

NGO Contributions to Creating Wealth Through Health Promotion in Ghana

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Abstract

Aims

The study investigates the role played by NGOs in promoting health as a tool for wealth creation in Ghana. It also delves into the successes and constraints faced by NGOs in creating health through wealth in Ghana.

Design

A qualitative approach was used by the study. Sampling was purposive and data was collected through in-depth interviews. Reports and other documentary evidence obtained from respondents were also used. The data was analyzed thematically and discussed within the context of relevant literature and evidence based practices.

Setting

The study set in the Dangme West (now Shai-Osudoku) District of Ghana and focuses on the local Area Development Programme (ADP) of World Vision Ghana. It covers the activities of the ADP in the district between 1996 and 2011.

Participants

The study interviewed 3 persons who had been involved in managing the ADP, 4 opinion leaders in the District and 3 representatives of the District Health Directorate.

Findings

World Vision was the key stakeholder of education, health and nutrition, agriculture, water and sanitation, emergency relief response and HIV/AIDS education and support in the district. Findings also show logistical, cultural and other resource barriers hamper the effective operations of NGOs in creating wealth through health. Limited community participation and commitment to World Vision's exit strategy were also major impediments.

Conclusion

NGOs are very instrumental in mitigating of the direct, indirect and intangible costs of health in rural areas of Ghana through capacity building, empowerment, public health interventions and Local economic development.

Introduction

Health is a word widely used in everyday conversation with little apparent ambiguity (Green, 2007). However, the WHO definition of health together with the wider Primary Health Care (PHC) concepts, suggests that much broader interventions including individual and community empowerment as well as antipoverty measures are necessary to promote health (Butterfoss, 2007). In return, enhancing the health status of individuals, communities and countries may well hold the key to sustainable socio-economic growth and development (Labonte, 1994, Magawa, 2012).

Because health in this sense affects the productive ability of the workforce, it is thus not seen as an end in itself but rather as an investment – a means to a greater end of productivity and wealth creation. Economic development strategies in developing countries, have therefore placed emphasis on ill-health as both a cause and a consequence of poverty such that socio-economic development and in fact wealth creation will be greatly enhanced if the negative impact of ill-health is reduced through health promotion (McManus, 2013, Nyamwaya, 2003). In Ghana specifically, this idea is the central focus of the ‘creating wealth through health’ strategy adopted by the Ministry of Health (MoH) in 2005.

The creating wealth through health strategy (MoH, 2005) is seen as a holistic approach to promoting good health with the objective to tackling the costs of ill-health and in effect making significant savings on health expenditure as well as enhance workforce productivity. It recognizes that health promotion and indeed good health is not only a human welfare issue but is a fundamental objective of socio-economic development. Further, no single Ministry, Department or Agency can ensure the health of the nation; it requires the concerted effort of the public and private sectors, NGOs, civil society, religious bodies and virtually all segments of the society. A concerted approach from all these stakeholders would not only lead to significant savings on health expenditure as a result of the reduced disease burden but ultimately accelerate the attainment of the Millennium Development Goals (MDGs).

Although considerable research has been done on the nature and extent of the efforts being put into ‘creating wealth through health’ by actors in the health sector as a bloc, evidence from (Yeboah, 2007) suggests that relatively little light has been thrown on the role played by NGOs and other non-state actors in health as a unit in achieving this goal. The study investigates the role played by NGOs in promoting health as a tool for wealth creation in Ghana. It also delves into the constraints faced by NGOs in creating health through wealth in Ghana.

Overview of key concepts

Health and wealth: Health as a resource

Health like wealth is a resource (Quashigah, 2006). With foresight, the Ottawa Charter (WHO, 1986) also defined health as a resource for everyday life rather than a goal in itself and outlined the strategic response in its five action areas for health promotion. Focus on health in contemporary times is thus on support lead strategies or creation of social opportunities to enable people live a healthier happier and productive life (Sen, 1999). However, the bias has been to equate health with expenditure and consumption rather than investment and production. In contrast, Whitelaw and Watson (2005) indicate that though this may be rational, it could be highly counterproductive, and take resources from societies and families that would be better invested in health- (and wealth) producing measures. Also, a society that spends so much on health care, that it cannot or will not spend adequately on other health enhancing activities, may actually be reducing the health of its population (Mittelmark, 2001). Consequently, expenditure to enhance health may well be better invested in other socio-economic interventions instead of direct injection into health care.

Wilkinson (2002) has also shown in his study of the health-wealth dichotomy that even in rich societies, significant health differentials are at work and that there are significant differences in life expectancy between social groups and between countries. Further evidence from Miringoff and Miringoff (1999) show that while gross domestic product has increased significantly in the developed economies, the index of social health has decreased, and the two measures now seem to be depicting quite different phenomena and separate dynamics in society. This indicates that health patterns closely mirror not only the economic but also the social characteristics of a society. Kalache et al. (2002) caution however that above a certain level of wealth, it is not the wealthiest societies which have the best health, but those that have the smallest income difference between rich and poor.

Deriving from the above therefore, health has been cited without reservations across literature as a dominant determinant of wealth. Specific measurable contributions of health to wealth creation include the fact that staff energy levels and motivation will noticeably improve (Dooris, 2006), physical and mental health problems stop before they start (Hawe et al., 2000), vulnerable individuals will be guided towards the supportive care they need and absence levels will drop (McQueen Vowel Repetition

There is one particular feature that appears to emerge in some catchy pop songs, and is something of a secondary type of hooking device. Where I would classify vowel elongation and prosodic devices (such as lyrical rhythm) as primary hooking devices, vowel repetition and phrase repetition are to be considered secondary hooking devices.

and Anderson, 2002), increased self-responsibility will improve time management, creativity, productivity and ultimately profitability (Lee and Vowel Repetition

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Whitman, 2003), and enhanced staff retention and reduced sickness and recruitment costs (Rychetnik, 2004).

The health status of any population determines its level of productivity, hence the old adage “a healthy population is a wealthy population”.

Ghana's creating wealth through health promotion policy

This strategic direction of improving human capital makes health central to Ghana's development efforts: only a healthy population can bring about improved productivity and subsequent increase in GDP, and by doing so ensure economic growth. Consequently, a core function of the Ministry of Health is to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, population and nutrition services for all people living in Ghana and promoting the development of a local health industry (MoH, 2006b). This mission puts the concept of health beyond the confines of curative care to other socio-economic determinants of health which require more focus on promoting good health.

In fact, Bosu et al. (2004) provide that the poor environmental conditions in which Ghanaians live, work and go to school have a major impact on their health, wellbeing and productivity. MoH (2006a) also identifies that the state of the productive workforce and their dependents are adversely affected by improper disposal of waste, emission of dangerous gases from industries and vehicles, smoke from burning of waste and bush fires, poor waste management infrastructure and practices, limited access to potable water, road traffic accidents and unhealthy lifestyles and habits. These factors among others, together with the known environmental factors that manifest in a high level of mortality, morbidity and disability in Ghana are preventable. Yet, About 90% of the diseases and conditions hindering workforce productivity and the general wellbeing of Ghanaians could easily be prevented if appropriate environmental and lifestyle measures were to be taken rather than focusing on curative measures (MoH, 2008, Quashigah, 2005).

Consequently, the creating wealth through health policy was incepted as a paradigm shift from curative action to health promotion and the prevention of ill-health. The policy argues that a healthy population and workforce can only be achieved through tackling the

negative effects of health through adequate prevention measures and promoting good health practices. It aims to use health as a tool for promoting healthy lifestyle and environment, providing the needed manpower, material and financial resources for economic growth, and the mobilization of sector-wide resources for national development.

The policy seeks to promote a vibrant local health industry that supports effective, efficient, and sustainable service delivery, creates jobs and contributes directly to wealth creation and attainment of national development objectives (MoH, 2007). It does this by providing the broad guidelines for the development and implementation of programmes by the central government, Ministries, Department and Agencies (MDAs), local authorities, the private sector, civil society organizations as well as local communities intended to guide health-enhancing actions of individuals, households and communities and corporate entities.

Framework for health development in Ghana

The conceptual framework underlying the development of the National Health Policy is derived from the national development goal of attaining middle-income status by 2015 and an affirmation of the contribution of health to this vision. At the core of this framework is the 'creating Wealth through Health' thought. The conceptual framework spells out two interacting and mutually reinforcing pathways through which the health sector contributes to socio-economic development in the country. The first pathway is based on the acceptance that improving health and nutritional status of the population leads to savings on treating preventable diseases, improved productivity, economic development and wealth creation. The second pathway recognizes that creating a local health industry supports and sustains health services and creates jobs and leads to economic development and wealth creation.

The framework recognizes that good health is intrinsically desirable and is a necessary ingredient for socio-economic development and places health activities and programmes within the framework of a health industry that sustains health delivery and creates jobs. Thus by promoting population health and nutrition status, preventing diseases and injuries and maintaining health, and restoring the health of the sick and disabled, the country can make savings on resources otherwise spent on treating preventable and avoidable diseases (MoH, 2006b). At the same time, improved health and nutritional status promotes intellectual capacity and productivity in the population (WHO, 2004), both of which are needed for economic development. Also a health industry has intrinsic and instrumental value for national development because it contributes directly to wealth creation by creating jobs, and indirectly through the provision of health services (Yeboah, 2007, WHO, 2003).

The conceptual framework is underpinned by four cross-cutting and interrelated themes that need to be pursued to achieve the objectives for the health sector – financing, capacity development, good governance and partnerships, and information. Table 1 shows the key shifts in health development policy in Ghana.

The costs and implications of ill-health to wealth creation and the GDP

Asante et al. (2005) posit that that health and ill-health have major implications on the survival, growth and development of every economy. With wide-reaching micro and macro effects, the gross wealth of an individual, community or country will affect and be affected by the ability to achieve and sustain an appreciable level of health and wellbeing. Consequently, promoting health and reducing the effects of ill health must therefore be of prime importance to all stakeholders of economic growth and poverty reduction (Marmot et al., 2008).

Figure 1.1 points out the costs of diseases to the individual, family, community, employer and the nation as being direct, indirect or intangible. Though not immediately evident, these costs when quantified in monetary terms will underscore the immense loss suffered by the country and its citizens as a result of health related factors. Significant gains, financial and non-financial, can therefore be made if the underlying causes of these health conditions are addressed. With preventive and promotive health being identified as the single most effective means of enhancing and sustaining health towards the goals of wealth creation, growth and development, all stakeholders in the health sector whether governmental or non-governmental have a significant role to play (Bloom et al., 2001, Hitiris and Posnett, 1992).

Methods and procedure

The study is set in the Dangme West (now Shai-Osudoku) District of Ghana and focuses on the local Area Development Programme (ADP) of World Vision Ghana. It covers the activities of the ADP in the district between 1996 and 2011. World Vision Ghana was selected because of its role as a major stakeholder of local government and rural development in Ghana. Its activities covers the health, education, agriculture and social welfare sectors of Ghana mainly at the grassroots and rural areas which have little or are totally deprived of governmental support.

A qualitative approach was used by the study. Sampling was purposive and focused on gathering the views of key persons involved in decision making and implementation of interventions by WVI. Primary data was collected through in-depth interviews. This technique was very useful because of its substantial flexibility in allowing significant data collection within the ordinary places of work of the persons involved in the study. A total of 10 interviews were conducted involving 3 persons who had been involved in managing the ADP, 4 opinion leaders in the District and 3 representatives of the District Health

Directorate. Appropriate permissions were sought from the relevant authorities at the district prior to data collection. The study and instruments used were also reviewed and approved by the research and conferences committee of UGBS.

The interview was semi-structured and aided by an interview guide specially prepared in accordance with the objectives of the study. The questions asked during the interviews, together with the probes and prompts were anonymous and focused on specific information with accompanying anecdotes on the contributions made by WVI to wealth creation as well as the challenges they faced during these activities. The interview guide was pretested and further modified before being validated for the study. The interviews were recorded and transcribed and later shown to participants for signing-off before being analysed.

The thematic analysis approach was used because it offers an accessible and theoretically-flexible approach to analysing qualitative data (Braun and Clarke, 2006). The initial step involved the derivation of broad headings based on the key objectives of the study. The transcribed data was then sorted and arranged under the headings under which they best fit. The data under these groups were reviewed and subthemes were developed. Finally, the subthemes were reviewed for consistency, coherence and substantive merit to aid the development of final themes. The final themes were derived from the merger of subthemes. During the process, specific examples and anecdotes supporting key information under themes were also noted. The discussion of the themes were done in the context of relevant literature, evidence based practices, reports and other documentary evidence on the topic under discussion.

Findings

As shown in table 2, all respondents had lived and worked in the District for more than three (3) years. 60% were female and all respondents had tertiary education and were knowledgeable and actively involved in the local economic development and health interventions in the district.

Findings show that World Vision and other NGOs were major partners for local development in the district. As the key NGO in the district, WVI adopted a multi-pronged approach to local wealth creation by initiating, promoting and supporting interventions in education, health and nutrition, agriculture, water and sanitation, emergency relief response and HIV/AIDS education and support in the district. By partnering the District Assembly, the district Health Directorate, community members and other CSOs in the district, WVI had made significant contribution towards creating wealth and building a healthier, safer community.

WVI created wealth at the local level by using health promotion measures to eradicate the cost of illness and subsequently, the cost to the GDP. As shown in below, it did this

through the direct financing of health related activities, provision of infrastructure and support services, and counseling, education and sensitization. This approach has had wide financial and economic implications on the lives of the people in the community. Within the context of the creating wealth through health policy, WVI had increased access to health, enhanced community participation in decision-making and enhanced the socio-economic empowerment of local artisans and women. Figure 2 presents a summary of how WVI creates wealth through health promotion

In terms of direct financing of healthcare care, findings show that WVI was the major financier of not only health, but local development initiatives in general in the district. Evidence provided by the ADP (table 3) showed for instance that over a five year period, WVI made direct financial contributions of \$331,166 to the district. Within this period, that amount that would have otherwise been spent by the district on health over the five-year period was freed up for use in other productive ventures within the district. Specifically, WVI provided financial support for the nutritional rehabilitation of the Orphaned and Vulnerable children (OVC) center in Kasunya, Osudoku, Ningo and Ayetepa and also paid honorarium to resource personnel and drama groups to educate groups on environmental sanitation. WVI also provided funds to support Persons Living with HIV/AIDS (PLWHAs) to acquire skills for living in Dodowa, provided funds for breast screening in Ningo and also provided funds for GHS to undertake immunization of children against the six childhood killer diseases. In addition, WVI also provided funds for purchasing and distribution of Insecticide Treated Nets (ITNs) for children in the district as well as funding for the National Immunization Day outreach programme (NID) in the district.

Findings also show that WVI was engaged in promoting health through empowerment, education, counseling and sensitization as a means of improving knowledge and awareness of local health conditions, how to prevent and manage them as well as how to promote good health and safe, healthy home and workplaces. It also facilitated inter-sectoral collaborations and partnerships between state and non-state actors towards enhancing the health and economic outlook of the district. Specifically, findings show that WVI engaged in peer education on HIV/AIDS, education on environmental sanitation, training of people living with HIV/AIDS (PLWHA) in positive living, training orphaned and vulnerable children (OVC) in value-based skills and education on breast cancer among others. The objective of these activities was to prevent the occurrence of ill-health and the associated costs that would be involved in treating these conditions. It was also aimed at preventing and helping local communities deal with the intangible costs of ill-health.

Findings also show that significant contributions were made by WVI tackling the indirect costs to health through the provision of infrastructure and support services in the district. Specifically, WVI built a clinic for the Osuwem community; built a modern Voluntary Counseling and Testing (VCT) center for the Dodowa Government Hospital which also

houses breast cancer, Adolescent Reproductive Health [ARH] and other units; built a Nutritional Rehabilitation Center (NRC) for Ningo clinic; and built institutional toilets for 30 schools in the district. Other health related activities being carried out by WVI in the district include the provision of supplementary food for preschool children in their project communities and their collaboration with the District Assembly (DA) to provide a \$29,000 dam for the people of Baabi in Ningo. Activities of WVI like free health screening, adolescent reproductive health workshops and clinics, voluntary counseling and testing, safe motherhood, personal hygiene and support for clean-ups had also increased awareness and positive health behaviour in their communities. Table 4 shows a summary of some interventions of WVI including the number of communities served and the approximate number of beneficial over a year.

“...health centers in communities and remote settlements provided by WVI had saved inhabitants the time, cost and inconvenience of travelling to the Dodowa government hospital (the only hospital within a 100 mile radius) for health care. The money that would have been used for this could be put to other productive use on their farms or engage in other income generating activities...”

Findings also unearth that attention had been given to the building, furnishing and resourcing of schools and clinics, provision of potable water, support for deprived and vulnerable groups and the disabled in the district. Screening, testing and treatment of local health conditions like malaria, cholera, breast cancer, childhood killer diseases, diabetes and hypertension were also an important activities undertaken by WVI.

Findings also show logistical, cultural and other resource barriers hamper the effective operations of NGOs in creating wealth through health. Limited community participation and commitment to World Vision's exit strategy were also major impediments. Additionally, poverty, illiteracy and limited inter-sectoral collaboration were also key challenges faced by WVI and other NGOs in the district. Also the migration trends of children and mothers within the district affected their activities.

Discussion

Literature abounds that NGOs have a clear and potentially powerful role in health promotion and reducing health inequalities. NGOs in this vein therefore serve as catalysts for improving health through lobbying, activism, service provision and advocacy (Pfeiffer, 2003); and outreach work, engaging peer educators and mentoring (Whitelaw and Watson, 2005). Considerable success has been chalked by grassroots community projects, civil society groups and women's organizations that have, for example, demonstrated their effectiveness in health promotion, and provided models of practice for others to follow. However, no effort designed at promoting the health status of individuals will yield any benefit if the target community has no access (Tengland, 2007). Accessibility

can be seen as the financial and geographical conditions that determine whether consumers of health services readily obtain all their health needs, at the time they want within a reasonable distance (Donabedian, 2002), and at a reasonable price (Ensor and Cooper, 2004).

Creating and enhancing access to healthcare, healthy lifestyle and healthier communities is a major role played by WVI. Quite apart from removing the geographical and financial barriers to health through provision of health centers and support for CHPS compounds, the free health care and screening, giving out ITNs, Oral Rehydration Salt [ORS] and other logistics for local health initiatives by WVI also greatly reduced the financial burden of health of the community. The acceptance that the health education, sensitization and counseling services provided by WVI to promote health had improved health circumstances in their communities confirm that the activities of WVI do not merely enhance access to health services but also positively influence the health circumstances of the people.

Also, health promotion hinges on empowering individuals to take control of their health (WHO, 1986, Mcqueen and De Salazar, 2011). It must therefore not be seen a transitive action but as one which involves stimulating people to participate in activities that influence their health outcomes. Wechsler et al. (2000) also confirm that health promotion actions guided and supported by community participation yield better results in developing countries. An effective health promotion strategy therefore focuses on building knowledge and skills among individuals, organizations and communities to act on issues that are important to their health and well-being. This also means creating opportunities for community members and organizations to participate in health.

NGOS play a key role in this regard by creating an environment that makes it possible for the community to participate in decisions that affect their health and economic choices. Empowerment and community participation interventions such as those undertaken by WVI in the District gives local people confidence and the awareness to take control of their health, livelihoods and future. Empowerment and participation are very important components and measures of NGO activities because they provide a means of promoting good health in the community and mobilizing community resources based on the philosophy that good health promotion and care must be shaped by and integrated with the context in which people live (Laverack, 2004, Mills and Ungson, 2003).

Ashraf et al. (2008) provides that there are direct costs in health promotion that may influence wealth creation positively or negatively. In other words, these costs consume a significant proportion of resources that will have alternatively led to wealth creation and subsequently increment in the Gross Domestic Product [GDP]. As shown in Asante et al. (2005), these direct costs of cover the financial and time costs to households as well as the human resource, infrastructure and procurement of drugs to communities. All efforts

at creating wealth through health must therefore address these direct costs to health based on the basic principle that the resources that will have been used for such activities will then be freed up for use as capital in other wealth creating activities. Along this line, NGOs have gained popularity for providing funding for projects especially in less developed countries where government funding is limited or lacking (Pfeiffer, 2003).

In this study for instance, it is clear that WVI in its health promotion efforts makes contributions to meet these direct costs in the Dangme West District. This is consistent with Swift (2011) findings that, in fact, the direct contributions and investments made by Non-governmental stakeholders to health and local level development were unmatched and had major positive impact on survival, growth and profitability of micro and macroeconomic activities. Within health limits, these efforts reduce illnesses, allowed for early diagnosis and treatment of conditions before they got out of hand and had enhanced the quality and scope of healthcare delivery at no cost to the community. Additionally, the money that would have spent on treating day to day illnesses like malaria as a community or individually had reduced, likewise the associated opportunity costs.

Indirect costs of health are those factors that affect the creation of wealth that have no direct financial implications (Koopmanschap and van Ineveld, 1992). However, when the value of these factors is computed in monetary terms, they form a significant portion of the gains that are lost to wealth creation through negative health circumstances. In other words, these are non-financial costs of health that have financial implications. Asante et al. (2005) identify the indirect costs of ill-health to wealth creation and the GDP as including the value of productive time lost due to mortality and morbidity; reduction in human capital accumulation due to effects on intellectual development; demographic effects on consumption, labour supply and so on; and the value of lifetime earnings lost due to premature mortality. Su and Flessa (2013) in similar fashion identify time and the supply of able-bodied persons as the principal indirect costs of health that have telling effects on the propensity of individuals and communities to generate and sustain appreciable levels of wealth.

Deriving from the above, efforts at creating wealth through health promotion can be assessed as a factor of the contributions made to address these indirect costs of health. WVI and NGOs in general are seen as active drivers of interventions aimed at tackling the indirect costs of health especially at the grassroots. While the time community inhabitants would have spent seeking treatment and the time that will have been lost through sickness had reduced, the activities of WVI had also ensured that there were more active and healthy people in the community and little productive time was lost to death and illness. Quite apart from the above, health promotion and prevention interventions such as those carried out by WVI in the district have proved to be an important means of reducing productive days lost to mortality, morbidity and disability in agrarian and riverine communities. Previous studies also confirm that local economic

development is also enhanced by Non-governmental efforts that sensitize community members on how to prevent and address common health problems like cholera, malaria, typhoid, diarrhoea, sexually transmitted infections and diseases, and pregnancy related conditions (Apt, 2013, Banerjee et al., 2004).

One of the key reasons why the Ghana Health Service (GHS) has classified some health conditions as Diseases Of National Importance [DONI] is the debilitating effect that these diseases have on individuals in the country. These effects are intangible and though not directly or indirectly related to finances are those that cause discomfort, suffering, pain and in some instances death. DONI as defined by the GHS includes malaria, HIV/AIDS, guinea worm, buruli ulcer and tuberculosis (Bosu, 2013). It is also key priority of the creating wealth through health policy to pay close attention to the prevention and control of such health conditions through promotive and preventive practices rather than curative ones. In line with the above therefore, actors in health promotion in addition to the interventions aimed at meeting the direct and indirect costs of ill-health also channel some effort in addressing these intangible costs of health. Asante et al. (2005) define the intangible costs of ill-health that need to be addressed in order to create wealth as including agony and distress, loss of leisure time, failure to participate in social activities, and modification of socio-economic decisions like the choice of crops and migration. These intangibles are those that influence not only the economic but also the psychosocial, religious, moral and cultural state of individuals by affecting their approach to work, choice of work, stress level and level of acceptance in the community. When neglected they tend to affect the productivity of individuals and have negative consequences on their potential to create wealth.

Stakeholders of wealth creation must therefore be interested in addressing these intangible variables and their effects through the provision for counseling, health fairs and seminars, training and education programmes, providing support for affected persons, periodic visits and encouragement, reintegration into society and reducing the stress of the burden of diseases. While governmental funding and efforts may be limited, evidence from this study shows how important NGOs are towards the attainment of this goal. These efforts are especially important in countries where the health system is medicalized and attention is often skewed in favour of provision of medical infrastructure, staff and services (Macdonald, 2013, WHO, 2009).

Another crucial effort by WVI and other NGOs in this line is empowerment. A core function of health promotion, the Ottawa charter defines empowerment as enabling people to increase control over, and to improve their health. It also refers to the capacity of individuals and communities to improve their lives by increasing control over the determinants that affect their day to day survival (Tones, 2001). Empowerment initiatives are effectively carried out through acts of advocacy, education, building social support systems and creating conducive environments that enable people to make healthy

choices and live healthy productive lives. Enhancing empowerment, be it socio-cultural, political or economic, has a positive knock on effect on ensuring community participation and ownership of development. It also provides an avenue for home grown solutions to health problems and other development mitigations. Importantly, it serves as a motivating force for local communities to create, own and share wealth rather than live on aids and grants (Smith et al., 2006) or become perpetual dependents on charity.

Though no alternative to health promotion as a way of responding to the rapidly emerging vicious cycle between ill-health and productivity exists, stakeholders in that venture have a myriad of challenges to contend with. For NGOs in developing countries in particular, economic conditions, poverty and illiteracy are key challenges that threaten to erode the gains made in creating wealth through health promotion (Wireko and Béland, 2013, Dooris, 2006, Kirch, 2005). In the Dangme West district for instance, WVI's activities were often limited by the vicious cycle of ill-health and poverty. This is consistent with WHO (2009) stance that poverty and its resulting poor living conditions of malnutrition, disempowerment, poor housing, environmental degradation and despair are major impediments to improving the health and local economic development in developing countries. On the other hand, ill-health also limits the productive ability of persons and therefore exacerbates the conditions for impoverishment.

Also, low levels of literacy and health literacy provide particular challenges for the health-promotion approach to creating wealth (Bryant, 2002). Education can be a special problem when trying to promote better health behaviour among indigenous people, where there may be poor levels of knowledge about the factors that contribute to the ill-health as well as means of mitigating them. Knowledge and awareness of ill-health and how it influences wealth creation are also important factors in breaking the ill-health-poverty nexus (Kochar, 2004).

Because NGO efforts are widespread at the grassroots and in deprived communities, these interventions are very costly and require extra effort from well-motivated and resourced staff (Gilson et al., 1994). While the needs of the communities being served by the NGOs are unlimited, NGOs often operate on tight budgets which are subject to donor priorities and a long sequence of processes to access. Consequently, even the limited funding available to NGOs is often delayed by the long processes and requirements demanded by donors. Quite apart from the delays, funding arrangements of NGOs also result in NGOs funding only those interventions consistent with donor priorities or those that yield quantifiable and physically visible benefits (Delisle et al., 2005). While this practice helps NGOs prove the impact of their interventions during monitoring and evaluation, it also results in the neglect of other pressing needs that may not be immediately measured or not situated within the donor priorities.

Apart from the challenge of financing, logistics and other resources needed have been perennial challenges of local economic development in developing countries. Within this context, the paucity of vehicles, physical structures, communication systems, electricity and even local community organizers and volunteers inhibit efforts at wealth creation through health promotion. Even easier to find items like stationary have been known to constraint NGO interventions in hard-to-reach settlements. Other important challenges identified that are consistent with literature and other studies include cultural barriers, beliefs and practices (Lewis, 2002), poor social infrastructure, limited community participation and commitment (Campbell and Jovchelovitch, 2000), illiteracy, weak intersectoral collaboration (Sambo and Kirigia, 2011), geographic conditions including harsh weather, poor terrain and susceptibility to natural disasters (Rasanathan et al., 2011). Also relevant in this context are the migration trends of working class peasant farmers and their families because of shifting cultivation or seasonal farming practices. Additionally, this study also identified that the exit strategy of NGOs as well as the change management and acceptance culture of other stakeholders are important in ensuring the continuity of interventions especially for programmes that outlast the NGOs tenure in the community.

Conclusion and lessons

WVI has over the years also contributed to meeting the direct, indirect and intangible costs of health in the district. It has done this through the direct injection of funds into health promotion activities in the district, the provision of infrastructure and support services, and through counseling, education and sensitization all of which would have been costs to the GHS, communities and individuals. In other words, the resources that would have otherwise been used to meet these costs by individuals, communities and GHS can now be channeled into other productive ventures. Additionally, individuals now have enhanced health owing to these contributions made by WVI and can therefore be more productive and create more wealth.

The multi-pronged approach adopted by WVI is consistent with the broad PHC tenets specified by the Alma Atta declaration and also consistent with the health promotion goals of the Ottawa charter. Specifically, through health promotion and other measures aimed at tackling the incidence and costs of ill-health, the community has benefitted from the reduction of the time and accompanying opportunity cost of seeking treatment for health conditions. The productive time that would have been lost through sickness and death in the district has reduced as a result of the health promotion initiatives. The reduction of the physical, social and psychological pain and suffering caused by illhealth and the empowerment of local community members to take control of their health and economic development are also important fruits of the WVI interventions.

The study provides hard evidence to support the idea that promoting health indeed creates wealth. Clearly, this study demonstrates that through health promotion, NGO interventions have positive impacts on the creation and sustenance of a healthy, productive health force as well as the prevention of loss of funds for treatment of health conditions including medications, consultations and tests. Other important contributions made by NGO interventions in this direction include the reduction of the time spent seeking treatment, taking care of sick and ailing community members; a reduction in the loss of bread winners felt by dependents of sick or dead community persons; a reduction in occupational and domestic injuries and accidents and its attendant effects of workforce productivity; as well the promotion of regenerative health practices aimed at reducing the socio-economic negative effects of sedentary lifestyle. Additionally, it provides further proof that NGOs play an important role in local economic development and are the major actors in addressing the vicious cycle between poverty and ill-health.

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