and structural constraints to synergies.

Study limitations

This was a qualitative case study of two countries. The theory generated needs to be further tested with more country case studies – the equivalent of replication in experimental studies – to confirm its generalizability or otherwise.

Declarations

Ethics approval and consent to participate

Ethical clearance was obtained from the Ghana Health Service Ethics Review Committee (GHS-ERC 007/03/19. Approval date 9th July 2019). Additional Clearance was obtained in Sierra Leone for the data collection there. Informed consent was obtained from all interviewees prior to conducting interviews.

Consent for publication

All authors have granted their consent for publication.

Availability of data and materials

The anonymized interview notes and transcripts are available from the country PI in Ghana (IAA) and in Sierra Leone (FMH)

Competing interests

The investigators of this study have no competing interests or conflict of interest to declare.

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Authors' contributions

The study protocol was designed all team members. HBA and ADK led the conduct of the KI interviews. TED and OO supported the desk review and some of the KI interviews. Data analysis in Ghana was done by IAA, HBA and ADK. Primary data collection and analysis in Sierra Leone was led by FMH. IAA led the conceptualization and drafting of this paper. All authors reviewed and approved the final draft.

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