NATIONAL MATERNAL AND NEWBORN
HEALTH QUALITY OF CARE STRATEGIC
ROADMAP AND OPERATIONAL PLAN

GHANA

NATIONAL MATERNAL AND NEWBORN HEALTH QUALITY OF CARE STRATEGIC ROADMAP AND OPERATIONAL PLAN

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FOREWORD

Maternal and newborn health are critical to the survival of every nation. Unfortunately mothers and newborn babies continue to die in many countries from preventable causes. For example, the three major causes accounting for about 80% of newborn deaths are infections, prematurity and low-birth-weight, and birth asphyxia, which are all preventable and treatable.

Globally, there are over 300,000 maternal deaths each year and 2.7 million newborns die each year. 2.6 million babies are stillborn, half of them (1.3 million) die during birth. In Ghana, 2015 statistics show an unacceptably high maternal mortality rate of 319 per 100,000 live births. Although there was a reduction in the newborn death rate in Ghana from 41 in 1993 to 29 per 1,000 live births in 2014, the contribution of newborn deaths to infant mortality rose from 53% in 1998 to 71% in 2014.

SDG targets 3.1 and 3.2 aim to reduce global maternal mortality to less than 70 per 100,000 live births, reduce newborn mortality to at least as low as 12 per 1000 live births in every country, and reduce stillbirth rate to at least as low as 12 per 1000 total births in every country. If these targets must be met then there is the need to address quality of care challenges because in spite of several interventions initiated to reduce maternal and newborn deaths and stillbirths, these remain unacceptably high in many countries. Key quality of care challenges include inappropriate approach by health workers, delayed diagnosis and delayed treatment, delays in referrals as well as late arrival at a health facility and lack of essential supplies.

Initiatives have been adopted both locally and globally to improve MNH quality of care. These have culminated in the global network to improve quality of care for mothers, newborns and children which was launched by the World Health Organization in 2017. The network has begun with 10 countries including Ghana, and it seeks to address four strategic objectives – (i) to build and strengthen national institutions and mechanisms for improving quality of care in the health sector (**Leadership**); (ii) to accelerate and sustain implementation of quality of care improvements for mothers and newborns (**Action**); (iii) to facilitate learning, share knowledge and generate evidence on quality of care (**Learning**);; and (iv) to develop, strengthen and sustain institutions and mechanisms for accountability for quality of care (**Accountability**).

This document provides the strategic blueprint and operational plan by which Ghana intends to address the four strategic objectives. The goal is that every mother and newborn receives quality care throughout the pregnancy, childbirth and postnatal periods. The pursuit of this goal shall hinge on the core values of quality, equity and dignity; and engaging women, families and communities in their care, and the targets are (i) reduce maternal and newborn mortality: reduce maternal and newborn deaths and stillbirths in participating health facilities by 50% over five years in participating facilities, and (ii) improve experience of care: enable measurable improvement in engagement of clients, families and communities in their care, and improvement in user satisfaction with the care received.

ACKNOWLEDGEMENT

A Technical Working Group (TWG) was constituted to lead the formulation of this strategy and operational plan for improving MNH quality care. The TWG further collaborated to develop an implementation guide which explains how the activities in this document will be undertaken. Members of the TWG are listed table below for acknowledgement. Mr Nuhu Omeiza Yaqub Jr is also acknowledged for reviewing the draft document and offering useful suggestions.

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List of Acronyms

CHAG Christian Health Association of Ghana
DANIDA Danish International Development Agency
DHIMS District Health Information Management System

EMEN Every Mother Every Newborn initiative

FHD Family Health Division

GDHS Ghana Demographic and Health Survey

GHS Ghana Health Service

HSMTDP Health Sector Medium Term Development Plan

ICD Institutional Care Division

IHI Institute for Healthcare Improvement

IHP+ International Health Partnership and related Initiatives

IME Information Management and Evaluation

JHPIEGO Johns Hopkins Program for International Education in Gynecology and Obstetrics

JICA Japan International Cooperation Agency
MBFHI Mother Baby-Friendly Health Initiative
MEBCI Making Every Baby Count Initiative
MNCH Maternal, Newborn and Child Health

MNH Maternal and Newborn Health

MOH Ministry of Health

NHIA National Health Insurance Authority
NHQS National Healthcare Quality Strategy

NNHSAP National Newborn Health Strategy and Action Plan

NQM National Quality Manager

PPME Policy Planning Monitoring and Evaluation

QoC Quality of Care

QCFP Quality of Care Focal Person (for MNH)

RMNCAH Reproductive, Maternal Newborn, Child and Adolescent Health

UNFPA United Nations Population Fund

UNICEF United Nations Children Education Fund

USAID United States Agency for International Development

WHO World Health Organization

1.0 INTRODUCTION

1.1 Ghana's Quality Journey

Initiatives to improve quality of care are not new in Ghana. All the health professional regulatory bodies have attributes of quality mainstreamed in their work. At the start of formal health care quality processes in the mid-1990s, there were two concurrent pilot projects in the country, one in the Upper West with support from DANIDA and one in the Eastern Region supported by the Liverpool School of Tropical Medicine¹. These projects were focused on process quality without ignoring structure and outcome quality.

A nationwide review of quality improvement initiatives conducted by the Ministry of Health (MOH) followed in 1998. Recommendations from the review included harmonization, institutionalization and pre-service and in-service training on quality in health care. Widespread training was then instituted and client satisfaction surveys became a useful tool for health facilities to identify quality gaps with a view to implementing improvement interventions.

Quality was mainstreamed in the mid-2000s with the setting up of a Quality Assurance Unit in the Institutional Care Division of the Ghana Health Service (GHS). Since then, GHS has developed a Quality Assurance Strategy, produced a large number of standards, protocols, and guidelines, a Patient Charter and three editions of Quality Assurance Manuals, culminating in writing of the book "Quality and Patient Safety in Health Care" in 2013. Additionally, the Health Sector Medium Term Development Plan (HSMTDP), 2014 – 2017 and 2018 – 2021 sought to improve quality of health service delivery.

1.2 The NHQS

The National Quality Forum of September 2015 determined to move the national quality agenda forward through the development of a national quality strategy (NQS) to guide all quality planning, quality assurance and quality improvement initiatives in the country. Subsequently a concept note was prepared by MOH and Institute for Healthcare Improvement (IHI) between October and December 2015 which spelt out the processes for developing the strategy. The national quality agenda was incorporated into the Aide Memoire of the 2016 Health Summit. With support from the Bill and Melinda Gates Foundation and the Institute for Healthcare

Improvement (IHI), the Ministry of Health led the development and launch of a National Healthcare Quality Strategy between May and November 2016 through a wide consultative process.

The ultimate goal of the strategy is to continuously improve the health and well-being of Ghanaians through the development of a better coordinated health system that places patients and communities at the centre of quality care.

The specific goals and strategic objectives of the National Healthcare Quality Strategy are:

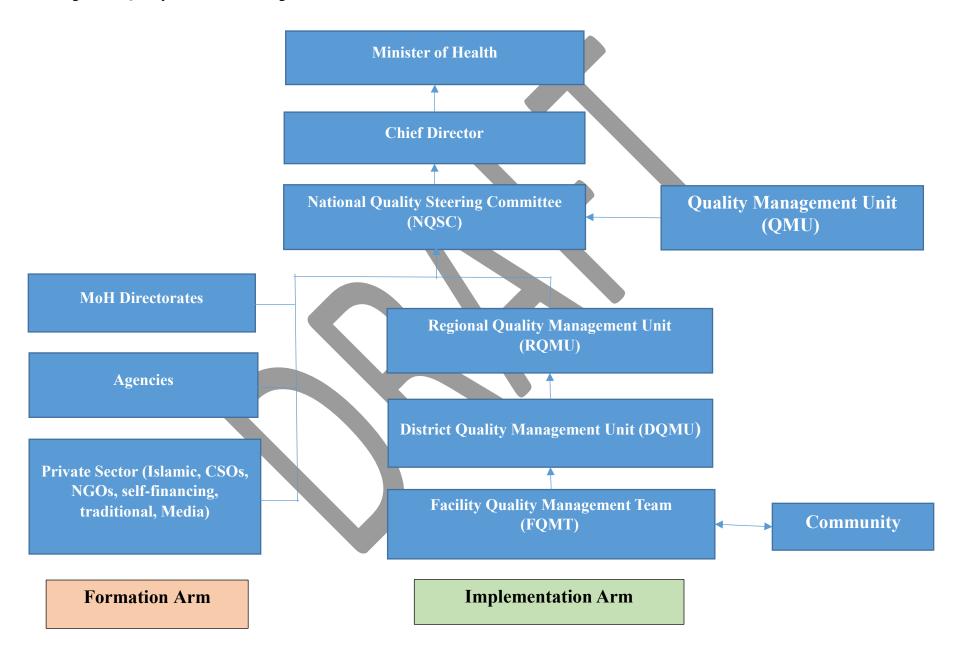
Specific Goal	Strategic Objectives	
Specific Goal 1.0: To	1.1: To improve the clinical skills of relevant health workers	
continuously improve health	to manage identified priority health interventions	
outcomes in the population health	1.2: To promote a quality culture and accountability for	
priority areas	quality in all health workers and sector agencies	
priority areas		
Specific Goal 2.0: To develop a	2.1: To create sustainable leadership and governance for	
coordinated health care quality	quality planning, quality control, and quality improvement at	
system in the areas of quality	all levels of the health care system	
planning, quality control, and	2.2: To strengthen coordination among all health sector	
quality improvement, including	agencies	
improved use of data for	2.3: To standardize collection of data and improve use and	
evidence-based decision-making	analysis of data at all levels (including by providers at the frontline)	
	for evidence-based decision making	
	2.4: To resource and strengthen regulatory agencies,	
	(especially HEFRA) to roll out a nationwide accreditation	
	process with clear links to facility-based quality management	
	teams for ongoing improvement action	
Specific Goal 3.0: To improve	3.1: To sustain patient safety at all levels of health care	
client experience by being	delivery	
responsive to the health needs	3.2: To improve client satisfaction and participation in	
and aspirations of the patient and		
the community	3.3: To build a culture of "joy at work" (financing, logistics,	
	recognition and reward) that creates the context for health providers	
	to treat clients with dignity and respect, deliver high quality care and	
	be motivated to continuously improve quality	

The priority areas that the strategy seeks to improve outcomes in are; maternal health, child health (neonate, infant, under 5), communicable diseases (malaria; epidemic prone diseases: cerebrospinal meningitis (CSM) and cholera), non-communicable diseases (hypertension, diabetes), mental health and geriatric care. This means that as a nation Ghana regards maternal and newborn care as a priority.

The governance structure for the implementation of the national quality strategy is depicted in Figure 1 below.



Figure 1: Quality Coordination Organizational Structure - Ghana



The improvement of quality of care is embedded within a larger global movement towards universal health coverage. This is addressed in Sustainable Development Goal (SDG) 3, which aims to ensure healthy lives and promote well-being for all at all ages². Specifically, SDG 3.8 sets the target to "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". This global agenda explicitly sets forth the idea that quality is essential to achievement of safe, effective care and improved health outcomes, even as access to care is expanded.

2.0 PROBLEM STATEMENT

2.1 Global Maternal and Newborn Care

Globally, there are over 300,000 maternal deaths each year; 2.7 million newborns die each year; 75% of neonatal deaths occur during the first week of life, and between 25% to 45% occur within the first 24 hours; 45% of all under 5 child deaths occur among newborns and 75% of infant mortality are contributed by neonatal deaths; 2.6 million babies are stillborn; half of all stillbirths (1.3 million) began labour alive but died before birth; and 98% of all stillbirths occur in low- and middle-income countries³. The three major causes accounting for about 80% of newborn deaths are infections, prematurity and low-birth-weight, and birth asphyxia³. All these conditions are preventable and treatable ⁴.

The following MNH targets have been set under the SDG targets 3.1 and 3.2: to reduce global maternal mortality to less than 70 per 100,000 live births (Ghana = 319; Africa = 382, Global = 216); reduce newborn mortality to at least as low as 12 per 1000 live births in every country (Ghana = 29; Africa = 28, Global = 19); reduce stillbirth rate to at least as low as 12 per 1000 total births in every country; reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (Ghana = 60; Africa = 81, Global = 43) $^{2.5.4}$.

2.2 Maternal and Newborn Care in Ghana

Significant reductions in under-five mortality rates have been made between 2003 and 2014, decreasing from 111 per 1000 live births to 60 per 1000 live births ⁵. Similarly, improvements have been made in infant mortality, overall, with reductions from 64 per 1000 live births in 2003 to 41 per 1000 live births in 2014 ⁵ ⁶. Interventions that contributed to the improvement in these

areas were the implementation of the National Health Insurance Scheme, which guaranteed free maternal care, and an increase in the number of skilled birth attendants during delivery which increased from 59% in 2008 to 74% in 2014 ⁵.

Although, there was a reduction in the newborn death rate from 41 in 1993 to 29 per 1,000 live births in 2014, the contribution of newborn deaths to infant mortality rose from 53% in 1998 to 71% in 2014 ⁵. Maternal mortality also stands at the unacceptably high rate of 319 per 100,000 live births as at 2015 ⁷. There is thus the need to reduce disparities and deliver high quality care specifically targeted towards mothers and newborns.

2.3 Why the Focus on Quality of Care

The focus on quality of care is because facility-based childbirth is increasing globally and in Ghana, but higher proportions of avoidable maternal and perinatal morbidity and mortality still occur in facilities. A major roadblock has been found to be quality of care. For example, almost all pregnant women in Ghana (97%) receive skilled antenatal care and 74 per cent receive skilled care at birth, but this has not translated into acceptable maternal and newborn death rates ⁵. This is because beyond access, quality of care factors account for most of the deaths. These factors include inappropriate approach by health workers, delayed diagnosis and delayed treatment, delays in referrals as well as late arrival at a health facility and lack of essential supplies ⁸. There is therefore the need to go beyond maximizing coverage of essential interventions to ensuring quality of care to accelerate reductions in maternal and perinatal mortality and severe morbidity.

Up to two thirds of newborn deaths can be prevented if known effective health measures are provided at birth and during the first week of life. Quality care during this critical period will significantly impact on reduction in maternal deaths and early neonatal deaths. Quality health care is safe, effective, timely, efficient, equitable and people centred; and quality of care is also a key component of the right to health.

3.0 THE RESPONSE

3.1 Global Initiative

Globally, the WHO has articulated the vision of a world where "every pregnant woman and newborn receives quality care throughout pregnancy, childbirth and the postnatal period". In this

regard, between 2013 and 2014, the WHO and its partners led the introduction of initiatives such as Strategies toward Ending Preventable Maternal Mortality (EPMM) and the Every Newborn Action Plan' (ENAP) ⁹. Subsequently, the World Health Organization has led the initiation of a global network to improve quality of care for mothers and newborns, with the vision of halving institutional maternal and neonatal mortality in five years. This network is built on the WHO vision of quality for every mother and newborn, which is underpinned by the core values of the organization which are quality, equity and dignity¹⁰. In 2016 the WHO published standards for improving the quality of maternal and newborn care ¹¹, and in 2017 the global network to improve quality of care for mothers, newborns and children was launched. Ghana is one of the nine first wave countries in the network. The other eight first wave countries are Bangladesh, Côte d'Ivoire, Ethiopia, India, Malawi, Nigeria, Uganda and Tanzania.

The four strategic objectives of the network are to:

- 1. Build and strengthen national institutions and mechanisms for improving quality of care in the health sector (Leadership);
- 2. Accelerate and sustain implementation of quality of care improvements for mothers and newborns (Action);
- 3. Facilitate learning, share knowledge and generate evidence on quality of care (Learning);
- 4. Develop, strengthen and sustain institutions and mechanisms for accountability for quality of care (Accountability).

3.2 Local Initiatives

Besides the several activities that the Ghana Health Service, led by the Institutional Care Division was undertaking to improve quality generally, several initiatives have been led and supported by development partners to improve the quality of maternal and newborn care. For example, the Institute for Healthcare Improvement (IHI) led the introduction of the Project Fives Alive (PFA). The MDGs Acceleration Framework (MAF) and Making Every Baby Count Initiative (MEBCI) were two other initiatives. Additionally, the Mother and Baby-Friendly Health Initiative (MBFHI) has been established and incorporated into the Ghana National Newborn Strategy and Action Plan. This is a strategy for the expansion of the Baby-friendly

Hospital Initiative (BFHI) to include the optimal care of mothers and newborn babies during the intra-partum and early postnatal period. The focus is the revival, strengthening and expansion of the BFHI to go beyond breastfeeding to optimal care of the mother-baby pair at all levels of health facilities.

Recently, the Family Health Division of the GHS has developed a National Reproductive Health Service Policy and Standards document, highlighting a Quality Assurance vision which stipulates that quality of care shall be assured at all reproductive health service delivery points. Special attention would be paid to client-provider interaction, privacy and confidentiality, counselling for informed choice/decision, access to widest possible range of effective reproductive health services, provision of appropriate infrastructure, effective logistics management system, infection prevention and control, technical competence of service providers, effective referral system, and mechanisms to ensure follow-up.

To identify country-specific MNH quality of care gaps, the country conducted an MNH quality of care analysis where each of the four strategic objectives of the Network are analysed for strengths, weaknesses and priority actions, lead agency and collaborating partners. Annex 3 shows details of Ghana's MNH quality of care analysis. This strategy is informed by the key findings of the analysis.

This strategy is situated in the National Healthcare Quality Strategy (NHQS) which has already identified structures for the implementation of quality improvement initiatives in Ghana. The MNH strategy and operational plan actually serve to initiate the implementation of the NHQS. The MNH strategy therefore leverages on the NHQS and seeks to support existing structures rather than proposing new ones. Furthermore, beyond this strategy and operational plan, an implementation guide has been developed which provides details on how the planned MNH quality improvement activities will be undertaken.

4.0 GOAL

Every mother and newborn receives quality care throughout the pregnancy, childbirth and postnatal periods

The pursuit of this goal shall hinge on the core values of quality, equity and dignity; and engaging women, families and communities in their care.

Targets

- Reduce maternal and newborn mortality: reduce maternal and newborn deaths and stillbirths in participating health facilities by 50% over five years in participating facilities
- Improve experience of care: enable measurable improvement in engagement of clients, families and communities in their care, and improvement in user satisfaction with the care received

5.0 STRATEGIC OBJECTIVES, OUTPUTS AND PRIORITY ACTIONS

5.1 Strategic Objectives

The strategic objectives are:

- 1. **Leadership:** Build and strengthen national institutions and mechanisms for improving quality of care in the health sector
 - National Health Quality Strategy (NHQS); Quality Technical Committee;
 stakeholder engagement
- 2. **Action:** Accelerate and sustain implementation of quality of care improvements for mothers and newborns
 - O Package of interventions and services defined (e.g. well-established experience in MNH quality of care, MDSR, Safe Childbirth Checklist); competency development; strong partnership in service delivery
- 3. **Learning:** Facilitate learning, share knowledge and generate evidence on quality of care
 - o A plan for QI learning and strengthening; experience in different approaches to learning on clinical care
- 4. **Accountability**: Develop, strengthen and sustain institutions and mechanisms for accountability for quality of care
 - QI tools building on existing tools and experiences; QI metrics include MNH;
 community awareness and participation

5.2 Outputs and Priority Actions

This section outlines and explains the various outputs and corresponding priority actions that will be implemented in this plan.

Strategic Objective 1.0: Leadership – Build and strengthen national institutions and mechanisms for improving quality of care in the health sector

Output 1.1: National, regional, district and facility governance structures for quality of care are strengthened or established and functioning

The National Healthcare Quality Strategy (NHQS) mandates the strengthening or establishment of governance structures for quality at the national, regional, district and facility levels. Since the launch of the NHQS, a national Technical Committee comprising technical persons from MOH agencies has been inaugurated and a national Quality Management Unit established with a Quality Manager. Maternal and newborn health (MNH) has been identified as a pilot to the implementation of the NHQS. In this regard, it is critical to support the strengthening or establishment of these governance structures and to coordinate MNH quality of care activities.

Priority Actions

- 1.1.1: Support the strengthening or establishment of governance structures at national, regional, district and facility levels to project MNH and to oversee quality of care for MNH in facilities through capacity building
- 1.1.2: Strengthen collaboration between the Newborn and Safe Motherhood committees

Output 1.2: National vision, strategy and operational plan for improving quality of care in MNH services is developed, funded, implemented, monitored and regularly reviewed

As a pilot to the implementation of the NHQS, a costed national MNH quality improvement vision, strategy and operational plan will be developed in synergy with the NHQS to guide interventions for the improvement of quality of care in MNH services. The MNH strategy and operational plan will be disseminated alongside the NHQS for efficiency, implemented and monitored.

Priority Actions

- 1.2.1: Develop a costed national operational plan for halving facility-based maternal and newborn deaths in 5 years as part of the quality of care network and cost existing strategies on MNH initiatives
- 1.2.2: Disseminate the MNH Quality of Care Strategy and operational plan alongside the National Healthcare Quality Strategy (NHQS)
- 1.2.3: Implement and monitor the progress of the MNH vision, strategy and operational plan

Output 1.3: National advocacy and mobilisation strategy for quality of care is developed and implemented

An advocacy and mobilisation plan will be developed to escalate the quality of care of MNH services to national prominence. The Minister of Health has demonstrated his commitment to improving the health of mothers and newborns in the country. This is an opportunity to engage relevant MDAs, partners, professional associations and other stakeholders to project MNH quality of care on the national agenda.

Priority Actions

- 1.3.1: Develop national advocacy, communication, and resource mobilisation plan and explore more funding sources
- 1.3.2: Use existing platforms to engage relevant MDAs, partners, professional associations and other stakeholders to project MNH quality of care on the national agenda

Strategic Objective 2.0: Action – Accelerate and sustain implementation of quality of care improvements for mothers and newborns

Output 2.1: Evidence-based standards of care for mothers and newborns are adapted, disseminated and used

The World Health Organization (WHO) identifies 8 quality of care domains which translate into 8 standards of care. Five of the domains are related to the provision of care and three are related

to experience of care. The five standards pertaining to the provision of care are evidence-based practices for routine care and management of complications; actionable information systems; functional referral system; competent and motivated human resources; and essential physical resources available. The three standards covering experience of care are effective communication; respect and dignity; and emotional support. The eight standards of care translate into 31 quality statements and 349 quality measures ¹¹.

Specific maternal and newborn interventions such as Safe Motherhood, Mother and Baby-friendly Health Initiative (MBFHI) and Making Every Baby Count Initiative (MEBCI) have identified standards of MNH care that align with the WHO standards of care. For example, the EMEN/MBFHI sets out nine standards which are grouped under clinical care, respect and dignity, governance, essential physical resources, competent and motivated human resources, actionable information system, and functional referral system ¹².

Under this output an inventory of all available protocols and standards of maternal and newborn health care will be conducted, standards and protocols adopted through consensus building and disseminated to all levels, ensuring that all facilities and pre-service institutions receive the standards.

Priority Actions

- 2.1.1: Conduct inventory of available protocols and standards of maternal and new born health care
- 2.1.2: Complete adaptation and disseminate standards and protocols to all levels and ensure availability at facility levels and in pre-service institutions

Output 2.2: National packages of improvement interventions are adapted or developed and disseminated

Ten high impact MNH interventions have been recognised for ensuring the survival and health of the mother and newborn. These are skilled care at birth; basic emergency obstetrics; comprehensive emergency obstetrics; basic newborn care; neonatal resuscitation; kangaroo mother care; management of pre-term birth; routine postnatal care; treatment of severe infections; and in-patient supportive care for sick and small babies.

Specific strategies, guidelines and intervention packages to improve maternal and newborn care include National Safe Motherhood Service Protocols, Ghana National Newborn Health Strategy and Action Plan (2014-2018), Mother and Baby Friendly Health Initiative (MBFHI) and Making Every Baby Count Initiative (MEBCI). Development partners supporting MNH interventions include WHO, UNICEF, Ubora/IHI, USAID Systems for Health, PATH, USAID, JHPIEGO and JICA. The WHO MNH quality of care network provides guidelines on the development of a strategic framework and implementation plan to guide the operationalisation of interventions to improve MNH quality of care. In the implementation of this plan, a national package of interventions will be decided and disseminated and strengthening of the referral system supported.

Priority Actions

- 2.2.1: Adapt/develop national packages of improvement interventions and disseminate
- 2.2.2: Support the strengthening of the referral system

Output 2.3: Clinical and managerial capabilities to support quality improvement are developed, strengthened and sustained

To empower health workers to apply the agreed standards in implementing the identified national improvement interventions to achieve good health outcomes, there is the need to build the capacities of managers and the clinical skills of the health professionals. Capacity will be built in attitude, customer care and technical disciplines, and logistics supply chain management improved to make the necessary inputs available to the health worker to work with.

Priority Actions

- 2.3.1: Build capacity of staff (skills, attitude, customer care, counselling) to implement interventions at district and facility levels
- 2.3.2: Continuously improve the technical skills of health workers through supportive supervision, coaching and mentoring
- 2.3.3: Build capacity to improve on supply chain management of logistics

Output 2.4: Quality improvement interventions for MNH are implemented

The identified MNH quality improvement interventions will have to be subjected to scientific rigours to improve the chances of a successful nationwide implementation. The interventions will therefore be implemented in selected districts (demonstration districts). Participating facilities in those districts will be identified and baseline assessments conducted to determine appropriate interventions for each district. Lessons learned from the demonstration districts will be harnessed to inform nationwide roll out of the interventions.

Priority Actions

- 2.4.1: Identify demonstration districts and engage with the districts to identify facilities
- 2.4.2: Conduct a baseline assessment for the demonstration districts and identify the interventions appropriate for them and partners willing to support
- 2.4.3: Implement agreed package of MNH interventions in the demonstration districts and facilities, with the involvement of patients and communities
- 2.4.4: Develop and implement a plan for scale up of initiative following a successful implementation in the demonstration districts

Strategic Objective 3.0: Learning – To facilitate learning, share knowledge and generate evidence on quality of care

Output 3.1: Data systems are strengthened to support improved quality of care

The WHO identifies 8 domains of quality, which translate into 8 quality standards, 31 quality statements and 349 quality measures. Ghana will define its minimum set of MNH indicators. These will be adapted from the global set of indicators, to track MNH quality of care. Any selected indicators not currently in DHIMS will be incorporated into the system. Data collection tools may need to be developed for newly added indicators and the relevant staff trained in the documentation, collection, analysis and use of the new data.

Priority Actions

3.1.1: Define a minimum set of country MNH quality indicators aligned with the global indicators

- 3.1.2: Review the current indicators in DHIMS in the light of the national standards and the operational plan and incorporate additional ones if necessary
- 3.1.3: Review and update data collection tools as necessary and build capacities for data collection and analysis in the districts and set up a system for documenting and collecting qualitative data
- 3.1.4 Build the capacity of healthcare managers for the use of data in decision making

Output 3.2: Mechanisms to facilitate learning and share knowledge through a learning network are developed and strengthened

Several learning systems exist in Ghana at the national, regional and district levels. The systems include monthly, quarterly and annual review meetings as well as an annual national quality conference. Other platforms include the national health summit, National Newborn Subcommittee, Paediatric Society of Ghana, Society of Obstetricians, National Newborn Stakeholders meeting, and Family Health Division retreat. These will be strengthened and community, facility, intra-district and inter-district systems strengthened or established. Additionally, there are virtual learning systems such as MOH website, GHS website, Newborn website, Quality of Care WhatsApp and Quality of Care teleconference. The virtual learning systems will also be strengthened to facilitate learning on the district, regional, national and global platforms. The Research and Development Division of the Ghana Health Service will provide leadership for strengthening the learning systems.

Besides this routine activity, targeted research in identified areas will be undertaken with the guidance of the Research and Development Division of GHS.

Priority Actions

- 3.2.1: Strengthen virtual national, regional and district learning systems to share knowledge and link to global learning platform anchored in an MN improvement website.
- 3.2.2: Strengthen existing face to face national, regional and district learning systems for sharing knowledge, e.g. annual, quarterly and monthly review meetings, and link to global learning platform

- 3.2.3: Leverage on annual national conference on quality and safety in healthcare to disseminate best practices
- 3.2.4: Assist districts to set up learning collaborative of facilities in the district as well as inter district collaborations
- 3.2.5: Organize more focused facility-community interface by supporting districts to communicate and advocate for better maternal and newborn care to communities
- 3.2.6: Conduct research to address emerging quality of care issues

Output 3.3: Data and practice are analysed and synthesized to generate an evidence of quality improvement

The NHQS advocates league tables to compare like facilities for appropriate awards to be accorded the winning facilities in each category. During the implementation of the MNH quality improvement interventions, data and service delivery will be analysed for each health facility. PPME of GHS will support this activity.

Priority Actions

- 3.3.1: Improve data capture, analysis and use
- 3.3.2: Support the operationalisation of the league table and dashboard in the DHIMS, and award system mandated by the NHQS
- 3.3.3: Improve collaboration between health research centres and service agencies in the capturing and use of surveillance data

Strategic Objective 4.0: Accountability – Develop/strengthen and sustain institutions and mechanisms for accountability for quality of care

Output 4.1: National framework and mechanisms for accountability for quality of care are established and functioning

The existing learning forums and any new systems that will be created will continue to serve as an opportunity for managers, leaders and workers to account for their stewardship. As mandated in the NHQS, it is expected that there will an update of performance management contracts of leaders and managers to include quality of care indicators to further serve to improve leadership

commitment to quality. Top performers in MNH quality of care of all cadres of staff at all levels (national, regional, district, sub-district, facility and community levels) will be identified to benefit from award systems prescribed by the NHQS. Enhanced awareness in the population about patients' rights and professional code of ethics will empower the community to participate in the definition, measurement and improvement of quality of care generally and quality of maternal and newborn care specifically. Such empowerment will enable the population to demand quality, equity and dignity.

Priority Actions

- 4.1.1: Build on existing review meetings and forums, and consider establishing review meetings specifically for MNH quality of care
- 4.1.2: Identify MNH quality of care champions and recommend them for national and regional recognition and awards
- 4.1.3: Train budget officers in financial and resource tracking and reporting for improved financial accountability
- 4.1.4: Facilitate regular review of DHIMS data and strengthen the use of the RMNCAH and the operationalisation of the community Score card
- 4.1.5: Support the creation of awareness in the population using patients' rights and involve patients and the community in the definition, assessment and improvement of quality of care
- 4.1.6: Advocate for the update of performance management contracts of leaders and managers to include quality of care indicators

Output 4.2: Progress and impact of the initiative on MNH quality of care is regularly monitored and evaluated

The envisioned impact or ultimate measure of success resulting from Implementation of the MNH strategy and operational plan is the halving of maternal and newborn deaths in participating health facilities in five years. To determine whether or not this has been achieved, we shall follow the progress of outcome measures. Details of monitoring and evaluation are set out in Section 6.

Priority Actions

- 4.2.1: Monitor the progress of health outcomes for mothers and newborns, the care seeking behaviour and practices of clients, and user satisfaction including user perception of quality, equity and dignity
- 4.2.2: Evaluate the initiative for its impact on maternal and newborn mortality and morbidity in year 3 (mid-term evaluation) and year 5 (end of initiative evaluation)

6.0 MONITORING AND EVALUATION

6.1 Monitoring Components

Monitoring aims to track the implementation of this plan and the results accruing from the implementation. In this regard, monitoring covers progress towards achievement of implementation milestones, improvements in MNH quality of care and progress towards the achievement of MNH health outcomes. The monitoring system takes cognisance of existing standards of MNH care, such as the WHO standards of care, Safe Motherhood standards, MBFHI and EMEN standards, and MEBCI standards. It also takes cognisance of the Monitoring Logic Model of the WHO-led network to improve quality of care for mothers and newborns. The monitoring logic model shown in Fig. 2 below illustrates the links between the network's strategic objectives of Leadership, Action, Learning, and Accountability and the goal of reducing maternal and newborn mortality. The monitoring logic model builds on several important conceptual models including the WHO Vision paper and framework of standards, quality statements and measures, the Primary Healthcare Performance Initiative (PHCPI), IHP+, and the WHO health system building blocks ¹³¹⁴¹⁵ and it is a helpful organizing principle.

The network's participating countries are enjoined to capture some indicators from each of the logic model's four central elements of Management and Organization; Access to Care; Provision of Care; and Experience of Care.



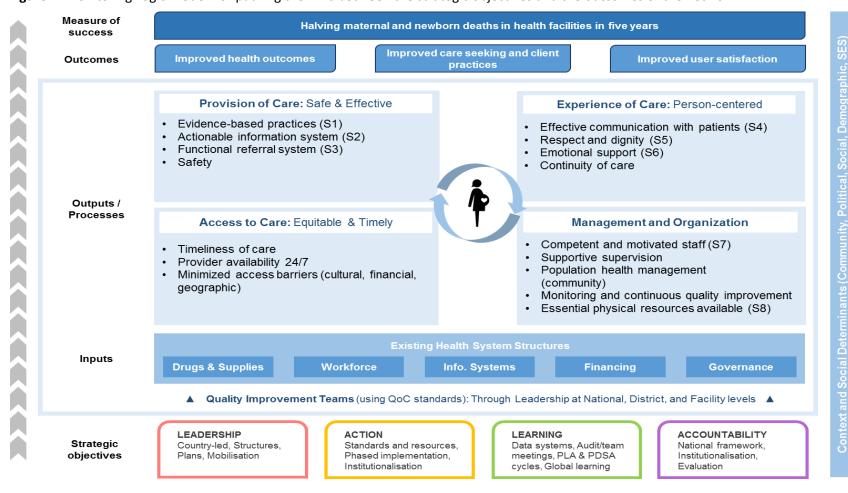


Figure 2: Monitoring Logic Model: Unpacking the links between the strategic objectives and the outcomes of the network

Note: S1-S8 reflect the numbering from the WHO Standards for Improving Quality of Maternal and Newborn Care in Health Facilities¹¹.

6.2 Indicators

Indicators have been identified for monitoring the progress of implementation of this plan and the progress of the expected results of implementation. The levels at which each indicator will be used have been indicated. The set of indicators for facility level are for use by QI teams to support rapid improvement of specific care processes and health outcomes. They are country-prioritised measures linked to WHO quality statements in eight standards and some indicators may require purpose-built data collection systems such as a checklist or a column added to a register.

The Network prioritises a set of 15 indicators, which are maternal deaths, maternal deaths by cause, newborn deaths by cause, facility stillbirth rate disaggregated by fresh and macerated, pre-discharge neonatal mortality rate, obstetric case fatality rate, pre-discharge counselling for the mother and the baby, companion of choice, verbal or physical abuse, breastfeeding within one hour of birth, immediate postpartum uterotonic administration, facility newborns weighing, kangaroo mother care for premature newborns, basic hygiene provision, and availability of basic sanitation to women and families.

Annex 2 lists an expanded set of indicators that widens the options. The set of indicators determined for district and regional use aim to track capability to implement the plan, plan implementation and results of implementation. To monitor implementation are indicators to track progress of implementation steps along the four strategic objectives of leadership, action, learning and accountability. These indicators are relevant to all stakeholders. Additional implementation indicators useful to the district and regional levels comprise measures of facility readiness in terms of human resource availability and skills, availability of standards, availability of essential inputs/logistics and readiness for referrals in and referrals out. Key performance measures will inform the district and region of quality activities, selected outputs and outcomes. These indicators will mainly be obtained through facility reports, visits and through the DHIMS.

For use at the national level are indicators on implementation milestones and indicators on key results of implementation. The latter are measures largely related to important MNH care processes and outcomes for tracking to facilitate shared learning within and across countries and most of

them will be obtained from routine information systems. The national set of indicators are of interest to national, regional, district, facility and global stakeholders, including the MNH network and civil society.

6.3 Data Collection and Management

Indicators will usually be calculated and used by facility QI teams and district/regional level as part of regular monitoring to improve care. Most indicators will be calculated using **routine** measurement methods and data sources. Supplementary collection methods such as periodic facility assessment and client satisfaction surveys can complement routine monitoring to inform understanding of critical quality gaps and to inform the design and evaluation of QI interventions.

6.3.1 Data sources

Key data sources will comprise routine and periodic sources.

1. Routine (continuous) data collection sources

Routine data sources will include:

- **DHIMS** comprises selected data aggregated from health facility registers and can provide information on issues such as service utilisation, provision of high impact interventions, case fatality and mortality, RMNCAH scorecard, malaria scorecard and community scorecard
- Patient records and facility registers: can provide more detailed information on interventions provided and adherence to standards of care that are not typically aggregated in DHMIS at subnational or national level
- Maternal Death Surveillance and Response (MDSR) and perinatal death audits: provide detailed case-by-case information about cause of death and underlying contributors, including quality of care provided

- Civil registration and vital statistics: such as births and deaths registry provide information on mortality and population-based denominators (e.g. estimated births)
- Logistics and supply chain management: The availability, distribution and quantity of medicines, commodities and medical supplies can be tracked through routine documentation or in supply chain management systems from central warehousing to service delivery points, such as health facilities.
- **Human resources and staff training:** The placement, availability and training of health staff is routinely documented and may be tracked at facility, district, regional and/or national levels in human resource information systems (HRIS).

2. Periodic data collection sources

- Client surveys: structured quantitative questionnaires (e.g. brief client exit survey) or focus group discussions can provide information on client's priorities for care and experience of care
- Staff/provider interview: for assessing provider knowledge, self-reported practice, training and perceptions of the work environment
- **Simulations of care**: for assessing provider competence and skills for discrete tasks, e.g. resuscitation of newborn using mannequin; postpartum counselling
- **Observation**: e.g. for assessing provider performance and adherence to standards of care during real-time clinical care, or for assessing the availability of inputs or safety variables such as the state of water and sanitation facilities
- **Periodic health facility assessments:** Periodic health facility assessments using a combination of routine and non-routine data sources can provide a deeper understanding of the quality of care

- Community based surveys: can provide information on intervention coverage, treatment seeking behaviour, and patient self-reported practices and experience of care
- Ghana Demographic and Health Survey: provides useful information on outcome and impact measures
- Multiple indicator cluster survey (MICS)
- Ghana Maternal Health Survey

6.3.2 Data collection tools

Existing data collection tools will be used to collect data. Where no tools exist for the collection of specific data, new data collection tools will be developed. This may involve the development of a complete data collection tool or the addition of a field or more to a form or register. Staff who will be tasked with data collection will be trained in the use of data collection tools such as the filling of the relevant forms or registers and how to input data into the DHIMS.

6.3.3 Data use

Facility managers will be trained and encouraged to use data collected within their facilities to guide management decision making. Managers at higher levels will be encouraged to analyse data received and to pay attention to data trends to track implementation milestones and progress.

7.0 SUSTAINABILITY

Sustainability has been built into this strategy and operational plan in several ways. In the first place, this strategy is rooted in the National Healthcare Quality Strategy (NHQS), which is a national agenda to institutionalise quality in the entire health sector of Ghana. Indeed, the operationalisation of maternal and newborn health quality of care improvement has been chosen to serve as a demonstration for the implementation of the NHQS. Similar to the NHQS, structures for the implementation of the MNH quality of care strategy have been built on

existing structures which cannot be dismantled easily. Another factor that will contribute to sustainability is the fact that healthcare managers and workers responsible for operationalising the MNH quality strategy are not novices but have extensive knowledge and experience with quality improvement systems and methodologies.

The incorporation of MNH quality of care data into the DHIMS substantially helps to entrench the processes that generate that data. Moreover, almost all development partners in the country have been engaged in supporting the improvement of MNH quality of care in diverse ways and they have demonstrated support for the development and implementation of this strategy and operational plan. Funding is therefore expected to continue to be available for MNH quality of care improvement.

ANNEXES

Annex 1: Operational Plan

Milestones

The key implementation milestones for this strategy are:

- 1. Adopt/adapt MNH quality of care standards
- 2. Adopt/adapt national MNH quality of care interventions for implementation
- 3. Assess baseline performance in demonstration districts
- 4. Implement agreed MNH intervention packages in demonstration districts
- 5. Scale up implementation using lessons learned in the demonstration districts
- 6. Strengthen data systems for MNH quality of care
- 7. Strengthen learning and accountability systems to accelerate improvement
- 8. Monitor and evaluate implementation of the plan

Operational plan

STRATEGIC OBJECTIVE 1.0: LEADERSHIP					
To build	To build and strengthen national institutions and mechanisms for improving quality of care in the health sector				
CODE	ACTIVITY	TIME	RESPONSIBILITY		
		FRAME			
Output 1.	1: National, regional, district and facility governance structures for quality of	care are streng	thened or established		
and funct	ioning				
1.1.1	Support the strengthening or establishment of governance structures at	Q3 2018	QoC TWG		
	national, regional, district, sub-district and facility levels to project MNH and				
	to oversee quality of care for MNH in facilities through capacity building				
1.1.2	Strengthen collaboration between the Newborn and Safe Motherhood	Ongoing	FHD		
	committees				

Output 1.	Output 1.2: National vision, strategy and operational plan for improving quality of care in MNH services is developed,			
funded, in	funded, implemented, monitored and regularly reviewed			
1.2.1	Develop a costed national operational plan for halving facility-based	Jun-Aug	TWG	
	maternal and newborn deaths in 5 years as part of the quality of care network	2018		
	and cost existing strategies on MNH initiatives			
1.2.2	Disseminate the MNH Quality of Care Strategy and operational plan	Aug-Nov	National Quality	
	alongside the National Healthcare Quality Strategy (NHQS)	2018	Manager; TWG	
1.2.3	Implement and monitor the progress of the MNH vision, strategy and	From Jan	National Quality	
	operational plan	2019	Manager; TWG	
Output 1.	3: National advocacy and mobilisation strategy for quality of care is developed	d and impleme	nted	
1.3.1	Develop national advocacy, communication, and resource mobilisation plan	Ongoing	TWG	
	and explore more funding sources			
1.3.3	Use existing platforms to engage relevant MDAs, partners, professional	Ongoing	TWG	
	associations and other stakeholders to project MNH quality of care on the			
	national agenda			

STRATEGIC OBJECTIVE 2.0: ACTION					
To accelerate	To accelerate and sustain implementation of quality of care improvements for mothers and newborns				
CODE					
		FRAME			
Output 2.1: H	Evidence-based standards of care for mothers and newborns are adapted, a	disseminated an	d used		
2.1.1	Conduct inventory of available protocols and standards of maternal and	Aug 2018	TWG		
	newborn health care				
2.1.2	Complete adaptation and disseminate standards and protocols to all	By Q4 2018	TWG, ICD		
	levels and ensure availability at facility levels and in pre-service				
	institutions				
Output 2.2: National packages of improvement interventions are adapted or developed and disseminated					
2.2.1	Adapt/develop national packages of improvement interventions and	Q3 2018	TWG		

	disseminate		
2.2.2	Support the strengthening of the referral system	Ongoing	TWG/ICD
Output 2.3: (Clinical and managerial capabilities to support quality improvement are de	veloped, streng	thened and sustained
2.3.1	Build capacity of staff (skills, attitude, customer care, counselling) to	Ongoing	TWG, ICD
	implement interventions at district and facility levels		
2.3.2	Continuously improve the technical skills of health workers through	Ongoing	ICD, TWG
	supportive supervision, coaching and mentoring		
2.3.3	Build capacity to improve on supply chain management of logistics	Ongoing	TWG/SSDM
Output 2.4: Q	Quality improvement interventions for MNH are implemented		
2.4.1	Identify demonstration districts and engage with the districts to identify	Q3 2018	TWG, RHDs
	facilities		
2.4.2	Conduct a baseline assessment for the demonstration districts and	Q3 2018	TWG, RHDs
	identify the interventions appropriate for them and partners willing to		
	support		
2.4.3	Implement agreed package of MNH interventions in the demonstration	From Q3	TWG
	districts and facilities, with the involvement of patients and communities	2018	
2.4.4	Develop and implement a plan for scale up of initiative following a	From Q1	TWG
	successful implementation in the demonstration districts	2020	

STRATEGIC OBJECTIVE 3.0: LEARNING					
Facilitate	Facilitate learning, share knowledge and generate evidence on quality of care				
CODE	CODE ACTIVITIES TIME RESPONSIBI				
		FRAME			
Output 3.	Output 3.1: Data systems are strengthened to support improved quality of care				
3.1.1	Define a minimum set of country MNH quality indicators aligned with the	Q3 2018	TWG, PPME, ICD		
	global indicators				
3.1.2	Review the current indicators in DHIMS in the light of the national standards	Q1 2019	TWG, PPME		
	and the operational plan and incorporate additional ones if necessary				
3.1.3	Review and update data collection tools as necessary and build capacities for	Q3 2018	TWG, PPME		

	data collection and analysis in the districts and set up a system for		
	documentation and collecting qualitative data		
3.1.4	Build the capacity of healthcare managers for the use of data in decision	From Q3	TWG, RHD
	making	2018	
Output 3	.2: Mechanisms to facilitate learning and share knowledge through a le	earning networ	k are developed and
strengthe	ned		
3.2.1	Strengthen virtual national, regional and district learning systems to share	By Q4 2018	TWG, RDD
	knowledge and link to global learning platform anchored in an MN		
	improvement website		
3.2.2	Strengthen existing face to face national, regional and district learning	Q1 2019	TWG, RDD
	systems for sharing knowledge, e.g. annual, quarterly and monthly review		
	meetings, and link to global learning platform		
3.2.3	Leverage on annual national conference on quality and safety in healthcare	Q4 2018	National Quality
	to disseminate best practices		Manager
3.2.4	Assist districts to set up learning collaborative of facilities in the district as	By Q4 2018	TWG, RDD, ICD,
	well as inter district collaborations		PPME
3.2.5	Organise more focused facility-community interface by supporting districts	From Q1	TWG, RHDs, ICD
	to communicate and advocate for better maternal and newborn care to	2019	
	communities		
3.2.6	Conduct research to address emerging quality of care issues	Q1 2019	TWG, RDD
Output 3.	3: Data and practice are analysed and synthesized to generate an evidence of	quality improve	ment
3.3.1	Improve data capture, analysis and use	Q3 2018	TWG, PPMED
3.3.2	Support the operationalisation of the league table and dashboard in the	Q3 2018	TWG, PPMED, ICD
	DHIMS, and award system mandated by the NHQS		
3.3.3	Improve collaboration between health research centres and service agencies	Q4 2018	TWG, RDD
	in the capturing and use of surveillance data		
-		•	•

STRATE	GIC OBJECTIVE 4.0: ACCOUNTABILITY		
Develop/s	strengthen and sustain institutions and mechanisms for accountability for q	uality of care)
CODE	ACTIVITIES	TIME	RESPONSIBILITY
		FRAME	
Output 4.	1: National framework and mechanisms for accountability for quality of care	are establishe	ed and functioning
4.1.1	Build on existing review meetings and forums, and consider establishing	Q1 2019	TWG, RDD
	review meetings specifically for MNH quality of care		
4.1.2	Identify of MNH quality of care champions and recommend them for	Q2 2019	TWG, RHDs, ICD
	national and regional quality awards		
4.1.3	Train budget officers in financial and resource tracking and reporting for	Q1 2019	TWG, Accounts
	improved financial accountability		
4.1.4	Facilitate regular review of DHIMS data and strengthen the use of the	From Q3	TWG, PPME
	RMNCAH and the operationalisation of the community Score card	2018	
4.1.5	Support the creation of awareness in the population using patients' rights and	Q2 2019	TWG, RHDs
	involve patients and the community in the definition, assessment and		
	improvement of quality of care		
4.1.6	Advocate for the update of performance management contracts of leaders	Q1 2019	TWG, QMU
	and managers to include quality of care indicators		
Output 4.	2: Progress and impact of the initiative on MNH quality of care is regularly m	onitored and	evaluated
4.2.1	Monitor the progress of health outcomes for mothers and newborns, the care	From Q4	TWG, PPME
	seeking behaviour and practices of clients, and user satisfaction including	2018	
	user perception of quality, equity and dignity		
4.2.2	Evaluate the initiative for its impact on maternal and newborn mortality and	Q1 2022	TWG, PPME, RDD
	morbidity in year 3 (mid-term evaluation) and year 5 (end of initiative		
	evaluation)		

Annex 2: Monitoring Matrix

The monitoring matrix defines priority quality measures for routine tracking at national, regional, district, sub-district and facility level; targets in the immediate term (by end of 2018), short term (by end of 2020) and medium term (by end of 2022). While some quality measures will be tracked and analysed on a routine basis, other measures will be monitored by a QI team for a finite period of time (sometimes using purpose-built data sources such as checklists or columns added to patient registers) - while the team works to improve a specific process of care (e.g. improve management of newborn asphyxia). Not all such measures will need to be, or should be, incorporated into routine national or local health information systems.

MNH QUALITY OF CARE INDICATORS

CODE	INDICATOR	TARGET 2018 END	TARGET 2020 END	TARGET 2022 END	DATA SOURCE	PERIODICITY	LEVELS APPLICAB LE	LEVEL OF DATA COLLECTI ON
A. IMPA	CT INDICATORS							
A1	Institutional maternal mortality ratio (MMR)				HMIS	Routine		Facility
A2	Institutional neonatal mortality rate (NMR)				HMIS	Routine		Facility
A3	Institutional stillbirth rate				HMIS	Routine		Facility
B. OUTC	OME INDICATORS							
B1	Maternal satisfaction score (quality, equity, dignity, engagement in their care)				Client satisfaction survey	Quarterly		Facility
B2	Proportion of women with pre-eclampsia prevented from developing eclampsia				Special survey	Annual		Facility
В3	Proportion of women with PPH successfully managed				Special Survey	Annual		Facility
B4	Proportion of asphyxiated babies resuscitated successfully				Special Survey	Annual		Facility
C. PROC	ESS INDICATORS							
C1	Proportion of deliveries conducted by skilled birth attendants							
C2	Proportion of deliveries where delivery attendant washed hands with soap				Special survey	Annual		Facility

C3	Proportion of women administered immediate post-partum	Special Survey	Annual	Facility
	uterotonic (i.e. active management of the third stage of labour)			
C4	Proportion of newborns breastfed within one hour of birth	DHIMS	Annual	Facility
C5	Proportion of babies receiving the first postnatal visit within 48 hours			
C6	Proportion of babies receiving the second postnatal visit by day 7			
C7	Proportion of neonates with birth asphyxia provided basic (or comprehensive) neonatal resuscitation	DHMIS	Routine/ Quarterly	Facility
C8	Proportion of preterm births under 34 weeks gestational age administered corticosteroids			
C9	Proportion of newborns under 2000 grams initiated on facility-based kangaroo mother care (KMC)	Special survey	yearly	Facility
C10	Proportion of infections in hospital-born newborn babies requiring admission to the neonatal special care units			
C11	Proportion of maternal and perinatal deaths and near misses reviewed with standard audit tool	MDSR reports	routine	Facility
D. LEAD	ERSHIP			
D1-D5	Percentage (%) of health managers and leaders at national, regional, DHD, SD and facility levels trained on QI (NB: Disaggregate indicators into levels)	Report(s) /HRIS	Routine	RHD, DHD, SD
D6-D9	Percentage (%) of RHDs, DHDs, SDs and facilities with functional quality management units/teams (team formed, minutes of regular meetings)	Report(s)	Yearly	RHD, DHD, SD, facility
D10	Proportion of facility heads participated in the facility regular QI meeting and addressed key administrative and logistic issues	Report(s)	Quarterly	Facility
D11- D14	Percentage (%) of RHDs, DHDs, SDs and facilities with quality management unit/teams trained in QI	Report(s)	Yearly	RHD, DHD, SD, facility
D15- D18	Percentage (%) of RHDs, DHDs, SDs and facilities with quality management annual action plans (action plan developed, plan aligned to national level plan, plan being implemented)	Report(s)	Yearly	RHD, DHD, SD, facility
D19	TWG for MNH QoC are established and functional at national level	Report(s)	Routine	National
D20	Number of advocacy events for MNH QoC implemented through any of the outlets: web site, bulletin or mass media at national and regional levels	Report(s)	Routine	National and RHD
E. ACTIO	ON			
E1	MNH QoC standards and protocols are adapted and disseminated in both hard and soft copies to all levels, including facility level and in	Report(s)	One off event, reviewed as needed	National

	pre-service institutions				
E2	Percentage (%) of facilities where MNH standards are available and in use	Report(s)	Annual	National, RHD	Facility, DHD
E3	Number of health staff trained on QI and MNH quality of care standards	Report(s) /HRIS	Routine		National, RHD
E4	National packages of MNH improvement interventions adapted/developed and disseminated	Report(s)	Routine		National
E5	Percentage (%) of facilities where MNH intervention guidelines are available and in use	Report(s)	Routine		National, RHD
E6	Number of health staff trained on the implementation of national packages of MNH quality improvement interventions	Report(s) /HRIS	Routine		National, RHD
E7	Number of best practices on MNH QoC documented and published	Report(s)	Routine		National, RHD
E8	A set of core indicators for MNH QoC are incorporated and reported in the DHMIS	DHMIS	Routine		National
E9	Percentage (%) of health facilities which benefited from supportive supervision, coaching and mentoring in the past twelve months	Report(s)	Annual		Facility
E10	Percentage (%) of health facilities which conducted performance assessment on MNH QoC standards and identified priority gaps	Report(s)	Quarterly		Facility, SD
E11	Percentage (%) of health facilities which developed and implemented improvement plans to address priority gaps	Report(s)	Quarterly		Facility, SD
E12	Percentage (%) of districts within the region which conducted supportive supervision, coaching and mentoring on MNH QoC in over 50% of its SDs in the past twelve months	Report(s)	Annual		Facility
E13	Percentage of districts with documented best MNH QoC practices within over 50% of its facilities and sub-districts to share	Report(s)	Annual		RHD, SD
E14	Percentage of districts with improved supply chain management within over 50% of its facilities and sub-districts	Report(s)	Annual		RHD, SD
E15	Number of regions with improved referral system	Report(s)	Routine		RHD, SD
E16	Number of regions which conducted supportive supervision, coaching and mentoring on MNH QoC in over 50% of its DHDs and health facilities in the past twelve months	Report(s)	Annual		Facility
E17	Number of regions with documented best MNH QoC practices within over 50% of its districts	Report(s)	Annual		RHD, SD
E18	Number (%) of SD engaged in joint capacity building of facilities (supportive supervision, mentoring, coaching)	Report(s)	Routine		Routine

F. LEAR	NING			
F1	Minimum set of country MNH quality indicators aligned with the global indicators defined	Report(s)	One off event, reviewed as needed	National
F2	Additional indicators incorporated into DHIMS as necessary and data collection tools developed as necessary	DHIMS	One off event, reviewed as needed	National
F3	Proportion of MNH QoC core indicators integrated in DHIMS-2 that are routinely collected and reported from facility dash board	DHIMS	Routine	National, RHD
F4	Proportion of facilities within the district visited by the monitoring and evaluation team annually	Report(s)	Annually	National, RHD, DHD
F5	Availability of tools for collecting and reporting case histories and stories from the field for dissemination at facility, district, regional and national levels	Report(s)	Quarterly	SD and facilities
F6	Proportion of facilities within the district visited /mentored on timely basis for data quality assurance standards	New	Quarterly	National and RHD
F7	Proportion of health information technicians in facilities or HMIS focal points trained on data analysis and use	Report(s)	Annually	National ,RHD and facility
F8	Availability of national virtual learning system for improving MNH QoC that can be accessed and linked to the global learning platform	Report(s)	Annually	National
F9	Availability of social media platform as a learning means for MNH QoC	Report(s)	Routine	National
F10	Number of regions participating in national learning collaborative sessions	Report(s)	Routine	National, RHD, DHD
F11	Proportion of districts with active intra-district learning collaborative	Report(s)	Routine	National, RHD, DHD
F12	Percentage (%) of facilities within district participated in district learning collaborative	Report(s)	Quarterly	Facility, DHD, RHD
F13	Average number of learnings submitted from the districts to the region learning system and disseminated	Reports	Quarterly	National, RHD, DHD
F14	Proportion of facilities with assigned person to track progress, feed learning and participate in learning through the national learning platform	Report(s)	Quarterly	Facility, DHD, RHD, national
F15-F18	Proportion of planned review meetings with MNH QoC input conducted at national, regional, district and sub-district (NB; Disaggregate indicator into levels)	Report(s)	Quarterly	SD, DHD, region and national
F19	Proportion of annual national quality conferences with MNH QoC input conducted	Report(s)	Annually	National
F20	Number of awards given for MNH QoC at annual national quality	Report(s)	Annually	National

	conference			
F21	Proportion of health facilities within each district attending annual	Report(s)	Annually	National
	national quality conference			district
F22	Number of published case reports and successful quality	Quality	Annually	
	improvement best practices and disseminated	indicator		
F23	Proportion of lead hospitals that planned and provided supportive	Report(s)	Quarterly	Region,
	supervision, coaching, mentoring support to their cluster of			District,
	hospitals as per plan			facility
	DUNTABILITY			
G1	Average number of community health durbars held in the year by	Report(s)	Annual	District
	each health facility			
G2	Proportion of community health durbars which discussed maternal	Report(s)	Quarterly	District
	and newborn care, client/family/community involvement in their			
	care, client satisfaction and community satisfaction			
G3	Proportion of health facilities that publicly display patient's charter	Report(s)	Quarterly	Facility
	and routinely inform patients at information/front desk			
G4	Proportion of health facilities within district implementing the	Report(s)	Quarterly	District,
	community score cards to improve the MNH QoC			Facility
G5	Proportion of facilities with timely reports on indicators that	KPI , HMIS	Quarterly	Facility
	measure clients' satisfaction in the labour and delivery ward in the			
	health centre and lower levels	<u> </u>	T	N
G6	Performance management of leaders and managers include quality	Appraisal	Twice a year	National,
	of care indicators	forms/reports		RHD, DHD, SD, facility
G7	Percentage (%) of health facilities implementing DHIMS2	Report(s)	Routine	National,
G/	Percentage (%) of health facilities implementing Driffwisz	Report(s)	Routine	RHD, SD
G8	Percentage (%) of health facilities conducting regular quarterly	Report(s)	Quarterly	Facility,
U6	client/mother satisfaction survey	Report(s)	Quarterry	DHD, RHD,
	chemomother satisfaction survey			national
G9	Number (%) of regions where toll free telephone service for client	FMHACA	Annual	National
	grievance handling are established			1 tational
G10	CPD material designed to train future MOH staff to use systems	Report(s)	Routine	National
	improvement methods to lead, manage and implement change	Troport(s)		T (MII)
H. MILE	STONES OF MNH STRATEGY IMPLEMENTATION			
H1	Adopt/adapt MNH quality of care standards			
H2	Adopt/adapt national MNH quality of care interventions for			
	implementation			
Н3	Assess baseline performance in demonstration districts			

H4	Implement agreed MNH intervention packages in demonstration				
	districts				
H5	Scale up implementation using lessons learned in the				
	implementation districts				
Н6	Strengthen data systems for MNH quality of care				
H7	Strengthen a learning and accountability system to accelerate				
	improvement				
Н8	Monitor and evaluate implementation of the plan				

Annex 3: MNH Analysis – Ghana

MNH Analysis

Code	Deliverable	Suggested Actions	Strengths	Weaknesses	Lead Agency	Partners
1.0	LEADERSHIP				<u> </u>	
Output 1	1.1: National leadership a	and governance structures for	QoC are strengthened (or esta	blished) and functioning		
	National Quality Strategy to support MN and other national care priorities	Establish or reinforce a Directorate or Office of Quality within MOH	ICD and FHD of GHS already oversee quality of care (QoC) for maternal and newborn health (MNH) A National Quality Steering Committee established for the development of the NHQS	Strengthen the sub-national levels (regions and districts) to oversee QoC for MNH in facilities	MOH, GHS (ICD, FHD)	Partners in the Health Sector Working Group (HSWG): WHO, UNICEF, UNFPA, USAID, DFID, DANIDA, KOICA, UNDP, DUTCH, GTZ, JHPIEGO
		Establish or strengthen Ministerial Multisector Quality Steering Group.				
		Develop, strengthen or utilize existing National Quality Strategy that coordinates the planning, assurance and improvement aspects of quality and supports priority programming like MNH	National Healthcare Quality Strategy (2017-2021) developed and launched	Dissemination to the regions and lower levels not yet done	PPME to provide resources for dissemination and see to the implementation of strategy by all agencies of the MOH, with focus on MNH	
Output 1	1.2: National operational		care in MNH services is develo	ped, funded, monitored and r	egularly reviewed	
	Costed National Operational Plan for halving facility-based maternal and newborn deaths in 5 years	Strengthen (or establish) a government-led, multi- stakeholder steering group for quality improvement in MNH services. (Technical Working Group, TWG)	A number of TWGs on MNH already exist in the sector Safe Motherhood Steering committee National Newborn Subcommittee	Costed National Operational Plan for halving facility-based maternal and newborn deaths in the next 5 years yet to be developed The MAF is costed but it is ending	Develop a Costed National Operational Plan for halving facility-based maternal and newborn deaths in 5 years as part of the network. This could be done as part of the Country's adaptation of the Global strategy on WCAH (2016 - 2030)	MOH and the Service Delivery Agencies of MOH (GHS, TH,CHAG)
		Build off existing MN country plan to develop a planning document that accelerates progress towards improved outcomes: includes the vision	Policies and strategies on MNH exist e.g • Reproductive Health Policy and Standards • Ghana National Newborn			

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		(half by five), strategy (district-	Health strategy			
		based demonstration, scale up,	MDG Acceleration framework			
		sustainability), and	and country action plan (MAF)			
		implementation plan (WHO				
		standards and implementation				
		interventions, learning system).				
		Develop a sustainable funding	Health Financing System of		Cost strategies on	MOH and the Service
		strategy to ensure needed	MOH and other partners with		MNH initiatives and	Delivery Agencies of
		resources (physical and human).	initiatives on MNH: UNICEF,		explore more funding	MOH and partners
			USAID, UNFPA, PATH		sources	•
Output 1	.3: National advocacy an	nd mobilisation agenda for qua	lity of care is developed and in	nplemented		
	National will and support	Minister publicly articulates	MNH and QoC for MNH are		Advocate for the new	MOH & service
	demonstrated for MN	support for participation in the	already a priority for the country		minister of health to	Delivery Agencies
	initiative	Alliance as a priority	aneady a priority for the country		maintain this as a	Benvery rigeneres
	Supportive coalition of	government initiative.			priority	
	key stakeholders	Identify national champion for	Directors of ICD and FHD of		Identify and build	
	-		the GHS			
	(government, women,	country accelerated MN plan			capacity of sub-	
	civil society, professional		Heads of Quality assurance		national champions	
	groups, technical partners		units of ICD and NHIA			
	and funders) to support		 Regional Deputy Directors for 			
	the MN initiative		Clinical Care			
			 Regional Newborn Focal 			
			Persons			
		Ministry commits to resources			Develop national	
		required for intervention and to			advocacy and	
		data transparency (national and			mobilisation plan	
		global)			-	
		Ministry provides regular public	Annual Health Summits,			
		updates on progress of the	Annual divisional review			
		initiative.	meetings, annual newborn			
			stakeholder's meetings,			
			quarterly and monthly TWG			
			and Sector Working Group			
			meetings are good opportunities			
			for involvement of stakeholders			
		11 11 01 24 4 4 11	and review of progress	A 1 C 1 1 1	A 1 C	MOIL 0
		Hold QI summit that assembles		Agenda often loaded	Advocate for an	MOH & service
		stakeholders and articulates			inclusion of QoC on	Delivery Agencies
		Ministerial will, vision,			MNH on the agenda as	
		strategy, and operational plan.			a priority; Use some of	
					the existing	
					governance structures	
					to project MNH	

	1	Hold regular meetings with	1	<u> </u>	1	1
		larger stakeholder group				
		(annual) and specific sub-				
		groups regularly to maintain				
		and build will and support.				
	Aligned and mobilized	Develop clear mechanisms for				
	partners	technical partners to participate				
		in stakeholder steering group				
		and sub-group meetings.				
		Map stakeholder engagements	Development Partners Group as		Advocate for more	DPs Sector Lead
		and commitments in current	a forum to mobilise and align		partners to support	
		MN programming.	various partners; Rotating		QoC in MNH	
			Sector Lead can whip up			
			commitments			
		Agree on roles, responsibilities				
		and commitments from				
		partners.				
		Orient stakeholders to support				
		institutionalization and				
		sustainability of QoC (clinical				
		and systems technical				
		competencies) so that the scale				
		up and future of QoC is led and				
		managed by the country				
		leadership				
	Regular transparent	Engage partners in regular				
	review of progress against	meetings of the MN working				
	targets	group to allow course				
		corrections and design				
		improvement over time				
Code	Deliverable	Suggested Actions	Strengths	Weaknesses	Lead Agency	Partners
2.0	ACTION				6	
		country adapted OoC standar	ds, best practices and impleme	ntation interventions is compi	led, incorporated into	the operational plan
_	eminated	transfer to the second			F	· F · · · · · · · · · · · · · ·
	Set of contexts specific	TWG to adapt and update	Various protocols/guidelines for	Some national standards and	Complete adaptation	MOH and the Service
	evidence-based national	national standards and	delivering quality care for	protocols yet to be widely	and disseminate	Delivery Agencies of
	QoC standards and	protocols, using WHO	mothers and children	disseminated to the lower levels	standards and	MOH and partners
	protocols	standards of MNH care as a	Safe Motherhood Service		protocols to all level.	
	F-300010	reference	Protocols		Ensure availability at	
			Mother Baby Friendly Facility		facility levels and in	
			Initiative (MBFFI)		pre-service institutions	
			Baby Friendly Hospital		pre service institutions	
	1	1	- Davy Phendry Hospital	1	1	

		Initiative • Job-aids for Maternal and Newborn care • Standard Treatment Guidelines • Maternal health and death audit guidelines • National Perinatal Audit Tool and Guidelines • National Health Insurance Credentialing guidelines and tools GHS with support of partners adopting the WHO QoC		
Set of national practice tools to support QoC standards Widespread availability of QoC standards and tools at facilities and training institutions	TWG to review and update national practice tools in support of QoC standards Disseminate and facilitate uptake of updated national standards, protocols and practice tools to training institutions and health facilities	standards	Partner with the private sector to distribute the protocols etc and consider distribution of soft	Health Training institutions Secretariat and the training institutions
Set of best practices for implementation QoC standards	Hold an initial (and then annual) workshop with MoH and technical partners to assemble and improve a national package of improvement best practices along the continuum of facility-based care and other WHO QoC standards	Existing annual, quarterly and monthly review meetings	copies • Utilize existing annual (e.g Newborn stakeholders meeting), quarterly and monthly review meetings to review progress. • Consider establishing an annual workshop focused on QoC for MNH and disseminate best practices and standards	MOH and the Service Delivery Agencies of MOH and partners
Survey of implementation interventions and existing capabilities (MoH and technical partners) to support these interventions	TWG undertakes a "sense-making" review of the existing QoC activities in the country, the technical partners capable of supporting these interventions, and incorporates them into the operational plan.	MOH / GHS mapping of interventions and partners	sundarus	

Output 2.2: Establish readiness f	or implementation of the MN	initiative		
Set of indicators of QoC	Develop core indicator set at	Some Core indicators on MNH	QoC indicators on MNH in the	
at national, district and	national, district and facility	already captured in the DHIMS	DHIMS are not comprehensive	
facility level	level		•	
Baseline performance at a	Establish a set of key system			
District level	input, process and outcome			
	measures that reflect the			
	performance of the MN delivery			
	system.			
	Measure the performance of as	Annual progress/review reports	Existing baseline data may not	
	many districts as practicable,	of districts and the DHIMS has	be comprehensive	
	starting with the selected	some baseline performance data	•	
	demonstration Districts.	•		
Resource gaps addressed,	Prioritize the resources		Limited funds for the sector;	
starting with	required to support the		Lack of basic Logistics such as	
Demonstration Districts	initiative, starting with the		equipment	
	Demonstration Districts			
	Allocate resources through		Weak HR capacity (skills,	
	planning and prioritization to		attitude, Numbers, turnover and	
	support QoC standards		attrition); Poor Referral system	
	(financial, information systems,			
	commodities procurement and			
	distribution, trained/supported			
	staff, referral transport, etc.).			
Output 2.3: Initiate district-base				
Demonstration Districts	Demonstration Districts	District structures and profile	Demonstration districts yet to	Identify demonstration
selected	selected according to ability to	well documented	be selected	districts to implement
	inform scale up: sizeable			interventions
	population for learning,			
	engaged District management,			
	resource issues not			
	overwhelming (not worst, not			
	best in nation), technical partner			
	committed and funded to support			
	effort.			
Selected Districts	Engage with District to select			Engage with district to
supported with requred	facilities collect, baseline data,			identify facilities.
resource inputs	provide prioritized resources as			
	described in District level			
	guidance			
Selected Districts	Engage with District to match	DHMTs aware of stakeholders	Some ongoing interventions	Identify the
supported with required	the stakeholders to the different	in the district	have limited geographical	intervention

	technical inputs	implementation interventions		coverage	appropriate to the	
	teenmear inputs	(e.g. clinical training, audit,		Coverage	Districts and partners	
		improvement coaching, data			willing to support	
		feedback, etc)			wining to support	
	Learning collaborative	With support from technical			Assist District to set up	
	established in	partner, assist District to set up			learning collaborative	
	Demonstration Districts	learning collaborative of			of facilities in that	
		facilities in that District			District	
Code	Deliverable	Suggested Actions	Strengths	Weaknesses	Lead Agency	Partners
	3.0 LEARNING				g,	
Output		en data systems for quality of	care improvement	<u> </u>		
	National data system (e.g. DHIS) that supports improved MN care	Strengthen and develop national data systems (e.g. DHIS) to report key indicators for MN care. Establish a process to test and add new indicators required to track key processes and outcomes	Data capturing system such as DHMIS already exist	Weaknesses in data collection	Definition of minimum set of MNH quality indicators aligned with the global indicators Inclusion of additional QoC indicators in the DHIMs Update data collection tools as necessary Improve collaboration between Health Research Centres and GHS in the capturing and use of surveillance data	MOH, GHS HQ, Regional and district health directorates and facility heads
	Core data sets for national and district level reporting	Agree a minimum set of MNH quality of care indicators for district, subnational and national levels aligned with the global indicators	There are three Research Centres with surveillance system		or survemmee data	
	Regular data dashboard reports at national (quarterly), district (monthly) and facility (monthly) level.	Provide guidance and tools to standardize data collection, synthesis and reporting	Availability of communication Technology			
	Qualitative data available for learning and will building	Develop a system for collecting and reporting case histories, stories from the field and			Set up system for collecting qualitative data	

	Data available/suitable for planning Reliable data collection and reporting	testimonials about the importance of the improvement process that can be disseminated at facility, district and national levels Strengthen MoH planners to understand data variation, benchmarking of data and use data for prioritization, intervention and planning Build technicial capabilities of data processors at national, district and facility level for data collection synthesis and		No or few data managers at the district and facility levels	Build capacities for data collection and analysis in the districts	
Output	2 2. Establish a vintual w	use	estom to shane knowledge and	ink to global learning platform	<u> </u>	
Output	3.2: Establish a virtual na National- Global learning system	Co-develop with global and national partners and maintain a national learning system (anchored in a MN improvement website) that is a resource for improving MN QoC for the country and links to the global learning platform for quality of MNH care.	The ministry of health and its agencies have websites that could be linked, RMNCAH Score card	ink to global learning platfori	Establish a virtual national and district learning system to share knowledge and link to global learning platform taking into consideration the suggested actions Strengthen inbuilt quality checks in DHIMS Use available and cheaper communication technologies with an administrator to share good practices, solutions	MOH and the Service Delivery Agencies of MOH and partners especially the PPME
		Process for TWG to regularly (quarterly) review progress of MN initiative and feedback design improvements. Links to Global platform				
	District-National learning system	District management to review progress monthly and feed learnings to national learning system (see District guidance)				

	Repository of knowledge	TWG to co-develop with				
	products and tools	technical partners a mechanism				
		to regularly upload knowledge				
		products and tools on QoC				
		including easy to follow				
		summaries, overviews and				
		manuals, supplementing				
		knowledge products and tools				
		available on the global learning				
		platform				
Output 3	3.3: Establish a face to face	ce national and district learnin	g system to share knowledge a	nd link to global learning plat	form	
		Commit to sharing knowledge	,		Establish a face to	MOH, GHS HQ,
		and learn from others through			face national and	Regional and district
		cross-country visits and			district learning system	health directorates and
		attendance at global convening			to share knowledge	facility heads
		attendance at global convening			and link to global	racinty neads
					learning platform	
					Inter district and	
					within district	
					collaborations will	
					have to be deliberately	
					developed by building	
					on the existing	
					meetings etc	
	Inter-district collaboration	Foster collaboration by	DHMTs and Facility managers			
		connecting facilities, leaders	in place with some regular			
		and managers around the	meetings			
		country				
	Within District	Use collaborative learning as a				
	collaboration	regular means of face to face				
		learning between facilities.				
		Use naturally occurring District			Strengthen district,	
		wide gatherings to foster			regional and national	
		learning between facility teams.			reviews.	
		learning between facility teams.			Recognise model	
					facilities and make	
					them share their	
					experiences	
					• Use the Senior	
					Managers meeting to	
					share information on	
					innovative	
					interventions	

					Establish institutional mechanism to operationalize workable and cost-effective interventions Organize more focused facility/community interface	
		Train district supervisors and managers in systems improvement methods and use facility visits as an opportunity to share knowledge between facilities				
	District-community collaboration	Support District efforts to communicate and advocate for better maternal newborn care to communities and patients and to collect information on patient and community satisfaction	Some level of community/facilities interface exist			
Output 3	3.4: Build evidence, infra	structure and will for future s		scale up		
	National set of best practices (change package) to inform initiative redesign and scale up Adaptive design for	TWG to co-develop an enhanced change package of tested change ideas to inform program delivery and next phase of scale up TWG takes learnings from	A number of TWGs already exist in the sector with a strong will for scale of successful interventions		This phase will begin following a successful implementation in the demonstration districts. Systems and resources must be put in place to ensure rapid scale up Improve collaboration between Health Research Centres and GHS in the capturing and use of surveillance data	MOH and the Service Delivery Agencies of MOH
	future project phases	demonstration and tests of scale incorporated into the design and planning for the future scale up.				
	Build evidence for excellent QoC	Identify best practices, develop and publicize case reports, use benchmarking to illustrate excellence and variation				

	Districts identified for	After demonstration phase, new				
	next phase of scale up	districts selected to test scale				
		up, reflecting a diversity of				
		contexts found in other parts of				
		the nation (e.g. rural, urban).				
	Future scale up districts	Physical infrastructure, human				
	infrastructure prepared	resources, clinical training,				
	for scale up	systems training, protocols,				
		tools are in place in target scale				
		up sites based on learnings from				
		initial demonstration				
	Receptive environment	Ministry leads advocacy and				
	for scale up	transparent planning for				
		ongoing scale up of initiative,				
		publicizes results, visible				
		presence in demonstration and				
	5 11 11	future scale up districts.	G. J	***	T 7.4	D 4
Code	Deliverable	Suggested Actions	Strengths	Weaknesses	Lead Agency	Partners
	4.0					
	ACCOUNTABILITY					
Output 4		and mechanisms for accountal			T	
	transparent initiative	Progress towards achieving	Quarterly and monthly TWG	Weak operational capacity of	Build on existing	MOH and the Service
	progress reports	deliverables, process and	and SWG meetings as well as	HEFRA	review meetings and	Delivery Agencies of
	(quarterly)	outcome targets are	existing national, regional,	Rewards and sanctions are not	consider establishing	MOH
		transparently available and	district and facility review	appropriately enforced	review meetings	
		reported quarterly to national	meetings are good opportunities	Monitoring systems to identify	specifically for quality	
		and global communities	for review of progress	lapses, safety and mal-practices	of care for MNH	
	° 1 1	36.1	MOHILL	in the system are weak	TD : 1 1	
	financial and resource	Mechanisms are strengthened at	MOH budget execution rate and		Train budget officers	
	tracking reports	national and district level to	monitoring system; Audit		in financial and	
	(quarterly)	track and report financial, human and materials resources	Review Implementation		resource tracking	
		numan and materials resources	Committee(ARIC) of various agencies exist; • Public		reports	
			Financial Administrative Act			
			(FAA – 2016) is available			
	annual review	Conduct multi-stakeholder	Annual Health Summits.		Advocate for an	
	aimuai ieview	dialogue to review the progress	Annual divisional review		inclusion of QoC for	
		and remedy bottlenecks	meetings, annual newborn		MNH as priority	
		and remedy bottlenecks	stakeholder's meetings		agenda item	
	public accountability	Experience of care data, and	8			
1		commitment to close				

		transparently on a regular basis				
Output			country-led scale-up and susta	ainability		
	MoH Quality Directorate/teams have the capability to scale up and sustain MN improvements	Specific set of skills (leadership and management of change) as required, are strengthened with support from technical partners at district and national level to ensure that the MoH can independently deliver the scale up and sustain progress, and transfer skills to other clinical programs as needed.	ICD and FHD of GHS already oversee quality of care (QoC) for maternal and newborn health (MNH) • A National Quality Steering Committee established for the development of the NHQS		Institutionalize systems for quality improvement and quality assurance at all levels Regular review of DHIMS data, RMNCAH Score card Resource and build capacity of the MOH M&E to steer the affairs of IME Create awareness in the population using patients' rights and enforce professional code of ethics Retool facilities to ensure maintenance of standards in practice Update performance management of leaders/managers to include QoC indicators Set up an independent health care quality commission that will oversee all aspect of quality including the work of agencies of the MOH including NHIS, HEFRA	MOH and the Service Delivery Agencies of MOH
	Routine knowledge sharing and learning systems become standard work in MoH	A culture of learning, transparency and data feedback evolves in MoH through institutionalization of improvement structures, tools and protocols.	The existence of Maternal Death and Peri-natal audit system Peer review system, which checks on some quality indicators, is available and can be used to advance the course of			

		QoC		
		 Patient charter is available for 		
		further sensitization		
	Capacitate managers and	Institutional Monitoring and		
	leaders to use systems thinking	Evaluation (IME) technical		
	and data to drive decision	team, PPME exists		
	making.			
MoH develops or	MoH builds capability to train		• Set up an	
strengthens its own	future staff to use systems		independent health	
capability to use and	improvement methods to lead,		care quality	
sustain systems	manage and implement change		commission that will	
improvement methods			oversee all aspect of	
			quality including the	
			work of agencies of the	
			MOH including NHIS,	
			HEFRA	

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