MINISTRY OF HEALTH

NATIONAL HEALTHCARE QUALITY STRATEGY

REVISED EDITION

(2024-2030)

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ACKNOWLEDGEMENT

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FOREWORD

The Ministry of Health is pleased to present the revised National Healthcare Quality Strategy (NHQS) for the period 2024-2030. This document represents a comprehensive and collaborative effort to enhance the quality of healthcare delivery across Ghana, ensuring that every citizen has access to safe, timely, effective, and patient-centered care.

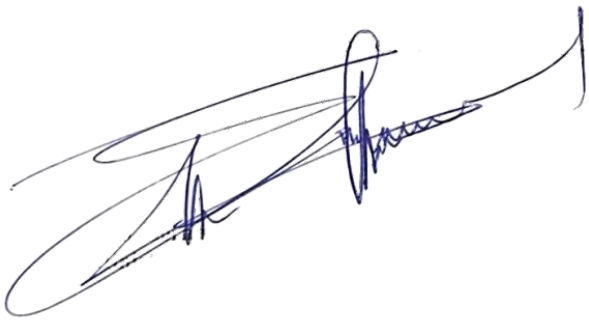
Since the implementation of the first NHQS (2017-2021), significant strides have been made in establishing quality governance structures and improving service delivery. However, the end-term assessment of the previous strategy revealed critical gaps and areas that required further attention. This revised strategy builds on the lessons learned and aims to address the identified weaknesses by strengthening the health system's capacity, improving regulatory mechanisms, and enhancing community involvement.

The NHQS 2024-2030 aligns with the overarching goals of the National Health Policy and the Universal Health Coverage (UHC) roadmap. It is designed to create a robust and sustainable quality culture within the healthcare delivery system, with clear measurable standards in terms of safety, efficiency, effectiveness, timeliness, equity, people-centered care, and integrity.

The development of this strategy involved extensive consultations with key stakeholders, including health professionals, non-governmental organizations, patient support groups, and development partners. Their insights and contributions have been invaluable in shaping a strategy that is both comprehensive and implementable.

As we move forward, the Ministry of Health is committed to ensuring the successful implementation of the NHQS 2024-2030. This will involve coordinated efforts across all levels of the health system, robust monitoring and evaluation mechanisms, and continuous engagement with our partners and communities. Together, we can achieve our vision of a healthy population for national development.

We extend our heartfelt gratitude to all those who have contributed to the development of this strategy and look forward to working collaboratively to improve the quality of healthcare in Ghana.



Hon. Bernard Okoe Boye
Minister for Health

LIST OF ACRONYMS

AHPC	Allied Health Professions Council
CHAG	Christian Health Association of Ghana
CSO	Civil Society Organizations
FBOs	Faith-Based Organizations
HeFRA	Health Facilities Regulatory Authority
MDC	Medical & Dental Council
M&E	Monitoring & Evaluation
MoH	Ministry of Health
NCCRM	National Centre for Coordination of Early Warning and Response Mechanism
NGO	Non-governmental organization
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NHQS	National Healthcare Quality Strategy
N&MC	Nursing & Midwifery Council
NQTC	National Quality Technical Committee
PPME	Policy, Planning, Monitoring & Evaluation
QM	Quality Management
QMU	Quality Management Unit
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

1. Background

1.1 The Journey towards improved healthcare quality

Healthcare quality is the extent to which health services for individuals and the population increases the likelihood of desired outcomes [1–3]. Eight dimensions of healthcare (i.e., safety, timeliness, effectiveness, equity, efficiency, people-centered care, integrity and integrated) defines its quality[3,4]. Poor quality healthcare is responsible for a large percentage of morbidity and mortality that occurs especially in low- and middle-income countries(3) and impedes achieving Sustainable Development Goal (SDG) 3 which seeks to ensure the provision of quality healthcare as an integral part of achieving Universal Health Coverage (UHC). Without quality, the quest for UHC will remain an empty promise even when there is increased geographical and financial access[5]. In the wake of the Sustainable Development Goals and the quest for countries such as Ghana to attain Universal Health Coverage (UHC), there is a growing expectation from citizens for better quality of services and improved health outcomes.

In 2016, Ghana developed and implemented its first National Healthcare Quality Strategy (NHQS 2017-2021)[6] that sought to improve its quality and outcomes of care. Until then, anecdotal evidence had suggested that the quality of healthcare being provided across health facilities (both public and private) was sub-optimal and needed urgent redress. The strategy laid out the vision, goals and objectives for healthcare quality in the country, indicators for measuring these and an implementation plan. The NHQS 2017-2021 was thus envisioned "to create a harmonized and coordinated healthcare quality system that places the client at the center of healthcare and ensures continuously improved measurable health outcomes" [6]. It was that document that would guide the national effort to ensure that all people living in Ghana had timely access to high-quality health services irrespective of their ability to pay. The goal of the NHQS 2017-2021 was "to continuously improve the health and well-being of Ghanaians through the development of better coordinated health system that places patients and communities at the centre of quality care"[6]. The strategy had 3 specific goals: 1) continuously improve health outcomes in the population health priority areas, 2) develop a coordinated healthcare quality system in the areas of quality planning, quality control, and quality improvement- including improved use of data for evidence-based decision making, and 3) improve client experience by being responsive to the health needs and aspirations of the patient and the community.

It was developed in response to the call to integrate the varied quality and patient safety efforts and to rally the required expertise. Further, the Strategy provided an opportunity for addressing the myriad of quality and patient safety issues bedevilling healthcare service delivery in the country. It also helped to build upon the previous national quality initiatives to improve care outcomes.

At the end of its period of implementation, an end-term assessment of the NHQS 2017-2021 was conducted in July 2023. The review showed that the first NHQS emphasized the establishment of quality governance structures such as the Quality Management Unit (QMU) across various institutions (public and private) and levels of the health system, interventions

were mainly focused on service delivery agencies. In addition, it was observed that weaknesses existed in all the components of the health systems building blocks which posed significant barriers to the successful implementation of the strategy and the achievement of its desired overarching goal.

The country's experience in implementing the previous NHQS (2017-2021) and inability to attain the MDGs 4, 5 and 6 on reducing maternal and infant mortalities, and HIV gives credence that quality healthcare can only be attained with a strengthened health system[7]. Given this, quality improvement initiatives have been initiated to institutionalize the culture and practice of quality, including establishing quality governance structures in both public and private health facilities and capacity building of institutions and individuals.

This NHQS 2024-2030 is in sync with the policy thrust of the revised National Health Policy (NHP) of developing a "*robust and sustainable quality culture institutionalized in the healthcare delivery system with clear measurable standards in terms of safety, efficiency, effectiveness, timeliness, equity and patient-centeredness*"[8].

1.2 Organization of Healthcare in Ghana

Ghana operates a pluralistic and five-tier level healthcare system- national, regional, district, sub-district and community. The health sector is led by the Ministry of Health (MoH) tasked with the responsibility of providing policy direction, monitoring and evaluation, resource allocation and financing, health training, health research and regulation of the entire health sector. There are 26 specialized agencies and affiliated organizations of the MoH [9] that support the execution of its mandate and are made up of service delivery, regulatory and training institutions. At each of these levels, there are health administrative structures and health service delivery facilities.

The health service delivery system is decentralized and operates at the primary, secondary, and tertiary levels. It aims to provide cost-effective, efficient, and affordable care to clients. These services are organized from the national to the community levels, including the regional, district, and sub-district levels. The public service delivery agencies include the Ghana Health Service *(the largest public health service provider)* and the six (6) teaching hospitals. The government's efforts in health service delivery are supplemented by the private sector, including self-financing and faith-based organizations such as CHAG and the Ahmadiyya Missions Hospitals, as well as civil society organizations (CSOs) that help to improve quality and access by generating demand.

Estimates on the size, scope and practice of the private (self-financing) healthcare sector in Ghana vary. It has been said to provide between 19%[9] and 42% of outpatient department services in Ghana[10] while in the GLSS 7, 51.7% of people surveyed had sought care from private health facilities in the 2 weeks preceding the survey[11]. In the private(self-financing) sector more so than in the public, there exists a great inequity in the geographic distribution of facilities with two regions, Greater Accra and Ashanti, accounting for more than 50% of the total number of these facilities[10]. The self-financing private sector in Ghana is beset with many

challenges including, insufficient supply of skilled health workforce, poorly enforced quality standards, poor governance in many of these facilities and increased informality at lower levels of care[12]. Anecdotal evidence suggests that this has affected the implementation of the NHQS and the provision of quality healthcare in most of them.

1.3 Current Situation of Healthcare in Ghana

The country has made significant strides in improving its health outcomes in its disease priority areas i.e., maternal and child health, communicable diseases (malaria, and epidemic-prone diseases such as cerebrospinal meningitis and cholera), non-communicable diseases (hypertension and diabetes), mental health and geriatric care[8,9] largely due to progressive investments, expansion of access, advancement in science, medicine and technology. Ghana's population has seen an increase from 6.7 million in 1960 to 30.8 million in 2021 with a median age of 21 years[13]. There has been an increasing trend of rural – urban migration with the proportion of the population living in urban areas increasing from 36% to 55% between 1990 and 2016[9].

Though Ghana did not meet the MDG targets on maternal health, it has made significant efforts to improve maternal and child health outcomes. For instance, under-five mortality rate has decreased from 111 per 1000 live births in 2003 to 40 per 1000 live births in 2022. Similarly, infant and neonatal mortalities have seen decreases from 64 per 1000 live births to 28 per 1000 live births, and 43 per 1000 live births to 17 per 1000 live births from 2003 to 2022. In addition, institutional maternal mortality has also decreased from 147 per 100,000 live births[14] to 102.6 per 100,000 live births[15]. However, more still needs to be done in improving access to skilled delivery and pregnant women with 4+ ANC visits as these only saw a marginal increase between 2018 and 2022[15].

The incidence of malaria has decreased from 341 per 100 population in 2018 to 178 per 1000 population in 2022[15] with institutional malaria under-5 case fatality rate decreasing from 0.2% in 2017 to 0.09% in 2021[14]. Malaria parasite prevalence in Under 5 children also decreased from 20.6% in 2016 to 14.6% in 2019[16]. The malaria vaccine implementation programme was launched in 2019[16].

There have been no recorded outbreaks of the epidemic-prone diseases of CSM and Cholera in the country in recent years. There was however global pandemic of COVID-19 which also affected Ghana. Ghana reported its first case of COVID-19 in March 2020 and as of January 2022, it had recorded 153,514 cases with 1343 fatalities[17]. The country commenced its vaccination drive against the disease a year later on 1st March 2021[18].

While there is a "lack of nationally representative data on mental health and NCDs"[9], hypertension has consistently featured among the top 10 causes of OPD morbidity in recent years accounting for between 2.0% and 2.3% of all OPD visits[14]. Studies from 2011 to 2022 have also reported a diabetes prevalence of between 2.8% and 2.95%[19]. It has been noted that, based on various surveys and reports, the incidence of NCDs as well as their associated risk factors is on the increase[20]. Concerning mental health, despite there being several challenges with mental health service provision in the country, the delivery of these services remains a key priority area for the government [9]. Some improvements have been recorded which include an increase in the number of community-based mental health facilities from 131 in 2011 to 454 in 2020[21]. Additionally, between 2020 and 2021, all district and regional hospitals had mental health units to provide mental health services while the GHS and the Mental Health Authority are working together to ensure that mental health services are gradually available in

all primary healthcare facilities[14,21]. In the area of legislation, the implementation of the Mental Health Act was augmented in 2019 by the passage of the Mental Health Regulation which spells out the processes for implementing the Act[3].

Studies have identified that many challenges exist with geriatric care in Ghana including an absence of dedicated professionals for their care and financial challenges that occur even with the exemption of patients over 70 from paying NHIS premiums[22,23]. The GCPS is however making efforts to train more specialists in geriatrics to help address one of the challenges[24].

Financial access to health care in Ghana is either from out-of-pocket payments at the point service or through the National Health Insurance Scheme (NHIS) and other private health insurance schemes.

1.4 Health system's capacity for quality

Strong health systems facilitate the attainment of desired health outcomes, hence the urgent need to strengthen the health systems of Ghana as revealed by the end-term assessment to maximize the effect of its interventions. In the wake of the Sustainable Development Goals and the quest for countries such as Ghana to attain Universal Health Coverage (UHC), there is a growing expectation from citizens for improved health outcomes. Strong health systems, designed to be responsive to healthcare quality, facilitate the attainment of desired quality of health outcomes.

Skilled and competent health workforce, effective leadership and governance, effective organization of care, availability of requisite "tools of the trade" (including resources, medication, technology and data), partnerships across all agencies/sectors, and communities that have trust and confidence in the health system remain the foundation of any effective health system capable of delivering the desired quality of care outcomes and impact. *People, equity, resilience and efficiency are four values that inform high-quality health systems*[3]. Unfortunately, Ghana continues to experience fragmentation and inequities in its health service delivery due partly to the disproportionate support of vertical health policies and programmes which have led to sub-optimal healthcare[8].

1.4.1 Leadership and Governance

The MoH through its Quality Management Unit under the PPME Directorate provides leadership for national quality planning, control/assurance, and improvement efforts. While a national governance structure for quality across all levels of the healthcare system exists, these are not as functional as they ought to be. Through quarterly meetings of the National Quality Technical Committee, agencies of the MoH as well as development partners and NGOs in health have a platform to interact and share ideas for quality improvement. At the facility level, leadership accountability for quality is inadequate. However, a few other agencies and facilities are doing well. In general, the leadership buy-in, commitment and support for the institutionalization of quality is a challenge in many of the public and private health institutions.

1.4.2 Regulation

A critical requirement to ensure the institutionalization of quality is the strength of regulation. Regulatory activities in the health sector of Ghana are by 12 regulatory bodies[1] that focus on regulating the training of personnel, services and protecting the client/consumer by ensuring that the required and appropriate human resources are available in adequate numbers and competence at the point of service delivery in both public and private health institutions. They also ensure that healthcare institutions and healthcare providers deliver services that meet the minimum regulatory standards[25,26] In addition, regulation aims to ensure that standards of practice and accreditation of health facilities are maintained and adhered to. There are also regulatory institutions whose object is to "licence and monitor facilities for the provision of public and private healthcare services"[27] and "for the regulation of food, drugs, food supplements, herbal and homeopathic medicines, veterinary medicines, cosmetics, medical devices, household chemical substances, tobacco and tobacco products and the conduct of clinical trials"[28].

The end-term assessment observed that there were inherent weaknesses in the existing regulatory mechanisms to ensure quality and safe standards were met and adhered to at all times in protecting the population. Although there have been significant efforts and initiatives to improve the regulatory environment, there are still inherent weaknesses that affect their ability to enforce their mandate for the provision of quality and safe services. Further, "there are also capacity and resource limitations of regulatory bodies to accredit, license, renew, monitor, supervise, enforce and provide technical support"[12,25,29] to professionals and health institutions (public and private).

1.4.3 Health Workforce

The country faces challenges with the numbers, skill mix, and distribution of health workers. In the context of quality, irrespective of the human resource challenges mentioned, all health workers need to have an orientation towards healthcare quality.

Currently, those responsible for leading the quality-of-care agenda at the various levels have limited technical capacity. There are different cadres of health professionals (nurses, doctors, administrators, medical laboratory scientists, etc) leading quality. However, they do so as an additional responsibility to their core professional work schedules.

There is no established position for this role nor a defined career path. There is a lack of significant pre-service, in-service and post service training for the health workforce in healthcare quality. The development partners have provided support in this area by providing capacity building at some levels of the health system while in some institutions such as teaching

[1]Health Facilities Regulatory Agency (HeFRA), Food and Drugs Authority (FDA), Medical and Dental Council (MDC), Nursing and Midwifery Council (N&MC), Pharmacy Council (PC), Allied Health Professions Council (AHPC), Psychology Council, Traditional Medicine Practice Council, Ghana College of Physicians and Surgeons (GCPS), Ghana College of Pharmacy (GCP, Ghana College of Nursing and Midwifery (GCN&M), Mortuaries and Funeral Facilities Agency[9]

hospitals, these efforts are internally driven. A health workforce (both leadership and frontline) with knowledge, skills and competency, in healthcare quality is fundamental.

1.4.4 Health Information System

There are high levels of data reporting into the national health information system, DHIMS2 by the public and Faith-Based Organizations (FBOs) (CHAG and Ahmadiyya) facilities. In recent times, there have also been improvement in reporting by the self-financing private facilities into the DHIMS2. However, most of them together with the teaching hospitals still maintain parallel systems. The use of data collected to inform decision-making at the local

level is another challenge. Most of the quality indicators set out by the NHQS 2017-2021 were yet to be fully incorporated into the DHIMS2; making monitoring and evaluation of progress difficult.

In addition, in spite of the rigorous processes in place to ensure data quality, there are still gaps from respective data sources and domains such as health service use and consumption, clinical efficacy, epidemiology, equity, costs and quality of life(22). In many instances, the data is also aggregated and this makes analysis at the unit level often impossible. The present HMIS though able to count the number of services delivered is yet to be able to measure how care is actually delivered.

1.4.5 Health Financing for quality of care

Health financing in Ghana is through multiple revenue sources which can be categorized into public, private, and external. Currently, the interplay of the decreasing health sector share of government expenditure, the challenging macroeconomic conditions in the country, and the decreasing proportion of total health expenditure funded by external donors with a greater focus on technical assistance than direct operational support means that there is a constraint on the availability of resources for the health sector. In most instances, there are no budget lines and allocations for quality activities nationally, and where there is, these gaps are filled in by donors/partners. The situation is no different at the health facilities as well. Over the years, quality and patient safety activities have been funded by donors/partners such as USAID, JICA and the UN Agencies notably the WHO and UNICEF. However, funding for quality and patient safety activities in the private sector and the teaching hospitals is mostly done by them.

1.4.6 Medical Products, Vaccines and Technology

Ghana's supply chain for logistics and essential medicines is beset by many challenges leading to stock-outs of medicines occurring even for medications for the management of key priority areas such as infectious disease (e.g., HIV) and child health. The presence of national systems, strategic plans, Health Commodity supply chain master plan (2021-2025), and guidance for supply management have had minimal positive effect on key supply chain indicators. The introduction of the Ghana Integrated Logistics Management Information System (GhiLMIS), Framework contracting and Last Mile Distribution (LMD) are aimed at mitigating some of the challenges identified with medical logistics. There are also challenges with access to and availability of quality essential medicines especially in the public sector often as a result of stockouts, poor transportation, storage and counterfeiting. Further, inadequate supply chain

workforce *(in numbers and skills)* also compromises the safety, effectiveness, efficiency and timely distribution of medicines and health products across the country. The FDA has on a number of occasions had to recall some medicines off the market as a result of quality and safety concerns[30–32]. Even though there is increased accessibility and availability in the private sector, this comes at a higher cost.

1.4.7 Partnerships

There are a number of health partners who are supporting the national quality program and efforts. Partners continue to support the national quality efforts through financing and technical assistance. The country has benefited from being a part of the Quality-of-Care Network for Maternal Newborn and Child Health which provided a forum for learning from the quality improvement efforts of other countries and to accelerate efforts to improve

outcomes in maternal and newborns, which was one of the priorities of the NHQS 2017-2021. One of major challenges identified during the end-term assessment with partnership for healthcare quality has to do with "weak coordination" which has in some instances resulted duplication of efforts. Also, even though a lot of efforts and progress have been made in public-private partnerships evidenced during the COVID-19 pandemic, much more needs to be done to further strengthen this relationship to ensure improved quality health service delivery.

1.4.8 Community Involvement and Participation

The end-term assessment found that the general public has been passive in the healthcare delivery environment of the country. Unfortunately, their role in demanding quality healthcare has in most instances been non-existent. They have often been unaware of their rights, privileges, and responsibilities and more importantly, their expected role to collectively ensure accountability and improved outcomes. There is however an emergence of various support groups like the Sickle Cell Association of Ghana, Ghana Diabetes Association and Cancer Survivors Association who have all been advocating for the provision of quality and safe healthcare for their members among others. In addition, there is also the National Coalition of NGOs in Health that is also supporting the demand side, though there is more to be done.

Community participation in improving the quality of care has received a boost with the introduction of the Community Scorecard. The scorecard with its integration into the CHPS systems through the Community Health Management Committee members, provides an avenue for health service provision to be assessed by nine indicators that cover various dimensions of healthcare quality. This novelty is, however, yet to be scaled up to all GHS health facilities across the country and modelled by other service delivery agencies under the Ministry of Health.

Other avenues for community involvement in the delivery of quality and safe healthcare include client feedback systems in various health facilities. One of the major challenges was the integration of the feedback to redesign and improve service delivery. In addition, many of the existing institutional quality governance structures do not have a representative of the community to contribute to the design and provision of health services.

1.4.9 Service Delivery

1.4.9.1 Access

Ghana continues to accelerate its efforts at improving and ensuring equitable access to quality healthcare services. Access to equitable quality primary healthcare (PHC) services for the population is recognized by the UHC Roadmap (2020-2030) and the National Health Policy: Revised (2020). There is also the establishment of the Networks of Practice (NoP) as one of the national strategies that seek to reform and strengthen the PHC system to address access, quality and equity gaps[9,33]. There is also the CHPS concept established to address gaps in access to quality healthcare services at the community and household level through the provision of basic preventive and curative services for minor ailments. Complimenting the public sector in improving accessibility is the private sector (i.e., self-financing and faith-based) that is collectively providing quality healthcare services to about 45% of outpatient department services[29] and owns 22% of health facilities in the country. Access to healthcare services varies according to the level of care. For instance, access to emergency transport systems, radiological services, and equipment such as breathing and intervention, and sterilization equipment was less accessible at the primary than the secondary and tertiary levels. However, access to some services such as paediatric HIV services, care and support and antiretroviral therapy are only available in hospitals and polyclinics. Improving financial access and reducing catastrophic health expenditure especially by the poor and vulnerable is also a key consideration of the MoH as it accelerates efforts towards attaining the UHC.

1.4.9.2 Availability

The availability of health services in Ghana still varies depending on many factors which include location, whether rural or urban, level of facility, age and disease. The Harmonized Health Facility Assessment by the GHS in 2022 found that the availability of preventive and curative services for children under 5, reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services as well as general service availability for malaria and HIV were high[34]. It also found that although lower-level facilities are not expected to provide in-patient facilities, 13% of health centres and 28% of clinics and maternity homes offer these services (30). For instance, more than half of women (54%) surveyed in the GDHS 2022 have at least one problem accessing healthcare [35]. Where services were found lacking, were in the areas of cancer services and comprehensive emergency obstetric and newborn care. Additionally, only 15% of facilities below the district level surveyed had all 7 basic emergency obstetric and newborn care signal functions[34]. Over 50% of primary-level facilities lacked basic equipment and infrastructure[36]. There are also challenges in the areas of emergency preparedness (for both natural disasters and disease outbreaks), safety planning and routine maintenance of infrastructure[34].

1.4.3 Utilization

Utilization of facility-based healthcare services in Ghana has remained stable as evidenced by the OPD visits per capita between 2018 and 2022 with a peak during this period of 1.19 per capita in 2021 and the lowest figure of 0.96 per capita in 2020, influenced by the COVID-19 pandemic[14]. The 7th Ghana Living Standards Survey showed that of the people who reported ill health in the two weeks preceding the survey, only 45.3% had sought healthcare for a remedy[11]. Various studies have shown that there is poor health-seeking behaviour by Ghanaians, especially concerning orthodox medicine with these studies finding most people

first resort to self-medication and local chemical or drug stores. This behaviour has variously been attributed to financial barriers, convenience, cultural beliefs and socioeconomic status[37–39]. Enrolment in the NHIS has however been positively associated with good health-seeking behaviour[38].

1.4.4 Coverage

Ghana has identified primary health care as the primary vehicle in achieving Universal Health Coverage even as systems are put in place to improve access to specialized care[36]. While the country has improved coverage of primary health care services through the implementation of the CHPS strategy, many challenges persist with its implementation (33) Between 2019 and 2021, there has only been a marginal increase in the proportion of functional CHPS zones set up from 78.5% to 79.67%[14]. Peculiar challenges in rural settings include low functionality in remote rural areas, uneven distribution of Community Health Officers and a lack of accommodation for these officers. In the urban setting, there is poor utilization of CHPS zones due to the absence of traditional leadership structures, a lack of trust in CHPS staff who do not live in or come from the communities they serve and a preference for patronising private facilities[40]. The NHIS serves as the main financial risk protection tool to remove financial barriers to accessing primary healthcare. 54.5% of the country's population had NHIS coverage as of 2022 up from 35.8% in 2018[15]. Unfortunately, a smaller percentage (21%) of the NHIS's expenditure is spent on PHC services in comparison to 79% spent on secondary and tertiary care. Coupled with this is the prescribed package of services at the CHPS level for which the NHIS reimburses in the face of the changing disease profile towards NCDs. All these threaten the ability of the CHPS strategy to effectively deliver PHC.

1.5 Quality of healthcare service delivery

Anecdotal and empirical evidence suggests that the quality of health service delivery as described by providers and clients is not optimum in spite of the many efforts and initiatives[6,9]. There is evidence of unsafe care, long waits, poor client experiences, and limited adherence to the existing protocols, guidelines and standards leading to significant variation in the quality of service provided even in the same institution[41–44]. This needs to be addressed in line with the goals of Universal Health Coverage (UHC) in Ghana. The quality of healthcare in this section is discussed along the eight (8) dimensions[3] of safety, timeliness, equity, efficiency, effectiveness, people centered care, integrity and integration.

1.5.1 Safety

Like in many other areas of healthcare in Ghana, there is a dearth of data on patient safety issues. However, in a study to assess response to patient safety incidents among health workers in three regions in Ghana, the authors found the prevalence of medication errors, wound infections, pressure sores and falls to be 30.4%, 23.3%, 21.3% and 18.7% respectively[45]. These causes of patient harm are similar to what pertains elsewhere. There has however been an increasing awareness in Ghana on the need for patient safety, to ensure that patients are not exposed to preventable harm or that the risk of such harm is reduced to the barest minimum[46,47]. Further, the knowledge and learning in patient safety in selected health facilities across the country was high[46,47]. In addition, there are evident weaknesses in patient safety surveillance research and an absence of dedicated funding for patient safety activities in health facilities[46,47]. Similarly, the burden of hospital associated infections (HAIs) was estimated at 8.2% among a total of 2107 inpatients surveyed in 10 hospitals *(i.e., tertiary, secondary and primary)*[48].

1.5.2 Efficiency

The efficiency of the health facilities in Ghana has been shown to vary greatly, depending on the type of facility as well as the metrics used to assess the efficiency. The different approaches used in the assessments of efficiency make comparison among them difficult. Irrespective of the weaknesses in assessment methods, there is evidence of underutilization of available capacity and some level of wastage of resources that is occurring in the face of rising patient numbers, staff shortages and limited resources available in the health sector[49,50]. This inefficiency has been variously attributed to poor coordination across the various levels of care[50]. These challenges lead to duplication of services across the levels of the health system, poor referral services, a mismatch between the need for staff and their distribution as well as a focus on donor-funded programs to the detriment of other general services.

1.5.3 Effectiveness

This is the extent to which the anticipated outcomes of health service delivery are attained using the available evidence. Though evidence-based decision-making as a concept is not new to the Ghanaian health system, there remain gaps in the availability of data to generate evidence and its application once generated[51,52]. The end term assessment of the NHQS 2017-2021 identified that while protocols for the management of some conditions under the health priority areas identified had been developed, adapted, and updated to improve the standard of practice for providing care to patients, the availability of these protocols and guidelines as well as adherence to them by health workers remains poor. It was found during an electronic folder review for patients with a diagnosis of community-acquired pneumonia that adherence to the Standard Treatment Guidelines for its management was only 32%[53].

It was also identified that the inadequate use of protocol and adherence is a major cause of preventable adverse events[43] which is to some extent blameable on the weakness of regulatory agencies and health facilities themselves in enforcing that these standards and guidelines be adhered to[43]. There is a weakness in evidence-based decision making at the lower levels of the health system and this is likely due to the top-down nature of decision making with priorities decided and planning done at higher levels with little room for variation based on local contexts[52].

1.5.4 Timeliness

Timeliness of healthcare service delivery can be defined as the system's capacity to provide care quickly as soon as a need is identified[54]. This is in turn affected by the ability to access healthcare services and the ability of the health system to evaluate and treat the patient once healthcare is accessed[55]. In Ghana, timely access to healthcare services is better at the primary level but decreases the more specialized the service required leading to more time spent in accessing care. Challenges also exist with the referral system, transportation facilities and access to ambulance services as well as the emergency response times of the national ambulance system[56–58].

Once at the health facility, patients then face delays in being evaluated and treated due to human resource and infrastructure challenges[59]. For instance, the median waiting time for obstetric services was estimated to be more than four hours (39) and 40 minutes in a tertiary and secondary facility respectively and these are far greater than the internationally accepted

standard of 10 minutes[60]. All these mean that patients are unlikely to get timely care once the decision to access care is made.

1.5.5 People centred care

People-centred care has been described as care where the provider and patient work in partnership, considering the patient's preferences, values and healthcare goals in order to achieve truly universal healthcare. Unfortunately, in some instances, access to care that is considered people centred has been shown to be positively correlated with increased educational and income levels as well as utilization of private health services even in public health facilities where separate systems are available for paying clients[61,62]. In addition, the satisfaction of clients to health services offered by the public facilities is very low compared with the private facilities[25]. There is therefore a need to address issues related to the client's experience of care; the inequities in accessing people-centred care to improve patient outcomes and improve utilization of healthcare services[62].

1.5.6 Equity

Gains in the overall population health in Ghana over the past decade, mask several health inequities which exist mainly between different income groups but also geographically[63]. An assessment of spatial access to health services in some Ghanaian cities, found that, access to healthcare services in Tamale in the northern part of the country was lower compared to Accra, Kumasi and Takoradi. Even within these cities (i.e., Accra, Kumasi and Takoradi) there was a disparity in access with those of a lower income level having to travel greater distances to access health services[64]. For the rural population, access to health services is poorer, with distance and time being a major challenge[65,66]. There are also inequities in the distribution of health staff with the majority of doctors and university-trained nurses working in the two largest cities of Accra and Kumasi, leaving other areas, especially rural, underserved[67].

More worrying, is the fact that the NHIS, which was set up as a pro-poor policy to bring about health equity has been shown to be excluding the poor (especially the rural poor)[63,68,69]. Studies have shown that children, females, urban residents and those with higher education and socio-economic status were more likely to be enrolled unto the scheme (67). An analysis of the enrolment by socio-economic quintiles found that it decreased from 44.4% in the richest quintile to 17.6% in the poorest[68]. The reason for this is that though the premium was low, it was still beyond the means of many poor people leading to their exclusion from a policy meant to protect them. There are also challenges with the distance people who do not have access to the means to utilize avenues such as the NHIS short code and app for renewal, have to travel to renew their cards in rural areas. In addition, there are difficulties with the determination of the socio-economic status of people to help in excluding the very poor from premium payments[63,68–70].

1.5.7 Integrity

This is the extent to which health services are provided without collusion and corruption. The healthcare sector, like other sectors in Ghana, is not immune from collusion and corruption. Oxfam, in a ten-year analysis of financial irregularities and unaccounted public funds from the Auditor-General's reports, noted that eliminating waste and corruption could potentially almost double spending on health [63].

CHAPTER 2

STRATEGY LEGAL AND POLICY CONTEXTS

1.6 Global Policy and Legal Contexts

Following the publication of the publication of the Lancet Global Health Commission Report on high quality health systems in the SDG, that revealed gaps in the provision of quality health care generally, it has become a global imperative for countries to develop national quality policies and strategies to improve care outcomes. In view of this, this NHQS 2024-2030 takes into consideration the various global, regional and sub-regional policy frameworks and strategies which include:

1. The African Union (AU) Vision 2063;
2. The WAHO Vision 2030;
3. The United Nations Sustainable Development Goals (SDGs) themed, "Transforming our World: the 2030 Agenda for Sustainable Development;
4. The Accra Declaration on Universal Health Coverage, 2022
5. The October 2018 Astana Declarations on PHC;
6. The African Health Strategy (2016-2030)
7. The Ouagadougou Declaration on PHC and Health System 2008
8. Handbook for National Quality Policy and Strategy (2018)
9. National Quality Policy & Strategy, WHO Meeting Report, 2017
10. Improving the quality of health services- tools and resources, 2018

1.7 National Policy and Legal Contexts

Ghana is committed to achieving quality universal health coverage by 2030. It is further committed to ensuring that, health services are "delivered through enhanced coordinated network facilities *(CHPS compounds, health centers, hospitals, etc)* both public and private, that collectively provide the appropriate package of healthcare services *(preventive, promotive, curative, rehabilitative and palliative using a life-course approach)* to the population"5.

This NHQS 2024-2030 recognizes the following key national policy and strategic frameworks that have a bearing on its implementation to ensure improved outcomes of care:

1. National Health Policy, 2020 (NHP, 2020)
2. Health Sector Medium Term Development Plan (2022-2025)
3. Universal Health Coverage Road for Ghana (2020 – 2030);
4. National Pre-Hospital Emergency Medical Service Policy (2020);
5. National Blood Policy (2020)
6. Policy on Antimicrobial Use and Resistance (2017)
7. Environmental Sanitation Policy (ESP 2010)
8. Ghana Pharmaceutical Traceability Strategy (2022)
9. Mental Health Policy
10. Mental Health Act, 2012 (Act 846);
11. National Health Insurance Act, 2012 (Act 852)
12. Public Health Act, 2012 (Act 851)

CHAPTER 3

STRATEGY FRAMEWORK

3.1 Rationale for Strategy

Ghana, like many other countries are striving towards the attainment of the SDGs including UHC. However, without quality, UHC remains an empty promise[5].

The purpose of this strategy is therefore to support the NHP 2020 policy thrust *"to develop a robust and sustainable quality culture institutionalized in the healthcare delivery system with clear measurable standards in terms of safety (providers and patients), timeliness, efficiency, effectiveness, equity, people-centered care, integration and integrity"*[8].

3.2 Scope of the strategy

This NHQS 2024-2030 seeks to facilitate and guide the provision of quality healthcare that is safe, timely, effective, efficient, equitable, people centered, integrated and with integrity in all public and private (self-financing and FBOs) institutions in Ghana. This strategy shall provide the enabling environment and framework within healthcare quality should be organized and implemented. It seeks to bring the required coordination and foster the necessary collaboration among all the stakeholders in the healthcare quality space to ensure the attainment of the desired outcomes.

3.3 The NHQS development process

The NHQS 2024-2030 was developed in close consultation with key stakeholders from the MoH, its agencies, NGOs in health, health professional associations, patient support groups and development partners. The process was led by a consultant and a Technical Working Group constituted in consultation with all stakeholders. An inception meeting was held at the MoH, to clarify expectations and agree on the approach and timelines for the Strategy development process.

A Technical Working Group (Appendix 7) with representation from MoH and its agencies, academia as well as development partners, and quality experts had a series of workshops, that culminated in the final NHQS 2024-2030.

The end-term assessment report of the NHQS 2017-2021, formed the basis for identifying gaps and areas for consideration and focus. The situational analysis from the end term assessment was updated to reflect changes that had occurred in the health sector to garner a full representation of quality in the country.

3.4 Vision, Goal, Strategic Objectives

The conceptual thinking informed by the findings of the end-term assessment is to strengthen regulatory capacity to facilitate accountability and institutionalization of quality; strengthen the health system for quality and empower service users to demand for and participate in improving the quality of healthcare. The goal and strategic objectives are thus derived from this:

3.4.1 Vision

The vision of the NHQS aligns with the National Health Vision as stipulated in the National Health Policy that is, a *healthy population for national development.*

3.4.2 Goal

To continuously improve health outcomes in the population

3.4.3 Strategic Objectives

Building on the achievements of the NHQS 2017-2021, the following strategic objectives have been set for the NHQS 2024-2030:

1. **Strengthen regulatory capacity to facilitate accountability and institutionalization of quality.**
2. **Strengthen the health system to sustainably deliver quality.**
3. **Improve the demand for quality healthcare.**

3.5 National Healthcare Quality definition and Priorities

3.5.1 Definition

The definition of quality adopted in this National Healthcare Quality Strategy (NHQS) 2024-2030) was derived from findings from the end-term assessment, review of the NHQS 2017-2021 and collaboratively with key stakeholders of the health system.

Healthcare quality is thus defined as:
*"**Healthcare delivery which places patients/clients, their families and the community at its center and achieves the best outcomes guided by evidence-based practice provided by an empowered workforce in an enabling environment**" (NHQS Interviewees & TWG 2023)*

3.5.2 National Health Priorities

Ghana is committed to achieving quality universal health coverage by 2030. It is further committed to ensuring that, health services are "delivered through enhanced coordinated network facilities (CHPS compounds, health centers and hospitals, etc) both public and private, that collectively provide the appropriate package of healthcare services (preventive, promotive, curative, rehabilitative and palliative using a life-course approach) to the population"[8]

The priority for this strategy, consistent with the NHP is
"to develop a robust and sustainable quality culture institutionalized in the healthcare delivery system with clear measurable standards in terms of safety (providers and patients), timeliness, efficiency, effectiveness, equity, people-centered care, integration and integrity"[8].

3.6 Core Values and Guiding Principles of the Strategy

3.6.1 Core values

The core values that are expected to guide every stakeholder to facilitate a successful implementation of the NHQS 2024-2030 include the following:

Core values

Integrity: All healthcare providers will be guided by honesty and adherence to moral principles in the discharge of their duties at all times.

Professionalism: All healthcare providers will be required to practice the highest work ethics. They will be required to show utmost respect and regard to self, their respective institutions and their clients.

Customer focus: It will be ensured that health services are provided to meet or exceed the expectations and needs of cherished clients/service users. Services shall be designed that place them at the center and make them actively involved in the service delivery process.

Excellence: There will be a strive towards the attainment of the highest level of excellence when it comes to carrying out assigned duties. The Ministry, through its agencies, will inculcate this value in all its professionals.

Teamwork: The work of providing the highest level of quality healthcare cannot be done by only one person, institution or MDA. Different professionals and institutions must therefore come together and work together by sharing ideas and brainstorming to identify mutually beneficial approaches and strategies for improving the quality of care outcomes.

Creativity and Innovation: Mindful of our resource constraints, creativity and innovation that does not compromise the quality and safety of service provision shall be encouraged at all times.

3.6.2 Guiding Principles

Implementation of this Strategy shall be guided by the following guiding principles:

Guiding Principles

The guiding principles for the NHQS 2024-2030 are adopted from the National Health Policy (Revised Edition) (2020):

Multi-sectoral collaboration: This strategy shall support all existing and future policies, actions and strategies to facilitate the achievement of quality universal health coverage (UHC) for the population.

Strategic Partnerships: This strategy recognizes partnerships with non-state actors (CSOs, industry, development partners, FBOs, communities, etc) in all its forms towards delivering appropriate health and wellness interventions for the population.

Equity: This strategy shall ensure that the provision of quality healthcare services is done devoid of ***all forms of discrimination***

Citizen's involvement and Social Accountability: This strategy shall empower the population to participate in and contribute towards the design, planning and execution of interventions that will improve their health status and receive feedback from respective duty bearers for their action

CHAPTER 4

STRATEGIC INTERVENTIONS

The strategic interventions are designed to address the gaps identified during the end-term assessment of the NHQS 2017-2021 and to ensure the goals and objectives for the NHQS 2024-2030 are achieved.

4.1 Strategic objective 1:

Strengthen regulatory capacity to facilitate accountability and institutionalization of quality.

Desired outcome:
Increased health personnel and institutional awareness and compliance to regulatory standards

Measure of the outcome:
Percentage of registered healthcare facilities and professionals in good standing

Strategic interventions

The high-level strategic interventions to achieve this objective include:

4.1.1 Establish an independent body to monitor quality healthcare indicator performance
4.1.2 Facilitate the establishment of national healthcare quality standards
4.1.3 Regularly update standards (e.g., STGs, EML); mechanisms for rewards and sanctions, to address the respective quality parameters
4.1.4 Improve public access to information on regulatory status (accredited, licensed, credentialed etc)
4.1.5 Strengthen regulatory agencies to execute their regulatory functions (accreditation/credentialing/ certification) through resourcing and improving efficiency.
4.1.6 Integrate mandatory CPD in quality management as a requirement for renewal of professional licenses
4.1.7 Enhance collaboration and stakeholder engagement among regulatory agencies

4.2 Strategic objective 2:

Strengthen the health system to sustainably deliver quality

This strategic objective is guided by the conceptual thinking that, a resilient health system is fundamental for the achievement of the desired health systems outcomes including quality. In view of this, there will be increased efforts to ensure a resilient and robust health system across all the building blocks. In this strategy, the health system is recognized to comprise of the following components[71]:

1. **Leadership and governance for quality**
2. **Human resource**
3. **Health financing**
4. **Service delivery**

5. **Medicines, Vaccines & Technology**
6. **Health Management Information Systems (HMIS)**
7. **Research**
8. **Partnerships for Health**
9. **Community engagement & empowerment**

The high-level outcomes and proposed strategic interventions are:

4.2.1 Leadership & Governance

Desired outcome:
Health institutions are quality-focused, with policies, strategies, guidelines, processes, procedures, performance frameworks and targets that support the achievement of healthcare quality standards.

Measure of the outcome:
Percentage of health facilities that are implementing policies, strategies, guidelines, processes, procedures, and performance frameworks that are supporting the achievement of healthcare quality standards.

Strategic interventions

The high-level strategic interventions to achieve this objective include:

4.2.1.1 Drive quality as a business case *(the costs and benefits)* in all public and private health institutions
4.2.1.2 Promote a quality culture in public and private health sector institutions.
4.2.1.3 Strengthen the capacity of leadership in quality management (to provide the enabling environment)
4.2.1.4 Strengthen mechanisms to hold leadership accountable for quality management
4.2.1.5 Strengthen existing governance structures for quality management (NQTC, at the Agency level) to make them functional
4.2.1.6 Public and private health sector institutions should develop an implementation guideline in alignment with the NHQS
4.2.1.7 Strengthen the capacity *(training, resourcing, etc)* of the M&E Units of the MoH and its agencies to deliver on their M&E mandate
4.2.1.8 Improve supportive supervision across all MoH directorates, sector agencies and all service delivery sites in the public and private sectors
4.2.1.9 Involve service providers including the private service providers in the implementation of QoC plan

4.2.2 Human resources for health

Desired outcome:
Sufficient numbers of qualified and competent health professionals to lead and sustain the provision of quality health care delivery.

Measure of the outcome:

Percentage of health facilities with the required qualified and competent health professionals leading and sustaining the provision of quality healthcare delivery

Strategic interventions

The high-level strategic interventions to achieve this objective include:

4.2.2.1 Create the "Joy at work" environment through the provision of essential inputs, incentives, recognition and rewards.
4.2.2.2 Integrate skills and competencies in Quality Management as part of the requirements for promotion/appointments to leadership positions (CEOs, directors, medical superintendents, heads of departments, ward in-charges etc)
4.2.2.3 Establish the post of quality and patient safety professional
4.2.2.4 Create job descriptions and career pathways for quality and patient safety professionals
4.2.2.5 Develop a database of personnel with quality management competencies and skills
4.2.2.6 Improve the skills and capacity of healthcare workers in quality service delivery
4.2.2.7 Liaise with existing academic institutions to design quality management curricula and train healthcare workers in quality management
4.2.2.8 Facilitate the integration of health service quality management modules into pre-service, in-service, post-basic and specialist curriculums
4.2.2.9 Advocate for the ministry to address the mass exodus of health workers because of its impact on quality health service delivery

4.2.3 Health Management Information Systems (HMIS)

Desired outcome:
Available, accessible, accurate, timely and reliable data on quality of care that is used for decision-making

Measure of the outcome:
Percentage of facilities making quality improvement decisions informed by available, accessible, accurate, timely and reliable data on quality**.**

Strategic interventions

The high-level strategic interventions to achieve this objective include

4.2.3.1 Review and standardize the analytical framework *(determining the core metrics/indicators along the quality dimensions)* for quality
4.2.3.2 Review and update guidelines for the preparation of reports at all levels of the health system to ensure improved care outcomes
4.2.3.3 Integrate key quality indicators into the health sector performance framework
4.2.3.4 Improve the source documents where the indicators are taken from through the use of technology
4.2.3.5 Build the capacity of the public and private sectors in data management.

4.2.4 Health Financing

Desired outcome:
Availability of and accessibility to dedicated financial resources for quality improvement activities

Measure of the outcome:
Percentage of facilities with dedicated financial resources for quality improvement activities
Strategic interventions

The high-level strategic interventions to achieve this objective include:
4.2.4.1 Integrate the funding of quality activities into the plans and budget of all institutions (public and private)
4.2.4.2 Mainstream and create dedicated budget lines for quality improvement research at all levels.
4.2.4.3 Mobilize resources to support the implementation of the NHQS
4.2.4.4 Implement mechanisms to ensure prudent use of resources for the implementation of the NHQS

4.2.5 Health service delivery

Desired outcome:
Provision of care that meets the national quality standards

Measure of the outcome:
Proportion of care rendered that meets the national quality guidelines

Strategic interventions

The high-level strategic interventions to achieve this objective include:
4.2.5.1 Update, review and develop new guidelines and protocols where relevant
4.2.5.2 Increase adherence to protocols, guidelines and standards in the provision of service.
4.2.5.3 Conduct regular supervision, monitoring and evaluation
4.2.5.4 Establish mechanisms for regular feedback from the users of the service
4.2.5.5 Improve the quality of health service delivery to address issues of safety, timeliness, efficiency, equity, effectiveness, people centered care and integration

4.2.6 Medical products, vaccines and technology

Desired Outcome:
Available medical products, vaccines and technology that meet the required standards

Measure of the outcome:
Proportion of medical products, vaccines and technology that meet the required standards.

Strategic interventions

The high-level strategic intervention to achieve this objective is:

Monitor adherence to quality, efficacy and availability standards for medical products, technologies and vaccines.

4.2.7 Research

Desired outcome:
Relevant scientific evidence is locally generated and used to support the design and implementation of more impactful quality improvement interventions.

Measure of the outcome:

1. Proportion of health facilities that conduct operational research on quality improvement
2. Proportion of facilities that implement the recommendations of operational research conducted

Strategic interventions

The high-level strategic interventions to achieve this objective include:

4.2.7.1 Liaise with the research, statistics and information management directorate to incorporate quality and patient safety research into the national research agenda

4.2.7.2 Strengthen capacity for research conducted into quality, implementation and use for decision-making at all levels.

4.2.8 Partnership for health

Desired outcome:
Improved coordination and collaboration of health sector (Ministry, departments and agencies) with themselves and other partners towards the implementation of the NHQS.

Measure of the outcome:
Percentage of intra-and inter-sector partnerships supporting the implementation of NHQS.

Strategic interventions

The high-level strategic interventions to achieve this objective include

4.2.8.1 Identify and coordinate the support of partners towards the implementation of the NHQS

4.2.8.2 Mobilize relevant MMDAs towards the implementation of the NHQS

4.3 Strategic objective 3:

Improve the demand for quality healthcare

The strategy recognizes the important role that communities including clients (i.e., patients, relatives and providers) play in any national quality of care effort. In view of this, the strategy will seek to increase the demand for quality healthcare by empowering and engaging communities and clients (i.e., patients, relatives and providers) to play active roles in the design and provision of health services. In addition, this strategy will ensure that, health service is provided in a manner that is dignifying, respectful, compassionate; and ensures that, the needs of the clients are addressed.

Desired outcome:
Service users are empowered to and proactively demand for quality healthcare.

Measure of the outcome:
Percentage of service users who make inputs (complaints, recommendations) and/or participate in advocacy to improve the quality of healthcare.

The high-level strategic interventions that are proposed include:

4.3.1 Strengthen mechanisms (e.g., client service units, community scorecards, community durbars, surveys, etc) for clients (i.e., patients, relatives, providers) and the communities to contribute or make inputs to improve the quality of healthcare
4.3.2 Conduct patient/client and provider satisfaction surveys at various levels of the health system (and incorporate findings into the holistic assessment)
4.3.3 Strengthen systems to empower clients (e.g., patients, relatives and providers) and communities (on their rights, responsibilities, facility standards etc) to demand quality healthcare
4.3.4 Publish the quality status of health inputs such as commodities, human resource, infrastructure (e.g., to Related Links of Agencies on MoH website)
4.3.5 Publish rankings of like agencies and like facilities in league tables for the general public

CHAPTER 5

IMPLEMENTATION ARRANGEMENTS

In the implementation of this strategy, the MoH will focus on its role of identifying priorities and leading policy, planning, regulation and coordination. Concerning frontline implementation, the MoH will support the sector agencies whose mandate covers respective strategic intervention areas.

5.1 Implementation by the Ministry of Health

The MoH, however, recognizes that there is the need for a structure within the ministry responsible for coordinating quality, and it has commenced action in this direction by prioritizing the strengthening of the NQTC chaired by the Director of Policy Planning Monitoring and Evaluation of the MoH; and made up of all heads of agencies of the MoH and partners, and reporting directly to the Chief Director of the MoH.

For the day-to-day running of the quality function, a national Quality Management Unit (QMU) has been set up within the PPME Directorate of the MoH. The QMU is headed by the National Quality Manager (NQM). The new strategy requires that all public and private sector health institutions must establish appropriate functional quality governance structures (i.e., quality management units, committees and/or teams) at all levels of their establishments to implement the national strategy. The MoH does not intend to create parallel structures but, as much as possible, to integrate into existing structures. There will be the strengthening of the National Quality Technical Committee (NQTC) made up of representatives from both public and private health institutions to effectively support the QMU in coordinating the implementation of the NHQS 2024-2030. Meetings of the NQTC will be chaired by the Director, PPME.

As with the agencies and private sector facilities, the MoH is expected to develop an annual operational plan reflective of the strategy interventions it contributes to and is expected to lead. A draft template to guide agencies to develop their own implementation plan or workplan for the implementation of the strategy in Appendix 6.

The national level institutional arrangement for implementing the strategy is as in Figure 1 below. The roles and responsibilities of the various actors and key stakeholders are in Appendix 3.

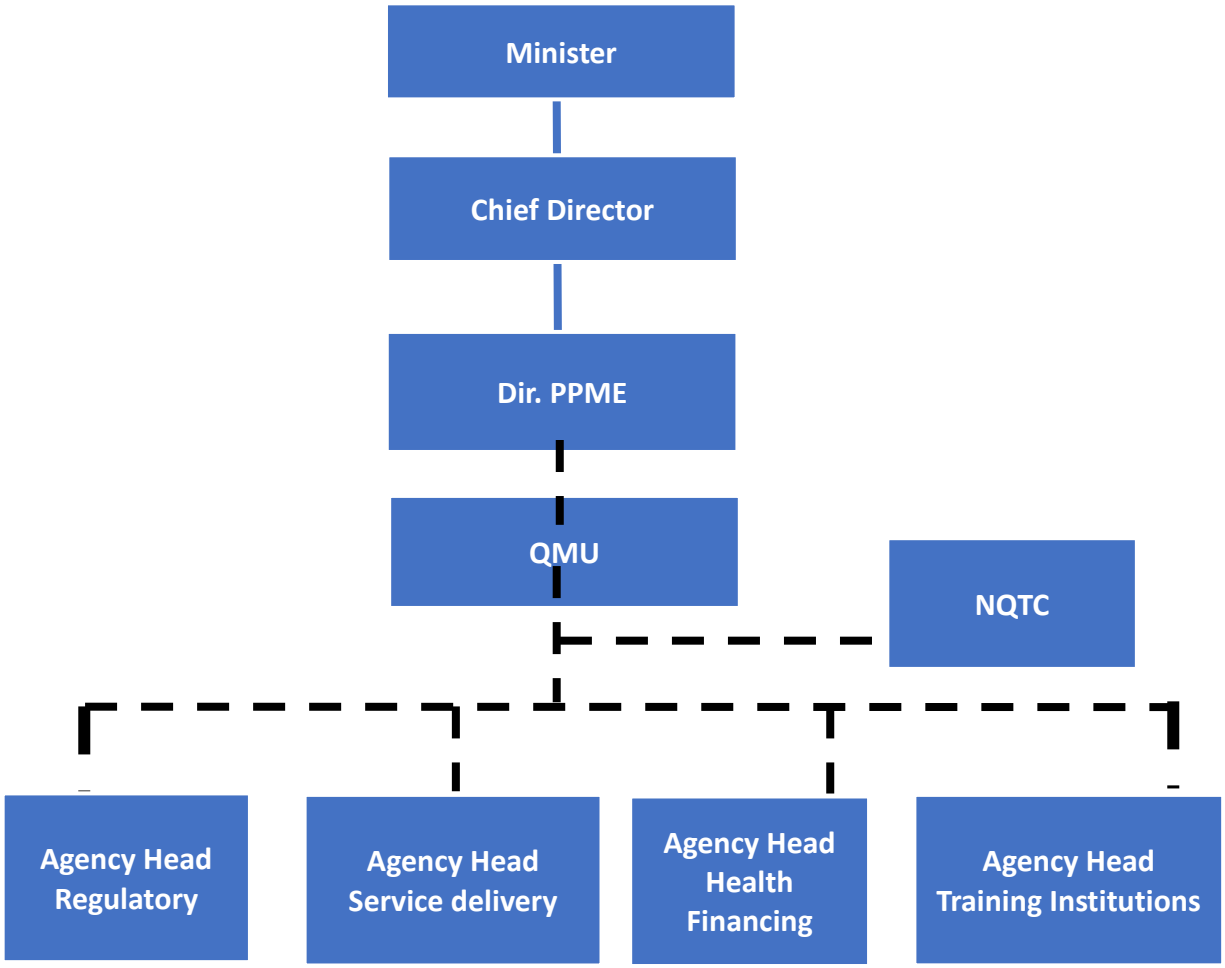


Figure 1: Organization of quality at the national level

5.2 Implementation by Agencies and the private sector

At the health agency or institutional level (public and private), a quality governance structure should be established to implement relevant aspects of the NHQS 2024-2030. Agencies and private sector facilities will be expected to develop an annual program of work informed by and aligned to the goal, strategic objectives and high-level strategic interventions as applicable within their mandate, functions and jurisdiction. This is to ensure that stakeholder interventions, aside from improving the quality of care in their respective institutions contribute to the collective effort to improve the quality of healthcare across the country.

The implementing agencies and the private sector will be held accountable for the implementation of the NHQS within its mandate.

5.3 Support from health development partners

The MoH will work with all the development partners interested in and committed to supporting the attainment of the goal and objectives of this Strategy. Development partners and stakeholders should be informed by and directly supportive of the strategic objectives and high-level strategic interventions of the NHQ 2024-2030.

5.4 Resource Mobilization

The MoH desires to ensure that the implementation of quality practices is sustained across the level of the health system and in all healthcare organizations including the public and private sector. As a result of this, the MoH will lead and work with all the relevant agencies and stakeholders to mobilize the required resources internally and externally towards the successful implementation of the NHQS 2024-2030. The MoH will work with all the development partners interested in and committed to supporting the attainment of the goal and objectives of this Strategy. All the implementing agencies of the MoH and other health service providers will also take the necessary initiative to mobilize their own resources to implement relevant aspects of the strategy. In addition to identifying new resource opportunities will be to ensure prudence in the use of the existing resources. In the short-term, all agencies of the ministry and other health service provider organizations will be expected to develop a costed implementation plan annually and use their internally generated funds for the purpose as they explore other sources of funding.

CHAPTER 6

MONITORING, EVALUATION AND LEARNING

6.1 Monitoring, Evaluation and Learning

The effective implementation of the NHQS 2024-2030 hinges on a strong and robust monitoring system to determine that key implementation milestones are on course and being achieve, and to assess progress toward achieving objectives of the strategy. Comprehensive indicators to measure progress have been developed and included in the MEL Framework. In addition, a list of health service indicators adopted from the HSMTDP have also been included for monitoring over the NHQS implementation period. The progress and achievement of the NHQS 2024-2030 will be routine and continuous (i.e., quarterly, half-yearly and annually) and will be the responsibility of the MoH.

Routine monitoring

Quarterly monitoring of the strategy implementation process with a focus on whether activities are being implemented according to plan and whether expected implementation milestones are being reached will be the ultimate responsibility of the Ministry of Health (PPME), but immediate responsibility will lie with the NQSSC/QMU which will report findings to the ministry, with appropriate recommendations.

Monitoring of the progress and achievement of health outcomes will be through regular bi-annual reports from the public and private health institutions to the QMU using agreed indicators (Appendix 4) and reporting formats. The QMU will in turn synthesize the reports and apprise the NQSSC and the MOH (PPME). In addition, the QMU will undertake validation through random surveys and monitoring visits.

Beyond monitoring by the QMU and the NQSSC, NHQS indicators should be integrated into existing monitoring mechanisms within the MoH such as the Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS).

6.2 Review of the strategy

The QMU will receive annual reports from the public and private health institutions. Beyond that, annual reviews will be built into the existing annual review mechanisms of the Ministry of Health including the Independent Annual Reviews and Holistic Assessment.

CHAPTER 7

COMMUNICATIONS STRATEGY

7.1 Communication and dissemination

A major component of the implementation of the NHQS 2024-2030 will be communication and dissemination. This will serve as a major driver to motivate and inspire all implementing institutions as well as the population (the health community) towards the achievement of the stated goal and objectives. This is to ensure that all stakeholders and partners are fully aware of the requirements of the NHQS, and to foster ownership and compliance. The effective communication and dissemination of the strategy will in addition, create awareness, empower the population as well as generate population interest in the quality paradigm shift intended by the NHQS.

The dissemination of the NHQS shall be done centrally by the MoH to all agencies, the private sector and key stakeholders at the national level. Further, all agencies of the MoH will be expected to organize their respective institutions/organizations to disseminate the NHQS to their respective stakeholders at those levels.

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Appendix 1: Implementation Matrix/Framework

Objective	Strategy	Responsibility		2024	2025	2026	2027	2028	2029	2030
		Lead	Collaborator							
1.0 Build regulatory capacity to enable the regulatory bodies to be independent and objective in playing their role.	1.1 Establish an independent body to monitor quality healthcare indicator performance	MoH	Agencies, development partners, private sector, NGOs in health, Parliamentary Select Committee on Health, relevant MDAs, health facilities					*		
	1.2 Facilitate the establishment of national healthcare quality standards	MoH	Agencies, development partners, private sector, NGOs in health, Parliamentary Select Committee on Health, relevant MDAs, health facilities		*	*				
	1.3 Regularly update standards (e.g., STGs, EML, etc), mechanisms for rewards and sanctions, to address the respective quality parameters	MoH	relevant agencies, development partners, private health sector			*				
	1.4 Improve public access to information on regulatory status (accredited, licensed, credentialed etc)	Regulatory bodies	relevant agencies, development partners, private health sector		*					
	1.5 Strengthen regulatory agencies to execute their regulatory functions (accreditation/credentialing/ certification) through resourcing and improving efficiency.	Regulatory institutions	MoH Agencies, MDAs, Private Sector,			*				
	1.6 Integrate mandatory CPD category in quality management as a requirement for renewal of professional licenses	Health professions councils	MoH, relevant agencies				*			
	1.7 Enhance collaboration and stakeholder engagement among regulatory agencies	Regulatory institutions	MoH, relevant agencies							

Objective	Strategy	Responsibility		2024	2025	2026	2027	2028	2029	2030
		Lead	Collaborator							
2.0 Strengthen the health system to deliver quality	**2.1.0 Leadership & governance**									
	2.1.3 Strengthen the capacity of leadership in quality management (to provide the enabling environment)	MoH	Agencies, DPs			*				
	2.1.5 Strengthen existing governance structures for quality management (NQTC, and at the Agency level) to make them functional	heads of institutions	MoH		*					
	2.1.6 Public and private health sector institutions should develop an implementation guideline in alignment with the NHQS	Relevant agencies	MoH		*					
	2.1.7 Strengthen the capacity *(training, resourcing, etc)* of the M&E Units of the MoH and its agencies to deliver on their M&E mandate	Relevant agencies	MoH, DPs				*			
	2.1.8 Improve supportive monitoring across all MoH directorates, sector agencies and all service delivery sites in the public and private sectors	MoH	Agencies, DPs, private health sector							*
	2.1.9 Involve service providers including the private service providers in the implementation of QoC plan	MoH	Agencies	*	*	*	*	*	*	*
	2.2 Human resource for health									
	2.2.1 Create the "Joy at work" environment through the provision of essential inputs, incentives, recognition and rewards	Agencies	MoH				*			
	2.2.3 Establish the post of quality and patient safety professional	MoH	Agencies; private sector health institutions							*

Objective	Strategy	Responsibility		2024	2025	2026	2027	2028	2029	2030
		Lead	Collaborator							
	2.2.4 Create job descriptions and career pathways for quality and patient safety professionals	MoH	Agencies; private sector health institutions		*					
	2.2.5 Develop a database of personnel with quality management competencies and skills	MoH	Agencies; private sector health institutions			*				
	2.2.6 Improve the skills and capacity of healthcare workers in quality and patient safety	MoH	Agencies; private sector health institutions				*			
	2.2.7 Liaise with existing academic institutions to design quality management curricula and train healthcare workers in quality management	MoH	Agencies; private sector health institutions; academic institutions				*			
	2.2.8 Facilitate the integration of health service quality management modules into pre-service, in-service, post-basic and specialist curriculums	health training institutions including universities	MoH, public/private, DPs					*		
	2.2.9 Advocate for the ministry to address the mass exodus of health workers because of its impact on quality health service delivery	Coalition for NGOs in health; Civil society groups; Media; health professional associations	MoH, public/private, DPs		*					
	2.3 HMIS									
	2.3.1 Review and standardize the analytical framework *(determining the core metrics/indicators along the quality dimensions)* for quality (look at the MoH indicators to indicate what is available and what is not)	MoH	public/private; DPs	*						

Objective	Strategy	Responsibility		2024	2025	2026	2027	2028	2029	2030
		Lead	Collaborator							
	2.3.2 Review and update guidelines for the preparation of reports at all levels of the health system to ensure improved care outcomes	MoH	public/private; DPs		*					
	2.3.3 Integrate key quality indicators into the health sector performance framework	MoH	Agencies, private sector health institutions, DP		*					
	2.3.4 Improve the source documents where the indicators are taken from through the use of technology	Agencies, private sector health institution	MoH, DPs	*						
	2.3.5 Build capacity of the public and private sectors in data management	MoH	Agencies, private sector health institutions, DP							*
	2.4 Finance									
	2.4.1 Integrate the funding of quality activities into the plans and budget of all health institutions (public and private)	MoH	Agencies, private sector health institutions		*					
	2.4.2 Mainstream and create dedicated budget lines for quality improvement activities at all levels.	MoH	Agencies, private health institutions			*				
	2.4.3 Mobilize resources to support the implementation of the NHQS	MoH	Agencies, private health institutions, DPs	*						
	2.4.4 Implement mechanisms to ensure prudent use of resources for the implementation of the NHQS	Agencies, private sector health institutions	MoH							
	2.5 Health service delivery									

Objective	Strategy	Responsibility		2024	2025	2026	2027	2028	2029	2030
		Lead	Collaborator							
	2.5.1 Update, review and develop new guidelines and protocols where relevant	Agencies, private sector health institutions	MoH, DPs		*					
	2.5.2 Increase adherence to protocols, guidelines and standards in the provision of service.	Agencies & private sector health institutions	MoH, DPs							*
	2.5.3 Conduct regular supervision, monitoring and evaluation	Agencies, private sector health institutions	MoH, DPs					*		
	2.5.4 Establish mechanisms for regular feedback from service users	Agencies, private sector health institutions	MoH, DPs						*	
	2.6 Medical products									
	2.6.1 Monitor adherence to quality, efficacy and availability standards for medical products, technologies and vaccines	Agencies and private health sector institutions	DPs, Coalition for NGOs in Health							*
	2.7 Research									
	2.7.1 Liaise with the research, statistics and information management directorate to incorporate quality and patient safety research into the national research agenda	MoH	Agencies, private health sector, DPs, Coalition for NGOs in Health	*						
	2.7.2 Strengthen capacity for research conduct into quality, implementation and use for decision-making at all levels	MoH	public/private				*			
	2.8 Partnerships									

Objective	Strategy	Responsibility		2024	2025	2026	2027	2028	2029	2030
		Lead	Collaborator							
	2.8.1 Identify and coordinate the support of partners towards the implementation of the NHQS	MoH	Agencies, private health sector, DPs, Coalition for NGOs in Health			*				
	2.8.2 Mobilize relevant MMDAs towards the implementation of the NHQS	MoH	Agencies, private health sector, DPs, Coalition for NGOs in Health						*	
3.0 Improve the demand for quality	3.1 Strengthen mechanisms *(e.g. client service units, community scorecards, community durbars, surveys, etc)* for clients (i.e., patients, relatives, providers) and the communities to contribute or make inputs to improve the quality of healthcare	MoH, All Agencies	CSOs, DPs, Private Sector, Community Health Committees	*						
	3.2 Strengthen systems to empower clients (e.g., patients, relatives and providers) and communities *(on their rights, responsibilities, facility standards etc)* and patient right advocacy groups to demand quality healthcare	MoH, All Agencies	CSOs, DPs, Private Sector, Community Health Committees		*					
	3.3 Publish the quality status of health inputs such as commodities, human resource, infrastructure *(e.g., to Related Links of Agencies on MoH website)*	MoH, All Agencies	CSOs, Community Health Committees			*				
	3.4 Publish rankings of like agencies and like facilities in league tables for the general public	MoH, All Agencies	CSOs		*					

Appendix 2: Monitoring, Evaluation & Learning Framework

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
1.0 Build regulatory capacity to enable the regulatory bodies to be independent and objective in playing their role.	1.1 Explore the feasibility of establishing an independent healthcare quality commission	1.1.1 number of stakeholder consultation conducted 1.1.2. availability of a feasibility study report	No existing commission	1. At least 4 engagements 2. Report of feasibility studies produced	2028	1. Report of meetings 2. Feasibility study report	MoH	Agencies, DPs, private sector, NGOs in health, Parliamentary Select Committee on Health, relevant MDAs
	1.2 Regularly update standards (e.g., STGs, EML, etc), mechanisms for rewards and sanctions, to address the respective quality parameters	1.2.1 STGs, EML and other standards reviewed/updated at stipulated timelines	existing documents	STGs, EML and other standards reviewed to include current developments	2026	STGs, EML and other relevant standards reviewed documents	MoH	relevant agencies, development partners, private health sector
	1.3 Improve public access to information on regulatory status (accredited, licensed, credentialed etc)	1.3.1 number of visits to the websites of the regulatory agencies 1.3.2 number of public education sessions (e.g., TV, radio, social media) conducted by regulatory institutions	no existing information	information on regulatory status of regulatory bodies accessible to the public	2025	reports of regulatory bodies	regulatory bodies	relevant agencies, development partners, private health sector

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	1.4 Strengthen regulatory agencies to execute their regulatory functions (accreditation/credentialing/ certification) through resourcing and improving efficiency.	1.4.1 number of staff deployed to quality management department/unit 1.4.2 percentage of health budget allocation regulatory agencies	1. not readily available	1. at least 2 members of staff in QMU 2. GoG allocation to regulatory bodies increased by 10% annually	2026	appointment/ reassignment letters	Regulatory institutions	MoH Agencies, MDAs, Private Sector,
	1.5 Integrate mandatory CPD category in quality management as a requirement for renewal of professional licenses	1.5.1 number of personnel who undertake CPD in quality management 1.5.2 proportion of regulatory agencies with mandatory CPDs in quality management	not readily available	1. 100%	2027	training reports of regulatory institutions	Health professions councils	MoH, relevant agencies
2.0 Strengthen the health system to deliver quality	**2.1 Leadership & governance**							
	2.1.1 Strengthen the capacity of leadership in quality management (to provide the enabling environment)	2.1.1.1 number of leaders (heads of agencies, departments/units) trained in QM	not readily available	all leaders have their capacities built in leadership for quality	2026	training report	MoH	Agencies, DPs

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	2.1.2 Strengthen existing governance structures for quality management (NQTC, and at the Agency level) to make them functional	2.1.2.1 number of institutions with established QMUs 2.1.2.2 number of institutions with dedicated persons responsible for quality 2.1.2.3 number of meetings held per year 2.1.2.4 number of QI projects being implemented	not readily available	all institutions have functional quality governance structures	2025	1. quality reports 2. annual reports 3. minutes of quality management meetings	heads of institutions	MoH
	2.1.3 Public and private health sector institutions should develop an implementation guideline in alignment with the NHQS	2.1.3.1 number of institutions that have developed an NHQS implementation guideline aligned with the NHQS	not readily available	all institutions have developed implementation guideline aligned with the NHQS	2025	implementation guideline document	Relevant agencies	MoH
	2.1.4 Strengthen the capacity *(training, resourcing, etc)* of the M&E Units of the MoH and its agencies to deliver on their M&E mandate	2.1.4.1 number of institutions with basic resource (min of 2 personnel, at least 1 computer, access to vehicle) in their M&E units 2.1.4.2 number of institutions with personnel trained in the required M&E competencies	not readily available	1. all M&E units of the agencies of the MoH are resourced with the required personnel and logistics 2. all institutional M&E units have their staff trained in the core competencies of M&E	2027	1. training report of institutions 2. annual reports of agencies 3. procurement report	Relevant agencies	MoH, DPs

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	2.1.5 Improve supportive monitoring across all MoH directorates, sector agencies and all service delivery sites in the public and private sectors	2.1.5.1 number of performance reviews conducted	not readily available	1. MoH- 4 (1 performance review for MoH directorates, 2 performance reviews for agencies and DPs; 1 annual health summit) per year 2. MoH- 3 field visits	2030	1. performance review reports 2. field monitoring reports	MoH	Agencies, DPs, private health sector
	2.1.6 Involve service providers including the private service providers in the implementation of QoC plan	Number of private service providers who indicate the satisfaction with their level of involvement in the implementation of the NHQS	Not readily available	80%	2028	1. annual QoC reports of the MoH		
	2.2 Human resource for health							
	2.2.1 Create the "Joy at work" environment through the provision of essential inputs, incentives, recognition and rewards	2.2.1.1 percentage of public and private health institutions with incentives, recognition and rewards systems in place 2.2.1.2 staff satisfaction rate	not readily available	1. at least 50% 2. 75%	2027	1.compensation policies 2. staff satisfaction survey report	Agencies	MoH
	2.2.2 Establish the post of quality and patient safety professional	2.2.2.1 quality professional position established	not available	quality professional position established	2030	annual report	MoH	Agencies; private sector health institutions

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	2.2.3 Create job descriptions and career pathways for quality and patient safety professionals	2.2.3.1 JD for quality and patient safety professionals created 2.2.3.2 career pathways for quality and patient safety professionals created	not available	1. JD for quality and patient safety professionals created 2. career pathways for quality and patient safety professionals created	2025	1. job description 2. document of career pathways	MoH	Agencies; private sector health institutions
	2.2.4 Develop a database of personnel with quality management competencies and skills	2.2.4.1 database of competencies with QM skills and competencies developed	not available	database of competencies with QM skills and competencies developed	2026	database	MoH	Agencies; private sector health institutions
	2.2.5 Improve the skills and capacity of healthcare workers in quality and patient safety	2.2.5.1 number of healthcare workers trained in quality and patient safety	not available	competencies and skills of healthcare workers in quality management improved	2027	1. training reports 2. annual reports	MoH	Agencies; private sector health institutions

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	2.2.6 Liaise with existing academic institutions to design quality management curricula and train healthcare workers in quality management	2.2.6.1 quality management curriculum designed 2.2.6.2 number of institutions implementing the QM curriculum 2.2.6.3 number of healthcare workers trained in QM	not readily available	1. quality management curriculum designed by academic institutions 2. healthcare workers trained in QM	1. 2026 2. 2027	quality management curriculum	MoH	Agencies; private sector health institutions; academic institutions
	2.2.7 Facilitate the integration of health service quality management modules into pre-service, in-service, post-basic and specialist curriculums	2.2.7.1 number of pre-service, in-service, post-basic and specialist's curriculum with QM integrated	not available	QM modules integrated into pre-service, in-service, post-basic and specialist curriculums	2028	curriculums of training institutions	health training institutions including universities	MoH, public/private, DPs
	2.2.8 Advocate for the ministry to address the mass exodus of health workers because of its impact on quality health service delivery	2.2.8.1 number of health workers leaving the country for greener pasture 2.2.8.2 number of advocacy sessions organized	1. 2. not readily available	1. number of advocacy sessions organized to address the mass exodus of healthcare workers	2025	1. reports of advocacy sessions	Coalition for NGOs in health; Civil society groups; Media; health professional associations	MoH, public/private, DPs
	2.3 HMIS							
	2.3.1 Review and standardize the analytical	2.3.1.1 analytical framework for quality reviewed	not readily available	1. analytical framework for	2024	1. analytical framework	MoH	public/private; DPs

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	framework *(determining the core metrics/indicators along the quality dimensions)* for quality (look at the MoH indicators to indicate what is available and what is not)	2.3.1.2 analytical framework standardized		quality reviewed to include indicators along the quality dimensions		document 2. annual reports of MoH		
	2.3.2 Review and update guidelines for the preparation of reports at all levels of the health system to ensure improved care outcomes	2.3.2.1 number of public and private sector institutions that are reporting on the core metrics/indicators along the quality dimensions/domains	not readily available	all public and private health sector institutions reporting their core quality metrics/indicators along the dimensions/domains of quality annually	2025	annual reports	MoH	public/private; DPs
	2.3.3 Integrate key quality indicators into the health sector performance framework	2.3.3.1 key quality indicators integrated into health sector performance framework	not readily available	health sector performance framework integrated with quality indicators	2025	health sector performance framework document	MoH	
	2.3.4 Build capacity of the public and private sectors in data management	2.3.4.1 proportion of public and private health sector institutions that offer training for their personnel in data management	1. not readily available	70%	2030	1. training reports	MoH	Agencies, private sector health institutions, DP
	2.4 Finance							

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	2.4.1 Mainstream and create dedicated budget lines for quality improvement activities at all levels.	2.4.1.1 availability of dedicated budget lines for QI activities	not available	dedicated budget lines created for QI activities at all levels	2026	budget report	MoH	Agencies, private health institutions
	2.4.2 Mobilize resources to support the implementation of the NHQS	2.4.2.1 number of partners supporting the implementation of the NHQS 2.4.2.2 number of partners whose quality programs are aligned to the NHQS	1. not readily available	all relevant partners mobilized around the implementation of the NHQS	2024	1. partners engagement report	MoH	Agencies, private health institutions, DPs
	2.5 Health service delivery							
	2.5.1 Increase adherence to protocols, guidelines and standards in the provision of service.	2.5.1.1 number of institutions that have the required protocols, guidelines and standards 2.5.1.2 number of providers who are adhering to the available protocols, guidelines and standards	not readily available	1. all the relevant protocols, guidelines and standards are available 2. 80% increase in adherence by the end of 2030	2030	1. reports of protocol adherence 2. reports of training	Agencies & private sector health institutions	MoH, DPs
	2.6 Medical products							

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	2.6.1 Monitor adherence to quality, efficacy and availability standards for medical products, technologies and vaccines	2.6.1.1 number of institutions that adhere to quality, efficacy and availability standards for medical products, technologies and vaccines 2.6.1.2 stock out rates for medical products and vaccines	not readily available	1. quality, efficacy and availability standards for medical products, technologies and vaccines adhered to 2. Five (5) percent stockout rate of essential medical products and vaccines	2029	1. annual reports 2. reports on adherence	Agencies and private health sector institutions	DPs, Coalition for NGOs in Health
	2.7 Research							
	2.7.1 Liaise with the research, statistics and information management directorate to incorporate quality and patient safety research into the national research agenda	2.7.1.1 quality and patient safety research incorporated into the national research agenda	not available	quality and patient safety research incorporated into the national research agenda	2024	national research agenda	MoH	Agencies, private health sector, DPs, Coalition for NGOs in Health

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	2.7.2 Strengthen capacity for the conduct of research into quality and patient safety, implementation and use for decision-making at all levels	2.7.2.1 capacity to conduct research into quality and patient safety, implementation and use of research for decision-making strengthened	1. not readily available	capacity for the conduct, implementation and use of research findings strengthened in public and private health institutions by 2027	2027	research report	MoH	public/private
3.0 Improve the demand for quality	3.1 Strengthen mechanisms *(e.g., client service units, community scorecards, community durbars, surveys, etc)* for clients (i.e., patients, relatives, providers) and the communities to contribute or make inputs to improve the quality of healthcare	3.1.1 number of public and private health institutions who have a community member on their quality committee 3.1.2 number of public and private health institutions with systems/mechanisms (such as client service units, client feedback platforms, client satisfaction surveys etc) that enables clients to contribute or make inputs into care	1. not readily available	mechanims for clients, families and communities to contribute or make inputs to improve the quality of healthcare strengthened (i.e., suggestion box, community member etc) in all public and private health sector institutions	2024	1. client experience/satisfaction reports	MoH, All Agencies	CSOs, DPs, Private Sector, Community Health Committees

Objective	High-Level Strategic Interventions	Indicator	Baseline	Target	Timeline	Means of Verification	Responsibility	
							Lead	Collaborator
	3.2 Strengthen systems to empower clients (e.g., patients, relatives and providers) communities *(on their rights, responsibilities, facility standards etc)* and patient right advocacy groups to demand quality healthcare	3.2.1 number of clients who are educated at the various service delivery points about the health status 3.2.2 number of persons who are aware of quality and safety-related issues 3.2.3 number of radio/TV discussions that bother on quality healthcare 3.2.4 number of medico-legal suits 3.2.5 number of persons in the general public who are knowledgeable about their rights, responsibilities and standards)	1. not readily available	the public is empowered to demand for quality health service	2025	1. reports of quality and patient safety incidents 2. reports on medico-legal suits against health professionals and institutions 3. client experience/satisfaction reports	MoH, All Agencies	CSOs, DPs, Private Sector, Community Health Committees
	3.4 Publish rankings of like agencies and like facilities in league tables for the general public	3.4.1 performance of public and private health sector institutions published	1. not readily available	League tables of public and private health institutions published	2025	1. league table report	MoH, All Agencies	CSOs
	3.5 Conduct patient/client and provider satisfaction surveys at various levels of the health system (and incorporate findings into the holistic assessment)	3.5.1 Clients satisfaction rate 3.5.2 number of agencies that performed client satisfaction survey	1. not readily available	1. 80% of clients satisfied 2. all agencies undertake client satisfaction survey	2025	Client satisfaction survey report	MoH, All Agencies	CSOs

Appendix 3: Organization of quality at the national level: The composition, roles and responsibilities of the various actors

No	Key Actor/Stakeholder	Roles/Responsibilities
1	Director, Policy Planning Monitoring & Evaluation (PPME)	1. Chair NQTC meetings 2. Decide and apply indicators for monitoring the implementation of quality plans, policies and health outcomes in the priority areas 3. Define data requirements for the measurement of quality at the various levels of the health system 4. Provide guidelines/policy for compliance to data quality and reporting 5. Strengthen leadership and ownership among stakeholders in the health system on quality planning, quality assurance and quality improvement at all levels, in all sub-sectors and in all sector agencies 6. Provide a platform for inter-agency knowledge sharing and learning 7. Monitor implementation of NHQS in all agencies at all levels 8. Establish criteria for identifying and celebrating teams and individuals improving health care and patient outcome
2	Quality Management Unit (QMU)	1. Day to day oversight of quality across all agencies, sub-sectors and all levels on behalf of Director PPME, MOH 2. Facilitate the conduct of operational research/National quality surveys/ Health systems research 3. Lead the monitoring of NHQS implementation 4. Identify required policies, standards and protocols with respect to quality and patient safety and initiate the development process 5. Publish annual State of Quality in Ghana reports
3	Heads/ Representatives of Agencies & Private Health Institutions	1. Day to day oversight of quality across all units/departments of the agency 2. Facilitate the conduct of operational research/ Health systems research within the agency 3. Lead the monitoring of NHQS implementation across all units/departments of the agency 4. Participate and contribute to QMU meetings and Activities
4	Community	1. Participate and contribute to activities related to quality delivery at the national level 2. Demand for quality at the point of service delivery 3. Contribute to feedback mechanisms to improve quality at service delivery points

Appendix 4: Tracer indicators for agencies in the health sector

Indicators for the service delivery agencies i.e., Public (Ghana Health Service (GHS), Mental Health Service, Teaching Hospitals), Self-financing private sector, Faith-based organizations (CHAG and Ahmadiyya)

[These are expected to be reported on by agencies, be tracked by MOH through the creation of a Dashboard, and be included in Holistic Assessment Report]

Quality Dimension	Sample measures	Description/Definition
Safety	Rate of adverse events (pressure ulcers/bed sores, falls, ventilator associated pneumonia, HAIs e.g., UTI, SSI, wound infection, neonatal infections, Central Line Associated Blood Stream Infection (CLABSI), septicaemia/blood stream infection, transfusion reaction, medication reaction)	An infection occurring in a patient in hospital or healthcare facility in whom the infection was not present or incubating at the time of admission. This includes infections acquired in the hospital but appearing after discharge and also occupational infections among staff of the facility. It also includes injuries (falls, wrong side surgery etc)
	Percentage of health staff with accidental needle stick injuries	any cut or prick to a frontline healthcare worker by a needle previously used on a patient, is work-related and sustained within the hospital premises.
	Percentage of patients with foreign object retained after surgery (retained surgical item)	Any surgical item that is inadvertently left in various body spaces after surgery/total number of surgeries
	Percentage of staff acquiring occupational health illnesses/injuries of any kind	Number of healthcare workers who have an injury that is caused, contributed or significantly aggravated by events of exposures in the work environment/total number of health workers
Efficiency	Financial (Risk) Protection	Out-of-pocket expenditure on health (as % of total health)
		Per capita health expenditure
		Public expenditure in health as % of total public expenditure
	Out of Pocket (OOP) expenditure	share of the total current expenditure on health paid by HH expressed as a % of the total current expenditure on health in 12 months period.

	Average length of stay of patients in health facilities	Describes the duration of a single episode of hospitalization i.e. the number of days a patient stayed in the hospital for treatment. For ERs, it is the total time (hours) a patient spends in the ER from the time of registration/triage to when the patient leaves the ER
	Percentage equipment down time	
	Facility cost per patient day equivalent for selected conditions	
Effectiveness	Mortality	annual number of deaths from any cause Number deaths recorded by the service/total number of cases seen by the service
	% of cases managed in accordance with standard guidelines	
	Clinical audit recommendations implemented	Number of clinical audit recommendations implemented/total number of clinical audits done
Timeliness	Average waiting time for a service	Percentage of patients who wait at the respective service delivery points for more than 2 hours
	door-to-needle time for emergency treatment	Percentage of patients requiring emergency treatment who receive definitive care within 2 hours of reporting to the ER.
	Average time taken to resolve complaints	The average time it takes an agency/institution to resolve complaints/total number of complaints
Person centered care	Proportion of patients satisfied	Percentage of clients who are satisfied with the service they received /the total number of patients utilizing that service
	Proportion of staff satisfied	Percentage of staffs who are satisfied with the service conditions (environment)/ total number of staff providing that service
Equity	Access to core set of essential health package	Access to essential medicines, skilled health worker and basic lab services

Indicators for other agencies. These refer to the National Ambulance Service (NAS), National Blood Service (NBS), HeFRA, Mortuary, Mortuary, Colleges, Councils, FDA, and NHIA

Quality Dimension	National Ambulance Service (NAS)	National Blood Service (NBS)	HeFRA	Mortuary
Safety	▪ % of staff acquiring occupational health illnesses/ injuries	▪ % of staff acquiring occupational health illnesses/ injuries ▪ Proportion of voluntary unpaid donations	▪ % of staff acquiring occupational health illnesses/ injuries	▪ % of staff acquiring occupational health illnesses/ injuries
Efficiency				
Effectiveness		▪ Number of mobile blood collection sessions organized ▪ Rate of blood transfusion reactions	▪ Proportion of health facilities (public and 100 private) Licensed	▪ % of corpses embalmed within the required time
Timeliness	▪ Average time taken to resolve client complaints. ▪ Ambulance response time	▪ Average time taken to resolve client complaints.	▪ Average time taken to resolve client complaints.	▪ Average time taken to resolve client complaints.
People centredness	▪ Client satisfaction rate ▪ Staff satisfaction rate	▪ Client satisfaction rate ▪ Staff satisfaction rate	▪ Client satisfaction rate ▪ Staff satisfaction rate	▪ Client satisfaction rate ▪ Staff satisfaction rate Average staff satisfaction score
Equity				

Indicators for other agencies. These refer to the Colleges, Councils, FDA, and NHIA

Quality Dimension	Colleges	Councils (Pharmacy, Medical& Dental, Nursing, Psychology)	Food and Drugs Authority (FDA)	National Health Insurance Authority (NHIA)
Safety	▪ % of staff acquiring occupational health illnesses/ injuries ▪ % of training institutions in good standing	▪ % of staff acquiring occupational health illnesses/ injuries ▪ % of licensed practitioners in good standing ▪ % of complaints resolved	▪ % of staff acquiring occupational health illnesses/ injuries ▪ Adverse drug reactions investigated and reported on	▪ % of staff acquiring occupational health illnesses/ injuries
Efficiency	▪ Faculty-resident ratio	▪ Percentage of new applications processed within the stipulated time frame Average time taken to complete renewal of licences	Percentage of new applications processed within the stipulated time frame	
Effectiveness	▪ Pass rate (primary, membership, fellow ship)	▪ % of illegal facilities shut down	▪ % of unlicenced products on the market ▪ % of fake products on the market ▪ quality pass rate for food and medicinal products	▪ Proportion of audited
Timeliness	▪ % of residents passing on first attempt (membership and fellowship)	▪ Average time taken to resolve client complaints.	▪ Average time taken to resolve client complaints.	▪ Average time taken to resolve client complaints. ▪ Average time of claims settlement ▪ Average time of claims reimbursement
People centredness	▪ Residents' satisfaction score ▪ Faculty satisfaction rate	▪ Practitioner satisfaction score ▪ Faculty satisfaction rate	▪ Client satisfaction rate ▪ Staff satisfaction rate	▪ Client satisfaction rate ▪ Staff satisfaction rate
Equity	▪ Resident male: female ratio ▪ Faculty male: female ratio			▪ NHIS population coverage ▪ Population with active NHIA membership

Appendix 5: Template to guide the development of an Institution (agency, facility-specific action plan for NHQS at national and sub-national levels

1. Background

a. A brief background about the agency and its mandate

2. Current situation of quality of healthcare in the agency

a. Health systems capacity for quality- Preferably, the agency should do a baseline assessment to determine the strengths and weaknesses of the ability of its health systems building block *(e.g., leadership/governance; human resource; service delivery; health finance; medicines, vaccines and technology; health information; community involvement and participation; partnerships for health)* to support the implementation of a quality program.

b. Quality of services provided- Preferably, the institution should assess the quality of services it is providing along the quality dimensions of safety, timeliness, effectiveness, efficiency, equity, people cantered care and integrity

3. Strategy Framework

a. Rationale & Scope

a. The rationale and scope should be in alignment with the NHQS 2024-2030.

b. Development of the action plan

i. The process in the NHQS should serve as a guide. The development of the institution-specific action plan should be consultative and team-based with inputs from all the key stakeholders i.e., directors, heads of departments/units and staffs in the various units/departments and patients/clients.

c. Vision, Goal & Strategic objectives

i. These should be the same as the NHQS. The agency should identify the appropriate strategic objectives that are/is consistent with its mandate and function and align accordingly.

d. National Healthcare Quality definition and priorities

i. The quality definition of the NHQS is the same for all agencies. This should be adopted

ii. The priorities of the NHQS are the same for all agencies.

e. Core values and guiding principles

i. This should be the same as in the NHQS

4. Strategic interventions

a. The strategic interventions are key actions that should be implemented to enable an agency to achieve the strategic objectives. Lists of strategic interventions have been proposed in the NHQS 2024-2030. Agencies, are only required to select strategic interventions that are relevant to them and proceed to identify specific activities that will be carried out towards achieving the desired outcome of the strategic

5. Implementation arrangements

a. The agency should describe what structures, processes and procedures will be utilised to ensure a successful implementation. The first consideration for every agency should be to establish the quality governance structures to support the implementation of the action plan.

6. Resource mobilization

a. The action plan should be costed. The agency should determine the resources required to successfully implement its action plan. The identified sources of funds should include that from its internally generated fund.

7. Monitoring, Evaluation & Learning (MEL)

a. This should be in alignment with the MEL component of the NHQS. The agency could identify and select other indicators that are relevant, peculiar or pertinent to its mandate and function.

Appendix 6: List of supporting individuals and institutions

S/N	**NAME**	**DESIGNATION/INSTITUTION**
1	Hon. Dr. Bernard Okoe Boye	Hon. Minister of Health
2	Hon. Alexander Akwasi Acquah	Hon. Dep. Minister
3	Hon. Adelaide Ntim	Hon. Dep. Minister
4	Alhaji Hafiz Adams	Chief Director
5	Emma Ofori Agyemang	Director PPME
6	Dr. Darius Osei	Technical Advisor to Hon. Minister
	TECHNICAL WORKING GROUP MEMBERS	
7	Selina Dussey	Ministry of Health
8	Dr. Eric Nsiah Boateng	Ministry of Health
9	Dr. Maureen Martey	Ministry of Health
10	Benjamin Nyakutsey	Ministry of Health
11	Dr. Cynthia Bannerman	Accra College of Medicine
12	Dr. Ernest Konadu Asiedu	Ministry of Health
13	Christiana Akufo (PHD)	Ghana Health Service
14	Dr. Gilbert Buckle	Technical Expert
15	Dr. Lawrence Ofori Boadu	Ghana Health Service
16	Joseph Ofosu Siaw	Food and Drugs Authority (**FDA**)
17	Vera Antwi Amamoo	Nurses and Midwifery Council
18	Dr. Bernard Kwanin	Health Facilities Regulation Agency
19	Bernice Ofosu	Korle Bu Teaching Hospital
20	Abena Osae Kumiwa	Ministry of Health
21	Dr. Joseph N. O Dodoo	Ministry of Health
22	Kafui Danso	Ministry of Health
23	Aminu Zuleiha	Ministry of Health
24	Lukas Annan	Ministry of Health
25	Alex Moffat Kpakpo	Ministry of Health
26	Sarah Boampong	Ministry of Health
	CONSULTANT AND TEAM	
27	Prof. Alfred Yawson	Lead-Consultant
28	Dr. Elom Hillary Otchi	Consultant
29	Yankey Mishael	Consultant
29	Dr. Afua Boatemaa Owusu	Consultant
	DEVELOPMENT PARTNERS	
30	Nadia Tagoe	USAID
31	Dr. James Sarkodie	USAID (Q4H)
32	Sarah Amisah- Bamfo	USAID (Q4H)
33	Francis Ashagbley	USAID (Q4H)
34	Dr. Felix Osei Sarpong	UNICEF
35	Dr. Peter Kwarteng	UNICEF
36	Dr. Paul Dsane- Aidoo	UNICEF
37	Dr. Sofonias Asrat	WHO
38	Dr. Angela Ackon	WHO
	VALIDATION OF STRATEGY	
39	National Healthcare Quality Technical Committee	All Agencies under MOH
40	Philomina Amofa	Ubora Institute


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unicef