

CHRISTIAN HEALTH ASSOCIATION OF GHANA  
(CHAG)



Executive Secretariat

Progress report

1 January- 30 June 2008

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## **Executive Summary**

Committed to comprehensive planning and doing business, CHAG now presents its first integrated technical and financial progress report, which includes all activities carried out between January and June 2008, irrespective of contractual management arrangements and sources of funding, even though the reporting is done per 'budget line item' and type of intervention.

The report serves as an internal planning, management and monitoring tool, and it analyses why implementation of some activities was delayed and what measures have been taken to remedy the situation.

It also seeks to inform the Board of Directors, MOH- CHAG Partnership Committee, the Board of Directors, Member Institutions and Development Partners of recent developments within CHAG.

So far the implementation of the 2008 Annual Programme of Work (AWP) is 'on track', particularly those programme activities geared at strengthening the capacities of the technical and managerial capacities of the Secretariat towards becoming the driving force behind the implementation of the 2008-2011 Strategic Plan.

It is therefore anticipated that during the remainder of the year more time and resources will be allocated to addressing the main challenges the Association is being confronted with, such as strengthening the use of management information, health financing and health insurance, human resource development and improving quality of care. In view of this, additional (technical) staff is being recruited to provide the necessary advisory and training support services to the Church Health Coordinating Units (CHCUs) and Member Institutions (MIs), making up CHAG.

Now that a new Board of Directors is in place and has become functional, it is also anticipated that some specific governance and policy issues will be receiving additional management attention.

Executive Director of CHAG  
Philibert Kankye

## 1. Introduction

Since the adoption of the 2008-2012 draft Strategic Plan, CHAG has embarked on a major undertaking to:

- Strengthen the capacity of its Secretariat in coordination, lobbying, advocacy, monitoring, evaluation and technical support
- Strengthen the competencies of its Church Health Coordinating Units (CHCUs)
- Intensify partnership with international and local development agencies and
- Become more actively involved in the national debate on health sector development

As a first step towards achieving the overall objectives of the Strategic Plan, an Annual Programme of Work (APW) for 2008 was developed, with active involvement of all National Church Health Coordinators. After its adoption at a meeting of the CHCUs this plan was approved by the CHAG Board and the CHAG-MOH Partnership Steering Committee in April 2008.

The CHAG Secretariat have since then been making efforts to catch up with some of the delayed first quarter activities, while at the same time trying to reach the rest of the targets for the year.

This report draws up the balance of what has been achieved during the first six months of 2008 and summarises the main activities and the degree of progress made under each of the four 'result areas' for this year's Annual Programme of Work as listed below:

1. Appropriate (technical and financial) planning, management, support and information systems strengthened and functioning at the level of MIs
2. Strengthened capacity at CHCU level for monitoring, supervision and evaluation of MIs
3. Strengthened capacity of CHAG Secretariat in health sector planning, health financing, resource mobilisation, coordination and technical support to the CHCUs and MIs
4. Strengthened capacity of CHAG for policy development, advocacy and engagement with public and private stakeholders

## **2. Recent developments within the health sector**

CHAG participated in the annual Health Sector Review process by attending a series of policy and technical meetings, which were held in the first quarter of the year. This provided CHAG with more insight into issues related to the various developments that are currently taking place within the health sector.

### **Shift in priorities:**

The 2007 Annual Health Summit held in April this year advocated for the need to revisit some of the strategies that were adopted earlier due to concerns raised about the slow improvements in health outcomes, persistent under-nutrition, persistence of some diseases that can be easily controlled, neglect of other diseases which intensify poverty, growing burden of non-communicable diseases and uneven performance and productivity.

Increased Intersectoral action, more engagement with District Assemblies, integration and linkages of health initiatives like Maternal and Child Health (MCH) - (including High Impact Rapid Delivery (HIRD)) programmes, Community Health Planning Services (CHPS), Regenerative Health and Nutrition Programme (RHNP) and Integrated Malaria and Childhood Infection (IMCI) control programmes were identified as some of the proposed options to improve sector performance.

### **Wage bill under pressure**

Recent data suggests that approximately 95% of the health budget is spent on wages and salaries. The seriousness of the issue was discussed at a 'Round Table Conference on Human Resource Development', organised on 11 April 2008.

The meeting, agreed on a wide spectrum of measures, ranging from more resource-based planning and performance to defining staffing indicators and norms and cost containment, as actions required for putting this alarming situation on hold.

### **New budget policies and priorities**

During the MOH Budget Committee Meeting of 26 May, a projection was made of the 2009 health sector resource envelope. It was estimated that the envelope will amount to GH¢477.18 Million, of which GH¢309.08 was to come from GOG contribution, GH¢0.12 from IGF and GH¢167.97 from donor sources.

While recognising that the 2008 priorities should be consolidated, four new priorities were introduced for the 2009 budgeting cycle, namely:

- Target safe water and food
- Target quality of clinical care, including referrals and emergency services
- Agree on facility rationalisation, based on service availability mapping and developing collaboration for investments within health industry and
- Strengthening health sector budget and public financial management systems.

### **Need for better alignment between providers and NHIA**

Despite general good progress being reported on the introduction of the new health insurance scheme, it is observed that there are quite some outstanding operational bottlenecks/issues affecting CHAG institutions, such as lack of clarity in billing methods, delays in payment and other administrative procedures in respect of claims management.

This will not only call for additional training of those working with the insurance fund, but also intensified coordination between the MOH, the provider organisations (i.e. GHS and CHAG and other private institutions) and the National Health Insurance Authority (NHIA).

### **3. Recent developments within CHAG**

In the beginning of 2008, CHAG initiated a process to operationalise the overall goals and objectives agreed upon during last year's strategic planning exercise.

After a series of internal meetings and consultations, an Annual Work Plan was drawn up. This draft AWP was extensively discussed with all Church Health Co-ordinators (CHCUs) and subsequently approved by the Board of Directors and endorsed by the CHAG-MOH Partnership Steering Committee (PSC) in April. In endorsing the AWP, the PSC Committee recommended that CHAG strive towards the development and compilation of a more comprehensive Work Plan for 2009 to reflect the commitments of all churches that constitute CHAG in addition to those from (external) Development Partners (DPs).

Recent experience indeed confirms that in addition to the MOH, UNFPA, the Government of Denmark, other funding institutions (e.g. the World Bank, Global Fund, Bill and Melinda Gates Foundation) and NGO's would also welcome the idea of CHAG working along the lines of a more programmatic, rather than project approach.

However, to meet the (technical and administrative) requirements of these DPs, CHAG is well aware that the (technical) management capacities of the Secretariat as well as its Member Institutions need further strengthening. Provided that the necessary management structures, systems and procedures are in place, CHAG will only start soliciting these funds as of 2009.

Meanwhile, initiatives towards intensifying technical cooperation among CHCUs and strengthening the functioning of the Secretariat have been taken. These include among others:

- The monthly platform between the Secretariat and all 17 CHCUs, where issues of common interest and concern are now systematically being discussed
- The establishment of an inter- CHCU Task Force and Implementation Task Team to promote the use of health management information across the network
- The recruitment of more technical staff at the Secretariat (including health insurance expert, HMIS officer and management advisor)
- The ongoing restructuring of the Secretariat
- The initiative of introducing the concept of a 'service level agreement' between the Secretariat and CHAGs CHCUs
- As well as ongoing activities towards improving access to quality reproductive health services in CHAG facilities within the target districts of the UNFPA-Ghana 5<sup>th</sup> Country Programme.

#### **4. Result Area I: Appropriate (technical and financial) planning, management, support and information systems strengthened and functioning at the level of MIs**

##### **Training in health financing, contract and claim management and the use of the new tariffs**

The Secretariat offered training on new NHIA tariffs and medicines list for all CHAGs MIs from the 19<sup>th</sup> to 29<sup>th</sup> May 2008. The training, which was conducted on three different locations, was attended by over 180 medical and administrative staff from across the country. A detailed report, including course outline and results achieved, is included in annex 1.

##### **Facility Needs Assessment for improving Emergency Obstetric Care (EmOC) and Adolescent Sexual and Reproductive Health (ASRH) in 10 CHAG facilities in the Volta Region**

In June, CHAG and UNFPA initiated a study on improving emergency obstetric care and ASRH services in 10 CHAG facilities in the Volta Region. A team of local consultants was recruited and has meanwhile started the field work. The results of the study are expected to become available in the course of August. CHAG offered to co-fund this study from DANIDA's financial contribution to the 2008 AWP.

Funds for carrying obstetric outreach and other related activities were disbursed to the three CHAG pilot facilities under CHAG-UNFPA collaboration.

##### **Strengthening the use of health management information**

Promoting the use of health management information was identified as one of the main priorities under the 2008 AWP. Following a series of technical discussions with the CHCUs, the MOH and representatives from the Netherlands based CORDAID/ICCO/SNV/KIT consortium, a methodology and plan of action were prepared to rapidly promote the establishment of a data base and management information system within CHAG facilities so as to meet the multiple information needs (e.g. from the MOH, National Health Insurance Authority, Church Management Boards, CHAG, DP's, etc.).

The importance of accelerating implementation the HMIS initiative was subscribed by all 16 CHCU's during a recent meeting and the National Catholic Health Secretariat has confirmed its availability to provide the necessary manpower and expertise in support of the 'rolling out'.

It is anticipated that a (draft) report, including all baseline data on CHAG facilities can be compiled before the end of this year.

##### **Strengthening the 2009 budgeting process**

In the last week of June, a three day working session was organised in Kumasi to assist CHAG member institutions to duly prepare (line-item 2 and 3) the 2009 budget. The event was attended by 159 health facilities, approximately 50% more than previous year. . Though the outcome of the training was satisfactory, it is generally acknowledged that the process should have started much earlier.

## **Result Area II: Strengthened capacity at CHCU level for monitoring, supervision and evaluation of MIs**

### **Monthly meetings CHCUs**

CHAG is a complex organisation from an institutional, administrative and managerial point of view, in the sense that this provider's network is made up of 169 (faith based) health facilities and training schools with different governance structures and business cultures. While preparing CHAGs 2008-2011 Strategic Plan, the importance of having effective management and communication systems within the network, was underlined by all involved.

Since early this year, initiatives are being undertaken to build up a technical coordination and consultation platform throughout the network. A monthly meeting with all 16 (soon to be 17) CHCUs has now been established.

During the first half of the year, three meetings were held, i.e. on the 10<sup>th</sup> of April (review of draft composite CHAG 2008 Annual Work Plan), on 5<sup>th</sup> May (discussion on health financing, health management information, briefing on recent developments within the health sector) and on 9<sup>th</sup> June (review of the AWP, management arrangements within CHAG, planning of peer review). Attendance to these meetings has been very encouraging.

### **Need assessment among CHCUs**

With a view of better understanding the dynamics within each of the participating churches and identify future areas of work between the CHCUs and the Secretariat, a visit was conducted to 8 out of the 16 CHCUs in May. The first round of interviews, revealed that:

1. CHCUs vary considerably by the number of health facilities they are managing
2. There are major discrepancies among CHCUs in terms of staffing
3. Some CHCUs have inadequate knowledge of current developments within the health sector
4. With the exception of the Catholic, Presbyterian and Pentecostal Church, most CHCUs have not yet defined medium to long-term development plans
5. Knowledge of health (facility and hospital) planning and costing is limited among most CHCUs
6. CHCUs are not aware of operational experiences and 'best practices' elsewhere in the network; hence the need for promoting more technical cooperation and partnership between CHAG health institutions
7. Increasingly staff mechanisation within CHAG facilities would need to be considered within the context of economic parameters and should be justified by sustainable service provision
8. Relationships between CHAG facilities and GHS need further strengthening
9. Status of CHAG facilities will need a critical analysis and review as part of the proactive preparations for the soon to come NHIA accreditation inspection.

Considering these discrepancies between CHCUs and MIs, no wonder training and (technical) support needs also differ. It is therefore being examined whether a 'service level agreement' between the Secretariat and respective CHCUs would be a better option to 'doing business'.

Such 'service package' could include among others:

- Information support services (on clinical management, public health, health planning, financing, management, (support) systems and procedures)
- Consultancy and training support services (in the areas of strategic, business planning, costing, budgeting, monitoring and evaluation)
- Support in capacity building and resource mobilisation
- Guidance and coaching in health financing, health insurance
- Project management

## **Result Area III: Strengthened capacity of CHAG Secretariat in health sector planning, health financing, resource mobilisation, coordination and technical support to the CHCUs and MIs**

### **Organisational development**

Under CHAG's 2008 Annual Programme of Work and budget, substantial provisions have been made to enable the Secretariat to strengthen its designated role as coordinating /advocacy /technical support office for its customer groups (i.e. CHCUs and MIs).

Concerned about the fact that the Secretariat is currently inadequately staffed and equipped to perform this newly designated role, a process of revisiting the internal functioning of the Secretariat was embarked upon in the second quarter. With the support of a locally recruited facilitator, a two day workshop on 'leadership and teambuilding' was conducted for the entire office staff on 5<sup>th</sup> and 6<sup>th</sup> June 2008 (training report is presented in annex 2).

This workshop has undoubtedly resulted in a better understanding among staff of their changing (professional) role in the current development phase of CHAG. The retreat also revealed that there is potential overlap in functions between the various units, which need urgent attention.

Subsequently, a series of internal meetings were arranged to discuss the specific mandate of the various units and explore the options for internal efficiency improvements. A proposal for restructuring the Secretariat is scheduled for the third quarter.

### **Management Team**

Going through a major process of change (from 'administrative' to 'technical support' office, from project to output-funding), an effective (internal) planning, coordination and communication system at the Secretariat is essential.

Against this background, it was deemed necessary to establish a Management Team (MT) which meets weekly. The MT currently comprises the Executive Director, Administrative Manager, Projects Coordinator and the Management Advisor. Other line managers yet to be appointed will also join this team.

### **Staff development**

With the position of Finance Manager having been vacant for over a year, efforts to identify a suitable candidate were accelerated during the second quarter. An interim Finance Manager has been recruited who will assist the Secretariat in financial accounting and putting in place new administrative systems and processes.

To improve the technical capacities of the Secretariat, two new positions were created for a health insurance expert and HMIS officer. Both positions have meanwhile been filled, by an external (from the network) and internal candidate.

During the period under review, a new driver was also recruited, as well as a 'process facilitator' (from SNV) who will assist in the implementation of the HMIS-project.

A proposal for a new staff establishment is being worked at the moment.

### **Human resource development**

In accordance with the HRD plan agreed upon for the year, an internal teambuilding exercise was conducted (see above). No other staff training was carried out during the period.

Since the international procurement training in Denmark was postponed to 2009, CHAG's candidate could not attend the course.

Currently arrangements are being made for the 'Health Insurance Officer' to attend a 'Flagship Course' at the World Bank in October.

### **Capital development**

In order to give the Secretariat a facelift and resource it to carry out its business, restricted tenders were launched in May, a 'works tender' for renovating the office and a 'supply tender' for the procurement of IT equipment

The newly established Procurement Committee will start evaluating the bids after the deadline has expired (i.e. 1 July).

### **Public Relations and marketing**

Due to a variety of (mainly) operational problems, CHAG's Website has not been updated for quite some time now. A local internet provider was requested to prepare a proposal for Website redevelopment including the option of linking CHAG's new Website with others.

This proposal is currently awaiting approval of Management.

## **Result Area IV: Strengthened capacity of CHAG for policy development, advocacy and engagement with public and private stakeholders**

### **Board Meeting:**

The Board of Directors of CHAG was officially constituted at their first ordinary general meeting held on the 19<sup>th</sup> December 2007 at which the old Board handed over to the new Board. Subsequently the new Board held two other ordinary general meetings to begin the 2008 agenda. Main issues considered for the period between January and June included:

- The approval of the 2008 Annual Programme of Work
- Consideration of critical issues requiring advocacy work, e.g. the problem of re-imburement for service charges submitted by CHAG hospitals and clinics to the Health Insurance Schemes
- Organization of the Annual Council Meeting, the forum at which the Board renders its stewardship to the Church Leaders and the Members as well as Stakeholders, including the Ministry of Health and Development Partners.

This forum is so important to CHAG and its entire membership for various reasons including but not limited to the following:

- a. It is considered a neutral platform to table critical issues for lobbying and advocacy.
- b. It is a platform created for our development partners to provide us with feedback on our performance in the Sector.
- c. It offers all members the opportunity to fraternize and share experiences

### **Annual Council**

The Council of CHAG is the highest decision making body which provides the policy direction for the Association. It is composed of the Church Leaders, the Board of Directors, the National Church Health Coordinating Units and Representatives of all registered Health Institutions of CHAG in good Standing. The Council meets once a year to take stock of the previous years' activities, and initiate new policy issues.

This year's Annual Council meeting coincided with the 40<sup>th</sup> anniversary of the existence of CHAG and was therefore planned to initiate the celebration as such. Activities carried out included:

1. Breakfast show on GTV to showcase CHAG; what it stands for and its contribution to the health service delivery in Ghana.
2. Free outreach health services in five selected communities in the Kumasi Metropolis.
3. Series of lectures on important issues relating to our Christian health care delivery.

The Deputy Minister for Health, Hon. Dr. Mrs. Gladys Ashitey delivered the Opening Address, with solidarity messages given by some Development Partners.

At the end of the Annual Council meeting, a communiqué was issued, the details of which can be found in annex 3.

## 6. Expenditure Report

Following a recent policy decision by the Board of Directors and Partnership Steering Committee, CHAG has now adopted ‘activity-based budgeting’ as one of its lead principles. This implies that the Secretariat is gradually moving away from (parallel) ‘project’ funding. Instead, a medium-term Plan of Work, with associated expenditure framework are being developed, for which funding will be sought, from internal and external sources. It is CHAG’s ambition to have these plans ready towards the end of this year.

Meanwhile, an integrated budgeting and financial reporting system are being established enabling CHAG to compare expenditures against budget-line items and activities.

The following table shows the expenditures which have been incurred during the first six months of 2008, according to funding sources.

Sources of funding	Amount	Expenditures Q1 & 2/2008	Balance per 30/06/08
Contribution from member institutions (dues)	51,165	27,486	23,679
Interests on previous investments	303	0	303
Government contribution (salaries)	181,994	61,958	120,036
Government contribution (administrative costs)	1,800	45,479	(43,679)
UNFPA project funding	137,200	1,015	136,185
Danida funding	611,030	89,543	521,487
<b>Total</b>	<b>983,492</b>	<b>225,481</b>	<b>758,011</b>

Note that:

- UNFPA and DANIDA funds are based on contracts
- Contributions for MIs is based on the expectation that all MIs will effectively pay their dues
- Government’s contribution towards salary is based on an estimate

The Royal Danish Embassy agreed to contribute an amount of 611.030 Cedi to the funding of the 2008 AWP. Following approval of the 2008 AWP, 50% of this amount, i.e. 305.515 Ghana Cedis was paid into a Special Account at the ECO-bank.

From that amount, the following expenses have been paid during the second quarter (note that no expenses have been incurred during the first quarter, since the 2008 AWP had not yet been endorsed).

<b>COST CODE</b>	<b>ITEM DESCRIPTION</b>	<b>AMOUNT GH¢</b>	<b>EXPENDITURES (Q1 &amp; Q2 of 2008)</b>	<b>BALANCE</b>
102	Personnel	25,300.00	828.75	24,471.25
202	Administrative Expenses	3,500.00	96.00	3,404.00
204	Publications	7,000.00	4,470.71	2,529.29
206	Travel Cost	36,000.00	1,187.20	34,812.80
208	Financial Charges	4,000.00	0	4,000.00
301	Service	430,680.00	82,959.36	347,720.64
402	Purchase of Computer & Accessories	30,550.00	0	30,550.00
403	Repair & Maintenance of Office Building	74,000.00	0	74,000.00
	<b>TOTAL</b>	<b>611,030.00</b>	<b>89,543.02</b>	<b>521,486.98</b>

From the Danish contribution, an amount of GH¢89,543 (i.e. 14.7%) has been spent to date, notably to fund:

- The monthly technical coordinating meetings with the CHCUs
- The 3 workshops on new NHIA tariffs and medicines list
- The training on budgeting
- The leadership and teambuilding training
- CHAG's Annual Council meeting and
- some monitoring visits.

To date, an amount of over 250.000 Cedis has been committed to the following: works tender (35.000), supply tender (30.000), attendance fee for international training (10.000), redevelopment of Website (5.000), temporary recruitment of staff (10.000), contribution to UNFPA study (8.500), peer review (50.000) and HMIS-training (110.000). Expenditures in the third quarter of the year are likely to increase substantially.

## 7. Lessons learnt and the main priorities for next quarter

Despite delay in starting up the 2008 AWP, some essential steps towards achieving the operational targets for the year have been made, particularly with regard to:

- Upgrading the technical capacity of the Secretariat ( i.e. a Health Insurance Expert, Management Advisor and Health Management Information Officer were recruited)
- Improving (financial) planning, management and reporting systems and procedures (e.g. an interim Finance Manager joined the Secretariat)
- Better defining the expectations from the Secretariat’s main clients, i.e. CHCUs, MOH, NHIA, DPs and Board of Directors.

The latter will eventually result in the definition of a package of ‘products and services’, which the Secretariat could offer to its respective customer groups upon demand.

For each of these ‘customer groups’, proposed products and services are presented in the following table:

<b>Client groups</b>	<b>Products and services</b>
Member Institutions	<p>Information support services (on clinical management, public health, health planning, financing, management, (support) systems and procedures</p> <p>Consultancy and training support services (in the areas of operational planning, budgeting, monitoring and evaluation and HRD)</p>
CHCUs	<p>Information support services (on clinical management, public health, health planning, financing, management, (support) systems and procedures</p> <p>Consultancy and training support services (in the areas of strategic, business planning, costing, budgeting, monitoring and evaluation)</p> <p>Support in capacity building and resource mobilisation</p> <p>Guidance and coaching in health financing, health insurance</p> <p>Project management</p>
Board of Directors	Provision of (technical and financial) management information

MOH & DPs	Support to policy preparation; Technical and financial analysis; Financial audits
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Having laid a better foundation for the Secretariat to play its designated role as ‘support agency’ in advocacy, coordination, policy development, resource mobilisation, technical assistance and training, further efficiency gains could be made during the remainder of the year.

In addition to renovating the office, operationalising the organisational structure of CHAG (which will result in a new staff establishment and more detailed job descriptions for all staff), and modernising internal accounting and control systems, most activities planned for the 3<sup>rd</sup> quarter will focus on the CHCUs and MIs.

The priorities for the period 1 July to 30 September are summarised in the following table:

<b>RA 1: Appropriate (technical and financial) planning, management, support and information systems strengthened and functioning at the level of MIs</b>
- Implementation of HMIS initiative (according to plan)
- Completion of assessment on comprehensive emergency obstetric care and ASRH services in Volta Region ( along with UNFPA);
- Start of Peer Review
<b>RA 2: Strengthened capacity at CHCU level for monitoring, supervision and evaluation of MIs</b>
- Compilation of data base on CHAG facilities
- Installation of HMIS system at CHCU level ( according to plan)
- Identification of 2009 training needs
- Preparation of 2009 AWP for CHAG
<b>RA 3: Strengthened capacity of CHAG Executive Secretariat in health system development, health financing, coordination and technical support to CHCU’s and MI’s</b>
- Completion of audited statement for 2007
- Establishment of computerized accounting system
- Completion of restructuring
- Implementation of HMIS initiative (according to plan)
- Start of Peer Review
- Completion of renovation project
- Redevelopment of Website
- Monthly planning & monitoring meetings with CHCUs
<b>RA 4: Strengthened capacity of CHAG for policy development, lobbying, advocacy and engagement with stakeholders</b>
- Retreat Board of Directors
- Holding of Partnership Steering Committee

## **ANNEX 1: REPORT ON TRAINING ON NEW NHIA TARIFFS AND MEDICINES LIST.**

### **INTRODUCTION**

The National Health Insurance Authority has introduced a new payment mechanism, the G-DRG to replace the fee for service.

This new G-DRG received Ministerial approval in March 2008 and implementation took effect from 1<sup>st</sup> April, 2008. Training on the new tariffs and medicines list was organized by the National Health Insurance Authority (NHIA) through the District Mutual Health Insurance Schemes (DMHIS) for Hospitals and Clinics. However, most CHAG hospitals and clinics could not start implementation on the 1<sup>st</sup> April due to inadequate training and lack of clarity on some concepts. It is against this background that the CHAG Secretariat organized refresher training sessions for member institutions, with the approval from the Church Health Coordinating Units (CHCUs).

### **PARTICIPANTS**

Two officers from each hospital and one from each clinic were invited. In all 180 participants attended.

### **METHOD**

The training was organized at three main centres:

1. Dery Hotel, Techiman, for member institutions in Upper East, Upper West, Northern Region and Brong Ahafo from 19<sup>th</sup> to 22<sup>nd</sup> May 2008.
2. Lavicus Hotel, Kumasi, for member institutions in Ashanti, Central and Western Regions from 22<sup>nd</sup> to 24<sup>th</sup> May 2008.
3. Oyinka Hotel, Koforidua, for member institutions in the Eastern Region, Volta Region and Greater Accra Region from 26<sup>th</sup> to 28<sup>th</sup> May 2008.

The training took the form of open discussions; presentations, group exercises and group presentations.

### **FACILITATION**

Facilitators were drawn from the NHIA Regional offices, the Ghana Health Service Health Insurance Coordinating Office and CHAG. This provided the appropriate forum for sharing of experiences and exchange of ideas. The facilitators were: Mr William Sabi, Mr Collins Danso, Mrs Leticia Amoah, Mr Philip Akazinge and Mr Alex Mensah.

### **PRE- WORKSHOP EVALUATION**

Participants were asked to give their views on the new tariffs and medicine list to test their level of understanding and to help focus on the problem areas. They were also asked to mention areas of difficulty to help identify areas requiring emphasis in course of the training. The following issues came out:

#### **Concerns of Participants**

1. Difficulties in keeping forms for the two weeks duration of spell for OPD cases.
2. Tariffs are different for Districts and Regional facilities.

3. Some Diagnosis are not found in the claim forms; e.g. false labour and true labour.
4. The rational use of drugs is a problem since some cases take more drugs than scheduled.
5. Some drugs are not found in the drug list e.g. column V has no drug list.
6. Recording of visits is a problem
7. Managing of some cards at OPD e.g. Hypertension and Diabetes (acute and chronic) may bring some losses.
8. Clinics having no tariffs and asked to use that of GHS Clinics.
9. Special cases hospitals; eg. St. Joseph's Orthopaedics Hospital with special facilities should be catered for in the review session.
10. Scheme Managers and other administrators to blame for not starting with the new tariffs on time due to:
  - Claims booklet not available
  - Corrections on claims form not reflected on claims forms supplied
  - Claim forms supplied not sufficient – Manna Mission, Teshie South
  - Training slated for 5 days but done in two days.
  - Health Insurance Code and name of Scheme promised at the training was not found.
  - Drugs code was not found
  - National Health Scheme Number Eleven whilst District is Fourteen
  - Drugs – space provided for name so small
  - Form – value Book and so were constrained not to add anything.
  - Effective date 1<sup>st</sup> April but it took 1 -2 weeks before logistics came in.
  - Drug – Some essential drugs not in the list
  - Attendance 3 times – if the patient refuses to come – what do we do with our claims
  - No tariffs for observation
  - Bundling and unbundling not clear
  - Investigation difficult to find as unbundled case
  - Infant case for Malaria
  - We have not been able to locate the tariff.

Personnel from the NHIA admitted that there are a lot of difficulties since it was a new scheme.

The above issues formed the basis of the training for the first day at all the three centres. The subsequent days were used to take participants through the entire claim administration. This was followed by group work and presentations, using folders from Holy Family Hospital, Techiman.

Participants were taken through a complete case handling:

- i. Charges for General OPD
- ii. Charges for Consultations only and
- iii. Inpatient case scenarios.

Each group was made to fill claim forms for the above case scenarios and make a presentation to justify why they chose to handle them as such. The group presentation was used as a post training evaluation with questions and criticisms by participants as the basis of assessment. Gray areas identified after the group presentations were then handled by the facilitators.

## **OUTSTANDING ISSUES**

There is urgent need to address the following:

1. Tariffs from CHAG Clinics were not provided: CHAG Clinics were asked to use the approved tariffs for GHS Clinics which defeats the principle of equality, since overhead cost of the CHAG Clinics have been overlooked.
2. CHAG Hospitals providing specialized care: the issue of member institutions providing specialist care needs to be addressed. Hospitals like Agogo Presbyterian, Battor Catholic Hospital, St. Joseph's Hospital, Koforidua, St. John of God, D/Nkwanta, etc... were charging fees as per the services provided without any hindrance. The new DRG limits the fees to that of District Hospitals providing general care without considering their specialty areas. The proposal is to upgrade such Hospitals to apply the fees for Regional Hospitals which provide similar care.
3. **NON-INVOLVEMENT OF CHAG**  
It has been noted that meetings on Health Insurance Programmes are sometimes held without any invitation extended to CHAG. E.g. Kumasi – Training of Trainers on new tariffs, Kumasi – Medical Superintendents (from GHS hospitals) meeting on matters arising from implementation with some personnel from the NHIA. Key decisions taken at such gathering do not have any input from CHAG. Such decisions are sometimes to our disadvantage.

The training sessions addressed all the problem spots and ended with a post training evaluation. Some comments from the evaluation are summarized below:

1. Use of unqualified personnel: It was observed that some facilities presented staff who had no idea about the billing work and found it difficult to understand the basic concepts.
2. Absence of written contract between providers and schemes: It was again observed that most hospitals and clinics have no written contract with their respective schemes and are thus subjected to any treatment at the whims and pleasure of the Scheme managers.
3. Poor relationship between Scheme and provider facilities: Related to the above issue of absence of written contract, it was realized that some schemes are not on good terms with the hospitals and clinics they work with.
4. Some Hospitals do not have staff assigned for Health Insurance claims and related issues and relies on personnel from the District Health Insurance Scheme to prepare their claims.

## **CONCLUSION/RECOMMENDATIONS**

It was a worthy exercise as pertinent issues that hitherto hindered the smooth implementation of the new tariffs were addressed to the satisfaction of both member institutions and the National Health Insurance Authority Personnel present. The forum has prepared the grounds for a better working relationship and claims management.

It was recommended that the following issues are addressed by the CHAG Secretariat as a matter of urgency:

1. The team assembled for the monitoring of the implementation of this new regime should meet once every quarter to collate their grievance before the review date. This will enable CHAG make a comprehensive presentation on the salient matters that need to be changed.
2. CHCUs must be encouraged to engage qualified personnel for the preparation and management of claims to help avoid rejection of claims and to ensure that all services provided are reimbursed. The sustenance of institutions hinges on the claims administration.
3. There is need to arrange a meeting with the Chief Executive of NHIA and the Executive Director of CHAG to address issues on recognizing CHAG as a separate block from the Ghana Health Service in all matters relating to the national health insurance scheme.
4. A similar meeting with the Director of Operations of the NHIA will also be useful in addressing matters of unpaid bills / rejected claims as well as the delays in reimbursement.

## **ANNEX 2: REPORT ON TRAINING PROGRAMME “INSPIRATIONAL LEADERSHIP AND TEAM BUILDING”**

### **INTRODUCTION**

The programme was held for sixteen (16) staff members of CHAG. Prior to the training session, a pre-training interview was held on 31<sup>st</sup> May 2008. In all ten (10) staff members were interviewed. The interview questions ranged from their knowledge of the overall purpose of the team, their contribution to the team, what they expected from the other team members, the extent to which expectations of clients were being met, the barriers they foresaw as likely to interfere with the team’s success and their perception of the strengths of the team.

### **Results**

The results were revealing:

- Most of them (about 70%) knew the purpose of CHAG. Although the interviewees knew their roles in the team, it was not clearly expressed and this accounted for the overlaps in functions.
- It was also noticed that some staff members worked independently not willing to help other team members in other departments.
- On who their clients were and their expectations from CHAG, interviewees admitted lack of adequate capacity to meet the demands of the member institutions because they (interviewees) perceived staff did not possess the skills and qualifications to render services. Lack of adequate data on the member institutions was also said to be a limitation on knowing their clients well.
- Team spirit was also found to be low. Members were able to outline the barriers that affected the success of the team. These were:
  - (i) Lack of communication among members and also from top to bottom
  - (ii) Lack of openness
  - (iii) Lack of motivation especially non-cash motivation
  - (iv) Lack of trust among staff members
  - (v) Apathy
  - (vi) Overlaps in functions
  - (vii) Inconsistency in the application of staff policies
  - (viii) Lines of authority not well defined and structured
  - (ix) Welfare of staff not adequately catered for

### **COURSE OBJECTIVES:**

- To be aware of the changing environment in which they are operating.
- To boost employee morale and improve communication skills

- To develop conflict resolution skills and enhance creative problem solving
- To help employees get to know one another better to increase team efficiency
- To get the group motivated and energized towards company goals and build organizational trust
- To improve customer service through better understanding of customers

## **AREAS COVERED**

- **The Art of Leadership and Team Building**
  - Organizational Purpose
  - Vision, Mission, Objectives and Values
  - Managing Key Stakeholders
  - Understanding your own strengths and those of your organization
  - Understanding the role and characteristics of a successful leader.
  - Recognizing and reviewing your personal style of leadership.
  - Leadership Development and Effectiveness
  - Organizational and Individual Behaviour
- **The Effective Team**
  - Identifying the traits of an effective team
  - The key techniques for competent team working
- **Building a Successful Team**
  - Creating continuous and sustainable corporate improvement
  - Building a workforce committed to corporate success
  - Distinguishing team roles and responsibilities
  - Building trust and confidence in those you lead
  - Mentoring others to greatness
  - Praising and giving constructive feedback
  - Problem Solving and Conflict Resolution within the team

## **METHODOLOGY**

During the training programme, a combination of lectures, ice breakers and energizers and team building exercises were used to give participants a body of information and the opportunity to discuss relevant and peculiar issues which they encountered during their day-to-day activities.

A Team Health Check (THC) was administered. The THC was administered for members of staff to record their own assessment of how the team was currently operating. Questions asked revolved around Purpose/Direction, Team Leadership, Understanding Differences, Processes, Communication and Relationships in the team. Participants were then put in four (4) groups and each group was to develop an overall team score.

A team alignment exercise was also conducted among staff members. They were put in three functional groups i.e. Administration, Finance and Projects and Programmes.

The team alignment exercise was a brainstorming exercise to help the team through discussions to define themselves, their purpose and the conditions and processes under which they will function as a team. The aim was that individuals will leave the session as a newly formed team.

## **FACILITATORS**

The programme was facilitated by Theophilus Appah, Dr. Ofori and Dr. Sakyi.

## **EVALUATION**

### **From Participants**

Participants were impressed with the quality of delivery and the course content which they saw as very relevant. This was due to the fact that it brought out the challenges that existed within and among departments which interfered with the team's success.

They commented that although the bottlenecks had been identified and solutions offered during the training session, they were of the view that the duration of the programme was short. They also said in future such programmes should be held periodically and outside the premises of CHAG.

### **From Facilitators**

Through the various exercises, participants were able to identify the issues that acted as barriers to the realization of team goals.

The average score of the various teams during the Team Health Check (THC) was 2.2 which was very low. Most effective teams should aim to reach a target score of 4 or more in the longer term. A score of less than 3 indicated that there were particular issues that need to be addressed.

Some teams were unable to list the standards or criteria that indicated success in their various departments. Those who managed to list some success criteria did not indicate challenging standards.

Participants were able to identify the factors and conditions that could make the team most satisfying for each member. Factors like trust, openness, cooperation, acceptance, commitment, recognition of individual efforts, selflessness, and understanding of individual roles and availability of resources were mentioned.

Communication both intra department and inter department was found to be a challenge to all team members. During the Team alignment exercise team members in the Accounts Department had problems relating to each other and this affected work in that Department.

Participants were willing to bury their differences and apathy to keep the team moving forward.

The course on the whole was interactive and each participant played an active role during the training session.

## **RECOMMENDATIONS**

1. There is the need for a clear purpose and direction of all departments. This means that staff members should each know their job descriptions and their responsibilities. Formal roles should be followed by everyone and attempts to adopt informal roles discouraged.
2. Performance should either be part of regular agenda or discussed often during staff meetings. Individual goals should be checked to ensure they are relevant to the organization. Further individuals should be encouraged to share information about their goals. This requires the implementation of a performance management system where deadlines and targets are clearly established and agreed to by members.
3. Staff meetings should be held regularly and members encouraged to participate in discussions during meetings. Emphasis should be on problem-solving and task oriented.
4. Staff should be encouraged to develop themselves in the areas of Personnel and Management Programmes to address staff weaknesses.

As a follow up to this programme, two (2) in-house programmes are being proposed to management for consideration.

They are:

- Building A Positive Workplace Attitude; this programme will show participants how to help their staff build a happier and more productive workplace through the use of concepts of positive psychology and emotional intelligence.
- Effective Organization, Planning and Time Management; this programme will help participants acquire skills and techniques to prioritize their work, avoid time wasting events and make the most out of their time.

**ANNEX 3: COMMUNIQUÉ ISSUED BY CHAG AT THE 40<sup>TH</sup> ANNUAL COUNCIL MEETING HELD AT THE CHRISTIAN VILLAGE, SANTASI KUMASI FROM 22<sup>ND</sup> TO 27<sup>TH</sup> JUNE, 2008**

We the members of the Christian Health Association of Ghana (CHAG), having met for the 40<sup>th</sup> Annual Council Meeting at the Christian Village, Santasi in Kumasi from the 22<sup>nd</sup> to the 27<sup>th</sup> June 2008 on the theme: **“40 YEARS OF SERVICE TO THE POOR AND THE VULNERABLE IN GHANA: CHALLENGES AND THE WAY FORWARD”** reflect as follows:

1. Having provided health care to the poor, the marginalized and the good people of Ghana over the past forty years, we reaffirm our commitment to sustaining the delivery of quality health care in the years ahead.
2. We highly commend the efforts of government at improving safe motherhood, especially through the recent policy on free medical care for all pregnant women and also decoupling the registration of parents from that of their children less than eighteen years of age for the National Health Insurance Scheme, thereby reducing the high maternal and infant mortality rates in the country.
3. We further express our appreciation for the continuous collaboration between the Ministry of Health and CHAG through the implementation of the Memorandum of Understanding (M.O.U.) and the Administrative Instructions (AI), culminating in the posting of some Doctors and Nurses to CHAG Institutions.
4. Giving cognizance to the 2007 communiqué of the Council on the subject of reimbursement of health insurance claims, we reiterate our stance that there is the urgent need by the Ministry of Health and the Health Insurance Council to streamline the re-imbursement process to ensure timeliness in order to forestall the collapse of health care provision in CHAG institutions.
5. The policy of Regenerative Health is a laudable one needing motivation to see it through, yet the resources to support it seem to elude CHAG Institutions. We therefore demand that as key stakeholders providing 40% of health care, CHAG institutions need to be seriously integrated into its implementation.
6. In our resolve to strengthening partnership and collaboration with the Ministry of Health, we call on the Ministry to disseminate the M.O.U. and the Administrative Instructions at all levels i.e. the Regional and District Health Directorates who seem to know nothing about the M.O.U. and the Administrative Instructions.
7. We express concern about the deteriorating on-going violent situation in Bawku and we commend government's efforts at maintaining peace in the Bawku area. We strongly entreat the government, the Churches and the civil Society in general to find a lasting solution to the problem in order to create a conducive atmosphere for health staff since the escalating violence is scaring health staff from the area, thereby further endangering the lives of the poor and the marginalized.

**Board Chairman**

**Executive Director**