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PUBLIC HEALTHCARE ADMINISTRATION IN GHANA: A FOCUS ON THE KORLE-BU TEACHING HOSPITAL (1923-2020)

Abstract: *Since the pre-colonial period to the post-colonial era, public health administration has been intertwined with several issues ranging from the inadequacy of public health facilities and health workers, improper settlement planning, insanitary conditions, inadequate laws, their implementation and enforcement of same. Using a qualitative approach of research, the study focused on the historical interpretation of the challenges and effects of public health administration on health workers and patients in Ghana. This empirical study focused on responses from workers in the Accident and Emergency Department of the Korle-Bu Teaching Hospital (KBTH), Ghana. The study teased out information from expert informants to make useful generalizations to shape public health administration in relation to similar facilities in Ghana and elsewhere in Africa. Among other things, it also studies how reported sicknesses and or medical cases such as COVID-19 and the management of same at the Korle-Bu Teaching Hospital in contemporary times. Again, based on the empirical responses, the study provided empirical prescriptions to help improve public health administration in health facilities in Ghana, which has wider ramifications for related facilities on the African continent. Attention and resources should not only be given to clinical care, to the neglect of public health. Efforts should cut across every sector of healthcare and fully equip the office of public health administration to do a more efficient work. There is also the need to make inferences from the various past challenges and effects of public health administration in the Korle-Bu Teaching Hospital and Ghana at large to know how to deal with similar challenges emanating from the day to day running of*

Ghana's health institutions including the required preparednes to deal with epidemics and pandemics at the local and national levels.

Key words: *Public Healthcare Administration, Korle-Bu Teaching Hospital (KBTH), Health Workers, Patients, Ghana*

UPRAVLJANJE JAVNIM ZDRAVSTVOM U GANI: FOKUS NA KORLE-BU UČITELJSKU BOLNICU (1923-2020)

Apstrakt: *Od prekolonijalnog perioda do postkolonijalne ere, upravljanje javnim zdravstvom bilo je isprepleteno s nekoliko problema, uključujući nedostatak javnih zdravstvenih objekata i zdravstvenih radnika, nepravilno planiranje naselja, nezdrave uvjete, nedostatak zakona, te njihovu implementaciju i provođenje istih. Koristeći kvalitativni pristup istraživanju, studija se usredotočila na historijsko tumačenje izazova i utjecaja upravljanja javnim zdravljem na zdravstvene radnike i pacijente u Gani. Ovo empirijsko istraživanje usredotočilo se na odgovore radnika u Odjelu za nesreće i hitne slučajeve Bolnice Korle-Bu (KBTH) u Gani. Studija je izdvojila informacije od stručnih informatora kako bi napravila korisne generalizacije za oblikovanje upravljanja javnim zdravljem u odnosu na slične objekte u Gani i drugdje u Africi. Među ostalim, istražuje i kako se prijavljene bolesti i/ili medicinski slučajevi poput COVID-19 i njihovo upravljanje istima obrađuju u Bolnici Korle-Bu u suvremenom dobu. Također, temeljem empirijskih odgovora, studija pruža empirijske preporuke kako poboljšati upravljanje javnim zdravljem u zdravstvenim objektima u Gani, što ima šire posljedice za povezane objekte na afričkom kontinentu. Pažnja i resursi ne bi se trebali usredotočiti samo na kliničku njegu, na uštrb javnog zdravstva. Napore bi trebalo proširiti na svaki sektor zdravstva i potpuno opremiti ured za upravljanje javnim zdravljem kako bi obavljao efikasniji posao. Također je potrebno izvlačiti zaključke iz različitih prošlih izazova i utjecaja upravljanja javnim zdravljem u Bolnici Korle-Bu i Gani općenito kako bi se znalo kako se nositi s sličnim izazovima koji proizlaze iz svakodnevnog vođenja zdravstvenih institucija u Gani, uključujući potrebnu pripremljenost za suočavanje s epidemijama i pandemijama na lokalnoj i nacionalnoj razini.*

Ključne riječi: *Upravljanje javnim zdravstvom, Bolnica Korle-Bu (KBTH), zdravstveni radnici, pacijenti, Gana.*

Introduction

Before the colonial era in Ghana, health was controlled by traditional rulers who introduced measures such as communal labour, taboos, and other rules and regulations that helped to ensure cleanliness and prevent diseases. Traditional healers controlled medicine at that time and used herbs and other traditional means such as wearing amulets to prevent and cure diseases.[1] In the mid-nineteenth century, with strong European presence at the Gold Coast, the Europeans realized that their health could no longer be guaranteed, even if they isolated themselves from the local people. Again, they realized that unless the local population's health needs were met, their plans for healthy living would also not be met.[2] Kunfaa (1996) has asserted the view that British rule brought about Western or modern health systems into Ghana. The health system in the country at the time of British rule focused on hospital-based clinical care, which was initially to serve the expatriate civil servants and merchants. Most health facilities were centered in ports, towns, and cities.[3] Senah (2001) has argued that the colonial medical service during this time was largely curative. The provisions of health services were urban-based, and fees were charged for the delivery of healthcare. With this, even at the height of the colonial medical service, not more than ten percent of the population had access to allopathic care.[4] Thus, before the establishment of the sanitary branch, it was imperative to ensure that there was a clean environment and the prevention of diseases related to the environment and filth. Curative medicine was urban-based and expensive, rather than preventive medicine, which only became effective after the establishment of the sanitation branch.

In 1868, the Cape Coast hospital was built including several rural dispensaries. Also in 1923, the British Colonial Administration built the Korle-Bu Teaching Hospital (KBTH) which served curative purposes. Other public health measures such as piped water, drainage systems, and sanitary facilities were provided during this period to meet the social and public health needs of the Europeans and the African population in the Gold Coast. Upon the defeat of Asante, in 1901, and the annexation of the Northern Territories; through colonial

[1] Edward Brenya and Samuel Adu-Gyamfi, Interest Groups, Issue Definition and the Politics of Healthcare in Ghana. *Public Policy and Administration Research*, vol. 4, no. 6 (2014), 89.
[2] Charles M. Good, Pioneer Medical Missions in Colonial Africa, *Social Science and Medicine*, (1991), 1-10. http://doi.org/10.1016/0277-9536(91) 90120-2.
[3] E. Y. Kunfaa, Sustainable Rural Health Services through Community-Based Organizations, *Spring Research Series*, (1996), 25, 54.
http://www.raumplanung.tudortmund.de/rel/typo3/fileadmin/download/spring_publications/SRS%2016.pdf.
[4] Samuel Adu-Gyamfi, Peter Nana Egyir, Edward Brenya, Public Health in Colonial and Post-Colonial Ghana: Lesson-Drawing for the Twenty-first Century. *Journal of Studies Arts and Humanities*. vol. 3 (2017), 1-3.

legislation, the local authorities (chiefs) played various roles in the provision of public health services to prevent diseases.[5]

Malnutrition and poor sanitation were the main causes of diseases such as yaws, malaria, and fever in pre-colonial Ghana.[6] Addae (1996) cited in Adu-Gyamfi (2017) argues that a shortfall in public health and the inadequate provision of public health services were the major causes of diseases before 1880. This was because of the unsanitary conditions in the Gold Coast, especially along the coast. Bushes and beaches were used as places of convenience, likewise there was improper disposal of waste at the beaches and in the open environment.[7]

Again, contact with the Europeans and colonialism brought about various public health measures such as preventive health care methods which would be initiated as a result of the Europeans protecting themselves against diseases and other related health challenges that were endemic in the Gold Coast (Ghana). Preventive health care has been defined as "a pattern of nursing and medical care that focuses on disease prevention and health maintenance. It includes early diagnosis of diseases, discovery, and identification of people at risk of development of specific problems through counselling, and other necessary interventions to avert a health problem. Screening, testing, health education, and immunization programmes are common examples of preventive care".[8] These methods would not only help prevent diseases but also ensured a healthy nation or the advancement of the social and economic status of the people. On the other hand, Public health has been defined by the World Health Organization (WHO) as "the art and science of preventing disease, prolonging life, and promoting health through the organized efforts of society".[9] In furtherance to that, Public Health Administration can also be explained as "a field of public health that concerns itself with the administration, leadership, and management of health care systems, such as hospitals, networks, and public health systems".[10] Again, it encompasses all the duties required in the management of facilities that provide health care services, such as hospitals, social services organizations, and government agencies. Public health

[5] *Ibidem*.
[6] *Ibidem*.
[7] Samuel Adu-Gyamfi, Prince Osei-Wusu Adjei, Daniel Owusu-Ansah, Preventive Healthcare Strategies and Impact among the Asante People of the Early Twentieth Century Gold Coast: A Historical Narrative and Lessons for the Present Sanitation Challenge in Kumase, *Journal of Studies in Social Sciences*, vol. 5 (2013), 214-215, http://infinitypress.info/index.php/jsss/article/view/412/221.
[8] *Ibidem*.
[9] E. D. Acheson, On the state of the public health (the fourth Duncan lecture). Public Health, 102 (5), 1988, 431-437. Available on: https://www.euro.who.int/en/health-topics/Health-systems/public-health-services. Assessed in (2022, March 14).
[10] Careers in Public Health. (2022). Available on: https://www.careersinpublichealth.net/resources/what-public-health-administration/. Assessed on (2022, February 10).

administration deals with plans, policies, and programmes of public health including the management of personnel, finance, and other related matters.[11]

Public health has many dimensions; for example, the assessment and monitoring of the health of communities and populations, the identification of health problems and priorities, and the formulation of policies to address health problems. It also includes ensuring that all populations have access to appropriate and cost-effective healthcare as well as the advancement of health by establishing disease prevention services.[12]

There have been several works and research done on public health administration in Ghana. For instance, Adua, et al. (2017) discussed the healthcare expenditures and health outcomes (that is; infant mortality, under-5 mortality, and life expectancy) from 1995 to 2014 in Ghana. They further highlighted the challenges of Ghana's health system. The major challenges included inadequate financial investments in health, limited health workforce and facilities, poor hygiene and sanitation, inadequate medical equipment and logistics, transportation, and communication.[13] Again, the research of Botchwey and Ahenkan (2021), describes the challenges of nurses' work motivation and job satisfaction and examines the strategies for minimizing their effects on the performance of active nursing staff. Their research revealed that mismanagement of the hospital's resources, inadequate logistical supplies, poor conditions of work and service, intermittent intimidation of subordinate nurses, the inability of nurses to express their views on issues affecting their welfare and the lack of a medical plan for nurses were some of the challenges affecting nurse's motivation and job satisfaction at the Korle-Bu Teaching Hospital (KBTH).[14] In a similar work by Adu-Gyamfi, et al. (2017), they analysed the public health system in the colonial era to draw lessons for twenty-first century Ghana.[15]

The work of Ahenkan et al. (2018) also examines the major ethical challenges facing nurses and doctors in their practice and how these affect the delivery of quality healthcare. It was revealed that doctors and nurses in the public healthcare administration do experience ethical dilemmas, which lead to undue stress on health professionals, waste time and resources, and prolong the

[11] P. Shrestha, (BPH 306.2-PHAM) *Introduction to Public Health Administration and Management: PHA-Unit 16-17*, 2020. https://www.slideshare.net/Dipesh Tikhatri/unit-1-introduction-to-public-health-administration-management-bph-3062-pham.
[12] *Ibidem*.
[13] See for e.g, Eric Adua, Kwasi Frimpong, Xia Li, Wei Wang. Emerging issues in public health: a perspective on Ghana's healthcare expenditure, policies and outcomes. *Article in EPMA Journal,* vol. 8 (2017),197-206, https://www.researchgate.net/publication/319187602.
[14] See for e.g, Charles Owusu-Aduomi Botchwey, Albert Ahenkan. A perceptional Study on Nature of Nurses 'motivation and Job Satisfaction in Ghanaian Healthcare Sector: A case study of the Korle-Bu Teaching Hospital in Accra. *Article in International Journal of Education and Psychology in the Community*, 11 (1/2), 2021,82-92.
[15] See for e.g, Samuel Adu-Gyamfi, Peter Nana Egyir, Edward Brenya, Public Health in Colonial and Post-Colonial Ghana: Lesson-Drawing for the Twenty-first Century. *Journal of Studies Arts and Humanities*, vol. 3 (2017), 1-2

suffering and treatment of patients. Some key causes of the dilemma were found to be resource constraints, conflicts in relation to ethical codes, religious beliefs, and personal values hampering smooth decision-making, and poor working relations among staff.[16]

Mensah and Adjei (2015) have also provided empirical findings on the relationship between the demographic factors of medical records management personnel at the Korle-Bu Teaching Hospital in the Greater Accra region of Ghana and their commitment to work.[17] Notwithstanding the numerous or existing works on public health administration, little attention has been given to public healthcare administration in Ghana. Especially, aspects concerning the challenges and effects on health workers and patients in the Korle-Bu Teaching Hospital, which has wider ramifications on other health systems in Ghana and Africa in general. Indeed, it is imperative to pay critical or full attention to this relevant social and intellectual question, which is scant in the historical literature in Ghana in particular.

Therefore, the main objective of this article was to assess the history of public healthcare administration in Ghana, focusing on the responses by some health workers and patients of the Accident and Emergency Department of the Korle-Bu Teaching Hospital. The other objectives included the exploration of how public healthcare issues have been addressed and managed by the Korle-Bu Teaching Hospital, examine the effects of healthcare delivery on health workers and patients, identify the challenges of public healthcare administration at the Accident and Emergency Department of the Korle-Bu Teaching Hospital, and ascertain what could be done to help improve public healthcare administration in this domain in particular and Ghana and West-Africa in general.

Approach

To achieve the aforementioned objectives, the study further adopted a qualitative research approach. Both primary and secondary data were sourced. The primary data included interviews with key expert informants at the Accident and Emergency Department of the Korle-Bu Teaching Hospital. Archival documents from the Public Records and Archives Department, Accra, were also sourced. These archival documents included hospital reports and records, which aided the provision of accurate information about the history of public health administration in Ghana focusing on health workers and patients, particularly in the Korle-Bu Teaching Hospital. The study relied on detailed information from

[16] See for e.g, Albert Ahenkan, Mavis B Afari, Thomas Buabeng. Ethical dilemma of health professionals in Ghana: experiences of doctors and nurses at the Korle-Bu Teaching Hospital. *African Journal of Management Research*, 25, 2018, 29-44.

[17] See for e.g, Monica Mensah, Emmanuel Adjei, *Demographic factors affecting the commitment of medical records personnel at the Korle-Bu Teaching Hospital in Ghana*, 2015. http://197.255.68.203/handle/123456789/8757.

eight (8) key expert informants and interviewees. They included the administrator of the Accident and Emergency Department, health workers such as nurses, and patients of the Accident and Emergency Department of the Korle-Bu Teaching Hospital.

Concerning the secondary sources, books and journal articles that relate to the theme were selected and reviewed thoroughly to build relevant arguments and narratives. Information was also gathered from websites. These sources were analysed thematically to provide a useful historical synthesis that are relevant to the objectives of the study.

Discussions

To proceed into the empirical aspects of the research which speaks to the objectives, the research has been grouped into four sections. The first section, which is already discussed, deals with the introduction of the study that problematizes the study and clearly defines the research objectives and the approach. The second section which comprises the units of this discussion deals with the history of public healthcare administration in Ghana. In the first instance, it captures the profile of the study area; Korle-Bu Teaching Hospital (KBTH) – Accra. The second theme under the discussions focuses on how reported sicknesses and/or medical cases such as tuberculosis and COVID-19 as well as the management or treatment of same have been undertaken within the Korle-Bu Teaching Hospital. The others include the challenges of public healthcare administration on health workers and patients in the Korle-Bu Teaching hospital, the effects of the challenges of public healthcare administration on health workers and patients, and factors which have been relevant in helping to improve public healthcare administration in the Korle-Bu Teaching hospital from 1923 to 2020. The final section concludes the discussions of the study. The period 1923 is significant because it relates to the period in which the Korle-Bu Teaching Hospital was established and 2020 marks the period of increasing COVID pandemic in Ghana and further encapsulates themes in the twenty-first century.

Public Health Administration through the lens of Korle-Bu Teaching Hospital

The Korle Bu Teaching Hospital is located in the Accra Metropolitan District in the Greater Accra Region of Ghana. The Hospital was formerly known as the Gold Coast Hospital which was built by Governor Gordon Guggisberg on

October 19, 1923.[18] Korle Bu, in the local Ga parlance, means, "the valley of the Korle Lagoon".[19] It is believed that the Korle Bu Teaching Hospital is the premier tertiary healthcare facility in Ghana. Also, to improve public health, Guggisberg focused on sanitation and pipe-borne water supply to Accra, Sekondi, and Winneba among other areas. The population of Ghana at that time was 2.3 million with 4,000 people living in Accra.[20] Again, Guggisberg extended medical services to other areas but recognized the primary need for a larger modern hospital fully equipped for the care of the sick and the training of local health personnel. This necessitated the building of the Korle Bu Teaching Hospital.[21] The hospital gained Teaching Hospital status in 1962 when the School of Medicine and Dentistry formerly became the University of Ghana Medical School, established to train doctors.[22]

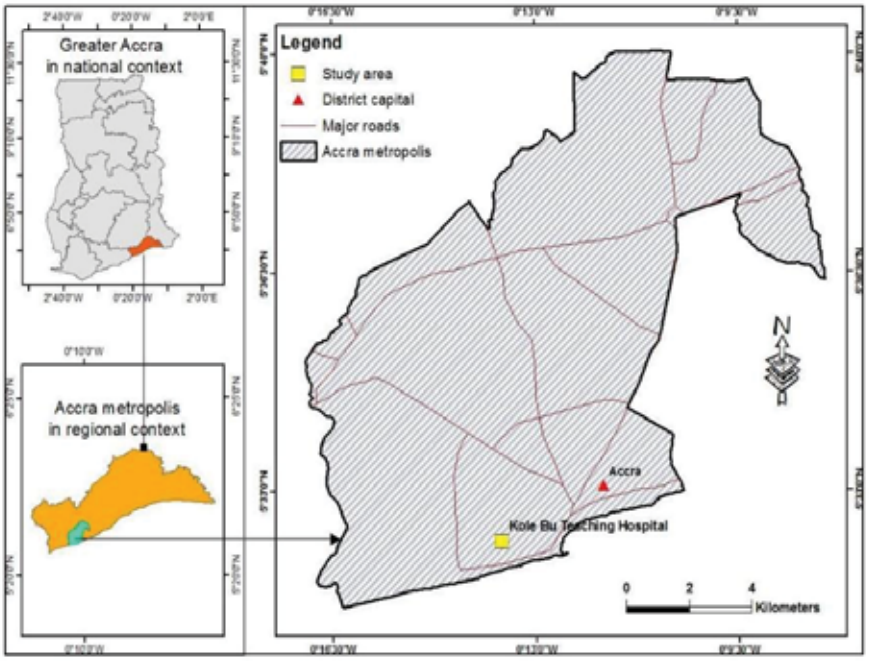

Figure 1. *A map indicating the national, regional, town, and district boundaries of Korle Bu Teaching Hospital*. Source: *Department of Geography and Rural Development, KNUST, Kumase-Ghana.*

[18] Michael, O.S, Great Teaching Hospitals in Africa: Korle Bu Teaching Hospital, Ghana. *Annals of Ibadan Postgraduate Medicine* 7, no.1 (2009), 40-44.
[19] *Ibidem.*
[20] *Ibidem.*
[21] *Ibidem.*
[22] *Ibidem.*

Public Health Administration Issues in the Korle-Bu Teaching Hospital (1923-2020)

Traditionally, public health was under the directives of the traditional institution and its primary concern was to ensure the social, economic, and spiritual well-being of its subjects.[23] Arhinful argues that the establishment of various traditional mechanisms in the form of taboos, customs, and laws helped to promote sanitation within the period before the arrival of the Europeans.[24] Concerning the current research, interviewees have hinted among other things that: Public health is generally the healthcare that takes care of health issues that affect the general public. In other words, it is more in charge of the preventive aspects of healthcare.[25] An interviewee hinted:

> As a public health nurse in the Accident and Emergency department, I seek to address the diseases of public health interest, which includes communicable and non-communicable diseases in the community.[26] What public health officers normally do in the wards is to deliver health talks, counselling, Antigen and Polymerase Chain Reaction (P.C.R) screenings, and what you just saw me doing before the interview was an HIV screening. Also, public health workers are responsible for child health, antenatal care, post-natal care, weighing, and vaccination for tetanus, and polio among other things.[27]

It can be inferred from the works of Alatinga and Williams (2014) that the historical development of modern healthcare policy in Ghana, formerly the Gold Coast, dates to the 1920s.[28] Senah, also cited in Adu-Gyamfi (2017) observed that the development of the colonial health service may be seen essentially in three major phases. The first phase (1471-1844) was characterized by medical apartheid whereby white settlers were physically segregated from the local population and given medical coverage.[29]

The intensity and the type of racism that the former employees of Korle-Bu experienced varied, based on the magnitude of subordination they found themselves. However, it is reported that authority was always vested in the

[23] Samuel Adu-Gyamfi, Aminu Dramani, Kwasi Amakye-Boateng, and Sampson Akomeah, Public health: Socio-political history of a people, *Journal of Arts and Humanities* 6, no. 8 (2017), 11-32.
[24] K. Arhin, *Traditional Rules in Ghana, past and present*, 1985.
[25] An interview with Mr. Issah Stannard Mohammed, Dated 5th August. 2022 at the Accident and Emergency Department, Korle Bu.
[26] An interview with Jemimah, Dated 5th August. 2022 at the Accident and Emergency Department, Korle Bu.
[27] An interview with Daniel Nii Acquaye, Dated 8th August 2022 at the Accident and Emergency Department, Korle Bu.
[28] Kennedy A. Alatinga and John J. Williams, Development Policy Planning in Ghana: The Case of Health Care Provision, European Scientific Journal, November 2014 edition vol.10, No. 33
[29] Samuel Adu-Gyamfi, Peter Nana Egyir, Edward Brenya, Public Health in Colonial and Post-Colonial Ghana: Lesson-Drawing for the Twenty-first Century. *Journal of Studies Arts and Humanities*. Vol. 3 (2017), 1-2

Resident Medical Officer and the Hospital Matron, and they were specifically aware that these positions would never be held by Africans.[30]

With no element of surprise, some of the staff resented the fact that they could never advance to become administrators. Dr. Easmon who worked at Korle-Bu in the 1940s, recalled that all of the African staff members were aware that a "core of whites" ran the institution, and that colonial subjects would always be "under the yoke" of white supervision.[31] As one African-born British- trained physician phrased it, the black employees at the hospital were required to work under the "pressure of white supremacy" with no prospect of advancement into upper management.[32] Nurses also recalled instances when white supervisors abused their authority.[33] In particular, they disliked one head nurse named Sister Evans, whom they described as an exacting perfectionist, "one of those Europeans with imperialistic stamp about them."[34] Another nurse, Miss Marr, was described as someone "who exuded imperial arrogance from every pore and was obsessed with the idea of putting the native in his place."[35] The British colonial dreams of seeing "white nursing sisters and black nurses combine to look after the sick natives of the country" had been realized, but not without the frictions inherent in the racial hierarchy of colonial rule.[36]

As much as the African staff might have been insulted by the arrogance or racism of their white supervisors, they could not oppose it; talking back was not tolerated, and hospital employees could be summarily dismissed for any insolence.[37] As a former dispenser at the hospital, A.K. Addy recalled; the African staff members were obliged to tolerate the racial slurs thrown their way: as much as the staff worked hard to justify a good report from superior officers, there were the usual abuses showered on them whenever there happened to be

[30] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 77.
[31] Addae, *Evolution of Modern Medicine*, 413-415.
[32] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 77
[33] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 78; Dr. C.O. Easmon claimed that the work of the white nursing sisters at Korle-Bu was a "cake walk: the black nurses did the work, the white sisters in their impeccably white starched uniforms, supervised, drank tea and wrote reports." Jonathan Roberts, Remembering Korle Bu Hospital: Biomedical Heritage and Colonial Nostalgia in the "Golden Jubilee Souvenir", *History in Africa*, Cambridge University Press, Vol. 38 (2011), 219.
[34] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 68. Working at Korle Bu was a choice, but once taken, it required training in the comportment and behaviour within British nursing culture. Shula Marks notes that black nurses in South Africa "were even taught how to walk – 'always keep on the left - look alert' - and the regimentation of the nursing hierarchy was formidable," and her informants told her that "nursing taught you to be ladies". Jonathan Roberts, Remembering Korle Bu Hospital: Biomedical Heritage and Colonial Nostalgia in the "Golden Jubilee Souvenir", *History in Africa*, Cambridge University Press, Vol. 38 (2011), 219.
[35] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 94.
[36] Jonathan Roberts, Remembering Korle Bu Hospital: Biomedical Heritage and Colonial Nostalgia in the "Golden Jubilee Souvenir", *History in Africa*, Cambridge University Press, Vol. 38 (2011), 220
[37] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 77.

some slight fault. The abuses were in the form of "Hurry you son of a bushman" "You silly ape" or "You Western Kangaroo."[38] Like many other former employees of Korle-Bu, he resented how white supervisors belittled their subordinates, but he also noted that such treatment was understood to be a condition of working at a colonial institution. After all, Korle-Bu was the only teaching hospital in the colony, so any subject of the Gold Coast who wanted to train as a doctor, nurse, or dispenser was obliged to endure discrimination.[39]

Though the African employees at Korle-Bu were trained in almost all aspects of biomedicine, they were not able to control the way that the hospital wards were used at Korle-Bu. Although the hospital was intended to be a place where African and European patients would be treated without discrimination, the former employees of Korle Bu recalled that the intentions of its architects were not always realized. As one former nurse remembered, she was surprised to find out one day that the isolation ward was not reserved for patients who were being treated for infectious diseases but as a private ward for white patients:

"The old Korle-Bu Wards will have an interesting story to tell if they could speak. It may be observed that there was one block of these wards which was reserved as "ISOLATION BLOCK". It was not used at all for cases requiring isolation. It was used for hospitalizing European patients".[40]

In a similar reference to the above statement in contemporary times, a public health nurse at the Accident and Emergency Centre of the Korle-Bu Teaching Hospital hinted that there was some sort of discrimination between the clinical and public health nurses at the Accident and Emergency Centre of the Korle-Bu Teaching Hospital, but their differences have been resolved. Each individual in the unit knows his or her role.[41]

The second phase of the colonial health service according to Senah cited in Adu-Gyamfi et. al (2017) was born when health coverage was extended to African domestic servants and those in the colonial civil and military service.[42] In 1939, there was a regulation on hospital fees referring to out-patients "attending" a hospital or Dispensary, but the wards that mattered were available to receive patients for treatment for pulmonary tuberculosis". Also, the Governor in Council was pleased to make some regulations in terms of giving free

[38] *Ibidem*.
[39] One doctor who refused to abide by the racial barriers at Korle-Bu was Dr. Nanka- Bruce, who recalled that the "arrogance and thinly veiled contempt for the African on part of expatriates" working at Korle-Bu was too overbearing for him. After several years of enduring the racially divided workplace of Korle-Bu, he retreated to private practice. PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 95.
[40] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 76.
[41] An interview with Daniel Nii Acquaye, Dated 8th August.2022 at the Accident and Emergency Department, Korle Bu.
[42] Samuel Adu-Gyamfi, Aminu Dramani, Kwasi Amakye-Boateng, and Sampson Akomeah, Public health: Socio-political history of a people, *Journal of Arts and Humanities* 6, no. 8 (2017), 21.

treatment of all pulmonary tuberculosis cases at any government hospital [43] Towns with a sizeable European presence were provided with piped water, a drainage system, and other sanitary facilities.[44] Under the governorship of Gordon Guggisberg, there was a rapid expansion in the provision of infrastructural facilities.[45] Under his governorship, Korle-Bu Hospital was built in 1923 to be used by Africans and also for research into tropical diseases. The Colonial medical service was largely curative although in the 1930s a sanitary branch was set up to oversee public health.[46] It was also urban-biased, and fees were charged. Thus, even at the height of the colonial medical service not more than 10 percent of the population had access to allopathic care.[47]

In relation to the above, in contemporary times, the administrator of the Accident and Emergency Department at the Korle-Bu Teaching Hospital listed some of the issues confronting public health administration in the hospital. They included the presure which came about as a result of the novel COVID-19 pandemic, road accidents, limited staffing, limited space and beds, and limited personal protective equipment. He said:

> speaking from the perspective of a hospital administrator of the accident and emergency department, the outbreak of COVID-19 was a serious issue, because we were the first point of contact and are currently worried about the new viruses which are "Marburg virus" and "Monkey Pox", which has made us as a unit very alert. Generally, there are road accidents and injured persons are first sent to accident or emergency units before they are eventually admitted as in-patients.[48]

Again, the head of public health nurses in the same department reported that;

> Obviously with public health, they would always have one or two challenges. One of the greatest challenges was during the COVID-19 pandemic. Since it was a novel virus, there was the need to look for different hands or experts to be on board to support. Again, it was difficult to decide which section of the unit could be closed, and which section could be used as an isolation unit, but as time went by, we were able to overcome the challenges when they emerged.[49]

[43] PRAAD, Accra, File No. 154/39, *Patients suffering from Tuberculosis and admitted to hospital-ruling re-treatment and maintenance of*, 1939.
[44] Kennedy A. Alatinga and John J. Williams, Development Policy Planning in Ghana: The Case of Health Care Provision, *European Scientific Journal*, November 2014, edition vol.10, No. 33.
[45] *Ibidem*.
[46] *Ibidem*.
[47] *Ibidem*.
[48] An interview with Mr. Issah Stannard Mohammed, Dated 5th August. 2022 at the Accident and Emergency Department, Korle Bu.
[49] An interview with Jemimah, Dated 5th August. 2022 at the Accident and Emergency Department, Korle Bu.

The Question of Accomodation and Space at The Korle-Bu Teaching Hospital Since 1923

The issue of accommodation had been a problem since the time Korle-Bu Teaching Hospital was built. The initial accommodation provided by the small building was so inadequate that it had to be enlarged during the Governorship of Sir W. Brandford Griffith. Griffith erected a second block with a connecting veranda. Though this hospital was a distinct advance from the makeshift buildings which had previously been used as the hospital, it was soon found that its accommodation was too limited to supply the growing needs for treatment of the inhabitants of Accra, who, under the influence of education and interactions with Europeans, were being gradually weaned off their faith in native traditional medical practitioners or Indigenous Priest Healers (IPHs) and were daily becoming more alive to the efficacy and advantages of European methods of treatment.

The necessity for a new hospital with largely increased accommodation for patients, up-to-date appointments, and provision for the application of the latest discoveries and achievements of medical science to the healing of disease, was generally recognized and was especially advocated by the late Dr, F. G. Hopkins who was the principal Medical Officer of the Gold Coast. His recommendation was opportunely supported at the time due to an earthquake that cracked the eastern block from end to end. This part of the hospital was then condemned as dangerous, but it was patched up, and still in use today.[50]

Concerning the contemporary history of the hospital, Mr.Mahama claimed that:

> Talking from the perspective of a hospital administrator of the accident and emergency department, the outbreak of COVID-19 is a serious issue because we were the first point of contact and currently worried about the new viruses "Marburg virus and monkey pox." Also, there is a challenge of "space" because of the nature of the emergency department. This is because we do not have an isolation center where we could keep and treat patients with the COVID-19 virus. We had to create a space or an isolation center for those patients.[51]

Jemimah, a public health nurse in the accident and emergency unit at the Korle-Bu Teaching Hospital also argued concerning COVID-19 that:

> The problem was which section of the unit should be closed down and used as an isolation unit was a problem, but as time went by, we were able to overcome some of these challenges, when they

[50] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 46-47.
[51] An interview with Mr. Issah Stannard Mohammed, Dated 5th August. 2022 at the Accident and Emergency Department, Korle Bu.

> emerged.[52] Obviously, with public health, we would always have one or two challenges one way or the other. What is equally important is how well we communicate our own issues. We should also adopt right strategies to make the necessary investment into it. One of the greatest challenges was during the COVID-19 pandemic, when we needed to get a lot of people on board. In terms of health crisis like the COVID-19 pandemic, our department or unit, needed a lot of help.[53]

Mahama confirmed the statement above that:

> The staff were afraid, which made some of them reluctant to come to work due to the fear of contracting COVID-19. When a patient is brought in at the first instance, it is difficult for the health workers to see if the person has COVID or not. Also, there was shortage of beds for real accident and emergency cases with a high cost of Personal Protective Equipment (PPEs). The small working space, the shortage of staff and beds worsened our plight.[54]

Moreover, Agormenda and Hannah who are also public health nurses hinted that there was inadequate training of a lot of the nurses in the testing or screening of patients for COVID-19 test coupled with limited tools and equipment.[55] Acquaye who is also a public health nurse in the same department, also confirmed the inadequate provision of Personal Protective Equipment (PPEs). He argued that:

> Due to the upsurge of COVID-19, there were serious emergencies which affected expenditure. Our unit had to make more new purchases due to the changing and increasing trend of the COVID-19 pandemic. It also created the space for shortages due to the challenge of limited finances or fiscal constraints, which could not mitigate the pressing increasing changing demands.[56]

Again, Abby,Teye, and Acheampong who were also patients made a very insightful argument concerning the challenges they mostly faced in terms of receiving health care. They reported that the challenge of delay in healthcare delivery, congestion, and long queues persists. The above responses from the interviewees clearly show the challenges that persist within the medical facility.

[52] An interview with Jemimah, Dated 5th August. 2022 at the Accident and Emergency Department, Korle Bu.
[53] *Ibidem*.
[54] An interview with Mr. Issah Stannard Mohammed, Dated 5th August. 2022 at the Accident and Emergency Department, Korle Bu.
[55] An interview with Mrs. Mabel Agormenda and Madam Hannah, Dated 8th August. 2022 at the Accident and Emergency Department, Korle Bu.
[56] An interview with Daniel Nii Acquaye, Dated 8th August. 2022 at the Accident and Emergency Department, Korle Bu.

However, it also emphaizes the efforts that have been made during the colonial period and contemporary times to mitigate respective challenges. In the present times, the COVID pandemic was initially a puzzlement. However, it reflected the already challenge of limite health infrastructure in Ghana and further the quintessence of the African health spoof.

Effects of The Challenges of Public Health Administration on Health Workers and Patients in the Korle-Bu Teaching Hospital

The process of administering health services has always influenced both health workers and patients. Some transactions that go on between the caregiver and the receiving persons always tend to have both positive and negative effects on both sides. Considering providing healthcare services in the context of public health administration, there are traces of challenges that both the health workers and patients face ranging from the administrative level down to the services provided. During the colonial period and even in contemporary times, the Korle-Bu Teaching Hospital has faced a lot of challenges which has serious ramifications on health workers and patients.

From the onset of the hospital's establishment, it was faced with the crisis of insufficient bed spaces for patients. During the colonial era, the hospital could only admit a total of 192 in-patients. From the year 1922 up to July 1972, the hospital had 1134 beds, 144 cots, 228 Treasure cots, and 18 incubators.[57] This caused major stress on the hospital because, during that period, the population was increasing rapidly, and the people had come to rely on the healthcare services they received at the hospital. In contemporary times, this issue persists in the hospital and was revealed or realized when the COVID-19 pandemic hit the world. Ghana was not exempted from it. Being a novel virus as it was, the need for an isolation space for cases recorded became the topmost priority for the hospital. The Korle-Bu Teaching Hospital, which was facing the challenges of insufficient beds, facilities, staff, and so on, due to the rise of the COVID-19 pandemic, was compelled to make extra room for isolation concerning individuals or patients who came in with the novel virus. In an interview session with the head of public health nurses in the Accident and Emergency department, she reported:

> We had to divide the staff into two, for the various cases treated, which led to the collapse of a unit. So, in effect, the bed capacity was reduced, because one space had been designated for COVID-19 cases and due to that, they did not have a broader space to work with initially. In particular, the Accident and Emergency unit which still needs expansion in terms of staff strength, compounded the extent of the pressure which was brought on the unit. Same applied to their bed capacity because some were designated for COVID-19

[57] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 48.

> patients. This narrative was consistent in every department of the hospital".[58]

Like the above statement, Mahama who is the administrator of the Accident and Emergency Department also hinted that:

> The COVID-19 pandemic was a troubling time for health workers, especially the nurses, who out of the fear of contracting the virus felt reluctant to come to work. This is because, when a patient is brought in, it is difficult for the health workers to easily find out if the person has the virus or not. Health workers had to pull out long hours shifts and sometimes work overtime giving them no period to rest. The major effect on the part of management was financial, because they had to buy a lot of sanitizers, and PPEs which were heavy on the finances of the Korle-Bu Teaching Hospital. This is because it was not part of their regular schedule. Also, unexpected budgeting made incoming donations, "a drop in an ocean"[59].

As the years pass by and technology and medicine keep improving, there is a sytematic shift from record-keeping system which used to be manual or paper-based, where a patient's information was documented in a folder, which was usually saved in a cabinet at the Records department of the hospital. Upon the arrival of patients, especially those visiting for the first time, a new folder is usually opened for the patient but when the patient has visited the hospital before, the person's folder will be retrieved to continue to record the patient's diagnosis in his allocated folder of which the doctors too can make references in making a proper diagnosis and prognosis. Essentially, smartphones and tablets have been used widely in the Western world, creating and providing enomous benefits in healthcare. The Ministry of Health in Ghana has an e-Health strategy to integrate such resources into the healthcare system. Whilst numerous health projects are going on in Ghana, there is the need to have more evidence of doctors using such devices in their practice.[60] Going paperless makes the work of doctors and nurses easier and limits patients' waiting time. The Korle-Bu Teaching Hospital in partnership with Mindray Medical Limited has opened a new laboratory with a digital analyzer to enhance investigations and diagnostics. The analyzer, known as the Mindray SAL 6000, is a digital equipment made to undertake general chemistry, hormones, or immunoassays such as special proteins, cardiac and lipid panels, diabetes panels, and anaemia panel investigations. The analyzer can also

[58] An interview with Jemimah, Dated 5th August. 2022 at the Accident and Emergency Department, Korle-Bu.
[59] An interview with Mr. Issah Stannard Mahama, Dated 5th August at the Accident and Emergency Department, Korle-Bu.
[60] Barnor-Ahiaku E. Exploring the use of smartphones and tablets by medical House Officers in Korle-Bu Teaching Hospital. Ghana Med J. 2016 Mar; 50(1):50-6. Doi: 10.4314/gmj.v50i1.8. PMID: 27605725; PMCID: PMC4994487.

investigate thyroid and infectious diseases. The machine can attend to 400 laboratory investigations at a time and produce reports within an hour. According to a press release, the Chief Executive of the Hospital, Dr. Daniel Asare said the equipment was to help avert the situation where patients must go outside the Hospital for laboratory investigations.[61]

Emanating from the above, Jemimah who is the head of public health nurses in the Accident and Emergency Department hinted that:

> The paperless system used in keeping the health records of patients has been very helpful. It has reduced the congestion of patients in the department. It has also reduced the ease with which communicable diseases could spread among sick persons within the medical facilitty. The days patients used to hold their folders which easily lead to the spread of disease among the nurses, doctors, and patients themselves, is gradually becoming a thing of the past.[62]

Factors to Help Improve Public Health Administration at The Korle-Bu Teaching Hospital

As health workers became more aware of the acute shortages in the hospital like masks, ventilators, limited intensive care unit (ICU) capacity, and staff hamstringing the heroic efforts of healthcare professionals to address the pandemic, including the right supply chain strategies, it was anticipated that the foregone plus management practices were urgently needed to optimize scarce resources, alleviate shortages, and expand capacity quickly. While good management can never be a substitute for dedicated and skilled medical practitioners, improving the management of supply chains was crucially needed to ensure that these professionals had the resources to do their jobs. Tackling shortages and supply constraints required a comprehensive strategy aimed at both the demand- and supply-side roots of the problem. A pandemic generates an enormous demand shock for healthcare systems already running at close to full capacity. Though social distancing measures, travel restrictions, and shelter-in-place orders could reduce demand, they were only part of the solution in dealing with the prevailing COVID-19 challenge. It is still necessary to manage the way patients enter and proceed through the various nodes of the health care delivery system in Ghana and elsewhere in Africa.[63]

[61] Korle-Bu Teaching Hospital, "Korle Bu Sets up State-of-the-Art Laboratory", https://kbth.gov.gh/korle-bu-sets-up-state-of-the-art-laboratory/#:~:text=The%20Hospital%20has%20opened%20a,panel%20and%20aneamia%20panel%20investigations.

[62] An interview with Jemimah, Dated 5th August. 2022 at the Accident and Emergency Department, Korle-Bu.

[63] KC, Diwas and Christian Terwiesch. 2009. Impact of Workload on Service Time and Patient Safety: An Econometric Analysis of Hospital Operations. *Management Science* 55 (9):1486-1498.

Mr. Mahama suggested some solutions to help improve public health administration at the Korle-Bu Teaching Hospital. He said:

> The government needs to pay a lot of attention to public health generally in a sense that they are focusing too much on the clinical side especially in the Korle-Bu Teaching Hospital (KBTH) to the neglect of the public, which should cut across everything. Even though I see that now, every department has a public health worker, some of them in other departments do not have offices to work from. However, in our unit, we are very much aware of the pressing needs for public health workers to support the general healthcare system to prevent avoidable sicknesses and death. Indeed, issues of public health in KBTH needs to be taken seriously. Also, there is the need to equip the office of public health to do a proper work".[64]

One of the critical areas to pay attention to is managing flow. Managing flow means proactively shaping how, when, and where among these nodes' patients; both the infected and uninfected receive care.[65] During the COVID-19 outbreak, hospitals were forced to redesign patient flow in real-time, grappling with such issues cocnerning which care can be moved from a hospital to an alternative setting even the home, which procedures are required to be done on patients but can be safely postponed? and what policies could be put in place to determine how long patients (those with and those without COVID-19) needed to stay in the hospital or utilize an ICU? To help alleviate system congestion, healthcare managers were advised to follow two principles including being aware of systems interdependencies and unintended consequences and to forecast short-term demand.[66]

It is reported that healthcare systems are composed of many interconnected points of care, and the demands across them are not independent. For example, demand for baby delivery rooms spurs demand for postpartum and neonatal care.[67] Diwas and Terwiesch have already emphasized the need to avoid poor choices or decision about patients who are not suffering from COVID to avoid complicating the existing challenges.[68]

System interdependencies mean that changes in one part of the system can generate unintended consequences. For instance, a study of ICU care by Diwas and Terwiesch found that as ICUs reached full capacity utilization, physicians responded by shortening length of stay for patients. This "early"

[64] An interview with Mr. Issah Stannard Mohammed, Dated 5th August. 2022 at the Accident and Emergency Department, Korle Bu.
[65] KC, Diwas and Christian Terwiesch. 2009. Impact of Workload on Service Time and Patient Safety: An Econometric Analysis of Hospital Operations. *Management Science* 55 (9):1486-1498.
[66] KC, Diwas and Christian Terwiesch. 2009. Impact of Workload on Service Time and Patient Safety: An Econometric Analysis of Hospital Operations. *Management Science* 55 (9):1486-1498.
[67] *Ibidem*.
[68] *Ibidem*.

discharge strategy indeed worked to open capacity in the short term, but there was an unintended consequence: It increased the "bounce-back" (re-admission) rate to the ICU, thus increasing demand for the ICU and effectively reducing peak ICU capacity.[69] The general implication of this study is to be careful not to inadvertently make a bad capacity situation worse by diverting patients from specific points of care. Postponing broad swaths of routine care a strategy being pursued by many hospitals today could create similar false economies if some patients who may eventually require more intensive care later because of the postponement.

The lesson here is to carefully stratify patients by the risk of postponement to manage not only their current health but also their future demand for the scarcest health resources. In the context of the COVID-19 pandemic and the new virus such as Monkeypox and Marburg virus, for instance, it is imperative to be very careful about postponing care that increases the risk of a patient to require an ICU or ventilator support a few weeks down the road. The acute shortages of ICU capacity and ventilators due to COVID-19-related demand is a big enough problem and has already exacerbated health systems.[70]

There is also the question about emphasis on system perspective. Significantly, Diwas and Terwiesch have argued for a system perspective route. Taking a system perspective also means that providers should consider available resources, bottlenecks, and capabilities outside their walls.[71] Hospitals under stress quite naturally focus their attention on hospital resources like beds and medical staff. But in doing so, they risk neglecting the constraints faced by providers of community and home health care whose personnel and infrastructure capacity are already stretched. Diverting non-critical patients from hospital settings to home care helps free up hospital capacity for the critically ill and reduces the incidence of contagion.[72] But this strategy needs to be complemented with the appropriate infrastructure and technology; for example, mobile care units and telemedicine capabilities to monitor and coordinate such care. If this scenario is not adhered to, more home-bound patients may end up requiring hospitalization or intensive care later than otherwise would be the case.[73]

Again, Diwas and Terwiesch have argued that when demand is exploding and systems are overwhelmed, it may seem futile to make the effort to forecast demand a week or two out.[74] Therefore, while no forecast is perfect, having some visibility into short-term future demand provides hospitals and other care sites the opportunity to plan patient flows proactively. This may include the

[69] *Ibidem*.
[70] *Ibidem*.
[71] *Ibidem*.
[72] *Ibidem*.
[73] *Ibidem*.
[74] *Ibidem*.

oursuit of pre-emptive diversionary strategies.[75] There is now enough data from around the world on COVID-19 infection rates and their impact on care providers for local providers to make perhaps rough but sufficiently useful short-term forecasts, considering population density, social distancing policies, the daily testing rates that can be achieved, the time it takes to process the tests, among others.[76]

It is further reported that managing demand also needs to be complemented with effective strategies for managing the supply of resources needed to care for patients. It has been argued that same is crucial since not doing so could trigger vicious cycles. Indeed, COVID-19 cases around the world increased demand for tests and staff. The increase in demand for tests initially resulted in test shortages. Hospital staff needed protective gear both to perform tests and to treat patients. Essentially, increases in patient flow created shortages of masks and other protective equipment. Shortages of both testing and protective equipment left staff vulnerable to infection and this confirmed the statement made by Mahama that "the medical staff were afraid, which made some of them reluctant to come to work due to the fear of contracting the disease. The dilemma was that it was difficult to easily ascertain in the first instance, if a patient had COVID-19 upon reporting in the hospital or medical unit."[77] Significantly, it has been reported that high rates of infection among healthcare workers did not only make bad staffing shortages worse but also increased demand when infected staff become agents for transmission to patients who did not have the COVID-19.[78] The solution which have been proposed to deal with the question of supply shortages include de-bottlenecking, pooling and coordinating resources across organisations innovating and learning in real time, focusing on information and fast decision making and learning among other things.[79]

Engaging in systematic de-bottlenecking means, not just focusing on existing bottlenecks, but also identifying future potential bottlenecks; forecasting them and addressing them before they materialize or become acute.[80] Dealing with acute shortages means identifying the root source of the shortage and focusing efforts there to expand or leverage available supply. Due to the fact that the medical staff including other supporting staff are critical resource in almost every phase of healthcare delivery, safeguarding their health should be the number one priority. Increasing ventilator production or creating new ICU beds is helpful only to the extent that there is staff available to operate that new equipment and care for the patients.[81]

[75] *Ibidem*.
[76] *Ibidem*.
[77] An interview with Mr. Issah Stannard Mohammed, Dated 5th August. 2022 at the Accident and Emergency Department, Korle Bu.
[78] *Ibidem*.
[79] *Ibidem*.
[80] *Ibidem*.
[81] *Ibidem*.

In highly interdependent supply chains, bottlenecks will shift. For instance, if testing capacity is limited by the availability of cotton swabs, it does little good to increase the availability of testing kits or to increase laboratory capacity to process tests. Getting ahead of supply shortages requires forecasting the next bottleneck in the system, which requires excellent information about the inventory available in the entire supply chain (not just one's inventory), the capacity of suppliers, demand patterns, and rates of consumption.[82]

In healthcare organizations, it is natural to focus on the shortage of ventilators, masks, protective gear, and swabs and those shortages were required to be addressed urgently. However, hospital managers have been encouraged to be aware that future shortages in other commodities and resources could be lurking due to emerging epidemics and pademics. The sooner they identified them, the better the chance to resolve them before they become acute.[83]

Significantly, attacking a shortage of hospital equipments and others materials for the treatment of the sick or the onfected required creative technical and organizational solutions. In response to the short supply of masks (especially N95 masks), many hospitals in advanced economies developed and started producing alternative designs that were useful for non-COVID-19 patients. Repurposing post-anaesthesia care units (PACUs) into ICUs became another example of innovation in some hospitals in North America and other Western countries. Again, human assets could also be repurposed. In the United Kingdom, for instance, generalist nurses were trained to manage ventilator under the supervision of a specialist critical care nurse, thus effectively increasing the number of ventilated patients each specialist nurse could care for.[84] It has also been reported that some of the challenges of repurposing are more institutional or organizational than technical. For example, most countries or professional societies require certification for healthcare specialists to perform certain tasks. Relaxing these requirements could help alleviate staff shortages.[85] Hospitals and providers need to experiment with new approaches, but they also need to share information candidly so that others can learn and that everyone can make the right mid-course corrections.[86] Good information and fast feedback loops can accelerate learning to identify, implement, and diffuse innovative approaches.[87]

It is important to emphasize that the COVID-19 crisis is testing both the medical and managerial competencies of healthcare systems throughout the world, resolving these operational challenges exacerbated by the COVID-19 crisis would require coherent, comprehensive, systematic efforts that span both

[82] *Ibidem*.
[83] *Ibidem*.
[84] *Ibidem*.
[85] *Ibidem*.
[86] *Ibidem*.
[87] *Ibidem*.

demand and supply forces. To implement these efforts, healthcare managers need to focus on information, fast decision-making, and learning.[88]

Again, they are required to do more community surveillance and education in their surrounding communities, to survey the outbreak of diseases in the community. This among others have the propensity to prevent or reduce the levels of impact of epidemics or pandemics on medical facilities like Korle Bu Teaching Hospital.[89]

Summary

Traditionally, the public health system has gone through a lot of transformations over a long period of time. Public health within the pre-colonial era in Ghana was highly practiced even though knowledge about hygiene was not overtly emphasized. Regarding the respect people had for the traditional institution at that time, all customs, taboos, and superstitions that were directed toward public health were obeyed. From the scientific perspective, these traditional practices (taboos, superstition, and other customs) were seen as uncivilized and of poor quality, however, the study appreciates the fact that having a deep insight into these traditional practices showed the level to which several traditional aetiologies could be explicated, even though there were some spiritual beliefs attached to them.

Historically, from the arguments raised in the subsequent sections, the various challenges, and effects of public health administration in Ghana were brought to light. It was established that public health policies in colonial Ghana were both reactional and responsive in nature. This can be argued from the fact that the colonial administration looking at the high mortality rate among the various Europeans realized that the practice of what Senah, cited in Adu-Gyamfi (2017) termed as medical apartheid was effective since they were surrounded by the natives whom they blamed for the cause of the many deaths among the Europeans.[90]

However, the arrival of the Europeans marked a new transformation in Ghana's health care. The primary mission of the colonial medical services during the early decades of colonial rule was first and foremost to protect the health of European officials and then other Europeans. Their next duty was to look after African civil servants, the military and police, and asylums. Although little attention was paid to the native population, they were not completely ignored.

[88] *Ibidem*.

[89] An interview with Mr. Daniel Nii Acquaye, Dated 8th August. 2022 at the Accident and Emergency Department, Korle Bu.

[90] Samuel Adu-Gyamfi, Peter Nana Egyir, Edward Brenya, Public Health in Colonial and Post-Colonial Ghana: Lesson-Drawing for the Twenty-first Century. *Journal of Studies Arts and Humanities*. vol. 3 (2017), 1-2.

Again, from our archival sources in reference to the Golden Jubilee Souvenir of the Korle-Bu Hospital from 1923-1973, we realized that although the hospital was intended to be a place where African and European patients would be treated without discrimination, the former employees of Korle-Bu recalled that the intentions of its architects were not always realized. As one former nurse was surprised to find out one day that the isolation ward was not being used to contain infectious diseases but as a private ward for white patients.[91]

However, the initial response of natives, especially non-officials, to hospital admissions was near boycott because, before the advent of colonial rule, the native Gold Coaster was used to indigenous medicine provided by the traditional healer whose cosmology was based on physical as well as social causation of illness. Their services included consultations, treatment of illnesses, and prevention through protective charms. Experienced healers passed on their skills through apprenticeship training. However, due to a lack of appreciation and understanding of their practice, the British administration sought to eliminate the activities of traditional healers during the colonial period whereby the missionaries contributed to the denigration of the practice of traditional healers. Likewise, the British administration devised a method to neutralize the influence of healers through a so-called "enlightenment" campaign directed at educated Africans, urban dwellers, and opinion leaders, which characterized traditional healers insincere, and quacks who lived on the neurosis of their illiterate folks. Additionally, the construction of the firm foundations of medical services during the colonial period can be attributed to Governor F.G. Guggisberg. His general medical policy was to deal with diseases in the order in which they mostly affect the general life of the people.

The study further established a historical study on public healthcare administration in Ghana focusing on the responses from health workers and patients at the Korle-Bu Teaching Hospital, using the Accident and Emergency Department as the bases to create a useful generalization in helping to shape public health administration in the Korle-Bu Teaching Hospital. It goes further to discuss the challenges and effects confronted by health workers in administering public health during the pre-colonial, colonial, and post-colonial period.

The findings and analysis of the study revealed that, the current public health system in Ghana and the Korle-Bu Teaching Hospital to be precise owned much gratitude from the pre-colonial and the colonial period. In view of this, the hospital which is in an urban area has a trait of the European style of public health administration since it was a colonial hospital in terms of ensuring the total well-being of the people in Accra and Ghana at large. Throughout the study, it was discovered that during the colonial period, the natives in Accra disliked this

[91] PRAAD, Accra, R/160. 1973. Korle-Bu Hospital. 1923-1973. Golden Jubilee Souvenir, 76.

European style of public health. However, the force implementation of some public health policies impacted positively on the lives of the people of Accra. Public health administration and policies in Accra and precisely the neighbouring communities around the Korle-Bu Teaching hospital such as Korle-Gonno, Chorkor, Mamprobi among others have undergone several transitions within the traditional society up to the twenty-first century. However, a comparative study of the two periods indicate that public health in the twenty-first century Korle-Bu has not yielded some of its expected gains despite the numerous public health care interventions made by various governments. Inadequate infrastructure, shortage of public health workers, inadequate tools and equipment, choked gutters, poor location of refuse dump-sites, inadequate latrines leading to open defecation, which leads to the spread of diseases among others have been the major characteristics of the challenges of public health administration faced by health workers and patients at the Korle-Bu Teaching Hospital and the inhabitants in the surrounding communities. This could be attributed to inadequate attention paid to public health administration and public health. It is therefore necessary for the government both at the national and local levels to pay proper attention to public health administration. Attention and resources should not only be given to clinical care, to the neglect of public health. Efforts should cut across every sector of healthcare and fully equip the office of public health administration to do a more efficient work. There is also the need to make inferences from the various past challenges and effects of public health administration at the Korle-Bu Teaching Hospital and Ghana at large to know how to deal with similar challenges emanating from the day to day running of Ghana's health institutions including the required preparednes to deal with epidemics and pandemics at the local and national levels.

Zaključak

Tradicionalno, javni zdravstveni sistem prošao je kroz mnoge transformacije tokom dugog perioda vremena. Javno zdravlje u prekolonijalno doba u Gani bilo je visoko prakticirano iako se znanje o higijeni nije otvoreno naglašavalo. Što se tiče poštovanja koje su ljudi imali prema tradicionalnim institucijama u to vrijeme, svi običaji, tabui i sujeverja koji su se odnosili na javno zdravlje bili su poslušani. Sa naučne perspektive, ove tradicionalne prakse (tabui, sujevjerje i ostali običaji) smatrane su necivilizovanim i loše kvalitete, međutim, studija cijeni činjenicu da dublje razumijevanje ovih tradicionalnih praksi pokazuje nivo do kojeg su različite tradicionalne etiologije mogle biti objašnjene, iako su uz njih bile povezane i neka duhovna vjerovanja.

Historijski gledano, iz argumenata iznesenih u narednim sekcijama, različiti izazovi i efekti upravljanja javnim zdravljem u Gani došli su do izražaja. Utvrđeno je da su javnozdravstvene politike u kolonijalnoj Gani bile reakcionarne i responsivne prirode. To se može argumentirati činjenicom da je

kolonijalna administracija, osvrćući se na visoku stopu smrtnosti među različitim Evropljanima, shvatila da je praksa onoga što je Senah, citiran u Adu-Gyamfi (2017), nazvao medicinskim aparthejdom bila efikasna jer su bili okruženi domorocima koje su krivili za uzrok mnogih smrti među Evropljanima.

Međutim, dolazak Evropljana označio je novu transformaciju zdravstvene zaštite u Gani. Primarna misija kolonijalnih medicinskih službi tokom prvih decenija kolonijalne vlasti bila je prije svega zaštita zdravlja evropskih zvaničnika, a zatim i drugih Evropljana. Njihova sljedeća dužnost bila je briga o afričkim državnim službenicima, vojsci i policiji, te azilima. Iako se malo pažnje posvećivalo domorodačkom stanovništvu, oni nisu bili potpuno zanemareni.

Ponovo, iz naših arhivskih izvora u vezi s Zlatnim jubilejom Korle-Bu bolnice od 1923. do 1973. godine, shvatili smo da iako je bolnica trebala biti mjesto gdje će afrički i evropski pacijenti biti tretirani bez diskriminacije, bivši zaposlenici Korle-Bu-a su se prisjetili da namjere njenih arhitekata nisu uvijek bile ostvarene. Jedna bivša medicinska sestra iznenadila se jednog dana kada je saznala da se izolacioni blok nije koristio za zbrinjavanje zaraznih bolesti, već kao privatni blok za bijele pacijente.

Međutim, prvobitna reakcija domorodaca, posebno nezvaničnih osoba, na prijem u bolnice bila je skoro bojkot jer je, prije dolaska kolonijalne vlasti, domaći stanovnik Zlatne Obale bio naviknut na indigenu medicinu koju su pružali tradicionalni iscjelitelji čija je kosmologija bila zasnovana na fizičkom, kao i socijalnom uzroku bolesti. Njihove usluge uključivale su konsultacije, liječenje bolesti i prevenciju putem zaštitnih amajlija. Iskusni iscjelitelji prenosili su svoje vještine putem obuke kroz praksu. Međutim, zbog nedostatka cijenjenja i razumijevanja njihove prakse, britanska administracija je nastojala eliminirati aktivnosti tradicionalnih iscjelitelja tokom kolonijalnog perioda, pri čemu su misionari doprinijeli obezvređivanju prakse tradicionalnih iscjelitelja. Također, britanska administracija osmislila je metodu neutralizacije utjecaja iscjelitelja putem takozvane "prosvjetiteljske" kampanje usmjerene prema obrazovanim Afrikancima, stanovnicima gradova i vodećim ličnostima, koja je tradicionalne iscjelitelje karakterisala kao "nesrdačne, kao šarlatane koji žive na neurozi svojih nepismenih ljudi". Dodatno, izgradnju čvrstih temelja medicinskih usluga tokom kolonijalnog perioda možemo pripisati guverneru F.G. Guggisbergu. Njegova opća medicinska politika bila je baviti se bolestima redom kojim najviše utječu na opći život ljudi.

Studija je dalje uspostavila historijsko istraživanje o upravljanju javnim zdravstvom u Gani s fokusom na odgovore zdravstvenih radnika i pacijenata u Korle-Bu Učiteljskoj bolnici, koristeći Odjel za nesreće i hitne intervencije kao osnovu za stvaranje korisnih generalizacija koje pomažu oblikovanju upravljanja javnim zdravljem u Korle-Bu Učiteljskoj bolnici. Ide dalje u diskusiji o izazovima i efektima s kojima su se suočavali zdravstveni radnici u upravljanju javnim zdravljem tokom prekolonijalnog, kolonijalnog i postkolonijalnog perioda. U procesu upravljanja javnim zdravljem, ova studija je pružila osnovu

putem koje se javno zdravlje može ispitati. Nalazi i analiza studije otkrili su da trenutni javni zdravstveni sistem u Gani i Korle-Bu Učiteljska bolnica imaju mnogo zahvalnosti iz prekolonijalnog i kolonijalnog perioda. S obzirom na to, bolnica koja se nalazi u urbanoj oblasti ima osobinu evropskog stila upravljanja javnim zdravljem jer je bila kolonijalna bolnica u smislu osiguravanja ukupnog blagostanja ljudi u zajednici u kojoj se nalaze i na ovaj ili onaj način, naciju uopšte. Tokom studije otkriveno je da su domoroci u Akri tokom kolonijalnog perioda nevoljko prihvatili ovaj evropski stil javnog zdravlja, međutim, primjena nekih javnozdravstvenih politika pozitivno je uticala na živote ljudi u Akri. Upravljanje javnim zdravljem i politike u Akri i precizno okolnim zajednicama oko Korle-Bu Učiteljske bolnice kao što su Korle-Gonno, Chorkor, Mamprobi i drugi su prošle kroz nekoliko tranzicija od tradicionalnog društva do sadašnjeg društva 21. vijeka. Međutim, komparativno istraživanje ova dva perioda pokazuje da javno zdravlje u 21. vijeku u Korle-Bu je ostvarilo očekivane dobitke uprkos brojnim intervencijama u javnom zdravstvu koje su napravili različiti vlade. Nedostatak infrastrukture, nedostatak javnih zdravstvenih radnika, nedostatak alata i opreme, začepljene kanalizacije, loša lokacija deponije smeća, nedostatak toaleta što dovodi do otvorenog vršenja nužde i lako širenje bolesti među ostalim su glavnim karakteristikama izazova u upravljanju javnim zdravljem s kojima su se suočavali kako zdravstveni radnici tako i pacijenti i stanovnici okolnih zajednica u Korle-Bu Učiteljskoj bolnici. To može biti zbog nedovoljne pažnje koja se posvećuje upravljanju javnim zdravljem i javnim zdravstvenim radnicima i slabe saradnje ljudi s bolnicom. Stoga je neophodno da vlada (bilo nacionalna ili lokalna) posveti odgovarajuću pažnju upravljanju javnim zdravljem u Korle-Bu Učiteljskoj bolnici umjesto što sve svoje resurse usmjerava na klinički aspekt, na štetu javnog zdravlja koje bi trebalo obuhvatiti sve sektore i potpuno opremiti kancelariju za upravljanje javnim zdravljem kako bi se obavio pravi posao. Takođe je potrebno da se izvuku zaključci iz različitih prošlih izazova i efekata upravljanja javnim zdravljem u Korle-Bu Učiteljskoj bolnici i u Gani uopšte kako bi se znalo kako se nositi sa sličnim situacijama.

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