EFFECTIVE LEADERSHIP AND WORKING TOGETHER ACCELERATES PACE OF BETTER HEALTH AND WEALTH CREATION IN THE UPPER EAST REGION

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Preamble
Health delivery is multi-sectorial requiring all hands on deck all year round to deal effectively with the inherent challenges. Over the years, adequate, well trained and well motivated Human Resources for Health (HRH, Community-based health service delivery and general health systems strengthening have been major strategies to achieve the sector’s vision for better health and wealth creation for all people living in the Upper East region.

The human resource for health situation in the Upper East region remains precarious with dwindling numbers and skill-mix particularly doctors, midwives and laboratory staff, their persistent refusal of postings to the region, disproportionate attrition and poor staff attitude. Thus Municipal/District hospitals are still manned by only one Ghanaian doctor. Inadequate and poor state of health infrastructure was exacerbated by the 2007 and 2009 floods. Poor maintenance culture, inadequate diagnostic facilities particularly at the sub-municipal/district levels despite the ever increasing service demand also had serious implications for our service output and health outcomes. Other key challenges included weak data management processes particularly at collection points, high institutional deaths and malnutrition, high incidence of malaria cases, decreasing/stagnation service indicators e.g. EPI and Safe-motherhood indicators as well as weak leadership and governance at all levels. The National Health Insurance (NHIS) implementation with its attendant tripling out-patient attendance and corresponding huge indebtedness to providers as a result of untimely release of funds and piecemeal release of GoG funds had serious implications for resource availability, quality care and health outcomes.

What we did
This situation called for affirmative action on innovations that can make the difference. This in turn depends on effective leadership and getting stakeholders to work together effectively
to produce the desired results. It is about understanding the challenges confronting the attainment of our vision for health as a region, a common resolve that available expertise and resource envelop are practically harnessed and directed at the agreed high impact rapid delivery priority interventions.

My major focus therefore revolved around effective leadership and governance, staff motivation and productivity enhancement, improving access and quality of health care services, proactive resource mobilization, allocation and prudent management and improving research, partnership and collaboration.

1. Improving Leadership and Governance Drive
In 2008 after assumption of duty in the region, BMC leadership reshuffle was done with clear performance standards set for District Directors and Medical Superintendents. This was followed by a 3-day leadership orientation programme for all BMC heads and Senior Management Committee members of the Regional Health Directorate. District Parents were reconstituted for greater participation and mentoring. In 2009, the Regional Clinical care and Public Health BMCs were strengthened with the appointment of Deputy Directors. Regional retreat of Senior Managers and key district and sub-district staff was also institutionalised to have common understanding of what we are not doing right at the operational levels with an agreement on clear follow-up actions at each level of the health care delivery system.

This was followed by an ultimatum that Regional Health Directorate and BMC initiates and sponsored continuing leadership development programmes for Senior Managers in line with the region’s 3-year staff training and development plan that was developed. There is an open door policy established by the RDHS.

2. Enhancing Staff Motivation and Productivity
Workplace and residential environment improvement initiatives were embarked upon resulting in renovation, refurbishment and equipment of care facilities, office and staff accommodation at all levels through pooling and prudent use of both regular and special initiative resources mobilised. The regional quota and selection system under the Ghana Health Service (GHS) new staff posting policy was implemented combined with staff counselling, bond enforcement, active tracking of new staff for the region through contact phoning and withholding of appointment letters or blocking of salaries. Staffs were retained through promotion out-of-turn, staff career development plans, staff-management engagements on policy implementation issues and challenges, performance target appraisal and transparent reward administration, regular orientation and customer care. A comprehensive regional staff attraction and retention policy was initiated through public advocacy, direct lobbying and incentive package drafting for regional brainstorming and consensus building and implementation. Following this a document was produced to engage and attract staff to the region. Since then two medical officers were attracted to the region.

3. Improving Access and Service Quality
In order to improve quality of care in the various facilities, we trained identified hard working health extension workers as laboratory assistants and procured basic equipment including microscopes and Rapid Diagnostic Test kits (RDTs) to improve diagnostic services at sub-municipal/district health facilities. Data validation and quality teams were established and trained at all levels to resolve some of the chronic bottlenecks and facilitate learning and mentorship. Specific interventions were intensified to improve coverage of all health indicators. Maternity units at sub-district facilities were refurbished and equipped to help improve skilled attendant deliveries and new born care. The Cuban Medical Brigade were motivated to close the yawning gap in medical doctors in the region through special regional initiatives including living conditions improvements, provision of internet facility, monetary incentives were regularly reviewed upward. We also introduced a door-to-door health commodity delivery system to guarantee commodity security at service delivery points from the Regional Medical Stores all year round. One 3-ton Mitsubishi goods delivery van was purchased from Regional Medical Stores (RMS) internally generated funds in 2009. The RMS space was expanded with the construction of medicines production and storage unit. With this the RMS now produces its own mixtures for distribution to all facilities in the region. To improve availability of medicines and non-medicines at the RMS, procurement of regional commodity needs through National Commodity Tendering was established in 2008 bringing annual drug and non-drug availability to 98% year round for 2009. Sub-district facilities no longer spend client service time using the only vehicle and fuel with cost of wear and tear to source few commodities from the RMS at Bolgatanga the regional capital. Through intersectoral engagement and lobby, the RHD secured two transformers from the VRA establishing dedicated transformers to guarantee equipment safety and regular power supply at the RMS and the Regional Health Directorate.

CHPS compounds are being staffed with two (instead of one) CHO and permanent or visiting midwives to improve home visits, outreach services as well as domiciliary and facility-based deliveries, family planning, postnatal and newborn care follow-up services. Clinicians and specialist outreaches in sub-districts were undertaken with particular focus on newborn care and reduction in the high neonatal deaths. Deputy Director Clinical care since 2009 was mandated to visit facilities for monitoring, clinical consultations and mentorship. Provider case management capacity building was done to reduce high incidence of malaria and other conditions and improve treatment outcomes. Motivation and use of community “foot-soldiers” such as CBA volunteers, Red Cross mothers’ clubs and others for IMCI, breastfeeding, defaulter tracing and case finding among others was intensified through training, support supervision, employment, logistics and financial incentives.

Through demonstrating leadership by example, the Regional Director set aside one day each week for district field visits and supervision while providing surgical services at the Navrongo War Memorial Hospital every Thursday and at the Bolgatanga regional hospital whenever there are emergencies.

4. **Resource Mobilisation, Allocation and Accountability**
The strategy was high integration of programmes and activities and resource pooling of all inflows to address agreed regional priorities at all the levels. There was general consensus on the initiative and BMCs were coached on the pooling and prudent application of earmarked and other funds to implement high impact rapid delivery interventions of all programmes and units at all levels particularly the community/CHPS compounds.

Intense proposal writing for funding activities were instituted across programmes and units. These attracted special funding in addition to the regular inflows from development partners to finance special regional initiatives. Activity and financial report submission improved to build partners’ confidence and motivation to sustain and improve funding support. A transparent, fair and equitable resource allocation criteria regularly reviewed is used to direct resources to the operational levels. The NHIS was fully engaged on provider payment, information sharing, joint provider monitoring among others.

5. Improving Research, Partnership and Collaboration

With my personal interest in research, we encouraged research initiatives of individuals, groups and partners. A new two room office block was constructed at the Regional Health Directorate fully equipped as the Operations Research Unit (ORU) of the RHD. Scientific workshops on emerging clinical and public health topical issues are organized jointly with the Cuban Medical Brigade and funded by BMCs. The Navrongo Health Research Centre (NHRC) technical support is tapped through joint clinicians outreach activities in sub-district and service delivery at Navrongo Hospital by medical doctors of the NHRC.

The Regional Health Directorate developed new research initiatives. The Mobile Technology for Community Health (MoTeCH) research and service delivery project was introduced in 2009 to increase the coverage of essential health interventions targeting pregnant women, neonates and infants. CHOs capacity building through standardised essential equipment for CHPS compounds and training of CHOs are being done and clients will receive service uptake prompts through mobile phone services.

Four Nigerian States’ Commissioners and Health Authorities and one region in Tanzania understudied the region’s Community-based health Service delivery system in the past one year. New partnership opportunities were sought. Partnership links with Afrikids and the Southampton University Hospitals Trust Hospital were initiated to improve the region’s capacity to increase access to quality maternal, child and diagnostic services through training, logistic support and service delivery.

Engagements with Local governments improved at the regional and district levels with MPs and District Assemblies supporting in Human Resource for Health and health infrastructure plans of all the district health administrations. Through lobbying, the Regional Coordinating Council also released land for construction of a GHS Regional Training Centre complex being funded through special funding initiatives, proposal funding including contributions from BMCs, The RHD also through support from the RCCC also secured MOFA abandoned structures at Zuarungu which were rehabilitated for the Health Assistants (Clinical) Training
School. In addressing the HRH challenges, the region got the Regional Minister to direct all District Chief Executives to sponsor at least five medical students with bonding to serve the region on completion. The region actively partners the Ghana Red Cross Society of Ghana in the implementation of HIRD and related community-based health interventions over the years through very active involvement of their mothers clubs.

**What are some of our achievements?**
Some evidence of success can be seen from the fact that,

1. Per capita outpatient visit increased from 0.75 in 2007 to 1.36 in 2009  
2. Supervised deliveries for the first time in decades hit 52.6% mark from a maximum of 44% in 2008. There has been consistent improvement in the yearly coverages.  
3. Family planning services though still very low also improved from 26% in 2007 to 31.7% in 2009.  
4. Under five malaria case fatality consistently reduced from 2.1 in 2007 to 1.2 in 2009  
5. Functional CHPS zones increased from sixty eight (68) in 2007 to eighty eight (88) in 2009 through collaboration.  
6. TB treatment success rate is improving consistently from 71.4 in 2007 to 77.4 in 2009 though still below the 85 target.  
7. Six flood affected CHPS compounds rehabilitated and expanded with special funding support from UNICEF secured through proposals.  
8. Funding proposals secured funds for construction of four bungalows for doctors in four district hospitals  
9. Construction of state of the art Regional In-Service Training Centre and Conference Complex has started in December, 2009  
10. The Regional Health Directorate office block and premises underwent total transformation with the pooled funding initiative.  
11. We purchased one 33-seater Toyota coaster bus, One 15-seated Toyota Hiace bus and one 3.5-toner Mitsubishi goods delivery van from special funding proposals and the RMS internally generated funds both to improve services and motivate staff.  
12. 100 motorbikes and 15 vehicles were successfully auctioned mainly to staff and replaced with 400 and 17 new motorbikes and vehicles respectively. 85% of motorbikes went to sub-district facilities, particularly CHPS compounds.  
13. The door-to-door health commodity delivery initiative attained 98% medicines availability, improved operational efficiency of health facilities particularly clinics and CHPS compounds as well as improved service quality  
14. Medicines production and storage unit was constructed from special funding initiative improved commodity availability and security.  
15. We secured two dedicated transformers from VRA for uninterrupted power supply to RMS and the RHD leading to staff motivation and improved efficiency in health delivery.

**Conclusion**
“Leadership is cause, all other things are effects” as the adage goes has been demonstrated in the region’s experience. Practical recognition is given to staff as the followers who can make the difference in the better health delivery and wealth creation vision of the region.
Staffs generally feel positive changes in their work environment through the clear strategic leadership direction, all-inclusive health delivery and management approach, rewards policies and remarkable resource mobilization and equitable deployment to all levels of service delivery particularly the sub-districts. Staff work attitudes potentially are changing for the better, demonstrated by better commitment to improving service coverages and health outcomes and team work. This positive development will be sustained and improved through accelerated leadership support and greater networking and recognition of all partners in our success stories as the years go by. Logically, we are more confident that the stage is set for accelerated improvement in our health indicators.