Quality Assurance Strategic Plan for Ghana Health Service 2007-2011

Institutional Care Division, GHS

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List of Abbreviations

5YPOW	5 Year Programme of Work
A & E	Accident and Emergency
ACSD	Accelerated Child Survival and Development
ACT	Artemisinin Combination Therapy
ADHA	Additional Duty Hours Allowance
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
BEU	Biomedical Engineering Unit
BMC	Budget Management Centre
BPEMS	Budget Planning Expenditure
CHAG	Christian Health Association of Ghana
CHPS	Community Health Planning and Services
CSO	Civil Society Organisations
DANIDA	Danish International Development Agency
DDHS	District Director of Health Services
DHA	District Health Authority
DHMT	District Health Management Team
DOTS	Directly Observed Therapy – Short Course
EOC	Essential Obstetric Care
EPI	Expanded Programme on Immunization
FBO	Faith-based Organisation
FDB	Food & Drugs Board
GDHS	Ghana Demographic and Health Survey
GF	Global Fund
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GHS	Ghana Health Service
GOG	Government of Ghana
GRMA	Ghana Registered Midwives Association
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune-Deficiency Syndrome
HRDD	Human Resources Development Directorate
HRU	Health Research Unit
ICD	Institutional Care Division
IEC	Information Education & Communication
IGF	Internally Generated Fund
IMC	Institutional Management Committee
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPC	Infection Prevention and Control
IPT	Intermittent Preventive Treatment
ISC	Inter-sectoral Collaboration
KATH	Komfo Anokye Teaching Hospital
M & E	Monitoring & and Evaluation
MCA	Millennium Challenge Account
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOEd	Ministry of Education
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NCD	Non Communicable Diseases
NGO	Non Governmental Organization
NHIC	National Health Insurance Council

NHIS	National Health Insurance Scheme
NMR	Neonatal Mortality Rate
PAMSCAD	Programme of Action to Mitigate the Social Cost of Adjustment
PFP	Private-for-Private
PNC	Post-natal Care
PNP	Private-not-for-profit
POW	Programme of Work
PPAG	Planned Parenthood Association of Ghana
PHC	Primary Health Care
PHD	Public Health Directorate
PMI	President's Malaria Initiative
QA	Quality Assurance
QAP	Quality Assurance Programme
QASP	Quality Assurance Strategic Plan
QAT	Quality Action Team
QHP	Quality Health Partners
RBM	Roll Back Malaria
RDHS	Regional Director of Health Services
RH	Reproductive Health
RHMT	Regional Health Management Team
SAP	Structural Adjustment Programme
SDHS	Strengthening District Health Systems initiative
STI	Sexually Transmitted Infections
TB	Tuberculosis
TH	Teaching Hospital
U5MR	Under-five Mortality Rate
TMP	Traditional Medical Practitioner
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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1. Introduction

The Ministry of Health (MOH), Ghana is the government organisation with oversight of the health sector. It is responsible for policy formulation, monitoring and evaluation of performance and mobilisation of resources for health sector development. Implementation of its policies are carried out by a number of agencies that may be grouped into five sectors, namely; the government sector, the quasi-government, private and traditional health sectors and the other health-related sectors.

The Ghana Health Service is the largest MOH agency with about half of all health facilities and almost two-thirds of health personnel in the formal sector. It is responsible for ensuring the maintenance of high level of performance in the provision of preventive, promotive and clinical care services at the sub-district, district and regional levels. It is also responsible for the management of institutions at these levels.

The Institutional Care Division (ICD) of GHS is directly responsible for the development, support to, monitoring and review of comprehensive clinical care services. One of its core areas of responsibility is the development and implementation of quality assurance (QA), clinical governance and infection prevention and control systems consistent with national and international practice. The Quality Assurance Department (QAD) has been established within ICD to provide leadership for QA programmes.

The rest of this section provides the background and rationale for preparing a quality assurance strategic plan and outlines the methodology used in its preparation.

1.1 Background[1]

At the time of its independence in 1957, Ghana was an economically prosperous country having large gold reserves and high prices from cocoa for which Ghana was a leading producer. An ambitious development programme, unfair world trade practices and a series of disruptive coups d'etat led to a decline in the economy in the early 1970s and 1980s. By 1983 inflation had reached a peak of 123 percent.

The economic decline had a profound effect on health. Health infrastructure deteriorated severely with little expansion to meet the needs of the increasing population. Health care equipment and supplies such as drugs became scarce and many health professionals left the country to work elsewhere. As a result of these factors the quality of health care fell drastically. This was accompanied by intense public and media outcry over the shortage of drugs and basic medical supplies and the uncaring attitudes of health personnel.

Government responded by introducing user fees in 1983 to supplement central funding. While this led to increased revenue for health facilities and in some instances improved basic supplies it also led to a sharp and sustained decline in utilisation of outpatient services in all facilities, especially in rural health centres[2]. Quality of care received increasing attention as clients demanded value for the money they paid for services. Subsequent local and global initiatives gave impetus

[1] This section has used material from the introduction of Adogboba et al March *2000 "Towards a unified QA strategy for Ghana: Quality Assurance review 98"*

[2] Waddington C, and Enyimayew K.A; 1989. *"A Price to pay - the impact of user charges in Ashanti-Akim district, Ghana"* International Journal of Health Planning and Management, Vol. 4 (1) p17-47.

for tackling the poor quality of care. These included the Structural Adjustment programme (SAP) and its related Programme of Action to Mitigate the Social Cost of Adjustment (PAMSCAD), Strengthening District Health Systems (SDHS) initiative of the late 1980s through 1990s, the Health Sector reforms, and the experimentation with mutual health insurance which later evolved into the countrywide National Health Insurance scheme (NHIS) aimed at addressing the negative effects of user-fees.

On the international scene a number of initiatives have emerged out of a concern to improve the quality and availability of health services to address existing and emerging health problems. These include Roll Back Malaria (RBM) partnership launched in 1998 to coordinate the global approach to fighting malaria, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM, Global Fund or GF) set up in 2002 to fund the fight against three global epidemics responsible for over 6 million deaths a year; the Millennium Declaration of 2001 with its Millennium Development Goals (MDGs) that aim to significantly reduce child mortality, maternal mortality and the incidence and prevalence of HIV, malaria and other diseases by 2015[3]. In 2005 the US launched the President's Malaria Initiative (PMI) with the promise to give 1.2 billion dollars to fight malaria over the following five years.

Quality assurance initiatives in Africa and other developing regions of the world have been highlighted at a series of meetings organised by the International Society for Quality in Health Care (ISQua)[4]. The meetings noted that increasing numbers of developing countries have been introducing quality assurance programmes into their health care system since early 1990s. Though countries had adopted diverse methodologies and approaches to QA, all had consistently brought about policy changes which impact on the way services are organised and delivered. One group of countries (mostly from Latin America) emphasises a more formal and structured approach to QA and is pursuing accreditation for health facilities and licensing of providers. Another group emphasises the development and implementation of standards as a way to improve quality of health services. A third group has placed initial emphasis on quality deficiencies in specific health programmes on health facilities with primary attention on improving health care delivery processes. The meetings concluded that programmes must be tailored to meet specific national circumstances, noting for example that accreditation cannot be imported from elsewhere without modification; that standards need to be developed in relation to existing conditions; and improvement objectives need to recognise existing resource constraints.

Significantly the report stated that *"perhaps the single most important characteristic that appears to determine the ultimate success and sustainability of quality assurance methods is the presence of a culture of quality, a culture in which the desire to provide quality services is pervasive"* The report noted the need for the presence of leadership with both the vision and the appropriate management structure to make the vision come true.

These conclusions remain as valid today as they did when formulated a decade ago.

[3] Goal 4. Reduce child mortality; Target 5.Reduce by two thirds, between 2000 and 2015, the under-5 mortality rate. Goal 5. Improve maternal health; Target 6. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. Goal 6. Combat HIV/AIDS, malaria and other diseases; Target 7.Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

[4] Van Zenten TV 1995. *Quality assurance in developing countries.* Report on a consultative meeting held in St Johns, Newfoundland in May 1995 in conjunction with the 12th ISQua World Congress. Int'l Journal for Quality in Health Care, Vol 8 No 1 pp 89-91, 1996

1.2 Rationale for a QA strategic plan in Ghana

One of the earliest discussions on ways of improving quality of health care delivery was at the Regional Directors' conference of 1989. It was in response to concerns raised by clients and health providers throughout the country. This was followed by a series of studies among patients and health staff aimed at identifying key issues for improving the quality of health care in Ghana. In subsequent years, quality of care remained a recurring theme for policy makers and various health professional groups.

In 1997 the Ministry of Health outlined five strategic goals in its Medium-term Health Strategy for 1997-2001 and its operational document the *Health Sector 5-year Programme of Work (5-Year POW)*. These were to[5]:

- Improve access to basic health services, geographically and financially;
- Improve service quality;
- Improve funding of the health sector;
- Improve efficient use of resources; and,
- Strengthen linkages with communities, health related sectors and the private sector.

The same strategic goals were continued into the second 5 Year Programme of Work (POW 2002-2006) and specifically identified client needs and health worker performance as areas to address to improve service quality.

Strategies drawn up to improve quality of care included: provision of more resources for health care; improved and expanded human resource development; strengthening of health care management; and, introduction of quality assurance (QA) programmes.

A review conducted in 1998 concluded that while substantial progress had been made in setting up QA systems in the country, coverage of quality assurance interventions was low and varied approaches were being used where QA programmes were in place. The report observed that structures at all levels had not yet been organised to provide direction and guidance for QA in health institutions and recommended the mainstreaming of QA into planning and delivery of health care.

Since then the Quality Assurance Department of the Institutional Care Division, with support from partners, has introduced a number of initiatives to provide the foundation and impetus for future work. Strategies identified included the development of QA policy and strategies, development of clinical standards and guidelines the implementation of a national quality assurance program, strengthening monitoring and supervision, training of more health workers and improving their skills, and provision of drugs, equipment and infrastructure.

To provide focus to such future work the department is developing a five-year Quality Assurance Five-Year Strategic Plan (2007- 2011) that will provide the strategic framework for promoting and working toward the achievement of delivery of client-focused, safe, quality clinical care. The USAID-funded Quality Health Partners project (QHP) is collaborating with Institutional Care Division in the development of the strategic plan.

[5] MOH, Ghana, 1996, *5-Year Programme of work,*

1.3 Methods

Document review. The consultant reviewed a number of publications provided by QA Department and QHP. These were supplemented with documents on the internet and those provided by various key informants. A full list of documents is provided in the annex.

Key informant interviews. The team used a semi-structured questionnaire to guide discussions with selected key informants with relevant experience and/or information on quality of care issues. Informants were selected from all levels of health service and from other stakeholders. The interviews also provided opportunity to validate some information obtained from the document review.

Field visit. A two-person team visited the Central Region to gain first hand experience with QA programmes and activities carried out there. The team also had the opportunity to interview both staff and users of health facilities. Central Region was chosen as an example of a region with a well-established QA programme.

Multi-disciplinary group of experts The process of developing the QASP involved regular consultation with a group of experts in quality assurance and systems development. The group met to discuss and agree on report format and content, review progress and offer advice to the core team. They continued to provide support via internet during the course of the assignment.

A core group of four consisting of the head and deputy head of the QA Department of GHS, the QHP Project Director or his deputy, and the consultant, met more frequently to work on the details of the strategic plan.

Costing. Costing was based on activities defined in the plan. Targets and indicators in the strategic plan provided the basis for estimating numbers, quantities and intensity of activities. The consultant obtained unit costs from similar exercises and calculated activity costs. These were then compared with projected incomes and either scaled down or up to match anticipated budgets or to reflect critical priorities.

Consensus-building and Dissemination. To build consensus on the objectives, contents and feasibility of the QASP, the drafting team sought the opinion of policy makers and institutional managers of GHS, health partners during the data collection stage. An early draft of the report was shared with, heads of GHS directorates, all Regional Directors of Health Services and selected Medical Superintendents and District Directors of Health Services. The Institutional Care Division had responsibility to ensure that copies of the final product were distributed to all service delivery points and administrative units of GHS, other health sector agencies, health partners and other key stakeholders.

2. Context

The first part of this section describes the broad environment with quality assurance in the health sector operates. The second parts describes the health sector itself.

2.1 Environment

2.1.1 Demographic

Ghana's population in 2005 was estimated at 22.5 million[6], almost a three-fold increase from 8.5 million at independence. This has been accompanied by rapid urbanisation with attendant problems of poor sanitation and stress related ailments. Health services, like other social services, have not kept pace with the demands of a rapidly growing population; this has led to decline in quality of care

2.1.2 Economic

The current economic profile is typical of a developing country: low per capita income, low spending on health, significant levels of inflation and generally low levels of remuneration. The government has instituted a programme to launch Ghana into a middle income country by 2015. In spite of this, against the background of recent economic performance and budgetary allocation to the health sector, it is reasonable to assume that funding from government sources is unlikely to increase significantly in the next few years.

On the other hand, there are several global initiatives that fund specific health programmes and can thereby increase overall resources to the health sector. These include the Roll Back Malaria (RBM) partnership, the Global Fund (GFATM), the President's Malaria Fund mentioned earlier. In 2006 Ghana became the first country to receive funds from the Millennium Challenge Account[7] (MCA) for social sector development programmes.

Strategies for funding quality assurance should take account of these trends; that central government funds may not increase significantly but external aid sources may provide avenues for tapping into additional funds.

2.1.3 Political

Compared to other countries in the sub-region, Ghana's political environment is stable and provides a background for long term planning. Politico-administrative structures like the district assemblies and regional coordinating councils are being strengthened to better provide decentralised governance.

Communities and households are encouraged to participate in the political process through a credible balloting system and in oversight for public service programmes through representation on institutional management committees. This provides opportunity for policy makers to involve communities and civil society in finding solutions to local problems of poor quality and in ensuring accountability of public sector programmes.

2.1.4 Socio-cultural

There is a significant traditional health sector which is currently seen as competing with the formal health sector for the heart and soul of the people. To this may be added the charismatic and faith healing institutions. Clients and the general public have consistently expressed concern about the care provided by government health workers. The challenge to policy makers is first to address these concerns by finding

[6] Source. World Health Statistics 2006
[7] $547 million approved for Ghana in 2007

ways to incorporate helpful socio-cultural beliefs and behaviours in the design of quality assurance programmes.

2.1.5 Policy environment

Several policies and global initiatives have influenced health care delivery and its quality over recent decades. Key ones are discussed below.

Vision 2020[8]*:* In 1996 Ghana developed a long-term vision for growth and development that would move it from a low income to a middle income country by 2020 known as *Vision 2020: the first step.* The Vision 2020 document defines Ghana's areas for priority attention in the medium to long term as:

- Maximising the health and productive life of Ghanaians;
- Fair distribution of the benefits of development;
- Attainment of a national economic growth rate of 8 percent;
- Reduction in the population growth rate from 3 percent to 2.75 percent; and,
- The promotion of science and improved technology as tools for growth and development.

Specific health objectives of Vision 2020 were: significant reduction in infant, child and maternal mortality rates; effective control of risk factors that expose individuals to major communicable diseases; increased access to health services especially in rural areas; establishment of public health oriented health system; and, effective and efficient management of health system

Primary Health Care: The Primary Health Care (PHC) strategy of 1979 aimed to improve quality and access to care through decentralisation of health service management to district and community levels. The PHC strategy also promoted the concept and practice of integrated and decentralised health services. It also shifted the emphasis of health services from curative to preventive health services, based on evidence that a good balance between preventive and curative care gave better value for money in terms of the health of the population.

Implementation of this policy led to the development of a decentralised district-based health system which subsequently provided the structure for increasing access to health services through a multi-tiered system of care from community-based health services to specialised hospital care.

Financing of health services: In line with its socialist policies, the government of the first republic replaced the pre-independence fee for service at the point of use with free health service. Health services in the public sector were fully financed from central government funds.

The shrinking economy in the 1970s led to the enactment of the hospital fees law LI1313, to back the introduction of subsidised fees for service in public sector health services. The most vulnerable groups were exempted from payment in order to ensure their continued access to health services. The objectives to raise revenue to supplement government funding and to improve basic medical supplies were partly met; by 1987, 12 percent of MOH recurrent cost was generated from user fees. Drug supply to government facilities had improved significantly. However user-fee was associated with a sharp and sustained decline in utilisation of outpatient services in

[8] Source: Largely drawn from MOH, GOG August 2001. *The health of the nation: reflections on the first five year health sector Programme of Work – 1997-2001*

all facilities, especially in rural health centres[9]. Various studies showed that user-fee presented formidable financial barrier to many clients, especially the rural communities, and worsened existing inequities between them and urban communities in Ghana.

In 2004 Parliament passed the national health insurance law, Act 650, as part of a move to address the problem of financial barriers created by the cash-and-carry mode of payment. Health insurance is expected to reduce financial barriers to care and provide funds for improving the quality of health services. By the end of 2006, 38 per cent of the population was registered with the National Health Insurance Scheme (NHIS) with half of these (19 per cent of population) being issued with membership cards and therefore having full access to the provisions of NHIS. The rate of enrolment is impressive (though it falls short of the rather ambitious government target of 50 per cent) and points to a source that can significantly improve funding of health services if properly managed.

Human resources for health: The overall goal of the human resource policy is to improve and sustain the health of the population of Ghana by supporting appropriate human resource planning, management and training so that there is adequate production of appropriately trained staff and that the staff is motivated and retained to perform effectively and efficiently[10].

The main strategies to achieve this are to: involve households and communities in all health programs; increase the production and recruitment of health workers focusing on the middle level; retain, distribute equitably and increase productivity of health workers by strengthening supervision, refining compensation and incentive schemes and enhancing legislation and regulation; and, advocate and mobilize other professionals related to health care to contribute to the promotion and maintenance of health.

2.1.6 Re-defining the health policy

Taking a cue from the Vision 2020 and to accelerate progress to meet the Millennium Development Goals[11], the Minister for Health has led the health sector to redefine its policies to re-focus on healthy life style while still improving on its core business of providing good quality health services. This is known as the *National Health Policy: Creating Wealth through Health*[12]

The objectives of the current health policy will be achieved through strategies based on the following principles:

- People-centred services focusing on individuals, families and communities in their life settings;
- Recognise the inter-generational benefits of health; and,
- Reinforce the continuum of care approach to health development

A successful people-centred health service will be good evidence of good quality health services.

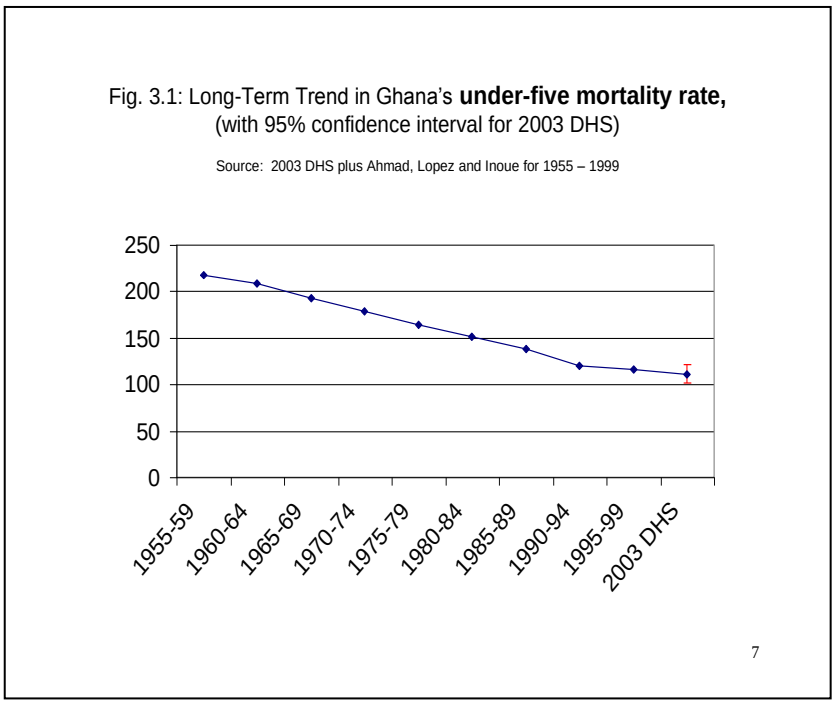
[9] Waddington and Enyimayew (as in FN 2)
[10] Source: MOH September 2006. *Human resource policies and strategies for the health sector 2007-2011 (Draft)*
[11] See footnote under Section 1.1 for MDGs
[12] MOH 2006. *National Health Policy: Creating Wealth Through Health*

2.2 Health status and health services in Ghana

2.2.1 Health status

Health of Ghanaians has improved over the last few decades. Key health indices of Ghanaians have been improving since independence in 1957. For example, life expectancy at birth has increased from 45 years at independence to 56 years in 2003. Under-five mortality rate (U5MR) has decreased from about 220 deaths per 1,000 live births in 1957 to 110 deaths per 1,000 live births in 2003 (Figure 1). The prevalence of childhood killer diseases like neonatal tetanus and measles has declined over the last two decades. These trends can be attributed to improved quality and access to health services since the post independence era as well as to improvements in the general socio-economic conditions of the country.

Figure 1: Long-term trend in Ghana's under-five mortality rate



Trend has stagnated in recent years. In spite of the impressive performance outlined above, there is evidence that some key indicators have stagnated or reversed in recent years. For example after showing a consistent improvement for decades, the Infant Mortality Rates and Under-five Mortality Rates increased from their 1998 levels of 57 and 108 deaths per 1000 live births to their current levels of 64 and 111 deaths per 1000 live births. See Table 1.

Table 1: Trends in IMR and U5MR in Ghana 1983-2003

Survey year	Infant mortality rate	Under-five mortality rate
1988	77	155
1993	66	119
1998	57	108
2003	64	111

Source: GDHS 2003

Detailed analytical work undertaken in the IMCI analytical review reveals that most of the stagnation is caused by a reversal in trends in neonatal mortality and suggest that future investments (in improving health outcomes) should mainly be directed at reducing neonatal mortality and mortalities due to malnutrition, malaria and pneumonia.

Variations in health status. There are wide variations in the health status of the population especially across geographical location and socio-economic groupings. For example, infant mortality rate shows a three-fold difference between the best (Upper East) and the worst (Upper West) regions; 33 and 105 deaths per 1000 live births respectively (GDHS 2003) with U5MR showing a similar pattern. See Table 2

Table 2: Variation in IMR and U5MR by geographical location

Region	**Infant mortality**	**Under5 mortality**
Upper East	33	79
Greater Accra	45	75
Central	50	90
Brong Ahafo	58	91
Eastern	64	95
Western	66	109
Northern	69	154
Volta	75	113
Ashanti	80	116
Upper West	105	208
National average	**64**	**111**

Source: GDHS 2003

The GDHS also reported that under-five mortality rate of the lowest socio economic quintile is 128 per 1000 live births compared to 88 per 1000 live births for the highest quintile.

These wide variations suggest the need to develop strategies that specifically target the worst affected regions and population groups for accelerated or enhanced interventions.

Little impact has been made on existing causes of morbidity and mortality while new ones have emerged. The leading causes of morbidity and mortality four decades ago were predominantly communicable diseases of malaria, respiratory tract infections, diarrhoeal diseases, in addition to malnutrition and pregnancy related diseases.

Over the last two decades non-communicable diseases like diabetes, cardiovascular accidents and injuries have appeared alongside the old ones as leading causes of

morbidity and mortality in hospitals. These are the so-called diseases of life-style and point to the need for strategies that deal effectively with communicable diseases and the so-called life style diseases. The burden of diseases on different age groups is presented in Annex 5. Malaria is by far the leading cause of diseases and death in all age groups followed by respiratory tract infections and diarrhoea in younger age groups and hypertension and complications of pregnancy in the older age groups.

The implication for quality assurance is that management and control of these diseases should be a priority if the health system is to make major impact on the health status of Ghanaians.

2.2.2 Types of health services

Two broad categories of services are available, namely, curative services and preventive/promotive services.

The curative services provide diagnosis and treatment to a sick client. In more complex facilities like hospitals, these two broad functions may be distributed among several units like outpatients department, inpatient care, laboratory and diagnostic services, pharmacy, and support services for laundry, catering, transport, and administration.

Preventive and promotive services provide clients and communities with services that aim to keeping them healthy. Programmes under this category include child health, adolescent health, maternal and reproductive health, communicable diseases, non-communicable disease, health promotion and nutrition.

2.2.3 Access to services

Access to health services also reveals a wide variation between socio-economic groupings and geographical areas. For example the GDHS of 2003 revealed a five-fold difference in access between the best region, Greater Accra (GAR) and the worst region, Upper West (UW) with 62% and 12 % respectively of population living within 30 minutes walk of a health facility.

2.2.4 Health service providers

The two broad categories of public and private health services identified earlier on also describe the main providers of health services in Ghana. Sub-categories of providers and the number of health facilities they operate are listed in Table 3 below; further details on type of facility operated by providers are provided in Annex 5. There are 2,262 facilities in Ghana. Ghana Health Service, which is the single largest provider, has 1108 facilities (49%) including 10 regional hospitals[13], 75 district hospitals and 622 health centres.

Table 3: Health care providers and number of facilities operated

Provider	Total	[%]
Public sector		
Ghana Health Service	1,108	[49]
Teaching hospital	2	[]
Quasi-government	48	[2]
Private sector		
Private-not-for-profit (PNFP)		
CHAG institutions	184	[8]
PPAG clinics	42	[2]
Private for profit (PFP)		
Hospitals & clinics	477	[21]
GRMA clinics	401	[18]
Traditional Medicine sector	NA	
All providers (excluding TMP)	**2,262**	**[100]**

NA = Not available

Source: MOH Sept 2006. *Human resource policies & strategies for the health sector 2007-2011 (Draft)*

2.2.5 Human resources for health

The quality of health services are affected by the quality of resources used. This section is on human resources, the single most important input for health service delivery.

There are about 67,000 people involved in the health care delivery in Ghana; only 48,000 of these are in the formal sector[14]. The Ministry of Health employs about 39,000 (82%) of which 27,000 (54%) are in the Ghana Health Service. GHS employs health workers of all categories.

[13] 10 if Ridge Hospital is included as regional hospital for Greater Accra.

[14] Directorate of Traditional and Allied Medical of MOH estimates that there are 21,788 registered TMPs and 367 registered TBAs in Ghana. It further estimates that the traditional medicine sector employs 200,000 people.

Measures of adequacy of health staff reveals that Ghana fares poorly compared to better resourced economies (Table 4). The World Bank estimates for doctor per population ratios gives an indication of how far Ghana has to go to reach middle income status. They are: one doctor per 350 population for high income countries; 1:550 for middle income countries; 1:2,000 for low income countries; and, 1:10,000 for Sub-Saharan Africa.

Table 4: Population per health worker in Ghana and selected countries

Country	Doctors	Nurses	Pharmacists
Uganda (2002)	1:20,000	1:20,000	1:200,000
Togo (2001)	1:16,667	1:5,887	1:33,333
Ghana (2005)	**1:10,700**	**1: 1,587**	**1:14,286**
South Africa (2001)	1:1,449	1:257	1:4,166
USA (2000)	1:182	1:130	1:1,470
Cuba (2002)	1:169	1:134	N/A

Source: MOH Sept 2006. *Human resource policies & strategies for the health sector 2007-2011 (Draft)*

Current HR challenges in the public sector include: inadequate numbers and types of staff, inequitable distribution of available staff, attrition of health workers, low morale of health workforce, inadequate supportive supervision, weak management systems and inadequate collaboration between MOH and MOEd training institutions.

Recent real increases in salaries of public sector health workers have not been matched by demonstrable improvements in morale and attitude of staff. Indeed the increases have been accompanied by disruptive strike actions as different professional groups vie with each other for better conditions. There are however anecdotal accounts of a reduced rate of attrition especially among nurses.

2.2.6 Organisation and management of health services[15]

The Ministry of Health is the central government body with the mandate to formulate policies for the entire health sector, determine priorities for public spending on health, monitor the performance of health sector agencies against agreed objectives, and mobilise funds for the health sector. Its main agencies are the public sector agencies (Ghana Health Service, teaching hospitals, regulatory bodies) and private sector agencies (private not-for-profit like CHAG and the private-for-profit institutions). The health services has a three-tier structure (national, regional and district). The district level which has the main function to implement programmes is sub-divided into a sub-district and community based level.

The Ghana Health Service is the largest agency (with 48% of health facilities and 62 % of staff) and is *de facto*, the leading agency in quality of health care issues.

The Quality Assurance Department in the Institutional Care Division has responsibility to develop and implement quality assurance, clinical governance and infection prevention and control systems in all health facilities; and, to develop standards and protocols to ensure quality, effectiveness and efficient service delivery[16].

[15] Based on following sources: MOH Dec 1996 *"Institutional reforms in the health sector"*
[16] Source GHS website www.ghanahealthservice.org

3. Status of quality of health care in Ghana

The Institutional Care Division defines quality of health care as *the proper performance (according to standards) of interventions that are known to be safe, affordable to society and impact positively on morbidity, disability and mortality*.[17]

It further defines quality assurance as *"a planned, systematic approach for continuously assessing, monitoring and improving the quality of health care within available resources to meet the expectations of both providers and users"*[18]

The Service Provision Assessment Survey of 2002 defines quality assurance activities as *"monitoring quality of care, identifying problems and instituting changes that resolve the problem."*[19]

Several reviews conducted over the last decade have judged the quality of health services in Ghana to be inadequate both by objective measures and in the opinion of health providers and clients.[20]

In 1998 a quality assurance review by staff of ICD, Eastern Regional health directorate and Liverpool School of Tropical Medicine established that the monitoring of quality-related activities from both national and regional levels was erratic and unstructured. While a variety of quality indicators had been developed and was in use they were not standardised and their definitions were not always the same. It reports further that though a good number of guidelines, protocols and standard operating procedures had been developed to improve clinical quality, their dissemination and use was unsatisfactory. Furthermore quality action teams (QAT) may be too busy with clinical or administrative tasks or lack the training or supervision to tackle QA activities, and funds may be inadequate.

In 2004 a baseline census of 165 facilities found that a little less than one-third had quality assurance teams in place.

A 2006 review of several researches on quality of care concluded that poor staff attitude was the most common complaint when clients were interviewed about quality of care received in government health facilities.

Concerns about poor quality can be placed under two categories: professional/technical perspective and client perspective.

3.1 Client perspective of quality of care

Client satisfaction with the quality of health care is based on considerations such as: affordable fees, promptness of attention, good staff attitude, respect for patients and

[17] Source: Bannerman C et al, GHS Nov 2006 *GHS Health Care Quality Assurance Manual*
[18] Source: Bannerman C et al, GHS Nov 2006 *GHS Health Care Quality Assurance Manual*
[19] GSS, HRU, ORC Macro August 2003. *Ghana Service Provision Assessment Survey 2002*
[20] 1) MOH March 2007 *Independent review of POW-2006* First Draft 2)Enyimayew, N. Bannerman C, Twumasi P. Dec 2006 *A synthesis of Research Conducted under the Ghana-Dutch Project* 2)GSS, HRU, ORC Macro Aug 2003 *Ghana: Service Provision Assessment Survey 2002* Adogboba et al March 2000 *Towards a unified QA strategy for Ghana: Quality assurance review 98*

their rights, provision of privacy and confidentiality, provision of adequate information, availability of drugs and other logistics and clean environment.

A 2006 review of six research reports on quality of care commissioned by the Health Research Unit (HRU) of GHS found that though there was high satisfaction with specific programmes and services, clients were dissatisfied with long waiting time, poor staff attitudes, illegal charges, high cost, and dirty environment. D'Ambruso et al have reported that health centres are under-utilised due to mothers' perception of poor quality relating to birthing position, fluid intake during delivery, caring actions and attitudes of health staff.

Key informants interviewed during collection of information for this strategic plan consistently lamented the poor attitude of staff toward patients and often gave examples of clients' complaints against staff or health institutions that they personally knew about.

The field team directly witnessed instances where clients could have received better attention from providers. In one institution, facilities provided for clients' complaints had been abandoned and suggestion boxes, though available, were not used. In another instance the team noted that a client did not receive adequate explanation on drugs given (she was given six separate drugs for a presumptive diagnosis of malaria). In yet another instance where a good location and facilities had been provided for customer complaints, the person at the station was using discretion inappropriately to decide which complaints to deal with and which ones to ignore. Later discussion revealed that the particular staff member had received very limited orientation for the important job of dealing with complaints of sick clients.

3.2 Provider/technical perspective

Health providers' perspective of quality focuses on whether services are rendered according to the standards and ethics of the health professions. Provider assessment of quality is based on considerations such as availability of standards, outcomes of treatment, conducive environment such as safety and team work, human resource development adequate drugs, logistics and other inputs

The Independent Review team of POW-2006 found that health centres are not functioning as they should to provide basic intra-partum care. Specific areas of concern noted included inadequate treatment of obstetric complications, inadequate first aid procedures for stabilising women before transportation, poor management of the third stage of labour, lack of skills in newborn resuscitation etc. Available health services are of poor quality. There is persistent shortage of basic supplies and equipment. Staff numbers are inadequate and available personnel were de-motivated by poor working conditions.

The review of the HRU-sponsored research on quality of care found a number of shortcomings common to the institutions studied. Inadequate numbers of skilled staff was a key concern. So also were unreliable and inadequate supply of water and electricity, inadequate equipment, shortage of logistics, low drug availability and stock out of vaccines, serious gaps in provider knowledge (a third of the health workers in a study in Techiman did not know tetanus was among the EPI target diseases). Health workers were dissatisfied with administration of the additional duty hours allowance (ADHA) and irregularities with promotion. Facility records review in one district revealed poor recording on OPD cards and treatment recorded at variance with the diagnosis.

The Ghana Service Provision Assessment survey of RCH services in 428 facilities provides useful insight into various aspects of quality in health in both public and private in 2002. Some selected findings are:

Facility infrastructure: Sixty-six percent of facilities reported they had on site water and 39 percent that they had water all year round. Only 38 percent have 24 hour electricity supply and 29 percent had no electricity at all.

Infection prevention and control: Soap was available in only 70 percent of service delivery areas and only 54 percent of facilities had gloves in all relevant service areas. While 67 percent of facilities had functioning equipment for high-level disinfection or sterilisation, only 51 percent had both the equipment and staff who knew the correct processing time.

Service availability: A full package of RCH services[21] was available in only 28 percent of facilities. Seventy-two percent of hospitals but only 13 percent of all facilities had all items necessary to provide quality 24-hour service. All hospitals but only 26 percent of clinics had a qualified health care provider

Facility management: Only 23 percent of all facilities had a management committee that holds documented meetings at least twice a year; only 14 percent had documented QA activities. Seventy percent of facilities had received external supervision in the 6 months preceding the survey. Forty-nine percent of health workers had received in-service training in the previous 12 months.

The survey recorded near-100 percent score for provision of curative care five or more days a week, use of individual client card and visual and auditory privacy.

3.3 Interventions to improve quality of care

Since 1998 when a QA review was done a number of interventions have been carried out to improve on quality. These include:

1. Establishment of a Quality Assurance Department in the Institutional Care Division of the Ghana Health Service with a substantive head, a deputy and a secretariat.
2. Since mid 2004, the department has targeted support from Quality Health Partners, a project largely dedicated to improving quality of care in GHS and a range of private institutions. It has targeted 30 districts with more than 200 health facilities.
3. Production and cataloguing of numerous policies and operational guidelines and standards on care (See Annex for list)
4. Production and use of tools for monitoring and supervision.
5. General in-service training to improve competencies of staff
6. In-service training focused on quality assurance and customer care
7. Supervision and monitoring visits focussed on quality of care. Visits from national level to regions and from region to other levels were carried out quarterly
8. Annual national quality assurance conferences – (Six held since 2000; see annex for themes and number of participants)

[21] Consists of curative services for children provided 5 days per week, STI services offered at least 1 day per week, immunisation, growth monitoring, antenatal care, temporary methods of family planning provided at least 1 day a week.

9. The QA department has produced annual reports since 2003
10. Regional, district and institutional QA teams have been established
11. Accreditation criteria developed for national health insurance scheme has used defined standards of quality as criteria and is intended to be used for self assessment
12. Improvements in infrastructure; drug and equipment supply

Though there are no studies of long term trends in quality of care indicators the recent literature indicates a general improvement in most key indicators. See Box 1 and Annex 9.

Box 1: Trends in Regional Quality Assurance[22]

A baseline census of facilities in QHP-supported districts was conducted in December 2004. Using a facility audit tool with a set of agreed indicators, these same facilities (n=165) were visited again in December 2006.

At baseline 34.4% of facilities had a quality assurance team and of these 22.9% had an action plan (n=157). In 2006 47.7% of facilities had a quality assurance team and 62.8% of these teams had an action plan, representing a significant increase (p=.02) in the uptake of QA programs in target facilities. The increase in the percentage of health centres with a QA team from 22.3% to 35.8% was also significant (p=.03).

In 2004 only 70 health workers were trained in QA in 9 regions[23]; the number increased to 1369 in 2005.

While regional hospitals recorded improvements in their QA activities, district performance increased slightly while little improvement was seen in sub district performance.

Most managers acknowledge that important achievements have been made in putting quality assurance on the agenda but they also note that efforts to date have yielded less than expected results. The underlying causes for this are non-sustained efforts in quality improvement activities due to irregular and inadequate funding; lack of commitment of managers to quality; and an absence of quality maintenance mentality or culture. Various efforts to improve quality of health services are still uncoordinated, leading to wasteful duplication. A consequence of all these is inadequate monitoring and supervision of post intervention activities.

3.4 Current Challenges

Despite efforts to improve quality of care over the past decade several challenges remain to be tackled. Key among these are:

- Users routinely complain of abusive and humiliating treatment by health providers[24]. Long waiting time, high cost of care and illegal charges are commonly cited as reasons for dissatisfaction with public sector services. They have limited avenues to seek redress.

[22] Source QA-ICD 2006 Annual report. See Annex for detailed findings
[23] i.e. all regions except Northern.
[24]

- Though numerous trainings have been instituted to improve the professional competence of health workers, these are not routinely practised and compliance with guidelines on basic patient care, workplace safety and staff working environment is poor. Health providers describe working conditions as difficult and demoralising. There are anecdotal reports of increasing trends in legal suits pending against practitioners in Ghana with wrong-site surgery.

- Shortage of equipment, consumable supplies and some essential drugs undermines facility functioning, damages reputation, inflates out-of-pocket costs to patients and fuels a spiral of distrust and alienation.

- In many health facilities, standard managerial practices that ensure effective use of (limited) resources are not universally practised.

- Poor coordination between different parts of the health care delivery system (even in the same health facility) continues to be a major hindrance to efficient service delivery; and poses inconvenience to clients as they shuttle between different departments.

- Referral systems are weak or non-existent in many districts, and, within health facilities, compounds the poor coordination between different levels of care and within facilities and further compromise care of seriously ill patient.

Any future efforts to improve quality of care and thereby the health status of Ghanaians must address these challenges and others not mentioned here. The analysis presented above points to a need to pay attention to clients' needs, to address technical and provider shortcomings, and to deal with systemic and managerial constraints.

4. Quality Assurance Strategic Plan

This section presents and discusses the details of the quality assurance strategic plan.

4.1 Purpose

To provide a framework for developing, promoting and working toward good quality clinical care in all GHS facilities from 2007-2011.

4.2 Defining the scope of the quality assurance strategic plan

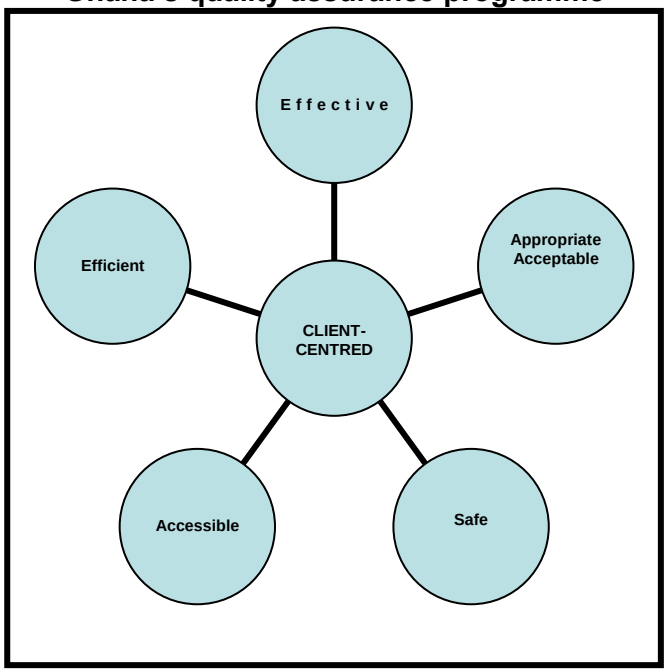
Services: The primary focus of the strategic plan is to address quality and safety matters in the clinical care setting at all levels of the public sector service delivery. It will focus on delivering clinical services that are client-centred, of good technical quality and managed efficiently to achieve desired effect. This focus is presented schematically in Figure 2 below.

The plan recognises the interdependence of different divisions of health services in the production of effective, efficient, affordable and acceptable services. It has identified Human Resource Management (HRM) as the most crucial of these and has identified activities that link this with quality assurance interventions. QAD will engage other departments in designing quality improvements in such components as drugs and medical supplies, health information system, and equipment and infrastructure.

Health Facilities: This strategic plan covers all GHS facilities and district hospitals owned by Faith Based Organisations. Selected private sector facilities may be included during the five year period.

Time frame: Five years: 2007-2011.

Figure 2: Schematic presentation of core principles of Ghana's quality assurance programme



4.2 Goal

To improve the quality of clinical services in Ghana

4.3 Strategic objectives

The strategic objectives refer to broad improvements to be made in five years to achieve the goal. Details of each strategic objective are provided in a set of intermediate objectives and each intermediate objective is further defined by a cluster of activities. The strategic plan thus comprises four (4) strategic objectives and (22)

twenty-two intermediate objectives. Each intermediate objective has up to eight clusters of activities.

During implementation regional and district administrations and service delivery points will be guided by these clusters of activities so that there is a standardised approach to the quality assurance programme. However each implementing unit will need to spell out additional details depending on the local situation (availability and expertise of QA team, financial resources, previous experience with the defined cluster of activities, etc). The development of standards guidelines and policies will be done at the national level but regions, districts will be responsible for training, dissemination and monitoring compliance. For example *"Activity 1.1.1 Develop guidelines for clients' complaints"* will require more detailed activities like; assemble and review available guidelines; prepare draft guidelines; test guidelines in selected facilities; use feedback to finalise guidelines, print copies, distribute and disseminate to users.

The four strategic objectives are:
1. Improve client-focused services
2. Improve patient safety
3. Improve clinical practice
4. Improve management systems and accountability

Each strategic objective and its intermediate objectives are discussed in more detail below. The indicators, expected outcomes and key activities are also presented in the narrative while the detailed targets and the timing of activities are presented in a matrix in Section 6.

4.3.1 Strategic Objective 1: Improve client-focused services

A leading concern of clients, health care providers and the public at large is poor customer relations at public sector health facilities. Five intermediate objectives have been defined to address this problem. They are designed to provide clients with information which allows them to make informed decisions regarding their own healthcare and also to have a meaningful input into the operations of the healthcare system. They are also aimed at orienting health workers to be client focused. The activities also measure patient satisfaction and patient experience of health services.

Intermediate Objective 1.1: Establish a client complaints system in all GHS health facilities.

The primary aim of a QA programme is to promote client satisfaction. 'Complaint' is an expression of dissatisfaction by a customer who is not happy with a service provided by the organization. It is therefore useful to design ways of finding out clients' complaints and their suggestions about the services provided. This provides a basis for developing an effective customer care programme.

The set of resources, procedures and outputs put in place to enable service providers find out and address clients' complaints constitutes a complaints system. Its components are defined in the GHS manual *Health Care Quality Assurance Manual* and reproduced in Annex 10. It includes, among other things:

- A clearly labelled suggestion box in a conspicuous location, an assigned person(s) to empty the box, analyse its contents, and report findings to management
- A client information and complaints desk sited in a conspicuous place and readily accessible, well-trained staff with excellent interpersonal skills stationed at the desk to give clients a listening ear, appropriate information and ensure that complaints are addressed
- Prompt handling of complaints

Client complaints systems should be established in all 1,108 GHS health facilities categorised in Annex 6.

Objectively verifiable indicator
Number/percentage of facilities with functioning client complaints systems in place.

Intermediate Objective 1.2: Introduce a 'Customer Care' programme in all health facilities

'Customer (or client) care' is used to describe the process of taking care of customers or clients in a positive manner. The term may be used in place of complaint handling (see 1.1 above) and is a reminder that customer care is a priority.

A well functioning programme includes a well-conceived service strategy, client involvement in its design and monitoring, and client-friendly people. It is not a simple undertaking, especially in the current environment of a public sector social service with limited experience in customer care, and it requires that marketing and management expertise be engaged to help set up the programme.

Objectively verifiable indicator
Number/percentage of health facilities with functioning customer care programme.

Activities
Activities leading to the establishment of an effective customer care programme include:

- Conduct client satisfaction survey
- Analyse data
- Use information to design and test a customer care programme, and to develop a medium-term implementation plan

- Introduce the programme incrementally to cover all service delivery points by 2011
- Evaluate and improve further on the quality of the customer care programme
- Use evaluation findings to improve the quality of the customer care programme
- Institute incentives to encourage adoption of the programme, including awards for best 'customer care' practice by facilities, teams or individual health workers

Intermediate Objective 1.3: Ensure continuous education of clients on GHS Patient's Charter and Code of Ethics

The GHS *Patient's Charter* and *Code of Ethics* provide guidelines on the rights and responsibilities of patients in GHS facilities, and responsibilities and professional conduct of GHS staff. Although both documents have been in circulation for several years they are not adhered to partly because both clients and staff are not adequately informed about their contents. Furthermore previous efforts have been

hampered by the lack of funds and absence of standardized and coordinated approach

Objectively verifiable indicator
1. Proportion of health facilities which have an effective information system on the Charter in place.
2. Proportion of patients with adequate knowledge of the Patients Charter and Code of Ethics.

Activities
The cluster of activities under this intermediate objective is targeted at clients and involves:

- Print and distribute adequate copies of the GHS Code of Ethics and Patient's Charter
- Display the GHS Patients' Charter and Code of Ethics at all service delivery areas in all health facilities
- Provide education on the Patients' Charter and Code of Ethics to clients at the OPD and other service units at least once a week. Facility mmanagement takes measures to address infringement of patient's rights.
- Monitoring

Intermediate Objective 1.4: Establish a system of accountability to clients in all GHS facilities

This intermediate objective contributes to the improvement of client focused services by giving clients an active role in service provision. The intention is to enable clients and the general public to participate in the improvement of client-centred services through provision of appropriate information on service providers and representation in the management of health services.

Objectively verifiable indicators
Number/percentage of facilities that have held community forums in the last 12 months

Activities
A system of accountability to clients requires the continuous performance of the following activities:

- Ensure use of official name tags /ID cards by all staff for easy identification
- Train/orientate all staff on the GHS Patient's Charter, Code of Ethics and Code of Conduct at least once every two years
- Brief (annually) Regional Coordinating Councils, District Assemblies, Health Committees, Media, CSOs and other key stakeholders on clients' rights and responsibilities to ensure that they are adequately informed about their roles as social watchdogs over public services
- Establish health facility advisory boards that include community representation
- Ensure the involvement of community representative at annual performance reviews of health facilities, districts and regions by giving them active roles to play in the review process

Intermediate Objective 1.5: Ensure that facilities have systems for informed-consent for medical procedures.
Informed consent is a requirement of a well functioning health services. It ensures that the patient is adequately informed about his/her conditions and can participate in discussion and choice on appropriate interventions. This level of participation can allay patient anxieties and can improve care and subsequent healing. Informed consent may also be an ethical and statutory requirement and provides a safeguard against legal suits

Objectively verifiable indicator
Number/percentage of health facilities using standardized informed consent forms for clients undergoing surgical procedures

Activities

- Develop a standard informed consent form for clients undergoing surgical procedures for use at all health facilities. The standard form will be developed at the national level to replace the outdated one currently being used.
- Monitor

4.3.2 Strategic objective 2: Improve patient safety

Patient safety is an integral part of quality of care and includes initiatives designed to reduce medical errors thus making healthcare safer. Poor patient safety is a reflection of failure or weaknesses of the system rather than on individuals
A health facility with poor patient safety records readily loses credibility and sooner or later will lose its clients. Patient safety is also an important indicator of quality of services. Furthermore good patient safety will enable management to avoid preventable deaths, unnecessary injuries, disability and damaging legal suits against the institution.[25]

[25] There are anecdotal accounts of increasing numbers of legal suits against government hospitals and their staff.

The objective is to raise awareness on patient safety, establish a system of monitoring and documenting unsafe events and introducing interventions to continuously reduce the incidence of such events during the plan period.

Intermediate objective 2.1: Establish standardised adverse event reporting systems in all GHS facilities

An adverse event is an unintended injury or complication caused as a result of health care activity rather then the disease which a patient originally present. It may lead to prolonged stay in hospital, in disability or death.

A patient safety reporting and learning systems is primarily intended to enhance patient safety by learning from failures of the health care system. Most problems that occur are not random but are provoked by weak system. When adverse events are reported, analysed and actions are taken to prevent re-occurrence patient care is improved.

Objectively verifiable indicators

1 Number/percentage of public sector facilities with adverse incident monitoring guidelines/ registers

2. Number/percentage of facilities that use guidelines correctly

Activities

- Develop policy and guidelines on adverse events
- Develop adverse events register
- Disseminate guidelines on adverse events to all regions
- Conduct continuous training/orientation for all staff on the prevention and management of adverse events
- Implement adverse event monitoring as part of routine service provision
- Monitor adverse events.

Intermediate objective 2.2: Strengthen implementation of guidelines on prevention of wrong-site surgery in all GHS hospitals and in health centres and polyclinics that perform surgeries.

Wrong site surgery refers to all surgical procedures that are performed on the wrong patient, on the wrong part of the body or at the wrong level of the correctly identified anatomical site. It is a devastating problem that affects the patient, the surgeon and the hospital in which it occurs. Apart from the ethical and professional dimensions, institutions are liable to expensive and time consuming legal suits. It is a result of poor pre-operative planning and lack of institutional control and can be prevented by implementing control measures in surgical practice.

Objectively verifiable indicators

1. Number/percentage of hospitals which have guidelines on wrong-site surgery available

2. Number/percentage of facilities correctly using checklist on wrong-site surgery

Activities

- Assess level of adherence to existing guidelines on prevention of wrong-site surgery to establish baseline
- Extend implementation to all hospitals
- Print and distribute standard guidelines
- Continue orientation for relevant staff on the prevention of wrong-site surgery
- Monitor wrong-site surgery incidents as part of routine supervision and monitoring activities.
- Evaluate and improve performance of facilities in wrong site surgery prevention

Intermediate Objective 2.3: Establish clinical risk management system in all GHS facilities

Clinical risk management is an approach to improving the quality and safe delivery of health care by placing special emphasis on first identifying circumstances that put patients at risk of harm and then acting to prevent or control those risks. Such events are monitored and analysed to identify strategies that will minimise risk to patients. A key element in managing risk is developing within the health staff an attitude prompts them to be continuously on the look out for actual and potentially dangerous situations or procedures to and to their clients and themselves.

Objectively verifiable indicators

1. Number/percentage of staff trained
2. Number/percentage of facilities using risk management guidelines correctly

Activities

- Develop policy and guidelines on Risk Management
- Disseminate guidelines on Risk Management to all regions
- Conduct continuous orientation for all staff on risk management through in-service training
- Monitor implementation of Risk Management system quarterly
- Incorporate prevention of risk management into clinical care monitoring checklist at all levels

Intermediate Objective 2.4 Strengthen Infection Prevention and Control practices in all GHS clinical service delivery points (with focus on hand hygiene and sterilisation)

Health care associated infections affect many patients every year. These infections may cause serious illness leading to prolonged hospital stay and long term disability. In addition they lead to unexpected health care costs for patients and their families and an increased financial burden on the health system.
Hand hygiene is the primary measure for reducing infections. Though this is a simple intervention which must practiced in all health facilities the practice falls short of guidelines hence the need to strengthen and extend its practice in each facility.

In addition to improve hand hygiene standards and practices the strategic plan also emphasizes waste management and sterilization of equipment.

Objectively verifiable indicators
Number/percentage of facilities adhering to IPC standards.

Objectively verifiable indicators
Number/percentage of facilities adhering to IPC standards by the end of year 5

Activities
- Conduct survey to establish base line for infection control in all facilities(already done)
- Provide inputs for effective infection prevention and control
- Launch hand hygiene campaign
- Conduct continuous orientation for all staff on infection prevention and control
- Supervise and monitor infection prevention and control practices
- Evaluate and improve IPC practices

4.3.3 Strategic objective 3. Improve clinical practice

Good clinical practice involves a set of activities that lead to the correct diagnosis and successful treatment of illness presented by a patient. The first part involves making the right diagnosis through history taking, physical examination and laboratory investigation and interpreting the information obtained to reach a correct diagnosis[26]. The second part involves the treatment and care of the patient; this includes referral of the patient to a health facility or level of care that can best deal with his or her needs. Worldwide, clinical practice has well-developed standards and guidelines. Current levels of practice in the Ghana health sector are below acceptable levels.
Good clinical practice also depends on availability of good infrastructure, equipment, drugs and supplies.

This strategic objective focuses first on selected health problems contributing significantly to the poor health indices presented in the situational analysis, and second on a set of essential management practices (e.g. auditing and in-house supervision) that lead to improved clinical care. The health problems include malaria, respiratory infections, diarrhoea and other common childhood diseases, pregnancy-related conditions and non-communicable diseases like hypertension and diabetes.

The objective is to increase the numbers and proportion of health facilities providing clinical practice according to agreed guidelines in all public sector health facilities. Adequate and timely provision of basic equipment, supplies and other logistics is a further objective to be achieved.

[26] Mason S, Swash M, 1981 Hutchison's Clinical Methods

Intermediate objective 3.1: Improve knowledge and skills of clinical staff in maternal and child health and other common clinical conditions (Hypertension, diabetes etc)

This intermediate objective covers a number of clinical conditions that fall within the scope of work of the Reproductive and Child Health unit, non-communicable diseases unit, and Institutional Care Division. Many of the units/departments have well-documented policies, strategies and implementation plans to improve clinical management and QAD will work closely with them to ensure good synergy of efforts.

Objectively verifiable indicators
Availability of policy, guidelines/protocols/job aids
Nr of staff trained in priority health problems
Nr of staff practicing clinical procedures correctly

Key activities

- Develop/Review and disseminate clinical guidelines/protocols/job aids and priority health problems and intervention (including IMCI case management modules, Safe motherhood protocols, Guidelines for management of malnourished, low birth weight and pre-term children, Clinical guidelines for non-communicable diseases e.g. hypertension, diabetes)
- Train health workers on selected priority problems and interventions including IMCI, Safe motherhood, Children with special needs e.g. malnutrition etc, Non-communicable diseases
- Provide supplies and basic equipment
- Identify and share best practices
- Monitor compliance to guidelines/protocols in hospitals

Intermediate Objective 3.2: Establish clinical/death audit systems in all regional and district hospitals
This is a quality improvement process that seeks to improve patient care and outcomes through a systematic review of care against standards.

If well conducted clinical and death audits are able to identify underlying reasons for unacceptable outcomes of clinical management; e.g. death. It enables the health team to avoid similar events in future not only on case by case basis but also provides a basis for defining or adapting policies for improved patient care. To be effective it must be conducted regularly as integral part of patient management and should involve all members of the health team and should avoid the danger of being a fault-finding or finger-pointing exercise. There should also be a commitment by management to correct problems that emerge from the audit.

Objectively verifiable indicators
Availability of audit guidelines and reports.

Activities

- Develop/Review and disseminate clinical guidelines/protocols/job aids on priority health conditions and interventions
- Establish and operationalise a confidential audit committee at the national level

Refer also to Intermediate Objective 4.2 and to HRDD strategic plan

Activities

- Develop and implement performance systems for health workers (link to HRDD)
- Develop guidelines for clinical supervision
- Train middle level (supervisors) managers in health facilities on guidelines
- Monitor performance of middle level managers in clinical supervision
- Develop and implement self assessment tools for health workers in health centres and communities

Intermediate Objective 3.3: Establish QA system in all health facilities

Objectively verifiable indicators
Number/percentage of health facilities with a QA team

Activities

- Form QA teams in health facilities
- Train health providers in QA
- Organize regular regional/ district QA meetings/conferences/seminars
- Improve infection prevention and control practices (Refer section on IO 2.4)
- Supervise and monitor activities of QA teams (Refer I IO 4.2)
- Review the annual QA conferences to determine its strengths and shortcomings and use findings to improve future conferences
- Organize annual national QA conference

Intermediate Objective 3.4: Improve recording/documentation of patient information by health workers

Objectively verifiable indicators
1. Availability of standards/ guidelines
2. Number/percentage facilities meeting criteria for good documentation

Activities

- Develop guidelines/standards on documentation of patient records
- Disseminate and orientate health workers on guidelines/standards
- Supervise and monitor adherence to guidelines (refer IO 4.2)

Intermediate Objective 3.5: Improve referral practice between facilities

Referral is a set of activities undertaken by a health care provider in response to its inability to provide the necessary intervention to meet the patient's need. It requires a two-way system i.e. from the community the appropriate level of care and back.[27] It includes both direct patient care and the support services to provide the appropriate care at the right facility, e.g. transport.

[27] Ghana Health Service Feb 2006. Referral Policies and Guidelines

The health referral system in Ghana is weak as a result of absence of standard procedures for referral, non-use or non-enforcement of use of existing forms and standards, delays in referral, poor reception of patients and lack of feedback. Health workers may be poorly-trained and ill-equipped to provide effective referral services. This has resulted in patients seeking direct care at secondary and tertiary health facilities and often leading to congestion and work overload at these facilities, under-utilisation of first level facilities and increased cost to both the patient and the health service. An effective referral system will also undermine the gate-keeper mechanism required to make the National Health Insurance Scheme efficient and sustainable.

Objectively verifiable indicators
Number/Percentage of facilities with referral guidelines, protocols and tools
Number/percentage of facilities referring according to agreed guidelines

Activities
- Define and disseminate levels of care and mix of services for each type of facility in the regions.
- Agree on roles and responsibilities of major health care providers and other key stakeholders in the regions.
- Define and promote use of standard case management (See Intermediate objective 3.1)
- Promote use of referral guidelines - policies, protocols and administrative through education, directives, reward and sanction
- Equip facilities with referral forms and relevant tools
- Educate health workers and public on the referral system
- Monitor and supervise referral practices and support mechanism

4.3.4 Strategic objective 4. Improve management systems.

'Management' in this context refers to the processes used to improve the quality of clinical care in Ghana. The key components are planning, organising (i.e. mobilising and allocating human and other resources for assigned tasks), leading and supervising; and, monitoring, evaluating and correcting deviations.

At the national level responsibility for some of these processes and the resources involved lie with other divisions and departments of the health service. Therefore critical as they are for the success of the programme QAD has little direct influence on them. For example leadership and supervision, in-service training, staff performance appraisal system, and workplace safety are responsibility of Human Resources Development Directorate (HRDD). Other management processes like the creation of quality assurance teams to support the development of QA systems and ensure compliance with agreed standards can be directly influenced by QAD.

QAD will collaborate with such departments to agree on responsibilities and activities that contribute to the common objective of improving quality of care.

The distinctions described above become less important as one moves down the hierarchy to the health facility level. As such it is easier for managers at lower levels to directly influence these processes to ensure improvements in quality.

Intermediate Objective 4.1: Liaise/collaborate with HRDD to strengthen core human resource management processes in leadership in clinical practice, staff safety, staff appraisal reward and sanction)

Activities
The priority activity at headquarters is the establishment of forums for discussing and developing a plan and guidelines to achieve the outcomes below.

- Link up with HRDD to conduct a situational analysis on leadership positions in GHS facilities including numbers, qualifications, age and performance as leaders
- Prepare 5-year plan to build the leadership qualities of existing and potential leaders (succession plan/functional organogram) in all facilities
- Implement capacity building plan using accredited/reputable institutions
- Institute a programme for team building for hospital management (e.g. problem-based methodology)
- Monitor/evaluate the implementation plan regularly (do a mid-term and end of term review)

Staff performance appraisal procedures
- Monitor staff performance
- Improve incentive and sanctions systems in use in all facilities

Intermediate objective 4.2 Strengthen monitoring and supervision within all facilities and at all levels
Activities
- Review existing supervision and monitoring tools related to quality assurance and adapt into composite monitoring tool
- Update supervision and monitoring tools and guidelines every three years
- Disseminate supervision and monitoring tools and guidelines to all regions and facilities
- Provide continuous orientation on supportive supervision and monitoring in all facilities
- Conduct visits, write reports and give feed back
- Conduct facilitative internal supervision regularly.

Intermediate Objective 4.3: Ensure close collaboration with HRDD, HASS etc and other GHS directorates at Regional and District levels to improve the quality of resources management in all health facilities

The Quality Assurance Department exists as part of a larger system. It is therefore important for its success to identify and work with those units that most directly affect the outcome of its programmes and contribute to the achievement of its objectives and targets.

Activities

- Take advantage of National, Regional, District and Facility forums and meetings to raise and discuss issues regarding resource management and quality improvement.
- Follow up and ensure implementation of any recommendations made.

Intermediate Objective 4.4: Improve use of health information for quality improvement within an integrated HMIS

An effective information system is critical for monitoring progress toward agreed targets. It also enables staff and management to assess their performance and take decisions based on facts and figures rather than mainly on personal experience. A good information system also enables others to learn and replicate successful programme on the basis of documented and validated information. Such a system must be dynamic, assessed regularly to determine its relevance as health situation changes, technologies improve and new policies emerge.

Activities

- Collaborate with Centre for Health Information Management to assess needs for periodic training in patient records keeping and data management, and provide training to address those needs
- Continually assess the efficiency and effectiveness of the MIS to generate data that is useful for monitoring quality of care
- Provide regular and timely feedback of aggregated data to all levels
- Encourage use of reliable data for planning and decision making
- Supervise and monitor adherence to guidelines

Intermediate Objective 4.5 Ensure that all facilities meet the accreditation criteria

"Accreditation criteria" refers to standards developed for accreditation of health facilities under the National Health Insurance Scheme. The criteria define what constitutes good practice and cover the scope of work of hospitals and health centres including quality assurance, safety, organisation and management and performance in various units of a health facility

Activities

- Region/District to form teams to conduct pre-inspection of facilities using accreditation checklist
- Facility managers prepare facility for inspection
- Task team to inspect facilities regularly (at least once in 2 years) to identify gaps and provide feedback to management
- Facility management provides resources for addressing shortcomings
- Region/District present their own certificate of accreditation and award for good performance
- Promote the use of accreditation check list for self assessment and to resolve shortcomings locally as far as possible
- Collaborate with National Health Insurance Council (NHIC) on accreditation of facilities and other measures to improve quality (e.g. contracting arrangements)

Intermediate Objective 4.6: Collaborate with the various regulatory and professional bodies to ensure that all staff are of good standing on yearly basis

Activities

- Set up task team to identify ways of collaborating with professional regulatory bodies and associations on continuous professional development for health staff

Intermediate Objective 4.1: Liaise with HRDD to strengthen leadership and management of health facilities
Intermediate Objective 4.2 Strengthen supervision and monitoring within all facilities and at all levels

4.4 Budget

(See separate document)

5. Organisation and management for implementing the strategic plan

. Most of the interventions in the plan are being carried out at various degrees of proficiency in every region. What the plan offers is a common goal with structured development of activities under clear objectives, targets and time frames. This provides every client, every health worker, each management team and every community with identical objectives and targets against which to monitor progress or hold public institutions accountable.

Organisational structure
Implementation will use existing organisational structures of regional and district health directorates and facility management bodies.

The QA Department of the ICD will have national oversight for implementing the plan. It will source funds, provide guidelines; monitor performance of regions and provide feedback. It will provide incentives or carry out sanctions as far as is possible under existing practice.

The department will work through regional health directorates at all times. Activities that require direct contact with facilities and districts will, as a matter of courtesy and good practice, be done with members of the regional directorate.

Each level of administration and each facility in the public sector will eventually have a unit within its management assigned to watch over quality of care issues. Until this is achieved every facility will receive technical support from its supervising level to implement QA programmes.

Roll out of plan

Roll out of the programme starts in the last quarter of 2007.
Activities in the first two years include developing or adapting and disseminating guidelines, conducting surveys to provide supplementary information; and selective training to improve skills in weak areas like customer care.

Prioritisation: Initial focus in the first two years will be on regional and district hospitals and selected health centre. Remaining health centres and clinics will be targeted from 2008 on.

Coverage. All regional hospitals, all district hospitals and at least 50 percent of health centres must have the required inputs and processes in place by 2011.

Subsequent phases from 2012 will focus on consolidating achievements and extending good practices to all private sector facilities with appropriate modification to accommodate the specific requirements of that sub-sector.

Integrating QA into the wider health sector. The first QASP is deliberately limited in scope to clinical care within the public sector but built into it are activities that will build up relationship between different directorates, agencies and organisations without whom total quality care cannot be achieved. The QA unit will continuously engage with these units and, as it improves in capacity, will extend to them its expertise in developing quality assurance practices with the view of evolving a coherent health sector quality assurance system.

6. Quality Assurance Strategic Plan - Ghana Health Service, 2007-2011

Summary of Strategic objectives and Intermediate objectives

SO1. Improve client-focused services
Intermediate Objective 1.1: Establish a client complaints system in all GHS health facilities.
Intermediate Objective 1.2: Introduce a 'Customer Care' programme in all health facilities
Intermediate Objective 1.3: Ensure continuous education of clients on GHS Patient's Charter and Code of Ethics
Intermediate Objective 1.4: Establish a system of accountability to clients in all GHS facilities
Intermediate Objective 1.5: Ensure that facilities have systems for informed-consent for medical procedures.

Strategic Objectives 2: Improve patient and staff safety
Intermediate Objective 2.1: Establish standardised adverse event reporting systems in all GHS facilities
Intermediate Objective 2.2: Strengthen implementation of guidelines on prevention of wrong-site surgery in all GHS hospitals, health centres and polyclinics
Intermediate Objective 2.3: Establish clinical risk management system in all GHS facilities
Intermediate Objective 2.4 Strengthen Infection Prevention and Control practices in all GHS clinical service delivery points (with focus on hand hygiene and sterilisation)

Strategic Objective 3 Improve clinical practice
Intermediate Objective 3.1: Improve knowledge and skills of clinical staff in maternal and child health and other common clinical conditions (Hypertension, diabetes etc)
Intermediate Objective 3.2: Establish clinical/death audit systems in all regional and district hospitals
Intermediate Objective 3.3: Establish QA system in all health facilities
Intermediate Objective 3.4: Improve recording/documentation of patient information by health workers
Intermediate Objective 3.5: Improve referral practice between facilities

Strategic Objective 4: Improve management systems (Focus on HR capacity-building for QA, supervision and monitoring and reporting)

Intermediate Objective 4.1: Liaise/collaborate with HRDD to strengthen core human resource management processes in leadership in clinical practice, staff safety, staff appraisal reward and sanction)
Intermediate Objective 4.2 Strengthen monitoring and supervision within all hospitals and health centres and at all levels
Intermediate Objective 4.3: Ensure close collaboration with HRDD, HASS etc and other GHS directorates to improve the quality of resources management in all health facilities
Intermediate Objective 4.4: Improve use of health information for quality improvement within an integrated HMIS
Intermediate Objective 4.5 Ensure that all facilities meet the accreditation criteria
Intermediate Objective 4.6: Collaborate with the various regulatory and professional bodies to ensure that all staff are of good standing on yearly basis

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
SO1. Improve client-focused services								
Intermediate Objective 1.1: Establish a client complaints system in all GHS health facilities.	**Nr./% of facilities with functioning clients complaints systems in place**		**98 hospitals (100%); 622 health centres (100%)**					
1.1.1 Develop guidelines on dealing with clients' complaints			1 Guideline	*				
-Set up working group with clear TOR on developing guidelines, leaflets and audio-tapes			1 working group		*			
- Print copies of Guidelines and distribute			2000 copies		*			
1.1.2 Develop leaflets, audio tapes and other educational material for the public about the complaints system.					*			
- Print copies of leaflets and distribute to all facilities			20000 copies (5000 per year fro 4 years)		*	*	*	
- Develop and distribute recorded tapes with information on complaints system.			1000 tapes					
1.1.3. Establish a system for receiving and responding to in-patient and out-patient complaints (e.g. information desks, boxes etc) at all facilities			85 hospitals; 622 health centres	*	*	*	*	*
1.1.4 Train staff to man the information areas/desks			2 per hospital; 1 per health centre		*	*	*	*
1.1.5 Provide resources including –space, communication gadgets (telephones), registers and stationery for the information desks to function			98 hospitals; 622 health centres		*	*	*	*
1.1.6 Monitor performance of complaints system quarterly (Use Chapter 7 of QA manual as guide)			Refer 4.2		*	*	*	*
1.1.7a Conduct client satisfaction surveys in health facilities annually			98 hospitals; 622 health centres		*	*	*	*

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
1.1.7b. Conduct community surveys on service delivery annually			98 hospitals; 622 health centres		*	*	*	*
1.1.8 Conduct "community-facility forums" on yearly basis to discuss and address community concerns on service quality.			98 hospitals; 622 health centres					
Intermediate Objective 1.2: Introduce a 'Customer Care' programme in all health facilities	**Nr/% of health facilities with functioning costumer care programme**		**98 hospitals (100%); 311 health centres (50%); 195 MCHS+CHPS (50%)**					
1.2.1 Assess client satisfaction and customer care needs in sample health facilities and analyse data			1 assessment report		*			
1.2.2 Use survey results to design and test a customer care programme			1 piloted programme		*			
1.2.3. Use test findings to develop a medium term customer care plan			1 costumer care programme			*		
1.2.4 Introduce programme incrementally to cover all health facilities .			98 hospitals (100%); 311 health centres (50%); 195 MCHS+CHPS (50%)			*	*	*
1.2.5 Supervise and monitor customer care practices in all health facilities			Refer 4.2	*	*	*	*	*
1.2.6 Conduct annual survey on best practices in 'customer-care' in health facilities and give awards			136 districts; 12 regions; 1 national	*	*	*	*	*
1.2.7 Evaluate programme at mid-term and end of fifth year. Use evaluation results to improve further the customer care programme			2 evaluations			*		*
Intermediate Objective 1.3: Ensure continuous education of clients on GHS Patient's Charter and Code of Ethics	**1)Nr/% of facilities that provide client education at least 1x week 2)% of surveyed clients with correct understanding of Charter and Code 3)Nr/% facilities that demonstrate evidence of continuous improvement in compliance with Charter and Code**		**98 hospitals (100%); 311 health centres (50%); 195 MCHS+CHPS (50%)**					

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
1.3.1 Print and distribute additional copies of posters on GHS Code of Ethics and Patients' Charter			5,000 copies of each	*	*	*	*	*
1.3.2 Display the GHS Patients' Charter/Code of Ethics at all service delivery areas/units in all health facilities			10 locations per hospital; 4 locations for other facilities		*	*	*	*
1.3.3 Provide regular education on the Patients' Charter/Code of Ethics to clients at the OPD and other service units (at least 1x week)			1 per week in 1108 facilities		*	*	*	*
1.3.4 Supervise and monitor compliance with the Patients' Charter/Code of Ethics			Refer to 4.2		*	*	*	*
1.3.5 Conduct client surveys twice a year to determine client understanding of the Code and Charter and use result to improve client education.			Refer 1.2	*	*	*	*	*
Intermediate Objective 1.4: Establish a system of accountability to clients in all GHS facilities	**1)Nr/% of hospitals and health centres that have functional 'IMCs' Advisory Boards with community representation 2)Nr/% of facilities conducting training session for staff on Charter and Code 3)Nr/% of facilities that have held community forums in last 12 months**		**98 hospitals (100%); 311 health centres (50%); 195 MCHS+CHPS (50%)**					
1.4.1 Institutionalize use of name tags /ID cards for all staff identification through repeated administrative directives			Directives issued	*	*	*	*	*
1.4.2 Print and distribute copies of GHS Code of Ethics to all staff			27000	*	*	*	*	*
1.4.3 Train (orientate) all staff on the GHS Patients' Charter/Code of Ethics and Code of Conduct at all health facilities.			98 hospitals (100%); 311 health centres (50%); 195 MCHS+CHPS (50%)	*	*	*	*	*

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
1.4.4 Conduct briefing sessions on clients' rights and responsibilities for Regional Coordinating Councils, District Assemblies, Health Committees, Media, CSOs and other key stakeholders. (Part of group to which facilities should be accountable)			Annually: 136 districts; 12 regions; 1 national	*	*	*	*	*
1.4.5 Establish or reconstitute Advisory Boards with community representation for health facilities to improve accountability to the communities.			98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%)		*	*	*	*
1.4.6 Include community representation) at annual performance reviews of health facilities			98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%)		*	*	*	*
Intermediate Objective 1.5: Ensure that facilities have systems for informed-consent for medical procedures	**Proportion of health facilities using standardized informed consent forms for clients undergoing surgical procedures**		**98 hospitals (100%)**					
1.5.1 Develop a standard informed consent form for clients undergoing surgical procedures			1 Standard Form			*		
-Review existing client consent forms						*		
-Revise to ensure standardised content and procedures						*		
-Test standardised forms						*		
1.5.2 Print and distribute copies for all health facilities			10000 per year			*		
1.5.3 Orient staff in the use of the informed consent forms			6000 clinical staff (75%)			*	*	*
1.5.4 Use consent form as integral part of patient treatment			98 hospitals			*	*	*
1.5.5 Supervise and monitor performance of facilities in use of consent forms			Refer 4.2					
Strategic Objectives 2: Improve patient and staff safety								

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
Intermediate objective 2.1: Establish standardised adverse events monitoring system that also capture near-miss events	**1) Nr of staff trained 2) Nr/% of public sector facilities with adverse events monitoring guidelines. 3)Nr/% of facilities that use guidelines correctly 4)Incidence of adverse events/near-misses**		**98 hospitals (100%); 311 health centres (50%); 195 MCHS+CHPS (50%)**					
Activities								
2.1.1 Conduct survey to establish baseline on adverse in different types of heath facilities			Refer 2.2					
2.1.2 Develop policy and standard guidelines on adverse events			1 policy document; 1 set of guidelines		*			
2.1.3 Develop adverse events/incident register			1 adverse event register		*			
2.1.4 Distribute guidelines on adverse events to all facilities			98 hospitals (100%); 311 health centres (50%); 195 MCHS+CHPS (50%)		*	*	*	
2.1.5 Conduct continuous training/orientation for all staff on the prevention and management of adverse incidents			6000 clinical staff (75%)		*	*	*	*
2.1.6 Implement adverse incident monitoring as part of routine service delivery					*	*	*	*
2.1.7 Monitor adverse incident monitoring activities			Refer 4.2		*	*	*	*
Intermediate objective 2.2: Strengthen implementation of guidelines on prevention of wrong-site surgery in all GHS hospitals, health centres and polyclinics	**1. Nr/% of hospitals which have guidelines on wrong-site surgery available 2) Nr/% of facilities that use guidelines correctly 3)Incidence of wrong-site surgery**		**98 hospitals (100%)**					
2.2.1 Assess level of orientation of staff and implementation			Regional reports		*			
2.2.2 Print and distribute standardized guidelines			2000 copies		*			

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
2.2.3 Conduct continuous orientation for all staff on the prevention of wrong-site surgery			2000 clinical staff (25%)		*	*	*	*
2.2.4 Supervise and monitor wrong-site surgery incidents as part of routine supervision and monitoring activities.			Refer 4.2		*	*	*	*
2.2.5 Evaluate and improve performance of facilities in wrong site surgery prevention and management						*		*
Intermediate Objective 2.3: To establish Risk Management system in GHS facilities	**1) Nr/% of staff trained 2) Nr./% of facilities using risk management guidelines correctly 3)Incidence of major risks in facilities**		**98 hospitals (100%); 311 health centres (50%); 195 MCHS+CHPS (50%)**					
2.3.1 Identify types of risks to quality service delivery health facilities			1 survey				*	
2.3.2 Develop policy and guidelines on risk management			98 hospitals (100%); 311 health centres (50%); 195 MCHS+CHPS (50%)		*			
2.3.3 Disseminate guidelines on risk management to all facilities			2000 copies		*	*	*	*
2.3.4 Conduct continuous orientation for all staff on risk management through in-service training			Refer 2.2		*	*	*	*
2.3.5 Supervise and monitor implementation of risk management system quarterly			Refer 4.2		*			
2.3.6 Evaluate and improve risk management activities						*		*
Intermediate Objective 2.4 To strengthen Infection Prevention and Control system in all GHS clinical service delivery points (with focus on hand hygiene and sterilisation)	**Nr/% of facilities adhering to IPC standards 2) Nr of staff trained in IPC 3) Incidence of hospital acquired infections**		**1) 98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%) 3)Declining trends in hospital acquired infections**					

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
2.4.1 Provide inputs for effective infection prevention and control					*			
2.4.2 Conduct continuous orientation for all staff on infection prevention and control. Launch hand hygiene campaign			8000 clinical staff (100%)		*	*	*	*
2.4.3 Supervise and monitor infection prevention and control practices			Refer 4.2		*	*	*	*
2.4.4 Evaluate and improve IPC practices						*		*
Strategic Objective 3 Improve clinical practice								
Intermediate objective 3.1: Improve knowledge and skills of clinical staff in maternal and child health and other common clinical conditions (Hypertension, diabetes etc)	**1) Availability of policy, guidelines/protocols/job aids**							
3.1.1 Review/develop clinical guidelines/protocols/job aids in collaboration with RCH and other units				*				
To include: IMCI case management modules; Safe Motherhood protocols; Guidelines for management of malnourished, low birth and pre-term babies; Clinical guidelines for hypertension, diabetes and selected non-communicable diseases								
3.1.2 Train and conduct on-site follow-up of health workers in listed health conditions					*	*	*	*
- IMCI			1000MAs; 1000 midwives					
- Safe motherhood			1000 midwives/doctor					
- Children with special needs e.g malnutrition etc			640 Drs and nurses					
- Non-communicable diseases			640 Drs		*	*	*	*
3.1.3 Provide supplies and basic					*	*	*	*

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
equipment								
3.1.4 Identify and share best practices	Identify 1 best practice each year		I best Practice each year		*	*	*	*
3.1.5 Monitor compliance to guidelines/protocols in hospitals	All hospitals and all regions		98 hospitals (100%)					
Intermediate Objective 3.2: Establish clinical/death audit systems in all regional and district hospitals	**1)Availability of audit guidelines 2)Nr/% of facilities performing clinical/death audit according to guidelines**		**98 hospitals (100%)**					
3.2.1 Develop national guidelines for clinical/death audit				*				
3.2.2 Disseminate guidelines			98 hospitals (100%)		*	*	*	*
3.2.3 Provide continuous training for staff on guidelines for and practice of clinical/death audit			6 per hospital (approx 600)		*	*	*	*
3.2.4 Establish a confidential audit committee at the national level (identify members, define clear TOR, provide secretarial support, and other resources)			1 Committee formed	*				
3.2.5 Monitor audit systems in health facilities			Refer 4.2	*	*	*	*	*
Intermediate Objective 3.3: Establish QA system in health facilities (Note: Though the whole strategic plan is on quality assurance this IO specifically deals with establishment of general QA systems and structures	**Nr/%of health facilities with a QA team**		**98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%)**					
3.3.1 Develop QA policy and strategy to guide national QA process			1 Policy and Strategic Plan developed	*				
3.3.2 Print and supply policy and strategy all facilities			2000 copies	*	*	*	*	*
3.3.3 Form QA teams or assign QA focal person in all health facilities			1) 98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%)	*	*			

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
3.3.4 Provide continuous training for on QA policy, strategies, procedures and tools			5,000 health workers (1000 teams, 5 per team)	*	*	*	*	*
3.3.5 Use QASP as guide to develop QA action plan at regional, district and facility level and ensure it is part of institutional annual plan			10 regional, 136 district, 720 hospitals and health centre plans	*	*	*	*	*
3.3.6 Supervise and monitor QA activities in all facilities			Refer 4.2	*	*	*	*	*
3.3.7 Review the annual QA conferences to determine its strengths and shortcomings as a reporting, monitoring and planning forum and use this to improve future conferences			1 review report	*				
3.3.8 Hold annual national QA conference using review findings to improve its organisation and output.	Meeting of 50 persons once a year		1 per year	*	*	*	*	*
Intermediate Objective 3.4: Improve recording/documentation of patient information by health workers	**1) Availability of standards/ guidelines 2) Number/percentage facilities meeting criteria for good documentation**		**98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%)**					
3.4.1 Develop guidelines/standards on documentation of patient records								
3.4.2 Disseminate and orientate health workers on guidelines/standards								
3.4.3 Supervise and monitor adherence to guidelines (Refer IO 4.2)								

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
Intermediate Objective 3.5: Improve referral practice between facilities	***Objectively verifiable indicators*** **Number/Percentage of facilities with referral guidelines, protocols and tools Number/percentage of facilities referring according to agreed guidelines**		**98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%)**					
3.5.1 Define and disseminate levels of care and mix of services for each type of facility				*				
3.5.2 Agree on roles and responsibilities of major health care providers and other key stakeholders				*				
3.5.3 Define and promote use of standard case management (See Intermediate Objective 3.1)				*				
3.5.4 Promote use of referral guidelines - policies, protocols and administrative through education, directives, reward and sanction				*	*	*	*	*
3.5.5 Equip facilities with referral forms and relevant tools				*	*	*	*	*
3.5.6 Educate health workers and public on the referral system								
3.5.7 Monitor and supervise referral practices and support mechanism								
Strategic Objective 4: Improve management systems (Focus on HR capacity-building for QA, supervision and monitoring and reporting)								
Intermediate Objective 4.1: Liaise with HRDD to strengthen leadership and management of health facilities	**Nr/% of senior managers who have received leadership training**							

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
4.1.1 Collaborate with HRDD to conduct a situational analysis on leadership positions in GHS facilities including numbers, qualifications, age and performance as leaders			1 Situational analysis report	*				
4.1.2 Conduct a situational analysis of hospital management teams (Core and extended) and recommend appropriate filling of vacancies and team work			Refer 4.1.1		*			
4.1.3 Define criteria for good leadership in clinical care and use to assign/appoint to key positions			Set of specifications		*	*	*	*
4.1.4 Prepare 5-year plan to build the leadership qualities of existing and potential leaders (succession plan/functional organogram) in all facilities			1 Medium term plan		*			
4.1.5 Implement capacity building plan using accredited/reputable institutions	TOT to be provided by Regional first yr		10 RHA teams; 136 DHA teams; 98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%) teams		*	*	*	*
4.1.6 Institute a programme for team building for hospital management (e.g. problem-based methodology)			98 hospitals (100%); 311 health centres (50%)		*			
4.1.7 Monitor/evaluate the implementation plan regularly (do a mid-term and end of term review)			Refer 4.2					
Intermediate Objective 4.2 Strengthen supervision and monitoring within all facilities and at all levels	**1) Nr/% of facilities reporting use of composite supervision and monitoring tools in the facility 2) Nr/% of planned supervisory and monitoring activities carried out between level of care**		**10 RHA teams; 136 DHA teams; 98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%) teams**					
4.2.1 Adapt NHIS accreditation tools and available QA monitoring tools into a composite quality of care monitoring tool for health facilities			1 Composite monitoring tool		*			

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
4.2.2 Develop guidelines for clinical supervision			1 Set of guidelines for clinical supervision		*			
4.2.3 Disseminate supervisory guidelines and composite monitoring tools to all regions and facilities			98 hospitals (100%); 622 health centres (100%); 390 MCHS+CHPS (100%)			*	*	*
4.2.4 Provide continuous orientation on clinical supervision and monitoring in all facilities			98 hospitals (100%); 622 health centres (100%)		*	*	*	*
4.2.5 Promote the use of tools for self-assessment of health workers and facilities			98 hospitals (100%); 622 health centres (100%)		*	*	*	*
Intermediate Objective 4.3: Ensure close collaboration with HRDD and other GHS directorates to improve the quality of resources management in all health facilities	**1) No. of meetings**							
4.3.1 Take advantage of National, Regional, District, Facility and other fora to raise and discuss issues relating to resource management and quality improvement.				*				
4.3.2 Follow up and ensure implementation of any recommendations made.				*	*			
4.3.3. Collaborate with H.A.S.S in the provision of infrastructure, equipment, etc.					*	*	*	*
Intermediate Objective 4.4 Collaborate with the relevant Divisions/ Units/ Departments to improve use of health information for quality improvement within an integrated HMIS	**1) Availability of standard guidelines on management of patient information 2)Nr of staff trained in management of patient information 3)% of health workers who receive periodic feedback on aggregated service data from facility management, district, regional and national levels**		**Complete, accurate and timely information for planning and decision making available**					

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
4.4.1 Collaborate with the Centre for Health Information Management to assess needs for periodic training in patient records keeping, data management and provide training to address those needs	2000 health workers (50 HW per region per year from 2008)		1 guideline		*			
4.4.2 Continually assess the efficiency and effectiveness of the MIS to generate data that is useful for monitoring quality of care	10 visits from headquarters to region, 136 visits from region to district				*	*	*	*
4.4.3 Provide regular and timely feedback of aggregated data to all levels					*	*	*	*
4.4.4 Encourage use of reliable data for planning and decision making			Evidence of use of data for plans and management decisions		*	*	*	*
4.4.5 Supervise and monitor adherence to guidelines			Refer 4.2					
Intermediate Objective 4.5 Ensure that all facilities meet the NHIS accreditation criteria	Proportion of facilities accredited		**98 hospitals (100%); 622 health centres (100%)**					
4.5.1 Ensure NHIS accreditation tools are available in all facilities				*				
4.5.2 Provide continuous training/orientation to staff				*				
4.5.3 Promote the use of accreditation check list for self assessment by rewarding its use and sanctioning non-use				*	*	*	*	*
4.5.4 Address short-comings identified in self assessment				*	*	*	*	*
4.5.5 Ensure clinical care teams in each region monitor adherence to accreditation criteria					*			
4.5.6. Provide recognition and award for good performance					*	*	*	*

Narrative Summary	OVI	Baseline	2011 Target	07	08	09	10	11
Intermediate Objective 4.6: To collaborate with the various regulatory (and professional) bodies to ensure that all staff are of good standing on yearly basis	Proportion of staff on good standing on yearly basis							
4.6.1 Set up task team to identify ways of collaborating with professional regulatory bodies and associations on continuous professional development for health staff					*			