GHANA HEALTH SERVICE

IMPLEMENTATION GUIDELINES FOR NETWORKS OF PRACTICE

2024

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FOREWORD

The Networks of Practice (NoP) initiative reinforces the commitment of the Health Sector to identify innovative approaches to increase access to quality essential health care and population-based services for all. This is in line with the strategic focus to achieve Universal Health Coverage (UHC) by 2030. Ghana's Primary Health Care (PHC) strategy remains the bedrock of our approach to achieving UHC with the focus of improving health outcomes.

This strategy has yielded significant improvements in key health indicators such as health care utilisation, maternal health, access to immunisation services and child health. However, some significant barriers to service delivery at the sub-national level, such as poor referral systems, inefficient provider-payment mechanisms and inadequate capacity to deliver the basic package of PHC services remain as key operational challenges that call for redress.

Evidence, however, suggests the NoP initiative can significantly improve the delivery of PHC services by reducing fragmentation in coordinating referrals and services, ensuring accessible PHC for diverse communities, and leveraging limited funds and human resources to maximise performance at all levels of the health system.

The initiative shall be tailored to existing health structures where providers work in concert to deliver health services to the populace within a geographical area. This involves planning to address service gaps, sharing of resources and performance management, to provide comprehensive, patient-centred networks that deliver equitably distributed high-quality continuous care for common health conditions. These include non-communicable diseases (NCDs), reproductive, maternal, neonatal, child health, adolescent health and nutrition (RMNCAHN). Additionally, the initiative recognises the complementary contributions of other stakeholders, such as the Christian Health Association of Ghana (CHAG), other faith-based organisations, the National Ambulance Service (NAS), National Health Insurance Authority (NHIA), Health Facility Regulatory Agency (HeFRA) as well as Civil Society Organisations and the Private Sector, as vital to leveraging the potential opportunities of the networks to improve coverage, innovation and efficiency in the provision of health care.

Given the novel and collaborative nature of the initiative under reference, these guidelines have been developed, through broad-based consultations and consensus-building with various stakeholders of the Ministry of Health (MoH) and Health Development Partners, to provide the essential concepts, definitions, procedures and processes for the implementation of NoP.

It is envisaged that the guidelines shall serve as the reference material and management guide for all health sector stakeholders and provide a step-by-step process for the operationalisation of NoP in Ghana. It shall also enhance the capacity of the operational levels to understand and effectively apply the core principles of the NoP initiative for timely access to quality essential services towards the achievement of the UHC objectives.

All health managers, staff, and relevant stakeholders within the Ghana Health Service and across other agencies are encouraged to support the implementation of this NoP initiative, as it aims to foster better collaboration and strengthen the health system as a whole.

DR. PATRICK KUMA-ABOAGYE
DIRECTOR-GENERAL

ACKNOWLEGEMENT

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8. Ghana Medical and Dental Council
9. Ghana Education Service
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13. United States Agency for International Development
14. Results for Development
15. United Nations Development Programme
16. United Nations Population Fund
17. United Nations Children's Fund
18. World Bank
19. World Health Organisation

The list of all contributors can be found in Annex XIII

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LIST OF ABBREVIATIONS

ATF	Accounting Treasury and Financial
BEmONC	Basic Emergency Obstetric and Neonatal Care
CERS	Centre for Remote Sensing
CETS	Community Emergency Transport System
CHAG	Christian Health Association of Ghana
CHAP	Community Health Action Plan
CHMC	Community Health Management Committee
CHPS	Community-Based Health Planning and Services
CLA	Continuous Learning and Adaptation
CSO	Civil Society Organization
CWC	Child Welfare Clinic
DA	District Assembly
DCE	District Chief Executive
DDPH	Deputy Director Public Health
DHD	District Health Directorate
DHIMS	District Health Information Management System
DHMT	District Health Management Team
EHSP	Essential Health Services Package
EmONC	Emergency Obstetric and Neonatal Care
ETS	Emergency Transport System
FBO	Faith-based Organization
GCNH	Ghana Coalition of NGOs in Health
GES	Ghana Education Service
GHS	Ghana Health Service
GIS	Geographic Information Systems
HC	Health Centre
HeFRA	Health Facilities Regulatory Agency
HSSA	Health Systems Strengthening Accelerator
HSWG	Health Sector Working Group
IALC	Inter-Agency Leadership Committee
JICA	Japan International Cooperation Agency
KOICA	Korea International Cooperation Agency
LCA	Lifetime Course Approach
MDC	Medical and Dental Council
MoH	Ministry of Health
MoHC	Model Health Centre
MOU	Memorandum of Understanding
NAS	National Ambulance Service
NCDs	Non-communicable Diseases
NGO	Non-governmental Organization
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NMC	Nursing and Midwifery Council
NoP	Networks of Practice

OTCMS	Over the Counter Medicine Seller
PC	Pharmacy Council
PCPN	Primary Care Provider Network
PFM	Public Financial Management
PHC	Primary Health Care
PPMED	Policy Planning Monitoring and Evaluation Division
QG	Quasi Government
R4D	Results for Development
RCC	Regional Coordinating Council
RCH	Reproductive and Child Health
RDHS	Regional Director of Health Services
RHD	Regional Health Directorate
RHMT	Regional Health Management Team
RMNCAH	Reproductive, Maternal, Newborn, Child & Adolescent Health
RUM	Rational Use of Medicine
S4H	Systems for Health
SARA	Service Availability and Readiness Assessment
SDHMT	Sub-District Health Management Team
TAMD	Traditional and Alternative Medicine Directorate
ToR	Terms of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WB	World Bank

CHAPTER 1: BACKGROUND AND POLICY CONTEXT

1.1 Introduction

Over the past two decades, health system strengthening at the district level in Ghana has primarily focused on Community-Based Health Planning and Services (CHPS) and the district hospitals to the neglect of health centres, which, in the district health system are to serve as a referral link between the district hospitals, CHPS zones and the communities. It is on record that as at 2018, only 43% of health centres had the full complement of equipment[1]. The 2020 Ghana Emergency Obstetric Neonatal Care (EmONC) assessment also revealed that the availability of Basic Emergency Obstetric and Neonatal Care (BEmONC) in the health centres declined from 7% in 2010 to 4%. This weakness is a major obstacle to the implementation of the "gatekeeper system" as defined in Ghana's Referral Policy and Guidelines of 2013[2]. To address this weakness, the Ghana Health Service and the Ministry of Health have proposed an initiative to develop Networks of Practice (NoP) among sub-district health facilities to improve the quality of service delivery and in the process upgrade health centres to "Model Health Centres" (MoHC).

The desire to address these gaps in the delivery of Primary Health Care (PHC) therefore led the Ghana Health Service and the Ministry of Health (MoH) to commission a pilot project on Primary Care Provider Networks (PCPN) with support from the Systems for Health Project funded by United States Agency for International Development (USAID), from 2017 to 2019[3]. The results of the pilot project showed that networking increased collaboration and mutual technical and operational support among the facilities and increased the range of service delivery activities, thus demonstrating that networks had the potential of delivering equitable, high-quality PHC services whilst serving as a potential vehicle for achieving Universal Health Coverage (UHC) by 2030. Based on these results, the pilot project was later scaled up to 10 additional districts from 2020 to 2021 to explore a long-term PHC model that could sustainably deliver equitable, efficient, affordable and high-quality PHC services.

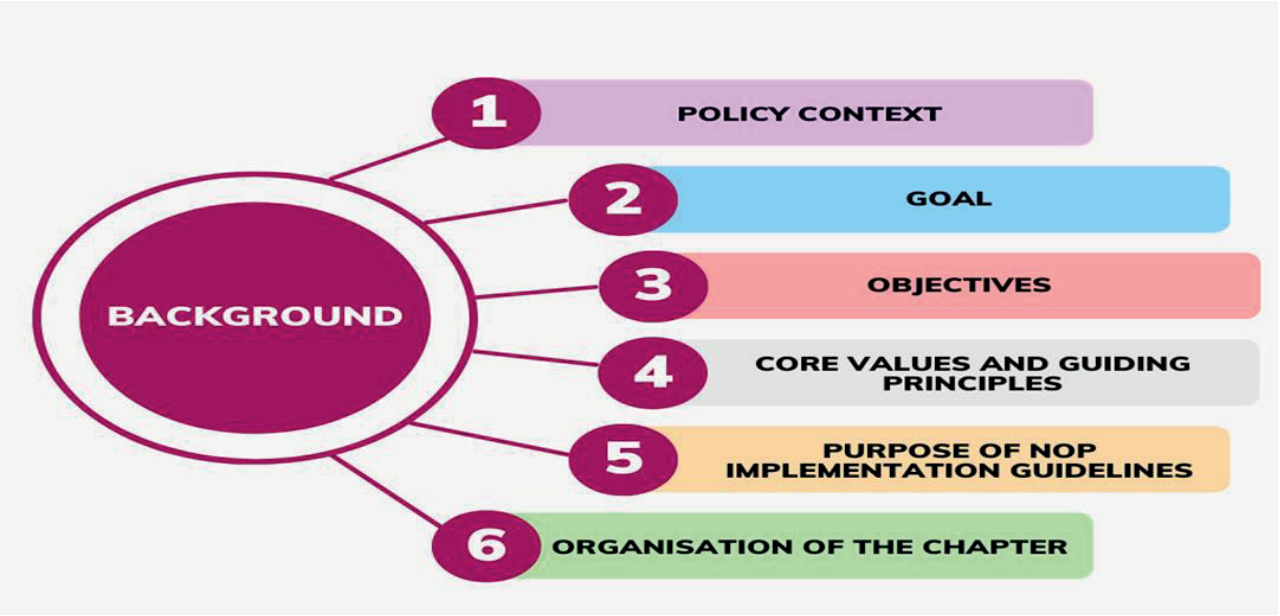
It was recognised from experiences in other contexts that the formation and support of Primary Care Provider Networks is one innovative approach to catalyse individual providers with relatively weak capacity to form more robust PHC organisations that can deliver the complete package of PHC services[4]

[1] [Ghana's Roadmap for Attaining Universal Health Coverage 2020 – 2030]

[2] [Ministry of Health May 2012. Referral Policy and Guidelines]

[3] [Systems for Health Ghana. (2019). Universal Health Coverage Through PHC: Preferred Primary Care Provider (PPP) Networks in Ghana. Network Models for Improved Organizational Management and Service Delivery. Systems for Health. Accra, Ghana.]

[4] [Birdsell, J., Matthias, S., and colleagues (2003). Networks and their role in enhancing research impact in Alberta. Alberta, Canada: Alberta Heritage Foundation for Medical Research (unpublished document)].



1.2 Policy Context

Ghana has undertaken several health sector reforms aimed at improving the health outcomes of the population. The current National Health Policy (2019)[5] emphasises systems strengthening, improving service availability for the population through community health services and expansion of public health interventions.

Ghana's vision of the UHC 2030 *"All people in Ghana have timely access to high-quality health services irrespective of ability to pay at the point of use"* is to further deepen the reach and scope of previous interventions while improving access and quality of services provided.

Ghana's National Health Policy (NHP, 2020) "Ensuring Healthy lives for All" and Ghana's Roadmap for Attaining Universal Health Coverage (2020-2030) are the two overarching health sector policies that seek to emphasise equitable access to a well-defined and contextually appropriate package of health services. Decentralisation and community ownership in Ghana's PHC therefore remains the main anchor of health system reform efforts.[6]

The Networks of Practice (NoP) is one of Ghana's strategies to achieve Universal Health Coverage (UHC) at the primary level with a focus on improving quality health services, partnership and innovation. It involves creating a network of health facilities within a defined geographical area to provide comprehensive health services. Networking allows a fluid system of managing and sharing resources without significant adjustment to the existing organisational structures. The network shall be created around health centres (Hub) with all other health providers within the sub-district as spokes. Whilst upgrading the health centres to attain the status of MoHC, the networks shall have the flexibility to manage and share available resources within and outside the NoP.

The roadmap specifies the networking of health facilities as a priority intervention to achieve these goals and provide the policy context for Networks of Practice in Ghana. Currently, the government's strategy to reform and strengthen the PHC system are the Networks of Practice (NoP) and the Model Health Centres (MoHC).

[5] [Ministry of Health January 2020. National Health Policy: Ensuring healthy lives for all. Revised Edition]

[6] [Ministry of Health Dec 2019. Ghana's Roadmap for Attaining Universal Health Coverage - 2020-2030]

1.3 Goal

The overall goal of Networks of Practice is to increase access to quality essential health care and population-based services for all by 2030.

1.4 Objectives

1. Promote universal access to better and efficiently managed quality healthcare services.
2. Reduce avoidable maternal, adolescent and child deaths and disabilities.
3. Increase access to responsive clinical and public health emergency services.

1.5 Core Values and Guiding Principles

Equity: Focus on essential health service package, the poor and vulnerable with emphasis on pregnant women and children, adolescents and the elderly.
Patient centeredness: Patients shall be handled with respect and dignity and included in decision-making about their health.

Quality of Care: Adherence to the highest standards of care

Strengthened referral systems: The NoP shall work in line with the district health system, maintaining the gatekeeper system such that clients can receive timely and effective care at the most appropriate level of the health delivery system.

Internal collaboration and relationship building: Foster teamwork among the key players in direct service delivery, management and resource utilisation.

Partnership at the operational level: Flexibility to include the Christian Health Association of Ghana (CHAG), other faith-based organisations, private maternity homes, community pharmacies, chemical sellers and other private providers in networks as needed to ensure access to an essential package of PHC services. Work with the district assemblies, communities, district level of the National Health Insurance Authority (NHIA) and at the national level with Health Development Partners for the scale-up of NoP.

Commitment to working together and supporting each other: Promote inclusiveness, transparency and fairness.

Community engagement: Understand community health needs and promote patronage of NoP by the community members.

Continuous learning and adaptation: As NoPs evolve, monitoring and documentation shall identify lessons and challenges to inform course adjustment, development of tools and dissemination of best practices.

1.6 Purpose of NoP Implementation Guidelines

This implementation guideline outlines the essential concepts, definitions, procedures and processes for the implementation of NoP in Ghana. The guideline is intended for:

1. District, regional and national health managers who have a role in providing technical management support and facilitation to the networks.
2. District hospitals and other hospitals (including CHAG, other FBOs and private sector providers) in the district who have a role to play in the implementation.
3. District stakeholders including district/municipal/metropolitan assemblies, NHIA, CSOs, Community Pharmacies, School Infirmaries and NGOs who have a role in coordination and direct material support (construction of CHPS compounds, funding and smooth NHIS reimbursements).

4. Health development partners who have a role in providing technical assistance, monitoring, coordination and funding support.
5. Communities, traditional authorities and other stakeholders who have roles in the advocacy, social accountability, resource mobilization and operationalisation for the sustainability of the NoP.

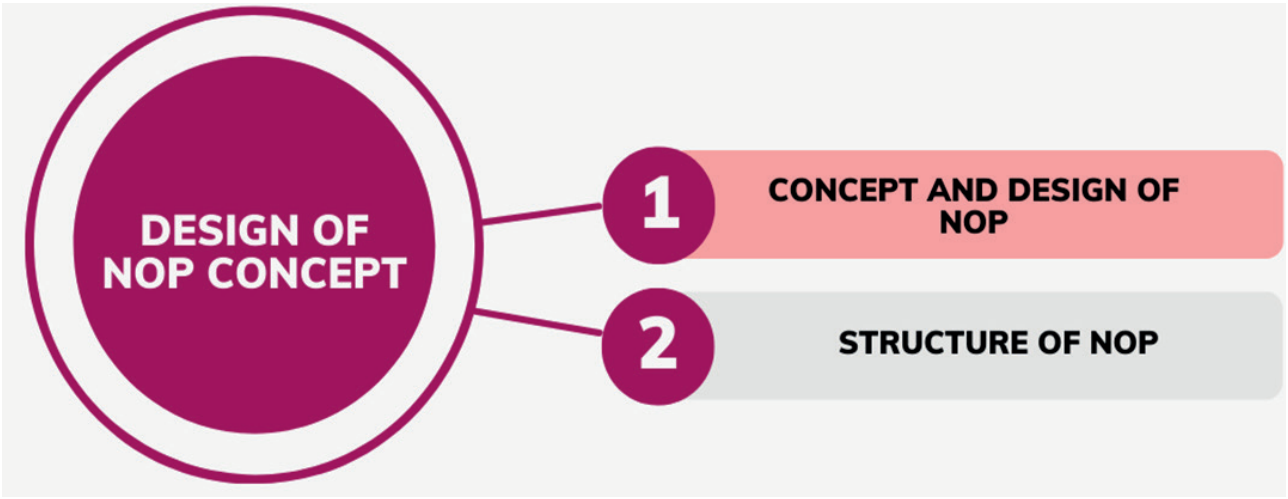
1.7 Organisation of the Chapters

The implementation guideline is organised into seven (7) chapters:

CHAPTER I: Background and Policy Context.
CHAPTER II: Design of Networks of Practice Concept.
CHAPTER III: Roles and responsibilities of Stakeholders in Implementation.
CHAPTER IV: Establishment of Networks of Practice
CHAPTER V: Operations of Networks of Practice
CHAPTER VI: Monitoring, Evaluation and Learning
CHAPTER VII: Sustainability for Networks of Practice

CHAPTER 2: DESIGN OF NOP CONCEPT

2.1 Concept and Design of Networks of Practice



Models for the Networks of Practice

"A group of public and/or private health service delivery sites deliberately interconnected through an administrative and clinical management model, which promotes a structure and culture that prioritise client-centred, effective, efficient operation and collaborative learning, enabling providers across all levels of care and the community to work in teams and share responsibility for health outcomes" (Carmone et al 2020).[7]

The sub-district health system offers the platform to form NoP hence, the organisational model of the networks perfectly aligns with the existing health system. The network structure uses an anchor establishment (hub) complemented by secondary establishments (spokes), which constitute the hub and spoke model within the sub-district health system.

[7] Carmone AE et al. Developing a Common Understanding of Networks of Care through a Scoping Study Health Systems Reform 2020, VOL. 6, NO. 2, e1810921 (13 pages) https://doi.org/10.1080/23288604.2020.1810921

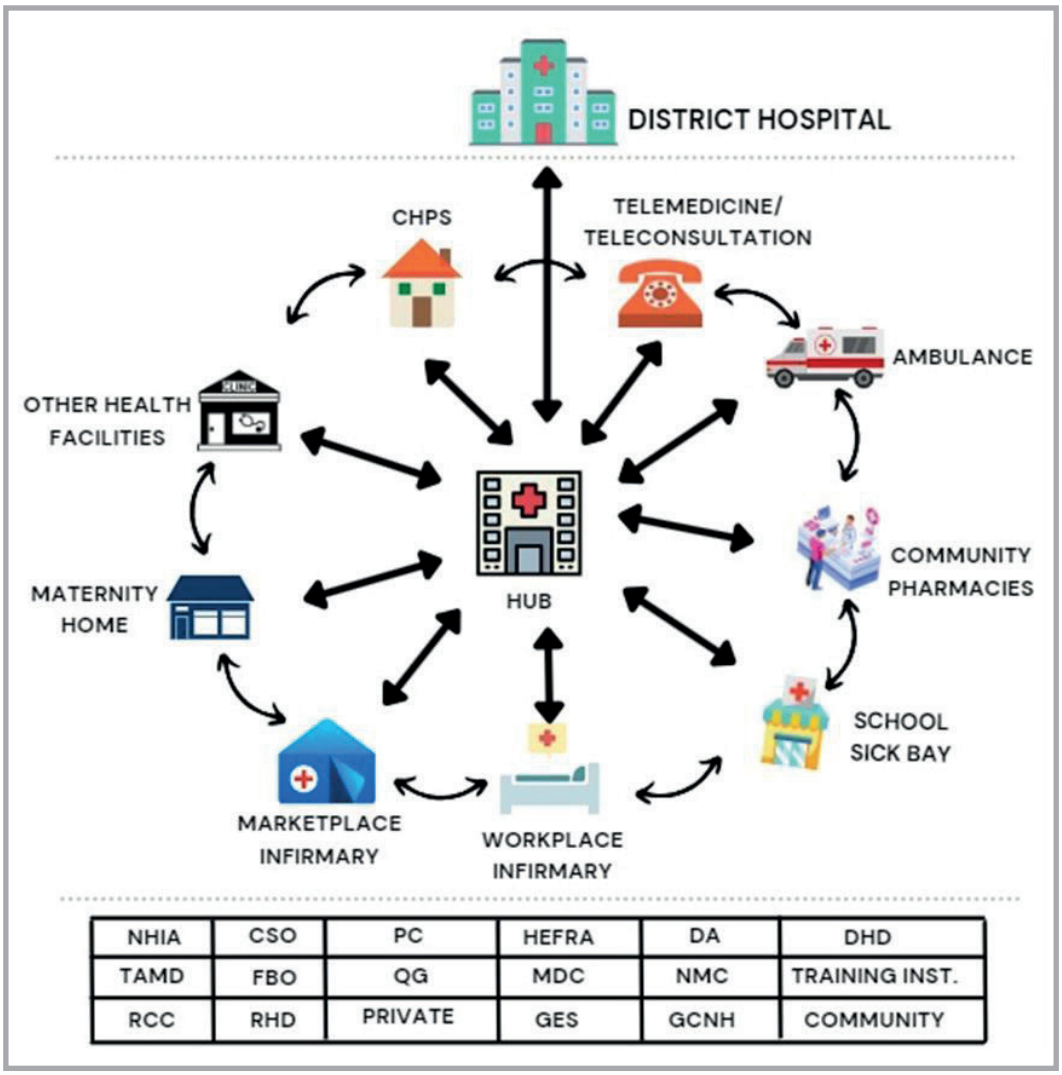


Figure 1: Framework of Networks of Practice (NoP)

The "Hub" is a health centre. The hub shall provide technical and operational support to the spokes. Complex medical services, especially those that are technology and skill intensive, are centralised at the hub, including human resource management, marketing, and related operations. In the NoP, the hub shall be developed into a "Model Health Centre" that meets the standard criteria defined below for supporting the network to perform effectively.

The "Spokes" are a group of health delivery points that are connected to the 'hub' from where they receive technical and operational support and share data. These are mostly CHPS but include other public and private health facilities such as workplace infirmaries, school-based or marketplace clinics, maternity homes, community pharmacies and over-the-counter medical sellers (OTCMS).

Hub-and-spoke networks can be expanded with spokes added as and when needed. NoP can make use of technology through telemedicine to bridge access and/or skill gap and enhance the quality of services.

In the majority of cases, a network shall comprise CHPS zones/compounds (the spokes) working with the health centre - the hub (Figure 2). Networks within a district shall relate to the district hospital through referral, technical and clinical support. Basic healthcare services shall be broadly distributed across the network, thereby permitting the bulk of healthcare needs of the populace to be addressed locally.

2.2 Structure of Networks of Practice

Sub-Districts with a Health Centre: Most networks shall be formed within a sub-district with the health centre as the hub and its surrounding facilities including CHPS, maternity homes, pharmacies, CHAG, faith-based and private health facilities as spokes.

Sub-Districts without a Health Centre: Where there is a sub-district without a health centre, the District Director of Health Service shall designate a well-resourced CHPS with a midwife to serve as the hub. This network shall receive additional support from the District Health Directorate (DHD) and District Hospital to enhance its capacity. Where a sub-district has a polyclinic, the polyclinic becomes the hub. In cases where there is a hospital or private clinic that has the capacity, such facilities can also serve as hubs.

Sub-Districts with more than one Health Centre: Where there is more than one Health Centre, the District Health Directorate shall support the affected sub-district to select one of the Health Centres as the hub.
District Hospital: The district hospital is connected to all networks within the district by providing clinical support through referral and supportive supervision.

CHAG and other Faith-based organisations/Private hospitals: These can serve as referral centres if they are better resourced in medical care services, staffing, and related services.

In instances where none of the above scenarios hold, the District Health Directorate shall support the affected sub-district to select one of the facilities as the hub.

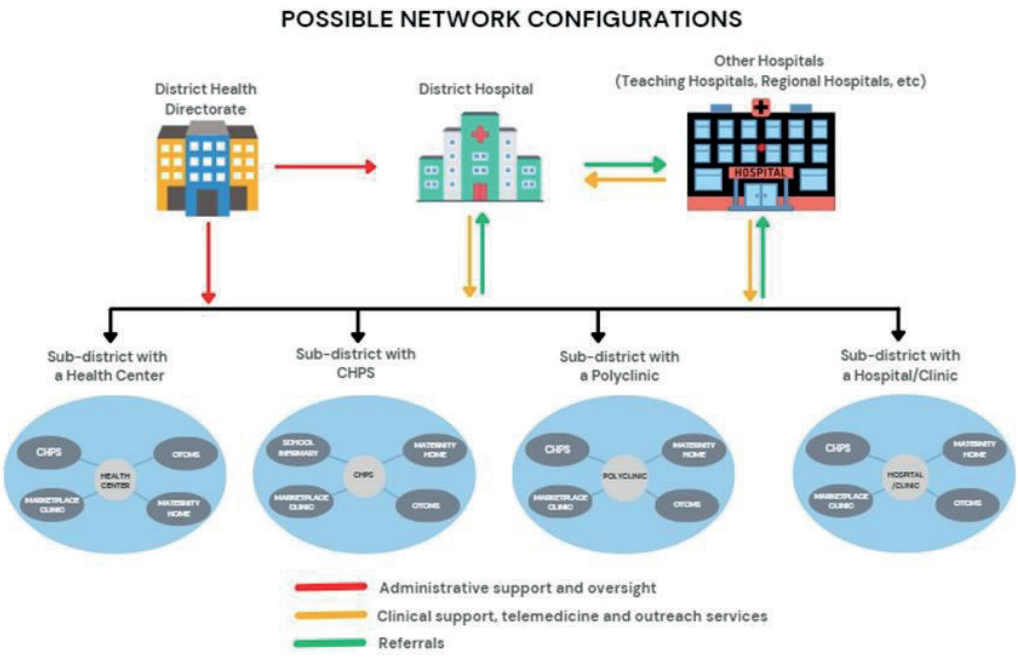


Figure 2: Possible Network Configuration within the District Health System Structure

CHAPTER 3: ROLES AND RESPONSIBILITIES OF STAKEHOLDERS IN IMPLEMENTATION

3.0 Introduction

The organisation and management of the NoP shall be within the existing health system structure and functions. The content of this chapter is summarised below.

To ensure smooth coordination and implementation of the networks, the specific roles of key health institutions and agencies are outlined as follows:

3.1 Ministry of Health

1. Formulate policies and create a favourable policy environment for the NoP to thrive.
2. Use existing fora/structures like Inter-Agency Leadership Committee (IALC), Health Sector Working Group (HSWG), Holistic Assessment and Annual Sector Performance Review as a forum for policy dialogue and reporting on national progress.
3. Provide resources needed for the implementation of the Networks of Practice and the Model Health Centres.
4. Mobilise adequate resources to implement and sustain the NoP.

3.2 Ghana Health Service Headquarters

1. Lead the design process for the NoP and secure commitment for the establishment and operation of NoP for improved health services.
2. Provide strategic direction to stakeholders in the implementation of the NoP.
3. Coordinate and provide general oversight of the country-wide scale-up of NoP and collaborate closely with all agencies of the Ministry of Health to ensure the achievement of expected results.
4. Coordinate health development partners' activities that support the development and implementation of NoP.

5. Mobilise and disburse funds to support implementation in the regions, districts and sub-districts.
6. Lead and coordinate the production and dissemination of resource materials and tools including adapting those already developed.
7. Participate in supportive supervisory visits to the networks.
8. Lead in the annual evaluation of the implementation of the Networks of Practice.
9. Conduct implementation research on NoP.
10. Lead the development of advocacy and communication strategies to support NoP implementation.
11. Institutionalise capacity building programmes and activities in the implementation of the NoP at all levels.
12. Provide logistic and technical support for the smooth and continuous running of the networks.
13. Undertake advocacy at the national level with relevant stakeholders to provide infrastructure and resources for NoP.

3.3 Regional Health Directorate (RHD)

1. Serve as the intermediate level between the headquarters and the operational level at the district.
2. Coordinate and supervise the implementation of the guidelines for the scaling up of NoP within districts.
3. Resource and strengthen the capacity of health centres to function as Model Health Centres (MoHC).
4. Supervise and monitor NoP implementation at the district and networks levels.
5. Ensure the integration of NoP reviews into existing performance review systems and sharing of best practices for learning.
6. Undertake advocacy to the regional coordinating councils, metropolitan, municipal, and district assemblies and other stakeholders to provide infrastructure and resources for NoP.
7. Undertake regular (quarterly) integrated supportive supervision to cover DHDs and networks.
8. Adapt and implement advocacy and communication strategies to support NoP implementation in the region.

3.4 The District Level

3.4.1 District Health Directorate (DHD)

The DHD is responsible for the implementation of the NoP, with respect to the following:

1. Undertake sensitization, demand generation, formation, and operation of NoP based on national guidelines.
2. Provide oversight of all the network activities within the district with the support of the district hospital.
3. Continuously define capacity gaps for equipment and infrastructure.
4. Mobilise resources from the MMDAs, NGOs, RHDs, GHS HQ and other stakeholders to support NoP implementation.
5. Provide technical support, quarterly supervision, mentoring and training in network operations and financial management.
6. Ensure the maturity of health centres into MoHC.
7. Collaborate with NHIA, HeFRA, MMDAs, CHAG facilities, Faith-Based Organisations, National Ambulance Service, Traditional Council and other private facilities that operate in the network.
8. Integrate NoP progress implementation reports as part of the district performance reviews.
9. Adapt and implement advocacy and communication strategies to support NoP implementation at the district level.
10. Facilitate communication between district hospitals and hubs.

3.4 2 District Hospital

The district hospital is the apex Service Delivery Point (SDP) within the district health system and plays a critical role in the functioning of the networks. The district hospital shall:

1. Provide clinical and technical support to the health centres and other facilities in the network.
2. Collaborate closely with DHD, NAS and other hospitals/clinics in the district, if any, to strengthen the referral system and feedback mechanisms through dedicated communication platforms.
3. Collaborate with the DHD to undertake supportive supervisory visits to the NoP to improve adherence to standards.

3.4.3 Sub-District

The sub-district is the level at which NoP is formed, with a typical configuration of a health centre as the hub and CHPS as the spokes (although, these configurations may vary). The health centre is the apex referral level in the sub-district and receives referrals from CHPS at a lower level. The sub-district shall perform the following functions:

1. Form and operate NoP in collaboration with DHD.
2. Coordinate and oversee the NoP committees in all networks.
3. Take lead in conflict resolution.
4. Provide Community Health Management Committee (CHMC) members with accurate and timely information about the NoP for community sensitisation, resource mobilization and support for NoP development and implementation.

Health Centre

1. Serves as the highest service delivery point and hub of the NoP in accordance with the Management Manual for Sub-Districts (2020).
2. Provides both preventive and curative services as well as outreaches to communities within their catchment area.

Network Committee at the Sub-District Level

The Network Committee, made up of the network lead and heads of the spokes from each member facility shall oversee the effective and efficient operations of the networks. The main activities of this committee are to:

1. Organise planning sessions to develop joint network activity and quality improvement plans.
2. Ensure the network's facilities serve as effective gatekeepers for referrals to and from the hospital.
3. Organise need-based capacity building programmes for network members.
4. Mobilise and manage resources for service delivery and monitor network performance.
5. Convene monthly network meetings to review progress in delivering the agreed essential package of services, identify gaps for action, receive feedback and make decisions on finances including NHIS claims and reimbursements.
6. Set up efficient platforms for communication and referral.
7. Report on NoP implementation progress, document and share best practices and innovations for submission to the DHD.
8. Conduct sensitisation and educational campaigns across communities to promote NHIS registration and inform communities about access to all facilities within a network.
9. Advocate and communicate strategies to support NoP implementation.

3.4.5 Model Health Centre (MoHC)

The MoHC is an adequately resourced, HeFRA licensed and NHIA credentialed health centre that meets set standards for the provision of an essential package of services[8]. The MoHC shall catalyse or encourage sub-district level providers to partner together to deliver better quality services as well as maximise efficiency in the use of resources. The NoP concept intends to resource all health centres to function as MoHCs.

The criteria for attaining MoHC status include:

1. Having the right mix of human resource capacity requirements in line with the GHS staffing norms as found in Annex I.
2. Ability to provide the basic package of services as stated in the essential package of services document such as:

1. Maternal and neonatal health services.
2. Child health and nutrition services including immunization and Vitamin A supplementation.
3. Adolescent health.
4. Family planning services
5. Prevention, control, and management of communicable diseases including Malaria, TB and HIV/AIDS
6. Prevention and management of non-communicable diseases and mental health conditions
7. Prevention and management of public health emergencies
8. Clinical care services and emergencies including Basic Life Support (BLS)

3.5 Community Level

Within the network, CHPS, maternity homes, CHAG facilities, sick bays, community pharmacies, faith-based and other private facilities at the community level, which provide services directly to the catchment populations, serve as the spokes. Community Health Management Committees (CHMCs) shall play a key role in community sensitisation and mobilisation to increase awareness and access to the available services.

In addition to their routine services, facilities at the community level that serve as spokes shall participate in all NoP activities. The NoP activities at this level include:

1. Mobilise, in collaboration with Community Health Management Committee (CHMC), communities to (re)register with the NHIS; inform communities about access to all facilities within a network and encourage communities to first use CHPS services with assurance of facilitated referral when needed.
2. Link up with the hub and other facilities within the network to provide comprehensive services to clients and refer to the appropriate level where necessary.
3. Reach out to the health centre (doctor/physician assistant, nurse prescriber and midwife) or other stakeholders within the network for technical and logistical support.
4. Participate actively in network planning and review meetings.

3.5.1 Community Health Management Committee (CHMC)

1. In addition to the role of the CHMC within the community set-up, the committee shall support NoP community sensitisation activities for the utilisation of services.
2. Provide feedback on the quality of services using the Community Scorecard.
3. Mobilise resources to support NoP activities.

3.6 Inter-agency and Other Collaborators

3.6.1 National Ambulance Service (NAS)

1. Continue to provide services to support the referral of patients.

[8] Ministry of Health 2021. Draft National Essential Health Service Package.

2. Collaborate with the local transport systems to support the referral of patients to and from various levels of care.
3. Explore innovative ways to link the Community Emergency Transport System (CETS) with the National Ambulance Service to facilitate referrals.

3.6.2 National Health Insurance Authority (NHIA)

1. The NHIA is the main purchaser of health services within the country and hence, shall continue to provide credentialing to all facilities within the network and ensure prompt reimbursement of approved claims.
2. NHIA district staff shall collaborate with network staff for community mobilisation to increase active membership of the NHIS in their catchment areas.

3.6.3 Private Sector

1. Collaborate with GHS for improved service delivery.
2. Use the NoP as a platform to facilitate collaboration with the public sector for the provision of essential health services within the catchment area.
3. Support in addressing the inequities in access to quality health services through creative partnerships.
4. Adhere to the health information standards and regulations of the health sector by operating strictly according to the Standard Operating Protocols and Guidelines of MoH.

3.6.4 Traditional Alternative Medicine

1. Traditional medicine providers who are part of the network shall collaborate with the facilities in the network to provide services as and when needed.
2. All the traditional medicine providers shall ensure that they are registered with the Traditional and Alternative Medicine Directorate of the MoH (TAMD).

3.6.5 Health Facilities Regulatory Authority (HeFRA)

Licensing with HeFRA is a statutory requirement for any provider seeking to operate a health facility in the country.

1. HeFRA shall collaborate with DHD and RHD to ensure timely licensing of all health facilities within the networks.

3.6.6 District Assembly

1. Collaborate with DHD to ensure that NoP and MoHC are made an integral part of the district development plan for the mobilisation of resources for its implementation.
2. Provide support for the DDHS and district NHIA Manager in the implementation of the NoP.
3. Have oversight responsibility in ensuring efficient and effective collaboration at district level.

3.6.7 Development Partners

1. Support the development and scale-up process at the national or sub-national levels.
2. Ensure that development partner-sponsored projects are aligned with the NoP concept to strengthen the provision of quality services.

3.6.8 Ghana Education Service

1. Liaise with the SHEP coordinators to ensure that their services are incorporated into network operations.

3.6.9 NCCE

1. Participate in network sensitisation and advocacy activities.

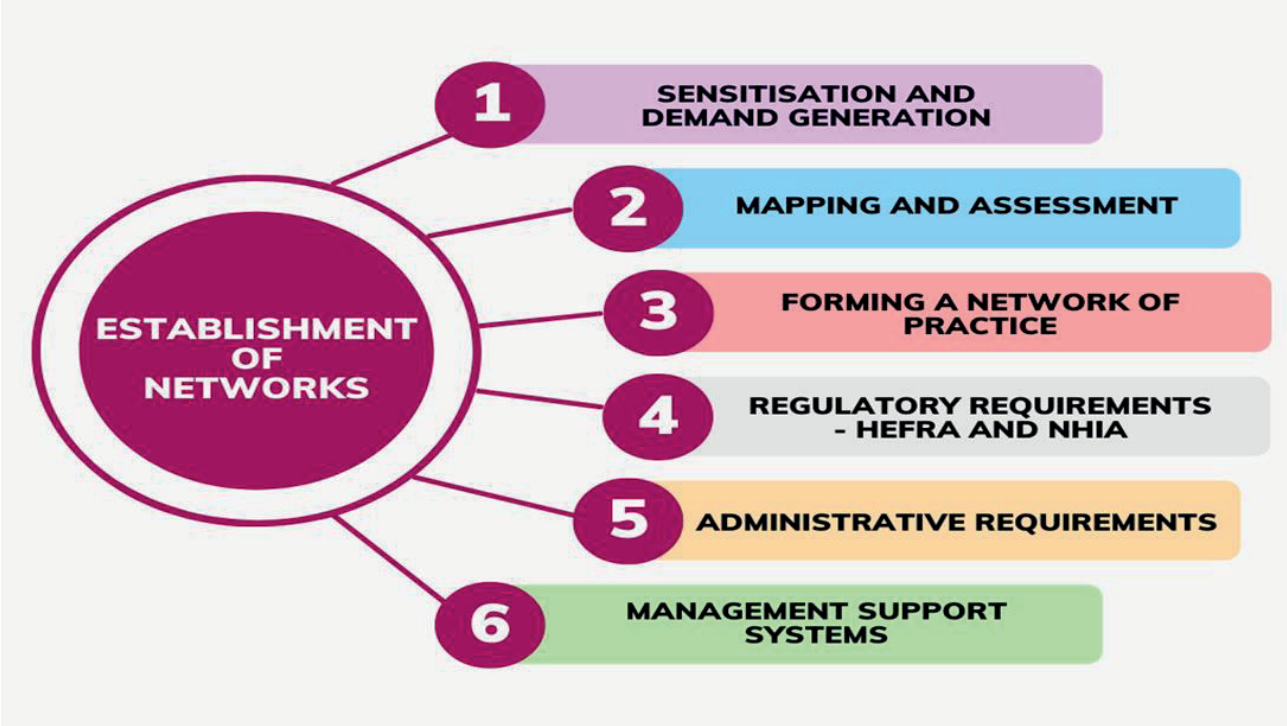
3.6.10 Traditional Councils

1. Support the sensitisation of the existence of NoP and their relevance to their constituents for smooth operations.
2. Jointly collaborate to ensure the peaceful existence of the networks where NoP overlap two or more traditional areas.
3. Support the NoP with logistics including funding.

CHAPTER 4: ESTABLISHMENT OF NETWORKS OF PRACTICE

4.0 Introduction

The process of establishing the Networks of Practice (NoP) involves the sensitisation of key stakeholders at all levels, mapping of facilities and the determination of hubs and spokes, the formation of NoP, regulatory and administrative requirements as well as management support systems.



4.1 Stakeholder Engagement, Community Sensitization, and Demand Generation

The first step in the creation of a network is the sensitization of stakeholders and demand generation.

4. The Ghana Health Service shall lead in the engagement and demand generation for stakeholders at the national and regional levels using the NoP implementation guidelines as one of the key strategies for achieving UHC. The goal of this process is to foster active participation and high commitment for sustainable and long-term implementation.
5. Technical teams will be established to oversee the implementation and operations of the NoP by leveraging existing structures at the national and sub-national levels. This team will be responsible for guiding the implementation process, addressing challenges and ensuring that the NoP aligns with the broader health goals of the nation.
6. The Regional Health Management Team (RHMT) and District Health Management Team (DHMT) will conduct sensitisation sessions for all stakeholders, including Sub-District Health Management Team (SDHMT) and community-level representatives with targeted messages about the concept and implementation guidelines of the Networks of Practice (NoP). The aim is to generate interest, support from stakeholders and ensure their buy-in. Additionally, the sessions will cover institutional arrangements for forming and operationalising the NoP.
7. The Networks of Practice as a policy concept shall be launched at the national and sub-national levels. The launch will be an opportunity to showcase the potential of the NoP, celebrate the commitment of stakeholders and generate further demand for its implementation.

4.2 Mapping of Facilities and Determination of Hubs and Spokes

The District Health Directorate (DHD) shall be responsible for the creation of NoP with technical support from the region using the UHC policy and NoP implementation guidelines. The creation shall involve mapping and assessment to determine the hubs and spokes.

4.2.1 Mapping of Facilities

The objective of the mapping process is to identify a geographical area, possibly aligning with the sub-district boundaries, where several health facilities e.g., health centres, CHPS zones, clinics, infirmaries, etc. can form a network.

The DHMT together with the sub-district heads, shall map all district facilities for the network formation using tools such as Geographic Information System (GIS) codes and other qualitative parameters. The mapping will identify facilities of all types (public, private, quasi, faith-based), their geographical locations, distances from other facilities and services currently provided.

GIS technology would be used to map the geographical distribution of healthcare facilities. This will help visualise the spatial relationship between facilities and identify areas with limited access to services.

In mapping a geographical area for a network, the following shall be considered:

1. The geographical area of NoP shall not be bigger than the sub-district in which the NoP is to operate.
2. The facilities within NoP may overlap a maximum of two sub-districts. Thus, a facility in one sub-district can be part of a network of another sub-district.
3. For each network, a hub may have between two (2) and twelve (12) spokes.

4.2.2 Determination of Hubs and Spokes

The DHMT shall convene a meeting with the sub-district heads and facility representatives for profile review and network configuration. During the assessment, participants will identify network hubs using the criteria below:

1. Geographical location– road network, proximity to spokes, etc.
2. Human resource capacity
3. Service delivery – BEmONC compliance, emergency preparedness and response, IPC
4. Logistics and supplies
5. Essential medicines
6. Infrastructure
7. Other contextual and qualitative parameters such as leadership, etc.

In creating the hub and spokes, the following shall be considered:

1. Where a health centre or polyclinic exists within a mapped network, the health centre or Polyclinic becomes the hub.
2. Where a CHAG or private facility is available and capable it could be considered a hub.
3. Where there are two health centres in a mapped network, the health centre with more and better Human Resource (HR) mix and service delivery capacity shall be selected as the hub.
4. Where there are no health centres in the mapped network, a more resourced CHPS facility shall be selected as the hub.
5. If a lower facility (below a health centre) is used as a hub, that facility shall not be upgraded to become a Model Health Centre.
6. Where a lower facility is selected as the hub and a new health centre is established, the new health centre automatically becomes the hub.
7. After the identification of the hub, the remaining facilities within the network become the spokes.
8. When a new health facility is established within a sub-district, it joins the network.
9. Networks can also be established inter-regionally where the hub may be found in one region and spokes in another region. In this situation, the network will operate functionally but such facilities will run administratively by the RHDs and DHDs.

The steps in the creation of networks are summarised in Box 1 below:

Box 1: Creation of NoP

The DHMT shall consider the following in creating the NoP:

1. Use the district health profile to guide the development of NoP.
2. Using DHIMS II data, list all the health facilities (by ownership) and their geolocation.
3. Validate the list of health facilities in the district.
4. Determine the services currently being provided by each facility within the district.
5. Demarcate the district into NoP, by identifying for each NoP, the Hub and Spokes.
6. DDHS shall submit the list of networks to Regional Director of Health Service for approval.

4.3 Forming a Networks of Practice

The process of forming NoP includes the following:

4.3.1 District Profile Assessment

The DHMT shall undertake a district profile assessment (Refer to Annex IV for profile template) capturing:

1. Number of sub-districts: facilities per sub-district, type, and ownership
2. Human resources at each facility
3. Infrastructure and
4. Logistics

4.3.2 Naming a Network

The head of the hub is the lead of the network. Where necessary, the network may select a coordinator to support the lead. It is important to have a name for every NoP because a few networks may fall outside its primary Sub-district. This is necessary to create, identity and measure performance.

One of the following nomenclatures may be used for naming NoP:

1. "Sub-district name and NoP." E.g., **Sokode NoP**
2. Where there is more than one NoP within one sub-district, the nomenclature shall be as follows; "Sub-district name and NoP#" where # represents the numerical numbering of the NoP. E.g., **Sokode NoP 1, Sokode NoP 2**

Upon the grouping of facilities into networks and selection of the hub, Districts shall write an official letter to the RDHS to submit the list of networks to Regional Director for approval. (See sample template in annex II, III & IV)

4.3.3 Orientation, Sensitisation and Training

1. The DHMT shall provide orientation to sub-district heads and facility in-charges on key message which details the network activities, roles, responsibilities of staff, etc.
2. Sensitisation of other staff and community by sub-district heads and facility in-charges.
3. Launching/Inauguration of the NoP: The Regional Director of Health Service shall work with District Directors of Health Service and stakeholders to formally launch the network.
4. The RHMT conducts training of networks on:
   i. leadership
   ii. teamwork
   iii. customer care
   iv. referral
   v. performance improvement
   vi. community scorecard
   vii. tele-medicine and tele-consultation where applicable
5. This training is done to build the capacity of service providers on the principles and operations of

the NoP (sharing human resources, financial management capabilities, logistics, equipment, and infrastructure within the NoP, data/records management within the network etc.)

4.3.4 Readiness Assessment and Launch

The Regional Technical Team conducts a first-round readiness assessment of the networks within three (3) months. This is done based on five indicators:

1. Staff awareness
2. Community awareness
3. Readiness of SDHMT and CHMC to support NoP.
4. Determination of baseline indicators or performance gaps
5. Development of an action plan

(Annex III provides a checklist for the sensitisation to the launching phase).

4.3.5 Functionality and Maturity of the Hub and the Network

Functionality refers to the capacity of the hub and the network to perform their assigned functions. Maturity refers to developmental stages in formation or establishment. The maturity level will directly influence the functionality.

4.3.6 Hub Functionality

For the assessment of hub functionality and maturity, the following subject areas are considered: human resource distribution, NCD management, IPC, BEmONC compliance, infrastructure and adherence to national policies and guidelines such as the Essential Medicines Package, Staffing Norms and other existing protocols for health centres.

All health centres must mature towards the highest prescribed level over time (Level 5). However, level 3 represents the basic requirements for functional networks of practice. The higher levels (4 and 5) add value and complexity to improve the effectiveness and efficiency of networks in reducing mortality and responding to clinical and public health emergencies.

****Approved programmatic standards during the implementation of the Networks of Practice shall be adapted when appropriate* ***

4.4 Maturity Model for Model Health Centre (Table 1)

In defining the Maturity Model for the MoHC, the following shall be considered:

1. Infrastructure for providing key primary health services - General OPD services, Maternal and Child Health (MCH) and Reproductive Health (RH), Laboratory etc.
2. Critical human resources
3. Selected services - BEmONC, Non-Communicable Diseases
4. Referral arrangements for EmONC and other clinical emergencies
5. Transport arrangements for clinical and non-clinical emergencies
6. Surveillance and reporting
7. Health Promotion and Community Mobilisation
8. HeFRA accreditation
9. NHIA Credentialing

Table 1: Maturity Model for the Health Centres

#	Item Description	Level 1	Level 2	Level 3	Level 4	Level 5
1	**GHS Designation as a HC**	GHS Designation as a HC	GHS Designation as a HC	GHS Designation as a HC	GHS Designation as a HC	GHS Designation as a HC
2	**Infrastructure**	Provides for General OPD, MCH including CWC, RH	Provides for General OPD, MCH including CWC, RH	Provides for General OPD, MCH including CWC, RH	Provides for General OPD, MCH including CWC, RH	Provides for General OPD, MCH including CWC, RH
		Provides labour Ward	Provides labour Ward	Provides labour Ward	Provides labour Ward	Provides labour Ward
		Provides a basic laboratory [1]	Provides a basic laboratory [2]	Provides a basic laboratory [3]	Provides a basic laboratory	Provides a basic laboratory.
		No potable water	No storage facilities for water storage	Provides facilities for water storage	Provides facilities for water storage	Provides facilities for water storage.
		Provides safe waste disposal	Provides safe waste disposal	Provides safe waste disposal	Provides safe waste disposal	Provides facilities for safe sanitation and waste disposal.
		No power supply	No power supply	Provides 24- hour power supply.	Provides 24-hour power supply.	Provides 24-hour power supply
3	**Human Resource**	At least one (1) Physician Assistant	At least one (1) Physician Assistant	At least one (1) Physician Assistant	Two (2) Physician Assistants	More than two (2) Physician Assistants
		At least 1 Midwife trained in EmONC within the last 2 Years	At least 2 Midwives trained within 2 years.	At least 2 midwives trained within 2 years.	At least 3 Midwives trained within 2 years	At least 4 Midwives trained within 2 years
		1 General Nurse	2 General Nurses	3 General Nurses	4 General Nurses	6 General Nurses
		1 Enrolled Nurse	2 Enrolled Nurses	3 Enrolled Nurses	4 Enrolled Nurses	5 Enrolled Nurses
		2 Community Health Nurses	3 Community Health Nurses	4 Community Health Nurses	6 Community Health Nurses	8 Community Health Nurses
		1 Technical Officer (Health Information) / Biostatistics Assistant	1 Technical Officer (Health Information) / Biostatistics Assistant	1 Technical Officer (Health Information) / Biostatistics Assistant	1 Technical Officer (Health Information) / Biostatistics Assistant	1 Technical Officer (Health Information) / Biostatistics Assistant
		1 Technical Officer (Disease Control) / Field Technician	1 Technical Officer (Disease Control) / Field Technician	1 Technical Officer (Disease Control) / Field Technician	1 Technical Officer (Disease Control) / Field Technician	1 Technical Officer (Disease Control) / Field Technician
		1 Technical Officer (Laboratory) / Laboratory Assistant	1 Technical Officer (Laboratory) / Laboratory Assistant	1 Technical Officer (Laboratory) / Laboratory Assistant	1 Technical Officer (Laboratory) / Laboratory Assistant	1 Technical Officer (Laboratory) / Laboratory Assistant
		1 Hospital Orderly/ Labourer	1 Hospital Orderly/ Labourer	1 Hospital Orderly/ Labourer	1 - 2 Hospital Orderly/Labourer	2 Hospital Orderly/ Labourer
		1 Security Personnel	1 Security Personnel	2 Security Personnel	2 Security Personnel	2 Security Personnel
		1 Field Technician	1 Field Technician	1 Field Technician	1 Field Technician	1 Field Technician

#	Item Description	Level 1	Level 2	Level 3	Level 4	Level 5
		1 Pharmacy Technicians / or Dispensing Assistant	1 Pharmacy Technicians / or Dispensing Assistant	1 Pharmacy Technicians / or Dispensing Assistant	1 - 2 Pharmacy Technicians / or Dispensing Assistant	3 Pharmacy Technicians / or Dispensing Assistant
		1 Storekeeper	1 Storekeeper	1 Storekeeper	1 Storekeeper	1 Storekeeper
		1 Accounts Officer (cash & NHIS)	1 Accounts Officer (cash & NHIS)	Finance Officer	Finance Officer	Accountant
		1 Driver	1 Driver	1 Driver	1 Driver	1 Driver
4	**Priority Equipment**	**See Annex IX**	**See Annex IX**	**See Annex IX**	**See Annex IX**	**See Annex IX**
5	**Selected Services: Emergency Obstetric and New-born Care Availability and Readiness to define Quality EmONC services for baby/mother pairs within the NoP maturation model.**					
	BASIC SIGNAL FUNCTION ***(Obstetric and Neonatal)***	5 Basic Obstetric Signal Functions and 5 Basic Neonatal signal function	5 Basic Obstetric Signal Functions and 5 Basic Neonatal signal function	6 Basic Obstetric Signal Functions and 5 Basic Neonatal signal function	All 7 Basic Obstetric Signal Functions and 5 Basic Neonatal signal function	All 7Basic Obstetric Signal Functions and 5 Basic Neonatal signal function
	COMMODITIES AND SUPPLIES	No Stock Out of essential commodities and supplies for more than One Month	No Stock Out of essential commodities and supplies for more than One Month	No Stock Out of essential commodities and supplies for more than One Month	No stock out of essential commodities and supplies throughout the year	No stock out of essential commodities and supplies throughout the year
	PROTOCOLS AND GUIDELINES	Availability of Job Aids for EmONC services. (At least 2)	Availability of Job Aids for EmONC services. (At least 2)	Availability Of Protocols, Guidelines, and Job Aids for EmONC services.	Availability of Protocols, Guidelines and Job Aids for EmONC services.	Availability of Protocols, Guidelines and Job Aids for EmONC services.
	TRANSPORT AND REFFERAL	Documented local transportation arrangement in Line with National Ambulance Service (NAS) Policies and Procedures Community Emergency Transport system	Documented local transportation arrangement in Line with National Ambulance Service (NAS) Policies and Procedures	Documented local transportation arrangement in Line with National Ambulance Service (NAS) Policies and Procedures	Documented local transportation arrangement in Line with National Ambulance Service (NAS) Policies and Procedures	Documented local transportation arrangement in Line with National Ambulance Service (NAS) Policies and Procedures
	CLINICAL GOVERNANCE Maternal and Perinatal Death Surveillance and Response	Identification & Notification of maternal and perinatal deaths	Identification & Notification of maternal and perinatal deaths	Institutional process in place for Maternal and Perinatal mortality and morbidity Audit (Death Review process)	Institutional process in place for Maternal and Perinatal mortality and morbidity Audit	Have Integrated system with the spokes for maternal and perinatal death surveillance and response

#	Item Description	Level 1	Level 2	Level 3	Level 4	Level 5
	MENTORSHIP	No processes	No processes	Institutional process in place for in-service training MNCH staff	Institutional process in place for in-service training MNCH staff	Serves as centre/ site for ongoing training of staff through preceptor and/or mentorship.
	MONITORING	Quarterly Monitoring and supportive supervisory visits	Quarterly Monitoring and supportive supervisory visits	Quarterly Monitoring and supportive supervisory visits	Quarterly Monitoring and supportive supervisory visits	Quarterly Monitoring and supportive supervisory visits
	NCD Management	NCD Screening and early detection	NCD screening and early detection Follow up care. Palliation	NCD Management according to existing protocols for the health centre level (diabetes and hypertension as proxy)	NCD Management according to existing protocols for the health centre level (diabetes and hypertension as proxy)	Management of additional NCDs to that of Grade 4 hubs – e.g., mental health services
5b	**Scope of NCD diseases**	Hypertension, Diabetes, malnutrition Screening for breast and cervical cancers (clinical breast exams and VIA). Early warning signs for childhood cancer Health education on risks of NCDs (reduction of salt /sugar & alcohol intake, weight loss and cessation of smoking) promotion of healthy diet and lifestyle), Health education in schools on all NCDs + General health education	Level 1 + mental health, oral health, eye health and injuries Level 1 + Public education on mental health, oral health, eye health and injuries (RTAs) + general health education	Level 2 + Hepatitis B & C Level 2 + public public education on Hepatitis B & C + general health education	Level 3 + sickle cell Level 2 + public education on hepatitis B & C + general health education	Level 4 + breast cancer, cervical cancer, Level 4 + Public education on sickle cell, HPV, breast cancer, cervical cancer + general health education
	Immunisation	immunization (EPI)	immunization (EPI)	Level 2+Hep B	Level 2+Hep B	Level 2+Hep B
	Treatment/ Management	Referral Counselling on diet and healthy lifestyle Follow up care in community.	Counselling on diet and healthy lifestyle + Management of patients with well controlled hypertension & diabetes	Level 2 + counselling of hepatitis B lifestyle modification	Level 3 + management of mental health cases	Level 4 +management of HPV

#	Item Description	Level 1	Level 2	Level 3	Level 4	Level 5
	Mode of service delivery	Outreaches, Community durbars, home visits, static clinics, community meetings/fora	Outreaches, Community durbars, home visits, static clinics, community meetings/fora	Outreaches, Community durbars, home visits, static clinics, community meetings/fora	Outreaches, Community durbars, home visits, static clinics, community meetings/fora	Outreaches, Community durbars, home visits, static clinics, community meetings/fora
6	**Communication and Referral Arrangements**	No reliable documentation of referral	Referral practice in place with documentation	Level 2 + WhatsApp (or other platform) based communication mechanism linked to District Hospital and to CHPS is in place.	Level 3 + organised access to ambulance or other means of emergency transport.	Level 4 + capability to assist spokes through telemedicine
7	**Monitoring and Supportive Supervision**	No monitoring and supportive supervision plans developed	Monitoring and supportive supervision plan developed	Level 2 + at least one supportive supervision visits to each spoke in the last 1 year	Level 3 +Improvement plans developed	Level 4 + training and mentoring conducted for spokes in the last 1 year
8	**Logistics**	At least one (1) bicycle	More than one (1) bicycle	More than one (1) bicycle. One (1) motorbike	More than one (1) bicycle. Two (2) motorbikes	(1) bicycle. More than Two (2) motorbikes
9	**HeFRA Accreditation**	Accreditation process initiated	Accreditation process initiated	Accredited	Accredited	Accredited
10	**NHIA Credentialing**	Credentialing process initiated	Credentialed	Credentialed	Credentialed	Credentialed

‡ - All 7 Basic Obstetric signal functions except Assisted Vaginal Delivery and Removal of retained products and all five basic neonatal functions
¥ - All 7 Basic Obstetric signal functions except Assisted Vaginal Delivery and all five basic Neonatal signal functions.

Pre-requisite for NoP (See Table 2)
Once networks are formed according to the guidelines, it must be ensured that those that are considered matured are carrying out selected priority NoP regular activities. The selected priority activities will cover the three principal functions of the NoP - service delivery, management and organisation, financing and payments. The maturity model is intended to assure all stakeholders that the Networks considered as Level 3 and above have the basic standards and capacity to operate optimally as NoP.

Table 2: Pre-requisite for NoP

#	Item Description	Level 1	Level 2	Level 3	Level 4	Level 5
	FORMATION OF NoP					
1	**District profile and mapping of facilities**	The process started but still in discussion/ consultation	The DHMT has undertaken district profile assessment according to standard template	The DHMT has undertaken district profile assessment according to standard template	The DHMT has undertaken district profile assessment according to standard template	The DHMT has undertaken district profile assessment according to standard template
2	**District planning and orientation meeting**	The process started but still in discussion/ consultation.	NoP Configurations defined (hub and spokes), Lead for NoP appointed, and NoP given a name.	NoP Configurations defined (hub and spokes), Lead for NoP appointed, and NoP given a name.	NoP Configurations defined (hub and spokes), Lead for NoP appointed, and NoP given a name.	NoP Configurations defined (hub and spokes), Lead for NoP appointed, and NoP given a name.
			Orientation provided during the planning session for all participants on key messages which details the network activities, roles and responsibilities of staff, community engagement etc.	Orientation provided during the planning session for all participants on key messages which details the network activities, roles and responsibilities of staff, community engagement etc.	Orientation provided during the planning session for all participants on key messages which details the network activities, roles and responsibilities of staff, community engagement etc.	Orientation provided during the planning session for all participants on key messages which details the network activities, roles and responsibilities of staff, community engagement etc.
3	**Approval of NoP**	The process started but still in discussion/ consultation	The process started but still in discussion/ consultation	RDHS approved district configuration and name of NoP.	RDHS approved district configuration and name of NoP.	RDHS approved district configuration and name of NoP.
4	**Declaration of NoP as ready to operate**	The process started but still in discussion/	The process started but still in discussion/	The Regional Technical Team declares NoP as ready after the first round of readiness assessment within 3 months after planning and orientation. Assessment based on five indicators: 1. Staff awareness of NoP 2. Community awareness of NoP 3. Initial determination of performance gaps within the NoP	The Regional Technical Team declares NoP as ready after the first round of readiness assessment within 3 months after planning and orientation. Assessment based on five indicators: 4. Staff awareness of NoP 5. Community awareness of NoP 6. Initial determination of performance gaps within the NoP	The Regional Technical Team declares NoP as ready after the first round of readiness assessment within 3 months after planning and orientation. Assessment based on five indicators: 8. Staff awareness of NoP 9. Community awareness of NoP 10. Initial determination of performance gaps within the NoP

#	Item Description	Level 1	Level 2	Level 3	Level 4 7. Development of an action plan	Level 5 11. 12. Development of an action plan 13. Evidence of CHMC mobilisation
5.	**Initial Capacity Building for NoP**	No training done	Scheduled for training.	First RHMT training of networks on leadership, teamwork, referral, performance improvement, community scorecard	First RHMT training of networks on Level 3 training plus customer care,	First RHMT training of networks on Level 4 training plus telemedicine and teleconsultation.
6.	**BASIC REQUIREMENTS FOR HUB AND SPOKES**[9] For Hub requirements refer MoHC maturity model above (Table 1) **SPOKES**					
1	**Infrastructure**	Provides consulting space, facilities for water storage, safe sanitation, and waste disposal	Provides consulting space, facilities for water storage, safe sanitation, and waste disposal	Provides consulting space, labour ward, facilities for water storage, safe sanitation, and waste disposal	Provides consulting space, labour ward, facilities for water storage, safe sanitation, and waste disposal, 24 hours power supply	Provides consulting space, labour ward, facilities for water storage, safe sanitation, and waste disposal, 24 hours power supply, radio link with the hub
2	**Basic equipment**	See Annex IX	See Annex IX	See Annex IX	See Annex IX	See Annex IX
3	**NHIA credential**	Credentialing process initiated	Credentialing	Credentialing	Credentialing	All network members are credentialed at the same time frame.
4	**HeFRA**	Accreditation process initiated	Accreditation process initiated	Accreditation	Accreditation	All network members provided accreditation within the same time frame.
5	**Selected services**	Home visits, Community sensitization and mobilization, Treatment of minor conditions, Referral	Home visits, Immunization, Community sensitization and mobilization, Treatment of minor conditions, Referral	postnatal care, Delivery, Home visit, Immunization, Community sensitization and mobilization, Treatment of minor conditions, Referral	Antenatal and postnatal care, Delivery, Home visit, Immunization, Community sensitization and mobilization, Treatment of minor conditions, including minor accidents and emergency,	Antenatal and postnatal care, Delivery, Home visit, Immunization, Community sensitization and mobilization, Treatment of minor conditions, including minor accidents and emergency, Referral

[9] The essence of including this section is to ensure that attention is not taken off CHPS because of emphasis on Model Health centres and NoP.

#	Item Description	Level 1	Level 2	Level 3	Level 4	Level 5
	OPERATION OF NoP					
6.	**Regular NoP meetings**	Undertake occasional network committee meetings	Undertake occasional network committee meetings Occasional network clinical meeting	Undertake at least quarterly network committee meetings with records of meeting At least quarterly network clinical meetings covered[10] 1 of 3	Undertake regular monthly network committee meetings with records of meeting Regular monthly network clinical meetings covered 2 of 3	Undertake regular monthly network committee meetings with records of meeting Regular monthly network clinical meetings covered 3 of 3
7.	**Network Planning Activities**	Network improvement plan not developed	Network Performance Improvement plan available; not up to date	Develops and updates Network Performance Improvement Plans with less than 50% score in implementation	Develops and updates Network Performance Improvement Plans with 50 – 70% score in implementation	Develops and updates Network Performance Improvement Plans with 50 – 70% score in implementation
8.	**NHIS**		Undertakes regular NHIS Claims vetting	Undertakes regular NHIS Claims vetting Action to improve NHIS enrolment	Undertakes regular NHIS Claims vetting Action to improve NHIS enrolment	Undertakes regular NHIS Claims vetting Action to improve NHIS enrolment
9.	**Strengthening Referral**	Reported referral without documentation	Reported referral without documentation	Evidence of referral with documentation, feedback and follow up	Level 3 + Evidence of Community Emergency Transport arrangements for referral, Evidence of collaboration and arrangements with National Ambulance Service	Level 3 + Evidence of Community Emergency Transport arrangements for referral, Evidence of collaboration and arrangements with National Ambulance Service
10.	**Monitoring and Supportive supervision visit**	No monitoring and supportive supervision plans developed	No monitoring and supportive supervision plans developed	Level 2 + at least one supportive supervision visits to each spoke in the last 6 months	Level 3 + Performance Improvement plans developed as a result of monitoring and supportive supervision visit	Level 4 + training and mentoring conducted for all spokes in the last 1 year as a result of monitoring and supportive supervision visit.

[10]Rational Use of Medicine, Clinical Updates and Morbidity and Mortality meetings

#	Item Description	Level 1	Level 2	Level 3	Level 4	Level 5
11	**Advocacy and Communication**	No advocacy and communication	Advocacy and communication plan developed	Evidence of collaboration with at least two key stakeholders[11]	Evidence of collaboration with at least two key stakeholders	Tangible evidence of collaboration – infrastructure, supplies, funds, private sector participation etc.
1	Innovations				At least one documentation of innovations beyond the Implementation Guidelines	More than one documentation of innovations beyond the Implementation Guidelines

4.4 Regulatory requirements

The NoP arrangement requires that several health facilities be brought together to operate as a unit while working within the existing legal and administrative framework.

4.4.1 Licensing / Accreditation by HeFRA

Licensing and accreditation with HeFRA is a statutory requirement for any provider seeking to operate a health facility in Ghana. Hence, the District Director shall guide all facilities within NoP that are not accredited and licensed to acquire their license for operation:

1. All facilities within NoP shall complete the approved licensing application form online.
2. The authority specified by HeFRA shall approve all submissions.
3. Facilities within NoP acquiring their new license shall be inspected at the same time.
4. The start date for licensing of new facilities shall be synchronised.

For facilities that would require renewal, the District Director shall guide all facilities within NoP to renew their license at the same time.

The procedure for registration and renewal for HeFRA licensing can be found on the HeFRA website http://hefra.gov.gh/index.php/services/licensing/

4.4.2 Credentialing by NHIA

HeFRA license is a prerequisite for NHIA credentialing. It is desirable for all facilities within the NoP to be NHIS credentialed.

1. All facilities within an NoP shall complete the credentialing application form online.
2. The authority specified by NHIA shall approve all submissions. Assessment of facilities within an NoP shall be conducted together.
3. Facilities within NoP acquiring their new credential shall be inspected at the same time. The start date for credentialing of facilities shall be synchronised.

The procedure for credentialing can be found on the NHIA web portal available at www.credentialing@nhia.gov.gh

[11]Community members, Community Health Management Committee, District Assembly, CHAG and other Private Providers, others

4.5 Administrative Requirements

4.5.1 Structure

1. The NoP committee shall oversee the administrative and management arrangements of the network.
2. Where there is more than one NoP in a sub-district, the Sub-District Management Team shall oversee the NoP committees in both networks.

4.5.2 Reporting

1. NoP shall rely on the existing management structure for reporting and coordination.
2. There shall be no separate data reporting requirement for the network. All the facilities shall report to DHIMS II as currently required.
3. Facilities shall be aligned to NoP in DHIMS II as one of the reporting levels, thus data analysis can be done at the sub-district level or network level.
4. Additional output measures may be developed to enhance the measurement of the effectiveness and efficiency of the network.

4.5.3 Resource Management

1. The district shall use the existing criteria for resource allocation to facilities within the network e.g., drugs, non-consumables, equipment and other infrastructure.
2. Local arrangements can be agreed upon within the facilities of a network to share resources.

4.6 Management Support Systems

4.6.1 Community Ownership and Participation

Community ownership in the context of the NoP refers to the active involvement of community leaders and members to understand and support the NoP. The community scorecard shall be used to facilitate such community engagements and participation. The results from the community scorecard shall be used for the planning and identification of interventions for improving health services and outcomes. The facilities within each network shall have a Total Assessment Score of at least 95% (green) for at least one quarter of each year. Within each network, the heads of the Community Health Management Committees shall form a network level committee to assess this performance at the network level.

4.6.2 Partnerships

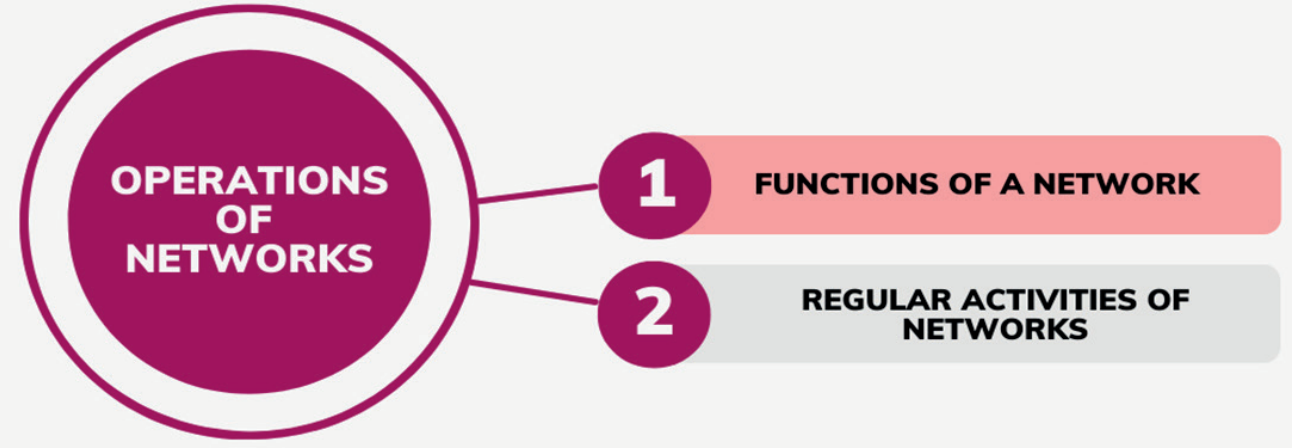
Where partners in the network include private providers, faith-based organizations, quasi-government institutions, etc.:

1. MoU shall be signed to guide their participation in the NoP.
2. The District Director shall engage partners in monthly planning meetings before the formation of the network and thereafter integrate them into quarterly performance review meetings.
3. The District Director shall also lead in resource mobilisation, training, supervision, coordination and monitoring.
4. The district quarterly performance review meetings (family health meetings) shall be used as platforms to assess the performance of the NoP. During these meetings, the leadership at the district must ensure that all providers in the network and stakeholders participate.

CHAPTER 5: OPERATIONS OF NETWORKS OF PRACTICE

5.0 Introduction

Networks shall be managed within existing management structures at the District and Sub-District levels of the health system. Implementation of the network arrangements in the district shall require new and improved ways of working and relating among the key stakeholders. This chapter shall guide how networks and external stakeholders collaborate to fully operationalise a network.



5.1 Functions of a Network

Networks shall perform the following three key functions:

5.1.1 Service delivery

1. Provide clinical and population-based services such as health promotion, disease prevention, curative, rehabilitative, palliative, pre-referral referral and emergency care.
2. Provision of Reproductive, Maternal, New-born, Child, Adolescent Health, and Nutrition (RMNCAHN).

1. Maternal and New-born (including EmONC)
2. Child Health and Nutrition
3. Adolescent health services and interventions
4. Family planning services
5. Services and interventions for women's and men's health including rehabilitation, Geriatrics care, physiotherapy, palliative care and care for Persons Living with Disabilities (PLWD).
6. Prevention, control and management of communicable diseases and risk factors such as Health promotion and prevention including vaccination.
7. Prevention, control and management of non-communicable diseases and mental health conditions and risk factors
8. Prevention and management of public health emergencies
9. Provision of out-patient Clinical and Emergency services
10. The mode of delivery of services shall be through in-patient and out-patient care, chronic care, home visits, the use of telemedicine modalities and outreaches. (Ref: Ghana's UHC Essential Health Services Package)

5.1.2 Referral Management Systems

Efficient referral systems promote early detection, reporting, appropriate care in transit and timely arrival for definitive care. The objective of referral is to have access to the appropriate care needed in a timely manner. In this regard, the NoP shall:

1. Use the National Referral Policy to train and build the capacity of providers to improve the referral and feedback system.

2. Keep an updated telephone directory monthly.
3. Establish an active referral committee to facilitate referrals.
4. Reduce the delays in referrals by reducing inappropriate referrals and facilitating timely referrals by efficient coordination between referring facilities, receiving facilities and other stakeholders.
5. Collaborate effectively with the NAS within respective Districts and the Community Emergency Transport Systems (CETS) to expedite the referral process.
6. Collaborate with the District Hospital to facilitate the referrals and feedback through the use of telemedicine and other referral communication platforms e.g., WhatsApp in line with approved guidelines.

5.1.3 Organisation and Management

1. Operate within the existing administrative and management structures.
2. Adopt appropriate strategies for data management and utilisation for informed decision-making.
3. Mobilise and maximise the use of available resources.
4. Provide technical guidance and support to each other.

Effective organisation and adhering to administrative processes are key to the effective running of NoP.
The networks shall:

1. Conduct monthly network committee meetings for:
1. Financial management including Planning and Budgeting, Book-keeping and Audit
2. Procurement and supply chain management
3. NHIS claims vetting
4. Review of NHIS vetting reports
5. Total Quality Management to identify and close performance gaps
6. Data validation and reporting
7. Conduct monthly clinical meetings to measure the rational use of medicines, provide updates on case management and review morbidities and mortalities.
8. Conduct Quarterly performance review meetings.
9. Organise quarterly community durbars to provide and seek community feedback.
10. Undertake quarterly Sub-District supportive supervision tailored to the needs of the NoP.
11. Hold regular information sharing sessions using in-person and/or digital modalities.
12. Conduct In-service training activities to build the capacity and competence of staff of the NoP.
13. Institutionalise Peer-to-peer mentorship within the NoP.
14. Continuously engage and sensitise community stakeholders on UHC policy and NoP implementation guidelines.

(Proposed list of activities by level provided in Annex V).

5.2 Financing and Payments

1. Improve NHIS claims processing through vetting of claims before monthly submission.
2. Review vetting reports and put in corrective measures to minimise claims deductions/adjustments.
3. Institute financial control measures through good bookkeeping and quarterly audits.
4. Collaborate with communities and the NHIA to increase NHIS enrolment through regular community engagements e.g., durbars, town hall meetings, information centres, etc. to help ensure no community member is left behind in healthcare accessibility.
5. Collaborate financially with stakeholders within the networks and adopt pooled-resources approach to provide services where feasible.
6. Procure drugs and supplies in bulk in order to enjoy economies of scale and create efficiencies in procurement and supply chain management.
7. The Framework Contract Agreement (FCA) approach shall be adopted on behalf of NoP by Sub-

District heads and District Directorates that have NoP supervisory roles.

8. Work in harmony and not in competition to avoid unhealthy rivalry among themselves.

5.2.1 Financial Arrangements and Management

Financial Management of NoP shall be in line with existing public financial management legislations: Public Financial Management (PFM) Act 2016, Act 921, PFM Regulations 2019, L.I. 2378, the MoH Accounting, Treasury and Financial (ATF) Rules and Instructions and the Sub-District Management Manual with specific reference to the Module on Health Centres financial arrangement in the ATF.

D1. General Arrangements

1. Services rendered by a network member shall be exclusively submitted for claims payments in the name of the network member involved and Payments shall be made directly to that facility.
2. Where services rendered to clients cut across more than one network facility, each facility shall submit claims in respect of the portion of services rendered for reimbursement.
3. All funds and donations given to individual NoP facilities shall remain as assets of the facility involved.
4. Dispute resolutions on financial inflows or outflows shall be managed by the SDHMT and the DHMT.

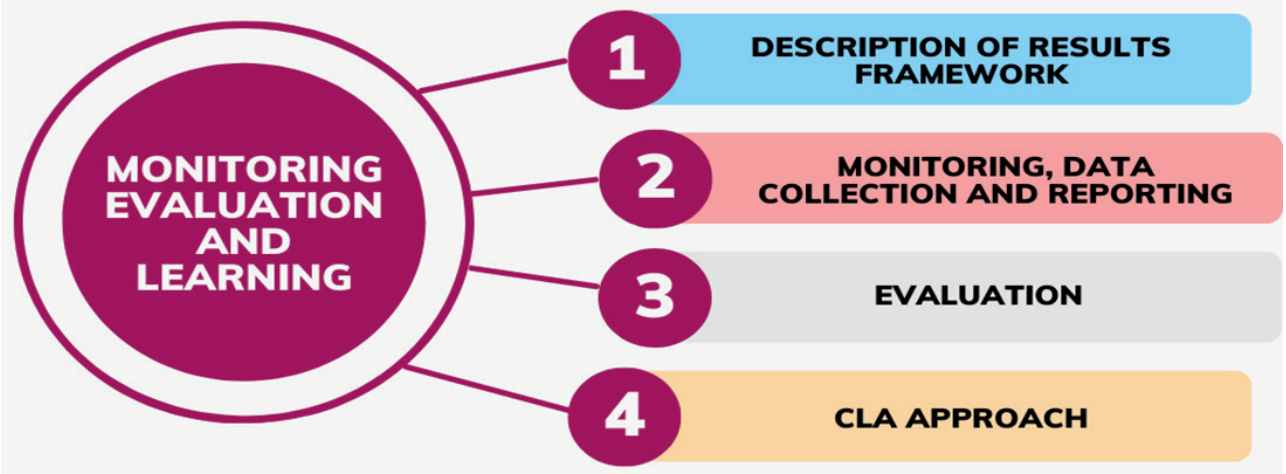
D2. Funding NoP Activities

1. The NoP shall have in place agreed annual plans and budget.
2. Activities of the NoP shall be in accordance with the agreed work plan and budget.
3. Funding for NoP activities may be by contributions by facilities in the NoP, GoG allocations, Health Development partners and donations.
4. Each facility in the NoP shall contribute an agreed amount quarterly into a designated account.
5. The NoP shall settle all overhead costs of as per the agreed/approved budget.
6. Where resources are donated for the purpose of network activities, they shall be applied according to the budget or for agreed activities/projects.
7. Where resources are donated to the NoP for allocation to network facilities, they shall be distributed to individual facilities of the NoP based on an agreed resource allocation criteria determined by the NoP or per the donor's allocation list.
8. Where a member facility requires the services of professionals outside agreed work plan and budget, the beneficiary facility shall bear the full cost.
9. There shall be quarterly audit of NoP operations.
10. The SDHMT shall ensure audit recommendations are implemented.

CHAPTER 6: MONITORING EVALUATION AND LEARNING

6.0 Introduction

Monitoring, Evaluation and Learning are to primarily track the progress of activities, performance and promote learning to achieve the expected results of the NoP. The existing routine monitoring and supportive supervision systems including facility-level peer reviews, regional and district-level reviews and holistic assessments shall be the platforms for monitoring the performance of the NoP. The Monitoring and Evaluation shall be based on the result areas defined in the Result Framework.

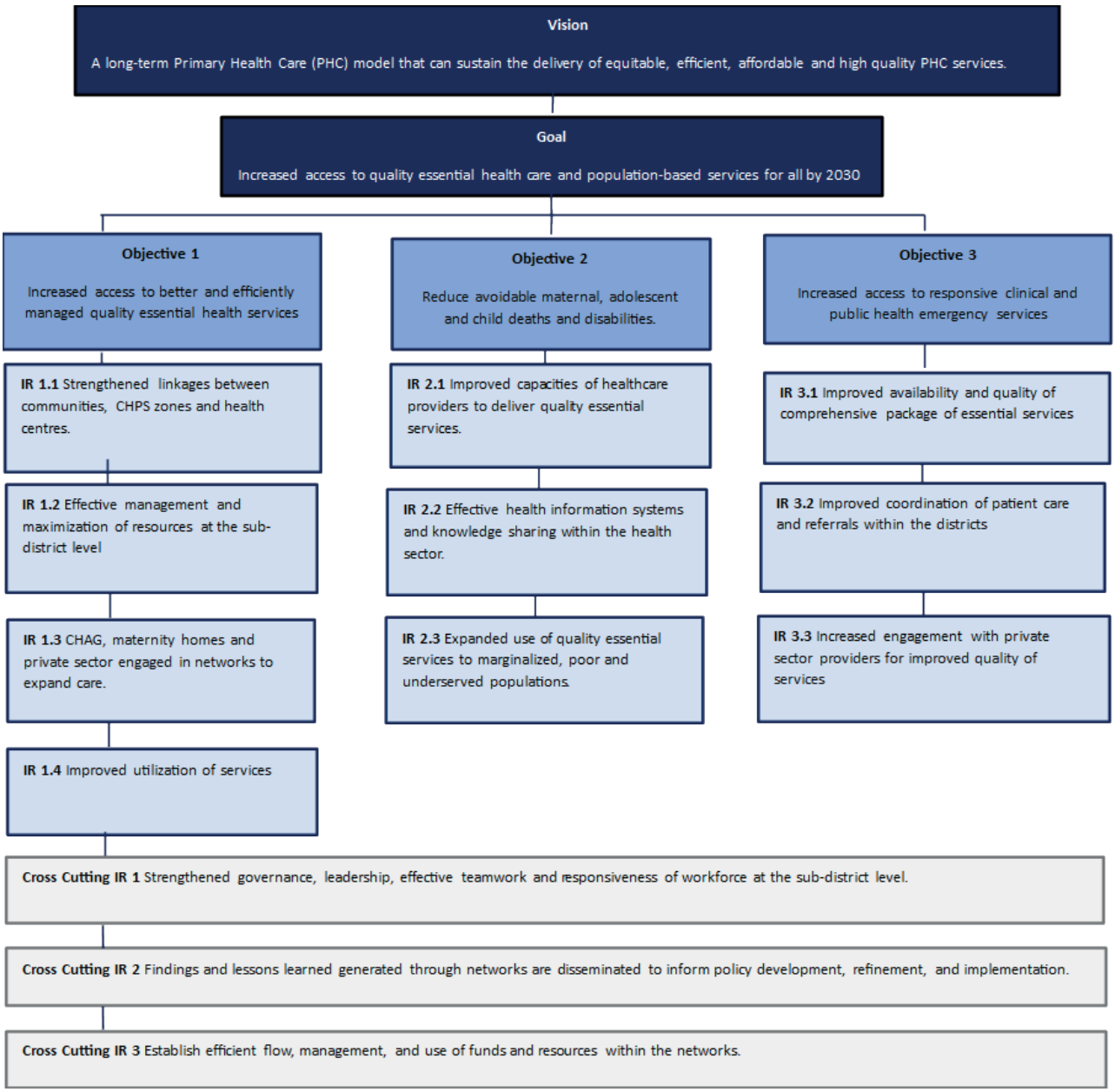


6.1 Description of Result Framework

The Result Framework is the management tool for tracking the performance of the Networks of Practice. It emphasises results at different operational levels in relation to the networks' formation, operations, and management.

It shows the objectives for the networks and the corresponding intermediate results for each objective that leads to the achievement of the ultimate goal. The NoP results framework is depicted in figure 3.

Figure 3


Vision
A long-term Primary Health Care (PHC) model that can sustain the delivery of equitable, efficient, affordable and high quality PHC services.
Goal
Increased access to quality essential health care and population-based services for all by 2030
Objective 1
Increased access to better and efficiently managed quality essential health services
Objective 2
Reduce avoidable maternal, adolescent and child deaths and disabilities.
Objective 3
Increased access to responsive clinical and public health emergency services
IR 1.1 Strengthened linkages between communities, CHPS zones and health centres.
IR 1.2 Effective management and maximization of resources at the sub-district level
IR 1.3 CHAG, maternity homes and private sector engaged in networks to expand care.
IR 1.4 Improved utilization of services
IR 2.1 Improved capacities of healthcare providers to deliver quality essential services.
IR 2.2 Effective health information systems and knowledge sharing within the health sector.
IR 2.3 Expanded use of quality essential services to marginalized, poor and underserved populations.
IR 3.1 Improved availability and quality of comprehensive package of essential services
IR 3.2 Improved coordination of patient care and referrals within the districts
IR 3.3 Increased engagement with private sector providers for improved quality of services
Cross Cutting IR 1 Strengthened governance, leadership, effective teamwork and responsiveness of workforce at the sub-district level.
Cross Cutting IR 2 Findings and lessons learned generated through networks are disseminated to inform policy development, refinement, and implementation.
Cross Cutting IR 3 Establish efficient flow, management, and use of funds and resources within the networks.

6.2 Monitoring, Data Collection and Reporting

Monitoring of the NoP shall be integrated and performed as a process to provide information to GHS and stakeholders to assess NoP results and impact. In addition to measuring the holistic assessment indicators, the Results Framework shall be measured with the indicators established for the objectives and intermediate objectives for NoP. See Table 3 below.

Table 3: Indicator Performance Matrix

Indicator #	Performance Indicator	Base Year	Baseline Value	Annual Target	Performance	Reporting	Data Source
Objective 1: Universal access to better and efficiently managed quality health services							
1.1	NHIA rejection rate	2022				Quarterly	Vetting report
1.2	Proportion of mothers receiving postnatal care (PNC) within 48 hours from birth	2022				Quarterly	DHIMS II
1.3	Percentage of ANC clients making 4th ANC visit.	2022				Quarterly	DHIMS II
1.4	Percentage skilled delivery	2022				Quarterly	DHIMS II
1.5	Total OPD Attendance	2022				Quarterly	DHIMS II
1.6	Percentage of monthly NoP planning meetings held.	2022				Quarterly	Meeting reports
1.7	Proportion of clients who are insured	2022				Quarterly	DHIMS II
1.8	Proportion of Adolescents accessing Sexual and Reproductive Health Service	2022				Quarterly	DHIMS II
1.9	Percentage availability of tracer medicines (ref. Annex)	2022				Quarterly	DHIMS II
1.10	Proportion of networked facilities that have a Total Assessment Score of 95% or above (green) at least one quarter in the year	2022				Quarterly	Community Scorecard (Total Assessment Score)
1.11	Proportion of non-GHS facilities that are part of a network disaggregated by facility ownership and type	2022				Quarterly	DHIMS II
1.12	Number of joint meetings or workshops organized between government and private healthcare providers disaggregated by organiser: government and private.	2022				Yearly	Meeting/ Workshop reports (Design a summary form in DHIMS)

Indicator #	Performance Indicator	Base Year	Baseline Value	Annual Target	Performance	Reporting	Data Source
1.13	Number of private facilities within a sub-district that join Networks	2022				Quarterly	DHIMS II
1.14	Family planning Acceptor rate (SDG)	2022				Quarterly	DHIMS II
1.15	Percentage of ANC coverage within Networks	2022				Quarterly	DHIMS II
1.16	Percentage of babies breastfeeding within 1 hour after delivery	2022				Quarterly	DHIMS II
1.17	Completeness of reporting by health facilities	2022				Quarterly	DHIMS II
1.18	Number of mother-baby pairs discharged	2022				Quarterly	DHIMS II
	Objective 2: Reduce avoidable maternal, adolescent and child deaths and disabilities						
2.1	Proportion of Pregnant women receiving IPT3	2022				Quarterly	DHIMS II
2.2	Percentage of children receiving Penta 1 vaccination	2022				Quarterly	DHIMS II
2.3	Percentage of children receiving Penta 3 vaccination	2022				Quarterly	DHIMS II
2.4	Incidence rate of hypertension (using OPD as proxy)	2022				Quarterly	DHIMS II
2.5	Incidence rate of diabetes (using OPD as proxy)	2022				Quarterly	DHIMS II
2.6	Number of maternal deaths	2022				Quarterly	DHIMS II
2.7	Proportion of children U5 with severe acute malnutrition	2022				Quarterly	DHIMS II
2.8	Neonatal mortality rate	2022				Quarterly	DHIMS II
2.9	Stillbirth rate 2022					Quarterly	DHIMS II
3.0	Number of Mother/Baby pair receiving quality BEmONC Services (Appendix)	2022				Quarterly	Facility Delivery Register
	Objective 3: Increase access to responsive clinical and public health emergency services						
3.1	Proportion of referrals with feedback	2022				Quarterly	Facility Register
3.2	Proportion of attempted suicide	2022				Quarterly	DHIMS II
3.3	Incidence of depression	2022				Quarterly	DHIMS II

6.2.1 Data Repository and Reporting

The main sources for data collection, reporting and performance appraisal systems, which include DHIMS II, E-Tracker, Scorecard, GhiLMIS, HRIMS, LHIMS and GIFMIS shall continue to serve as the sources of quantitative data for decision-making.

6.3 Evaluation

The evaluation of the Network of Practice (NoP) model in the Ghana Health Service (GHS) shall consider several key factors to assess its effectiveness and impact. The NoP model is a collaborative approach that also aims to improve knowledge sharing, learning and innovation within the Service. To evaluate this model, the following aspects shall be taken into account:

1. **Objectives and Goals:** The evaluation shall start by clearly defining the objectives and goals of the NoP model. This includes understanding the intended outcomes, such as improved communication, enhanced problem-solving capabilities, increased knowledge transfer and better decision-making processes within the Networks.

2. **Structure and Governance:** The evaluation shall examine the structure and governance mechanisms of the NoP model. This includes assessing how the network is organised, how members are selected or appointed, and how decision-making processes are facilitated. Understanding the roles and responsibilities of different stakeholders within the network is crucial for evaluating its effectiveness.

3. **Membership and Participation:** Evaluating the NoP model requires an assessment of membership and participation dynamics. This involves examining who is involved in the network, their level of engagement, and their contributions to knowledge sharing and collaboration. It is important to determine if there is diversity in terms of professional backgrounds, expertise and geographical representation among network members.

4. **Communication and Knowledge Sharing:** An evaluation of the NoP model shall focus on communication channels and knowledge sharing mechanisms within the network. This includes assessing the effectiveness of platforms used for information exchange, such as the use of telemedicine, online forums, workshops, conferences, or webinars. Evaluators shall also consider whether these channels facilitate timely and relevant information dissemination.

5. **Capacity Building:** The evaluation shall explore how the NoP model supports capacity building efforts within the GHS. This includes assessing whether members have access to training opportunities, mentorship programs, or resources that enhance their skills and competencies. Evaluators shall also examine the extent to which the NoP model promotes continuous learning and professional development.

6. **Collaboration and Innovation:** Evaluating the NoP model requires an assessment of its impact on collaboration and innovation within the GHS. This involves examining whether the network facilitates interdisciplinary collaboration, encourages the exchange of innovative ideas and supports the implementation of evidence-based practices. Evaluators shall also consider whether the NoP model has led to tangible improvements in health service delivery or health outcomes.

7. **Monitoring and Evaluation Mechanisms:** The evaluation shall assess the monitoring and evaluation mechanisms in place to track the progress and impact of the NoP model. This includes examining how data is collected, analysed and reported within the network. Evaluators shall also consider whether there are feedback loops that allow for continuous improvement based on findings from the evaluation.

8. **Sustainability:** Finally, evaluating the NoP model requires an assessment of its sustainability. This involves examining whether the network has a long-term strategic plan, financial resources and institutional support to ensure its continuity. Evaluators shall also consider whether there are mechanisms in place to address challenges or barriers that may hinder the sustainability of the NoP model.

There shall be evaluations every 4 years, however a mid-term review shall be conducted 2 years after implementation to track progress, identify challenges and document the lessons learnt for reviewing the NoP design and implementation strategies. The (2022) Regional Performance Assessment report shall serve as the baseline.

6.4 Collaborating, Learning, and Adapting (CLA) Approach

GHS shall apply the CLA approach as a continuous process by engaging and collaborating with internal and external stakeholders in analysing and interpreting information. It includes asking relevant questions about what is working or not and why, exploring challenges and failures, experimenting with new approaches, conducting research and information gathering. Performance reviews, assessments, coaching and mentoring, exchange visits and evaluation reports shall be harnessed to promote learning, peer collaboration, bridge knowledge gaps and generate value-added evidence for NoP implementation.

The Ghana Health Service in collaboration with the Ministry of Health shall incorporate the NoP concept into the curriculum of the Health Training Institutions.

6.4.1 DHIMS II NoP Design Configuration

The DHIMS II database shall be configured to allow easy identification of facilities that are within the network as a unit. This is to enhance the measurement of the performance of the networks on their service delivery statistics. Figure 4 illustrates the place of networks in the hierarchy of reporting and data analysis. All registers and reporting forms in DHIMS II shall remain unchanged except where required.

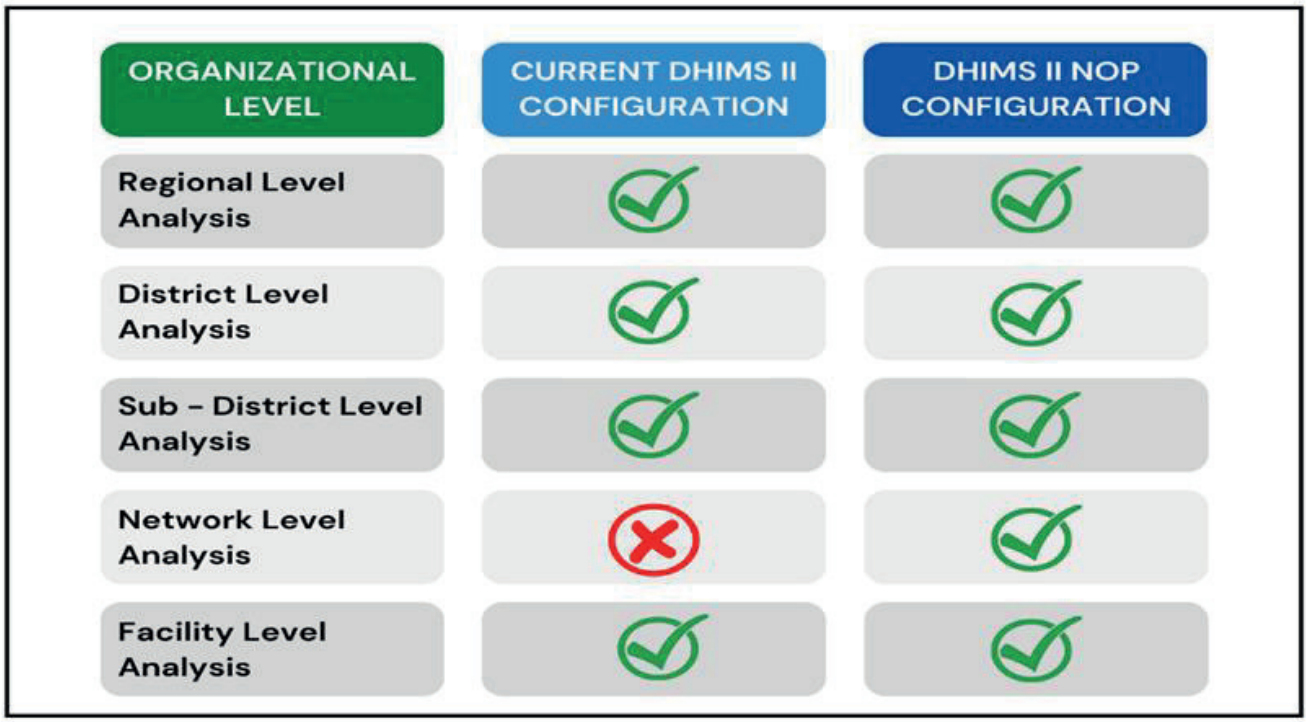


Figure 5: Organisational level comparison between GHS-DHIMS II and NoP Tracker

6.5 Methodology

1. The Networks of Practice Assessment tool provides a framework for comprehensively assessing the performance of all model health centres holistically on Disbursement Linked Indicators (DLIs).
2. It is a peer review process that provides opportunity for knowledge and experience sharing.
3. It makes use of various tools (instruments) to determine performance of the model health centres towards the achievement of set objectives.

6.5.1 Process

1. It involves data extraction from DHIMS2.
2. Review of key activity reports
3. Review of agreed checklist and registers

4. Observations will be made at the facilities.
5. Interaction with service providers

Objectives	Strategic Objectives	Indicators and milestone	Numerical value
Objective 1	Universal access to better & efficiently managed quality healthcare services	22 Indicators	-2, -1, 0 or +1, +2
Objective 2	Reduce avoidable maternal, adolescent & child deaths and disabilities	7 indicators	-2, -1, 0 or +1, +2
Objective 3	Increase access to responsive clinical and public health emergency services	3 indicators	-2, -1, 0 or +1, +2

6.5.2 Methodology Scoring

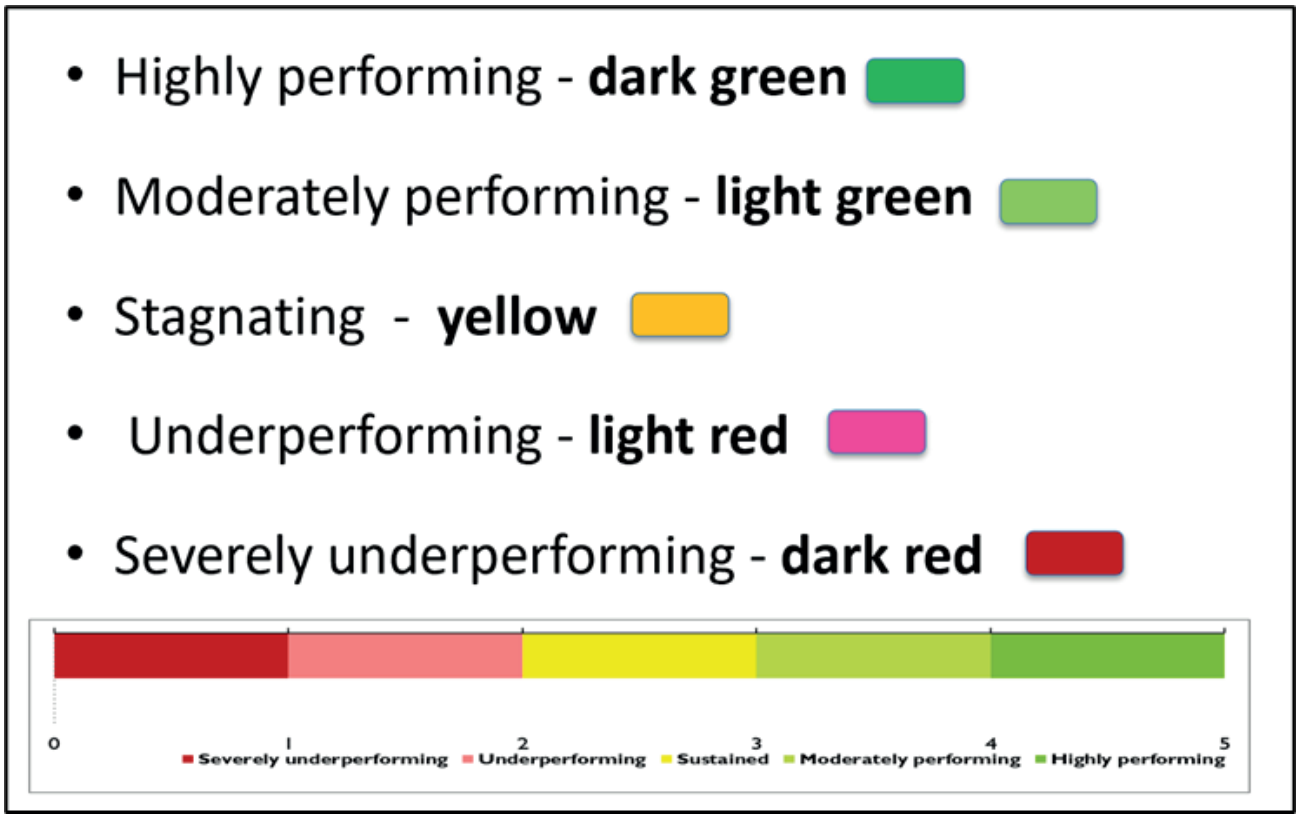


Table 4: Indicator Performance Matrix

Indicator #	Performance Indicator	Base year	Baseline Value	Annual Target	Performance	Reporting	Data Sources
1	Number of specified policy documents available at the hubs	2022				Annually	Number of policy documents Assessment report from the independent verification team
2	Number of Health Centres at level 3 maturity	2022				Annually	Number of level 3 Health Centres Assessment report from the independent verification team
3	Number of facilities within the NoP that have a Total Assessment score of at least 95% (green) in at least one quarter of the year	2022				Annually/Quarterly Web platform	Community Scorecard
4	Percentage of Networks with Physician Assistants					Quarterly	HRIMS/ DHIMS II
5	Proportion of facilities within a network with midwives.					Quarterly	HRIMS/ DHIMS II
6	Number of NoP that receive at least one support supervision	2022				Annually	
7	Number of District Health Directorates with GIFMIS capacity	2022				Annually	Number of District Health Directorates with GIFMIS capacity

CHAPTER 7: SUSTAINABILITY FOR NETWORK OF PRACTICE

7.0 Introduction

Sustainability of the NoP strategy shall require an integrated approach positioned within the existing systems and structures of the health sector and shall be maintained continuously over time as part of health system strengthening. Advocacy, ownership, resource mobilisation and accountability are key components for the sustainability of the networks of practice. The leadership at the various levels are expected to collaborate with stakeholders to undertake measures to promote and mobilise resources for NoP implementation.

7.1 Advocacy

The objectives of the advocacy strategy are to:

1. Sensitise stakeholders on the institutional and implementation arrangements of the strategy.
2. Obtain ownership and buy-in from all stakeholders for smooth implementation of the strategy.
3. Inform and assure the public of the government's commitment to achieving Universal Health Coverage (UHC).
4. Share the roles and responsibilities of the partners.
5. Mobilise and empower communities to ensure participation and ownership in the concept of NoP and Model Health Centres
6. Develop appropriate messages and identify channels to communicate the potential benefits of the NoP for quality health service delivery. (A communication strategy will be developed for effective advocacy. (All levels shall be required to use various channels and platforms in the communication strategy to reach the target audience and stakeholders.)

The concept of engaging in advocacy towards the sustainability of the NoP shall include activities such as community entry, stakeholder mapping and stakeholder engagement.
The discharge of advocacy role is carried out at different levels namely: community, district, regional and national levels.

At the community level, the Sub-District Management Team in collaboration with the Community Health

Management Committee (CHMC) play a pivotal role in ensuring advocacy with all stakeholders such as traditional authority, religious leaders, opinion leaders, market queens, youth leaders etc.

At the district level, the DHMT in collaboration with the DHC shall lead the advocacy campaign with relevant district stakeholders.

At the regional level, the RHMT with the support of the RHC shall ensure that advocacy is carried out with all relevant regional level stakeholders.

At the national level, the GHS Council in collaboration with the executive management of the GHS shall champion advocacy at the highest level as far as NoP sustainability and operability are concerned.

7.2 Ownership

The continuous sustenance of NoP shall heavily be dependent on how communities own the concept. The concept of Community ownership shall include ensuring that resources in the custody of the NoP are safeguarded and prudently utilised.

7.3 Resource Mobilisation

The resource mobilisation process shall involve eliciting support from health development partners, local government and community stakeholders. There are also existing traditional revenue inflows from Internally Generated Funds (IGF) and Government of Ghana support for the health sector on which NoP shall leverage for sustainability.

7.4 Accountability

To guarantee the continuous operation of NoP there is the need to ensure that there is accountability at the various facility levels and across networks for all resources entrusted to them to manage the NoP.
The accountability measures shall include regular and routine audit, regular problematic reporting, financial reporting and undertaking stakeholder review meeting.

7.5 Sustainability Measures

The table below provides information on specific sustainability measures for the NoP strategy across the various levels of implementation and how often they need to be undertaken.

Table 5: Sustainability Measures for Networks of Practice

SUSTAINANBLE MEASURES								
MEASURES	**NATIONAL**	**REGIONAL**	**DISTRICT**	**SUB**	**COMM DISTRICT**	**CHAG, QG & PRIVATE**	**DP**	**RATE**
Networks of Practice shall be included in the Performance Appraisals of Regional Directors	DG							Annually
Institute implementation research for documentation and learning.	RDD	X	X	X		X	X	Annually
NoP shall be included in the Performance Appraisals of Managers at each level	X	X	X	X				Annually
The MoHC shall be adequately resourced to function effectively.	X	X	X			X	X	Recurrent
Provide training for DHMT and SDHMT on team building		X	X			X	X	Recurrent
Continuous training needs assessment and organisation of in-service training for DHMT, SDHMT, and all cadre of staff within the networks	X	X	X			X	X	Bi-annually, annually
Formal assignment of Sub-District leaders to create more leadership accountability and responsibility.			X					Recurrent
Organise periodic family health meetings with all stakeholders			X	X		X		Monthly
Integration of the NoP concept into existing curriculums in training institutions.	DG							N/A

MEASURES	NATIONAL	REGIONAL	DISTRICT	SUB	COMM DISTRICT	CHAG, QG & PRIVATE	DP	RATE
Detection, Inclusion, and Recognition of all non-GHS stakeholders within the NoP in decision-making and effective management of the NoP.		X	X			X	X	Annually
Community ownership and involvement in decision-making.			X	X	X	X	X	Annually
Negotiate for NoP implementation activities to be included in the plans and activities of all relevant stakeholders such as Development Partners and Local Government to solicit support.	DG							Annually
Develop proposals for mobilising funds for NoP Implementation.	PPMED	X	X					Annually
Collaborate effectively with relevant stakeholders (District Assemblies, MP, Philanthropists, CSOs, DPs) to mobilize resources to support the NoP.		X	X				X	Annually
Provision of resources (support) from MP common fund for NoP implementation			X					Annually
Dialogue with community stakeholders to mobilise material and financial resources to support the NoP			X	X				Annually
Collaborate with CHMCs to galvanize logistics from communities to support NoP				X	X	X		Annually

Sustaining Programme effort

As part of efforts to sustain gains made at filling existing gaps, it is important to hold stakeholder dialogue at National, Regional, District and Sub-district levels, ensuring stakeholder participation in drawing up specific plans that meet local context.

ANNEX

ANNEX I: Staffing Norms for Health Centres

STAFF CATEGORY	WORKLOAD CATEGORY A		WORKLOAD CATEGORY B		REMARKS
	Minimum	Maximum	Minimum	Maximum	
Finance Officer	0	0	1	2	
Accounts Officer	1	1	1	2	
Biostatistics Assistant/Technical Assistant (Medical Records)	1	2	2	3	
Physician Assistant (Medical)	1	2	3	4	
Registered General Nurse	3	6	7	13	
Enrolled Nurse	3	5	5	8	
Midwife	2	4	4	6	
Community Health Nurse	4	8	8	12	
Registered Mental Health Nurse	1	2	2	3	
Field Technician	1	1	1	2	
Laboratory Technician	0	0	1	2	
Laboratory Assistant	1	2	2	3	
Dispensing Assistant	1	2	2	2	
Pharmacy Technician	0	1	1	2	
Storekeeper	1	1	1	2	
Technical Officer (Community Mental Health)	1	1	1	1	***Where HCs are Sub-District heads***
Driver	1	2	1	2	***Per the transport policy one driver per functional car. Where there is no car, there shall be no driver***
Technical Officer (Health Information)	1	1	1	1	***Where HCs are Sub-District heads***
Technical Officer (Disease Control)	1	1	1	1	***Where HCs are Sub-District heads***
Technical Officer (Laboratory)	1	1	1	1	
Technical Officer (Health Promotion)	1	1	1	1	***Where HCs are Sub-District heads***
Technical Officer (Nutrition)	1	1	1	1	***Where HCs are Sub-District heads***
Hospital Orderly	1	2	2	4	
Labourer	1	2	1	2	
Security Personnel	1	2	1	2	

Note: Staff categories with 'Sub-District' remarks are to be placed at Health Centre designated as the Sub-District headquarters.

ANNEX II: Tracer Drugs List

1. Tab Paracetamol 500mg
2. Syrup Paracetamol 120mg/5mls
3. Tab Folic Acid 5mg
4. Tab Multivitamin BP
5. Oral Rehydration Salt
6. Tab Metronidazole 200mg/400mg
7. Syrup Multivitamin
8. Tab Ferrous Fumarate 200mg
9. Tab Albendazole 200mg/400mg
10. Tab Mebendazole 500mg
11. Tab Diazepam 5mg/10mg
12. Injection Diazepam 10mg
13. Injection Oxytocin 10u
14. Injection ATS 1500u
15. Tab Artesunate Amodiaquine
16. Tab Artemether / Lumefantrine
17. Cap Amoxycillin 250mg/500mg
18. Tab Cotrimoxazole 480mg
19. Injection Anti-Snake Serum
20. Injection Anti Rabies Vaccine

ANNEX III: Proposal to Form a Network

LETTERHEAD

DATE

TO: REGIONAL DIRECTOR OF HEALTH SERVICE

APPROVAL TO IMPLEMENT NETWORKS OF PRACTICE XXX DISTRICT/MUNICIPAL/METROPOLITAN

The District Health Directorate [REPLACE WITH APPROPRIATE NAME] in consultation with other health providers in the district and [INSERT NAME] the District Chief Executive] have agreed to operate Networks of Practice in the xxx district.]

Xxx networks have been configured (see attached form and checklist). I am hereby seeking formal approval on behalf of the district to launch and roll out networks of practice and to request capacity-building support.
Attached to this request is the configuration of Networks in the District and Sub-District [REPLACE WITH APPROPRIATE NAME] and the profile of relevant characteristics.
Counting on your kind consideration.

Yours faithfully,

Attached:
District and Sub-District profiles with selected indicators

Cc
DISTRICT CHIEF EXECUTIVE [REPLACE WITH APPROPRIATE NAME
NHIA DISTRICT MANAGER

ANNEX IV: Formation of NoP Checklist

Activity	Status	Comment
Sensitisation/Dissemination		
District dissemination taskforce		
Sensitisation meetings with health staff		
Sensitisation meetings with communities		
Sensitisation meetings with other stakeholders		
Mapping and Assessment		
Mapping of facilities completed		
Assessment of health facilities capacity completed		
Formation of NoP		
Hub and spokes identified		
Administrative and management structures defined.		
Attach district network configuration		
Ready to launch?		

ANNEX V: Networks of Practice Profile

NETWORKS OF PRACTICE IN [NAME OF DISTRICT]
[NAME OF REGION]
NETWORK PROFILE (DATE)

Name of Network	Facilities in the Network	Type	Ownership	Credentialing Status	Lead Facility	Has PA, nurse prescriber or doctor	Number & Cadre of staff	Popn.	# Of Comm	The lead facility has an Account

ANNEX VI: Outline of Planned Activities for NoP implementation

DHD		QUARTERS			
		Q1	Q2	Q3	Q4
1.	Plan and undertake regular (quarterly) supportive supervision and mentoring to health centres and networks to reinforce network activities (ensuring participation of district NHIA and district Assembly)				
2.	Follow-on and refresher training for the Networks				
3.	Semi-annual and Annual Reviews: gather and report on information from NoP as an agenda item in district performance reviews.				

RHD		QUARTERS			
		Q1	Q2	Q3	Q4
4.	Plan and undertake regular (quarterly) Supportive Supervision of DHDs and networks				
5.	Semi-annual and Annual Reviews: gather and report on information from NoP as an agenda item in regional performance reviews.				

NATIONAL MANAGERS		QUARTERS			
		Q1	Q2	Q3	Q4
1.	Participates in selecting Supportive Supervision visits to the networks				
2.	Discusses progress and policy learnings of the NoP at the Health Care Financing Working Group Meeting				
3.	Participates in annual evaluation				
4.	Conducts implementation research on NoP				

DISTRICT HOSPITAL		QUARTERS			
		Q1	Q2	Q3	Q4
1.	Set up a WhatsApp platform (or similar) communication platform to link all network hubs and members to the district hospital, mainly for referral but also for other information and communications				
2.	Set up emergency referral contacts and teams for (i) maternity cases and (ii) other medical and surgical emergencies organised to respond 24/7				
3.	Plan and undertake regular (quarterly) clinical support and mentoring to health centres and networks, with a special focus on Physician Assistants/Doctors, Nurse Prescribers and Midwives				

DISTRICT HOSPITAL		QUARTERS
		Q1 Q2 Q3 Q4
4.	Identify gaps in clinical skills and quality of care and provide coaching, training and mentoring	
5.	Participate in district PCP Network support activities – supportive supervision and monitoring and district performance reviews	Continuous engagement on a monthly or as -needed basis

OPERATION AND MANAGEMENT ACTIVITY		MONTHS
		1 2 3 4 5 6 7 8 9 10 11 12
SUB-DISTRICT LEVEL:		
Network Hub (Health Centre, CHPS, CHAG or Private)		
6.	Form the network management committee	
7.	Convene joint planning sessions of all network members to develop joint network activity plans and quality improvement plans; then by quarterly progress reviews and updates	
8.	Convene monthly network management committee meetings to review progress in delivering the agreed PHC package of services; implementation of activity and quality improvement plans and identify gaps for action	Continuous engagement on a monthly or as-needed basis
9.	Summary financial statement/report by network Lead presented and discussed at monthly meetings	Continuous engagement on a monthly or as-needed basis
10.	Organise activities to train or brief on specific issues - NHIS claims and reimbursements; new instructions, technical areas identified for improvement	
11.	Set up Whats App or other such platforms for communication within the network and linked to the district hospital for referral and feedback	
12.	Communication – sensitisation and educational campaigns across communities	Continuous engagement on a monthly or as-needed basis
13.	Documentation – minutes of meetings, performance reports for submission to the DHD, innovations	Continuous engagement on a monthly or as-needed basis
Spokes (CHPS, Clinics, Maternity Homes, CHAG, or Private)		
14.	Providing a full set of CHPS-level services through home visits, outreach, services at the CHPS compound and community durbars	Continuous engagement on a monthly or as-needed basis
15.	Referrals to the health centre and/or district hospitals through communication platforms established.	Continuous engagement as-needed basis with tracking and monthly reviews
16.	Technical and Logistic support from the hub (Physician Assistant, nurse prescriber, doctor, and Midwife) or other CHPS through communication platforms established	Continuous engagement on an as-needed basis

Spokes (CHPS, Clinics, Maternity Homes, CHAG, or Private)		
17.	Communication – mobilise communities to (re)register with the NHIS; inform communities about access to all facilities within a network and encourage communities to first use CHPS services with assurance of facilitated referral when needed	Continuous engagement as-needed basis
18.	Participate actively in network planning and review meetings	Continuous engagement on a monthly or as-needed basis

ANNEX VII: Frequently Asked Questions (FAQs)

This is to serve as the basic presentations for all sensitisation meetings (may vary according to level and stakeholder type).

1. Why should we work as a Network?

Networks can help address gaps in capacities and supplies that an individual facility may have. In a Network, individual facilities have access to the resources available to the entire Network – including human resources, medicines and supplies. For example, a stand-alone CHPS compound with community health nurses only gains access to the expertise of larger facilities with a midwife, physician assistant, nurse prescribers and doctors. Networks also provide opportunities to better coordinate care for a referred patient and follow-up, as necessary. There are opportunities for improved financial management and hence better use of funds.

2. How would Networks (of Practice) benefit communities?

With improved capacities, access to a higher level of cadres and more resources, the networks can significantly increase the quality of care to their communities. Moreover, better-coordinated care and stronger referral systems shall help patients use essential services and have a better experience with health care.

3. I want Networks (of Practice) to be implemented in my district. Where do I begin?

The first step is to identify facilities for a Network, or, if the request is coming from a facility, to reach out to the District Director of Health Service (DDHS). The latter shall coordinate with the Regional Health Directorate (RHD), and the Ghana Health Service at the national level. This shall launch the process of setting up the Network and facilitating on boarding and orientation. Templates for letters to DDHS and RHD can be made available upon request.

4. How do Networks fit into the existing sub-district and district health systems?

The Networks perfectly align with the existing service delivery and oversight structures of the Ghana Health Service. The hub and spoke model naturally fits in the multi-layered service delivery system created by District Hospitals, Health Centres, Clinics and CHPS.

5. What is the role of a Network lead?

The lead (typically a midwife or physician assistant at a Health Centre, or a nurse prescriber or doctor at a hospital, polyclinic, or private clinic) monitors, supports and supervises Network operations, manages the Network account (with district oversight) and ensures Network members have what they need to provide services.

6. What are some activities of the Network?

Networks develop activity plans and routinely meet to review them. Activities can include joint community durbars, mobilisation and clinical outreach, immunisation visits, review and joint submission of National Health Insurance Scheme claims. The exact list shall largely depend on the priorities in your communities and districts. Members communicate through monthly meetings, WhatsApp groups and phone calls, to follow up on referrals and seek advice from each other.

7. Will I lose my clients to other Network members?

No, you shall not lose clients – on the other hand, you might be able to gain more due to improved patient experiences.

8. How much does it cost to operate a Network?

There is no extra cost to operating a Network after the initial start-up investments for training, sensitisation and monitoring have been made. In practice, Networks use existing planning, budgeting and financial man-

agement practices and guidance provided by the Ministry of Health, the Ghana Health Service and the National Health Insurance Scheme.

9. Can private facilities be involved in the Network?
Yes. For the sake of equitable access to services, the Networks in some districts shall be made up of public, Christian Health Association of Ghana (CHAG) and private facilities that coordinate care for patients. Special arrangements for sharing resources shall be made to accommodate the presence of private facilities in such Networks.

10. Who is the leader of this NoP?
The sub-district in-charge or head shall act as the NoP leader at the sub-district level.

11. How shall the NoP be governed / What are the governance structures for the NoP?
Since the networks are perfectly aligned with the existing service delivery and oversight structures, community level facilities shall therefore be supervised by the sub-district, then the sub-district shall be supervised by the district, and the district shall be supervised by the regional level and finally, GHS Headquarters shall supervise the regions.

12. If I am part of an NoP outside my original sub-district, to whom shall I report?
A facility shall always report to the head of the sub-district in which it is located. The district shall then collate all reports and submit them to the regional level for onward collation and analysis at GHS headquarters. All data reporting shall be channelled likewise as stated in the Standard Operating Procedures

13. How would data entry be done in my facility and the NoP?
Services provided and reported by a facility are transferred to the sub-district in which it is located. Analysis of data and reports by networks shall be done electronically by using a system created within the DHIMS2.

14. How shall capacity-building activities be done in this NoP?
Capacity building can be done in two ways; Sub-districts can organise training or capacity-building activities for facilities within their jurisdiction. A network can also recommend capacity-building activities for facilities within its network due to a felt need or gaps identified.

15. Shall the NoP operate a single financial account?
No. Networks shall not have a single financial account. Services that are delivered by two or more facilities are costed and reported for reimbursement by individual facilities per the kind/type of service rendered.

16. How does a facility become a MoHC?
A facility becomes a MoHC when it meets the set standards for the provision of a defined package of services. The criteria for attaining Model Health Centre status are based on many factors including HeFRA accreditation, NHIA credentialing, adequate staff requirement, provision of essential health services including the capacity to provide BEmONC services and identified core areas of public health and clinical interventions at the primary health care level.

17. What shall happen to my current HeFRA license and NHIA credentialing status if I join a network?
The license of a member of a network still holds. Members of a network shall be required at all times to ensure that their HeFRA license and NHIA credentialing status are up to date.

18. How would the NoP receive and disburse logistics?
The NoP shall receive and disburse logistics based on need and as agreed upon by the NoP committee. Logistics received by individual facilities are recorded in the asset register of the facility or member of the network.

ANNEX VIII: Medical Equipment List for CHPS Compounds

Medical Equipment List for CHPS Compound

ID NO.	DEPARTMENT	ITEM	QUANTITY
1	CHPS Compound	Baby weighing scale	2
2	CHPS Compound	Basins plastic, 14 litre	2
3	CHPS Compound	Bed linen, sets	2
4	CHPS Compound	Bedpan, stainless steel	1
5	CHPS Compound	Bedside Locker	1
6	CHPS Compound	bicycle	1
7	CHPS Compound	Bowl Stand on Castors SS with bowl	1
8	CHPS Compound	Bowls SS, 6 litres, with stand	1
9	CHPS Compound	Bulletin Board, 4'x6'	1
10	CHPS Compound	Cheatle Sterilizer forceps, 270mm with	1
11	CHPS Compound	Cold Boxes	1
12	CHPS Compound	Cooking utensils, set	1
13	CHPS Compound	Cupboard, with glass screened door	1
14	CHPS Compound	Delivery Bed with stirrups	1
15	CHPS Compound	Delivery set	2
16	CHPS Compound	Domestic bed with mattress	1
17	CHPS Compound	Dressing drum, SS	1
18	CHPS Compound	Dressing forceps, standard, straight, 300mm	1
19	CHPS Compound	Dressing scissors, straight, 180mm	1
20	CHPS Compound	Dressing Set	1
21	CHPS Compound	Examination Couch, adjustable head rest	1
23	CHPS Compound	Filing cabinet with safe	1
24	CHPS Compound	Foetal Stethoscope (Electronic)	1
25	CHPS Compound	Foetal Stethoscope (Pinard)	2
26	CHPS Compound	Gallipots, set of various sizes, Stainless Steel	1
27	CHPS Compound	Gas cooker, Table-top with cylinder	1
ID NO.	**DEPARTMENT**	**ITEM**	**QUANTITY**
28	CHPS Compound	Harrison Bowl Lifting Forceps, 300mm	1
29	CHPS Compound	Weighing scale with Height Measurement	1
30	CHPS Compound	Hospital Bed	1
31	CHPS Compound	Infant resuscitation set	1
32	CHPS Compound	Infusion stand	2
33	CHPS Compound	Implant insertion and removal set	2
34	CHPS Compound	IUD insertion and removal set	2
35	CHPS Compound	Jar without lid SS Cheatle, 100x200mm	1
36	CHPS Compound	Kidney dishes, set of various sizes, stainless steel	1
37	CHPS Compound	Large conical water jug	1
38	CHPS Compound	Lister Bandage Scissors, 180mm	1
39	CHPS Compound	Length board	1
40	CHPS Compound	MUAC Tape	1
41	CHPS Compound	Mackintosh sheets	2
42	CHPS Compound	Motor bike	2
43	CHPS Compound	Over-bed Table	1
44	CHPS Compound	Patient trolley	1
45	CHPS Compound	Pedal Dustbin, Stainless steel	3

46	CHPS Compound	Waterproof Aprons	2
47	CHPS Compound	Record Chart Holder	1
48	CHPS Compound	Screen, 4 folds, castors	1
49	CHPS Compound	Set of furniture, dining room	1
50	CHPS Compound	Set of furniture, sitting room	1
51	CHPS Compound	Snellen's Eye Chart	1
52	CHPS Compound	Solar Lamp	1
53	CHPS Compound	Sphygmomanometer, Aneroid, Big Ben	1
54	CHPS Compound	Stapler	1
55	CHPS Compound	Steam Steriliser with Gas Burner	1
56	CHPS Compound	Instrument Tray with lid	1
57	CHPS Compound	Tape measure	2
58	CHPS Compound	Adjustable stool	1
59	CHPS Compound	Stethoscope, dual head	1
ID NO.	**DEPARTMENT**	**ITEM**	**QUANTITY**
59	CHPS Compound	Dissecting Forceps, 1:2, 120mm	1
60	CHPS Compound	Stretcher, collapsible with mattress and mobile stand	1
61	CHPS Compound	Thermometers, Clinical	1
62	CHPS Compound	Tongue Depressors, packet	1
63	CHPS Compound	Towels for hand drying	3
64	CHPS Compound	Tray, instrument 14'x10'x2' stainless steel	1
65	CHPS Compound	Tray, instrument, SS, with lid, 12.5'x8'x2.75'	1
66	CHPS Compound	Trolley, instrument, SS, shelves 24'x18'x34'	1
67	CHPS Compound	Vaccine Carrier	2
68	CHPS Compound	Vaccine Refrigerator	1
69	CHPS Compound	Wall Clock	1
70	CHPS Compound	Weighing Scale, Adult, Bathroom type, metric	1
71	CHPS Compound	Weighing Scale, Baby's stand-alone, Metric	1
72	CHPS Compound	Weighing Scale, Hanging	1
73	CHPS Compound	Wheelchair	1
74	CHPS Compound	Length board	1
75	CHPS Compound	Mid-Arm circumference tapes	5
76	CHPS Compound	Bowls	1 set
77	CHPS Compound	Kitchen Knives	1 set
78	CHPS Compound	Cutlery	1 set
79	CHPS Compound	Sieves assorted	1 set
80	CHPS Compound	Handy measures	1 set
81	CHPS Compound	Food models	1 set

ANNEX IX: Medical Equipment List for Model Health Centre

FUNCTIONAL AREA	Item Description	QUANTITY				
		Level 1	Level 2	Level 3	Level 4	Level 5
Nurses station	Nurses station desk	**1**	**1**	**1**	**1**	**1**
Nurses station	Swivel chair	**2**	**2**	**2**	**2**	**2**
Nurses station	Three-in-one waiting area seat	**1**	**1**	**2**	**2**	**2**
Nurses station	Client chair	**1**	**1**	**1**	**1**	**1**
Nurses station	Wheel chair	**1**	**1**	**1**	**1**	**1**
Nurses station	Patient trolley	**1**	**1**	**1**	**1**	**1**
Nurses station	Non-contact thermometer	**1**	**1**	**1**	**1**	**1**
Nurses station	Weighing scale with height measure	**1**	**1**	**1**	**1**	**1**
Nurses station	TCBD BP apparatus	**0**	**0**	**1**	**1**	**1**
Nurses station	Desk top BP apparatus	**1**	**1**	**1**	**1**	**1**
Nurses station	Ward screen-4 fold	**1**	**1**	**1**	**1**	**1**
Nurses station	Stethoscope	**1**	**1**	**1**	**1**	**1**
Consulting room	Consulting room table with drawers	**1**	**1**	**2**	**2**	**2**
Consulting room	Swivel chair with castors	**2**	**2**	**2**	**2**	**2**
Consulting room	Client chair	**2**	**2**	**2**	**2**	**2**
Consulting room	Non-contact thermometer	**2**	**2**	**2**	**2**	**2**
Consulting room	Wall-mounted diagnostic set	**1**	**1**	**2**	**2**	**2**
Consulting room	Stethoscope	**2**	**2**	**2**	**2**	**2**
Consulting room	BP apparatus-desk top	**1**	**1**	**1**	**1**	**1**
Consulting room	Examination couch	**2**	**2**	**2**	**2**	**2**
Consulting room	Patient step	**2**	**2**	**2**	**2**	**2**
Consulting room	Laptop-office equipment set	**1**	**1**	**1**	**1**	**1**
Consulting room	Pedal dustbin	**1**	**1**	**1**	**1**	**1**
Consulting room	X-ray viewer	**2**	**2**	**2**	**2**	**2**
ANC	Patient step	**1**	**1**	**1**	**1**	**1**
ANC	Ward screen-4 fold	**1**	**1**	**1**	**1**	**1**
ANC	examination couch	**1**	**1**	**1**	**1**	**1**
ANC	TCBD BP apparatus	**1**	**1**	**1**	**1**	**1**
ANC	Weighing scale with height measure	**1**	**1**	**1**	**1**	**1**
ANC	Fetal heart detector	**1**	**1**	**1**	**1**	**1**
ANC	Pinard stethoscope	**1**	**1**	**1**	**1**	**1**
ANC	Pedal dustbin	**1**	**1**	**1**	**1**	**1**
ANC	Portable ultrasound	**1**	**1**	**1**	**1**	**1**
RCH	Examination couch	**1**	**1**	**1**	**1**	**1**
RCH	MVA	**4**	**4**	**4**	**4**	**4**
RCH	Examination lamp	**1**	**1**	**1**	**1**	**1**
RCH	Gynaecological examination set	**2**	**2**	**2**	**2**	**2**
RCH	Vaccine carrier	**4**	**4**	**4**	**4**	**4**
Treatment room	Examination couch	**1**	**1**	**1**	**1**	**1**
Treatment room	Patient step	**1**	**1**	**1**	**1**	**1**
Treatment room	Ward screen-4 fold	**1**	**1**	**1**	**1**	**1**
Treatment room	Examination lamp	**1**	**1**	**1**	**1**	**1**
Treatment room	Minor surgical instrument set	**1**	**1**	**2**	**2**	**2**
Treatment room	Waste bin set	**1**	**1**	**1**	**1**	**1**
Detention room	Patient trolley with accessories	**4**	**4**	**4**	**4**	**4**
Detention room	2 oxygen cylinder manifold	**1**	**1**	**1**	**1**	**1**

FUNCTIONAL AREA	Item Description	QUANTITY				
		Level 1	Level 2	Level 3	Level 4	Level 5
Detention room	Nebulizer	**2**	**2**	**2**	**2**	**2**
Waiting area	Three-in-one waiting area seat	**2**	**2**	**2**	**2**	**2**
IPC	Mop bucket set	**1**	**1**	**1**	**1**	**1**
IPC	Chlorine generating set	**2**	**2**	**2**	**2**	**2**
IPC	Tabletop autoclave	**1**	**1**	**1**	**1**	**1**
IPC	Boiling sterilizer	**1**	**1**	**1**	**1**	**1**
Labour ward	Delivery bed	**1**	**1**	**2**	**2**	**2**
Labour ward	Examination lamp	**1**	**1**	**1**	**1**	**1**
Labour ward	Cardiotocograph	**0**	**0**	**1**	**1**	**1**
Labour ward	Fetal heart detector	**1**	**1**	**1**	**1**	**1**
Labour ward	Resuscitation set adult	**1**	**1**	**1**	**1**	**1**
Labour ward	Resuscitation set infant	**1**	**1**	**1**	**1**	**1**
Labour ward	Infusion device-volumetric	**1**	**1**	**1**	**1**	**1**
Labour ward	Single use 4-in-one cord clamp	**50**	**50**	**50**	**50**	**50**
Labour ward	Ultrasound scanner with printer	**0**	**0**	**1**	**1**	**1**
Mobile x-ray		**0**	**0**	**0**	**1**	**1**
Communication	Intra-Inter-network communication system	**1**	**1**	**1**	**1**	**1**
Laboratory	HB spot check	**2**	**2**	**2**	**2**	**2**
Laboratory	Glucometer	**2**	**2**	**2**	**2**	**2**
Laboratory	Urine spot check	**2**	**2**	**2**	**2**	**2**
Laboratory	Haematology analyser	**0**	**0**	**0**	**0**	**1**
Laboratory	Glassware set	**1**	**1**	**1**	**1**	**1**
Laboratory	Chemistry analyser	**0**	**0**	**0**	**0**	**1**
Pharmacy	Pharmacy fridge	**0**	**0**	**1**	**1**	**1**
Pharmacy	Vaccine fridge	**1**	**1**	**1**	**1**	**1**
Power back up	Solar power system	**1**	**1**	**1**	**1**	**1**

ANNEX X: BEmONC Availability and Readiness Data Entry Tool

BEmONC AVAILABILITY AND READINESS DATA ENTRY TOOL

Area	Question	Options
Human Resource	1. How many practicing midwives are in this facility?	1 midwife
		2 midwives
		3 midwives
		4 or more midwives
	2. How many practicing midwives are trained in Essential Newborn Care (ENC) in the past 2 years?	1 midwife
		2 midwives
		3 midwives
		4 or more midwives
	3. How many have been trained in Life Saving Skills (LSS) /Safe Motherhood (SM) in the past 2years?	1 midwife
		2 midwives
		3 midwives
		4 or more midwives
Signal Functions	4. Have you administered uterotonics (oxytocics) in the past 3 months?	Yes - 1
		No - 0
	5. Have you administered parenteral antibiotics in the past 3 months?	Yes - 1
		No - 0
	6. Have you administered parenteral anticonvulsants (Magnesiun sulphate in the past three months?	Yes - 1
		No - 0
	7. Have you performed manual removal of placenta in the past 3 months?	Yes - 1
		No - 0
	8. Have you performed instrumental removal of retained products in the past 3 months?	Yes - 1
		No - 0
	9. Have you performed instrumental /vacuum extraction/ assisted vaginal delivery in the past 3 months?	Yes - 1
		No - 0
	10. Have you performed neonatal resuscitation with bag and mask in the past 3 months?	Yes - 1
		No - 0
	11. Have you administered parenteral antibiotics to newborns in the past 3 months?	Yes - 1
		No - 0
	12. Have you administered oxygen therapy with pulse oximeter monitoring to newborns in the past 3 months?	Yes - 1
		No - 0
	13. Have you provided immediate Kangaroo Mother Care in the past 3 months?	Yes - 1
		No - 0
	14. Have you provided early initiation and support for exclusive breast feeding?	Yes - 1
		No - 0
Commodities and Supplies	15. Has the facility been stocked out of any one of the following categories (Ref. EmONC Model 3)	Yes - 1
	a. Anticonvulsants	No - 0
	b. Uterotonics	
	c. Antibiotics	
	d Vacuum Extraction kits	
	e MVA Kits	
	f. Eye drops/ointment.	
	g. Vitamin K1	
	h. Chlorhexidine gel	
	i. Oxygen	
	j. Pulse oximeter	

	k. Bag and mask	
	l. Protective wear	
Protocols and Guidelines	16. Does the facility have safe motherhood protocols?	PPH flow chart
		Administration of Magnesium Sulphate
	17. Does the facility have essential newborn care guidelines?	Neonatal Resuscitation
		Manual Removal of Placenta
		AMSTL
		Partograph Use
		Management of Hypertensive Disorders
Transport and Referral	18. Is there an arrangement with the National Ambulance Service?	Emergency Contacts
		Memorandum of Understanding (MOU)
	19. Is there a transport arrangement available at this facility other than the ambulance service?	
CLINICAL GOVERNANCE	20. Has the facility received any supervision in the past 3 months?	
- Supportive Supervision		Region
		District
		Sub-district
CLINICAL GOVERNANCE	21 Does the facility have records of Maternal and Neonatal morbidity and mortality audit conducted in the past 12 months	
- Maternal and Perinatal Morbidity and Mortality Surveillance		Yes - 1
		No - 0
MENTORSHIP	22. How many EmONC related trainings have been done at the facility	- Training done for facility staff.
		- Training done for staff from other facilities

ANNEX XI: BEmONC Availability and Readiness Verification Tool

BEmONC AVAILABILITY AND READINESS VERIFICATION TOOL (For yearly Verification of the DLIs)

Area	Question	Options	Scoring
Human Resource	1. Number of Practicing midwives in the facility?	1 midwife 2 midwives 3 midwives 4 or more midwives	***YES = 2 or more midwives for more than 9 months*** ***No= Less***
Signal Functions	2 a. Have you administered uterotonics (oxytocics) in the past one year?	Yes - 1 No - 0	
	2b. Have you administered parenteral antibiotics in the past one year?	Yes - 1 No - 0	***Yes = Provision of at least Four or More Obstetric signal Functions and 5 Newborn Signal Functions in a year.***
	2c. Have you administered parenteral anticonvulsants in the past one year?	Yes - 1 No - 0	
	2d. Have you performed manual removal of placenta in the past one year?	Yes - 1 No - 0	
	2e. Have you performed instrumental removal of retained products in the past one year?	Yes - 1 No - 0	
	2f. Have you performed instrumental /vacuum extraction/assisted vaginal delivery in the past one year?	Yes - 1 No - 0	
	2g. Have you performed neonatal resuscitation with bag and mask in the past one year?	Yes - 1 No - 0	***No = Less***
	2h. Have you administered parenteral antibiotics to newborns in the past one year?	Yes - 1 No - 0	
	2i. Have you administered oxygen therapy with pulse oximeter monitoring to newborns in the past one year?	Yes - 1 No - 0	
	2j. Have you provided immediate Kangaroo Mother Care in the past one year?	Yes - 1 No - 0	
	2k. Have you provided early initiation and support for exclusive breast feeding in the past one year?	Yes - 1 No - 0	
Commodities and Supplies	3. Has the facility been stocked out of any one of the following categories (Ref. EmONC Model 3)	Yes - 1	
	a. Anticonvulsants	No - 0	***Yes = No Stock Out of essential commodities and supplies for more than One Month***
	b. Uterotonics		
	c. Antibiotics		
	d. MVA Kit		
	e. Vacuum Extraction kit		
	f. Eye drops/ointment.		***No = Stock out more than one month in a year***
	g. Vitamin K1		
	h. Chlorhexidine gel		
	i. Oxygen		
	j. Pulse oximeter		
	k. Bag and mask		
	l. Protective wear		

Protocols and Guidelines	4. Does the facility have safe motherhood protocols?		***Yes = Availability of Safe motherhood protocol in the facility*** ***No = Less***
Transport and Referral	5. Is there an arrangement for referral and transport?	Emergency Contacts	***Yes = Referral Register Available*** ***No = No referral register***

A health facility has to score "Yes" in all five domains to be considered Quality BEmONC for deliveries to be counted

MODE OF REPORTING AND VERIFICATION

Option A

The BEmONC Availability and Readiness Verification Tool will be filled quarterly by the midwife in charge of health centre and submitted to the District Director of Health Service for onwards submission to the Regional Director of Health Service through the Public Health Nurse. The BEmONC Availability and Readiness Verification Tool will be applied to determine the yearly score for each facility.

Option B

The BEmONC Availability and Readiness Verification Tool will be filled quarterly by the Clinical Monitoring and Supervision Team to each facility and submitted electronically through an app or Kobo collect application to the national level (FHD) where the BEmONC Availability and Readiness Verification Tool will be applied yearly to determine the score of each facility. Facilities that score YES in all five domains will be considered Quality BEmONC for the year and all deliveries will be counted. This verification process is expected to be done in the first week of December each year and deliveries counted in retrospect.

ANNEX XII: EmONC Signal Functions

Emergency Obstetric and New-born Care (EmONC)
Signal Functions (updated from Istanbul meeting 2023)

Basic Obstetric

1. Administer medications to treat PPH.
2. Administer parenteral antibiotics.
3. Administer magnesium sulfate.
4. Remove retained products of conception.
5. Perform manual removal of placenta.
6. Provide IV fluid replacement therapy.
7. Assisted vaginal delivery*

Comprehensive Obstetric

1. Administer antenatal Corticosteroids.
2. Performing caesarean section surgery to deliver a baby.
3. Availability of blood transfusion services.

Basic Neonatal

1. Perform newborn resuscitation with bag and mask.
2. Initiate and support early and exclusive breastfeeding.
3. Administer parenteral antibiotics.
4. Practice immediate kangaroo mother care for preterm and LBW infants*
5. Administer oxygen therapy with pulse oximeter monitoring for stabilization and transportation Perform Newborn resuscitation with bag and mask.

Comprehensive Neonatal

1. Provide CPAP (Continuous Positive Airway Pressure)
2. Provide Phototherapy
3. Perform Exchanged Transfusion

EmONC Essential Medicines, Commodities and Supplies

1. Oxytocin
2. Antibiotics
3. Anti-convulsant
4. Long gloves (Sterile)
5. MVA Kits
6. Vacuum extraction kits
7. Eye drops/ointment.
8. Vitamin K1
9. Chlorhexidine gel
10. Other protective equipment
11. Oxygen
12. Pulse oximeter
13. Bag and mask
14. CPAP
15. Phototherapy

Protocols/Guidelines and Job Aids for EmONC Services

16. National Safe Motherhood Protocols,
17. National Reproductive Health Policy and standards
18. Essential Newborn are Guidelines
19. Comprehensive Abortion Care Service Guidelines
20. Job Aids

1. Postpartum haemorrhage
2. Puerperal sepsis
3. Hypertensive disorders of pregnancy
4. Administration of Magnesium sulphate
5. Manual removal of placenta
6. Active management of third stage of labour
7. Newborn health care
8. Helping babies breathe action flow chart

* In those babies who do not need special newborn care. Those who need level 2 care should be referred to Comprehensive EmONC.
NOTE: In countries where providers are authorised and trained to perform assisted vaginal birth at Basic EmONC level, it should be included as a SF in Basic EmONC level [as well as Comprehensive CEmONC level].

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